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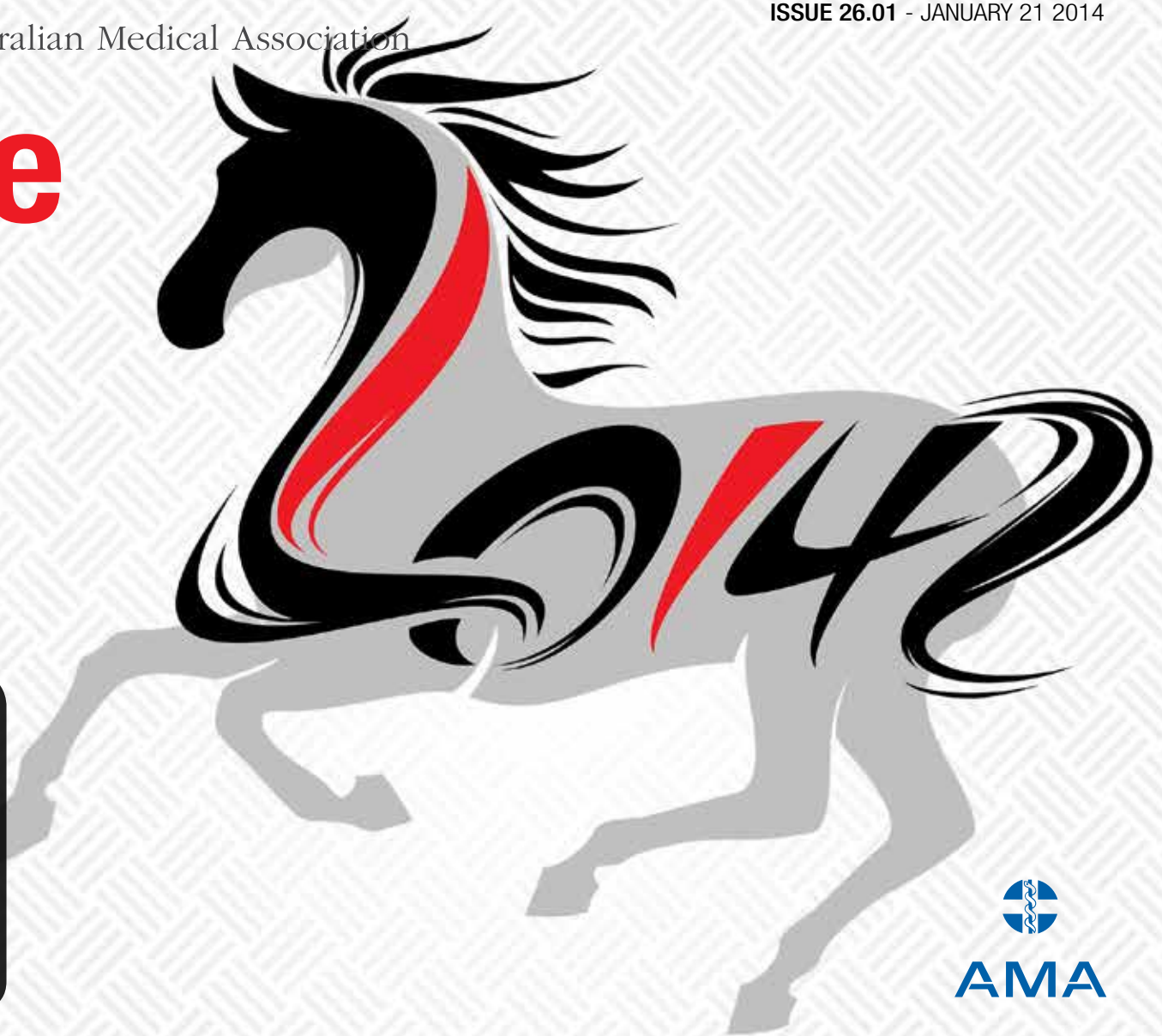
2014: Time for action

Health leaders and thinkers set their top priorities for Year of the Horse, p11

Steve Hambleton * Chris Baggoley * Mukesh Haikerwal * Lesley Russell * Stephen Leeder * Martin Laverty * Brian Morton



INSIDE

AMA

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In this issue

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PRESIDENT'S MESSAGE

BY AMA PRESIDENT
DR STEVE HAMBLETON

2014 holds promise, though funds look tight

Welcome to 2014. Before we all plunge into another hectic year caring for our patients and keeping up with demands of a busy practice, I thought it was important to pause for a moment to reflect on what it is we collectively achieve on a daily basis.

Glance at any international ranking of population health and medical care quality and Australia is consistently at, or very close to, the top.

Life expectancy in Australia is around the third highest in the developed world, cancer survival rates are up, infant mortality (apart from in Indigenous communities) is very low and smoking rates are dropping.

Of course, there remain plenty of health challenges.

Probably the major challenge for the future is our rate of obesity. Australia is now one of the fattest nations on earth, bringing with it all the attendant chronic health problems such as diabetes, cardiovascular and cerebrovascular disease, premature joint wear and renal disease.

The country is yet to close the yawning gap between the health of Aboriginal and Torres Strait Islander people and the rest of the community. We need to implement the recommendations that the AMA has repeatedly made in our Aboriginal and Torres Strait Islander health report cards (see https://ama.com.au/2012-13-ama-indigenous-health-report-card-healthy-early-years-getting-right-start-life).

> "Glance at any international ranking of population health and medical care quality and Australia is consistently at, or very close to, the top"

But there is much that, collectively, the medical profession should be very proud of.

The facts don't lie – we serve our patients very well.

What is more, we are delivering very high quality care at a fraction of the price paid in many other developed countries, particularly the United States.

This doesn't mean that things can't be done better.

As every practitioner knows, several health reforms and initiatives introduced in recent years have fallen well short of the mark.

To take just two examples, the Personally Controlled Electronic Health Records (PCEHR) system has, in its current form, proven to be of little clinical benefit, while Medicare Locals have, by and large, failed to add much to primary health care despite substantial taxpayer investment.

But on both these fronts 2014 promises to be a better year.

I was part of a three-member review panel that has recommended a number of substantial changes to the PCEHR. While I can't go into detail, it is clear that the Government wants to overhaul the program to realise all the advantages a proper electronic health system can bring.

And, just before Christmas, Health Minister Peter Dutton gave the AMA and doctors an early present by delivering on his promise to initiate a review of Medicare Locals.

It will come as no surprise to you that an AMA survey of more than 1200 GPs, conducted in December, found widespread dissatisfaction with Medicare Locals and the way most have so far operated.

Initial goodwill toward Medicare Locals has since soured in many areas because of a perceived lack of consultation, relevance or support when it comes to providing primary health care.

A common refrain has been that Medicare Locals have provided little or no assistance for the respondent's practices in preparing for the PCEHR, and their administration of after-hours GP care has increased complexity, reporting requirements and red tape.

Reflecting widespread disillusion, almost 72 per cent of GPs surveyed by the AMA felt their Medicare Local had done nothing to improve the delivery of primary care and ought to be abolished.

The AMA has presented this detailed feedback to the review, led by former Chief Medical Officer Professor John Horvath, and has high hopes that when he reports in March, Professor Horvath will recommend substantial reforms – not least increased numbers of GPs at the governance level to provide practical, grass roots advice on what is needed, and what works in each area.

MORE P4

PRESIDENT'S MESSAGE

2014 holds promise, though funds look tight

... FROM P3

I will be meeting with Professor Horvath in early January to press our case in person.

Other challenges remain.

The Government's contribution to the cost of providing health services continues to go backwards – Medicare rebates will remain frozen until the middle of the year, and there is no prospect that the gap between the Medicare schedule and the actual service cost will narrow any time soon.

Add to this the speculation about a mandatory patient co-payment for bulk billed GP services, and it is clear health costs will be a major issue in 2014, just as they have been in recent years.

Like all countries in the world, we know that health care costs are growing at an unsustainable rate. We do need to participate in prescribing a solution.

It is not just the health portfolio, though, that needs attention.

Frankly, fees are not the problem.

We need affordable housing. We need to ensure good access to early childhood education. We need to make it easier to eat the right quantity of the right food, and to get the exercise we need.

We need better urban design to make it easier and safer to walk or cycle to schools, shops and places of work.

We need to tackle the scourge of alcohol misuse, and to protect our youth from exposure to its advertising.

There is much to be done and, once again, the AMA will be looking out for the interests of its member practitioners and their patients, doing its best to ensure sensible policies and outcomes that keep the country near the top of the table when it comes to the health and wellbeing of Australians, while keeping it affordable and sustainable.

COMMENT

"There is much to be done and, once again, the AMA will be looking out for the interests of its member practitioners and their patients..."

INFORMATION FOR MEMBERS

Free tool to track registration requirements

The AMA has developed a free online tool to help doctors to keep track of the information they need to meet the Medical Board of Australia's annual continuing professional development (CPD) requirements.

Each September, practitioners, when renewing their Medical Board registration, may be required to provide evidence they have complied with the Board's CPD requirements.

The AMA CPD Tracker has been developed to enable doctors to progressively gather and organise the information needed to substantiate declarations made to the Board about CPD, so that evidence can be quickly and easily produced on demand.

The AMA CPD Tracker can be used to:

- List courses completed, including the organisation that accredited the CPD activity;
- Store all certificates of completion;
- Keep a log of practice-based reflective activities, including clinical audits, peer reviews and perfomance appraisals; and
- Log hours spent on online learning, reading journals, teaching and other activities.

The system keeps a tally of hours, enabling practitioners to keep track of what needs to be completed before the end of the registration year.

The Tracker has been developed taking full account of the requirements set out in the Medical Board's Continuing Professional Development Registration Standard.

The service is free to AMA members. Non-members can subscribe for an annual fee of $250.

To register for the product, please sign up here.

BY AMA SECRETARY GENERAL ANN TRIMMER

AMA adapting and preparing for important year in health policy

The start of a new year brings the breathing space to consider the year ahead after the pre-holiday rush, Christmas festivities and time away from the office. The coming year presents many opportunities to refresh the AMA's activities, build on work already underway and identify priority areas for attention.

As President Dr Steve Hambleton outlined in the last issue of *Australian Medicine* (16 December 2013), the Federal Council has approved substantial changes to the governance structure of the AMA which, if adopted by members at the Annual General Meeting in May this year, will provide a platform for a more agile organisation in the future. By creating a governance board of directors, the Federal Council will be freed to focus on the breadth of policy issues that affect health care in Australia.

These governance changes provide the opportunity for a more flexible structure for Federal Council deliberations, with the possibility of using small working groups and task forces to develop contributions to health policy debates, drawing on the expertise of specific members when we need to.

The AMA secretariat is starting the year with a day-long examination of major health policy issues, and the identification of emerging areas for attention by the next President and Federal Council, who will take office at the National Conference in May. The AMA should set the direction of the conversation in many areas of health care that affect doctors and their patients. Time spent analysing priorities and developing strategies is time well-spent.

The year has started with a heated debate about patient co-payments following a proposal for a compulsory contribution of $6 per visit. The quality of commentary has been variable, but what it has shown is the very high level of interest in constraining expenditure in our health system. Patient co-contribution is not the simple solution some have made it out to be. As always with health policy, the issues are more nuanced and deserve a more considered analysis. Health financing has always been a priority area for AMA policy consideration, and 2014 is shaping up as the year in which the AMA needs to tease out policies which will meet the long term interests of the profession and its patients.

Also high on the priority list are the many public health issues that affect health system costs and individual wellbeing. Public health policy is a growing portfolio within the AMA, covering topics as diverse as obesity, alcohol advertising, immunisation, air quality, and the sexualisation of children.

Late in 2013 the AMA leadership – State and Territory AMA Presidents and the Executive Council – spent time developing a roadmap for the strategic direction of the AMA, and this will inform many of our member-directed activities in 2014. It is some time since the AMA asked its members what they look for from the peak advocacy organisation for doctors, and so a member survey is on the agenda for 2014.

> "Public health policy is a growing portfolio within the AMA, covering topics as diverse as obesity, alcohol advertising, immunisation, air quality, and the sexualisation of children"

Doctors can be overwhelmed with communications. Some of it you no doubt find very useful, other communications less so. A key project for early 2014 is the launch of a doctor-focused portal which will be the repository of tools and information that will be of value in day-to-day practice. Look out for the launch – and let us know whether it meets your needs, and what additional tools or information will improve the site.

Best wishes for a productive and rewarding 2014.

$6 co-payment an illusory health saving

A proposed $6 patient co-payment for bulk billed GP and emergency department visits is an ill-conceived measure that fails to address the long-term causes of rising health costs, the AMA has warned.

As the Federal Government searches for ways to slow growth in health spending, concerns are mounting that it may adopt the patient co-payment suggested by Terry Barnes, a former health adviser to Tony Abbott, in a submission to the high-powered National Commission of Audit.

But AMA President Dr Steve Hambleton and a chorus of other health and economics experts warn that the idea would be, at best, a short-term expedient likely to come at the cost of an even greater national health bill in the future.

Mr Barnes, in a report for the Australian Centre for Health Research think-tank, said a $6 co-payment for each of the first 12 bulk billed visits to a GP each year would, if GP rebates were frozen as an incentive to take the co-payment, save the Government $750 million over four years and act as a deterrent for those seeing doctors unnecessarily.

"I make no apology for suggesting a modest price signal at point of access, provided that it doesn't deter people from going to the doctor," Mr Barnes wrote in *The Australian*, but added "world-leading health care comes at a price, and if small co-payments help some people reflect before they call on that system, surely that's not a bad thing."

He said the $6 amount was "the equivalent cost of a hamburger and chips or a schooner of beer", and the Commission needed to consider such "tough but fiscally fair" measures, not just for GP services, but for "health and other welfare infrastructure".

While the Government has made no formal response to the proposal, in an interview with Fairfax Media, Health Minister Peter Dutton said "it would be foolish to rule out ideas people are putting forward", and flagged the need for an overhaul of the Medicare system.

Mr Dutton said Medicare spending was growing at a rate that could become unsustainable, and there needed to be change.

The annual Medicare bill has climbed in the past decade from $8.1 billion to $17.8 billion, and the frequency of GP visits has jumped from 4.3 per person in in 2003-04 to 5.59 between April 2012 and March 2013.

"The threshold question is whether people want the health system of today strengthened for tomorrow, because at the moment the health system is heading to a point where it will become unmanageable," the Minister said.

One of the many problems identified by critics with the co-payment proposal is a lack of clarity about what problem it is primarily intended to address – is it perceived GP over-servicing or growth in health spending?

Either way, Dr Hambleton warned that targeting GP services for savings was a false economy that would lead to greater costs down the track.

General practice was the most efficient part of the health system, he said, helping minimise the number of people who ended up needing far more expensive hospital or chronic care.

Dr Hambleton said it was unclear that there was much of a problem with unnecessary use of GP services, and the greater concern was putting barriers in the way of people seeking relatively inexpensive GP treatment for health complaints that might develop into much more expensive and serious problems if not treated early.

"The main problems we've got with our health system are the growing amounts of chronic disease and our ability to treat lots of diseases that we couldn't treat that well in the past," he said.

"Our concern is that both people who need to go [to the doctor] and who don't need to go, will not go [because of the co-payment]," he told ABC radio.

Dr Hambleton said a particular concern was that a co-payment would deter people from going to their doctor for preventive health reasons, which were likely to be viewed as discretionary.

"That is the thing that is going to save us money in the long-term.

"If we're really thinking about long-term health care costs, we've got to talk about health maintenance, keeping people out of hospital.

"We should be targeting things like tobacco, alcohol, over-nutrition and under-exercise. That's where the real payback's going to be."

Grattan Institute health economist Professor Stephen Duckett said the proposed co-payment would have a disproportionate impact on the poor, and would likely result in people deferring both necessary as well as 'unnecessary' visits to their doctor.

As Fairfax economics correspondent Peter Martin put it, "the charge would apply to all visits to the doctor, both serious and frivolous. And we are not skilled at deciding what's frivolous. That's why we go to the doctor."

Writing in *The Australian Financial Review,* Professor Duckett said encouraging people to defer necessary visits to the doctor will only increase "downstream costs, as problems put off become more expensive to treat later."

"Although a $6 slap-down of consumers may be fiscally attractive, it does nothing to change the fundamentals of the health system, and is a distraction that does more harm than good," he said.

In its submission to the Commission of Audit, the AMA recommended a raft of changes to cut down on red tape and improve the efficiency and productivity of GP services.

It called for the PBS authority prescription system to be axed, for doctors to be allocated a single Medicare provider number, for Medicare payment processes to be streamlined, and for Medicare Locals to be reformed.

See also *GP co-payment no way to cut health costs* by Dr Lesley Russell, p32.

Adrian Rollins

COMMENT

Medibank's GP cover threatens universal health

A Medibank Private scheme to give members priveleged access to a range of GP services threatens to create a two-tier health system and could fracture the relationship patients have with their family doctor, the AMA has warned.

As the Federal Government proceeds with preparations for the sale of Medibank Private, it has been revealed by *The Australian* that in November the insurer commenced a trial with medical centre operator IPN in which its members are bulk-billed for GP consultations and get access to several service "enhancements", including guaranteed appointments within 24 hours and after-hours home visits.

The arrangement is so far being trialled at six IPN clinics in south-east Queensland (including one at which AMA President Dr Steve Hambleton practises), and it circumvents a Private Health Insurance Act prohibition on insurers paying for services that are eligible for Medicare rebates by limiting Medibank Private funding to assistance with covering the administrative and management costs of the trial.

But AMA Council of General Practice Chair Dr Brian Morton said the scheme violated the spirit of the law, and corroded basic principles regarding equity of access to care.

Dr Morton said that although the AMA wanted to see health insurers more involved in primary health care, the approach being trialled by Medibank Private was flawed.

"We do want to involve private health insurers in general practice, but we don't really see this as the best way of doing it," Dr Morton told *The Australian*, adding that any provision to allowed funds to cover primary health services should be open to all patients and GPs.

Anticipating that private funds might seek to give their members privileged access to GP services, the AMA in 2006 released a *Private Health Insurance and Primary Care Services Position Statement* (https://ama.com.au/position-statement/private-health-insurance-and-primary-care-services-2006) setting out the parameters for the expansion of health fund into primary health care and the dangers that needed to be avoided.

In its Statement, the AMA said that a "limited" expansion of private insurers into primary care may be of some benefit, but only where it provides or pays for services not covered by Medicare.

"There are inherent risks in supporting an expansion of health insurance fund services into primary care," the Position Statement said, noting especially that "limiting certain services to those who can afford private health insurance, particularly those related to preventive health measures, represents the establishment of a two-tiered system."

Other concerns identified by the AMA included the potential for the focus of health services to shift from quality and continuity to cost cutting; for insurers to develop models for rationing care; for the development of imprecise patient selection techniques; for a shift away from the provision to patients of information and education "related to their health needs"; and for patients being encouraged to visit participating GPs, who may or may not be their regular family doctor.

In its Position Statement, the AMA warned that any scheme or arrangement that created such risks or undermined the universality and equity of Medicare "will be rejected by the medical profession".

But so far the Federal Government has adopted a hands-off approach to the Medibank trial.

Health Minister Peter Dutton told *The Age* that he saw no evidence that the arrangement contravened the legislation, and appeared to give some encouragement to the initiative in a statement to *The Australian Financial Review.*

"I want every Australian to have a good relationship with their GP, so I wouldn't rule out any changes," Mr Dutton said. "Like the Australian Medical Association, I am open to greater involvement of the insurers, who cover 11 million Australians, to keep those people healthy and getting more regular access to primary care."

Aside from equity issues and potential distortions in the allocation and delivery of health services, critics warn Medibank-style arrangements could drive a surge in the Government's Medicare bill and the cost of its private health insurance rebate while forcing down the extent of GP bulk billing and raising doctor fees.

In a note obtained by *The Australian Financial Review*, the Health Department in 2008 estimated the scheme would spur a 5 per cent increase in demand for GP services and GPs would increase their fees, adding a massive $3.4 billion to the Government's Medicare rebate bill over five years.

In addition, because the initiative would likely boost private health insurance membership, the Government would also be liable for a $400 million increase in the private health insurance rebate, and GPs would likely reduce the extent to which they bulk billed patients.

The nation's second largest health fund, Bupa, has joined the criticism, warning that although insurance cover for GPs charges would likely be a boon for providers, it would drive up the Government's health bill.

The trial arrangement, and a suggestion that Medibank could assume responsibility for helping to administer the National Disability Insurance Scheme, has prompted speculation the Government is trying to boost the interest of investors in the purchase of the health fund, whose possible privatisation is currently the subject of a scoping study.

The pilot of private health cover for GP services has also come as the National Commission of Audit ponders a proposal for a $6 charge for GP visits [see also, *$6 co-payment an illusory health savin*g, p6].

Adrian Rollins

COMMENT

Govt told to think GP on Medicare Locals

The AMA has urged the Federal Government to transform the Medicare Locals system into a GP-led network of primary health care organisations amid widespread doctor dissatisfaction with its performance.

Calling for a fundamental overhaul of the $1.8 billion Medicare Locals structure set up by the Rudd Government to replace the Divisions of General Practice system, the AMA said there was "little evidence" it had resulted in any improvement in health care despite a massive injection of taxpayer funds.

> "The AMA delivered the unflattering assessment in its submission to a Government-initiated review of Medicare Locals overseen by former Chief Medical Officer Professor John Horvath"

The AMA delivered the unflattering assessment in its submission to a Government-initiated review of Medicare Locals overseen by former Chief Medical Officer Professor John Horvath.

The Horvath review's wide-ranging remit reflects the Government's scepticism about Medicare Locals in their current form, and its desire to pare back spending on what is sees as unnecessary bureaucracy and red tape.

Though in the lead-up to the Federal election Health Minister Peter Dutton backed away from an earlier commitment to abolish Medicare Locals, the review's terms of reference show he is far from convinced they should continue to operate, at least in their present form.

Professor Horvath has been asked to assess and report on the role of Medicare Locals and their performance against stated objectives; the extent to which they consume funds that would otherwise go to support clinical services; the degree to which they work in with Local Hospital Networks and other health services; the extent to which they support rather than compete with or hinder existing clinical services; and their ability to administer contracts and tenders.

In keeping with his rhetorical emphasis on the centrality of GPs to health care,

Mr Dutton has also asked the review to report on the extent to which Medicare Local functions and arrangements embody the concept of general practice as "the cornerstone of primary care".

The terms go to several of the AMA's core concerns with Medicare Locals, particularly the perceived marginalisation of GPs in their governance and operations and, related to this, a reluctance to consult with and listen to practitioners - most emblematically demonstrated in the botched administration of after-hours GP service contracts, many of which have had to be re-written because of onerous conditions.

AMA President Dr Steve Hambleton said the review was a welcome opportunity to overhaul the system and replace it with something much more useful and worthwhile.

"We recognise the need for a network of primary health care organisations to improve the integration of health services within primary health care, and to improve the interface between primary care and hospitals, but the current Medicare Locals model has not delivered," Dr Hambleton said. "The performance of Medicare Locals against their objectives has been patchy, and there is little evidence of improvement over the divisions of general practice structure they replaced, despite significant additional funding."

MORE P9

Govt told to think GP on Medicare Locals

... FROM P8

Health funding

The Government has framed the review in the context of a sharp deterioration in Commonwealth finances, underlining its warnings about the need to rein in spending.

Mr Dutton announced the review a day before the 17 December release of updated Budget figures showing a revised deficit in 2013-14 of $47 billion, up almost $30 billion from the May 2013 Budget estimate.

The update showed a blowout in health spending, with expenditure on the Medicare Benefits Schedule forecast to be almost $660 million greater than anticipated over the next four years.

Mr Dutton said the Government's priority in commissioning the Medicare Locals review was to ensure that health funding was used as effectively as possible.

"We are committed to reducing waste and spending on administration and bureaucracy, so that greater investment can be made in services that directly benefit patients and support health professionals who deliver those services to patients," the Minister said.

In its submission, the AMA argued that, in terms of effective use of taxpayer funds, Medicare Locals had so far fallen short.

It cited as an example the administration of GP after-hours care funding by Medicare Locals, which had been characterised by increased red tape and compliance costs for general practices.

Similarly, it reported that 50 per cent of more than 1200 GPs surveyed by the AMA found that their Medicare Local was duplicating existing services, not only wasting scarce health funds but providing unfair competition from an organisation that was meant to be supporting them.

The AMA said Medicare Locals suffered from a lack of input from GPs, who had an intimate knowledge of local health needs and gaps in services.

In its submission, it lamented that "from the outset, there was a concerted effort by the former Government and the Department of Health to dilute the role of GPs in governance arrangements for Medicare Locals. The current model is designed to deliberately constrain the level of GP input and leadership".

It argued that the inclusion of GPs at the highest levels of local leadership was fundamental to ensuring a strong and well-coordinated primary care system that could deliver good health outcomes and relieve pressure on beleaguered public hospitals.

Unsurprisingly, the Australian Medicare Local Alliance said the Horvath review would find the current network of 61 Medicare Locals was working well and delivering tangible and cost-effective benefits for patients and the Government.

AMLA Chair Dr Arn Sprogis said the review was an opportunity to measure and demonstrate what Medicare Locals had achieved, individually and collectively, "in a very short period of time".

Dr Sprogis said Alliance members had reduced hospital demand and costs by "keeping people well", had ensured more bang for taxpayer funds by tailoring and targeting local health services and cementing general practice as the cornerstone of primary care.

"Each of the 61 Medicare Locals has shifted the emphasis from a centralised approach to primary care to a system that is focused on service delivery at the local community level and, importantly, by reducing the bureaucracy," he said.

Professor Horvath has been directed to provide his recommendations to the Government by March, in time for any changes to form part of Budget deliberations.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

What to consider before ditching Warfarin

A guide to help GPs decide whether a patient currently taking Warfarin needs to be switched to another oral anticoagulant has been produced by the Department of Veterans' Affairs.

The guide, *The oral anticoagulant dilemma*, talks practitioners through the issues to consider when assessing whether a patient currently using Warfarin would benefit from being placed on one of three novel oral anticoagulants – Dabigatran, Apixaban and Rivaroxaban – listed on the Pharmaceutical Benefits Schedule.

The guide, prepared as part of the Department's *Veterans MATES* project, has been sent to 7100 GPs who, according to Repatriation Pharmaceutical Benefits Scheme data, treat patients taking oral anticoagulants.

The brochure cautions that patients on warfarin should not be changed onto another oral anticoagulant without careful consideration.

"We need to be careful that marketing promotion and familiarisation programs do not drive a needless trend to switch patients currently taking Warfarin to the new agents for perceived ease of use or claims of superior safety or efficacy," the guide says. "An informed decision and careful patients selection is recommended when considering treatment options, as many patients may not benefit from switching to the new agents."

A companion guide for patients, *New medicines: weighing up the benefits and risks*, will be distributed next month to veteran patients who had been dispensed at least two oral anticoagulant prescriptions between April and July the year.

For more information, including other topics covered by the *Veterans MATES* project, visit: www.veteransmates.net.au

Medicare Locals are duds: GPs

An overwhelming majority of doctors think their Medicare Local has done nothing to improve health care and ought to be scrapped, according to an AMA survey.

In a damning indictment of the previous Government's ambitious $1.8 billion replacement for the Divisions of General Practice system, almost 75 per cent of 1212 GPs surveyed by the AMA said the establishment of Medicare Locals had not resulted in any improvement in access to, or delivery of, primary health care, and should be scrapped.

The result reflects widespread disenchantment among GPs with Medicare Locals, not least regarding the inept and heavy-handed administration of after-hours GP care service funding, including the imposition of onerous contract conditions, and a lack of practical support for medical practices.

More than 55 per cent of GPs surveyed reported that the after-hours GP care access arrangements put in place by their Medicare Local were inadequate, and almost 46 per cent complained the contracts put in place were unfair and unreasonable.

Similarly, 57 per cent reported that the support they received from their Medicare Local in preparing themselves for the Personally Controlled Electronic Health Record system was "not effective".

In a damning outcome for an organisation meant to identify and fill gaps in care, virtually half of all respondents said Medicare Locals were duplicating existing GP services.

One observed that: "It appears that Medicare Locals are becoming more and more our competitors. I have a strong and respectful relationship with my local medical surgery competitors, however that cannot be said for our Medicare Local".

Reflecting widespread frustration that Medicare Locals were not heeding local expertise, almost 70 per cent of GPs said their Medicare Local had failed to engage with them about the design of health services needed in the area, and more than 60 per cent felt that their Medicare Local did not recognise or value their input.

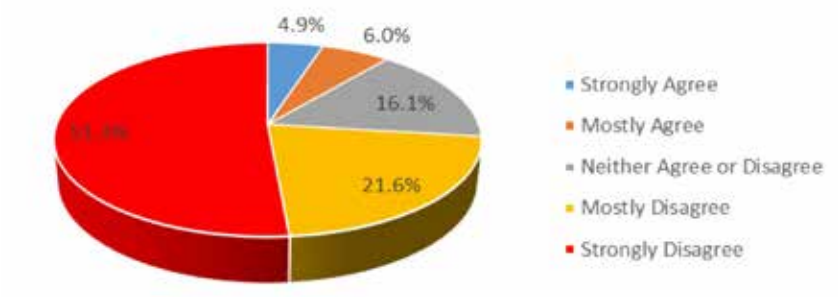
One survey respondent commented that: "I am a [Medicare Local] Board member, and I am sorry to say that the Medicare Local has been a failure in engaging with GPs. It has an adversarial attitude to general practice, which was the result of an acrimonious union of two divisions [of General Practice]".

Adrian Rollins

AMA Medicare Local survey

Performance in comparison to the former division of general practice

My Medicare Local has improved local access to care for patients in comparison to the former division of general practice:

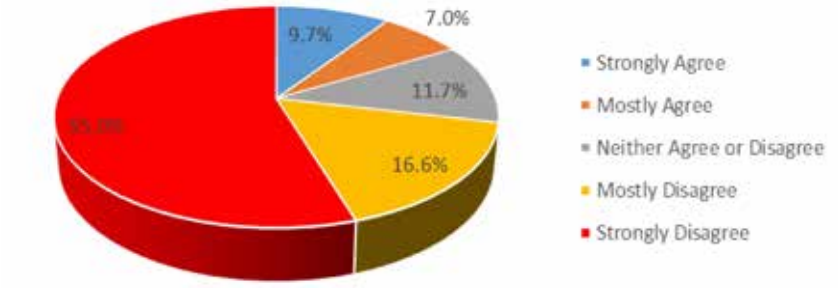


Key points:

- About three-quarters (73.0%) of respondents disagreed with the statement, 10.9% agreed and 16.1% neither agreed nor disagreed.
- The overwhelming majority of GPs surveyed believed Medicare Locals had not improved local access to care for patients in comparison to the former Division of General Practice.

Overall delivery of primary care

My Medicare Local has improved the delivery of primary care overall and should be retained:



Key points:

- A significant majority (61.9%) of respondents disagreed with the statement, 9.7% of respondents agreed with the statement and 28.5% neither agreed nor disagreed.
- The findings suggest Medicare Locals do not have effective programs to provide patients in aged care facilities with access to allied health services in a timely fashion.

COMMENT

The five most pressing health priorities in 2014

Trying to identify just five top priorities in an area as complex and ethically fraught as health care is a tough challenge, but that was the task *Australian Medicine* set for seven of the nation's leading health advocates and thinkers, including AMA President Dr Steve Hambleton, the nation's Chief Medical Officer Professor Chris Baggoley, health policy expert Dr Lesley Russell and World Medical Association Council chair Dr Mukesh Haikerwal. Here they provide their thought-provoking and insightful responses.

AMA President Dr Steve Hambleton

1. Make population health a cross-portfolio priority for all levels of government

Population health is not just about treating illness. It's also about keeping people well, and all portfolios (Agriculture, Defence, Education, Employment, Environment, Finance, Foreign Affairs and Trade, Health, Immigration and Border Protection, Industry, Infrastructure and Regional Development, Social Services, Treasury etc) need to do their part to fight the threat of non-communicable diseases which stem from tobacco, alcohol, over-nutrition and under-exercise.

2. Continue the investment in closing the life expectancy gap between Aboriginal and Torres Strait Islander peoples and all Australians

All governments need to keep up the investment, but not just in the health portfolio. There is stark evidence that investing in the social determinants of health and a good education, starting at birth, are major predictors of health outcomes.

3. Fix e-health and the PCEHR

We must be able to talk to each other in the same language -general practice, hospitals (public and private), public outpatients, private specialists, aged and community care. Too often the right message just does not get through. Let's get the (e) rail gauge right and use it.

4. Reduce unwarranted clinical variation

The fastest way to save health dollars and achieve better outcomes is to (as Professor Lord Ari Darzi advised at the 2012 AMA National Conference) "close the gap between what we know and what we do". We know we are doing a good job and are very cost effective. If we embrace the move of learned colleges toward clinical audit and self-reflection we can make best practice even better.

5. Invest in research

The human papillomavirus vaccine will save millions of lives. Research delivered and refined the place of statins, also saving millions of lives. We need new ways of treating infections, perhaps more antibiotics or better ways to use the ones we already have.

MORE P12

SPECIAL FEATURE

The five most pressing health priorities in 2014

... FROM P11

Professor Chris Baggoley, Australian Government Chief Medical Officer

It is not easy to nominate five priority areas for action, given that there are so many deserving areas that require our ongoing attention. Of course, in my role there are a number of areas where my direct involvement is needed to help made a difference.

Understanding that this list excludes other equally deserving priority areas, my list is:

1. Antimicrobial Resistance, where concerns we are facing a post antibiotic era are widely shared across the globe.

Australia is taking a leading role: we have adopted a One Health approach, a safety and quality approach (via the National Standards), and we are increasing our surveillance of resistant microbes and antimicrobial usage.

2. Emerging Infectious Diseases.

The appearance of avian influenza H7N9 in China in 2013, and the Middle East Respiratory Syndrome Coronavirus in 2012-13, has redoubled the focus of all areas of the health system to prepare to manage emerging infectious diseases, and this must remain a focus for 2014.

3. Immunisation coverage.

Public interest in the benefits of high levels of childhood immunisation was a particular feature of 2013, especially following the National Health Performance Authority report breaking coverage down to Medicare Local and postcode areas. Vaccine-preventable diseases should be prevented, and our attention to this aspect of health care in all areas must remain a priority.

4. Dementia.

While the first three areas are part of my daily work, this is not the case for dementia. Nonetheless, the case for research into the causes and prevention of dementia is apparent to all of us.

5. Improving the nation's mental health.

Much work is underway to improve our mental health. Improved community and professional understanding and reduction in stigma will assist sufferers of mental health illness to seek help, and assist their recovery.

Dr Lesley Russell, Visiting Fellow, Australian Primary Health Care Research Institute, Australian National University

National

1. Addressing health disparities

Prime among these is the need to Close the Gap on health disparities for Indigenous Australians, but we should not forget the disparities suffered by people with mental illness, people with disabilities, the homeless, and those who are isolated, both geographically and socially. These gaps will only be closed by a broader focus on the social determinants of health through a whole-of-government approach.

2. Changing the way we pay for healthcare services

It's time to move away from fee-for-service to a financing system that is (1) focused on value rather than volume; (2) rewards improved health outcomes and cognitive services as much as procedures; (3) encourages effective teamwork and collaboration; and (4) recognises time dedicated to education, mentoring, research, essential paperwork and communication.

3. Reworking the healthcare workforce

If we are to address the health and healthcare needs of the 21st century in a country as large and diverse as Australia, then we need an appropriate workforce and a system that enables every healthcare profession to work to full scope of practice. That means widening who can prescribe and who can work independently. The new workforce must include more Aboriginal and Community Health Workers to assist with outreach, education, care coordination and cultural sensitivity.

International

4. Antibiotic resistance

The growing threat of multiple resistance requires a major international effort involving the agriculture, food and health sectors and an increased focus on research to deliver solutions and new antibiotics.

5. Climate change

Everyone's way of life and even national security is under threat from climate change. Developed nations like Australia must show leadership in tackling both the causes and the impacts. In the absence of government action, communities must step in to lead the way.

MORE P13

SPECIAL FEATURE

The five most pressing health priorities in 2014

... FROM P12

Professor Stephen Leeder, Professor of Public Health and Community Medicine, University of Sydney

1. National data collection and evaluation

The collection of national hospital safety and quality data is critical to monitoring the use of drugs and controlling the rise of drug-resistant infections. Information is also needed to track progress in preventive health, such as in addressing obesity. Repeated surveys, done by the same people using the same survey instruments, are needed to judge our progress.

2. We need to tell the story of what we are achieving in health care for the tens of billions we invest in it.

The community who pays deserves to hear. Health Ministers need to enunciate what the goal of providing health care is, backed by stories that illustrate what is achieved every day in caring for people. These stories are needed to keep compassion alive in our democracy. "Look where my Medicare tax dollar goes!" would be a great thing to boast about, and would enable ordinary taxpayers to see that their tax contributes to something of immense social value.

3. Fixing IT.

We are 20 years behind best practice. We can see what it looks like in the US. It requires a huge investment, but the pay-off in quality is immense.

Martin Laverty, Chief Executive Officer, Catholic Health Australia

1. Causes of ill health need to constantly inform both health policy and practice.

Two-thirds of Australians are overweight, 16 per cent of Australians smoke, and 13 per cent drink at levels of risk. Implementing Senate recommendations on social determinants of health would revive efforts to prevent Australians, particularly the most disadvantaged, from suffering avoidable chronic illness.

2. Coordination of health services around a person's unique needs must become more of a priority, to improve patient outcomes and reduce waisted expenditure.

Ideally, any person with an ongoing health complaint would have a health plan worked out and appropriately managed to focus on right treatment in the right place, ongoing medication management, avoidance of duplicated service, and prevention of further disease.

3. Health workforce constraints and industrial barriers still haven't been resolved to ensure Australia will have enough medical, nursing, and allied health staff to meet Australia's growing and ageing population.

Role redesign of who does what in the health system remains essential, but as a nation we're no closer to being able to solve workforce constraints because of entrenched industrial perspectives.

4. Consumer choice underpins the new National Disability Insurance Scheme, and is being introduced into home care for the aged.

Better choice in health and aged care also needs attention, so that competition and contestability can drive improvements in financial and clinical outcomes.

5. End of life care needs the entire community's attention.

Health professionals and health consumers need to give new consideration to talking about, determining, and then implementing future care plans. Pastoral care for those in the final stages of life, indeed for any person dealing with significant illness, needs elevation as a priority for health and aged care providers.

Dr Mukesh Haikerwal, Chair of Council, World Medical Association, former AMA President

With a new federal administration in place, a fiscal Armageddon heralded and the health settings for Australia being less favourable, the usual troupe of kite-fliers have been showing their wares in the 'silly season'. What I think we need is to secure the fundamentals and enhance and support sensible collaborative work practices.

1. Support more care out of hospital - don't penalise quality holistic care in general practice.

Embed the notion of general practice as the bedrock, not only of primary health care and all out of hospital care, but also for health care delivery across the nation. The costs of the same care out of hospital, when appropriate, are a fraction of the cost in hospital.

MORE P14

The five most pressing health priorities in 2014

... FROM P13

Enhance hospitals and support the care provided there, and stop perverse penalties.

Support the existing hospital infrastructure that is struggling with the burden of increased demand and expectation from patients and from governments, which absurdly see them penalised for trying their hardest to cope with this. There needs to be a move from blame to re-setting costs and targets based on realistic care need evaluations, allowing for inevitable variation.

3. Embolden and formalise clinical leadership in health in a meaningful way.

Use clinical Senates - groups of cognisant, focussed individuals suggesting and supporting innovation in health care delivery. Enhance their work by trialling and evaluating changing concepts before whole-of-system adjustments, so that unforeseen consequences are outed and adjusted for in real situations with real doctors treating real patients.

4. Use e-health and telehealth logically in clinically safe and acceptable forms over and above the PCEHR, especially secure messaging delivery and web-based videoconferencing.

Use innovative technologies in health (e-health and telemedicine) for clinical purposes, with clinical needs and drivers at the forefront. We do have potential technology to support and enhance (but not replace) trusted, proven good clinical methods. This is over and above, but could include, the PCEHR. Secure email to connect information is the key element.

5. Innovate with translational research in real clinical situations, proving concepts before rolling them out.

In care settings, sequential work across disciplines and health care establishments, with clinical participants nutting out how to best to innovate. Use just one set of agreed best practice guidelines that promote translational research that have been promulgated to, and agreed by, relevant medical groups. Make sure the economics and medicine are understood: it may cost more to implement in the beginning, but it will save on costs down the track.

Dr Brian Morton, Chair, AMA Council of General Practice

1. End of life care

There is an expectation that modern medical technology and care will extend life, but at what cost to the quality of life? The preparation of an Advanced Care Directive when competent will bridge this gap.

2. Lifestyle health issues

The genesis of many health issues are related to poor lifestyle choices which then require medical solutions. We need brave governments to implement public health interventions to de-medicalise preventive management.

3. Obesity

A whole-of-community response is required to manage the obesity "epidemic", including responsible marketing and labelling of foods, appropriate food helping sizes, ready access to exercise programs, dietetic advice and legislative recognition that obesity is a risk factor for multiple chronic diseases.

4. Prostate cancer

A rational evidence-based and consensus approach is needed regarding screening and management.

5. Alcohol

A multifactorial societal approach is fundamental to alcohol management.

COMMENT

INFORMATION FOR MEMBERS

New PBS prescription pad, claims forms

The Department of Human Services is updating its suite of PBS stationery products.

From next month the Department will be issuing redesigned prescription pads and claims forms, including for PBS safety net payments.

The changes include a revised numbering format and an updated privacy statement.

While the new stationery will begin to appear from next month, the Department will continue to accept and honour prescriptions and claims made using existing forms.

Further details, including updates to reflect the new form numbers and formatting, can be obtained by visiting: http://www.medicareaustralia.gov.au/provider/pubs/forms/pbs-stationery-entitlements-tables.jsp

Govt drops shutters on asylum seekers health

The AMA has voiced "grave concerns" about the Abbott Government's decision to disband a group of medical experts advising on the treatment of asylum seekers.

In a shock move, the Department of Immigration and Border Protection peremptorily abolished the Immigration Health Advisory Group (IHAG), which included representatives from the AMA as well as general practitioners, psychiatrists, psychologists and other medical professionals, late last month.

The decision has heightened concerns about the health and wellbeing of asylum seekers, particularly given doubts about the adequacy of medical services for those being held in detention on Christmas Island and Manus Island.

AMA President Dr Steve Hambleton said many people seeking asylum in Australia arrived in poor health, and the experience of indefinite detention itself added to and exacerbated health problems, particularly regarding mental health.

Dr Hambleton said providing adequate care for such people required drawing on expertise from a range of specialties – something IHAG could provide.

"The [physical] and mental health conditions that asylum seekers experience are often multiple and complex, and the Immigration Department needs to avail itself of sound health and medical advice from a number of disciplines," the AMA President said. "IHAG had the capacity to provide this sort of advice. It is regrettable that the Department has disbanded this group."

The AMA's IHAG representative, paediatric psychiatrist Dr Choong-Siew Yong, said the decision, revealed in a letter from the Department sent to each Group member, was completely unexpected, and the reasons for it unclear.

In a statement released several days after the decision, the Department said IHAG had been disbanded because "[its] large membership…made it increasingly challenging to provide balanced, consistent and timely advice in a fast-moving policy and operational environment".

But Dr Choong-Siew said this did not match with his experience.

"I think we worked particularly well as a group," he told ABC radio 666. "We were always conscious that things change rapidly, and I think most of us were quite prepared to have a quick turnaround of advice. It was a good, high level of expertise in the group that allowed the Department to [respond] very quickly."

He said he suspected the real reason for the change in policy was to limit the involvement of external players in the immigration detention system.

"I suspect it's in keeping with the current policy of maintain the whole system in-house, within the Government, similar to the way in which information about boat arrivals is now done on a weekly basis at a briefing with limited information," he said. "My guess would be that the Department, and the Government, is wanting to manage all this within its own borders, rather than have external groups involved."

Dr Choong-Siew said that, in addition to their own expertise, the members of the group were able to draw on and co-opt others with specialist knowledge, as needed.

Dr Hambleton said the decision to disband the group and rely solely upon its outgoing Chair, former Army doctor Dr Paul Alexander, for advice, placed a massive responsibility on one person.

"This is an enormous responsibility for one person," he said.

IHAG was established in 2006 after the Palmer and Comrie inquiries into the detention of Vivian Alvarez and Cornelia Rau identified major shortcomings in the health care provided to immigration detainees.

Dr Choong-Siew said he was "very concerned" for the health and wellbeing of asylum seekers without the expertise of a group like IHAG on hand to provide advice.

> "The research is very clear that the longer you're in detention, and the greater the uncertainty, the greater the possible psychological harm"

He said evidence showed that those in immigration detention faced a significant risk of developing mental health problems.

"The immigration detention environment is not like being a convicted criminal. The problem with the immigration system is that the length that you might be detained [is indefinite] and [there is] uncertainty about your outcome.

"The research is very clear that the longer you're in detention, and the greater the uncertainty, the greater the possible psychological harm.

"Many of these [asylum seekers are] presenting with psychological and psychiatric problems, some of which are probably attributable to the actual detention and detention environment," Dr Choong-Siew said.

Dr Hambleton reiterated the AMA's proposal for the establishment of a "truly independent" medical panel to oversee and report on health services for asylum seekers being held in both on- and off-shore immigration detention centres.

In particular, the AMA recommended that such a panel be above the bureaucracy, and report regularly to Parliament, the Prime Minister and relevant Ministers.

Adrian Rollins

COMMENT

NEWS

Alcohol's bloody toll could be stumps for ads in sport

The AMA has reiterated its call for fundamental shift in social attitudes to alcohol, including its close association with sport, following a tragic spate of alcohol-fuelled assaults and deaths during the Christmas-New Year period.

Two young men have been killed and several more left fighting for their lives in a string of violent attacks related to alcohol across the country, prompting calls for governments to do more to curb access to alcohol and for the community to re-think its approach to drinking.

In a bloody tally of alcohol-related injuries during the festive season, Irish backpacker Thomas Jay Keaney, 23, died a week before Christmas after being assaulted in Perth, while 18-year-old Daniel Christie died following an unprovoked attack in Sydney's Kings Cross on New Year's Eve, a tourist visiting the Gold Coast on 29 December was put in an induced coma to treat brain injuries sustained in an attack, and a 23-year-old man was also treated for severe head injuries following an attack outside a pub in Bondi on 14 December.

AMA President Dr Steve Hambleton said the sight of young men with shattered skulls and suffering severe brain trauma was depressingly common for emergency workers and medical staff, and they were becoming increasingly fed-up with the heavy toll of death and injury related to alcohol.

"We see the results of that on every Friday and Saturday night in every capital city and, sadly, New Year's Eve was a good example of what happens on an occasion when the misuse of alcohol occurs," Dr Hambleton told ABC radio. "Now, our police suffer, our emergency departments suffer. We're needlessly spending money to counteract the effects of alcohol and the alcohol-related violence on our community."

Dr Hambleton said it was time for the community to discuss the many aspects of the nation's drinking culture, including the legal drinking age.

In 2012 the Association released a major report on the alcohol industry's use of social media to promote its products to young people, and last October it repeated its call for a major parliamentary inquiry into alcohol advertising, including getting rid of a loophole that allows alcohol companies to advertise during live sports broadcasts, circumventing a ban on alcohol promotion before 8.30pm.

Dr Hambleton said the insidious association between sport and drinking was being exploited by alcohol companies to market their products, particularly to young people.

"There's [alcohol brand] logos on uniforms; there's alcohol advertising in breaks; there's alcohol on billboards at the back of the sporting event. It links sport

with alcohol, and you'd be forgiven for thinking that you need to have alcohol and sport together," he said. "There's strong evidence that the more young people are exposed to alcohol over time, the earlier they start drinking, the more they drink, and the more alcohol-related harm they experience," he said.

The Australian Greens have taken up the call, and plan to move for a Senate inquiry into the promotion of alcohol to children when Parliament resumes next month.

Greens acting leader Senator Richard Di Natale told the ABC the major sporting codes were "very much tied up with" the alcohol industry.

"The time's really come to look at the relationship there and to decide whether we're going to start to put the breaks on the advertising, promotion and sponsorship of alcohol products that target young children," Senator Di Natale said. "Closing the bizarre loophole that exists at the moment that says you're not allowed to advertise to young children during children's viewing times, but will make an exception for televised sport, seems to be one obvious area where action is needed."

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Indigenous medical student scholarship

The AMA is inviting applications for its $9000 Indigenous Peoples' Medical Scholarship for 2014.

AMA President Dr Steve Hambleton said increasing the number of Aboriginal and Torres Strait Island doctors and health professionals was integral to closing the gap between Indigenous health and life expectancy and that of the rest of the population.

Dr Hambleton said the Scholarship had helped many Indigenous men and women to complete their medical training since its inception in 1995, and was contributing to the growth in the number of medical students from Aboriginal and Torres Strait Island backgrounds.

"There is evidence that there is a greater chance of improved health outcomes when Indigenous people are treated by Indigenous doctors and health professionals," the AMA President said. "The numbers of Indigenous doctors are steadily increasing, but every effort needs to be made to help make it possible for Indigenous people to study medicine."

The scholarship is open to students who are currently enrolled full time at an Australian medical school, and who are eligible for ABSTUDY.

Applications for the scholarship close on 30 January, 2014.

For details on how to apply, visit:

https://ama.com.au/indigenous-peoples-medical-scholarship-2014

Drop the tablets this summer: AMA

The AMA is urging adults and children to lift their eyes from television and computer screens this summer and instead talk to each other more.

International studies suggest Australians are among the world's most voracious users of technologies such as tablets, computers, music players, smart phones and gaming systems, and the AMA is concerned that excessive screen time can come at the cost of healthy development and social interaction.

AMA President Dr Steve Hambleton said such products can be a "fantastic" resource for children, providing them with enormous opportunities for learning, communication and games.

"Some apps and computer programs can enhance children's understanding in areas such as literacy, science and maths, and these apps and programs should be used in tandem with traditional learning methods at school and at home," Dr Hambleton said.

But he warned that such technology should be used as an adjunct to, rather than replacement for, other forms of learning and interaction.

"Children and young people are definitely growing up in times when people are increasingly reliant on technology, but this shouldn't come at the expense of genuine interpersonal interactions and real experience," Dr Hambleton said. "Parents should look for apps that promote higher order thinking and which could encourage interaction with parents and other family members."

The AMA recommended that parents limit the screen time of their children.

"For children over two years old, two hours per day should be the limit. Flat screens shouldn't be used as babysitters for extended periods of time," Dr Hambleton said. "It is also important to help children and adolescents balance their media usage. Too much time spent in front of a screen can be harmful to their development."

The AMA said it was not just children who should limit their use of technology, pointing out that many adults spent an enormous amount of time using smart phones, computers and online.

According to a recent report, Australians spent on average more than 23 hours a week using such technologies, including almost seven hours a week on social media – the highest rate in the world.

Dr Hambleton said people needed to be conscious of the amount of time they spent using screens, and acknowledge that it could come at the expense of other, more rewarding aspects of life.

"While technology is often seen to enhance communication, it may not always be the case - virtual communication is no match for a face-to- face get-together," Dr Hambleton said.

A 2011 study undertaken by Relationships Australia found that the more people used technology to communicate, the lonelier they were likely to be.

The survey also challenged the notion that the elderly were the most likely to be lonely, with findings indicating that those aged between 25 and 34 years were most likely to be lonely, followed by those aged between 18 and 24 years.

Adrian Rollins

COMMENT

Take care to avoid a bilious summer

> “ ... a casual approach to keeping food safe was not a minor problem, with more than 5.4 million Australians suffering food poisoning every year ”

The AMA has urged householders to be vigilant when storing and handling food during the warm summer months, in the wake of a Salmonella outbreak that left one woman dead and hundreds ill.

In one of the worst instances of food poisoning for some time, a 77-year-old woman died after eating food contaminated with Salmonella at a Melbourne Cup function in Brisbane, while an additional 200 people reported symptoms, including 11 who had to be hospitalised.

The outbreak, thought to have originated in a batch of eggs used by a catering company to make mayonnaise used at around 40 separate events, has underscored the importance of proper food handling.

AMA President Dr Steve Hambleton said outdoor entertaining was synonymous with summer and important part of the Australian lifestyle.

But Dr Hambleton said that, unfortunately, what should be a time of relaxation and fun was occasionally marred when food that had not been properly stored or handled went off and made people ill.

The AMA President said a casual approach to keeping food safe was not a minor problem, with more than 5.4 million Australians suffering food poisoning every year.

Dr Hambleton said the consequences of food poisoning could be serious and, in some cases, life-threatening.

“Symptoms can be quite nasty, ranging from nausea, stomach cramps, diarrhoea, fever and headaches to serious vomiting and dehydration requiring hospitalisation,” the AMA President said.

To avoid the chance of food poisoning, he said people should minimise the amount of time food is kept at between 5 and 60 degrees Celsius, which is the temperature range considered most conducive to the development of harmful bacteria such as Salmonella.

“Hot food should be kept hot by keeping it on the stove top or in the oven turned down to just below 1000C before serving, and cold food should be kept cold by keeping it in the fridge before consuming,” Dr Hambleton said.

The AMA President said during hot weather people also needed to regularly check their refrigerators to make sure they were maintaining a temperature below 5 degrees Celsius.

Because summer is a time for entertaining, fridges often can become overloaded, and Dr Hambleton suggested some tips to ensure food was kept safe, including clearing out beer to make room for food (“lukewarm drinks can’t make you sick”), putting whole fruit or vegetables in a cupboard or bowl, and taking jars of pickles, chutneys and sauces that contain vinegar out (“they can survive for a couple of days without refrigeration”).

He said following just a few simple food handling rules would go a long way to ensuring safe eating for all, including making sure food preparation surfaces are clean; the different utensils are used for raw and cooked meat; that any leftovers are refrigerated immediately and consumed within three days; that poultry, minces, sausages and other prepared meats are cooked until they reach 75 degrees Celsius; and that perishable nibbles like dips and soft cheeses are left out of the fridge for too long before being eaten.

Adrian Rollins

COMMENT

This sweltering summer, help the aged

Australia's notoriously hot summers can be a dangerous time, particularly for the old, the very young and the chronically ill, the AMA has warned.

As a succession of heat waves sweep the country, sending the mercury in many areas above 40 degrees Celsius, AMA President Dr Steve Hambleton has called on people to look out for each other, and to be especially vigilant for the wellbeing of elderly relatives, friends or neighbours who live alone, are chronically ill or have limited mobility.

"Many elderly have problems coping with hot weather, and they can all too easily suffer life-threatening heat stroke if others are not around to spot the warning signs and take action," Dr Hambleton said.

As people age, their ability to cope with extremes of temperature deteriorates. The fact that many also have chronic health problems, are often taking multiple medications, and may live alone, adds to their vulnerability, he added.

"Drop by every day or two, or a couple of times a day if they live alone or are bedridden, just to see how they are going," the AMA President said.

"Tell-tale signs that they are not coping include hot and dry skin, a rapid pulse, cramps, confusion, dizzy spells, fainting, nausea and vomiting."

Dr Hambleton said there are several things people could do to make sure their elderly relatives and friends stayed safe when the temperature soars.

"If they don't have air conditioning at home, take them to a cooler place like a shopping centre or library for respite from the heat.

"Make sure their home is adequately ventilated. In the absence of air conditioning, fans are a good way to move the air and help evaporation to keep bodies cool."

He said people should be aware of any medications their elderly friends and relatives may be using, because many common drugs, such as antihistamines, heart pills, diuretics and sedatives, increased the risk of heat stress.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Changes to veteran health care payment arrangements

Health care subsidy arrangements for defence force veterans injured or who suffered diseases in the course of their service before mid-2004 are being changed.

The Department of Veterans Affairs (DVA) has announced that veterans currently eligible for benefits under the terms of the Safety, Rehabilitation and Compensation Act 1988 (SRCA) will no longer have to seek reimbursement from the Department for care costs.

Instead, SRCA clients will be subject to normal DVA treatment card arrangements, including the use of the DVA benefits schedule.

The DVA's Principal Medical Adviser Dr Graeme Killer admitted that the change would in some cases result in lower payments to providers.

But Dr Killer said both providers and their patients would benefit from a smoother, faster, and more convenient and consistent payments process.

"Currently, payment for the treatment of SRCA clients is processed through reimbursement arrangements, with an administrative burden for both clients and providers," he said. "This involves seeking prior approval from the DVA for most services, before sending invoices in to either be paid to the treating provider, or as a reimbursement to clients for payments they have made."

Dr Killer said bringing the assessment and processing of payments for SRCA patients in line with those of the broader veteran community would benefit all.

"It is understood that in some situations the use of the DVA schedule will result in a lesser payment to providers," he said. "However, using the card will benefit providers, as there will be greater consistency across procedures when dealing with [the] DVA, faster turnaround in payment for services, and reduction in administrative burden on practices."

AMA IN THE NEWS

Your AMA has been active on policy and in the media on a range of issues crucial to making our health system better. Below is a snapshot of recent media coverage.

Print/Online

Fund fee rises fuel fears of exodus, *The Australian*, 24 December 2013

Private health insurance premiums are set for their biggest rise in nine years. AMA President Dr Steve Hambleton said it was difficult to determine whether the premium increases were justified amid a picture of increasing private health insurance payouts.

$5 fee to see your GP, *The Sunday Telegraph*, 29 December 2013

A visit to your local doctor could soon cost you a $5 up-front fee as the Federal Government grapples with a blow-out in bulk billing costs. AMA President Dr Steve Hambleton said patients would be less likely to go to a doctor if it was more expensive.

Fears fee will clog hospitals, *Courier Mail,* 30 December 2013

There are fears public hospital emergency departments will be overrun by patients trying to avoid a $5 fee to see a doctor, as has been proposed in a submission to a Government-appointed cost-cutting committee. AMA President Dr Steve Hambleton urged the Federal Government to discuss any proposals for a GP charge with doctors before it was introduced, in order to minimise any adverse outcomes.

Call to charge $6 fee for visits to emergency departments, *Canberra Times*, 31 December 2013

The author of the proposal to charge a $6 fee for GP visits said hospitals may have to charge a similar fee to stop patients clogging up emergency departments. AMA President Dr Steve Hambleton said if patients were forced to pay a small fee at emergency departments there would be serious implications.

No jab, no play now a reality, *The Daily Telegraph*, 2 January 2014

New laws aimed at raising immunisation rates have now come into effect in childcare centres across NSW. AMA President Dr Steve Hambleton applauded the new rules.

Dons drug use sparks rush, *Age*, 6 January 2014

The Essendon Football Club's drug and supplements saga has sparked a surge in the use of cosmetic and performance enhancing drugs, with experts reporting a disturbing rise in the number of young people injecting hormones and peptides. AMA President Dr Steve Hambleton said boys as young as 15 years were now experimenting with these drugs.

Bernardi puts abortion back on the agenda, *Australian Financial Review*, 7 January 2014

Coalition Senator Cory Bernadi has sought to re-ignite the abortion debate by describing pro-choice advocates as pro-death, and calling for a reduction in rates of the procedure in Australia. AMA President Dr Steve Hambleton said that, while abortion was legal, to have one was a still a very difficult decision for a women to make, and was not made lightly.

Radio

Dr Steve Hambleton, 612 ABC Brisbane, 19 December 2013

AMA President Dr Steve Hambleton discussed a child dying from the Group A Streptococcal disease the previous week at the Mater Children's Hospital. He expressed concern the common bacteria was evolving and becoming more invasive.

Dr Steve Hambleton, ABC NewsRadio, 20 December 2013

AMA President Dr Steve Hambleton discussed a push by the AMA for a major change in multi-billion dollar Medicare Locals policy. He said Medicare Locals have failed to deliver.

Dr Steve Hambleton, 4BC Brisbane, 24 December 2013

AMA President Dr Steve Hambleton discussed the importance of food safety, particularly during the festive season. He said seafood, chicken and turkey, as well as smallgoods such as hams and salami, can be high risk foods unless stored and handled properly.

Dr Steve Hambleton, 612 ABC Brisbane, 24 December 2013

AMA President Dr Steve Hambleton discussed the cost of private health insurance premiums, which set to jump in April 2014. He said there was a need to sustain a balance between public and private health insurance, and to keep costs down.

Dr Steve Hambleton, 5AA Adelaide, 30 December 2013

AMA President Dr Steve Hambleton discussed a proposal put before the Federal Government's National Commission of Audit for patients to pay a $6 fee for GP visits. He said the AMA was concerned it could discourage people from seeing their doctor, and increase the pressure on hospital emergency departments and ambulance services.

Dr Steve Hambleton, 774 ABC Melbourne, 31 December 2013

AMA President Dr Steve Hambleton discussed a proposed $6 charge for GP visits. He warned such an increase could push more patients into the public hospital system.

MORE P21

AMA IN THE NEWS

... FROM P20

Dr Steve Hambleton, 3AW Melbourne, 2 January 2014

AMA President Dr Steve Hambleton discussed Mark Latham's proposed health care accountability idea. He said greater equity of education and resources is needed before such systems of accountability could even be considered viable.

Dr Steve Hambleton, ABC NewsRadio Sydney, 2 January 2014

AMA President Dr Steve Hambleton discussed taking precautions in heatwave conditions. He said the most at risk were babies, young children, the elderly, pregnant and nursing mothers, and those with heart disease or high blood pressure.

Dr Steve Hambleton, 666 ABC Canberra, 3 January 2014

AMA President Dr Steve Hambleton discussed alcohol promotion during sports broadcasts, amid a push for the Federal Government to tighten restrictions on alcohol promotion, particularly during live sports broadcasts.

Dr Steve Hambleton, 3AW Melbourne, 6 January 2014

AMA President Dr Steve Hambleton discussed Essendon Football Club's supplements scandal and the increased sales of performance-enhancing drugs. He said such a roll-on effect was very disturbing, and that internet search results proved a lot of people were looking for performance enhancing drugs online.

TV

Dr Steve Hambleton, Channel 9 Adelaide, 29 December 2013

AMA President Dr Steve Hambleton discussed the proposal to introduce a $6 fee for bulk-billed doctor visits. He said it would put more pressure on hospitals and the public health system.

Dr Brian Morton, ABC1 Canberra, 29 December 2013

AMA Council of General Practice Chair Dr Brian Morton discussed the proposal put to the National Commission of Audit for a $6 fee for patients visiting bulk billing GPs. Dr Morton was critical of the proposal, warning it may discourage patients from seeing GPs.

Dr Stephen Parnis, Channel 10, 29 December 2013

AMA Victoria President Dr Stephen Parnis discussed the proposal to introduce a $6 fee for bulk-billed doctor visits. He said it would put pressure on hospitals and the public health system, as people would end up in emergency departments instead.

Dr Steve Hambleton, Channel 10 Melbourne, 30 December 2013

AMA President Dr Steve Hambleton discussed the proposal put to the National Commission of Audit for a $6 co-payments for visits to the GP. He said people should be encouraged to visit GPs, rather than have barriers put in their way, so as to reduce the burden on the public hospital system.

COMMENT

INFORMATION FOR MEMBERS

Guide for Practitioners: Notifications in the National Scheme

The Australian Health Practitioner Regulation Authority (AHPRA) has prepared a guide and a series of information sheets to explain to doctors what happens when it receives a notification about a practitioner from the Medical Board of Australia.

The publication, *A Guide for Practitioners: Notifications in the National Scheme*, and the information sheets can be viewed and downloaded at:

http://www.ahpra.gov.au/Notifications/Fact-sheets.aspx

The guide for practitioners was written by AHPRA, in conjunction with the various national boards, to explain to health practitioners the complaints process.

AHPRA Chief Executive Officer Martin Fletcher said that the majority of health care practitioners were highly skilled and deeply committed to providing safe care, and acknowledged it could be very confronting for them to be the subject of a notification.

The guide describes what occurs when AHPRA receives a notification from the Medical Board.

This information will complement the direct correspondence that individual practitioners will receive if a notification is made about them.

The AMA first called for the development of the Guide in its submission to the Senate Finance and Public Administrative References Committee in April 2011.

The document sets out the notification process, including the time limits that apply.

It is intended to enable practitioners to better understand the process and what is required of them, as well as providing a means to verify that their matter is being handled in a manner consistent with AHPRA processes.

GENERAL PRACTICE

AMA's 2014 appointment book filling up following a year of achievement

BY DR BRIAN MORTON

> "Fortunately, another Budget measure, the proposed $2000 cap on work related self-education expenses, has been scrapped by the Abbott Government following a vigorous campaign, of which the AMA was at the forefront"

It seems like only a short time ago that I wrote my last wrap-up for the year that was.

The speed with which I find myself reflecting on the challenges and wins of 2013 is testament to another full year of AMA advocacy on behalf of our members and the nation's general practitioners.

The start of 2013 had general practices struggling to understand the myriad requirements of preparing for the revised Practice Incentives Program (PIP) eHealth Incentive and the Personally Controlled Electronic Health Record (PCEHR). The AMA *Guide to Using the PCEHR* and the AMA checklist *Getting ready for the PIP eHealth Incentive and PCEHR* provided much needed clarity.

Notwithstanding this, the PCEHR has continued to be a real challenge for practices and doctors to understand, implement and use. AMA advocacy saw the new Health Minister Peter Dutton acting quickly to commission a high-level review of the PCEHR.

In May, measures announced in the Federal Budget were set to seriously erode Medicare and increase the pressure on GPs to providing more for less. Decisions including freezing Medicare rebates until July this year, raising the Extended Medicare Safety Net threshold, removing the medical expenses tax offset and eliminating so-called "double billing" all undermine access to medical care.

Fortunately, another Budget measure, the proposed $2000 cap on work related self-education expenses, has been scrapped by the Abbott Government following a vigorous campaign, of which the AMA was at the forefront.

A further challenge arose when Medicare Locals assumed funding responsibility for after-hours GP medical services. The contracts offered by Medicare Locals imposed onerous conditions on GPs, and the AMA stepped in to have them changed. Following AMA pressure, the Health Department clarified the guidelines for funding used by the Medicare Locals, and worked with the Australian Medicare Local Alliance to develop simplified contracts for after-hours GP services.

Given this experience, and a range of other concerns regarding the structure and governance of Medicare Locals, the AMA called for a review to assess the contribution Medicare Locals were making to the provision of quality primary care in Australia. The Government agreed to this and the AMA's submission to the review – led by former Chief Medical Officer Professor John Horvath and due to report by March - was strongly informed by the responses of grass roots GPs to an AMA survey on Medical Locals.

During last year the AMA was also successful in:

- obtaining Australian Competition and Consumer Commission authorisation for GPs in the same practice to set common fees;
- defeating an attempt by the Australian Nursing Federation to bargain on behalf of practice nurses;
- getting the PIP Teaching Incentive doubled; and
- increasing the profile and role of GPs through Family Doctor Week.

Just as 2013 presented many challenges, 2014 will no doubt have its share.

The AMA Council of General Practice, which I'm honoured to Chair, will in the coming year play a vital role informing AMA policy across a number of issues.

These are likely to include the medical home; pharmacists in general practice; barriers to GP teaching; GP engagement in private health insurance programs; the future of Medicare Locals; developments within programs such as the Practice Incentives Program and Mental Health Nurse Incentive Program; and increasing the breadth and depth of GP membership.

I look forward to meeting the challenges ahead.

Challenges and the promise of progress await DiTs in 2014

BY DR JAMES CHURCHILL

> “In 2014 we enter a critical time for DiTs’ advocacy on the medical training pipeline”

It’s an exciting time to be the incoming Chair of the AMA Council of Doctors-in-Training. I thank Will Milford and the secretariat for their work over the past 18 months, during which time many gains have been realised for doctors-in-training (DiTs) in each State and Territory.

The past three years have been a tumultuous period for DiTs, with significant medical workforce planning issuess due to the doubling in Australian-trained graduate numbers in the past decade, ongoing concerns about the mental health and wellbeing of medical students and junior doctors, and threatened assaults on the tax-deductibility of further medical education expenses.

In 2014 we enter a critical time for DiTs’ advocacy on the medical training pipeline.

The development of Health Workforce Australia’s *Health Workforce 2025* reports has heralded prospects for significant progress in medical workforce planning, with the formation of the National Medical Training Advisory Network (NMTAN) an important step in translating the reports’ findings into recommendations and actions.

For this group to succeed requires the buy-in of a range of stakeholders in medical training, including the profession. CDT will be represented on the Executive Committee, and it is hoped NMTAN will prove effective in helping develop a sustainable and efficient medical training system.

Medical workforce planning is complicated by a divided system of state-federal-university responsibilities. Aside from known national data on medical graduates and internships, deciphering the availability and allocation of PGY2+ prevocational positions in each State and Territory has proven extraordinarily complicated, and will no doubt require further coordination in order to remain efficient.

This year promises significant progress on issues regarding the quality of medical training. The proposal for an annual National Training Survey, which has been under development for some time, is expected to continue to mature in 2014. Overseas experience of similar surveys is positive, and the NTS promises to be a valuable tool for evaluating and improving the quality of medical education.

Following finalisation of its excellent work on accreditation standards and outcomes for the intern year, and an associated framework for the review of Postgraduate Medical Councils, the Australian Medical Council will soon be turning its attention to consulting on revised Standards for Specialist Medical Education.

Discussion of the standards will form a significant part of the 2014 Trainee Forum, to be held in Melbourne in March. CDT will be providing detailed trainee feedback on the standards, drawing upon the results of the AMA Specialist Trainee Survey conducted in 2010, and due for release again in April 2014.

The recent release of the *beyondblue* report on the mental health of doctors and medical students has prompted renewed calls to combat the stigma of mental illness among our colleagues. Many of the report’s findings were concerning, particularly regarding the vulnerability of doctors during early postgraduate years. The problem is defined, the data known, and now is the time for action on doctors’ mental health and wellbeing.

Turning to global health issues, in 2014 the AMA has an opportunity to lead discussion of how to meet trainees’ popular demand for broadened implementation of best-practice, integrated global health training opportunities for DiTs.

Clearly, CDT has an interesting and full program of work ahead in 2014, and I’m personally looking forward to the challenge of these and other issues. Leading CDT with me will be Julian Grabek, Deputy Chair, alongside representatives from each State and Territory DiT committee.

James Churchill
Chair, Council of Doctors-in-Training

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COMMENT

PUBLIC HEALTH OPINION

Feeling angry? This may be a good start for 2014

BY PROFESSOR STEPHEN LEEDER

I was in London for Christmas, visiting family and friends in the northern hemisphere deep mid-winter. Winds and storms thrashed and darkness closed each day at four. Best not mention the cricket.

But it's not the cricket or the weather that is making Brits angry.

Instead, according to a *Guardian*/Institute of Commercial Management poll of over 2000 people (http://www.theguardian.com/politics/2013/dec/26/fury-mps-not-voting-poll) conducted a week before Christmas and published on December 27, it is politics and politicians.

Well, that's not quite right. There may be many other things making Brits cross.

However, the poll concentrated on politics, asking respondents for "the single word that best described how or what you instinctively feel about politics and politicians".

Nearly half answered "angry", and a quarter said "bored'. Fewer than 20 per cent felt "respectful" or "inspired" (2 per cent).

Younger respondents were as likely to feel bored as angry, and the voting rate among them was almost half that of the over-65s at the last election. Two-thirds were put off voting because they felt politicians did not keep their promises, while half thought they were on the take. Underlining the depth of disillusion, a quarter each felt "the parties were much the same" and "neither takes any notice of my views".

Encouragingly, nearly 90 per cent of respondents still felt that government mattered, and that the decisions made in parliament were important. Most talked about politics once a week.

So, as the *Guardian* argues, it's better to be angry about something important than to be indifferent – the attitude that is more common among the younger respondents. Anger is not restricted to Britain.

In the 7 December issue of the *Economist*, Lexington, the newspaper's US correspondent, analysed why poll after poll revealed Americans were experiencing "crises of trust".

Whether as an aspect or a consequence of this angry feeling, Lexington sees the corrosion of trust as critical.

Trust, which was critical to "civic activity and a sense of community among neighbours" after the Second World War, has been declining since, and "anti-government cynicism is feeding on gulfs in society…The country faces a crisis of mutual resentment, masquerading as a general collapse in national morale."

Anger about Obamacare represents a "collapse in support among conservatives for government safety nets."

Australia, like the UK and the US, has not enjoyed high levels of democratic fitness in recent years.

And this has profound effects on the values of compassion, equity and concern that have served Australia's health care system over decades.

There has been a corrosive silence and lack of leadership on these important matters.

> "Australia, like the UK and the US, has not enjoyed high levels of democratic fitness in recent years"

Instead, we hear the babble of division, nay-saying and sledging in our parliaments. Misplaced anger, cynicism and wedge politics damage democratic fitness and the health of the nation.

So! If you are starting 2014 feeling angry, good!

But be specific, be diagnostic, and be active.

Search out what it is that is making you angry. Be sure it is not a piece of political ideological junk unworthy of your energy and anger.

Having clarified your concern, act. There is a greater health hazard, not just to you but to the nation, than obesity from your being a couch potato.

As our Chinese friends will soon celebrate, 2014 is the year of the horse. Time to get on ours!

COMMENT

Burdensome Authority Prescription arrangements come under review

BY PROFESSOR GEOFFREY DOBB

> "The PBAC decision is a direct result of the time and effort devoted by Therapeutic Committee members to preparing the AMA's submission to PBAC"

The AMA has had a couple of significant wins regarding therapeutics policy.

The Pharmaceutical Benefits Advisory Committee (PBAC) has agreed there should be a systematic review of each PBS medicine currently requiring an Authority to ensure the requirement "remains appropriate". It has requested the Department of Health to draft terms of reference for the review.

The AMA has been lobbying to remove the requirement for doctors to phone a clerk before they can prescribe a PBS medicine. Around 100 PBS medicines still fall under this regime.

However, as an interim measure, in July 2013 we submitted a detailed proposal to PBAC identifying eight medicines that should be removed from authority requirements altogether; 23 medicines that should require only an initial authority and then streamlined arrangements for the same patient in the same circumstances; and 12 medicines that should only require an authority for the initial prescription when used in palliative care circumstances.

The PBAC decision is a direct result of the time and effort devoted by Therapeutic Committee members to preparing the AMA's submission to PBAC.

In its response, PBAC advised that the AMA's submission had prompted its decision to initiate a systematic review, and that it would investigate our proposal that some medicines should only require an initial authority and then no or only a streamlined authority for the same patient in the same circumstances.

The AMA has also been concerned with increased threats to therapeutics supply in Australia, which have led to several serious medicine shortages over the last three years.

In 2012 and early 2013 I met with Catherine King, the-then Parliamentary Secretary responsible for the TGA, Medicines Australia and the Generics Medicine Industry, to discuss proposals for ensuring Australia had clear, consistent and coordinated systems for the timely notification and management of medicine shortages.

The TGA has now developed a protocol for Australian sponsors of medicines that will clarify the responsibilities of sponsors and the TGA.

The protocol will identify the circumstances in which sponsors should communicate potential and actual shortages to the TGA; the timing of such communications; when and how shortages should be communicated to other stakeholders such as medical practitioners; and the management strategies that may need to be implemented.

The TGA also plans to improve the transparency and timeliness of notifications, and the management strategies being implemented by publishing the information on its website.

While the medicine shortage protocol relies on voluntary sponsor compliance rather than mandated notification processes for high impact medicine shortages, as we would have liked, it is a considerable improvement on the current ad hoc and uncoordinated approach.

The TGA plans to have the medicine shortages protocol and a supporting website in place by June 2014.

The AMA will keep you up-to-date with developments in both PBS Authority medicines policy and the TGA medicines shortages protocol.

COMMENT

Open all hours: EDs pick up the pieces as celebrations go off the rails

During the peak of pre-Christmas festivities as many as one in every three patients in hospital emergency departments were there because of problems related to alcohol, according to a survey conducted by the Australasian College of Emergency Medicine.

In a striking result that underlines AMA concerns about the extent of alcohol-related harm in the community, a snapshot of patients attending 92 emergency departments on Saturday, 14 December at 2am, showed that more than 14 per cent were there because of excessive drinking, with the proportion rising to around 33 per cent in hospitals near notorious party hot spots.

The findings imply that, at any one time during weekend evenings and early mornings, emergency departments may be treating more than 400 patients ill or hurt because of alcohol.

The College said the study provided the first national statistical glimpse of the extent of alcohol's involvement in presentations at hospital emergency departments.

Principal investigator Dr Diana Egerton-Warburton, who is Chair of the College's Public Health Committee, said the result gave substance to oft-repeated complaints from emergency physicians that an enormous amount of their time was spent treatment people who had drunk to excess.

"Until now, we've had anecdotal evidence that the rates of alcohol presentations are high, but little prospective data to go on," Dr Egerton-Warburton said. "Emergency physicians are sick and tired of dealing with the 'bloody idiots' who drink alcohol in excess and end up in the ED."

The researcher said that, with as many as one in every three patients affected by alcohol, emergency departments often felt "more like a pub than a hospital".

She said this was an "intolerable" situation for staff, and was unfair on other patients.

"Imagine attending an ED with a sick child or elderly relative and having your care disrupted or delayed by a person affected by alcohol," Dr Egerton-Warburton said. "This happens on a regular basis in our EDs."

AMA President Dr Steve Hambleton said that although it was fine for people to relax and have fun, too often celebrations were blighted by heavy drinking that led to violence, risky sexual behaviour and illness.

"It's common at this time of year to relax with friends and family over a few drinks," Dr Hambleton said. "But all too often people over-indulge, exposing both themselves and those around them to harm."

Dr Hambleton said people often overestimated how many beverages it was safe to drink. He said official guidelines advised people should consume no more than two standard drinks a day.

Anger over alcohol-fuelled violence, including several deadly assaults during the Christmas-New Year holiday period, has increased the pressure on all levels of government to take action.

In New South Wales, senior police officers and public health advocates have argued for an extension of Newcastle's experiment with restricted venue hours and pub lockouts.

NSW Police Association President Scott Weber told a rally against alcohol violence held in Sydney late last year that his members wanted to see was "3am closing times, 1am lockouts, [and] restrictions in regards to sales of shots and heavy liquor".

Foundation for Alcohol Research and Education Chief Executive Michael Thorn told the *Canberra Times* it was not just an issue for state and local governments, and the Federal Government also needed to accept some responsibility.

Mr Thorn said the Abbott Government needed to reform the taxation system to prevent alcohol being sold for as little as 25 cents for a standard drink by taxing drinks according to their alcohol content, as well as to impose more stringent restrictions on alcohol advertising, particularly by closing as loophole that allows for drink ads on television before 8.30pm during live sports broadcasts.

Prime Minister Tony Abbott voiced concern about violent assaults in the entertainment precincts of the country's major cities, admitting that on occasion they have become "almost war zones because there is just so much alcohol-fuelled violence".

But he defended the NSW Government's cautious response to the issue.

"I know [NSW Premier] Barry O'Farrell wants to do more," the Prime Minister said. "Quite sensibly, though, he doesn't want a knee-jerk response. He wants a considered, effective response."

Meanwhile, Indigenous Affairs Minister Nigel Scullion has announced a parliamentary inquiry into alcohol misuse in Indigenous communities.

The Minister said the inquiry would be conducted to identify improved ways to tackle the problem, including by ensuring "regulators and lawmakers across all jurisdictions have the very best evidence under which to ensure that all our management plans really change those negative aspects of alcohol consumption".

Adrian Rollins

Governments fizz on alcohol policy

National Alcohol Policy Scorecard

Rank	Jurisdiction	Final score (%)
1	Australian Capital Territory	57
2	Western Australia	53
3	Tasmania	50
4	Victoria	46
5	Northern Territory	41
6	Queensland	39
7	South Australia	33
8	New South Wales	31
9	Australian Government	29

Source: National Alliance for Action on Alcohol

The Federal Government is the worst of a bad lot when it comes to action to tackle the harm caused by alcohol, the inaugural National Alcohol Policy Scorecard has found.

The Scorecard, the initiative of the National Alliance for Action on Alcohol (of which the AMA is a member), assessed the performance of the nation's Commonwealth, State and Territory governments against 10 alcohol policy criteria, and found that most failed when it came to developing and implementing evidence-based alcohol policy.

Only three jurisdictions – the ACT (57 per cent), Western Australia (53 per cent) and Tasmania (50 per cent) received a pass mark, while the Federal Government received the lowest mark (29 per cent), and NSW the second lowest (31 per cent). Among the other states and territories, Victoria was given a score of 46 per cent, Northern Territory 41 per cent, Queensland 39 per cent, and South Australia 33 per cent.

The Alliance said most governments scored well in terms of drink driving countermeasures, as well as treatment and early intervention policies and programs.

But it found performance was patchy or poor in other areas of policy, including the development and implementation of whole-of-government strategic plans, collecting and managing alcohol-related data and restrictions on the serving and consumption of alcohol.

Both WA and the Federal Government scored well for their data management practices, while the ACT got special mention for its measures to modify the drinking environment.

But the Federal, NSW, Northern Territory and Queensland governments were marked down for their lack of a whole-of-government approach.

The Alliance added that, aside from some features of the Federal excise on beer and spirits, alcohol pricing and tax policies that supported public health were absent in all jurisdictions, and most also scored poorly because of minimal or ineffective restrictions on alcohol marketing and promotion.

Adrian Rollins

COMMENT

Hip hop dancers get the rashy on

Health authorities across the country are on alert following an outbreak of measles among participants at a Sydney dance competition attended by more than 2000 people.

> “... the disease was spread through coughing and sneezing, and advised anyone who had attended the dance competition, or those who have had contact with them, to be alert for signs of the disease”

At least 15 people in New South Wales, Victoria, the ACT, South Australia, New Zealand and the Philippines have been diagnosed with the highly infectious disease, and it is feared many more may have been exposed to the infection following its initial spread at the World Supremacy Battlegrounds Hip Hop dance competition, held at Sydney Olympic Park in early December.

The first case, involving a competitor from Adelaide, was confirmed on 27 December, and since then participants from across the country and internationally have been diagnosed with the potentially-fatal disease.

In New Zealand, 10 cases were confirmed by early January, including three contestants from the dance competition and seven relatives and acquaintances.

Organisers told the ABC the likely source of the infection was a Filipino contestant who suffered flu-like symptoms at the competition but who did not develop the tell-tale measles rash until returning home, where he was subsequently diagnosed and hospitalised. He has since recovered.

But local health officials are concerned that other contestants, who came from as far afiled as Guam, Japan and Malysia, may be unaware they had been infected and have unwittingly spread it to friends, family and acquaintances.

NSW Health’s Director of Communicable Diseases Dr Vicky Sheppeard said measles was highly contagious among people who were not fully immunised.

Dr Sheppeard said the disease was spread through coughing and sneezing, and advised anyone who had attended the dance competition, or those who have had contact with them, to be alert for signs of the disease.

She said it typically took between 10 and 18 days after exposure for symptoms to appear, typically including a runny nose, a cough, sore eyes, fatigue and fever.

Dr Sheppeard said it could take several days after this for the tell-tale measles rash to appear, and complications of the disease could range from ear infections to pneumonia and swelling of the brain.

Authorities have advised anyone who suspects they may be infected to immediately seek medical attention.

Dr Sheppeard recommended that they phone ahead to their doctor before arriving, “to ensure you don’t share the waiting area with other patients”, and said all those who were not fully immunised to make sure they were as soon as possible.

Adrian Rollins

COMMENT

Army doctor brings quality care to Kandahar*

Dr Michael Reade

Dr Michael Reade, from Ascot in Brisbane, always seems to be in the right place at the right time.

The right place, right now for Dr Reade is the NATO Hospital in Afghanistan's Kandahar province.

Dr Reade is a Lieutenant Colonel in the Army who is in command of the hospital's Australian Specialist Health Group (ASHG), where he also works as one of the post's intensive care physicians.

It was Dr Reade's training as an intensive care physician, anaesthetist and trauma medicine specialist that helped him to land the prestigious job as head of the ASHG.

Dr Reade's work, and that of his nine medical specialists, have yielded massive benefits in terms of trauma research and treatment for the Australian Defence Force (ADF).

"At the moment we don't see battlefield trauma like this outside of Afghanistan," he said.

"It is very reassuring for us to see that we have the same quality of military trauma training in Australia as the US medical personnel here do."

Dr Reade said the deployment was also a fantastic opportunity for Australian medicos to form research collaborations with their US colleagues in analysing the Joint Trauma Registry, the largest comprehensive database of military trauma that has ever existed.

Dr Reade says he has always been in the right place at the right time because he has been in the Army Reserve for the past 24-years, since his time as a medical student at the University of Sydney, and then later at Sydney's Royal North Shore Hospital.

But recently Dr Reade joined the Army full-time, and was appointed to the prestigious position of Professor of Military Medicine and Surgery, a role created as part of a Strategic Alliance with the University of Queensland.

"I'm attached part-time to the Royal Brisbane and Women's Hospital back in Australia where, as well as working as a clinician, I conduct research relevant to military trauma medicine, develop ADF trauma medicine and surgery policy, as well as train ADF clinical staff," he said.

During his military career, Dr Reade has deployed to Bosnia in 1999, Kosovo in 2000 and 2001 (both times attached to the British Army), Timor in 2003, the Solomon Islands in 2004 and a previous deployment to Afghanistan in 2009, where he was the Clinical Director of the Role 2E hospital at Multi National Base – Tarin Kot.

Lieutenant Colonel Reade's previous deployments translate into a lot of time spent away from home, so when he returned to Australia in time for Christmas, his first priority, naturally, was to spend quality time with his wife and daughter at their home in Ascot.

** This article was provided by the Australian Defence Force*

COMMENT

Babies coming later in life, often with a knife

Women are, on average, delaying have their first baby until they are more than 28 years old, and fewer than 4 per cent are having them in their teens.

But, reflecting the advancing age of first-time mothers, the proportion experiencing normal vaginal birth is declining, with the instance of caesarean deliveries continuing to rise.

An Australian Institute of Health and Welfare analysis of official statistics shows that more than 297,000 women gave birth to almost 302,000 babies in 2011, a 1 per cent increase from the previous year and an 18 per cent jump in a decade.

Not only were more women giving birth to more babies, but they were having them later in life.

The AIHW report showed that the tendency of women to delay childbearing is well established. In the 10 years to 2011 the average age at the birth of the first children increased almost a year, up from 27.6 years in 2002 to 28.3 years in 2011.

Paralleling this increase, the incidence of caesarean sections grew from 27 per cent in 2002 to more than 32 per cent in 2011.

Reflecting the increased recourse to the procedure as the mother's age advances, just 18 per cent of teenage mothers gave birth by caesarean section, compared with 49 per cent of mothers aged 40 years or older.

While older first-time mothers are more likely to require a caesarean section compared with teenagers, they are less likely to have smoked during their pregnancy, or to give birth to a baby with low birth weight.

AIHW spokeswoman Professor Elizabeth Sullivan said almost 36 per cent of teen mothers smoked during their pregnancy, compared with 13 per cent of all mothers.

At the same time, little more than 6 per cent of all babies born in 2011 were of low birth weight (defined as less than 2.5 kilograms), but among women who smoked the likelihood of low birth weight almost doubled to 11 per cent.

COMMENT

Adrian Rollins

Roids all the rage in pursuit of body beautiful

Steroids and other performance- and image-enhancing compounds have rapidly become the prime drug of choice for illicit drug users, according to New South Wales research.

A study by the University of New South Wales' Kirby Institute, reported in the *Sydney Morning Herald*, has found a sharp swing in tastes away from methamphetamines and heroin toward drugs thought to boost strength and, more significantly, improve appearance.

The study of 2400 people taking part in the Australian Needle and Syringe Program Survey last year found that 74 per cent of those who stared injected illicit substances in the previous three years had sought out steroids and other performance- and image-enhancing compounds, up from just 27 per cent a decade earlier.

By comparison, the proportion of new users reporting a preference for methamphetamines plunged from around 50 per cent in 2006 to just 11 per cent last year.

AMA President Dr Steve Hambleton said the results showed a disturbing trend among young people, including increasingly young men, to pursue some idealised image of physical perfection.

"Steroid using is creeping more and more into younger people," Dr Hambleton told the *Sydney Morning Herald*. "It comes with this wish to win at all costs and to attain the perfect body immediately. We worry about our girls with body image, but it is just as much young men we need to worry about now."

Performance- and image-enhancing drugs are often used to promote muscle growth and reduce body fat, but carry a range of serious side effects including liver damage, cancer, heart problems and increased aggression.

Adrian Rollins

COMMENT

Haikerwal's attacker given ok to stay

Former AMA President and World Medical Association Council Chair Dr Mukesh Haikerwal has condemned a decision to allow a New Zealand man who bashed him savagely several years ago to remain in Australia.

According to the *Herald Sun*, the Administrative Appeals Tribunal has overturned a decision by Immigration Minister Scott Morrison to cancel the visa of Sean Gabriel, who in 2008 took part in an attack on Dr Haikerwal that left the GP so badly injured he had to be put in a medically-induced coma to save his life.

Dr Haikerwal told the newspaper the Tribunal had sent "a very poor message" with its decision.

"We've seen over the Christmas holiday period many people hospitalised and put into comas, and it's a very poor message where the rights of the individual assailant are much more important than that of the victims," he said.

Dr Haikerwal was attacked and bashed when Mr Gabriel and three other men mugged him as he walked along the Williamstown, Melbourne, waterfront in September 2008.

The assault, which included the use of a baseball bat, left the former AMA President with severe brain injuries, including blood clots, and he was placed in a coma to help save his life.

In announcing the decision, Tribunal Deputy President James Constance said Mr Gabriel had a "low to moderate" chance of reoffending, and faced better prospects if he remained in Australia - where he has lived since the age of 10 – than if he was deported to New Zealand, where "his recollection of his time living there is negative".

Dr Haikerwal said the ruling was very disappointing.

"Brain injury is devastating and often leads to death, the crimes are horrendous – and then we see decisions that are more in the interest of the perpetrators of crime," he told the *Herald Sun*.

Adrian Rollins

COMMENT

Road toll down, but cyclist deaths up

More than 1100 people died on the country's roads last year even as the nation recorded its safest 12-month period in almost 70 years.

Bureau of Infrastructure, Transport and Regional Economics figures show 1196 people died in traffic accidents in the 12 months to 30 November last year, a 9 per cent drop from the previous 12-month period and the lowest toll since 1945.

> "While technological advances will continue to make vehicles safer, there is no substitute for responsible and safe driving"

But road safety campaigners say the fact that 27 people died in Christmas-New Year holiday period (from midnight 23 December 2013 to midnight 3 January 2014) alone, shows that there was still a long way to go to improve road safety.

And record cyclist deaths have underscored the need for significant improvements in road infrastructure and driver behaviour.

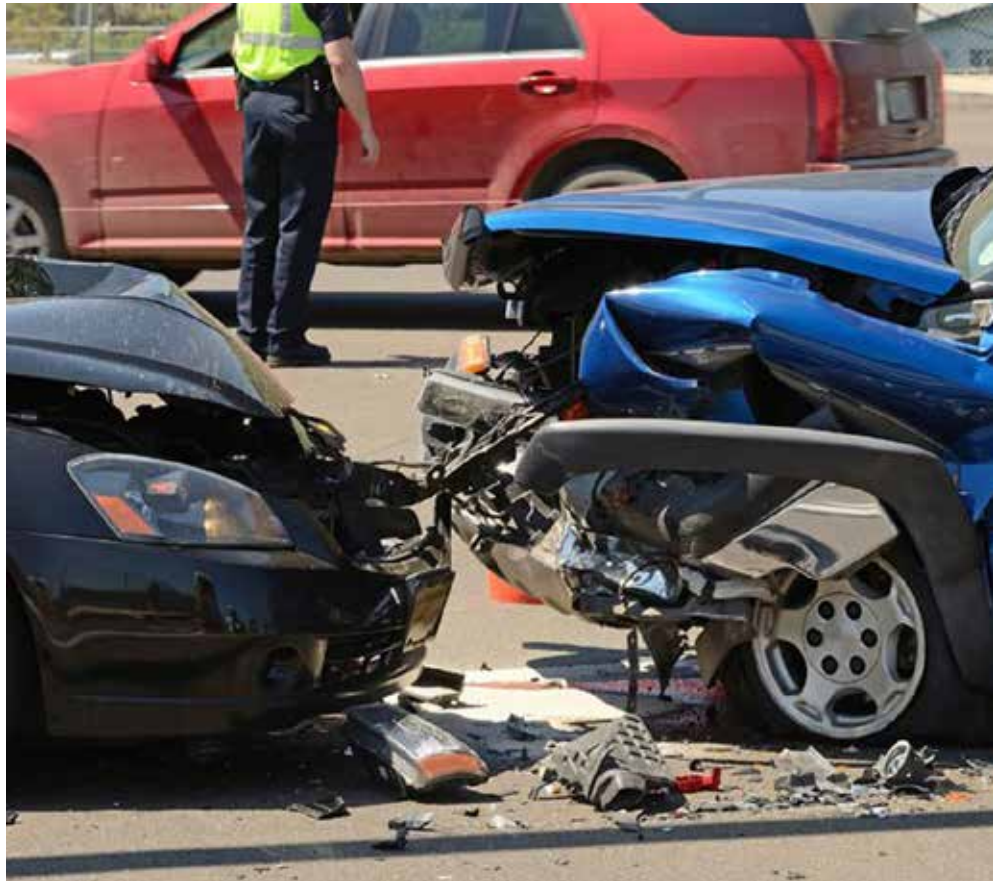
According to the Amy Gillett Foundation, around 50 cyclists died on the nation's roads in 2013 – a sharp increase from the annual average of about 35 deaths.

Much of the increase is likely to due to recent growth in the popularity of cycling, but the Australian Greens have seized on the figures to try to rally support for their legislation making it mandatory for motorists to allow a one-metre margin when passing cyclists – similar to laws enacted in many parts of the United States and Europe.

In Queensland, a parliamentary committee has recommended a two-year trial of such a law, accompanied by a public education campaign and back by significant penalties – motorists breaching the law could be fined up to $4400.

Assistant Minister for Infrastructure Jamie Briggs said that although there had been significant progress made in recent years in cutting the road toll, much more needed to be done, including by motorists themselves.

"We know that fatal road crashes can involve a number of factors, including the quality of the road infrastructure, the safety of the vehicle, the experience of the driver and the prevailing weather conditions," Mr Briggs said.



"But motorists can, and should, take a few simple precautions to keep the risks to a minimum."

The Minister said drivers should plan their trip ahead of time, get plenty of rest before heading off, ensure all passengers are buckled in, take regular breaks, drive to conditions and "of course, refrain from drinking, speeding and using mobile phones".

"While technological advances will continue to make vehicles safer, there is no substitute for responsible and safe driving."

The AMA has been at the forefront of efforts to improve road safety, including in New South Wales, where AMA NSW President Associate Professor Brian Owler has for several years been the public face of a high profile campaign urging motorists to "Choose Wisely" when considering the risks and potential costs of unsafe driving, particularly speeding.

Adrian Rollins

COMMENT

OPINION

GP co-payment no way to cut health costs

BY DR LESLEY RUSSELL

> “More worryingly, the largest negative impact of cost-sharing was on services for the chronically ill and prevention”

This article was first published in The Canberra Times on 31 December, 2013

Reports that the Abbott government is considering abolishing bulk billing and requiring most Australians to pay a $5 or $6 co-payment every time they visit a GP (and presumably also for associated pathology and diagnostic testing) has galvanised the electorate.

While the average Australian will be rightly concerned about yet another impost on the family budget, policy and political debates will rage on the basis of issues including cost containment, appropriate use of healthcare services and health outcomes.

The predictable result is that political philosophy or political reality will trump evidence-based policymaking - or the floated idea will magical disappear. Already it seems that the paper that put forward this proposal, published in October by the Australian Centre for Health Research, has disappeared from the centre’s website.

This proposal has its genesis in the flawed concept of moral hazard - the idea that if healthcare is free (or too inexpensive) people will use it inappropriately. Of course, in Australia, healthcare is not free - through the Medicare levy and taxation, everyone pays into the system on the basis of ability to pay and withdraws from the system on the basis of need. We know nothing about those segments of the population who purportedly visit the doctor unnecessarily or inappropriately, or about which population groups could instead take care of their own health problems, as suggested by the promulgator of this proposal.

Data from the Australian Bureau of Statistics shows that, in 2013, 81 per cent of Australians aged 15 years and older had visited a GP at least once in the previous year. The frequency of GP visits, not surprisingly, was a function of how healthy people considered themselves to be, whether or not they had a chronic illness and whether or not they were pregnant. If the main driver of this proposal is to generate budget savings, then it is widely accepted that higher co-payments will lead to reduced healthcare expenditures, at least over the short to medium term.

The gold standard of evidence here is the RAND Health Insurance Experiment - a randomised trial of higher cost-sharing conducted in the 1970s and, curiously, never repeated. It found that a 10 per cent increase in cost-sharing results in about a 2 per cent reduction in spending.

It also found that patients reduced the use of clinically appropriate services by the same amount as they reduced the use of services deemed clinically inappropriate. More worryingly, the largest negative impact of cost-sharing was on services for the chronically ill and prevention.

Other research demonstrates a wider range of adverse impacts on clinically important services. For example, relatively modest increases in co-payments reduce the use of preventive and screening services and medicines for managing chronic conditions such as diabetes and hypertension. The net effect is worse compliance with medication regimes, more visits to emergency departments, more hospital admissions and increased mortality. In contrast, other studies have shown that a reduction in co-payments can increase patient adherence to treatment regimes for chronic conditions.

The universality of our healthcare system is already being severely eroded as out-of-pocket costs grow. Co-payments comprise 17 per cent of health spending in Australia, a higher proportion than 13 out of 20 Organisation for Economic Co-operation and Development countries, including the US, and the third-largest source of health funding after federal and state and territory governments. Our concerns should be greatest for low-income people as these out-of-pocket costs lead to greater health disparities.

The government’s expressed concern is for the budget deficit. It is possible to reconcile the basic issues - financial responsibility, sustainability of Medicare and affordable access to healthcare for all Australians. But this requires time and effort to develop a sophisticated policy approach based on the available data and evidence, rather than applying a blunt instrument based on ideology that will have adverse, and potentially costly, consequences.

Australians understand universal access does not mean unlimited access by everyone to everything but affordable access to a package of value-based services. There is room for a policy debate around what should be part of this package and for increased public education and awareness about the costs and benefits of healthcare services.

All current evidence suggests what is needed is increased access to primary care services rather than a new tax that will fall heaviest on the sickest and poorest. It is quite possible that the answer to more cost-effective health care lies in reducing co-payments, at least for some population groups, rather than increasing them.

Dr Lesley Russell is a research associate at the Menzies Centre for Health Policy at the University of Sydney.

COMMENT

Member Profile

Australian Medicine profiles notable AMA members

In the latest instalment of an occasional series looking at the notable AMA members, *Australian Medicine* profiles Melbourne-based orthopaedic surgeon Dr Bruce Love.

Ask the average orthopaedic surgeon about the kilovolt efficiency of electricity transformers or the temperature rating of bitumen, and you would most likely draw a blank.

Unless, that is, you are talking with Melbourne-based orthopaedic surgeon Dr Bruce Love.

After representing the AMA at Standards Australia Council meetings for more than 20 years, Dr Love has developed an uncommon level of familiarity with the technical details of everything from stairways and ladders to power grids and electrical wheelchairs.

Not that this was ever his intention.

When the-then AMA President Dr Bruce Shepherd approached him in the early 1990s to be the AMA's delegate at Standards Australia, Dr Love agreed out because he thought it important for the Association to be involved in setting standards, particularly as they pertained to medical devices and equipment.

The surgeon freely admits that often the Council deliberates on technical issues and standards that are of little interest or relevance for the medical profession. For instance, it is hard to see that the AMA would have much to offer in discussions about the temperature at which pavement bitumen glues and holds together.

As Dr Love put it, "unfortunately, attending the annual [Council] meeting means that one sits in a lecture room for two or more hours and listens to various reports from worthwhile folk which, when one is not intimately involved with the executive team, has little impact".

But the AMA's presence is not merely for show.

"I think the AMA is an important organisation, and it needs to be represented at Standards Australia, because there are an enormous number of health standards out there," Dr Love said.

In the two decades he has been attending such meetings, across the country and internationally, Dr Love has contributed to the development of standards for an array of medical devices and equipment, most particularly orthopaedic implants.

Early on, he said, this work was particularly significant because Australia was "a bit of a leader" internationally in developing technical standards.

But more recently, the focus of his involvement has shifted, and he now devotes a considerable amount of his time as the AMA's nominee on the Department of Health's Prostheses List Advisory Committee.

Dr Love's work on the Committee involves scrutinising and assessing artificial hips, breast implants, knee replacements and other prostheses for their utility and safety.

He said that, whereas prostheses listed on the Medicare Benefits Schedule had to be approved by the Therapeutic Goods Administration, the Committee had responsibility for listing devices whose use could be covered by private health insurers.

Dr Love said the Committee had become more demanding than the TGA in the robustness of the evidence companies needed to provide in order to have their product approved for listing.

As his involvement in the work of the Committee has developed, Dr Love has felt the need to relinquish his representative role at Standards Australia, and he formally resigned his position late last year.

The AMA has invited expressions of interest from members interested in representing the Association at the Standards Australia Council.

All up, more than 40 members represent the AMA on 120 committees, panels, working groups and fora, making sure the voice of doctors is heard on issues affecting the medical profession and the health and wellbeing of patients and the broader community.

Adrian Rollins

COMMENT

Health on the hill

Political news from the nation's capital

Concern as govts lose focus on mental health

Federal, State and Territory governments have been urged to sign up to ambitious targets for mental health reform as part of a national strategy to reduce the incidence and burden of mental illness.

Mental health advocates have so far been scathing of the tardy and unconvincing response of the Council of Australian Governments to a National Mental Health Commission report highlighting the extent of the nation's mental health problem and the action needed to address it.

In a letter to Prime Minister Tony Abbott accompanying the Commission's *2013 National Report Card on Mental Health and Suicide Prevention*, Chairman Professor Allan Fels detailed the massive economic and social impact of mental illness on the community.

Professor Fels noted that Government spent $6.9 billion on mental health services in 2010-11, while supporting people with mental illness cost the nation about 2.2 per cent of gross domestic product, equivalent to $28.6 billion a year.

Professor Fels and other mental health advocates are concerned that the attention of governments is starting to drift after the issue gained national focus earlier this decade.

While the importance of tackling mental illness was elevated in 2011 when COAG committed to an ambitious strategy, follow-up since then had been disappointing, according to Mental Health Council of Australia Chief Executive Officer Frank Quinlan.

Mr Quinlan was particularly scathing of the fact that COAG had failed to respond to the Commission's 2012 Report Card before the 2013 Report Card was released.

"What is most disappointing is that the mental health sector stands ready to change, but that change must be led by governments. Such delays are unacceptable."

Professor Fels said mental health reform remained "far from complete", and he called upon COAG to sign up to ambitious national reform targets and indicators.

Mr Quinlan said the Federal Government's commitment to a far-reaching review of mental health was welcome, especially if the Commission was given sufficient time and resources, along with the right terms of reference, to conduct a meaningful investigation.

"We call on the Government to revitalise this clearly stalled process and get mental health reform moving again," he said. "We must see the sustained systemic reform our mental health system needs over the course of the next decade to improve the lives of millions of Australians living with mental illness."

Meanwhile, the AMA and 10 other members of the Private Mental Health Alliance have developed and released a set of principles to guide collaboration between practitioners and other service providers.

The Alliance said the shift in the focus of mental health care from institutions to the community setting in the last 20 years meant that there were far more health professionals involved in providing care than there were, creating the need for new processes for coordination and collaboration.

The *Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers* cover issues including patient and carer involvement, continuity of care, referrals and shared care.

"We have a vision for a mental health system that addresses the need for consumers and carers to have a robust referral pathway and process that promotes better communication between providers of mental health services in the private sector," the Alliance said. "We are confident that implementation of the Principles will help to improve outcomes for people with a mental illness and their carers."

Adrian Rollins

COMMENT

Health on the hill

Political news from the nation's capital

Govt urged to effectively assess pathology rent complaints

The Australian Association of Pathology Practices has renewed complaints that the rents paid by its members for pathology collection centres, many of which are located in general practices, have soared, putting the financial viability of smaller operators at risk.

Former Association Chief Executive Katherine McGrath told *The Age* recently that some rents had surged beyond commercial rates.

"The magnitude of these rents is clearly excessive," Ms McGrath said. "It's a serious threat to the viability of pathology providers."

AMA President Dr Steve Hambleton said current arrangements were serving patients well.

"But rents should be consistent with market value and not so excessive that they could be seen as an inducement to refer," Dr Hambleton said.

"The AMA is encouraging the Department of Health to work closely with the Department of Human Services (DHS) to immediately implement systems that will allow DHS to more effectively asses rents as part of the pathology collection centre application process.

"There must be a clear policy directive for DHS to seek further information on rents that appear to fall outside market value and decline those applications that are ultimately unable to establish compliance."

The pathology sector itself is divided over whether or not there is a problem with the system, or that is warrants a review.

In May last year, Primary Health Care Chief Executive Ed Bateman told *The Australian Financial Review* that freeing up collection centre licensing had been "hugely beneficial" for the community, and rejected complaints it had led to over-servicing or inflated rents.

"There is no reason to regulate rents, as they have been in line with expert predictions before regulation and, after rising, have fallen to normal commercial rates," he added.

He said his company adjusted its cost structure to accommodate the deregulation, and was critical of competitors, particularly major rival Sonic, which he claimed had failed to adapt to the new environment.

"We are strongly in favour of maintaining the status quo," he said.

Adrian Rollins

COMMENT

Govt mulls PCEHR overhaul

The Federal Government is considering its response to a review of the controversial Personally Controlled Electronic Health Records system.

The three-member review panel, which was chaired by UnitingCare Health Group Director Richard Royle and included AMA President Dr Steve Hambleton, delivered its report to Health Minister Peter Dutton on 20 December.

Though details of the report and its recommendations have not been disclosed, it is believed to suggest wide-ranging changes to the PCEHR to improve its clinical usefulness and encourage its adoption by patients and doctors.

Mr Dutton said the review looked into significant concerns about the progress and implementation of the PCEHR, and its report "provides a comprehensive plan for the future of electronic health records in Australia".

In its submission to the review, the AMA called for a fundamental change to the system to reduce patient control.

The AMA said the ability of patients to remove or restrict access to information in the PCEHR undermined its usefulness, because doctors could not be confident that it provided the comprehensive medical information needed to make an accurate diagnosis or properly assess the safety of proposed avenues of treatment.

AMA Vice President Professor Geoffrey Dobb said the capacity of patients to remove information from the record without trace was a fundamental flaw of the system.

"To encourage use of the PCEHR, GPs, community specialists and emergency department specialists must be confident that it contains accurate, up-to-date information," Professor Dobb said. "Without a fundamental change to increase clinical confidence, the PCEHR does not serve the best interests of patients. As a result, it would be rejected by many doctors, and would fail."

In a reversal of its previous position, the Consumer's Health Forum has backed a switch in the system to automatically enrol people unless they choose to opt out.

The Forum's spokesman Mark Metherell told the *Courier Mail* that "Australia should bite the bullet and make joining the national e-health records system automatic for everyone unless they actively choose to opt out".

The organisation's backflip has come amid continuing reluctance of most patients and doctors to sign up to the system.

Since it was launched in mid-2012, little more than one million people have registered to create an electronic health

MORE P36

Health on the hill

Political news from the nation's capital

... FROM P35

record, and only 1 per cent of records have had a clinical summary uploaded by a doctor.

Mr Dutton refused to set a timeline for the Government's response to the review's recommendations, saying it would make its views known "in due course".

Adrian Rollins

COMMENT

Industry tries to dim food health stars

Health experts are concerned the nation's health ministers are giving ground on food labelling to industry, which is pushing for last-minute changes to Health Star Rating System for packaged food products.

At a meeting held just before Christmas, the Legislative and Governance Forum on Food Regulation - the peak body for Australian and New Zealand Ministers responsible for food - endorsed the use of the Health Star Rating Calculator, which generates a score for each packaged food product that will be sold in Australia.

But Federal Assistant Health Minister Fiona Nash, who chaired the Forum meeting, announced she was directing the Commonwealth Health Department to "broaden the cost-benefit analysis of front-of-pack labelling to include evidence-based research and extensive industry consultations in the absence of a Regulatory Impact Statement, which was not agreed to by the Forum".

The announcement has heightened concerns that the food industry is making headway in its attempts to make additions and modifications to the Star Rating system that will make it more difficult and confusing for shoppers to use.

Health and consumer groups are seeking details of how broad the cost-benefit analysis will be, who will conduct it, over what period, and what opportunities there will be for groups involved in the development of the star rating system to make a contribution.

In the lead-up to the meeting, AMA President Dr Steve Hambleton urged the Ministers to resist food industry efforts to modify and complicate the system, which he said had been carefully developed through extensive and detailed consultations involving the AMA, the industry, consumer organisations and public health groups.

"Following the consultations, all stakeholders agreed that the Health Star Rating System was the form of labelling food manufacturers should adopt," Dr Hambleton said. "But since then, the food industry – led by the Australian Food and Grocery Council - has tried to make additions and modifications that will not add any useful information, and will instead make the system more difficult to use."

He urged the Minister to ignore such tinkering, which would "only confuse shoppers and dilute the simple 'at a glance' nature of the system."

In addition to a five-star rating scale, the system includes an information panel detailing how much saturated fat, sodium and sugar, as well as one other ingredient (chosen by the manufacturer) the food contains. Packages carrying the new labelling are due to appear on store shelves from the middle of the year.

While the food industry has been reluctant to move away from its Daily Intake Guide labelling system, research suggests many consumers do not use it and would prefer and trust a simpler labelling regime developed involving health and consumer groups.

Consumer organisation Choice conducted a survey that found 62 per cent of shoppers were unaware of, or rarely used, the Daily Intake Guide when buying food.

Instead, more than 60 per cent per cent indicated they preferred the star rating system, with a majority indicating they would put more trust in nutrition information developed by health and consumer groups, compared with 16 per cent who indicated they would trust industry.

Dr Hambleton said the system would be a great tool for doctors when advising patients, who come from a wide range of backgrounds, on how to make healthy choices in what they buy and eat.

In an important step to ease and speed the transition to the new labelling system, the Forum agreed on arrangements for an Oversight Committee to monitor and evaluate the effectiveness of the Health Star Rating System.

In a further boost, the New Zealand Government revealed it was "actively considering" joining the system.

Adrian Rollins

Temper of the time bodes ill for Glasson

Former AMA President Dr Bill Glasson is having another tilt at entering Federal Parliament following an announcement that a by-election for the Brisbane seat of Griffith will be held on 8 February.

MORE P37

Health on the hill

Political news from the nation's capital

... FROM P36

In the first electoral test for the Abbott Government since it won office last September, Dr Glasson will contest the seat for the Liberal National Party against Australian Labor Party candidate, industrial relations lawyer Terri Butler, following the resignation of its sitting member, former Prime Minister Kevin Rudd.

In the national poll, Dr Glasson secured a 5.4 per cent swing against Mr Rudd, though Labor retained the seat with a healthy 53-47 per cent two-part preferred margin.

But although the swing toward the Coalition won by Dr Glasson in the Federal election was almost 1 percentage point greater than the national swing, political analysts think it unlikely he will win enough votes to secure the seat.

Since Federation, a sitting Government has only once won a by-election against the Opposition, and recent polls suggesting the Abbott Government has enjoyed the shortest political honeymoon on record add to doubts about Dr Glasson's chances of success.

Voter surveys conducted since the September election show Prime Minister Tony Abbott and his Coalition Government suffered a stunning downturn in their political fortunes in the space of just a few months, with both the nation's major pollsters – Nielsen and Newspoll – indicating a post-election swing against it of about 6 percentage points, enough to turf it out of office if a national election was held now.

Adrian Rollins

COMMENT

Budget red ink stokes health cut fears

The Abbott Government has axed a $265 million package of funds for hospital upgrades and health programs across the country as part of measures to rein in Commonwealth spending.

In its Mid-Year Economic and Fiscal Outlook, released a week before Christmas, the Government revealed that it would not proceed with the package, prompting accusations it had broken its promise to quarantine the health budget from spending cuts.

Under the four-year Priority Health Initiatives program, detailed in the Pre-election Economic and Fiscal Outlook, the Commonwealth was due to provide Westmead Hospital with $100 million to fund the first stage of its redevelopment, $22 million for St George Hospital in Kogarah, $10 million for cancer services at Nepean Hospital, $10 million for the Children's Medical Research Institute, $10 million for cancer services in Queensland, $50 million for a package of stroke services, and $6 million for an MRI service at Mount Druitt.

The cut was contained in the MYEFO, which showed Government revenues had collapsed, forcing a massive blowout in estimates of the 2013-14 Budget deficit, from $18 billion in May to $47 billion.

Treasurer Joe Hockey warned accumulated deficits would reach almost $123 billion over the next four years, while gross Commonwealth debt would balloon out to more than $666 billion.

The health portfolio has contributed to the deterioration in the Budget. The Government said demand for medical services had grown more strongly than expected, with predictions of a $659 million surge in Medicare Benefits Schedule expenditure in the next four years.

In addition, in the next four years private health insurance rebates are expected to cost $873 million more than originally anticipated.

The grim Budget assessment has stoked concerns that health spending will come under intense scrutiny as the Government's National Commission of Audit hunts for savings.

Fear that health care will be affected by the austere budgetary environment has been heightened by warnings from Health Minister Peter Dutton that Medicare in its current form would become increasingly difficult to sustain, and his refusal to rule out suggestions that patients make a $6 co-payment when seeking care from a GP or hospital emergency department [see also, *$6 co-payment an illusory health saving,* p6].

To recoup some funds, the Department of Human Services aims to save around $23 million by cracking down on public hospitals trying to shift the cost of expensive diagnostic tests from state health budgets to Medicare.

Despite this, the Government claims it has not broken its pledge to "maintain existing levels of [health] funding", arguing that the Priority Health Initiatives program was a pledge by Labor and that many projects included in it were only identified after the previous Government entered caretaker mode.

But Shadow Health Minister Catherine King refuted the assertion, saying the funding for the projects was "budgeted for and included in the Pre-election Economic and Fiscal Outlook", and provided copies to back up her claim.

In a more promising outcome, the Government reported in MYEFO that the price disclosure regime for pharmaceuticals would save it almost $3 billion in the next four years.

Adrian Rollins

COMMENT

Health on the hill

Political news from the nation's capital

Biggest private health hike in years to cause widespread financial pain

The Federal Government has approved the biggest increase in private health insurance premiums in almost a decade, blaming an increase in claim costs it said was putting the industry under pressure.

Just two days before Christmas, Health Minister Peter Dutton revealed he had given the green light for the nation's 34 private health funds to increase their premiums by a hefty 6.2 per cent from 1 April.

The increase is the largest since 2005, and follows an average 5.6 per cent premium hike last year.

Insurer NIB revealed it would raise its premiums by 8 per cent, while the nation's largest private health insurer, Medibank Private, said its premiums would increase by an average of 6.5 per cent, and the third major health fund, Bupa, planned an average 6.4 per cent lift.

The increases are likely to hit many policyholders hard, including thousands who had paid their premiums up to 18 months in advance to secure the maximum Commonwealth rebate before new means-testing rules kicked in.

Compounding this, those ineligible for the rebate under the means-testing rules may not get relief from the new rules as quickly as the Coalition had indicated prior to the election, when it promised to overturn the means-testing legislation in its first term.

In its Mid-Year Economic and Fiscal Outlook, the Government revealed rebate spending would be $873 million greater than earlier anticipated, and Mr Dutton indicated the withdrawal of rebate means testing may be delayed beyond the Coalition's first term in office.

Mr Dutton said the Government had closely examined the premium increase application of each insurer, and the rise was necessary to ensure the viability of the industry.

During 2013 the industry experienced a higher than expected level of claims, which pushed the overall cost of benefits up by 8 per cent, the Minister said.

He said the magnitude of the increase would help the industry absorb its highest costs, and expressed confidence that competition in sector was intensifying and would keep premium increases as low as possible.

But there are concerns that competitive pressures in the industry are insufficient, and could be further diluted by the proposed privatisation of Medibank Private.

The Federal Government has commissioned a scoping study into the possible sale, and the AMA is among those apprehensive that unless it is conducted carefully it could lead to a diminution of competition within the sector, leaving consumers exposed to even greater premium increases in future.

Shadow Health Minister Catherine King said it was "entirely cynical for the Abbott Government to sneak [the premium increase announcement] out two days before Christmas".

Adrian Rollins

COMMENT

The answer is blowing in the wind

Prime Minister Tony Abbott has thrown his support behind a renewed investigation into the possible health effects of wind farms.

Though almost 20 studies conducted internationally have failed to find evidence that wind farms harm health, Mr Abbott said earlier this month that it was "perfectly reasonable" for the issue to be re-examined.

Federal Health Minister Peter Dutton and his Victorian counterpart David Davis are planning a research project, to be led by the National Health and Medical Research Council, to examine the issue following

persistent complaints from a small but vocal segment of the population who have blamed wind farms for a multitude of health complaints including headaches, herpes, weight loss and gain, cancer, nose bleeds, nocturia, dental infections, nightmares and vibrating lips.

In a review conducted in 2010, the NHMRC concluded that "there is currently no published scientific evidence to positively link wind turbines with adverse health effects".

Similarly, the World Health Organisation has found that "there is no reliable evidence that sounds below the hearing threshold produce physiological or psychological effects", a conclusion addressing one of the common claims made by the anti-wind turbine group the Waubra Foundation, that it is the sub-audible sound (also referred to as infrasound) produced by wind turbines that cause health problems.

The issue is a particularly sensitive one for the Coalition because wind farms (and hence, those who claim to be adversely affected) are in regional and rural areas.

MORE P39

Health on the hill

Political news from the nation's capital

... FROM P38

Complicating the picture, the issue has also become imbued with overtones from the broader climate change and alternative energy debate – not least by the Government's chief business adviser Maurice Newman, who has been a vocal critic of wind farms.

The Australian revealed earlier this month that the Federal and Victorian governments were in communication with each other soon after the election about setting up an inquiry into wind farms, and reported that Mr Abbott was enthusiastic about the idea.

"From time to time we do need to refresh the research; we do need to consider whether there have been new facts that impact on old judgements, and that is a perfectly reasonable thing to do," the Prime Minister said. "It is some years since the NHMRC last looked at this issue: why not do it again?"

Since 2010, the NHMRC has continued to monitor the science in the area through its Wind Farms and Human Health Reference Group, which has had its term extended to 2015.

According to *The Australian*, wind farm operator AGL has commissioned research showing no measurable change in infrasound levels in the location of its facilities, and scientists have pointed out that the infrasound associated with wind turbines is no greater than that which occurs in the natural environment from wind and other background noises.

Instead, many researchers have begun investigating the extent to which wind farm-associated health complaints are psychosomatic phenomena that attest to the power of suggestion.

One recent study, published by *The Conversation* (to view, visit http://theconversation.com/wind-turbines-dont-make-you-feel-sick-or-healthy-but-spin-can-20845) attempted to test the influence of the way the issue was framed on perceived symptoms, and found there was a positive correlation – those who were told there was a problem were more inclined to report symptoms than those who were not.

Adrian Rollins COMMENT

PBS co-payment rises, but cancer, diabetes drugs cheaper

Patients have been slugged with a 2 per cent hike in their co-payment for Pharmaceutical Benefits Scheme prescriptions, but will gain subsidised access to cancer and diabetes medicines from next month.

In an announcement on 3 January, the Government revealed that the PBS co-payment for general patients has been raised from $36.10 to $36.90 (for concession patients, from $5.90 to $6), and the safety net threshold has increased from $1390.60 to $1421.20.

The modest 2.2 per cent increase is in line with inflation but, combined with speculation the Government may back a proposed $6 patient co-payment for GP bulk billed services, heightens concerns that health care costs are increasingly being transferred directly onto families and may discourage people from seeking necessary care and treatment.

The PBS hike came after Health Minister Peter Dutton announced several drugs and combination medicines would be added to the PBS on 1 February.

Mr Dutton said the diabetes medications Aloglitpin and Metformin, which are currently listed individually, will from next month be listed as a combination dose (under the name Nesina Met), providing a substantial $36.90 saving to patients.

"More than 50,000 people are expected to obtain the combined medicine through the PBS over the next five years," he said. "With an average of seven packs each over that period, this represents a considerable saving to people with diabetes."

The Government has also approve the listing of cancer treatments Erlotinib (sold as Tarceva) and Gefitinib (sold as Iressa).

The drugs are used in the treatment of non-small cell lung cancer.

Several other listed medicines will become cheaper from 1 April as a result of price disclosure arrangements, including:

- gastric reflux treatment Rabreprazole, which will be up to $8.78 cheaper per prescription;
- depression medicine Escitalopram, up to $3.43 cheaper per script; and
- cholesterol treatment Simvastatin, up to $5.18 cheaper.

Adrian Rollins COMMENT

Powerful drug committee doubles meeting notice

The pharmaceutical industry has welcomed a move to increase the transparency of the powerful Pharmaceutical Benefits Advisory Committee amid mounting frustration with approval delays and listing rejections.

In a reform to its processes the Committee, which recommends on drugs to be listed on the Pharmaceutical Benefits Scheme, will now publish the agenda for each meeting 10 weeks ahead of time – up from six weeks.

The move was welcomed by peak industry group Medicines Australia, which described it as "practical [and] meaningful".

"It means consumers, consumer groups and members of the general public will now have more time to prepare submissions and make comments to the PBAC on new medicines and vaccines seeking listing on the Pharmaceutical

MORE P40

Health on the hill

Political news from the nation's capital

... FROM P39

Benefits Scheme," Medicines Australia Chief Executive Dr Brendan Shaw said.

The move came after reports the pharmaceutical industry has become increasingly unhappy with the operation of the committee, complaining of long delays in getting medicines listed and opaque decision making processes.

Dr Shaw told *The Australian Financial Review* that "it's clear that something needs to give in the process for listing new medicines".

Adrian Rollins COMMENT

Diabetes, dementia research shielded from cuts

The Federal Government has directed that $103 million of research funds be used to help develop treatments for diabetes, dementia and tropical diseases.

In an announcement that shields at least some research spending from cutbacks as the Abbott Government works on framing an austere 2014-15 Budget, Education Minister Christopher Pyne said $35 million had been allocated over five years for the Juvenile Diabetes Research Foundation Clinical Research Network to help find a cure for type 1 diabetes, while $68 million would be spent to support work developing treatments for dementia and tropical diseases.

"Investing and supporting medical research is one of the best long-term investments in health that a government can make," Mr Pyne said. "Diabetes and dementia, in particular, are among the biggest killers of Australians, so we must continue to fight these looming public health challenges by bringing our brightest and best minds to bear."

The Minister said that not only would the funding support much-needed research, it would also have a payoff for the economy.

"Medical research has the power to significantly strengthen the economy and create thousands more jobs," he said. "It is estimated that every dollar spent on medical research produces $2.17 in health benefits to the economy."

Adrian Rollins COMMENT

Govt puts onus on parents to curb child obesity

The Federal Government has flagged its reluctance to use taxes and regulations to shape the nation's eating habits, as politicians and public health experts around the world monitor Mexico's experiment with a levy on sugary drinks.

Health Minister Peter Dutton emphasised the responsibility of parents to ensure their children had healthy diets in an interview with the *Courier Mail* earlier this month.

"The vast majority of parents do the right thing, but those who use electronic devices in place of activity or sport, and [who] default to fast food each night instead of healthy meals, need to take responsibility," Mr Dutton said. "Food taxes and advertising bans don't trump parental responsibility. I want government out of people's lives."

Mr Dutton's comments came as research was released showing that children as young as four years are developing type 2 diabetes as a result of poor diets and unhealthy lifestyles, setting them up for a lifetime of health problems.

National Diabetes Services Scheme figures revealed by *The Sunday Mail* show that at least 52 children in Queensland have been diagnosed with type 2 diabetes.

Cairns Hospital endocrinologist Dr Ashim Sinha told the newspaper around 20 children from the State's far north and western areas had been diagnosed in the past year, including an obese five-year-old girl.

Dr Sinha said children as young as 13 years were being prescribed blood pressure and cholesterol-lowering medicines, as well as drugs to ward off the progression of diabetic kidney disease.

He said the problem was most prevalent in Indigenous communities, where

genetic, lifestyle and socioeconomic contributed to the situation.

AMA President Dr Steve Hambleton said it was "shocking" that children younger than 10 years were developing type 2 diabetes.

Highlighting the limitations of relying on parents to ensure children ate well and had a healthy lifestyle, the Australian National Preventive Health Agency has warned that many adults themselves understand the link between obesity and ill health.

The Agency, which is subject to speculation that it may be abolished by the Abbott Government as it searches for savings, noted in a submission to the National Commission of Audit that "people do not always choose in their self-interest in relation to health".

It said the lack of a clear understanding among many of the link between obesity and chronic diseases such as diabetes demonstrated a clear role for Government in promoting healthy diets and lifestyles.

Adrian Rollins COMMENT

Members' Forum

Here's a selection of what AMA Members have been saying about the latest issues affecting the profession:

AMACGP Chair Dr Brian Morton said the tragic death of an infant after parent who called the *healthdirect* 24-hour telephone helpline was mistakenly told their child's meningitis was a short-term 'tummy virus' underlined long-standing concerns about such services as a substitute for GP after hours care. The incident made one reader reflect on the willingness of governments to accept good advice.

Interesting that a working group, well represented by ethically minded medical groups, was disbanded by Government, when it had the temerity to point out that misguided plans of the Government. We must be doing the right thing. Perhaps the LNP Government may shoe some faith in honest and considered advice. Here's hoping.

Submitted by Bob Brown (not verified)

Doctors must always be prepared to provide treatment in emergency situations, regardless of whether or not this might conflict with their personal beliefs and values, the AMA has said, setting clear guides regarding the extent to which practitioners can follow the dictates of their conscience. Unsurprisingly, it is an issue that has provoked vigorous debate among readers.

Distress to the patient: what a naïve and politically correct approach to our basic rights of freedom of speech etc. So, if my choice to practice in private causes distress to my patient, then I am liable? I have a bible in my waiting room which could cause offence. Do I have to have atheist, Catholic, Protestant and Muslim books also? Or must I refrain from having private health insurance information, religious information, anti-vivisectionist, and pro- or anti-climate change info? Control of our personal practice by the PC police is coming from my own AMA now? You can have your views, but I can't have mine. Orwellian 1984 continues.

Submitted by Anonymous

The doctor does not practice in private, and their practice is not personal, because the patient is present. The ethical breech of not referring the patient on is the breech of abandonment. The doctor's rights and rights to free speech are limited, because doctors practice medicine for the benefit of the patient and within society's rules. The idea that a bible in one's waiting room might cause offense is a straw man, to answer the commenter's question.

Submitted by APenNameAndThatA (not verified)

The Victorian 2008 abortion laws appear to compel doctors to actively assist women seeking abortion for any reason, be it gender selection as in Dr Hobart's case, or other reasons which may be medically inappropriate or offend the doctor's moral conscience, such as late term abortion. It would be also be difficult for the doctor to refuse in cases in which he suspects coercion or abuse but has no proof. The doctor is no longer able to discriminate. This is what is so wrong about this law. Of course, doctors should assist a patient's access to treatment, but not to the point where the doctor is of the opinion the treatment may be harmful to the patient, as this law seems to do.

Submitted by Witheld

COMMENT

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

The AMA Council of General Practice has developed a resource that brings together in one place all the forms, guidelines, practice tools, information and resources used by general practitioners in their daily work.

The GP Desktop Practice Support Toolkit, which is free to members, has links to around 300 commonly used administrative and diagnostic tools, saving GPs time spent fishing around trying to locate them.

The Toolkit can be downloaded from the AMA website (http://ama.com.au/node/7733) to a GP's desktop computer as a separate file, and is not linked to vendor-specific practice management software.

The Toolkit is divided into five categories, presented as easy to use tabs, including:

- online practice tools that can be accessed and/or completed online;
- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

In addition, there is a State/Territory tab, with information and forms specific to each jurisdiction, such as WorkCover and S8 prescribing.

The information and links in the Toolkit will be regularly updated, and its scope will be expanded as new information and resources become available.

Members are invited to suggest additional information, tools and resources to be added to the Toolkit. Please send suggestions, including any links, to generalpractice@ama.com.au

Research

Eye test determines severity of MS

Scientists have developed a simple eye test to monitor and track the severity of multiple sclerosis (MS) in patients over time.

Building on the finding that eye pupil responses in MS patients are slower than those without the condition, Australian National University researchers have developed a diagnostic test using instruments that precisely measure the speed with which pupils respond to stimuli.

The researchers said that the eye test was a simple and quick way of tracking the severity of MS over time, with the slower the pupil response was, the more advanced the condition was.

MS is a neurological condition affecting the myelin sheath of nerve fibres, leading to sensory disturbances and muscle weakness. Vision, speech and walking are most often affected, and pain can occur. MS affects different people in different ways, but the condition get worse with age. In Australia there are about 12,000 suffers, and it is the most common neurological disability in adults.

Lead researcher Professor Ted Maddess, a vision scientist at the Australian national University, said although MS seems to be some sort of immune disorder, its cause is still obscure.

"There are many puzzling aspects to MS and there are many theories, but our main aim in this work was just to find a way of accurately monitoring the progression of the disease, a single measure that relates to the degree of the disability," Professor Madess said.

The study examined 85 patients with MS and found that the pupil response in MS patients was about 25 milliseconds slower than in a control group without the condition.

For the test, researchers used a device that emits special patterns of flashing lights. Infrared cameras capture light-induced changes in the diameter of both pupils, and computer tracking measures the diameter to within a micrometre, 30 times a second.

Professor Ted Maddess said although the study is preliminary, he believes the test has good potential for individual patients because it can precisely measure the speed of their response to within a millisecond.

"So, instead of an expensive MRI to track the condition, the new method gives an accurate readout after just a few minutes. That quick and easy test might, in future, allow MS patients to be assessed on the spot, and have their medication adjusted accordingly," Professor Ted Maddess said.

"if we can use our pupil measurements to monitor the decline, we might be in a better position to adjust medications, which often have unpleasant side-effects."

The device the researchers used to measure pupil response is the same as has been shown to be helpful in diagnosing vision loss in glaucoma, diabetes and age-related macular degeneration. The device was developed by Professor Maddess and colleagues, and is being commercially developed.

The research was published in the *Multiple Sclerosis Journal*.

Kirsty Waterford

COMMENT

You don't feel my pain

The age-old debate about who feels greater pain, men or women, may have finally be resolved.

And for angst-ridden males who might believe those who carry the Y chromosome feel pain more acutely, and put up with it more stoically, the news is not good.

According to neuroscientist Dr Mark Hutchison, a researcher at the University of Adelaide's School of Medical Sciences, the evidence shows that it is women, not men, who experience the greater pain.

Dr Hutchison said research had shown that glial cells, which act as the brain's immune cells, play a role in making the pain thresholds of men and women different.

"There are fundamental differences in the experience of pain between men and women," Dr Hutchison said. "These studies show that women's experience of pain is more severe, and the pain is harder to treat."

In his research, Dr Hutchinson has looked closely at why acute pain turns into chronic pain that can last for up to six months, and why such chronic pain is more prevalent and longer-lasting in women than in men.

Dr Mark Hutchinson said differences in the structure of female and male brains did not explain why women felt a higher rate of pain.

"There is a difference in sensitivity, we know that. But rather than just sensitivity to the drug used in females, there are multiple different pain systems," he said.

Dr Hutchison said the discovery raised the question of whether gender-specific painkillers needed to be developed.

He said it was already evident that some drugs for inflammatory bowel disease worked only on women and not on men.

"We are hoping our research will lead to the development of more sex-targeted drugs being developed," Dr Hutchinson said.

Sanja Novakovic

COMMENT

Research

Eternal youth may be yours, for just $43,000 a day

Like a bad fairy tale, scientists believe they have developed a way to stop people getting older, but at a cost that puts it out of the reach of all but the super-rich.

A team of researchers at the University of New South Wales, working in collaboration with geneticists at Harvard Medical School, claim to have unlocked the secret to eternal youth, and to have developed a compound they say not only halts the ageing process, but can turn back the years.

The catch is, the treatment is prohibitively expensive, with estimates it would cost the average 86 kilogram man $43,000 a day, and the average 71 kilo woman $35,500 a day.

The compound was developed based on an understanding of how and why human cells age.

A series of molecular events enable communication inside cells between the mitochondria – the energy source for cells, enabling them to carry out key biological functions – and the nucleus. The researchers found that when there is a communication breakdown between the mitochondria and the nucleus of the cell, the ageing process accelerates.

As humans age, levels of the chemical NAD (which initiates communication between the mitochondria and the nucleus), decline. Until now, the only way to arrest this process has been through calorie-restricted diets and intensive exercise.

But the researchers, led by University of New South Wales and Harvard University molecular biologist Professor David Sinclair, have developed a compound - nicotinamide mononucleotide - that, when injected, transforms into NAD, repairing broken communication networks and rapidly restoring communication and mitochondria function.

In effect, it mimics the results achieved by eating well and exercising.

“The ageing process we discovered is like a married couple. When they are young, they communicate well but, over time, living in close quarters for many years, communication breaks down,” Professor Sinclair said. “And just like a couple, restoring communication solved the problem.”

In the study, the researchers used mice considered equivalent to a 60-year-old human and found that, within a week of receiving the compound, the mice resembled a 20-year-old in some aspects including the degree of muscle wastage, insulin resistance and inflammation.

Professor Sinclair said that, if the results stand, then ageing may be a reversible condition if it is caught early.

“It may be in the future that your age in years isn’t going to matter as much as your biological age,” Professor Sinclair said.

“What we’ve shown here is that you can turn back your biological age or, at least, we think we have found a way to do that.”

The problem is, the compound is prohibitively expensive, at least at the moment.

It costs $1000 per gram to produce, and in tests so far it has been applied at a rate equivalent to 500 milligrams for every kilogram of body weight, each day.

Professor Sinclair admitted the cost was major consideration, and said the team was looking at was to produce the compound more cheaply.

As part of their research, the scientists investigated HIF-1, an intrusive molecule that foils communication but also has a role in cancer.

It has been known for some time that HIF-1 is switched on in many cancers, but the researchers found it also switches on during ageing.

“We become cancer-like in our ageing process,” Professor Sinclair said. “Nobody has linked cancer and ageing like this before, and it may explain why the greatest risk of cancer is age.”

Researchers are now looking at longer-term outcomes the NAD-producing compound has on mice, and suggest human trials may begin as early as next year.

They are exploring whether, in addition to halting ageing, the compound can be used to safely treat a range of rare mitochondrial diseases and other conditions, such as cancer, type 1 and type 2 diabetes, muscular dystrophy, other muscle-wasting conditions and inflammatory diseases.

The research was published in the journal *Cell*.

Kirsty Waterford

COMMENT

Continued dispensing - facts for AMA members

Pharmacists can now dispense oral contraceptives and statins to patients without a prescription in six out of eight jurisdictions in Australia.

Under 'Continued Dispensing', a pharmacist can supply a standard pack of an eligible PBS medicine to patients who requests it, without requiring a prescription from a medical practitioner.

The Continued Dispensing initiative was developed jointly by the Commonwealth Government and Pharmacy Guild of Australia under the Community Pharmacy Agreement.

The AMA lobbied hard to oppose legislation allowing Continued Dispensing within the Pharmaceutical Benefits Scheme, including writing to all Federal parliamentarians to explain the risks to patients. Despite these efforts, the legislation was passed last year.

Legislation in the ACT, NSW, Western Australia, Victoria, Tasmania and South Australia has now also been amended to specifically provide for Continued Dispensing, and may be passed in the Northern Territory and Queensland in the next few months.

Eligible medicines under Continued Dispensing are:

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

It is important that medical practitioners are familiar with the conditions under which pharmacists can dispense.

The practice guidelines issued by the Pharmaceutical Society for Australia state that 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; and
- there is an ongoing need for supply, and the medicine is safe and appropriate for that patient.

The practice guidelines 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.

In addition, the pharmacist must:

- be able to identify the most recent prescriber of the requested medicine and their practice address;
- not supply the medicine to a patient if the medicine has already been supplied by any pharmacy by Continued Dispensing in the previous 12 months; and
- advise the patient's medical practitioner within 24 hours that the medicine has been supplied without a prescription.

The AMA recommends you keep a copy of the pharmacist's notification to you about a Continued Dispensing episode on your patient's file.

Please refer to the AMA's fact sheet on Continued Dispensing [https://ama.com.au/continued-dispensing-pharmacists] for more detailed information, including the full list of eligible PBS medicines.

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 been useful?
- Has there been an impact on the management of your patient?

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

Dodgy PNG contract could cost lives

People are likely to die because of the Australian Government's decision to axe funding for the supply of medicines in Papua New Guinea, health experts have warned.

The Department of Foreign Affairs and Trade (DFAT) has withdrawn funding for a $38 million program to supply medical kits to almost 3000 health centres across PNG following a flawed tender process administered by the PNG Health Ministry.

The decision has been met with concern and dismay, with Medical Society of PNG Treasurer Dr Glen Mola warning in an interview broadcast on ABC's Radio Australia it could lead to shortages of quality medicines, putting lives at risk.

"If the health workers don't receive the medicine they need to treat the patients, well then, the patients die," Dr Mola told the ABC. "It's not like in Australia, where the patient can go just to a different facility or go to see a different doctor. When you're in a rural or remote area of Papua New Guinea, your health centre is the only health facility for your community – there's no alternative."

But locals admit the root of the problem is the PNG Government's handling of the tender to supply medical kits to the country's health centres.

Three years ago the PNG Government appealed to Australia for help after a corruption scandal left hospitals and other health facilities dangerously low on essential medicines.

For the past two years Australia has directly engaged the International Dispensary Association (IDA) to supply kits to health centres across the country, and Dr Mola told the ABC it had done "a good job".

But last year the PNG resumed responsibility for procuring the supply of medical kits for 2014 and beyond, which Australia agreed it would continue to fund, subject to a satisfactory and transparent tender process.

However, days after the tender process closed, the PNG Government informed bidders they would no longer be required to carry the international quality management accreditation, ISO 9001.

Subsequently, PNG's Central Supply and Tenders Board awarded the $28.3 million contract to the company Borneo Pacific Pharmaceuticals Ltd, which does not hold ISO 9001 accreditation, and which has been found in the past to supply substandard drugs.

An investigation conducted in 2011 found all four samples of antibiotics provided by Borneo Pacific from its supplier, the North China Pharmaceutical Group, were sub-standard, with one assessed as most likely a fake.

In addition to its worrying record, the Borneo Pacific bid was more than $9 million higher than that from IDA.

In a statement issued to the ABC, DFAT said its funding was "conditional on the Government of PNG purchasing the kits from a pharmaceutical firm which met international drug quality standards, through a fair, transparent international tender process. Unfortunately, these conditions were not met and the Australian Government will not fund the distribution of medical kits resulting from this tender process".

It is the outcome Dr Mola and his colleague Nakapi Tefuarani had feared.

In a letter published by the Devpolicy Blog website (http://devpolicy.org/) in late November, the doctors warned that Australia was likely to withdraw its funding if the successful bidder procured medicines from "non-GMP (International Good Manufacturing Process" suppliers.

"Then we will be left with local 'wantok' distribution companies sending out low-quality and possibly counterfeit medicines to our hospitals and health centres," they wrote. "This will lead to the deaths of many Papua New Guineans and also much disability."

Adrian Rollins

COMMENT

After a horror start, Obamacare finally gains some traction

A relieved Obama Administration claims more than two million people have signed up for insurance cover under its controversial health reforms following a surge of enrolments in December.

As President Barack Obama seeks to undo the significant political damage caused by the disastrous launch of the Federal Government's bug-riddled Health Insurance Marketplace website (https://www.healthcare.gov/) in October and November, White House officials claimed early this month that more than 2.1 million had enrolled in the system by the end of December.

Combined with about 4 million who have gained health coverage through the expansion of the Medicaid program (a key element of the Obamacare reform) or have for the first time been included in their parents' health insurance under the Children's Health Insurance Program, the Administration claims that an extra 6 million Americans have so far gained health insurance coverage as a result of its health reform.

MORE P46

After a horror start, Obamacare finally gains some traction

... FROM P45

But the accuracy of the claim has been attacked as Republican politicians and other critics of the Federal Government continue to exploit widespread unease and confusion about Obamacare in the American electorate.

Republicans have claimed that millions of people have had their existing health insurance policies cancelled as a result of the Affordable Care Act, seeking to imply that they have been left without coverage.

But a Washington Post analysis casts doubt on these claims, finding that most of the 4.7 million people who received a notice from their insurer notifying them that their old plan was cancelled, were at the same time informed that their coverage had been transferred to a new plan that was consistent with the basic requirements for health insurance inclusions as stipulated under the Act.

But the Obama Administration's claims have also come under scrutiny, particularly its definition of enrolment.

The Washington Post warned that White House figures included people who had chosen to enrol in an insurance plan, who but who may not have yet paid their premium.

While much of the political debate has so far centred on the raw enrolment numbers, perhaps more critical to the success of the Obamacare is the demographic breadth of insurance coverage – health funds need to enrol a substantial proportion of younger, healthier members to help offset the claims made by older, sicker members.

In a promising sign for the system, at least in one state, Kentucky earlier this month that 40 per cent of the 116,000 people who had enrolled in Medicaid or qualified health plans through the state's health insurance marketplace were younger than 35 years. According to the Washington Post, Government officials are looking for at least 30 per cent of enrolees to be younger than 35 years to make the reform sustainable.

After its very shaky start, White House officials are keen to get the system operating and generate positive media coverage.

In a statement issued on New Year's Day, the Secretary of Health and Human Services Kathleen Sebelius said the Government would work hard to ensure that "every American who wants to enrol in Marketplace coverage by the end of the open enrolment period on March 31, 2014, is able to do so - and enjoy the security and peace of mind that comes with having quality health coverage".

But the long-term viability of the reform remains uncertain.

As the *Washington Post* warned, "it's important to remember that the health care marketplace is not a single entity, but at least 51 different marketplaces, each with its own risk pool, so it is quite possible some states will do very well while others might end up with an unbalanced mix".

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

From graduates preparing their first resume to experienced doctors seeking to carve out a new career path in the Commonwealth public service, the AMA Careers Advisory Service is been on hand to provide practical advice and information.

Since the Service was launched in September, AMA Careers Consultant, Kathryn Morgan, has handled dozens of inquiries from members looking for help and advice on advancing their careers, both within medicine and beyond.

The Careers website, which is at: http://careers.ama.com.au/, gives members access to both general and specific careers advice and information. In addition to direct links to external websites and specific sources of information, the Service also offers practical advice for medical professionals as their medical careers advance.

The Careers Service provides information and support relevant to all stages of an individual's career, from medical students looking for assistance preparing internship applications - particularly writing resumes and covering letters - through to doctors in training who want to brush up their interview skills to give them a competitive edge at all-important medical college interviews.

But the Service is not only there for those in the early stages of their medical careers. It has also helped qualified medical professionals looking to apply their skills and expertise in jobs beyond medical practice. Among these have been those looking for non-clinical roles in Commonwealth and State public services that take advantage of their skills and experience.

The Service is constantly updating content on its website, including listings of career-related events being staged across the country, and uses feedback from members to help add and develop resources.

Members are encouraged to visit the website, if they haven't done so already, and we welcome feedback, which can be submitted via the online feedback form on the website.

There will be further updates on developments in the Careers Service in coming months as we develop more ways to assist members along their medical career path.

If you or your colleagues would like to convene a skills workshop facilitated by Kathryn, please contact her at:

Phone: (02) 6270 5410;
1300 884 196 (toll free)

Email: careers@ama.com.au

Fiat 500 - “l’arte di arrangiarsi”

BY **DR CLIVE FRASER**

MOTORING

2014 Fiat 500 Pop vs 1957 Fiat 500	
For	The cutest car in history.
Against	What could you ever replace it with?
This car would suit	Nostalgic Italian doctors in no hurry.
Specifications	1.2 litre 4 cylinder (0.5 litre 2 cylinder) petrol 51 kW power @ 5,500 rpm (9.7 kW) 102 Nm torque @ 3,000 rpm 5 speed (4 speed) manual Length 3.5 metres (2.97 metres) 5.1 l/100 km (4.5 l/100 km) combined $14,000 Drive-away (465,000 lire)
Fast facts	Fiat and Chrysler merged in 2013. The 2014 Fiat 500 is made in Poland and Mexico.

It’s been 60 years since Alberto Sordi starred in the 1954 Italian comedy “l’arte di arrangiarsi”, in which he was cast as a 20-year-old layabout with only two loves: women and money.

Like most Italians of the day, he was having an affair and, in keeping with the politics of the time, he went from being a Fascist to a Communist and then a Christian Democrat, only to end up pretending to be from Frankfurt, selling fake German goods on the streets of Rome.

If you haven’t figured it out by now, the title of the movie “l’arte di arrangiarsi” roughly translates into an Italian saying of the time, “the art of getting by”.

It was with the plot of this movie on my mind that I set off recently in a 2014 Fiat 500.

If there was an award for the cutest looking car ever, it would have to go to the Fiat 500.

Originally produced from 1957 to 1975, there were four million happy Fiat 500 owners who probably still regard it as the best little car they ever owned.

In its original incarnation, there was an air-cooled 497cc motor producing 13 brake horse power (9.7 kW) and no back seat.

Fiat 500s were assembled all over the world, but in their New Zealand-built version, the cars were lovingly called ‘Bambinas’, which will forever be the name that I know them by.

I have very fond memories as a medical student of trips in a colleague’s stretched Fiat 600 from the Italian suburb of St Lucia to Indooroopilly Shoppingtown.

There was room for all five from my Anatomy table in the little car.

It was slightly more powerful than the Fiat 500, with 28 brake horse power, and was water-cooled.

This was a particularly important feature, as it overheated constantly in the harsh Queensland tropics, and it was unwise to travel anywhere without plenty of water to top-up the radiator.

To celebrate the fiftieth anniversary of the Fiat 500, an all-new model was released in 2007, based on the Ford Ka, and that’s basically the same vehicle as is on sale in 2014.

For $14,000 drive-away, you can have yourself a brand-new Fiat 500 Pop, with a water-cooled 1.2 litre engine pumping out 51 kW. Automatic transmission adds $5979 to the price.

Just like the original Fiat 500, there still is no glove box. This storage would not have been missed by Gina Lollobrigida, who never wore gloves, or much at all.

Though there are a number of variants of the Fiat 500, with prices going all the way up to $75,865 for an Abarth 500 695 Ferrari, for $14,000 the Fiat 500 Pop is half the price of a Mini or VW Beetle, and I think at that price it’s a steal.

Safe motoring.

Email: doctorclivefraser@hotmail.com

COMMENT