

A U S T R A L I A N

Medicine

The national news publication of the Australian Medical Association

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Qld medicos heading for the exits

Flawed contracts driving doctors out of the State, p5



INSIDE

- 7** Accurate diagnosis needed for health overhaul
- 9** Momentum for national alcohol summit builds
- 21** ACT becomes first to ban sugary drinks at school
- 35** Nash stuck in conflict of interest quagmire
- 37** Food giants accused of selling out consumers
- 40** Breast cancer vaccine nears



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News 5-28, 42-43

Regular features

- | | |
|----------------------------|-----------------------|
| 3 VICE PRESIDENT'S MESSAGE | 34 HEALTH ON THE HILL |
| 29 GENERAL PRACTICE | 38 OPINION |
| 30 AMSA | 40 RESEARCH |
| 31 RURAL HEALTH | 44 BOOK REVIEW |
| 32 ECONOMICS AND WORKFORCE | 45 WINE |
| 33 INDIGENOUS HEALTH | |

Cover pic: AMA President Dr Steve Hambleton with rallying doctors outside Townsville Hospital under the Tree of Knowledge.

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BY AMA VICE PRESIDENT
PROFESSOR GEOFFREY DOOB

“ **The freeze on Medicare rebates has only exacerbated the problem. While rebates are frozen, practice costs continue to increase** ”

The health of general practice

Much of the silly season commentary this year has been around the ‘sustainability’ of Medicare and the floating a thought bubble about a \$6 patient co-payment for visits to a general practitioner.

There is no question that Medicare is sustainable - Australia lies around the middle of OECD countries in terms of the proportion of GDP we spend on health.

Nevertheless, Australia comes close to the top of the list when it comes to many objective health outcomes, suggesting our total spend on health is good value.

I am not a general practitioner, but perhaps this makes it easier to bring the perspective of an interested outsider to the discussion.

I am much more concerned about the financial sustainability of general practice under current funding arrangements.

Reports come to the AMA of practices closing because they are not financially viable under their bulk-billing business plan. Indeed, the costs in a bulk-billing practice are such that it is only viable if it is practising ‘six minute medicine’, it is receiving a full or partial subsidy for its infrastructure (for example, in a so-called Super Clinic), or it derives additional income from other activities, such as occupational medicine, mole clinics or cosmetic medicine. That is, they become a viable general practice only by not doing general practice.

More generally, general practices remain

sustainable through private billing. Here, privately billed patients effectively subsidise bulk-billed patients - in many cases the pensioners, children and socially disadvantaged. As the difference between the private fee and the MBS rebate becomes greater, so this Robin Hood approach to sustaining general practice becomes less viable and under increasing pressure.

The freeze on Medicare rebates has only exacerbated the problem. While rebates are frozen, practice costs continue to increase. Many of these costs, such as rates and electricity, are determined by levels of government. Others, such as rents and staff salaries, are determined by market forces that have no respect for a freeze on Medicare rebates.

The argument has been put forward that a freeze on Medicare rebates could drive greater efficiency. This ignores the very real efficiency gains that have already been made in general practice as rebates have lagged well behind general inflation and wages growth.

Much of the efficiency over the years has come from working in larger practices, so that overheads and the costs of receptionists, practice nurses and so on are shared between more general practitioners.

Of course, in many parts of country Australia,

coalescence into larger practices is not an option.

Nevertheless, the Productivity Commission’s *Report on Government Services 2014* shows that the real expenditure in general practice has hardly changed in 2012-13 dollar terms between 2006-7 and 2011-12.

With general practitioners providing services to an aging population, with more chronic disease and more issues being raised at each consultation, this is a remarkable outcome, and speaks highly for the efficiency of Australian general practice.

Any discussion of the distribution of general practitioners is meaningless without consideration of the business model in different locations.

General practices are small- to medium-sized businesses, with all the difficulties these experience operating in Australia, or they are run by corporate entities with executive bonuses to support and shareholders to satisfy.

If the business model works best with high levels of private billing, it is inevitable that practices and general practitioners will be drawn to locations where this is possible.

The decision-making is not too dissimilar to that of Ford, Holden and Toyota in abandoning their motor vehicle manufacturing in Australia. If the business model does not work in one location, look to another.

“ Any involvement by private health services in general practice would have to be within a model that maintains professional independence and the principle that the patient is the customer ”

The health of general practice

... FROM P3

The current fee structure rewards fast throughput medicine, yet studies in general practice show that seeing patients for longer reduces the overall number of consultations.

Time taken to conduct a detailed history and examination also has the potential to reduce dependence on pathology, imaging and specialist referral during patient care, with their associated costs.

Is it time to review the incentives within the MBS for general practitioners, and to increase their rebates for longer and more complex consultations? A pilot trial could provide more information on the impact, and perhaps show if there is also an effect on emergency department presentations and hospital admissions.

The Government has indicated it is loath to increase taxes so, if more money is to be directed to general practice, it has to come from other areas of the health budget or patients' pockets, either as a payment at the time of the service or, perhaps, from their contributions to private health insurance.

Currently the private health insurance contribution to general practice is very limited, though there is no such constraint on supporting services provided by physiotherapists, chiropractors, dieticians, and so on.

Any involvement by private health services in general practice would have to be within a model that maintains professional independence and the principle that the patient is the customer.

The other avenue to increase support for general practice is through practice incentive payments (PIP).

These provide incentives for services that match Government priorities and 'quality' general practice, but any change to the balance between fee-for-service and PIPs will need to be carefully thought through, not least because many doctors working in general practice get paid a percentage of their fee income.

The debate on health care needs to move from costs to value.

The Productivity Commission's Report shows that the Commonwealth spent \$7.4 billion on general practice, of which MBS rebates made up \$6.8 billion.

This is extraordinary value – consuming approximately 5 per cent of total health spending but providing the vast majority of consultations and chronic disease management services. It must be sustained and strengthened.

It is worth remembering that for both individuals and governments, it is better to have health than wealth in terms of overall wellbeing.

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 performance 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.



Qld dispute escalates as resolute doctors warn of mass exodus

Queensland public hospitals could be crippled by mass resignations of senior medical staff unless the Newman Government renegotiates employment contracts rejected as intolerable by mass meetings of doctors held at workplaces across the State.



Federal AMA President Dr Steve Hambleton, who has attended numerous meetings of hospital doctors on the issue in recent weeks, said feelings were running high, and many Senior Medical Officers were actively contemplating leaving the public hospital system or the State because of the contracts.

Dr Hambleton warned Queensland Health Minister Lawrence Springborg that the State's public hospitals would be hit by a mass exodus of specialists unless he changed course.

"The current path the Minister is taking is inevitably going to result in a significant loss of doctors out of the Queensland Health system," the Federal AMA President said. "I am absolutely confident there'll be large numbers of resignations."

The AMA is working closely with the Australian Salaried Medical Officers Federation (ASMOF) to galvanise support across the country amid concerns the Queensland contracts could set a very bad precedent for hospital medical staff nationwide.

"The AMA considers this dispute a potential national threat to the medical profession," Dr Hambleton said. "The underlying motivation for these inferior contracts, and the bullying tactics to get them signed in a hurry, are a threat to all hospital doctors in Australia."

"We need to win this battle to prevent other governments from trying to impose similar one-sided arrangements on doctors in other states and territories."

Mass meetings of hospital doctors across Queensland have unanimously rejected the contracts, specialists in Cairns and Townsville have warned they will leave unless there is a change, and a Prince Charles Hospital memo obtained by the *Courier-Mail* indicates 80 per cent of senior emergency department specialists will resign or cut their hours if the contracts go ahead.

Dr Hambleton said specialists in Cairns were having their homes valued and assessing alternative schools in preparation for a possible walkout.

So far, Minister Springborg has not wavered from his take-it-or-leave-it ultimatum to SMOs to sign the contracts.

The AMA is working with ASMOF on the details of an application seeking bargaining orders from the Fair Work Commission, potentially bringing SMOs within the jurisdiction of the Federal industrial relations system and shielding them from the State's contracts.

Dr Hambleton has also offered to hold talks with Queensland Premier Campbell Newman.

Qld dispute escalates as resolute doctors warn of mass exodus

... FROM P5

A joint AMA-AMAQ-ASMOF “Keep Our Doctors” campaign has been established, backed by a website (<http://keepourdoctors.com.au/>) and Facebook page (<https://www.facebook.com/keepourdoctors>), and the AMA has so far had more than 1000 responses to a survey of the attitude of members outside Queensland to the contracts being offered by Queensland Health.

The resolve of doctors to force changes has been stiffened by legal advice obtained by AMA Queensland showing the contracts in the present form were “draconian”, unfair, and stripped doctors of basic workplace rights and protections.

In his advice, prominent Queensland barrister Dan O’Gorman SC said the contracts offered SMOs inferior terms and conditions to those they already had, including accrued days off, public holidays, rosters for working extended hours, and overtime and on-call allowances.

In addition, SMOs could be arbitrarily dismissed, with no recourse to unfair dismissal procedures, they could be subject to arbitrary and unilateral changes to rosters, shifts, hours of work, remuneration and performance review, and face the possibility of being redeployed at short notice without consultation.

Dr Hambleton said the contracts were an attack on the basic workplace rights and conditions of hospital doctors, and accused Mr Springborg of treating them with the “utmost contempt”.

He warned the dispute had unsettled the entire Queensland medical workforce.

AMA Queensland President-elect Dr Shaun Rudd, who has

assumed full responsibility for leading the campaign on behalf of AMAQ, has written to Hospital Health Services (HHS) across the State warning that the contracts in their present form posed “a very real threat to the viability of your HHS”.

“Recent surveys show an overwhelming majority of SMOs are so concerned about the contracts they plan to reduce their hours, resign or take some other action,” Dr Rudd wrote. “It is vitally important that your HHS Board considers if it is prepared to impose these unfair contracts and suffer the consequences for recruitment, retention, training, research and clinical services.”

A spokesman for the Senior Medical Staff Association of the Cairns and Hinterland Health Service, anaesthetist Dr Sean McManus, told the ABC up to a 1000 SMOs working in Queensland Health may resign if forced to sign the contracts in their present form.

ASMOF President Dr Tony Sara said such a mass exodus of doctors would cause chaos in the public hospital system.

Dr Sara told the *Courier-Mail* that although patients in need of emergency treatment would continue to receive timely treatment, “elective surgery would grind to a halt”.

The Australasian Society for Emergency Medicine is the latest medical group advising its members not to take up offers to work in the Queensland public hospital system unless the contracts are renegotiated.

In a notice to members, the Society said the State Government’s current offer was “deeply flawed, denies natural justice and leave individual doctors in a perilous position... there will be significant adverse effects on staff retention”.

The notice follows similar advice from other medical groups across Australia and internationally warning doctors to steer clear of Queensland unless or until employment contracts are revised.

Prominent Federal MP Bob Katter, the Member for Mount Isa, has joined the fray, writing to Mr Springborg to warn him of a likely mass exodus of senior public hospital doctors, consultants and specialists because of the contracts.

“ I’ve had 85 emails from senior doctors throughout Queensland over the last week or so, and every single one of them said they would seriously consider leaving Queensland Health unless the Government makes an effort to re-negotiate these contracts”

“I’ve had 85 emails from senior doctors throughout Queensland over the last week or so, and every single one of them said they would seriously consider leaving Queensland Health unless the Government makes an effort to re-negotiate these contracts,” Mr Katter said. “This is not about money; it’s about senior doctors being coerced into signing a contract that appears to be manifestly unfair and removes any enterprise bargaining and other employment rights.”

“No wonder doctors have sought legal advice, and no wonder the advice is, ‘Don’t sign’.”

Mr Katter said he was particularly concerned about the effect on Mount Isa Hospital, which he said was especially vulnerable if senior doctors left and sought work elsewhere.

Adrian Rollins



Health budget cure needs accurate diagnosis

The Federal Government has been warned against taking a blunt approach to curbing health care spending as Health Minister Peter Dutton flagged the need for a fundamental overhaul of the Medicare system.

In what he said would be the first in a series of “headland” speeches, Mr Dutton told the Committee for the Economic of Development last month the health system was “tracking on an unsustainable path”, with expenditure more than doubling in the past decade to reach \$140 billion in 2011-12.

“... the focus should be on a Government-wide approach to tackle the causes of chronic disease, backed by ease of access to primary health care services”

“In the past 10 years, we have seen the cost of the Medicare Benefits Schedule increase 124 per cent, the cost of the Pharmaceutical Benefits Scheme increase 90 per cent, and the cost of hospitals increase 83 per cent – with no signs of slowing down,” the Minister said. “Doing nothing about sustainability is not an option.”

AMA President Dr Steve Hambleton said that it was “the right time” to be discussing rising health costs, but urged a considered approach that took into account evidence of effectiveness and efficiency as well as expense, and which did not result in policies which would ultimately be counterproductive.

Dr Hambleton said the per capita cost of GP visits had been stable for the past five years, while PBS spending had “actually come back a little” as expensive medicines had come off patent.

The AMA President said the focus should be on a Government-wide approach to tackle the causes of chronic disease, backed by ease of access to primary health care services.

“We’ve got to think about what the drivers of health care costs are, and make sure we deal with things like tobacco, alcohol, over-nutrition and under-exercise,” he said. “It’s not just the health portfolio that needs to focus on health care costs, it’s the other portfolios as well.”

Mr Dutton’s speech followed weeks of speculation that the Government was considering introducing a \$6 patient co-payment for GP visits, and the Health Minister appeared to lend weight to the idea when he said that “one important job of the Abbott Government is to grow the opportunity for those Australians who can afford to do so, to contribute to their own health care costs”.

He reinforced the point a day later in an interview with the *Daily Telegraph* in which he said, “I question whether someone on an income of \$200,000 can have an expectation of going to the doctor for free. That is one of the conversations we have to have.”

But the same day, Prime Minister Tony Abbott fuelled uncertainty about whether his Government would introduce a GP co-payment.

“Obviously, the Budget, generally, is under pressure, and it’s very important that we do what we can to fix the Budget,” Mr Abbott said. “But we’ve got to do it in ways consistent with our pre-election commitments.

“Don’t forget, I said we were going to be a no surprises Government. You might also remember that I was the Health Minister in a former Government, and... I used to say that that Government was the best friend Medicare had ever had.

“This leopard doesn’t change its spots – I want this Government to be, likewise, the best friend that Medicare has ever had.”

The Prime Minister’s comments were taken as some as killing off the idea of a GP co-payment, but *Australian Financial Review* political editor Laura Tingle cautioned that they did not rule out “much at all really, just anything he can’t argue will somehow be ultimately good for Medicare’s long-term health”.

More clearly, Mr Dutton flagged the likelihood that the private sector, particularly private health insurers, were likely to become bigger players in the health system.

There has been discussion about the possible involvement of private health funds in covering primary health care services – something that is prohibited under current legislation.

Health budget cure needs accurate diagnosis ... FROM P7

“Why shouldn’t we be 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?” the Minister asked. “We should be leveraging the private sector, not just for services, but to meet workforce training challenges.”

The Health Minister also flagged a fundamental change in the way health spending should be assessed.

“We need to look at increasingly moving from managing supply, as measured by the volume of services provided, to managing demand, as measured by improved health outcomes,” he said.

Dr Hambleton said the AMA was “very interested” in exploring opportunities for private health insurers to support the work of GPs.

But he said that must not come at the cost of equity of access to care.

The AMA President said that, similarly, the Government needed to be careful about the way it might seek to get the better off to make a greater contribution to their health care costs.

Dr Hambleton said Australian patients

already faced the fifth highest out-of-pocket expenses in the developed world, and making it more difficult for people to get primary health care could backfire.

“We’ve got to be very careful [that], if you use a blunt instrument like co-payments, that we don’t get perverse outcomes,” he said. “There are think tanks internationally saying if you want to increase the efficiency of your health system, you lower the barriers to primary health care, you don’t lift them.”

Dr Hambleton said that if patients deferred a visit to their GP, in many cases they might end up in hospital, where care is much more expensive.

The AMA President, who is due to meet with Mr Dutton later this week, said there was great potential for health efficiencies and savings through investing in primary health care, including by supporting GPs in looking after patients with chronic disease, as well as improved end of life care arrangements.

Adrian Rollins



Your AMA Federal Council at work

What AMA Federal Councillors and other AMA Members have been doing to advance your interests in the past month

Name	Position on council	Activity/Meeting	Date
Dr Ian Pryor	AMA Member	Medical Services Advisory Committee (MSAC) Review Consultation Committee for Inguinal Hernia	3/2/2014
		MSAC Review Consultation Committee for Rhinoplasty	10/2/2014
Dr Richard Kidd	AMA Representative for Queensland	Senate Community Affairs Inquiry into the care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD)	14/02/14
Dr David Rowed	AMA Member	Royal Australian College of General Practitioners (RACGP) GP Clinical Software Functionality Specifications Workshop	14/2/2014
Dr Brian Morton	AMA Chair of General Practice	RACGP GP Clinical Software Functionality Specifications Workshop	14/2/2014
		National Residential Medication Chart	27/9/2013
Prof Stephen Lee	AMA Representative for Dermatologists	MSAC Review Consultation Committee for Skin Services	21/2/2014
Dr Robyn Langham	AMA Representative for Victoria	Medicines Australia Code of Conduct Review Panel	22/10/2013



Alcohol marketing under fire as momentum for National Summit builds

The AMA has urged immediate action to clamp down on alcohol advertising as momentum builds for a National Summit on alcohol abuse and the harm it causes.

The AMA said a report by the Australian National Preventive Health Agency showing young people were being exposed to unprecedented volumes of drink ads highlighted the failure of existing industry self-regulation regime, which needed to be replaced by legislated, mandatory measures.

The draft ANPHA report *Alcohol advertising: the effectiveness of current regulatory codes in addressing community concern*, found that the proliferation of media and advertising channels, particularly through the recent emergence of digital media, meant that adolescents were being exposed to almost the same level of alcohol advertising as adults.

It cited a 2011 survey of 1113 adolescents aged between 12 and 17 years which found the majority had been exposed to alcohol advertising through a range of media channels, including television (94 per cent), magazines (75 per cent), billboards and posters 61 per cent), the Internet (55 per cent) and newspapers (53 per cent).

It also found that around half of all television alcohol advertising occurs during live sports broadcasts, which are exempt from laws banning alcohol ads on television before 8.30pm. Such programs were found to have a significant child and adolescent audience.

Dr Hambleton said the study confirmed the findings of a 2012 AMA report which raised the alarm about the extensive marketing of alcohol to young people, including through social media.

The AMA President said the existing regulatory regime was

badly flawed because it was voluntary, limited in scope, poorly enforced and without meaningful penalties for breaches.

“Ultimately, it fails to protect young people from continuous exposure to alcohol marketing,” he said, pointing to drink ads during live sports broadcasts as one of the most obviously failings of present arrangements.

The AMA has repeated its call for a parliamentary inquiry into alcohol advertising, and has urged the nation’s lawmakers to close the live sports loophole so that children are not exposed to drink ads while watching games.

Dr Hambleton there was an insidious association between sport and drinking that was being exploited by alcohol companies, and it had to end.

“You’d be forgiven for thinking that you need to have alcohol and sport together,” he said, adding that such exposure was linked to drinking in young people.

“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.”

The Australian Greens are pushing for the establishment of a Senate inquiry into the promotion of alcohol to children, and the AMA has urged the appointment of an independent, statutory regulator for alcohol marketing.

Research suggests the misuse of alcohol costs the community more than \$15 billion a year, and a spate of violent and deadly assaults in major cities in recent months have focused attention on the nation’s drinking culture.

In late January, the AMA grabbed national attention with its call for a National Summit on alcohol – an initiative that has now been backed by the NSW Government.

In its response to a NSW parliamentary inquiry on alcohol, the O’Farrell Government endorsed the need for a national approach to tackling the effects of alcohol misuse.

“Alcohol abuse is an issue which transcends jurisdictional boundaries and warrants appropriate responses and co-ordination at both the State and National levels,” the NSW Government said, adding that it intended to discuss with its Federal counterpart “the best way to bring together governments to develop a national approach to alcohol policy issues”.

The initiative will get a further push this week when Dr Hambleton and AMA Secretary-General Anne Trimmer discuss the National Summit proposal directly with Prime Minister Tony Abbott.

Dr Hambleton said the AMA did not want a talkfest: “We want a Summit that is all about action”.

“The AMA wants a whole-of-government approach from all governments that looks at harm minimisation, the marketing of alcohol and how young people are exposed to this marketing, pricing and taxation, venue licensing and opening hours,” he said.

The NSW Government late last month introduced strict rules for licensed venues in the CBD, including 1.30am lock-outs and 3am last drinks, as well as 10pm closing time for bottle shops across the State.

So far, the Federal Government has been non-committal about action on alcohol, including changes to pricing, taxation and marketing rules, arguing that the states and territories had primary responsibility for community safety issues.

Despite this, the Government has jacked up the alcohol excise, adding almost 30 cents to the cost of a slab of full-strength beer, and pushing up the cost of a 700 millilitre bottle of spirits by 38 cents.

Adrian Rollins

COMMENT



INVITATION FOR NOMINATIONS

AUSTRALIAN MEDICAL ASSOCIATION LIMITED ABN 37 008 426 793

INVITATION FOR NOMINATIONS FOR ELECTION TO FEDERAL COUNCIL AS AREA NOMINEES

The Articles of Association of the AMA provide for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Areas:

1. New South Wales and Australian Capital Territory Area
2. Queensland Area
3. South Australia and Northern Territory Area
4. Tasmania Area
5. Victoria Area
6. Western Australia Area

The current term of Area Nominee Councillors expires at the end of the AMA National Conference in May 2014.

Nominations are now invited for election as the Nominee for each of the Areas listed above.

1. Nominees elected to these positions shall hold office until the conclusion of the May 2016 AMA National Conference.
2. The nominee must be an Ordinary Member of the AMA and a member in the relevant Area for which the nomination is made.
3. The nomination must include the name and address of the nominee and the date of nomination. It may

also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.

4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA resident in the Area for which the nomination is made.
5. Nominations should be addressed to the Secretary General (marked "Private and Confidential") and to be valid must be received at AMA House, 42 Macquarie Street, Barton, ACT 2600 no later than **1.00pm (AEDT) Friday 7 March 2014**.
6. A nomination may be accompanied by a statement by the nominee of not more than 250 words. Such statement will be circulated with the ballot paper if it is approved by the Federal Council.

For a copy of a nomination form or any general enquiries, please contact Nadene Sharpe, Office of the Secretary General and Executive (tel: 02 6270 5460 or email: nsharpe@ama.com.au).

Anne Trimmer
Secretary General
30 January 2014

INVITATION FOR NOMINATIONS

AUSTRALIAN MEDICAL ASSOCIATION LIMITED ABN 37 008 426 793

INVITATION FOR NOMINATIONS FOR ELECTION TO FEDERAL COUNCIL AS CRAFT GROUP NOMINEES

The Articles of Association of the AMA provide for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Craft Groups:

1. Anaesthetists
2. Dermatologists
3. Emergency Physicians
4. General Practitioners
5. Obstetricians and Gynaecologists
6. Ophthalmologists
7. Orthopaedic Surgeons
8. Paediatricians
9. Pathologists
10. Physicians
11. Psychiatrists
12. Radiologists
13. Surgeons

The current term of Craft Group Councillors expires at the end of the AMA National Conference in May 2014.

Nominations are now invited for election as the Nominee for each of the Craft Groups listed above.

1. Nominees elected to these positions shall hold office until the conclusion of the May 2016 AMA National Conference.
2. The nominee must be an Ordinary Member of the AMA and a member of the relevant Craft Group for which the nomination is made.

3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.
4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Craft Group for which the nomination is made.
5. Nominations should be addressed to the Secretary General (marked "Private and Confidential") and to be valid must be received at AMA House, 42 Macquarie Street, Barton, ACT 2600 no later than **1.00pm (AEDT) Friday 7 March 2014**.
6. A nomination may be accompanied by a statement by the nominee of not more than 250 words. Such statement will be circulated with the ballot paper if it is approved by the Federal Council.

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Anne Trimmer
Secretary General
30 January 2014

INVITATION FOR NOMINATIONS

AUSTRALIAN MEDICAL ASSOCIATION LIMITED ABN 37 008 426 793

INVITATION FOR NOMINATIONS FOR ELECTION TO FEDERAL COUNCIL AS SPECIAL INTEREST GROUP NOMINEES

The Articles of Association of the AMA provide for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Special Interest Groups:

1. Salaried Doctors
2. Doctors in Training

The term of Councillors expires at the end of the AMA National Conference in May 2014.

Nominations are now invited for election as the Nominee for each of the Special Interest Groups listed above.

1. Nominees elected to these positions shall hold office until the conclusion of the May 2016 AMA National Conference.
2. The nominee must be an Ordinary Member of the AMA and a member of the relevant Special Interest Group for which the nomination is made.
3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other

relevant organisations.

4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Special Interest Group for which the nomination is made.
5. Nominations should be addressed to the Secretary General (marked "Private and Confidential") and to be valid must be received at AMA House, 42 Macquarie Street, Barton, ACT 2600 no later than **1.00pm (AEDT) Friday 7 March 2014.**
6. A nomination may be accompanied by a statement by the nominee of not more than 250 words. Such statement will be circulated with the ballot paper if it is approved by the Federal Council.

For a copy of a nomination form or any general enquiries, please contact Nadene Sharpe, Office of the Secretary General and Executive (tel: 02 6270 5460 or email: nsharpe@ama.com.au).

Anne Trimmer
Secretary General
30 January 2014

INVITATION FOR NOMINATIONS

AUSTRALIAN MEDICAL ASSOCIATION LIMITED ABN 37 008 426 793

ELECTION OF EXECUTIVE OFFICERS – CALL FOR NOMINATIONS

The four Executive Officers of the Australian Medical Association Limited for 2014/2015 will be elected at the 2014 National Conference of the AMA to be held on 23-25 May 2014 in Canberra.

The positions to be filled are **President, Vice President, Chairman of Council and Treasurer.**

Each will hold office until the conclusion of the National Conference in May 2015.

Any Ordinary Member of the Association may nominate for one or more of these offices.

The electors are the delegates to the National Conference.

Members who wish to nominate are now invited to do so.

Nominations must:

1. Be in writing and addressed to the Secretary General (marked "Private and Confidential");

2. State the position or positions for which the candidate is nominating;
3. Indicate the nominee's willingness to accept the nomination or nominations;
4. Include the names of two Ordinary Members who are nominating the candidate; and
5. Be delivered to:

Secretary General
Australian Medical Association
Level 4, 42 Macquarie Street
BARTON ACT 2600
by 1.00pm (AEST) Friday 2 May 2014.

For a copy of a nomination form or any general enquiries, please contact Nadene Sharpe, Office of the Secretary General and Executive (tel: 02 6270 5460 or email: nsharpe@ama.com.au).

Anne Trimmer
Secretary General
30 January 2014

Dump flawed rural classification system now: AMA, RDAA

The Abbott Government has been urged to make replacement of the flawed remoteness classification system for doctor incentives a top priority.

At a meeting on 18 February, the AMA and the Rural Doctors Association of Australia issued a joint call for the nonsensical Australian Standard Geographic Classification – Remoteness Areas (ASGC-RA) system to be dumped and replaced with a scheme that accurately reflects the situation confronting small rural communities.

The shortcomings of the ASGC-RA system have led to a host of incongruous outcomes, such as classifying well-serviced regional cities as being more remote (and hence, entitled to greater incentives) than many smaller rural settlements.

This can mean that doctors working in large regional centres receive greater incentive payments than do those working in small, remote communities, making it extremely difficult for them to compete for medical practitioners.

The system's deficiencies were acknowledged by former Health Minister Tanya Plibersek when she addressed the AMA National Conference last year, and AMA President Dr Steve Hambleton said the Coalition Government was also acutely aware of the ASGC-RA's terminal flaws.

"We know that Health Minister Peter Dutton and Assistant Health Minister Fiona Nash are

well aware of the significant drawbacks of the ASGC-RA classification system, and the negative impact it has had on many small rural communities," Dr Hambleton said.

"But action is now long overdue, and rural doctors and communities are starting to wonder how long they are going to have to wait to see some improvements."

RDAA President Dr Ian Kamerman said the system caused particular hardship for small rural communities, who often found it difficult to attract and retain doctors.

"Rural doctors provide a wide and vital range of services in these smaller communities," Dr Kamerman said. "The doctor you see in their practice is often the same one delivering your baby or treating your heart attack at the local hospital. A classification system that cannot take this into account – and cannot tell the difference between Townsville and Tumut, or Cairns and Cowra – is obviously flawed."

Both the AMA and the RDAA back the modified Monash Model of rural classification, which was developed based firmly on evidence, and which incorporates a range of factors such as population size that are not included in the ASGC-RA.

But both Dr Hambleton and Dr Kamerman stressed that in introducing and evaluating any replacement to the ASGC-RA, key stakeholders must be closely consulted and involved.

Adrian Rollins



GLOBAL PRACTICE
Australian Perspective



2014 AMA National Conference

23 - 25 May, National Convention Centre, Canberra



For more information please contact:

Email: natcon@ama.com.au

Web: www.ama.com.au/nationalconference



AMA

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

Cuts to health Labor's doing, *The Daily Telegraph*, 14 February 2014

Analysis from the AMA shows that the states and territories received \$134 million less public hospital funding than promised last year.

Federal cuts hit health system, *Herald Sun*, 14 February 2014

More than 18,000 patients waited more than 12 months for surgery last year as the Federal Government spent \$134 million less than it promised on public hospitals. AMA President Dr Steve Hambleton said public hospitals could not be expected to meet the performance targets if they were not getting the funding they needed.

Budget cuts may force longer wait for hospital care, doctor's fear, *The Saturday Age*, 15 February 2014

An AMA analysis of hospital performance across Australia found Victoria failed more measures than any other State or Territory. AMA President Dr Steve Hambleton urged the Federal Government to overturn its funding cuts.

Marijuana oil reduces toddler's seizures, *Sun Herald*, 16 February 2014

AMA President Dr Steve Hambleton said there was no scientific evidence of the benefits of cannabis in treating epidemic seizures, and that the negative effects of long-term marijuana use outweighed any gains.

GP fee to save \$1.5b, *Herald Sun*, 18 February 2014

A proposed \$6 patient co-payment for each GP visit has been heavily criticised by public health advocates including the AMA, who claim it will deter people from seeing a doctor.

Medicare 'dud' facelift, *Sunday Times*, 16 February 2014

Labor's dud Medicare Locals are to be rebadged and redesigned after GPs complained that the \$1.8 billion bureaucracy is failing to deliver real services to patients. The AMA released a survey showing that 75 per cent of GPs believed the program had not resulted in any improvement in health care.

Alcohol lobby link to health body's funding cut, *Canberra Times*, 18 February 2014

Assistant Health Minister Fiona Nash's former Chief of Staff, who was forced to resign amid conflict of interest allegations, played a key role in stripping the Alcohol and other Drugs Council of Australia of its funding. AMA President Dr Steve Hambleton said the funding cut should be reviewed.

Medico's contracts a prescription for pain, *Courier Mail*, 18 February 2014

Senior doctors are threatening to leave Queensland's public hospital system en masse over the Newman Government's decision to force them off a collective agreement and on to individual contracts. AMA President Dr Steve Hambleton said such an exodus would hurt patients and reduce the ability to train the next generation of doctors.

Doctors find fault in planned \$6 fee, *Hobart Mercury*, 22 February 2014

Doctors will be unlikely to charge the proposed \$6 GP fee because of stiff competition for patients. AMA President Dr Steve Hambleton has written an urgent supplementary submission to the Commission of Audit to bring its attention to errors in the proposal.

Waiting game isn't getting any better, *Northern Territory News*, 22 February 2014

Territory hospitals are falling behind in targets to cut emergency room and elective surgery waiting times. The AMA Report Card showed Commonwealth funding to NT Health had been cut from \$147 million in 2012-13 to \$141 million by 2013-14.

AMA IN THE NEWS

... FROM P13

AMA chief: co-payments on GP visits a distraction, *The Saturday Age*, 22 February 2014

AMA President Dr Steve Hambleton said the Federal Government should abandon any discussion of means-tested access to GP services and medical tests and look at more promising policies that will save money and improve people's health.

Hotel health care to cure pain of costs, *Courier Mail*, 24 February 2014

Plans to modernise the health system and tackle the spiralling cost of health care would see more patients treated in their homes. AMA President Dr Steve Hambleton insisted the prospect of mass resignations by senior doctors was not a hollow gesture.

Docs in line to leave, *Sunday Mail Brisbane*, 23 February 2014

The Newman Government has been warned public hospital elective surgery will grind to a halt if it refuses to renegotiate proposed contracts for medical specialists. AMA President Dr Steve Hambleton said if the Government holds out there will be many resignations.

Report slams TV alcohol ads, *The Age*, 25 February 2014

Current rules on alcohol advertising are failing to protect children and must be tightened, according to the government agency charged with preventing disease. AMA President Dr Steve Hambleton said the existing regulatory regime was badly flawed.

Health razor to cut deep, *Hobart Mercury*, 26 February 2014

Families in Braddon will bear the brunt of a proposed \$6 GP co-payment because they have higher rates of bulk billing. Any such change could cause some patients to pay up to \$36 for a GP visit if their doctor charges the AMA's recommended fee.

Radio

Dr Steve Hambleton, 4ZZZ, 13 February 2014

AMA President Dr Steve Hambleton urged all Queensland hospital doctors to reject Queensland Government contracts in their current form. He called on the Queensland Government to return to the negotiating table in good faith to reach a fair and balanced agreement.

Dr Steve Hambleton, ABC NewsRadio, 14 February 2014

AMA President Dr Steve Hambleton discussed the 2014 AMA Public Hospital Report Card. He said WA was doing well, but that NSW, Victoria and the Northern Territory were not meeting the 2012 baseline targets.

Dr Steve Hambleton, Radio National Canberra, 14 February 2014

AMA President Dr Steve Hambleton talked about the struggles of public hospitals in meeting patient demand and performance targets. He said Western Australia was the only state that has met the National Emergency Access Target.

Dr Steve Hambleton, Radio Adelaide, 17 February 2014

AMA President Dr Steve Hambleton talked about hospitals failing to meet targets set for emergency departments. He said inadequate capacity was making it hard for hospitals to reach targets.

Dr Steve Hambleton, 2GB Sydney, 17 February 2014

AMA President Dr Steve Hambleton discussed measles and the harm caused by anti-vaccination activists. He said that, due to falling vaccination rates, he is concerned about an increased incidence of measles this year.

Dr Steve Hambleton, ABC Sunshine Coast, 18 February 2014

AMA President Dr Steve Hambleton discussed Queensland public hospital contracts. He said recent surveys showed an overwhelming majority of the State's Senior Medical Officers planned to reduce their hours, resign or take up a position in another State.

Dr Steve Hambleton, 5AA Adelaide, 19 February 2013

AMA President Dr Steve Hambleton discussed whether people who injure themselves due to their own fault should pay for their hospital treatment. He said the AMA did not support this position.

Dr Steve Hambleton, 4BC Brisbane, 19 February 2014

AMA President Dr Steve Hambleton talked about alcohol-related violence causing emergency departments to be clogged with injured drunks, and the call by some for these patients to pay their way.

Dr Steve Hambleton, ABC NewsRadio, 20 February 2014

AMA President Dr Steve Hambleton talked about health funding. He suggested that health care costs were affordable, but that action was needed prevent cost blowouts.



AMA IN THE NEWS

... FROM P14

Dr Steve Hambleton, ABC Gold Coast, 20 February 2014

AMA President Dr Steve Hambleton discussed a proposed \$6 patient co-payment for GP visits. He said the focus should be on lowering the barriers to GP visits, not raising them.

Dr Steve Hambleton, 5AA Adelaide, 21 February 2014

AMA President Dr Steve Hambleton talked about suggested changes to Medicare. He said he did not agree with all the ideas being speculated upon, but did agree that health costs were rising and action was needed.

Dr Steve Hambleton, 4BC Brisbane, 24 February 2014

AMA President Dr Steve Hambleton talked about young people being exposed to alcohol advertisements. He said an Australian National Preventive Health Agency report showed that alcohol advertising influenced the behaviour of young people to start drinking at an earlier age.

Dr Steve Hambleton, Triple J Sydney, 24 February 2014

AMA President Dr Steve Hambleton discussed weight loss. He said a number of prescription weight loss pills have been taken off the market and none were a long-term solution.

Dr Steve Hambleton, 891 ABC Adelaide, 25 February 2014

AMA President Dr Steve Hambleton said patients may be put at a disadvantage if proposed Medicare changes were implemented. He said Australia's health spending was rising, and the question for debate was the size of contributions to Medicare.

TV

Dr Steve Hambleton, ABC News 24 Sydney, 14 February 2014

AMA President Dr Steve Hambleton launched the AMA's Public Hospital Report Card 2014. Dr Hambleton said 68 per cent of urgent patients were being seen within 30

minutes at emergency departments. He suggested investing in primary care while still making sure hospitals were supported.

Dr Steve Hambleton, WTV Perth, 15 February 2013

AMA President Dr Steve Hambleton discussed the suggestion of a Medicare co-payment. He said people need to go to the GP to get and remain healthy.

Dr Steve Hambleton, Channel 7 Brisbane, 18 February 2014

AMA President Dr Steve Hambleton talked about new employment contracts in Queensland. He said doctors have already started leaving the profession over the new contracts.

Dr Steve Hambleton, Sky News Sydney, 20 February 2014

AMA President Dr Steve Hambleton said proposed GP co-payments were not a solution to rising health costs for the Government. He said health costs have risen but costs per visit to GPs for Australians have flatlined for the last five years.

Dr Steve Hambleton, Today on Saturday, 22 February 2014

The Federal Government has proposed changes to Medicare. AMA President Dr Steve Hambleton said health costs were rising, and the original Medicare system was designed for acute, not primary, care. He said the nation needed to make sure people on low incomes could afford to see their GP.

Dr Steve Hambleton, Channel 9, 26 February 2014

AMA President Dr Steve Hambleton discussed the dangers of the sleeping drug Stilnox. He said Stilnox was a quick acting sleeping tablet that worked best in the short-term.

Dr Steve Hambleton, ABC News Radio, 26 February 2014

AMA President Dr Steve Hambleton talked about a study showing a link between paracetamol and an increased risk of ADHD in children. He said this was an observational study that showed a link, but did not show cause and effect.



AMA IN ACTION

In the past fortnight the AMA has been busy on a number of fronts advancing the interests of members and the broader community.

Industrially, attention has been dominated by the Queensland Government's push to force senior medical staff in public hospitals onto punitive employment contracts, and AMA President Dr Steve Hambleton and other AMA officials have attended numerous meetings of medical staff at public hospitals across the State to hear of their grievances and the damaging impact the dispute is having on themselves and their families. Dr Hambleton has addressed meetings in the Gold Coast, Brisbane, Cairns, and Townsville, and plans to attend many more in coming weeks.

In addition, AMA officials including Dr Hambleton attended a United General Practice Australia meeting in Melbourne, where the AMA President also met with the President of the Royal Australian and New Zealand College of Psychiatrists Dr Murray Patton, before joining with other AMA officials from around Australia to farewell departing AMA Victoria Chief

Executive Officer Jane Stephens.

During the past fortnight, Dr Hambleton has also attended several meetings in Canberra, including with Assistant Minister for Defence Stuart Robert to discuss Medibank Health Solutions and the performance of its contract to provide health service to Defence Force personnel, as well as the role played by International Health Medical Services in providing health services at immigration detention centres.

Late last month, the AMA Council of General Practice had a weekend-long meeting that considered a number of significant issues, including a proposed co-payment for GP visits, medical deputising services, the future role of primary health care organisations in Australia, teaching in general practice and the benefits of integrating pharmacists into general practice.

Dr Hambleton also had numerous media engagements, particularly to represent the AMA's views on proposals for a \$6 co-payment for GP visits, a new food labelling scheme and the performance of public hospitals.



AMA President Dr Steve Hambleton (L) meeting with assistant Minister for Defence Stuart Robert.



Nation needs to train more GPs

Affordable and timely access to the family doctor is under threat without greater investment in general practitioner training, the nation's GP leaders have warned.

Seizing on figures showing that for the first time specialists outnumber general practitioners, the umbrella group United General Practice Australia has called for urgent action to mitigate a recent decline in the nation's supply of GPs.

In a joint statement, the six organisations that make up UGPA – the AMA, the Royal Australian College of General Practitioners, the Australian General Practice Network, General Practice Registrars Australia, the Australian College of Rural and Remote Medicine and the Rural Doctors Association of Australia – said general practice needed greater Government support to boost trainee numbers and ensure there were sufficient GPs to continue to provide quality primary care.

The call followed the release of an Australian Institute of Health and Welfare report (see A special time to be a doctor: https://ama.com.au/node/13701?no_cache=1393814789) showing that, while the specialist workforce grew by more than 30 per cent between 2008 and 2012 to reach 217.8 full time equivalent specialists per 100,000 people, during the same period the proportion of GPs remained virtually stagnant at around 112 FTE per 100,000.

"[The report] showed a decline in the supply of GPs, despite recent increases to GP vocational training," UGPA

said.

The peak group also raised concerns that proposals to expand the scope of practice of pharmacists risked fragmenting patient care.

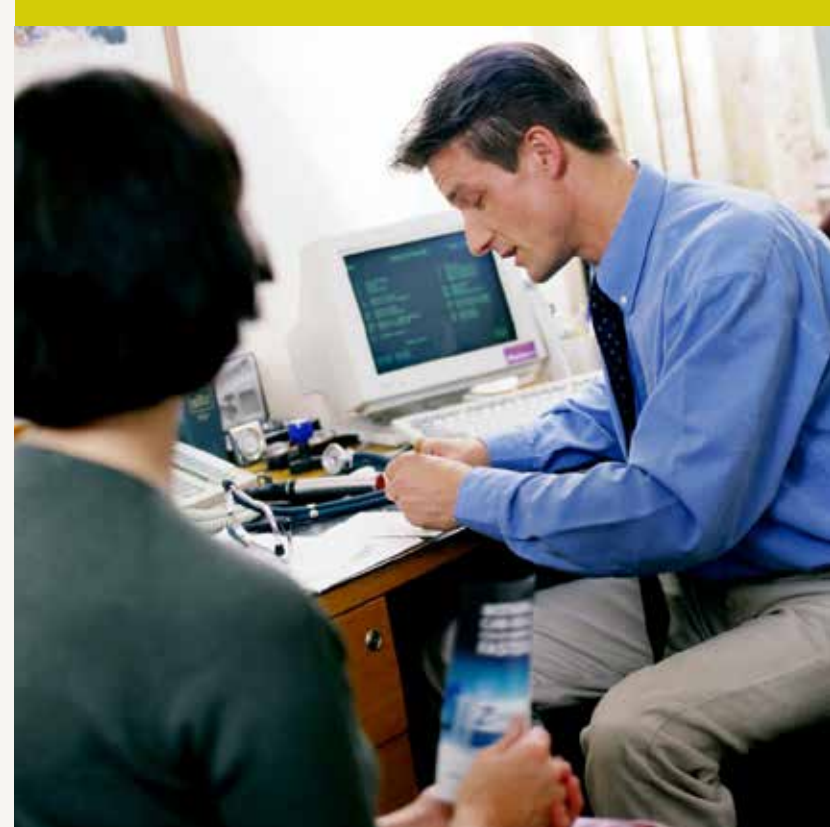
UGPA said there was a lack of evidence to support the suggestion by the Pharmacy Guild of Australia for the Government to pay its members to conduct basic health checks on their customers, and expressed concern about changes to ration access to Home Medicine Review services.

"UGPA is concerned programs that risk patient care and have no link to a GP are being proposed over those that facilitate the provision of collaborative care arrangements and quality patient care, particularly for patients with chronic and complex conditions," the peak group said.

It said a medically-led, team-based model of care ensured quality care, including preventing adverse events and maintain care continuity.

The peak group called on the Federal Government, in its forthcoming Budget, to "show a commitment to general practice" by lifting the number of community-based GP placements and vocational training numbers to 1700 a year by 2017.

UGPA said there needed to be an increase in training places to ensure appropriate supervision of trainees undertaking vocational training.



UGPA added that rural infrastructure grants, recently boosted by the Government, would be most effectively used, and have the greatest community benefit, if they were directed to general practices.

"General practice is the most efficient and cost-effective way to deliver quality patient care and successfully manage the rising burden of chronic and complex disease; treating the issue before secondary and tertiary care services is required," the group said.

UGPA said that "increasing the number of general practice training places is a positive initiative, provided clinical supervision capacity issues and appropriate infrastructure to facilitate high quality training, are adequately addressed".

Adrian Rollins



AMA Awards - Call for nominations

The following awards are being offered by the AMA in 2014

1. AMA Excellence in Healthcare Award

The AMA Excellence in Healthcare Award is for an individual, not necessarily a doctor or AMA member, who has made a significant contribution to improving health or health care in Australia. The person may be involved in health awareness, health policy or health delivery.

The recipient of this award will be an individual who has made a major contribution to health care in Australia under one or more of the following criteria:

- Showing ongoing commitment to quality health & medical care; or
- Contributing to medical research within Australia; or
- Initiation and involvement in public health projects or health awareness campaigns; or
- Improving the availability & accessibility of medical education and medical training; or
- Advancing health & medical issues in the political arena; or
- Promoting awareness of the impact of social and economic issues on health; or
- Contributing to community needs as a health care provider; or
- Improving health care services in any field.

Nominations for this award can be submitted by any member of the community.

2. AMA Woman in Medicine Award

The AMA Woman in Medicine Award is for a member of the AMA who has made a major contribution to the medical profession by:

- Showing ongoing commitment to quality care; and/or
- Contributing to medical research within Australia; and/or
- Initiation and involvement in public health projects; and/or
- Improving the availability and accessibility of medical education and medical training for women; and/or
- Contributing to medical politics.

Nominations for this award may only be made by a member of the AMA.

3. AMA Women's Health Award

The AMA Women's Health Award goes to a person who does not necessarily have to be doctor or a female but is somebody who has made a major contribution to women's health by:

- Promoting and contributing to public health initiatives; and/or
- Initiating, participating and promoting health awareness campaigns; and/or
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field of women's health.

Nominations for this award can be submitted by any member of the community.

4. AMA Men's Health Award

The AMA Men's Health Award goes to a person who does not necessarily have to be a doctor or a male but is somebody who has made a major contribution to men's health by:

- Promoting and contributing to public health initiatives; and/or
- Initiating, participating and promoting health awareness campaigns; and/or
- Contributing to community needs as a health care provider; and/or

- Improving health care services in any field of men's health.

Nominations for this award can be submitted by any member of the community.

5. AMA Youth Health Award (for outstanding contribution to the health of young Australians)

The AMA Youth Health Award goes to a young person of 15-27 years who has made a contribution to youth health in Australia by:

- Promoting and contributing to youth health initiatives; and/or
- Initiating, promoting or participating in youth health awareness; and/or
- Development of youth health promotion programs.

Nominations for this award can be submitted by any member of the community.

Nominations for each award must include:

- a personal statement by the nominator describing the merit of the nominee in relation to the criteria for the relevant award;
- a current curriculum vitae for the nominee; and
- any additional supporting documentation relevant to the nomination.

Nominations are to be addressed to:

Secretary General
 Australian Medical Association
 PO Box 6090
 Kingston ACT 2600

Closing date for receipt of nominations for each award is Friday 28 March 2014

Heatwaves the nation's deadliest natural disaster



Hundreds of people are being condemned to “private, silent deaths” as scorching heatwaves build in intensity and regularity, according to a report on changing weather patterns.

In an alarming report, the Climate Council warned that during severe heatwaves of the kind that baked much of the country in January and early February, there is a surge in the number of people dying or requiring medical treatment.

The Climate Council's report *Heatwaves: hotter, longer and more often*, said that although claims of 203 heat-related deaths and a 20-fold increase in ambulance call-outs in Victoria in January had not yet been verified, experience from previous heatwaves showed they were a dangerous time, particularly for the very old and the very young.

It said that during the heatwave that struck Melbourne in late January 2009, there were 374 deaths reported in excess of seasonal average, while a separate study of Adelaide health data between 1993 and 2006 found hospital admissions spiked 7 per cent higher during heatwaves, while the proportion of people needing ambulance transport jumped 4 per cent.

While most people could survive one extremely hot day, the report said, “heatwaves lasting even a few days, especially if coupled with high overnight temperatures, can cause serious health impacts”.

“It is the cumulative effects over a few days of an intense heatwave that lead to serious health impacts and deaths – and we tend to see these after the worst of the heatwave has passed,” it said, citing as evidence figures showing that in January 2009, Melbourne's death rate peaked in the last two days of the month, by which time temperatures were easing lower.

The Climate Council warned that heatwaves are likely to become more intense and frequent, with flow-on implications for health.

“Over the period 1971 to 2008, both the duration and frequency of heatwaves has increased,” the report said, with the number of recorded hot days doubling since 1950 and hot weather records being broken at three times the rate of cold weather records.

The report's findings echo concerns raised by the AMA about the health effects of climate change and the need for national and international action to address the threat.

“The AMA believes that climate change is a significant worldwide threat to human health that requires immediate action, and we recognise that human activity has contributed to climate change,” Dr Hambleton said recently.

“The AMA wants to see a national strategic approach to climate change and health, and we want health professionals to play an active and leading role in educating the public about the impacts and health issues associated with climate change.”

The Climate and Health Alliance, a coalition of representative health groups, said the Climate Council's report reaffirmed the serious threat posed by heatwaves.

“Heatwaves are now more frequent and more intense, and we are witnessing a dramatic increase in the number of near deaths and deaths from heatwaves over the last decade,” Alliance President Dr Liz Hanna said.

“Deaths and medical emergencies from [recent] heatwaves are an alarming portent of what is to come,” she said. “Failing to commit to credible emissions reductions in Australia is putting the health of Australians at risk. Acting on climate change is a vital and urgent public health initiative. Failure to act is killing people.”

See also Climate council: heatwave are getting hotter and more frequent, p38

Adrian Rollins



Child diabetes rates steady – for now

Children as young as seven years are being diagnosed with type 2 diabetes, but there is as yet no evidence that its incidence among the young is increasing despite rising rates of overweight and obesity.

In a result that does not sit easily with evidence of the nation's swelling waistline, the Australian Institute of Health and Welfare has reported that the incidence of type 2 diabetes among those aged between 10 and 39 years was largely unchanged in the 10 years to 2011-12, aside from a decline among 20 to 29-year-olds.

According to data analysed by the Institute in *Type 2 diabetes in Australia's children and younger people: a working paper*, each year on average around 150 children and adolescents aged between 10 and 19 years were diagnosed with type 2 diabetes.

Consistent with evidence that type 2 diabetes is predominantly a disease of the middle aged and elderly, the AIHW found that 92 per cent of diagnoses were among people aged 40 years and older, and that the incidence in this age group was 441 per 100,000, compared with just 3 per 100,000 among 10 to

14-year-olds.

But the Institute said the relatively low incidence of type 2 diabetes in the young (type 1 diabetes is much more common in children, accounting for 88 per cent of diabetes cases diagnosed in children aged 10 to 14 years) was no cause for complacency, for a number of reasons.

For one, though the number of young people with the disease was small, where it did occur its effects were typically more severe, the risk of complications was greater, treatment was more difficult and complicated, and the lifetime costs - in terms of treatment, reduced capacity to study and work, reduced life expectancy - were higher than for those who contracted the condition later in life.

Related to this, its incidence among Indigenous children was far higher than in the broader community. In its analysis, the AIHW found that Indigenous children aged between 10 and 14 years were eight times more likely to have type 2 diabetes than their non-Indigenous peers, while among Indigenous 15 to 19-year-olds the incidence was four times greater.

Secondly, the behaviour that increases the risk of developing type 2 diabetes – poor diet and a sedentary lifestyle

– has become increasingly common, as indicated by the rise in rates of overweight and obesity among children.

Thirdly, the Institute warned that existing data was likely to underestimate the incidence and prevalence of type 2 diabetes among the young because of estimates that about 25 per cent of people with the disease are undiagnosed, and the difficulty of distinguishing between type 1 and type 2 diabetes in children and adolescents.

In its Working Paper, the AIHW argued that it was important to monitor the incidence of type 2 diabetes in children and young people because of its severe lifelong effects and costs, the increase in risk factors, and the likelihood that it had so far been underreported.

"It is thought that the increased rates of obesity in young people will impact on type 2 diabetes, with greater numbers developing the disease at younger ages," the Institute said.

It said that, despite its limitations, the information examined in the Working Paper provided a baseline against which future monitoring readings could be assessed.

"There is scope to improve Australia's ability to monitor type 2 diabetes in children and young people, and to prevent this serious disease and its complications among young people," the Working Paper said.

Adrian Rollins

COMMENT

Hospital alarm following near-fatal attack

Doctors are pushing for upgraded security in public hospitals following a near-fatal attack on neurosurgeon Dr Michael Wong last month.

AMA Victoria President Dr Stephen Parnis has called on the Victorian Government to consider giving emergency department staff personal duress alarms, and to ensure hospitals have sufficient funds to employ properly trained security guards, install closed circuit security cameras and build behavioural assessment rooms.

Dr Parnis told *The Age* he had raised the issue of health worker safety during a meeting with Victorian Health Minister David Davis and Attorney-General Robert Clarke on 7 February, and he encouraged them to consider tougher penalties for people who attack any health professional in the course of their work.

The issue has claimed fresh urgency after the brutal attack on Dr Wong, who was stabbed repeatedly during a frenzied attack in the foyer of the Western Hospital, Footscray.

Dr Wong was attacked as he entered the hospital to begin work for the day, and suffered life-threatening injuries from multiple stab wounds.

Colleagues and onlookers who rushed him into the emergency department for treatment are credited with saving his life.

Late last month he was reported to be in a serious but stable condition in the hospital's intensive care unit.

A man, Kareem Al-Salami, 48, of Sunshine North, has been charged with attempted murder over the incident.

Adrian Rollins

COMMENT

School loses sugar coating

The ACT Government has become the first in the nation to ban the sale of soft drink and fruit juices in public schools, drawing warm praise from the AMA and other health groups.

In a measure it hopes will help curb rising rates of overweight and obesity among ACT schoolchildren, the Government has announced that the sale of fruit juices and soft drinks from vending machines will be prohibited at all public schools in the Territory from the end of Term One this year, with a complete ban to be in place by the end of the 2014 school year.

AMA President Dr Steve Hambleton said the ban sent a clear message that soft drinks and fruit juices should not be part of an everyday diet, and called on other governments and schools to take similar action.

"Soft drinks and fruit juices can be enjoyed occasionally as a treat, but there is no doubt that consuming these products daily is inconsistent with a healthy diet," Dr Hambleton said. "Positioning these in schools so that they are available every day sends the wrong message."

The ACT Government had originally planned to phase out sugary drinks at public schools over a five-year period by offering incentives for schools that agreed to stop selling them.

But late last year the Government toughened its stance following the release of data showing 63 per cent of ACT residents were overweight or obese, including more than 25 per cent of children.

Announcing the ban on 20 February, ACT Chief Minister Katy Gallagher said her Government had "a clear plan to reduce the amount of people who are overweight or obese, and a key way to achieve that is to reduce the availability of sugary drinks to children".

"The evidence for us is very clear," Ms Gallagher told the *Canberra Times*. "We've got to make this decision."

The ACT Chief Minister flagged the possibility the ban would be extended to other Government-controlled facilities, such as hospitals and ACT Government departments.

Dr Hambleton said obesity was a major public health issue, and it was important to



educate young people about healthy diets and exercise.

"The ACT Government has done a great job to show leadership in reducing the alarming rates of overweight and obesity in our young people," the AMA President said, and called on non-government schools and other State and Territory governments to take similar steps.

"Further, initiatives such as the sugary drink ban need to be followed up with action from all governments to reduce the targeted marketing of unhealthy foods and beverages to children, simplify food labelling, and increase opportunities for physical activity among all children and adults," he said.

The Public Health Association of Australia said the ACT Government should be given "full marks" for the sugary drinks ban in

public schools.

President Professor Heather Yeatman said that, as an Associate Professor in Public Health Nutrition at the University of Wollongong, and as a mother of two children, "I know that sugary drinks are not necessary in anyone's diet – on an occasional basis they may add variety or novelty, but they certainly are not an everyday choice".

The measure has been criticised by the industry group Fruit Juice Australia.

The group's Chief Executive Geoff Parker told the *Canberra Times* it was a "simplistic" approach that did not address the central issue of ensuring a balance between a child's level of activity and their diet.

Adrian Rollins

Attack on controversial sugar study intensifies

The authors of a controversial study claiming that Australians are reducing their sugar consumption have admitted to an error in the presentation of data as the research comes under sustained attack.

In their *The Australian Paradox* study, Professor Jennie Brand-Miller and her colleague Dr Alan Barclay reported that although rates of obesity had trebled, per capita consumption of nutritive sweeteners had, paradoxically, dropped 16 per cent.

But on ABC Radio's *Background Briefing* program, Professor Brand-Miller and Dr Barclay appeared to contradict one of the assertions made in their study, that per capita sales of sugar-sweetened beverages had decreased by 10 per cent.

On the program, Professor Brand-Miller said "it might be that a key word came out. It's possible that this should be, 'While nutritively sweetened

beverages... 10 per cent sweetened beverages decreased by 10 per cent.' So I'll double-check it." In an email sent to the program, Dr Barclay said "the 10 per cent decline could not possibly refer to per capita sales of nutritively sweetened soft drinks".

The basis for the study's findings has been called into question by a peer-reviewed paper published in the journal *BMC Public Health*, "Trends in sugar supply and consumption in Australia: is there an Australian Paradox?"

In their conclusion, the authors observed that "the Australian Paradox assertion is based on incomplete data, as it excludes sugar contained in imported processed foods, which have increased markedly".

"Available import data showed large increases in the volume and value of imported sweetened products between 1988 and 2010 to over 30 grams of sugar per person per day," the authors said. "Value estimates of local production

of sweetened products also show substantial increases in this period."

Prominent economist Rory Robertson, who has been a long-standing critic of the *Australian Paradox* study, said its interpretation of data was flawed: "Four of the authors' five separate indicators of consumption trend up, not down, in their own published charts, while their preferred measure is based on a data series that was discontinued as unreliable by the ABS after 1998-99".

“ Available import data showed large increases in the volume and value of imported sweetened products between 1988 and 2010 to over 30 grams of sugar per person per day ”

Mr Robertson said this was just one of many errors in the paper, and has called for its retraction.

Sydney University has appointed an external investigator to review the research.

Adrian Rollins



INFORMATION FOR MEMBERS

Aged care Administrator and Adviser Panels

The Department of Social Security is seeking applicants to serve on aged care Administrator and Adviser panels.

Panel members, who serve a three-year term, are called upon to assist aged care providers found to have breached its responsibilities under the Aged Care Act 1997.

As part of the sanctions posed on non-compliant providers, the Department may require that they appoint an approved adviser or administrator to help them meet their responsibilities under the Act.

The Act requires the Australian Government to establish an administrator panel and an adviser panel (the panels) from which approved providers must select an adviser or an administrator if they are required to do so as part of the sanctions process.

Panel applicants must be suitably qualified and experienced. The minimum criteria set out under the Act requires that each panel member must:

- have at least three years' experience in senior positions in managing, or providing professional advice and support to, an aged care service or similar undertaking;
- not be an Australian Government officer or employee;
- have no conflict of interest between their duties as a member of the panel and any of their other interests or duties; and
- not have been convicted of an indictable offence, be insolvent or be of unsound mind.

For further details, got to: www.dss.gov.au/our-responsibilities/ageing-and-aged-care

Full waiting rooms? This could be the tonic...

The time patients spend waiting for treatment in hospitals and medical practices across the country is often viewed as wasted.

But independent production company GSP wants to put it to good health effect.

Backed by sponsorships from NPS MedicineWise, National Asthma Council, Cancer Australia and other health groups, GPS – through its Tonic Direct service – transmits programs on health topics such as healthy eating, weight loss, reproductive health, asthma and diabetes direct into dozens of waiting rooms across the country.

The free service – Tonic Direct not only provides the programs without charge, but also televisions and connections – has been developed as a way to make the most of the time of both patients and doctors by giving waiting consumers accurate and useful basic health advice.

It is hoped that by improving the health literacy of patients, doctors will have more time in consultations to provide more detailed and specific advice and treatment.

The production company is co-founded by the ABC's Health Editor Dr Norman Swan, who also presenter, and Consumers' Health

Forum Board member Karen Carey is Executive Producer.

The system was piloted in three practices and two hospitals in Sydney and Brisbane in the first half of 2013, and full rollout began last November.

Ms Carey said feedback from the first 25 sites using the service had been “very positive, in particular in relation to the increased time efficiency of consultations, which was great for GPs, and that patients were initiating conversations about weight loss and other lifestyle interventions”.

Tonic Direct is a spin-off from the ABC's Tonic program, and Ms Carey said the company was required to comply with the public broadcaster's editorial guidelines regarding sources of funding.

“We do not take funding from pharma, our content is entirely free of commercial bias, and we have strict Ethical Advertising Guidelines to ensure that GPs and hospitals are comfortable with what their patients will see on the screens,” she said.

Ms Carey said GPs were encouraged to provide feedback so that programs could be refined to meet their needs as well as those of their patients.



“Essentially, we see ourselves as a tool for GPs to communicate directly with their patients information that they want their patients to know, but do not have time to deliver in a consultation, such as lifestyle modification,” she said.

Ms Carey said Tonic Direct was negotiating with the University of Melbourne and the University of Sydney to conduct a study into the effectiveness of Tonic Direct in helping improve health literacy and outcomes, and to evaluate the benefit GPs derive from having more health-literate patients.

Ms Carey said so far the focus has primarily been on hospitals and larger practices (of at least four GPs), but the service had been installed in smaller practices “where the need is significant”.

She said it had been installed in clinics in rural areas, and it was being installed in a prison, “where there are no GPs, but where the need for health information is great”.

Details of the service can be viewed at: <http://tonicdirect.tv/index.php/component/content/frontpage>

Adrian Rollins

COMMENT

Beauty parlours, cosmetic clinics may operate on wrong side of law



Doctors and beauty therapists offering Botox, dermal fillers and other cosmetic injections have been warned they may be breaking the law.

The Therapeutic Goods Administration said it was receiving “numerous” complaints each week about health professionals and beauty clinics advertising prescription-only cosmetic injections, in clear breach of the Therapeutic Goods Act.

The medicines watchdog said it was concerned that many individuals and businesses offering cosmetic injections

were promoting their services in ignorance or disregard of the law.

The TGA said that under the Act, any ads for cosmetic injections must not include the trade name, acronym, ingredients or colloquial term used for Schedule 4 or Schedule 8 substances.

For example, a business that provides Botox injection is not allowed to use that name in its advertisements, nor substitute terms such as botulinum toxin or BTX. Other names and terms that are unacceptable include Dysport,

Restylane, Dermalive, Sculptra, collagen, polylactic acid, hyaluronic acid, or HA.

Instead, the TGA has advised that general phrases are acceptable, such as “cosmetic injections”, “anti-wrinkle injections”, “wrinkle injections” and “injections for lips”.

“The TGA receives numerous complaints each week about health professionals and beauty/cosmetic clinics that are advertising prescription-only cosmetic injections to consumers,” the regulator said.

“The Act prohibits advertising therapeutic goods containing prescription-only medicines (substances included in Schedule 4 or Schedule 8 of the *Standard for the Uniform Scheduling of Medicines and Poisons* to the general public. This includes most injections that have a cosmetic use,” the regulator said.

The TGA said the law covered health professionals, professional bodies, media outlets and commercial ventures, and applied to all forms of media, including not only traditional media outlets but also electronic media such as websites, blogs, discussion forums and social media.

It said that often advertisers were unaware of the law and, in the first instance of a breach, it sought to inform and educate, rather than prosecute.

“However,” the Administration warned, “if this approach fails, the TGA may take regulatory action. The Act provides for financial penalties for advertising breaches”.

To help businesses and individuals to familiarise themselves with the rules, the TGA has developed a fact sheet *Advertising cosmetic injections – Applying the therapeutic goods legislation*, which can be found at:

<http://www.tga.gov.au/industry/advertising-cosmetic-injections.htm>

Adrian Rollins





Red Cross no ordinary symbol

BY DR MICHAEL GLIKSMAN*

Many of us associate the image of a red cross with the provision of medical services or assistance.

This association is unsurprising given that this is often how the symbol is portrayed in the media and popular culture.

Unfortunately, it is not well understood that the symbol of the red cross - as well as the red crescent and red crystal - has special meaning and protection under Australian and international law.

The red cross, the red crescent and the red crystal emblems are used in war zones to indicate that a person, vehicle or building is not part of the conflict, but is providing impartial medical aid and assistance to wounded soldiers, prisoners-of-war or civilians.

Every day, the emblems are used for these purposes to save lives - not just of the people who require assistance, but also of the staff who put themselves in dangerous situations. It is for this reason that the emblem must be protected and understood universally as meaning 'Don't Shoot!'

The emblem can be worn by medical military personnel and religious military personnel, as well as Red Cross workers.

Due to the importance of the emblems, their improper use in conflict situations can constitute a war crime.

The protected status of these emblems is enshrined in the Geneva Conventions of 1949 and their Additional Protocols. In turn, the emblems are protected under Australian law in the Geneva Convention Act 1957 (Commonwealth).

As outlined in this Act, use of the red cross emblem in Australia, without the permission of the Minister of Defence, is an offence.

Even the Australian Red Cross must have Ministerial approval to use the emblem, and then only within strict guidelines to indicate a link to the Red Cross/Red Crescent Movement.

Australian law also protects anything "so nearly resembling any of the emblems" of the Red Cross "as to be capable of being mistaken for" the emblems. This means that dark orange crosses or red crosses on backgrounds other than white also should not be used.

The idea for a universal protective emblem was created by the founder of the Red Cross/Red Crescent Movement, Swiss

citizen Henry Dunant, who witnessed the horrors of the aftermath of the Battle of Solferino in 1857 and the inadequate medical assistance that was provided to the wounded.

Mr Dunant was inspired by the Swiss flag (white cross on a red background) as a symbol of neutrality, and switched the colours to create the first Red Cross emblem.

In recognition of these origins, and the potential for confusion, Australian law confers on the Swiss flag the same protection accorded to the red cross, red crescent and red crystal symbols. The legislation precludes the use of a white cross on a red background.

Australian Red Cross assists the Minister of Defence to ensure the red cross emblem is correctly used and understood by the Australian community.

Often, when Red Cross contacts organisations that are misusing the emblems, we are asked why protection of the emblem in Australia matters.

The conflicts where these symbols are used are so far away and unlikely to occur in Australia, so surely these small uses of the symbols couldn't possibly make a difference?

The answer is that any use of the emblems outside their purpose dilutes their authority and power to protect during conflict.

Every country in the world is a party to the Geneva Conventions. By doing so, all have agreed that these are universal symbols of protection, and are to be understood as

such everywhere.

There are a range of alternatives to the red cross that can be used.

For instance, the image of a white cross on a blue background is used in common street signs around Australia to indicate the location of a public hospital.

Similarly, a white cross on a green background is used for occupational health and safety and to indicate first aid.

Australian Red Cross works to build understanding in the community of the protective authority of the emblems.

We contact organisations who misuse the emblem to make them aware of the emblems' meaning and their proper use.

Australian Red Cross asks for your assistance to ensure that the true meaning of the red cross emblem is upheld in Australia.

Not using the red cross emblem is a small but meaningful way to contribute to the safety of Red Cross workers and military medical personnel, as well as the people they are trying to protect.

If you notice an emblem misuse, please notify the Australia Red Cross so that we can continue our education work. Please email: emblemisuse@redcross.org.au

For more information, please visit Australian Red Cross' website: <http://www.redcross.org.au/the-emblem.aspx>

** Dr Glikzman is a member of the Australian Red Cross International Health Law Committee.*

Quelle horreur! Another French breast implant scare

Implants of a French-made silicon breast prosthesis have been suspended after the manufacturer was found to be in breach of quality standards.

French health authorities have shut down production of Cereform implants and recalled all non-implanted products after it was found that the sterilisation processes used by the manufacturer Cereplas had not been fully validated in accordance with current international standards.

So far, Australian authorities have not recalled implants sold here, but surgeons supplied with the implants have been contacted and planned implant surgeries have been postponed. Further supply of these implants has been suspended.

The French health regulator ANSM has not yet found evidence that the breach in manufacturing standards has resulted in any health risk, and the Therapeutic Goods Administration said its contact with surgeons who had implanted these devices had not found anything to suggest problems with the sterility of implants used in Australia.

The TGA said it had sought additional information from both ANSM and Cereplas, and “once this information is received, a decision as to whether or not a product recall is required will be made”.

The incident comes just two months after the founder of infamous breast implant manufacturer Poly Implant Prothese (PIP), Jean-Claude Mas, was convicted of fraud and sentenced to four years imprisonment by a French court following revelations in 2010 that PIP implants were being manufactured using industrial-grade silicone.

The discovery prompted a global safety alert, including in Australia, where health authorities imposed an immediate ban on the use of PIP implants amid fears rupture could leak toxic substances into the body.

Around 300,000 women worldwide have PIP implants, including an estimated 13,000 in Australia. In its latest update, the Therapeutic Goods Administration has confirmed 490 cases where PIP implants have ruptured, and a further 24 instances of unconfirmed ruptures.

Plans for a class action by Australian women against the company’s local distributor were abandoned after it was revealed it had only limited product liability insurance.

The scandal prompted the previous Government to agree to establish an opt-out breast implant registry after the TGA came under criticism over its vigilance regarding implantable medical devices, and the information it provided to the public.

In an alert issued on 21 February, the TGA assured women who have a Cereform implant that, unless they experienced an infection soon after surgery, they were unlikely to experience any problems “associated with this issue”.

It advised doctors with patients who have received a Cereform implant to be alert to the possibility of infection, and to reassure them that “if they were going to experience an infection related to this issue, it would occur in the immediate post-operative period”.

Adrian Rollins

COMMENT

Pfizer tried to clog arteries of competition: ACCC

Drugs giant Pfizer Australia has been accused of abusing its competitive position to try to corner the multi-million dollar market for anti-cholesterol medication.

The Australian Competition and Consumer Commission has alleged that in early 2012 Pfizer tried to induce pharmacies to stock up on its best-selling cholesterol-lowering drug Lipitor and its generic offshoot atorvastatin ahead of the expiry of the Lipitor patent in May 2012.

The ACCC has alleged the company offered pharmacies significant discounts and rebates in return for stocking at least a 12 months’ supply of Pfizer’s atorvastatin product.

The regulator said the offers were first made prior to the loss of patent, when other generic suppliers were prevented from making competing offers.

At the time, Lipitor was prescribed for more than one million people, and annual sales reached more than \$700 million.

ACCC Chairman Rod Sims alleged that Pfizer engaged in this conduct “for the purpose of deterring or preventing competitors in the market for atorvastatin from engaging in competitive conduct, as well as for the purpose of substantially lessening competition”.

Mr Sims said that deterring anti-competitive conduct was a top priority for the ACCC because of the harm it could cause to the economy and consumers, particularly when it involved such a widely-used product.

“This case also raises an important public interest issue regarding the conduct of a patent holder nearing the expiry of that patent, and what constitutes permissible competitive conduct,” he said.

The ACCC is seeking a pecuniary penalty, as well as legal costs and “declarations”.

The matter is listed for a directions hearing before the Federal Court in Sydney on 18 March.

Adrian Rollins

COMMENT

Let us decide when and how to die, say older Australians



A large majority of older people want the right to control the circumstances and timing of their death, and can envisage a situation in which they would seek help to end their life, a survey has found.

But, suggesting that talking about death remains a taboo topic for many, almost 36 per cent of 1804 people aged 50 years and older surveyed by the Council on the Ageing (COTA) NSW admitted they had not discussed their end-of-life care wishes with anyone.

Encouragingly, the online survey found that an overwhelming majority of older people (85 per cent) judged themselves to be in good or excellent health, while just two per cent rated their health as poor.

As part of the study, participants were asked

about access to health care, and almost 80 per cent reported driving to see their GP, highlighting concerns about the health implications for the elderly if they lose their driver's licence.

Reflecting this, 20 per cent said better public transport was needed in order to improve access to their GP, while more than 43 per cent thought there should be greater co-location of health services.

Among older people, consistency in GP care was rated highly – more than 40 per cent said the most important aspect of GP visits was seeing the same doctor every time. A further 22 per cent thought having their diagnosis and treatment explained so that they could manage their recovery was most important, while 19 per cent rated prompt service most highly.

When it came to hospital treatment, almost 50 per cent of those surveyed considered that having their diagnosis and treatment explained so that they could manage their recovery was most important, while almost 34 per cent set highest store on being treated with dignity and respect.

In a sign of unease among many about current arrangements, more than a quarter felt palliative care did not provide a comfortable end to life.

Of those who had discussed their end-of-life wishes with others, 64 per cent reported they had had such a conversation with their partner or carer, 58 per cent said they had discussed it with their children, 34 per cent had talked about it with friends, 22.6 per cent had discussed it with their GP and 20.6 per cent had had the conversation with their lawyer.

Most commonly (55 per cent), people wanted to die at home, while 12 per cent wanted to pass away in hospital, and many (26 per cent) remained unsure.

What was clear was that most (76.8 per cent) wanted the right to decide where and when they would die, including the possibility that they might be assisted in ending their life.

It is the latest survey suggesting that there is considerable support in the community for euthanasia laws.

COTA NSW said the survey showed that "older Australians are willing and able to take a high level of control over their lives, including the final phase of their lives".

Adrian Rollins



Medicine can be a choking hazard: TGA

Parents and doctors have been warned to be alert to the potential for young children to choke on soft gel capsules.

The Therapeutic Goods Administration said that although it has not received reports of children choking on gel capsules, parents and carers should take care in giving medicine in this form to children.

Soft gel capsules typically have a gelatine-based shell containing medicine in liquid form. They are used for a variety of medicines, including vitamins.

Medicines that come in the form of soft gel capsules are not necessarily unsafe products, and the choking risk posed by

these capsules is similar to that for many food items," the TGA said, adding that as the age of the child increases, the choking risk reduces.

"However, parents and caregivers are advised to be mindful of the risk of choking when medicines in the form of soft gel capsules are given to children, especially those aged under five year," the regulator said.

It recommended that doctors and other health professionals consider advising parents and caregivers of the potential risk, and the need to be careful in providing medicine to children.

Adrian Rollins



Booze buses, ads work well to deter drink driving

Harsh drink driving penalties are of little deterrence unless backed by effective random breath testing programs, an Australian Institute of Criminology review has found.

In a paper examining measures to reduce drink driving, Institute researchers Kiptoo Terer and Rick Brown found that the most effective deterrent was personal contact with a random breath test operation, either a stationary booze bus or one administered by police officers on patrol.

The researchers said the introduction of random breath testing had been associated with a significant reduction in fatal car crashes, including a drop of 15 per cent in the decade following their introduction in New South Wales, and a 35 per cent fall in Western Australia over four years.

According to the study, the effectiveness of RBT as a deterrent lay in perceptions about the likelihood of being tested and detected, and warned that their influence was likely to wane unless the effort of conducting tests (accompanied by prominent media campaigns) was sustained.

The researchers said RBT policies needed to aim to test a high proportion of drivers, though they admitted further research was needed to establish what the optimum percentage would be.

The report cited research showing that 58 per cent of drivers admitted to having driven under the influence of alcohol and, of these, 72 per cent said they had done it twice in the preceding 12 months.

All up, between 20 and 30 per cent of people caught drink

driving reoffend, and the researchers found that this group was the least responsive to deterrents like RBTs, public campaigns and social opprobrium.

According to the study, while the most effective drink driving penalty was loss of licence, even severe sanctions like imprisonment were largely ineffective unless there was a perceived reasonable likelihood of being detected.

Of interventions for repeat offenders, the study found the most effective was ignition interlocks, which require drivers to provide a breath sample before they can start their car, and which immobilise the vehicle if alcohol is detected.

The authors recommended that their use, which has so far been limited, be expanded significantly for repeat offenders.

The report came following the release of figures showing a drop in the nation's road toll, from 1303 in 2012 to 1193 last year.

The Australian Automobile Association said an extra 220 lives could have been saved last year if every other State and Territory had matched Victoria's road fatality rate of 4.24 people per 100,000.

The AAA added that, with the number of road fatalities decreasing, greater attention needed to be paid to reducing the number of serious injuries suffered in road accidents, citing National Road Safety Strategy estimates that around 32,500 people suffered serious injuries in road accidents each year.

Adrian Rollins



INFORMATION FOR MEMBERS

PBA nominations invited

AMA members are invited to nominate for a specialist position on the Pharmaceutical Benefits Advisory Committee (PBAC).

This is a challenging and stimulating position that provides the opportunity to contribute directly to pharmaceutical benefits policy in Australia.

PBAC is an independent expert committee that advises the Minister for Health on medicines in relation to the Pharmaceutical Benefits Scheme.

PBAC is required to consider the clinical effectiveness, safety and cost effectiveness of a medication compared with existing therapies. Members must be able to interpret the comparative outcomes of therapy involving a medicine, and appraise evidence.

The AMA has been asked to nominate candidates with expertise in infectious diseases/ microbiology and paediatrics.

The AMA's Federal Executive Council will assess nominations prior to forwarding them to the Minister for potential appointment.

PBAC meets for three, three-day meetings a year, and may occasionally hold additional one-day meetings. PBAC members currently receive an annual salary of \$36,750, and all travel costs are reimbursed. Appointments are for four years.

Further information about PBAC can be found on the Department of Health website at www.health.gov.au.

To nominate, please forward a curriculum vitae, including your contact details, that is no longer than 2 pages (Click here [https://ama.com.au/system/files/sample_cv.pdf] for an example) to cmoylan@ama.com.au **by Wednesday, 5 March 2014**. If you have any questions, please contact Georgia Morris on 02 6270 5466.



BY DR BRIAN MORTON

“The
Productivity
Commission
also backed the
AMA’s view that
the Government
should
implement a
single provider
number for each
GP”

Unravelling the red tape

The AMA has had a long standing interest in reducing the amount of red tape that wastes GPs time, extends their work day and reduces the time available for consultations.

A number of the red tape headaches for GPs were recently highlighted by the AMA in its submission to the National Commission of Audit - in particular, the PBS authority system, Medicare provider numbers, the registration process for the PCEHR, Centrelink documentation, and Chronic Disease Management items.

More often than not there is absolutely no justification for the regulatory burden imposed on GPs.

Take the PBS authorities as a case in point. The Department of Health, upon reviewing the impact on prescribing behaviour of moving PBS authority medicines to streamlined arrangements, found none. Meaning, GPs are prescribing appropriately. Of the 6.4 million calls received to the PBS authority line in 2008-09, only 2.8 per cent were denied authority. Even the Productivity Commission has recommended its abolition. I, for one, have no doubt that removing the PBS authority system would make a significant improvement to the productivity and efficiency of GPs across Australia.

The Productivity Commission also backed the AMA’s view that the Government should implement a single provider number for each GP.

Current rules require GPs to apply for and obtain a separate provider number for each location they work in. With many of us working in more than one location, this is convoluted and unnecessary, not to mention a significant issue for practices trying to obtain staff at short notice, and for GPs providing locum assistance. I’m at a loss as to why we need anything other than what the AMA has previously recommended, a single provider number with a location specific identification number.

Registering for the PCEHR has been one of the biggest red tape headaches in recent times. It is not surprising, given the complexity of what is required, that more than 80 per cent of PCEHR participant applications have been incorrectly completed. It has been a resource-intensive exercise, and if the Government wants to see other medical practices and healthcare organisations participate in the PCEHR, they are going to have to simplify the registration arrangements.

One red tape headache that can have a significant effect on a GP’s day is all the paperwork required by Government departments such as Centrelink,

and third parties such as WorkCover. The AMA has actively worked with Centrelink to improve and streamline their Medical Certificate and Treating Doctor Medical Report forms. These forms can now be completed and lodged electronically via the Health Professional Online Service (HPOS). Reports lodged this way prefill the provider details, and can be saved and used as the basis for generating future reports for that patient. Nevertheless, it would be much more efficient for GPs if forms such as these were integrated with our practice software.

The red tape that wraps up current chronic disease management (CDM) arrangements has more to do with regulating non-clinical tasks than it does with the provision of quality of care. Last year, the Department of Health reviewed CDM items with a view to improving their effectiveness. As part of this they were willing, where possible, to reduce red tape and simplify referral arrangements. Since the election this work has stalled.

The AMA believes there is significant scope to improve the operation of the CDMs, and is urging the Government to work with the AMA to develop sensible reforms that support the provision of quality care without tying GPs up in red tape.



BY AMSA PRESIDENT
JESSICA DEAN

“The maldistribution issue is complex, encumbered with geographical and social obstacles. The focus therefore needs to be on accessibility”

The nuances of the training crisis

The training crisis, long foreseen by organisations including AMSA and the AMA, is no great mystery.

In fact, the predictable nature of the crisis makes it all the more frustrating when governments repeatedly fail to effectively avert its effects.

While the equation is simple - medical graduates cannot serve communities until they are fully trained - the message has been muddled over the years. This has led to confusion in the community, and a corresponding lack of clear action.

One of the greatest challenges AMSA's advocacy team faces in 2014 is improving the community's understanding of the nuances of the training debate.

Two areas have become apparent where clarification of the issues seems almost as important as the changes we strive for.

New medical schools

There is a projected shortage and maldistribution of doctors in the future.

Health advocacy groups and the community agree this shortage adversely affects the health of Australians, particularly those in rural and remote Australia. But views diverge on the best solution.

The doctor shortage is not solved by simply training more medical students. The community needs specialists, not untrained medical graduates.

The scarcity of internships currently available, combined with the deficiency of vocational training positions, means that the paths for these graduates are long and fraught with insecurity.

The training pipeline has reached a bottleneck. Any attempt to push through more medical graduates will be about as effective as attempting to flood a blocked toilet. It will result in longer wait times before vocational training, leading to a shorter total number of years of post-vocational practice.

Considering the desperate shortage of trained specialists, a shortened working life will only exacerbate the problem.

AMSA's priority is to explain to the community that new medical schools are not the answer.

Australia has seen the creation of nine new medical schools in the last decade. If these additional medical students graduate without a proportionate increase in the number of internships available, they will have to search elsewhere to complete their training. The government's investment will be lost overseas.

Furthermore, any hope that the government will deliver a commensurate number of internships before these students graduate appears optimistic.

In 2004, Tony Abbott, as the-then Minister for Health, substantially increased the number of medical student places. The very relevant history

lesson is that the inevitable medical student tsunami did not result in a proportionate increase in the number of doctors, even though the government had the full length of the degree to prepare for the incoming graduates.

If the community wants doctors, these same funds would be better invested in training positions.

Rural GPs and specialists

The release last month of an Australian Institute of Health and Welfare report on the medical workforce sparked a fair amount of buzz in the media.

Firstly, the 16.4 per cent increase in medical practitioners appeared reassuring to some, even though the projected doctor shortage, based on Health Workforce Australia figures, remains relatively unchanged, at 2500 doctors in 2030.

Secondly, the media appeared to rejoice at the increase in the number of GPs per capita. One journalist asked me how I feel “now that we've fixed the rural GP shortage”. The report showed that the GP population was 133 per 100,000 population in rural areas, compared with 108 per 100,000 in metropolitan areas.

An increase in the number of rural GPs is part of the solution, but an increase in numbers doesn't necessarily translate to better patient outcomes.

The maldistribution issue is complex, encumbered with geographical and social obstacles. The focus therefore needs to be on accessibility.

The complexities of the training pipeline do not have a simple fix, and the nuances can be difficult to understand.

It is our role as future health professionals to explain the intricacies of these issues to the community.



BY DR DAVID RIVETT

Enough with the second-rate solutions for rural health

While the National Rural Health Alliance is full of well meaning and caring people, some of its proffered solutions for the rural workforce crisis are cloud cuckoo-land stuff.

The latest is to suggest rural pharmacists hold clinics and prescribe from the Pharmaceutical Benefit Scheme (PBS). Rightly, their discussion paper recognises a clear conflict of interest in such actions. However, few details are put forward for managing this.

Suggestions of this nature, based as they are on care provision substitution, are defeatist nonsense, espousing wrongly both that rural Australians should get second-rate health care, and that they would be happy to accept such an outcome.

They are driven by a relentless push from allied health workers, foremost among them pharmacists, to expand their fields of practice and, with this, their sources of income and self-aggrandisement.

Sadly they neglect, at the populace's peril, that pharmacists are not trained to diagnose, and that to prescribe without a correct diagnosis is downright dangerous. One only has to speak to

any pharmacist who has followed his pharmacy career with a degree in medicine to establish such.

“ Rural Australians are not stupid, and it demeans them to suggest that they will accept any level of health care - if they have a health problem, they expect to see a doctor to sort it ”

They have not learnt from previous experience, either – such as where nurse practitioners prescribe independently of the treating doctor, causing nothing but pain; or where a nurse practitioner creams off simple cases in a small town, making a rural medical practice no longer viable.

Rural Australians are not stupid, and it demeans them to suggest that they will accept any level of

health care - if they have a health problem, they expect to see a doctor to sort it.

We need more well-trained and well-supported rural doctors, not untrained dabblers in health care provision.

Until the National Rural Health Alliance understands and accepts that such basic cornerstone principles must underlie any sound solution to the rural workforce crisis, it is extremely difficult for any representative medical body to work with them.

So to those of you asking why the AMA is not an Alliance Member, I trust this is adequate explanation.

Looking for solutions to the workforce crisis, one cannot go past the AMA-RDAA Rural Workforce Rescue Package.

I recently met with Ian Kammerman, the new RDAA President, and both the AMA and the RDAA will work to reinvigorate and update this very sound solution to get more doctors to go to the bush.

We will keep members informed of work on this hopefully newly polished, politically sexy and most appealing package, as it transpires.





BY DR STEVE HAMBLETON

“ In any consideration of health financing arrangements, the AMA is in a strong position to show clinical leadership ”

Health financing sustainability

The Economics and Workforce Committee's first two terms of reference focus explicitly on the economics of health care financing and funding, and the financing and delivery of health care.

This reflects the importance for the AMA of having a clear and up-to-date perspective on health financing, with the needs of the broader community and our members in mind.

As part of this work, EWC has heard from experts such as Professor Andrew Wilson, Director of the Menzies Centre for Health Policy, University of Sydney, and Professor Elizabeth Savage, Professor of Health Economics, University of Technology Sydney, on health expenditure and alternative financing models and, more recently, from Dr Robert Grenfell, National Director - Cardiovascular Health at National Heart Foundation of Australia on improving hospital performance.

Their presentations demonstrated that the biggest factor driving growth in health care costs is the increasing volume of treatment per case, having twice the impact of either ageing or population growth.

At our meeting on 15 February, EWC focused directly on the question of health financing sustainability and the role of the medical profession.

At this meeting I also gave my impression of the broader political context: very little happening on health policy in general. Yes, we had an uninformed 'debate' over the New Year period on the so-called \$6 patient co-payment proposal, but no position from the Government and nothing like a common view from the various health commentators.

Suddenly that all changed. Four days after EWC's meeting, Health Minister Peter Dutton gave a very clear and public message that the Government is concerned about financial sustainability, and will be looking carefully at whether changes are needed to current health financing arrangements to ensure they are sustainable.

So, before it was publicly fashionable, EWC engaged in a wide-ranging and thoughtful debate about how the AMA should approach health financing sustainability.

Part of the context for this discussion is the opportunity for the medical profession to be stewards of the health system and its use of resources. This includes spending health dollars wisely, stopping doing things that we know don't make much of a difference, and doing the things that do make a difference.

As Lord Darzi told the AMA National Conference in

Melbourne in 2012, the low hanging fruit of health system efficiency is to translate what we know into what we do.

EWC agreed there was scope to test a more proactive approach by the AMA to health financing sustainability in a number of areas, and to put forward proposals that are clinically driven, and that we know will improve health outcomes.

The Minister's theme for health financing is sustainability. But he has also identified that he is not prepared to add costs to the system. By contrast, the Minister has identified that he intends for Australians to contribute to their own health care costs when they can afford to do so.

These are challenging parameters for the medical profession.

In any consideration of health financing arrangements, the AMA is in a strong position to show clinical leadership. This will involve working out how the profession can be better organised to collect and evaluate data to inform best practice in clinical care, and health financing arrangements that support that.

Your experiences and insights in these areas, and in health financing more generally, are valuable and can be added as comments to this column.



BY DR STEVE HAMBLETON

“With strong indicators of success like these, and with the versatility to be applied in many settings, it is hard to ignore the benefits of the Abecedarian approach to care-giving for Indigenous Australians”

Proven early childhood program a bridge to closing health divide

The AMA's 2013 Report Card on healthy early development for Aboriginal and Torres Strait Islander children was successfully launched by the Assistant Minister for Health, Ms Fiona Nash, at Parliament House in December last year.

Its key message was that a secure and healthy early childhood for Indigenous children is an investment in a healthier and happier later life – it is key to closing the gap in Indigenous life expectancy.

The AMA Report Card made seven sets of recommendations to the nation's governments about practical measures that can be implemented to protect Indigenous children against early life adversities.

One of these is a particular early childhood program that has had great success in turning around the life prospects of children who would otherwise be held back by a disadvantaged start in life.

There are lots of initiatives operating in a piecemeal and unsystematic way in local communities.

Many of these are community-developed responses to specific community problems and local issues, and they work well. But often, it is difficult to predict how successful an untried, locally-devised measure will be, and the question of how sound the investment is becomes an issue.

That is why the AMA's 2013 Report Card strongly recommended that the Commonwealth invest in the widespread implementation for Australia's Indigenous children of the Abecedarian program of early childhood interventions. It is backed by more than 30 years of international research and evidence of success in improving educational outcomes for disadvantaged children and, as programs go, its

costs are sustainable over the long term.

The Abecedarian program is a suite of high quality teaching and learning strategies based on the idea of 'enriched caregiving', where care for a child is seen as involving cognitive and educational enrichment. This approach has three key elements:

- **learning games** - a set of game-like activities between an adult and child that are integrated into the routines of caregiving and play;
- **conversational reading** – based on the idea of 'joint attention', where children are read to each day by adults; and
- **language priority** – where parents and educators emphasise language throughout daily events and routines, engage in extended conversations, and respond to a child's use of language.

These elements of Abecedarian enriched caregiving can be implemented in a variety of settings, such as in home visits, parent education classes, family childcare homes, childcare centres, kindergarten classes and family literacy programs.

The positive outcomes of the Abecedarian approach for disadvantaged and at-risk children are compelling. For example:

- children in the normal IQ range who receive the Abecedarian intervention are more likely to maintain their normal IQ as they age, compared with those who do not receive it;
- at-risk children who do not receive the Abecedarian program in the first five years of life are twice as likely to be placed in special education for one or more years by the time

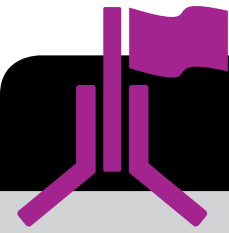
they are aged 15;

- low birth-weight babies who received the intervention have higher mathematics achievement, higher receptive vocabulary, and exhibit fewer risk-taking behaviours at age 18, compared with those low birth-weight babies who did not receive it;
- at age 21, 70 per cent of those who had received the Abecedarian intervention in infancy or pre-school years were in higher education or a skilled job, compared with 40 per cent who had not received the intervention; and
- benefits also accrue for the mothers of children who receive the intervention, including teen mothers, who are more likely to continue on to post-secondary education than teen mothers who do not participate in the Abecedarian intervention (80 per cent compared with 30 per cent).

With strong indicators of success like these, and with the versatility to be applied in many settings, it is hard to ignore the benefits of the Abecedarian approach to care-giving for Indigenous Australians.

In his report to Australian Parliament on Closing the Gap in February this year, Prime Minister Tony Abbott stressed that a priority for Indigenous health in his new government was to get Indigenous children to school, and to keep them there. In other words, to improve the educational outcomes and life prospects for Indigenous children.

The AMA believes that widespread implementation of the Abecedarian program would be a boon to meeting this challenge.



Health on the hill

Political news from the nation's capital

Sports supplement inquiry under cloud with imminent departure of anti-doping head

The status of a lengthy probe into the use of performance enhancing supplements by major sporting clubs has come under question following the decision of the nation's anti-doping czar to retire.

Australian Sports Anti-Doping Authority (ASADA) Chief Executive Officer Aurora Andruska has informed Sports Minister Peter Dutton she will retire when her term expires on 9 May.

The announcement follows increasing dissatisfaction among sport clubs and administrators with the speed of ASADA's inquiry into supplements programs at major sporting clubs including the Essendon Football Club and the Cronulla Sharks Rugby League Club.

It has been more than a year since ASADA announced it had launched an investigation into the use of performance enhancing supplements by clubs in two major sporting codes, and there is mounting frustration about how long the investigation is taking.

ASADA revealed late last month that its investigations had concluded, but no charges have yet been laid. A confidential interim report completed seven months ago

included the names of 12 Essendon Football Club players who had admitted to being injected with peptides, according to a report in the *Sunday Herald Sun*.

Both the AFL and the NRL have already taken action against clubs and individuals implicated in the scandal.

Last August the AFL fined Essendon Football Club \$2 million, banned it from playing in the 2013 finals series and taking part in the National Draft, and suspended senior coach James Hird for 12 months. Announcing the sanctions, the AFL acknowledged that there had not been any breaches of its Anti-Doping Code established "to date".

In December, the NRL found that Cronulla had breached the competition's Code of Conduct, and fined it \$1 million. Head Coach Shane Flanagan was suspended for 12 months (with a possible reduction to nine months upon completion of further education), and Head of Strength and Conditioning Trent Elkin was suspended indefinitely.

Announcing Ms Andruska's imminent departure, Mr Dutton paid tribute to her dedication and service, and added that "I know she will complete her current term unwaveringly to deliver the Australian Government's commitment to integrity in sport".

The Minister said Health Department Secretary Jane Halton would oversee the recruitment of Ms Andruska's successor.

Adrian Rollins



Home medicines services capped as spending blows out

Patient access to services aimed at improving medication use is to be rationed following concerns of a cost blowout.

The Federal Health Department and the Pharmacy Guild of Australia have agreed to cap services provided through the Home Medicines Review (HMR) and other medication programs amid fears funding for the service would run out before the current Community Pharmacy Agreement expires in mid-2015.

Under the changes, which came into effect on 1 March, a referral for a HMR will expire after three months, and there will be strict cap on the number of HMRs and MedsCheck/Diabetes MedsCheck services GPs, pharmacists and other health professionals can commission.

For HMRs, there will be a limit of 20 a month for each service providers, and for MedsCheck/Diabetes MedsCheck services there will be a combined limit of 10 services per month for each s90 pharmacy.

The Pharmacy Guild said "these changes have been agreed between the Guild and the Department of Health in the interests of patients, community pharmacy, the pharmacy profession and taxpayers".

Pharmacy Guild National President George Tambassis said the changes would ensure the continued viability of these services.

"The new capping arrangements for some medication programs are necessary to ensure that the programs stay within budget and do not compromise the range of other important programs and services funded through the Fifth [Community Pharmacy] Agreement," he said.

But the Society of Hospital Pharmacists of Australia has voiced alarm about the changes, claiming they had the potential to put patients at risk.

The Society said it had "grave concerns" that the HMR cap and changes to access to Residential Medication Management Reviews (RMMR) would compromise patient safety.

President Professor Michael Dooley warned the wellbeing of aged care facility residents, in particular, could be threatened.

"This group of patients is at high risk of medication misadventure, particularly when they become frail and their health deteriorates," Professor Dooley said. "A limit of on RMMR service every two years is entirely inadequate for this high risk group."

He questioned the policy priorities that appeared to underpin the changes.

"The focus should always be the patient, and their health and wellbeing," Professor Dooley said. "These changes appear to be focused on meeting budgetary targets rather than being a strategy to ensure that those



Health on the hill

Political news from the nation's capital

... FROM P34

consumers who most need medicines management reviews receive those services.”

But Mr Tambassis said “all of these changes are about making the best use of available funds to deliver the best possible services to patients who most need them”.

Adrian Rollins



Abbott tries to brazen out conflict of interest quagmire

Prime Minister Tony Abbott has thrown his unequivocal support behind embattled Assistant Health Minister Fiona Nash despite confusing and contradictory statements regarding the handling of an apparent conflict of interest involving departed senior staffer Alastair Furnival.

Mr Abbott repeatedly told Parliament last week that Senator Nash was doing “a fine job...and I back her to the hilt”.

But revelations that Senator Nash was aware for months that Mr Furnival held a stake in a lobbying firm with links to a major food manufacturer, and yet declared to the Senate on 11 February that he had “no connection whatsoever” with Australian Public Affairs (only to return to the chamber hours later and admit he was a shareholder in the company), have fuelled attacks on the Minister and intensified scrutiny of potential links between the Government and the food and alcohol industries.

The Opposition has mounted a concerted attack on the Government and Senator Nash after Mr Furnival was forced to resign amid accusations of a conflict of interest over the decision to direct the Health Department to take down the Food Health Star Rating website.

At the time, Mr Furnival was a shareholder and director of a lobbying firm that had had a major food manufacturer, Mondelez, among its clients.

It has subsequently been revealed that Senator Nash directed the website be taken down after a major food industry group had contacted her office earlier in the day to voice its concerns about the initiative.

During a Senate Estimates hearing last week, Senator Nash said she had known Mr Furnival for a decade, and had been aware of his involvement with Australian Public Affairs and the food industry.

She told the hearing Mr Furnival had agreed to divest himself of his APA shareholding and resign as a director when he joined her staff, but was still in the process of divestiture five months later.

The Senator told the hearing she was “completely aware” that Mr Furnival was still a shareholder and director of APA when she told the Senate he had no connection with the firm.

Appearing to implicate the Prime Minister's Office in the saga, the Minister told the Senate on 13 February that “all information around my chief of staff was given to the Prime Minister's Office, in accordance with appropriate timing”.

At the time of Mr Furnival's resignation, Mr Abbott gave as the reason that he had been “dilatatory” in divesting himself of APA shares, but last week shifted his ground, telling Parliament that Mr Furnival had resigned to avoid any perception of a conflict of interest.

“In order to prevent any perception of potential conflict of interest, the staffer in question resigned,” he said.

Meanwhile, Senator Nash has given no clear reason for her chief of staff's departure.

In Parliament last week, the Prime Minister attempted to play down the saga, seeking to dismiss it as “not so much a storm in a tea cup; it is not even a zephyr in a thimble; it is nothing, because the conflict-of-interest rules have been observed”.

He added that Senator Nash was “doing a fine job. Every single decision that has been made by her in that portfolio is eminently defensible and I back her to the hilt”.

But Mr Abbott risks being drawn more directly into the affair, with questions being raised about the circumstances surrounding his pledge last August to give chocolate maker Cadbury \$16 million to develop visitor facilities at its Hobart factory.

Earlier in the year, Mr Furnival had been lobbying the Tasmanian Government on behalf of Cadbury, and sat near Mr Abbott when the Liberal leader visited the factory last year to announce his pledge.

Adrian Rollins



Health body funding cut under scrutiny amid industry link revelations

Assistant Health Minister Fiona Nash's shock decision to axe funding to a renowned alcohol and drug advisory group has come under renewed scrutiny following revelations of links between her former Chief of Staff and the food and drink industries.

AMA President Dr Steve Hambleton said the move last November to withdraw Commonwealth funding from the 46-year-old Alcohol and Other Drugs Council of Australia should be reviewed.

Dr Hambleton's call came as it was revealed Senator Nash's former Chief of Staff, Alastair Furnival, conducted the meeting at which the Council was informed of the funding cut.

Council Board President, former Liberal MP Dr Mal Washer, said that at the meeting, the only reason given by Mr Furnival for the cut was that there was not enough money “and ‘have a nice day’.”

Dr Washer told the *Canberra Times* that neither Mr Furnival nor Senator Nash appeared to know much about the Council, including that it operated the National Drug Sector Information Service, a repository of almost 100,000



Health on the hill

Political news from the nation's capital

... FROM P35

resources on alcohol and other drugs, one of the most comprehensive such libraries in the world.

ADCA was blindsided by the Government's decision, having received a written assurance from the Health Department in April that its funding, worth around \$1.6 million a year, was secure through to mid-2015.

Following the withdrawal of its funding, the organisation put itself into voluntary administration while it assessed its on-going viability.

But there are renewed calls for the funding decision to be reviewed following revelations that, at the time the decision was made, Mr Furnival was a director of the firm Strategic Issues Management, which, according to Fairfax Media, in 2004 described itself as specialising in co-operatives in the alcohol, transport and agriculture industries.

Mr Furnival was last month forced to resign from Senator Nash's office after it was revealed that after joining her staff he not only had retained his position as SIM director, but was also a shareholder in the lobbying firm Australian Public Affairs, which had had food giant Mondelez Australia and Australian Beverage Council among its clients.

Dr Hambleton said the Government should revisit its decision to withdraw the Council's funding.

"When we see adverse effects and acute side-effects from a toxic product continuing to rise, we have to really question the wisdom of de-funding a body that is trying to reverse that," he told the *Canberra Times*.

Council Chief Executive David Templeman said he was "literally gobsmacked" by the Government's vetting processes.

The Council's patron, Emeritus Professor Ian Webster told the

Canberra Times that the Council had advocated a number of policies that were disliked by many in the alcohol industry.

"I do know that there are some powerful interests involved. We now have an alcohol-industrial complex at every different level promoting where each on its own is reasonable, but together does a great deal of harm to the community," Professor Webster said.

Adrian Rollins



Food giants accused of selling out their customers

AMA President Dr Steve Hambleton has launched a broadside at the food industry following revelations it has been actively campaigning to scuttle the breakthrough Food Health Star Rating system.

Dr Hambleton said he was "very concerned" by revelations peak food industry body the Australian Food and Grocery Council (AFGC) had been lobbying against the system just hours before Assistant Health Minister Fiona Nash ordered its new website to be taken down.

"The system's website was to be a major part of the public education campaign to make people aware of the new system, and how it works," the AMA President said.

The Brisbane GP said it was extremely disappointing that the food industry, which had been closely involved in the two-year development of the scheme, was now undermining it.

"Even though they worked closely with the public sector on the development of the new system, the AFGC has lobbied against the consumer-friendly labels since they were agreed by the Federal and State governments last year," he said.

Political furore erupted after Assistant Health Minister Fiona Nash ordered the Federal Health Department to take down the www.healthstarrating.com.au website just hours after it was launched.

It has since been revealed that the decision was taken soon

after a major food industry group contacted the Minister's office to express concern about the website.

Food and Grocery Council Chief Executive Officer Gary Dawson told the ABC he called Senator Nash's office the day the website went live to raise his objections.

"On the day, yes, we expressed a view that we thought it was premature," Mr Dawson said, though he denied asking for it to be taken down.

Senator Nash told the Senate she had ordered the Department to take down the website because "the health star rating is not yet in place. It would have been extremely confusing for consumers had that website been allowed to remain in place".

The decision cost the Minister's Chief of Staff, Alastair Furnival, his job after it was admitted that at the time he retained shares in a lobbying firm, Australian Public Affairs (APA), that had had major food companies among its clients.

Dr Hambleton said it was extremely concerning that the food industry appeared to be trying to scuttle the Food Star Rating system, which had been developed to enable consumers to make healthy food choices.

Under the system, which has been agreed upon by the Council of Australian Governments, all packaged food would be given a rating from half a star to five stars to indicate its nutritional value, as well as a panel detailing how much saturated fat, sugar, sodium and one other ingredient (to be determined by the manufacturer) it contains.

An analysis of several foods conducted by consumer organisation Choice found that several products manufactured by food giant Mondelez, which had been a clients of APA, scored poorly in the rating system by comparison with competitors.

Last week, 66 public health experts sought to outflank the Federal Government, writing to State and Territory food ministers urging them to "take whatever action is within their power" to get the food rating system implemented as soon as possible.





Health on the hill

Political news from the nation's capital

... FROM P36

One of the signatories to the letter, leading cancer expert Emeritus Professor Bruce Armstrong of the University of Sydney, told the *Sydney Morning Herald* he supported the move because giving consumers better information about food was crucial.

"Obesity is shaping up as being one of the major drivers of cancer rates into the future," Professor Armstrong said. "As a consumer myself, I see how extracting from the label the information you want to find out ... is really quite difficult."

At its meeting in December, the peak body for Australian and New Zealand food ministers, the Legislative and Governance Forum on Food Regulation, endorsed the food star rating system.

But at the meeting, Senator Nash announced the Federal Health Department would conduct a cost-benefit analysis of the scheme, even though it is due to be introduced from the middle of the year.

Dr Hambleton called on the food industry to drop its delaying tactics and instead honour its original undertakings to back the scheme, in the interests of better informing their customers.

"It is time that the food industry and its peak Council did the right thing and put their full support behind a bold initiative that will help people make healthier food choices and take some pressure off the health Budget," he said.

Adrian Rollins

COMMENT

Labor MP resigns frontbench due to family illness

WA Labor MP Melissa Parke has stepped down from her role as Shadow Assistant Health Minister because of an illness in her family.

In a statement issued on 17 February, the Member for Fremantle said that "a member of my immediate family is facing a serious health issue, and I need to make that a priority at this time".

"Every one of us working in Federal politics needs to strike a balance between the often extensive time and travel demands of Parliamentary work, and the important ups-and-downs of family life," she said. "At this point, I need to make my family and my electorate work the primary focus of my time and energy."

Senior political positions can be particularly demanding for Western Australian politicians because of the time they have to be away from family and the large distances they have to travel.

Ms Parke said it had been a privilege to be Shadow Assistant Health Minister, and she hoped that in future she would be in a position to make a similar contribution again.

In the meantime, she said she would remain an "active and vigorous" local Member.

Adrian Rollins

COMMENT

\$40m boost to private hospital internships

The Federal Government has taken a step toward easing the pressure on internship places, unveiling a scheme to place up to 100 medical graduates a year in private hospitals around the country.

Under the \$40 million scheme, to run over the next four years, up to 100 Australian-trained international medical graduates a year will be able to complete their training in private hospitals in regional areas.

Health Minister Peter Dutton said the Commonwealth Medical Internship Scheme will, in its first year, fund 61 internships in Queensland and 15 in WA.

Interns taking part in the scheme will be based in Townsville, Mackay, Bundaberg, Brisbane and Perth, and

will do rotations in Kingaroy, Noosa, Hervey Bay, Mount Isa, Joondalup, Mandurah and Tweed Heads.

"These private sector internships are an important addition to the internship places provided by the states and territories in public hospitals," Mr Dutton said.

A dramatic surge in the number of medical school graduates in recent years has placed enormous pressure on post-graduate training places, which have not increased sufficiently to meet demand, necessitating last-minute fixes involving the Commonwealth, State and Territory governments to ensure most graduates can get an internship.

Resolution of the issue has been dogged by disputes between the different levels of government over who should fund the extra internship places.

The AMA is on an advisory committee (the National Medical Training Advisory Network Executive Committee) that has been formed to recommend ways to improve the planning and coordination of training and get rid of wasteful bottlenecks and shortages.

Health Workforce Australia said the Network would enable, for the first time, the creation of a nationally coordinated medical training system.

In the meantime, Mr Dutton said the extra training places made available through the Commonwealth Medical Internship Scheme would help address the internship crisis.

"This investment will further support Australia's medical workforce and, with the shortage of doctors at critical levels in many areas across the country, it's important to provide these opportunities outside metropolitan centres," the Minister said.

Mr Dutton said working with private hospitals to enhance training opportunities was an example of the innovative solutions the Government was committed to delivering to strengthen the health workforce.

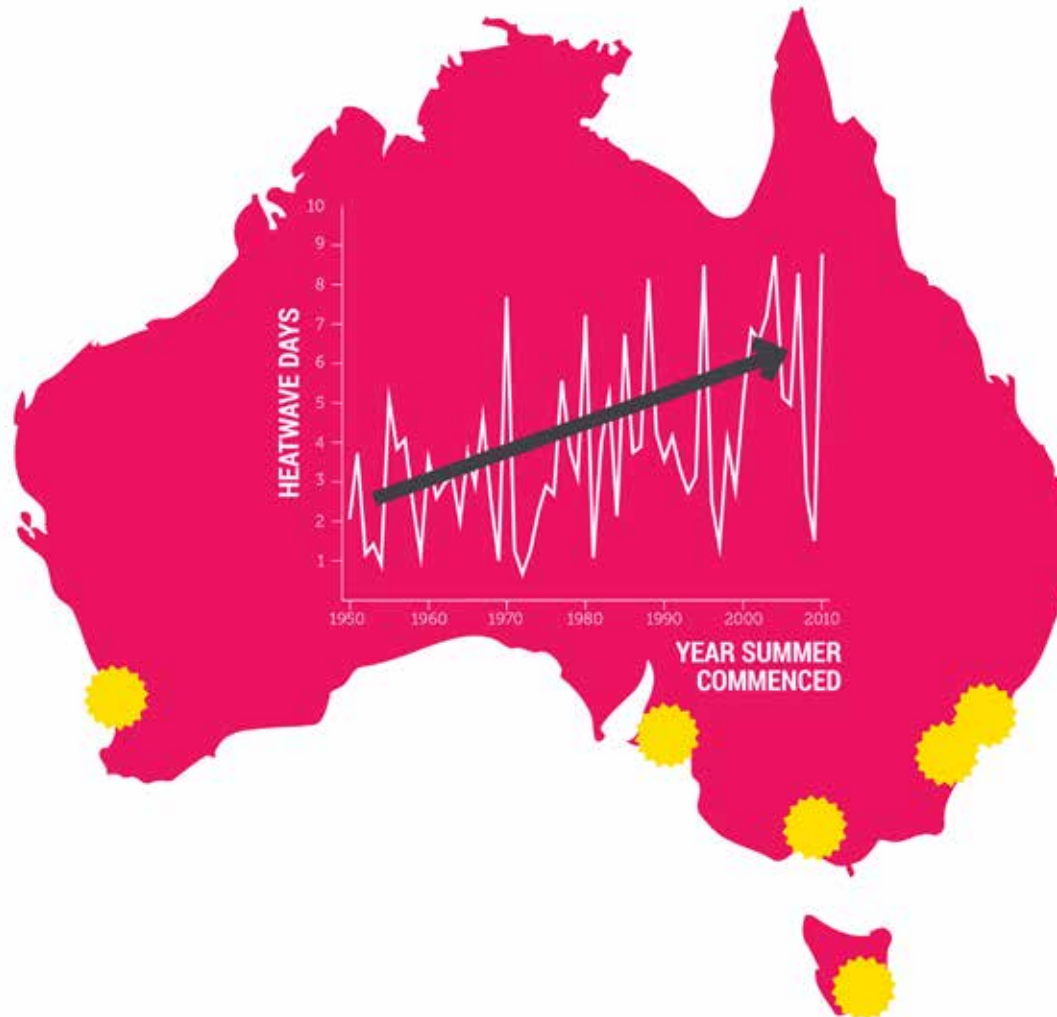
Adrian Rollins

COMMENT

Climate Council: heatwaves are getting hotter and more frequent

BY WILL STEFFEN, ADJUNCT PROFESSOR, FENNER SCHOOL OF ENVIRONMENT AND SOCIETY AT AUSTRALIAN NATIONAL UNIVERSITY, LESLEY HUGHES, HEAD OF THE DEPARTMENT OF BIOLOGICAL SCIENCES AT MACQUARIE UNIVERSITY, AND SARAH PERKINS, POST DOCTORAL RESEARCH FELLOW AT UNIVERSITY OF NEW SOUTH WALES

“heatwaves have widespread impacts including increased deaths, reduced workplace productivity, damage to infrastructure such as transport and electricity systems, mortality of heat-sensitive plants and animals, and stress on agricultural systems”



This article first appeared on The Conversation website on 18 February, and can be viewed by [clicking here](#).

Heatwaves are one of the most important climate-related risks for Australians. Sometimes called the “silent killers”, they cause the greatest number of deaths of any natural disaster type in Australia, and have significant impacts on infrastructure, agriculture and biodiversity. As the climate continues to warm, heatwaves are becoming hotter, longer and more frequent.

The extreme heat in Melbourne that frazzled the Australian Open tennis tournament and the record-breaking heat in large areas of Queensland this summer remind us of the risks that heatwaves pose. Hot on the heels of the “angry summer” of 2012/2013, this summer’s heat is part of a longer-term trend towards hotter weather.

Heatwaves on the rise

The Climate Council’s latest report – “Heatwaves: Hotter, Longer, More Often”, which we co-authored – delivers four key findings.

First, climate change is already increasing the likelihood and severity of heatwaves across Australia. Second, heatwaves have widespread impacts including increased deaths, reduced workplace productivity, damage to infrastructure such as transport and electricity systems, mortality of heat-sensitive plants and animals, and stress on agricultural systems. Third, record hot days and heatwaves are expected to increase further in the future. And finally, limiting future increase in heatwave activity requires urgent and deep cuts to greenhouse-gas emissions.

Since 1950, the annual number of record hot days across Australia has more than doubled, and both maximum and minimum temperatures have increased by around 0.9°C. Over the past decade, the frequency of record hot days has been more than three times the frequency of record cold days. The hottest area-

Climate Council: heatwaves are getting hotter and more frequent

... FROM P38

averaged national maximum temperature ever recorded was 40.3°C on 7 January 2013, and extreme temperature records were broken in every state and territory throughout the course of the 2012/2013 summer.

Almost all of Australia has experienced a lengthening of the heatwave season, with the first heatwave event occurring much earlier than it did 60 years ago. The intensity of heatwaves, as measured by the temperature of the hottest day (the peak of the heatwave), is also increasing.

This summer, Australians again endured record-breaking, extreme heatwaves and hot weather. On 3 January, Queensland experienced its hottest area-averaged day on record and for the week ending 4 January, average maximum temperatures were a staggering 8°C or more above normal in the southern inland part of the state.

Record high maximum temperatures occurred over 8.8% of Australia during the first four days of January, including 17% of New South Wales, 17% of the Northern Territory, 16% of Queensland and 8% of South Australia. On 2 February, Adelaide reached a new February record of 44.7°C, some 15°C above average.

The global picture

Heatwaves are also on the increase worldwide, with severe heatwaves affecting many countries and regions in the last 10-15 years. One of the most severe was the European heatwave of July and August 2003, with France and Switzerland particularly affected. This heatwave was followed in 2010 by an even more intense and widespread heatwave,

which scorched large swathes of Eastern Europe, including western Russia, Belarus, Estonia, Latvia, and Lithuania.

Long-term temperature reconstructions show that these were the hottest summers that Europe has experienced for at least 500 years. North America has also experienced several recent heatwaves, with a major heatwave affecting the state of Texas in July 2011 and a heatwave covering a greater area of the country in 2012.

Diverse impacts

The impacts of heatwaves are surprisingly large and diverse. The Bureau of Meteorology has dubbed heatwaves “the most under-rated weather hazard in Australia”. While heatwaves do not result in obvious violent effects on the landscape, unlike many other weather-related disasters such as high-intensity storms and bushfires, their impacts on health, the workplace, infrastructure, agriculture, and the environment are serious, costly and long-lasting.

While the 2009 Black Saturday bushfires killed more than 170 people, the preceding heatwave killed double this figure. The economic burden of heatwaves is significant, through the demand placed on emergency services, infrastructure stress and breakdown, and agricultural losses. For example, as temperatures soared during the 2009 heatwave, the Basslink electricity cable between Tasmania and Victoria reached maximum operating temperature, causing the system to shut down and resulting in widespread blackouts in Melbourne.

Plants and animals are also susceptible to extreme heat events, with flying foxes, birds and rainforest

marsupials being particularly vulnerable. Marine heatwaves can trigger coral bleaching events, affecting large areas of reefs. Bleaching events on the Great Barrier Reef have occurred repeatedly since the late 1970s, with none reported before then. These bleaching events have contributed to the observed 50% loss of coral cover in the Great Barrier Reef over the past 30 years.

The case for decarbonisation

As greenhouse gases continue to rise in the atmosphere, heatwaves will continue to worsen.

According to the Intergovernmental Panel on Climate Change’s 2012 Special Report on Extremes and last year’s release of the first part of the IPCC Fifth Assessment Report, it is virtually certain that hot extremes will increase and cold extremes will decrease through the century compared to the current climate. It is also very likely that the length, frequency and/or intensity of heat waves will increase over most land areas around the globe.

This is the critical decade for action. Global emissions are still rising and Australian emissions are yet to make a decisive turn downwards. Despite the promising developments in low-carbon technologies and energy-efficiency measures, there is not yet widespread acceptance in Australia of the urgent need to decarbonise our economy and implement policies to facilitate a decarbonised future. This challenge must be met if we are to minimise the risk of worsening heatwaves and other extreme events for ourselves, our children and grandchildren. It’s time to get on with the job.

The Climate Council is a crowdfunded body that advises the Australian public on climate change. You can read its Heatwave Report here (<http://www.climatecouncil.org.au/2014/02/13/heatwaves-report/>).



Research

Breast cancer vaccine coming soon



Australian researchers have developed a vaccine that can prevent breast cancer from returning and which could be on the market within five to 10 years.

The revolutionary vaccine uses the body's own immune system to fight the cancer, and may also be useful in treating and preventing pancreatic, ovarian, colon and lung cancer.

Lead researcher from the Burnet Institute Professor Ian McKenzie said it was hoped that eventually every woman would be able to have a vaccine to prevent breast cancer.

The researchers identified a protein called mucin 1 that is different in cancer cells than normal cells. They developed a sugar polymer, mannan, from baker's yeast that was able to bind with the protein, and attached a cancer antigen to it.

When it is injected into the body it prompts the body's immune system to fight cancer cells.

More than 90 per cent of breast cancers carry the mucin 1 protein targeted by the vaccine, and it also present in between 60 and 90 per cent of other types of cancer.

Researchers injected the vaccine into 16 women who had been treated for early breast cancer, and an additional 15 were given a placebo.

After 15 years, nine of the patients who received the placebo had seen their cancer return, while only two women who received the vaccine had a recurrence.

The researchers also found that the cancer took a longer time to return in the women who had received the vaccine – 118 months after the first surgery for the two vaccinated women, compared with 65

months for those on the placebo.

The treatment, unlike many cancer medications, does not require lengthy infusions.

Professor McKenzie said it is delivered in much the same way as a childhood vaccine, and the only side effects from the original trial were soreness and swelling at the injection site.

A second trial, involving 50 women with metastatic cancer, is being planned. Ascend Pharmaceuticals is looking for funding to run the second trial before proceeding to a full blown clinical trial.

Kirsty Waterford



Politicians petitioned to discuss dementia at G20

Alzheimer's Australia is supporting a petition to get dementia on the G20 agenda.

In 2010, the annual worldwide cost of dementia care was estimated to be more than \$US600 billion, and it is predicted to nearly double to \$US1.117 trillion by 2030.

Despite commitments made at a recent G8 summit to develop a cure for dementia by 2025, funding to research the disease is still quite low, with research funding for cancer currently about eight times and cardiovascular disease about six times that for dementia.

In many parts of the world research into dementia is non-existent, and Alzheimer's Australia hopes that by putting dementia on the agenda of the G20 this will change. To sign the petition, visit https://secure.avaaz.org/en/petition/Australian_PM_Tony_Abbott_Make_dementia_research_and_prevention_a_priority_agenda_item_at_the_G20/

Kirsty Waterford



Positivity needed to reduce the bulge



Doctors who approach overweight and obese patients about their weight compassionately and without making them feel judged, are more likely to see their patients achieve weight loss.

Researchers from Johns Hopkins University found that overweight and obese patients who feel their doctor is negatively judging their weight are more likely to try and reduce their waistlines, but are less likely to succeed.





Research

... FROM P40

Lead researcher Assistant Professor Kimberly Gudzone said that negative encounters can prompt a weight loss attempt, but the study shows that they do not translate into success.

“Ideally, we need to talk about weight loss without making patients feel they are being judged. It’s a fine line to walk, but if we can do it with sensitivity, a lot of patients would benefit,” Assistant Professor Gudzone said.

Assistant Professor Gudzone and her team set out to test whether the negative attitudes and weight stigma from some primary care doctors was limiting the effectiveness of advice given to obese and overweight patients.

The researchers surveyed more than 600 people with a body mass index of 25 or more and who regularly visited their GP. Participants were asked to identify if they had felt their doctor judged them in the past 12 months because of their weight. More than 20 percent of participants said they believed they had been judged.

Further, 96 per cent of those who felt they had been judged had tried to lose weight in the previous year, compared with 84 per cent of patients who didn’t feel judged.

However, only 14 per cent of those who felt judged and had discussed weight loss with their doctor lost 10 per cent or more of their body weight, while 20 per cent of patients who didn’t feel judged and also discussed weight loss with their GP lost a similar amount.

The study found that talking with their doctor about weight loss helped people lose more weight. Only nine per cent of those who felt judged but did not see their doctor lost more than 10 per cent of their body weight, and six per cent of those who did not feel judged and who did not see their doctor lost weight.

Assistant Professor Gudzone said overall, only two-thirds of participants said that their doctors brought up weight loss.

“Many doctors avoid the conversation because they don’t want to make anyone feel bad, worrying they’ll create a rift with

their patients if they even bring it up,” Assistant Professor Gudzone said. “But that is not in the patients’ best interest in terms of their long-term health.”

Assistant Professor Gudzone said it is helpful to start with small weight loss steps, such as a 10 per cent reduction in weight. A longer-term goal of losing 30 to 50 kilograms can be a setup for frustration and failure when tackled all at once.

“We don’t want to overwhelm them,” Assistant Professor Gudzone said. “If we are advocates in this process, and not their critics, we can really help patients to be healthier through weight loss.”

The study was published in the journal *Preventive Medicine*.

Kirsty Waterford



Relief in sight for sinus sufferers

People who suffer from painful and recurring sinus infections could soon have a new targeted spray treatment.

Researchers from the Woolcock Institute of Medical Research have been awarded a grant to develop a much-needed new treatment for chronic sinus infection.

Currently, 16 per cent of Australians suffer from severe discomfort and pain as a result of recurring sinus infections, triggered when mucus made in the



sinuses fails to drain properly.

Lead researcher Associate Professor Paul Young said it was amazing that chronic sinus infection affected such a large percentage of the population and yet there was currently no nasal spray or device capable of specifically targeting the condition.

Sufferers are prescribed antibiotics, mucus dissolvents or steroids, approaches that Woolcock researcher Associate Professor Greg King said gave virtually no access to the sinuses, and had limited therapeutic efficacy.

“Our goal is to develop a carefully targeted treatment that carries a formulation capable of simultaneously removing mucus, dispersing biofilms and killing bacteria hiding deep in the sinuses,” Associate Professor Greg King said.

Kirsty Waterford



Tough health choices loom in Land of the Rising Sun



The Japanese Government is moving to restrict access to expensive medications as it seeks to rein in rising health costs, in what is seen as a radical departure from the principles underpinning the country's universal health system.

The Central Social Insurance Health Care Committee (CSIHCC), which approves drugs to be covered the nation's health insurance scheme, is developing criteria under which, for the first time, medications will be evaluated to take into account the cost involved in prolonging or improving life.

The initiative is seen by some as a break with the free access philosophy at the core of the country's health system, opening the way for unequal access to health care.

Under the national health insurance system established after World War Two, the Japanese Government sets a uniform fee schedule that in effect sets the price of all medical procedures and drugs.

The price of health care is the same across

the country, and patients can receive treatment at any clinic or hospital as long as they contribute a specified co-payment, which is typically between 10 to 30 per cent of the fee.

But, in a refrain that sounds familiar to Australian ears, in recent years the system has come under increasing financial strain from the proliferation of effective but expensive medicines, particularly for the treatment of cancer and chronic illnesses.

Etsuji Okamoto, a senior researcher at Japan's National Institute of Public Health, said when the scheme was first established universal health care access was feasible because services and drugs were basic and cheap.

But, writing on the East Asia Forum website (<http://www.eastasiaforum.org/2014/02/22/farewell-to-free-access-japans-universal-health-coverage/>), Mr Okamoto said the advent of advanced drugs like the lymphoma treatment Zevalin were burning a hole in the health budget.

He said Zevalin cost \$29,000 per treatment, while Ilaris, used to treat rare chronic paediatric diseases, cost \$15,600 per dose.

Mr Okamoto said that, under the current system, doctors were able to prescribe drugs such as Zevalin without seeking authorisation, while patients could claim

much of the co-payment they made from insurers.

He said this relative absence of supply-side controls meant the adoption and use of such medicines could be rapid and sharp.

Under mooted changes, CSIHCC will subject drugs to economic evaluation, in the case of anti-cancer medicines attempting to assess the cost of prolonging life by one year. With drugs to treat chronic diseases, judgement will centre on the cost of improving quality of life compared with existing, cheaper medicine.

Mr Okamoto said the changes were not likely to come into effect in 2016, and price thresholds and other details were not yet clear.

But he warned the arrangement would be a major change for Japanese people.

"It is a radical departure from the 'free access' principle that came with Japan's universal health coverage half a century ago," Mr Okamoto said, pointing out that patients seeking treatment with a drug not covered by social insurance would have to foot the bill in its entirety.

"Inevitably, patients will be selected based on their ability to pay," he said, and added that in applying economic evaluation, not all lives would be treated equally.

"One life in pain and agony is value less than one year of life in full health.

"The departure from the free access principle is an inevitable compromise to sustain universal health coverage. Japan will have to face a grim fact that lives are not created equal."

Adrian Rollins



National Lead Clinicians Group – Awards for Excellence

Doctors, nurses and allied health professionals could be eligible for cash prizes worth up to \$10,000 under awards announced by the Department of Health's National Lead Clinicians Group.

The Group is calling for nominations for its National Lead Clinicians Group – Awards for Excellence 2014, with substantial prizes awarded for outstanding clinical leadership and collaboration.

Nominations are invited for three categories of award:

Category 1 – General;

Category 2 – Antimicrobial resistance; and

Category 3 – Cultural competence in Indigenous care.

Winners in each category will receive \$10,000 in recognition of their clinical excellence and efforts to share and promote best practice in their workplace.

In addition, up to 12 runners-up will each receive \$3000.

Further information, including application forms, can be found at the National Lead Clinicians Group website: <http://www.leadclinicians.health.gov.au/internet/lcg/publishing.nsf/Content/lcg-awards>

All nominations must be lodged by 5pm AEDT, 21 March, 2014.

Jest a queeck jeb from your local Kiwi pharmacist

New Zealand pharmacists have begun administering vaccines for whooping cough and meningococcal disease after acquiring authority to give flu jabs in 2012.

As Australian pharmacists intensify their lobbying for an expanded health role, including administering flu injections, their Kiwi counterparts were last month allowed to begin offering a wider range of vaccinations.

From 17 February, pharmacists at a number of pharmacies across the country who have undergone vaccination training were permitted to begin vaccinating people aged 18 years and older against whooping cough, and to immunise people aged 16 years and older against meningococcal disease.

Head of Professional Services at pharmacy chain Pharmacybrands, Alison Van Wyk, told news service Fuseworks Media the expanded role for pharmacists would help protect the community against serious disease by increasing access to vaccines.

“We have a network of 250 trained, professional pharmacists who are qualified to vaccinate adults throughout the country,” Ms Van Wyk said. “It’s about addressing some of our key public health needs and giving our community more options.”

Industry figures show New Zealand pharmacists administered more than 8500 flu vaccinations last year.

But the AMA has been highly critical of a push to give Australian pharmacists a similar role, warning that lives could be put at risk.

In Queensland, a trial of pharmacist-administered flu vaccinations has begun, but AMA President Dr Steve Hambleton said patient health could be put at risk because pharmacists did not have the knowledge and skills to safely vaccinate people.

Dr Hambleton said pharmacists did not have the training to assess the safety of a vaccine for each patient, or to recognise and respond to adverse reactions.

In addition, he said, there was a multitude of issues regarding patient privacy, indemnity coverage, appropriate facilities, the fragmentation of care and the integrity of medical records.

“Immunisation is a clinical service; it should be done in a clinical setting,” Dr Hambleton said.

He was equally concerned about a secret push by pharmacists to undertake annual health checks of their customers, in return for a Government rebate.

Under the plan, revealed in leaked documents obtained by News Limited newspapers, the Pharmacy Guild of Australia proposed its members be paid \$50 to conduct a 30-minute health check including weight, blood pressure and glucose and cholesterol levels.

Dr Hambleton said pharmacists were not trained to conduct such tests, nor to interpret the results: “If a problem is found, where do you go from there?” he asked.

Adrian Rollins

COMMENT

Spain tightens abortion laws

The access of Spanish women to abortion has been dramatically wound back after the nation’s conservative government successfully forced through some of the toughest abortion laws in Europe.

Under the changes introduced by the ruling Popular Party, abortion is now illegal except in instances of rape or when there is a risk to the physical and mental health of the mother – as verified by two doctors.

The restrictions come three years after the previous government passed laws legalising abortion before the 14th week of pregnancy, and have stirred violent protests amid widespread dissatisfaction with the change.

Opposition parties and community groups have condemned the new laws as an attack on women’s rights, and polls show that as many as 68 per cent of people oppose the changes.

There have been warnings that the laws, under which teenage girls will have to have the permission of their parents, and be accompanied by them, to have an abortion, will drive an upsurge in potentially deadly backyard abortions or force women to go abroad to seek treatment.

Spain’s Association of Accredited Abortion Clinics warned that 100,000 of the 118,000 abortions carried out in the country last year would have been illegal under the new laws.

The Popular Party, which is aligned with the Roman Catholic Church on social and moral issues, had made changing Spain’s abortion laws one of its central pledges in the 2011 general election that brought it to power.

Adrian Rollins

COMMENT

Under the Microscope

by Earl Owen

Random House Australia, RRP \$34.95, ISBN 9780857981196, pp302

With an economy of prose and using a conversational, emotive style, microsurgeon Professor Earl Owen tells us the story of his life.

Disabled - but not handicapped - with a congenital defect, Owen's mission is to help those around him through the advancement of microsurgery (a specialty of which he may be considered the father) and make amends for the firsthand, hateful experience he endured from a surgeon as a child.

He illustrates the salient lesson that adult doses don't translate to children, particularly for radiotherapy, using his own body as an example.

Independent of thought and dismissed as a troublemaker (a title he would never fully outgrow), Owen grew up in a Victorian household of doctors as a precocious and dextrous child.

He operated before he was formally qualified to do so, and soon realised that the practitioners of his day were limited by their bedside manner and available resources.

Owen foresaw future possibilities in the field of microsurgery, and literally developed the tools and terminology to make this happen. He never stops thinking – from designing the chairs of the Sydney Opera House to his thoughts on brain transplantation, Owen is a visionary.

Like all life stories, Owen arrived at many crossroads which would shape and define his path in life.

Success accompanied him because he seized entrepreneurial endeavours (contrasted with an example of a peer who did not).

From his motivation and passionate writing, it is easy to have an understanding of the man, though Owen is probably not an easy person to live with.

He readily pointed out the shortcomings of patients' wellbeing within the medical bureaucracy, a habit which rewarded him with dismissal as often as praise.

Owen was frequently pulled in many directions; from research

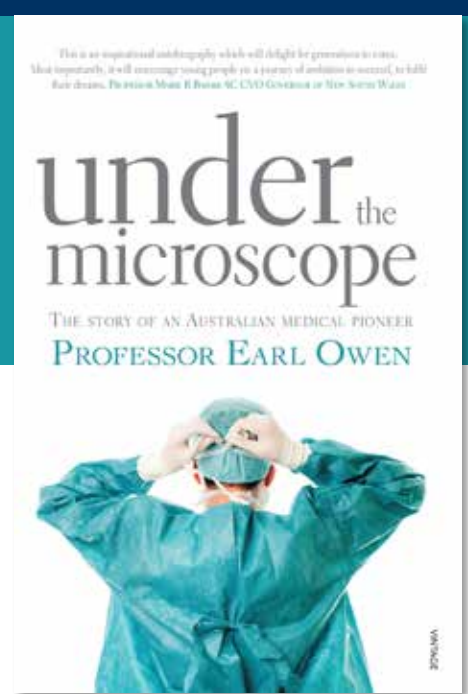
involving animal experimentation and vivisection (potentially off-putting to some readers), to advocating for thalidomide victims and fund-raising activities.

There were few pursuits away from medicine, presumably limited by time, though Owen was also a keen farmer, pianist, golfer and occasional family man. When others were retiring, he was pioneering limb and face transplantation.

His skill as a microsurgeon encroached on many other specialities (such as trauma, paediatrics, neurosurgery, fertility and transplantation medicine), earning him both supporters and detractors.

Regrettably, Owen was often let down by others, including an unsupportive first wife, and ambivalent colleagues and patients. There is the irony of Owen chiding a patient for their non-compliance then acting in the same manner!

At times he may be justifiably dramatic, such as when he observes,



“This assault on all my newborn tissue was to seriously affect my growth and health, and this was my destiny”.

We are privileged that such a high achiever and man of ideas has taken the time to write about his life, including some truly gripping sea voyage escapades.

Lesser people wouldn't dedicate their life to rectify the mistakes and conventions of the past.

Ultimately, this is a touching and engaging tale about a remarkable physician who healed himself and revolutionised a profession.

** Dr Zehetner is a Consultant Paediatrician, Pharmacist and Clinical Senior Lecturer.*

In oak we trust

BY DR MICHAEL RYAN

“Terrific Race, the Romans,” extolled an incarcerated Spike Milligan in Monty Python’s *The life of Brian*.

Apart from schools, sanitation and the aqueduct, they have provided us with many facets of our civilised lives, including the development of wine.

The Romans appreciated the effects of aging wines, using sulphur to reduce spoilage, and they understood the value of oak.

In particular, oak from the genus *Quercus* possesses characteristics that imparts flavour and structure in wine. In the past, cedar, palm wood and other oaks have been tested and used, but each have lost favour. The wood has to be

supple enough to work with, strong enough to form a barrel, and must not taint the wine.

The most common origin of oak is either from the French forests of Alliers, Limousin, Tronçais, Nevers and Voges or the American forests of the Eastern US.

The oak can be used at the fermentation phase, usually in Chardonnay and in the use of some old world techniques in making Riesling. In Chardonnay, French oak is dominant, and the infamous unoaked Chardonnay is on the decline after peaking earlier in the decade. I wonder why bother with unoaked varieties, as the correct oak exposure in fermentation can add layers of complexity, including hints of cinnamon and cloves.

Oak is not exclusive to Chardonnay.

Sauvignon Blanc can have some oak exposure, in which case it is denominated Fume Blanc style. A great example of this is Cloudy Bay TeKoko.

The most prolific use of oak is in ageing red wines. Oak reacts with wine to add phenols/lactones, which can be likened to vanilla and some tannins, to aid structure. The microscopic permeability of the wood allows small amounts of oxygen to react with the wine to soften it.

French oak usually is slow growing and has a tight grain which imparts more complex, savoury notes, while American oak, with its broader grain, adds strong sweet vanillin and coconut aromas.

French oak suits Cabernet Sauvignon, Pinot Noir, Merlot and cool climate Shiraz, while American oak adds the powerhouse hit to warm climate Shiraz wines, such as Penfold’s Grange. Oak ageing is avoided with most varieties of white wine, except Chardonnay.

Another variable can be the degree to which the barrel has been fired or toasted. This is a wine maker’s personal preference, but Pinot Noir is the most varied in toast effect.

Toasted barrels can add caramelised notes and hints of toffee. The oak has to be dried to mature the wood, and can be naturally dried between three to eight years, or dried by fire for a quick result.

Also at the wine makers discretion is the length of time left in oak. Modern day Pinot Noir is left between eight and 12 months, while for big reds like Grange it can be two or more years. Some Spanish reds, such as Rioja, can be left for eight years.

New or used oak and the size of the barrel add to this conundrum wrapped in an enigma. It all sounds a bit like the bloke in the corner store just wanting to buy milk that tastes like milk.

COMMENT



WINES TASTED

1. 2008 Cloudy Bay Te Koko Marlborough

While some noses are turned up knowing this is a Sauvignon Blanc, the exposure to eight months oak (10 per cent new oak) adds to the complex nose of white peaches and hints of lycee, but with a flowing nose of ginger and toasty oak. The palate is rich, with subtle creamy lemon curd minerality.

2. 2010 St Andrews Clare Valley Chardonnay

Fermented in French oak and aged for 10 months, this wine has white stone fruit aromas and hints of lime, marrying with nuttiness from the oak. There is a satisfying, well-rounded palate with a long finish.

3. 2009 Elderton Barossa Shiraz

This has been aged in American oak for 14 months. Along with the black fruits and some hints of chocolate, the essence of vanilla is evident. Full-bodied and nicely balanced tannin and American oak.

4. 2010 Cape Mentelle Shiraz

Aged in French oak for 15 months (25 per cent new), the blackberry fruits and hints of spice and pepper are accentuated by the savoury effect of the French oak. The palate follows on from the bouquet in a pleasing, full-bodied cool climate Shiraz.