AUSTRALIAN
Medicine
The national news publication of the Australian Medical Ass

Follow us on

PM listening on alcohol reform

...but not keen on National Alcohol Summit, p5

AMA

INSIDE

ISSUE 26.05 - MARCH 18 2014

AUSTRALIAN
Medicine

In this issue

Managing Editor: John Flannery
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford
Contributors: Debra Vermeer, Sanja Novakovic
Graphic Design: Streamline Creative, Canberra

Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

42 Macquarie St, Barton ACT 2600
Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499
Web: www.ama.com.au
Email: ausmed@ama.com.au

Executive Officers

President
Dr Steve Hambleton

Vice President
Prof Geoffrey Dobb

Chairman of Council
Dr Iain Dunlop

Treasurer
Dr Elizabeth Feeney

Executive Officer
Dr Brian Owler

Executive Officer
Dr Stephen Parnis

PRESIDENT'S MESSAGE

BY AMA PRESIDENT
DR STEVE HAMBLETON

The human face of contracts

The Queensland public hospital doctor contract saga continues, and emotions are running high.

I have spent much of the past week in intense and involved discussions with the Director General of Queensland Health and his team of advisers to reach a satisfactory resolution.

I have had the support of AMAQ President-elect, Shaun Rudd, and representatives of ASMOF, ASMOFQ, and the Together union. But the most important members of my negotiating team are the 'human face' of this contract dispute – some of the doctors whose lives and livelihoods are at stake.

I have personally witnessed the very real personal impact on these doctors as I have travelled around Queensland for meetings. People are not sleeping, and they are questioning their future in Queensland. There are raw emotions on show during these talks. The tears. The exasperation. The desperation.

To recap, the AMA is leading the fight to influence the Queensland Government to come back to the table to try to put fairness and balance back into the contracts they are offering senior doctors - SMOs and VMOs - who work across the State in the public hospitals.

The original contracts had stripped basic hard-won and reasonable workplace rights and conditions. These conditions reflected the seniority of the doctors, their importance in the health system, the demanding hours they work, the sometimes horrific and shocking injuries and illnesses they encounter, and their dedication to saving lives and putting damaged bodies back together.

These doctors provide a valuable service to Queenslanders. The community values them highly. Their patients value them even more highly. The Queensland Government contracts treat them with contempt and disdain.

The contracts are written in the hardest possible language that can only be interpreted in the most negative and unreasonable way. Sadly, Queensland Health has a long history of unreasonable management behaviour.

This is not the way to treat one of the most valuable assets that Queensland has: its highly-trained and dedicated medical workforce. These contracts treat doctors far more like servants than doctors. The contracts are directives, not agreements. The contracts do not encourage a partnership.

There is no evidence anywhere that I know of that harsh contracts extract the best from employees. There is much evidence that true partnership can deliver better outcomes in spades.

While our talks are making incremental progress, it is clear that the Departmental negotiators are constrained by a larger political agenda. They are confined in what they are allowed to do.

"The contracts are written in the hardest possible language that can only be interpreted in the most negative and unreasonable way. Sadly, Queensland Health has a long history of unreasonable management behaviour"

There is no doubt that the Director General shares our view that we wish to avoid any more harm to the health system in Queensland.

The major problem we confront is the possible complete collapse of public trust in the health system. This is where Queensland has been in the recent past on a couple of notable occasions, and nobody wants to go there again.

MORE P4

The human face of contracts

... FROM P3

The doctors have been key to rebuilding that public trust in the system. It is not wise for the Government to end that important partnership with the medical profession.

I have been involved in the negotiation and have been filled with pride by the actions of my colleagues in that process. They have been honest and earnest. They have cogently and clearly laid out their concerns.

The actions of the senior doctors throughout this dispute have not been the actions of rabid union thugs, as some in the Government have sought to portray them. These are the actions of highly-qualified and highly-respected clinicians who are trying to protect the quality and safety of the Queensland health system. They are trying to facilitate a partnership with the hospital managers.

But the contracts as currently written diminish the ability for doctors to discharge their ethical obligations to their patients by limiting their power to influence their non-clinical managers.

If driven by pure financial targets, non-clinical managers can impose something that is unsafe or unreasonable. The words of the Francis review of the Mid Staffordshire inquiry in the UK - http://www.midstaffspublicinquiry.com - ring in my ears. Putting financial targets before good medicine is what led to the Bundaberg Patel disaster in Queensland.

The contracts are capable of taking the 'health' out of health system.

Our demands on the Government are clear and reasonable. We are calling on the Minister to respond to the causes of the problem - the unfair laws and the unfair contracts. We cannot see that any other response is capable of relaxing the constraints put on the Director General to allow us to put together a framework to allow Queensland Health to build trust with its medical workforce.

If the Government responds positively to the doctors' needs, the tears will turn to cheers and we will be there standing side by side - doctors with managers, medico-political leaders with politicians.

The beneficiaries will be the people of Queensland.

COMMENT

BREAKING NEWS

Signs of progress on Qld contracts

The AMA and other doctor representatives have responded cautiously to Queensland Government moves to defuse a contract dispute that threatens to drive an exodus of specialists from the State's public hospital system.

Queensland Health Minister Lawrence Springborg has personally intervened to provide assurances that unacceptable features of the contracts would be altered and clarified to address doctor concerns.

Mr Springborg told a meeting attended by AMA President Dr Steve Hambleton and representatives from AMA Queensland, the Australian Salaried Medical Officers Federation, and Senior Medical Officers on 17 March that he would issue a directive removing the ability of the Queensland Health Director-General to alter employment agreements to the detriment of doctors, and would introduce an addendum to the contracts to establish binding dispute resolution procedures, to ban transfers without consultation and to provide unfair dismissal processes.

The offer represents a backdown by the Minister, who up until now has adopted a hardline take-it-or-leave-it position on the terms of the contracts.

But Dr Hambleton said it was too soon to declare that the dispute, which has caused enormous stress and disruption for hundreds of public hospital medical staff, had been resolved.

He said the detail of the Minister's proposals were yet to be disclosed, and doctors and their representatives would remain wary unless or until the changes were enshrined in legislation.

"We are closer to a resolution than we have ever been," the AMA President said.

"[But] we are still cautious because of the lack of trust felt by doctors regarding the Queensland hospital system," Dr Hambleton said. "They [the Government] are going to have to have a meaningful change in Hospital and Health Boards Act to remove the Director-General's authority to change contracts. That would go a long way to rebuilding trust."

The Minister's proposal was to be discussed at a mass meeting of public hospital specialists to be held in Brisbane on 19 March.

Adrian Rollins

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "The Abbott Government is yet to show its specific areas of interest in broader health issues"

AMA advocacy in action

Over the past month, the Federal AMA has become increasingly involved in supporting AMAQ and ASMOF in the dispute between Queensland SMOs and the Queensland Government over proposed terms and conditions of new individual contracts. President Dr Steve Hambleton has attended meetings of doctors around the State, and talked to media. This issue has become a very significant battle for the AMA. The AMA is protecting members' interests in the face of contract terms which include arbitrary dismissal and the absence of a binding dispute resolution clause.

It has also been a busy few weeks in Canberra since the resumption of Parliament. The President and I have had several meetings with senior Ministers, canvassing a broad range of issues of interest to the AMA. We have followed with interest the different positions taken by Minister for Health Peter Dutton and Prime Minister Tony Abbott on the issue of GP co-payments floated earlier in the year in a submission to the Commission of Audit. The Commission of Audit report is expected to be made public in advance of the Budget, although there has been no firm commitment from the Government to do so. It is expected that the Commission's report will propose a range of measures to tackle health expenditure, a topic of considerable interest to the AMA.

The President and I also met with the Prime Minister to advance the AMA's call for a National Summit on alcohol harm and strategies to address these harms. The AMA continues to advocate for changes in access to, and awareness of, alcohol. A loophole in current regulations that permit the promotion of alcohol during live broadcasts of sporting events, regardless of time of day, needs to be closed.

To coincide with International Women's Day, the AMA Position Statement on Women's Health was launched by Minister Michaelia Cash and Senator Nova Peris. Both MPs have a strong interest in addressing violence against women and used the occasion of the launch to highlight the impact that violence has on women's health.

At its meeting in March, Federal Council approved a revised version of the new Constitution for the AMA, which has been released to members via the AMA website at https://ama.com.au/constitutional-reform-australian-medical-association-limited. Members will be able to access answers to some commonly asked questions about the Constitution and proposed operational structure of the AMA in the future. The final version of the Constitution will be sent to members with the notice of meeting for the Annual General Meeting in May.

Registration is now live for the AMA National Conference, which will be held in Canberra this year from 23-25 May with the theme, *Global Practice: Australian Perspective*. The program will be examining trends in health that are affecting health systems internationally and applying them in the Australian context. All members are encouraged to register, not just those who are official delegates.

COMMENT

2014 AMA National Conference

23 - 25 May
National Convention Centre, Canberra

Conference session highlights include:

- The Global Challenge of Non-Communicable Diseases
- Practising Globally: Regional Challenges, Integrating Global Health Training and Postgraduate Medical Education in Australia
- The Health Budget
- Variation in Medical Practice – Are Australians getting world class health care?
- Overseas Conflicts and Disasters: the Challenge of Caring for Those Who Serve.

The National Conference is open to all medical professionals, not just AMA members and invited delegates. Join us for what is sure to be an outstanding event!

AMA

Find out more about the Conference:
www.ama.com.au/nationalconference
Conference Enquiries: natcon@ama.com.au

PM listening on alcohol reform

AMA President Dr Steve Hambleton and Secretary General Anne Trimmer recently met with Prime Minister Tony Abbott at Parliament House in Canberra.

The PM called the meeting in response to a letter from Dr Hambleton requesting an opportunity to discuss a range of alcohol reform issues, including the AMA's call earlier this year for a National Alcohol Summit to be convened by the Federal Government.

Mr Abbott acknowledged that alcohol-related harm in all its forms is a serious issue for the Australian community and said all governments are taking it very seriously.

The PM went public with his views about alcohol-fuelled violence in Sydney earlier this year.

He told Macquarie Radio in January that the attacks were "utterly cowardly".

"I am appalled by what seems to be happening in certain trouble spots here in this great city of ours," he said.

"I think we've got essentially two problems. The first problem is the binge-drinking culture that seems to have become quite prevalent amongst youngsters in the last couple of decades.

"The second problem, and this is a truly insidious thing - this rise of the disturbed individual who goes out not looking for a fight, but looking for a victim.

"And all of these king hits - or we're now calling them 'coward punches' - all these acts of gratuitous violence are unprovoked."

However, the Prime Minister told Dr Hambleton that he does not support the idea of a national alcohol summit at this time.

Recognising the concerns of the public health sector about alcohol-related harms, Mr Abbott is also conscious of the serious law and order aspects of the alcohol debate.

To this end, he said he would be referring the matter to a new Committee of COAG, which is being formed to deal with crime, law and justice issues across jurisdictions.

In the meantime, the PM has asked the AMA to provide his office with more detail about the specific public health concerns that the medical profession has with the misuse of alcohol in the community, including the impact on hospital emergency departments.

John Flannery

COMMENT

AVN gets new name… finally

The Australian Vaccination Network has changed its name to one that more clearly reflects its anti-vaccination views.

The controversial anti-vaccination group, which last year was ordered to change its misleading name, has finally complied with an order from the Administrative Decisions Tribunal.

The group will now be known as the Australian Vaccination-Skeptics Network.

The group links childhood vaccinations with autism, sudden infant death syndrome, and allergies.

The New South Wales Trading Department has been pursuing the group for some time after receiving many complaints about its name.

The organisation tried to challenge a direction to find a new name, but was last year ordered by the Administrative Decisions Tribunal to call itself something different.

The Tribunal found last November that the group's existing name suggested it was in favour of vaccination, and that people would be misled.

The Tribunal said the name should be changed so that it is not likely to mislead the public in relation to its main object.

"They've now complied with that request and the new title reflects their anti-vaccination stance," the Tribunal said.

AMA President Dr Steve Hambleton said the new name was not as misleading as the old one.

"I'd rather they call themselves the anti-vaccination network, but at least people will now know they are not looking at some government site with balanced information," Dr Hambleton said.

Sanja Novakovic

COMMENT

Women suffer 'horrendous' threats of violence

The AMA has urged coordinated national action to clamp down on family violence amid disturbing evidence that more than half of all women will be physically or sexually assaulted at least once in their lives.

Speaking at the launch of the *AMA Position Statement on Women's Health 2014*, AMA President Dr Steve Hambleton said violence against women was a major public health issue with serious and long-lasting detrimental consequences, and addressing it involved tackling the nation's alcohol problem.

"About 50 per cent [of women] have experienced domestic violence," Dr Hambleton said. "The rate in Aboriginal women is 35 times that…so it's a particular problem that we have to focus on."

At the launch, also attended by Minister Assisting the Prime Minister for Women, Michaelia Cash, Northern Territory Labor Senator and former Olympian Nova Peris backed the AMA's call for greater attention on family and domestic violence.

In a heart-felt appeal for action, Senator Peris said Indigenous women in the Northern Territory, in particular, were suffering "horrendous" rates of domestic violence.

"An Indigenous woman is 80 times more likely to be hopistalised for assault than other Territorians," Senator Peris said. "I shudder inside whenever I quote that fact, because it makes me picture the battered and bloodied women we see far too often in our hospitals. Every single night our emergency departments in the Northern Territory overflow with women who have been bashed."

The Labor Senator linked many of the assaults to the abuse of alcohol, citing figures showing a resurgence in violence after restrictions on the sale of booze to people with a history of domestic violence were lifted.

"One of the most alarming facts about these horrendous statistics is that so much of it is preventable – and that's because so much of it is caused by alcohol abuse," she said.

Senator Peris said there were 2500 on the Territory's Banned Drinker Register when it was scrapped following a change of government in 2012.

The following year, domestic assaults surged 22 per cent higher, and in the 14 months since its abolition, alcohol-related emergency department admissions have soared by 80 per cent, she said.

"I have met with doctors, nurses and staff from the emergency department in Alice Springs [Hospital], and they confirm these statistics represent the true predicament they face, day in, day out, on the front lines," the Senator said. "Every night the place is awash with the victims of alcohol fuelled violence, with the vast majority of victims being women."

Senator Peris called on the AMA to use its "extremely high standing in the community to advocate for more action in tackling alcohol-related domestic violence".

Dr Hambleton responded that "we do have to take up the challenge…to actually highlight the issues in relation to alcohol misuse".

Following the release of the Position Statement, the AMA President had a meeting with Prime Minister Tony Abbott during which the possibility of a National Summit on alcohol misuse was discussed. [see page 6].

"As a nation, the damage that alcohol is causing is something that we need to turn around," Dr Hambleton said.

The AMA Position Statement showed that alcohol-fuelled violence was just one of many serious issues affecting the health of women.

Dr Hambleton said it attempted to provide an overview of the many challenges of women's health, and its many aspects.

"We examine biological, social and cultural factors, along with socioeconomic circumstances and other determinants of health, exposure to the health risks, access to health information and health services, and health outcomes," the AMA President said. "Our Position Statement is comprehensive, but I fear it only scratches the surface."

Dr Hambleton said that, although women tended to live longer than men, they also suffered more bouts of ill health, had a higher burden of chronic disease, saw medical practitioners more frequently, and took more medicine.

The Position Statement can be viewed at: https://ama.com.au/position-statement/womens-health

Adrian Rollins

COMMENT

The flu season may be starting early this year

Doctors are being warned to prepare for an early flu season with a fivefold increase in cases reported for the first two months of this year.

More than 2500 Australians have already succumbed to the flu this year. The deadly strain has killed several younger patients around the world.

Experts say that flu sufferers aged between 24 and 65 years face the greatest risk of death from this year's flu virus, with 60 per cent of those who died from the flu in the US winter falling into that age group.

AMA President Dr Steve Hambleton said the fivefold increase was extraordinary. He warned that we need to be super vigilant and to watch the pattern closely to determine whether we are heading towards a flu epidemic.

"Flu surges happen and go in a 20-week period," Dr Hambleton said. "Usually our flu season starts in July, but we are already seeing an increase in flu cases for this time of year."

Dr Hambleton said the flu vaccine this year protects against the H1N1 strain, which we have seen affect Australians over the past few years, and strains that appeared in the most recent Northern Hemisphere winter.

Dr Hambleton said the best prevention against the flu is to get vaccinated. He said the benefits outweighed the risks, and he reminded people that, if they do get the flu this season, to follow proper hygiene etiquette and stay away from work.

Chief Medical Officer Professor Chris Baggoley has already written to doctors with important information about the 2014 Seasonal Influenza Vaccination Program.

Professor Baggoley has reminded doctors that bioCSL Fluvax must not be provided to children younger than five years of age. It is considered "off label use" when administered to children younger than five years and doctors may be exposed to legal risk. Professor Baggoley said bioCSL Fluvax was also not recommended for use in children aged five to nine years because of the higher risk that these children will develop a fever if administered. He said there were alternative vaccines available for use in children.

Individuals aged 65 years or older, of Aboriginal or Torres Strait Islander descent from 15 years of age, pregnant women, and individuals aged six months and over with medical conditions predisposing them to severe influenza are eligible to receive a free vaccine.

More information about the effectiveness of the influenza vaccine is available at www.immunise.health.gov.au

Kirsty Waterford

COMMENT

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

Nash's axe falls on Council, *Sydney Morning Herald,* 1 March 2014

Assistant Health Minister Fiona Nash announced that the Government would no longer fund the Alcohol and Other Drugs Council. AMA President Dr Steve Hambleton appealed to Prime Minister Tony Abbott to reinstate the organisation's funding.

Dead caught in doc fight, *Courier Mail,* 1 March 2014

AMA President Dr Steve Hambleton said if the Queensland contract problems were not sorted out, Queensland public hospitals could expect to lose specialist doctors.

Chemists want to inject, *Sunday Mail Adelaide*, 2 March 2014

AMA President Dr Steve Hambleton said a pharmacy was not the environment in which to administer vaccines.

Medicos fear contracts will slash earning power, *Courier Mail*, 5 March 2014

AMA President Dr Steve Hambleton said Queensland public hospital contracts were draconian and allowed conditions to be changed at whim.

Peris in pleas to AMA on domestic violence, *Northern Territory News*, 6 March 2014

Labor's first indigenous MP wants the AMA to help tackle alcohol-related domestic violence. The AMA was called to take on the challenge during a powerful speech by Senator Nova Peris.

Lump sum payments for GPs on the table, *Australian Financial Review*, 7 March 2014

Doctors may be given a lump sum payment to treat individual patients rather than be paid by the number of consultations they provide. AMA President Dr Steve Hambleton said he was not opposed in principle, but the way GPs were paid was not the biggest problem in the system.

System Failure, *Courier Mail*, 8 March 2014

Doctors say they've been handed the rough end of the pineapple in a pay deal with the State Government. The doctors, which include AMA President Dr Steve Hambleton and state president-elect Dr Shaun Rudd, are riled by a day of acrimonious debate over the contracts both inside and outside State parliament.

Plan to slug inner city more for GPs, *Sunday Telegraph*, 9 March 2014

Opposition health spokeswoman Catherine King said if the Government wanted to come clean with voters it should release the Commission of Audit report. AMA President Dr Steve Hambleton joined calls for the government to release the report.

Cord blood banking oversold, *Sunday Age*, 9 March 2014

Australian parents are paying thousands of dollars to store their babies' umbilical cord blood with private operators. AMA President Dr Steve Hambleton said he was concerned parents were being oversold the merits of storage and misled into spending money that was unlikely to have any benefit.

Doctors air misgivings on contract peace talks, *Sunday Mail*, 9 March 2014

Plans for a fresh round of talks to thrash out problems between the LNP Government and senior public hospital doctors are under threat of being derailed before they begin. AMA President Dr Steve Hambleton criticised the Government's demands to bind doctors to an unrealistic timetable.

Vaccination opponents sceptical, *The Daily Telegraph*, 11 March 2014

The controversial anti-vaccination group Australian Vaccination Network, which was ordered to change its misleading name, has finally complied with an order from the Administrative Decisions Tribunal. AMA President Dr Steve Hambleton said the new name was not as misleading as the old one.

MORE P10

AMA IN THE NEWS

... FROM P9

New program threatens turf war between doctors and pharmacists, *The Age,* 12 March 2014

Doctors have slammed a push by pharmacists to offer GP-like advice. AMA President Dr Steve Hambleton warned pharmacists would be breaching their area of expertise because they had different training and skill sets to GPs.

Medibank trail puts GP visits onto the political agenda, *Australian Financial Review*, 12 March 2014

Medibank Private is planning to expand a controversial foray into primary health care in Queensland. AMA Chair of General Practice Dr Brian Morton said he believed Medibank was not operating within the spirit of the law.

Radio

Dr Steve Hambleton, 702 ABC Sydney, 3 March 2014

AMA President Dr Steve Hambleton discussed plans to allow pharmacists to give vaccinations in chemist shops. He said at this stage, pharmacists do not have vaccination training.

Dr Steve Hambleton, ABC Goulburn Murray, 3 March 2014

AMA President Dr Steve Hambleton called on the Australian food industry to stop undermining the new five star rating system for food nutrition. He said the star rating system helps people choose better products.

Dr Steve Hambleton, 666 ABC Canberra, 3 March 2014

AMA President Dr Steve Hambleton talked about the Queensland public hospital contracts. He said the concerns of so many doctors cannot be ignored, and he is worried the contracts will compromise patient care.

Dr Steve Hambleton, 2GB Sydney, 6 March 2014

AMA President Dr Steve Hambleton discussed the release of the AMA's Position Statement on Women's Health.

Dr Steve Hambleton, 666 ABC Canberra, 10 March 2014

AMA President Dr Steve Hambleton discussed the Commission of Audit's recommendations to cut back entitlements for seniors. He said he wants the Commission of Audit's findings to be made public.

Dr Steve Hambleton, ABC Coffs Coast, 11 March 2014

AMA President Dr Steve Hambleton talked about the Australian Vaccination Network changing its name to the Australian Vaccination-Skeptics Network. He said the new name is now evident in search engines.

TV

Dr Steve Hambleton, ABC News 24, 5 March 2014

AMA President Dr Steve Hambleton discussed the release of the AMA's Position Statement on Women's Health.

Dr Steve Hambleton, Sky News Sydney, 5 March 2014

AMA President Dr Steve Hambleton released a Position Statement on Women's Health. He said the statistics of violence and sexual abuse against women are shocking.

Dr Steve Hambleton, ABC1 Melbourne, 5 March 2014

AMA President Dr Steve Hambleton discussed the Grattan Institute saying Australia could save one billion by tweaking its hospital system. He said there may be practices that need to be changed.

COMMENT

AMA IN ACTION

Over the past fortnight, AMA President Dr Steve Hambleton has been busy advocating the interests of members and the community by holding several meetings with senior politicians at Parliament House.

Dr Hambleton met with Green's Senator Richard DiNatale to discuss Indigenous Health and Medicines Australia's review into its Code of Conduct. He met with Health Minister Peter Dutton to discuss public hospital funding, end of life care, and chronic disease management. He also spoke with Prime Minister Abbott about the AMA's call for a national alcohol summit. Dr Hambleton and Queensland representative Dr Richard Kidd met with Senator Fifield to discuss aged care issues and the newly established Aged Care Sector Committee.

Dr Hambleton also launched the AMA Women's Health Position Statement with Minister Assisting the Prime Minister for Women, Michaelia Cash, and Northern Territory Labor Senator and former Olympian Nova Peris.

Dr Hambleton continued negotiations with the Queensland Government over the Queensland Hospital contracts.

Dr Hambleton also found time to squeeze in a few media interviews discussing golden staph infections, the relationship between doctors and pharmacists, and Australia's upcoming flu season.

COMMENT

Dr Hambleton with Prime Minister Tony Abbott

Botox for migrane sufferers listed on PBS

People who receive Botox injections to combat chronic migraines will feel even more relief with news that the treatment is now to be subsidised on the Pharmaceutical Benefits Scheme.

Neurologists have been injecting chronic migraine sufferers with botulinum toxin, or Botox, for some time, but, until now, each treatment could leave patients hundreds of dollars out of pocket.

To qualify to receive the PBS-listed Botox shot, patients must have experienced an average of 15 or more headache days per month, with at least eight days of migraine, over a period of at least six months before treatment commences.

The patient must also have failed to respond to other treatments and, after two treatment cycles, must show a specified reduction in headache days per month to continue to receive the subsidised Botox treatment.

The Pharmaceutical Benefits Advisory Committee (PBAC) considered a range of submissions about the use of Botox for migraine treatment before making its decision to list it for subsidy.

"The PBAC acknowledged that a clinical need exists for an effective treatment for patients with chronic migraine refractory to oral prophylactic treatments," the Committee said.

"The PBAC noted and welcomed the input received from individuals, health care professionals, and patient support organisations via the Consumer Comments facility on the PBS website.

"Most notably, comments cited reduced pain levels, improvement in quality of life, and increased ability to function as benefits associated with treatment with botulinum toxin."

Dr Karl Ng, from North Neurology and a senior lecturer at the University of Sydney, told *The Sunday Telegraph* newspaper that the toxin worked by blocking the nerves that convey pain sensation.

"It has certainly worked for quite a large number of my patients. For those with chronic migraine, you can't lead a normal life when half the month is affected by headache, you can't go to work and you can't function," he said.

Botox is well known for its cosmetic uses, but is also used to treat other medical conditions, including urinary incontinence in patients suffering from conditions such as spinal cord injury or multiple sclerosis; the treatment of crossed eyes in children and adults; and some other specific nerve spasm disorders.

Debra Vermeer

COMMENT

INFORMATION FOR MEMBERS

New guide to PSA testing

The National Health and Medical Research Council has released a new resource to provide health professionals with balanced and up to date information about the PSA test.

The resource, titled *PSA Testing for Prostate Cancer in Asymptomatic Men: Information for Practitioners,* examines the potential benefits and harms of subsequent follow-up investigations and treatments of PSA testing.

The guide is designed to assist general practitioners to provide consistent, evidence-based advice to asymptomatic men who are considering undergoing a PSA test. It does not make recommendations for or against PSA testing.

The guide can be downloaded from http://www.nhmrc.gov.au/guidelines/publications/men4

Expert to head up superbug program

The Federal Government has stepped up its fight against the growth of superbugs in Australia with the appointment of a senior medical expert to lead work on a national surveillance program for antimicrobial resistance and antibiotic use.

The Australian Commission on Safety and Quality in Health Care has appointed Professor John Turnidge as a Senior Medical Adviser to head up the program.

The Commission was funded in last year's Federal budget to coordinate national action to prevent and contain superbug resistance through enhanced surveillance systems.

A Senate Committee last year released a report warning that antimicrobial resistance is spreading rapidly worldwide, including in Australia, severely compromising the ability to treat many basic ailments.

The report, which drew on evidence from 38 submissions, including from infectious disease experts, warned that resistant infections were no longer confined to hospitals and were increasingly being acquired in the community.

It called for the establishment of a national organisation to help combat superbugs and monitor antibiotic use.

The Government has tasked the Australian Commission on Safety and Quality in Health Care to head up the work.

The Commission's Chief Executive Officer, Professor Debora Picone, said Professor Turnidge was eminently qualified in his field.

"He has been involved with many high-profile societies and committees, both nationally and internationally, dealing with issues of antibiotic resistance and its management," she said.

"Professor Turnidge's expert medical advice and leadership will be invaluable to this project and in Australia's response to AMR (antimicrobial resistance)."

The three-year project will enhance surveillance of AMR and antibiotic use in Australia and will work toward the establishment of a National Surveillance System.

The Commission will work with the Department of Health and the public and private health sectors to coordinate existing data collection, analyses and reporting activities for AMR.

Australia's action against superbugs is in line with movements across the world.

England's Chief Medical Officer, Professor Dame Sally Davies, captured international attention last year with dire predictions that, unless urgent action is taken to tighten infection controls and curb antibiotic use, basic medical procedures may soon become potentially deadly.

In her annual report to the British Government, Dame Sally said humanity risked losing the war against disease unless greater care and effort was expended regarding the use of existing antibiotics and the development of new drugs.

And, in America, the US Centers for Disease Control and Prevention has reported a steady increase in the prevalence of carbapenem-resistant Enterobacteriaceae (CRE) infections, associated with high mortality, in the past decade, mostly in hospitals.

The US agency said that, although the distribution of CREs was currently limited, they can spread rapidly in health care settings, have mortality rates close to 50 per cent, and pan-resistant strains have been reported.

Debra Vermeer

COMMENT

INFORMATION FOR MEMBERS

National Medicinewise Awards 2014

NPS MedicineWise is calling for nominations.

Across Australia there is a broad range of stakeholders involved in meeting existing and emerging challenges around medicines and medical tests. NPS MedicineWise is keen to hear about outstanding projects, services, programs and activities undertaken by individuals, groups and organisations: from clinical settings to private industry, academia, government, and consumer and other non-profit organisations.

The awards recognise excellent initiatives that contribute to a MedicineWise Australia in the following areas:

- Consumer initiatives: community level
- Consumer initiatives: population level
- Health professional programs: <$100,000 budget
- Health professional programs: >$100,000 budget
- Excellence in consumer information
- Excellence in e-health resources
- Excellence in media reporting

It is important that entries address the specific criteria for each award category as well as the overarching awards criteria.

You can nominate your own work for an award, or the achievements of someone you know.

Nominations for the awards close on Thursday 24 April 2014. For more information visit www.nps.org.au/nms2014/medicinewise-awards

New guidelines for managing asthma

New asthma management guidelines have been released.

The National Asthma Council Australia revised its guidelines to assist GPs, pharmacists and nurses in diagnosing and managing asthma.

Chair of the National Asthma Council Australia Committee Professor Amanda Barnard said asthma can be controlled and the new evidence-based, practical advice features clear diagnostic pathways for differential diagnoses of asthma.

“These guidelines will help people live the best life they can,” Professor Barnard said.

“New medications have been approved and the evidence base has changed substantially since 2006 when the last guidelines were released.”

The guidelines feature an emergency-treatment guide, as well as evidence on diagnosis, management, and lifestyle.

The guidelines focus on controlling asthma and provide detailed information on how doctors should go about increasing and decreasing medications until the optimum dosage is achieved.

“People should have no night-time waking, no shortness of breath, and should not be missing school or work,” Professor Barnard said.

“The thinking on diagnosis has changed over the years, with an acknowledgment in the guidelines that it is extremely difficult to accurately diagnose asthma in a child under two.

“Wheeze is common in young children, for a variety of reasons, and not all wheeze is asthma.”

“If there is no wheezing, chest tightness or difficulty breathing, it is unlikely to be asthma.”

Professor Barnard said the revised guidelines are a good opportunity for people to visit their GP to update their written action plans.

Sanja Novakovic

COMMENT

Urgent action needed on workplace suicide

Education and policy reform in the workplace is crucial in tackling Australia's suicide rate, a new position statement from a key advocacy group says.

Suicide Prevention Australia (SAP) has issued a paper arguing that urgent action is required to address a range of systemic issues in the workplace, including managing unemployment, workers' compensation, and coronial processes.

"In addition, we call on organisations of all sizes to implement workplace policies and programs that promote a mentally healthy workforce and prevent suicide behaviours," SAP says.

The position paper says that most deaths by suicide are among people of working age, with suicide the leading cause of death for men aged 25-44 and women aged 25-34. However, the proportion of suicides that are work-related is unclear.

One Australian study found that 17 per cent of suicides in Victoria from 2000-2007 were work-related. Applying this estimate to deaths across Australia, about 3,800 suicides over the decade to 2011 may be work-related.

"Adults spend about a third of their waking hours at work. The workplace provides a unique opportunity to provide key health information and intervention," the paper says.

"Suicide Prevention Australia sees the workplace as playing a vital role in the creation of a suicide safe community."

The paper says that the World Health Organisation has suggested that worker suicide is a result of a complex interaction between individual vulnerabilities and work-related environmental factors that trigger stress reactions and contribute to poor mental wellbeing.

Apart from the human cost, the SPA Report contains an estimate that suicide costs the Australian economy $17.5 billion per year.

"Employers have a legal responsibility to provide a safe and healthy workplace, including managing psychosocial stressors," the SAP paper says.

The paper calls on employers to: promote a workplace culture that is inclusive, destigmatises mental health problems, and encourages help-seeking; prioritise psychosocial workplace safety, including identifying ways to reduce work-related stressors; understand and value the person as a human being rather than a resource; promote mental health and suicide awareness within the workplace; establish mechanisms for the recognition and early detection of mental health and emotional difficulties in the workplace; provide employees with access to appropriate self-help or professional interventions and treatment; frame suicide prevention programs in a culturally sensitive manner; be prepared for suicide to touch the lives of employees and respond appropriately.

Mental health charity, SANE Australia, welcomed the Work and Suicide Prevention position statement, saying the workplace was a critically important focus for suicide prevention activities and the promotion of good mental health.

SANE Australia CEO Jack Heath said Australia has the capacity to halve the suicide rate within 10 years if the nation had the will and resources to do it.

"The tragic loss of life among working age adults is an issue that urgently needs to be tackled in the workplace itself, where we spend so much of our lives, and which can be the source of so much stress, especially to those who are vulnerable because of poor mental health or other factors," he said.

> "...the workplace was a critically important focus for suicide prevention activities and the promotion of good mental health"

"The workplace is also a great place to connect with men who might be struggling."

The paper also highlighted areas in which industry groups and government could assist, including adequate government funding for counselling services and intervention and support programs.

It proposes the review of the role of the workers' compensation system in suicide prevention, minimising harm and maximising opportunities for intervention with those vulnerable to suicide, and urges government to adequately resource coroners to ensure coronial investigations include the role of work in suicide deaths.

The paper is available at www.suicidepreventionaust.org

Debra Vermeer

COMMENT

New app to track medicines

Doctors are being urged to encourage their patients to make use of a new smartphone app, which is designed to let patients know about and manage their medicines, as well as record important health information.

The MedicineList+ app has been launched by NPS MedicineWise and operates on both Android and iOS devices.

It aims to help patients keep an up-to-date list of all the medicines they take, give reminders on when to take them, and can even keep track of more than one person's medicines list, making it useful for parents and people who care for older family members.

NPS MedicineWise clinical adviser Dr Philippa Binns said the free MedicineList+ app would be a great help to anyone who takes medicines, but especially people who take three or more prescriptions, over-the-counter or complementary medicines every day.

"We know that keeping a medicines list is an important part of being medicine wise, but according to our recent survey of people aged 65 years or older or their carers, only 55 per cent of older Australians keep a list of their medicines, while 30 per cent have no way of keeping track of them at all, which is not ideal," Dr Binns said.

"Of those people who do keep a medicines list, almost all keep track of their prescription medicines, but only 60 per cent list their over-the-counter medicines, and just 55 per cent list their complementary medicines such as herbs, vitamins, and fish oil.

"What's more, 54 per cent of people who keep a medicines list said they do not update it every time they stop or start a new medicine, and only 48 per cent said they would take their list with them every time they visited a health professional."

Dr Binns said the new app would make it easier to list all the medicines being taken, keep the list up to date, and have the information on hand when patients see their doctor.

The app can: generate a list of medicines that can be emailed, printed or saved for sharing with family members, carers and doctors; scan the barcode of medicine packaging to enter it straight into the medicines list; create multiple user profiles for managing family members' medicines; set a reminder for medicine doses or other medical reminders; store measurement and test results, such as blood pressure readings, weight, height etc; add free text and notes including general health reminders such as allergies and emergency contacts.

The development of the MedicineList+ app comes in the wake of news that patient access to services aimed at improving medication use is to be rationed following concerns of a cost blow-out.

The Federal Health Department and the Pharmacy Guild of Australia have agreed to cap services provided through the Home Medicines Review 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 Home Medicine Review will expire after three months, and there will be a strict cap on the number of the reviews and MedsCheck services that GPs, pharmacists and other health professionals can commission.

Debra Vermeer

COMMENT

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

New listings on PBS

Patients requiring growth hormones or suffering from diabetes, glaucoma, or a rare soft tissue cancer will feel some welcome help in the hip pocket, with the Federal Government approving new medicines for listing on the Pharmaceutical Benefits Scheme (PBS).

Federal Health Minister Peter Dutton said the PBS subsidies would make the medicines more affordable for Australians who needed them.

Diabetes patients will benefit from two combination medicines which have been listed: linagliptin with metformin (sold as Trajenta Duo®), and saxagliptin with metformin (sold as Kombiglyze®).

"Patients already had access to the individual medicines through the PBS, but many people need to use two medicines together to treat their diabetes," Mr Dutton said.

"With the combination dose now listed on the PBS, these patients will save up to $36.90 every time they get a script filled because they will only have to buy one fixed dose medicine, instead of two."

People suffering from advanced soft tissue sarcoma will also have access to cheaper treatment with the listing of Pazopanib (sold as Votrient®) on the PBS.

"Patients with this rare cancer would pay around $21,000 per treatment cycle for pazopanib without subsidised access through the PBS," Mr Dutton said.

"The Government believes that Australians should have access to new medicines through the PBS as soon as possible after they are proven."

The Minister also announced changes to the PBS Growth Hormone Program, which treats almost 1,900 children and adolescents in Australia.

The program is being extended to cover certain patients with hypothalamic-pituitary disease, who have a biochemical growth hormone deficiency.

This means that patients will be able to access higher doses of growth hormone through the program, if it is deemed clinically appropriate.

"Access to higher doses of growth hormone will especially help older children who have limited opportunity for further treatment before their skeleton has matured," Mr Dutton said.

The new additions to the PBS come as pharmaceutical lobby group, Medicines Australia, seeks to head off any cuts to the subsidy scheme by arguing that government expenditure on the PBS is not only sustainable but actually fell last financial year.

It said that a PBS scorecard update from Medicines Partnership Australia, released in February, outlines the current state of PBS spending, as confirmed by the Department of Health, the Federal Treasury, and the Productivity Commission.

They said the scorecard confirmed that PBS expenditure is contained and that price disclosure is delivering savings far in excess of what was expected.

Debra Vermeer

COMMENT

INFORMATION FOR MEMBERS

National Medicines Symposium 2014

The 2014 National Medicines Symposium will be held in Brisbane from 21-23 May and draws together an international and national audience of clinicians, health professionals, academics and researchers, health consumers, policy makers and industry. This year the symposium will explore current and future medicines challenges relating to sustainability, translating evidence into action and ethical decision making in health.

For more information about the symposium visit http://www.nps.org.au/about-us/what-we-do/campaigns-events/national-medicines-symposium

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

Health on the hill

Political news from the nation's capital

Food rating website on backburner

The healthy food star rating website that was controversially pulled down at the direction of Assistant Health Minister Fiona Nash will not be reinstated until after Federal, State and Territory food ministers meet in June.

The AMA has been a strong advocate for the website, with AMA President Dr Hambleton saying that it was to be a major part of the public education campaign to make people aware of the new star system rating. He said the health star rating system for food and beverages was a major public health initiative that would place Australia as a world leader in helping to reduce alarming rates of overweight and obesity in Australia.

Dr Hambleton's comments were supported by the consumer group Choice when they uncovered a surprisingly large difference in the nutritional content of seemingly similar snack foods under the healthy food star rating system.

Choice compared three products from multinational snack foods company, Mondelez, with similar products. Choice found Mondelez's Kraft Strip Cheese received only two out of five stars compared with Bega's Stringers, which received four and a half stars. Mondelez's Ritz Crackers got a half star compared to Arnott's Jatz original, which got two.

Choice campaigns manager Angela Catwright said she was able to use publicly available information to do the ratings and would consider doing more product analysis if the website was not reinstated.

A spokesperson for Mondelez told the *Sydney Morning Herald* that the system would mislead consumers and make labels more confusing considering Philadelphia Cream Cheese was considered healthier than an apple under the system.

Dr Hambleton called on the food industry to stop undermining the implementation of the new five star rating system for food nutrition and was backed by more than 65 professors from around Australia who co-signed a letter saying the threat to Australia's health posed by obesity needs urgent action and urges all ministers to take whatever action is within their power to implement the system as soon as possible.

However, there continues to be ongoing dispute within the Coalition whether the star health ratings should be implemented. Some politicians are calling on the Prime Minister to back the scheme starting in June, but others believe consumers do not need Government intervention.

Kirsty Waterford

COMMENT

Govt ponders major change in GP funding

The Abbott Government is considering a fundamental shift away from the fee-for-service model of GP remuneration as part of an overhaul of health funding.

Fuelling speculation that the Government is considering major changes in the way it pays for primary health care, Health Minister Peter Dutton said the Government was "open to a conversation" about changing the way GPs are paid for their services, flagging the possibility doctors might in future receive an annual fee for caring for their patients.

Mr Dutton said New Zealand's "blended" approach, under which doctors receive capitation fees and patients are charged co-payments, was being examined.

"I think there is an opportunity for us to perhaps look at doctors and other stakeholders in the conversation about blended payments," the Minister told a General Practice Registrars Australia (GPRA) conference on 6 March.

"There are international examples. New Zealand is perhaps the closest relevant example to us about the way in which they provide support to their GP network, which is a system of blended payments, probably skewed more towards capitation [than] fee-for-service."

AMA President Dr Steve Hambleton told the *Australian Financial Review* the Association was not opposed in principle to changes in the way GPs were remunerated, but said it was the wrong focus for efforts aimed at controlling rising health costs.

MORE P20

Health on the hill

Political news from the nation's capital

... FROM P19

"The Minister has been floating a lot of ideas," Dr Hambleton said. "We have to think about what is driving costs. Chronic disease management is the key, and we have to ensure we do that well."

In his speech to the GPRA conference, Mr Dutton acknowledged the significant and growing burden of chronic disease, and said the health system needed to be fundamentally recast if it was to continue to be effective.

"Without strengthening our health system, it will fall short of servicing the nation's health needs over the coming years and decades," he said. "We need to take what is currently a 1980s model and transform it into an effective, efficient and stable system of health."

The Minister said the fact that 10 per cent of the population used 46 per cent of Medicare-funded services showed the system was not working for them.

He said general practitioners were central to the Government's plans for a remodelled health system better able to tackle the challenge of lifestyle-related diseases and health risks, such as obesity and diabetes.

The alignment of incentives in the capitation system of remuneration is seen by some as better suited to treating and preventing complex and chronic disease, by paying doctors an annual fee for each patient enrolled in their practice, rather than being paid according to how often they provide treatment.

According to Melbourne Institute of Applied Economics Senior Research Fellow Peter Sivey, in an article on the *Croakey* website, "GPs do not receive more money for seeing their patients more often and, indeed, will benefit from lower costs themselves if patient health improves and they require less care in the future".

But, Mr Sivey added, the system is not without drawbacks: "For capitation to work, patients have to be enrolled in only one practice – say goodbye to the convenience of visiting one doctor near your workplace and one near home."

Emeritus Professor of Medicine at the University of New South Wales, John Dwyer, echoed Dr Hambleton's concern that the Government's apparent focus on models of GP remuneration were beside the point when seeking to address fundamental issues of health funding.

He said the Government's 'compartmentalised' focus on primary health care missed the main point, which was that "cost effectiveness can only be tackled with a whole of system analysis, not just a focus on the Federally funded Medicare program that supports our delivery of primary care".

In a piece on the blog, *Pearls and Irritations*, Professor Dwyer said giving primary care the support needed for effective prevention programs "is the most important initiative we need to implement in Australia. Around the world, the trend is to establish primary care systems that encourage citizens to enrol in a wellness maintenance program and benefit from the delivery of health care by teams of health professionals working as "first among equals" in the one practice".

"Many younger doctors considering general practice would prefer to move away from the traditional fee-for-service payment system to salaried or contractual payments. In New Zealand, over 85 per cent of GPs have voluntarily forsaken fee-for-service payments in favour of guaranteed remuneration in a capitation model," he said.

Adrian Rollins

COMMENT

GP training boost in the works: Dutton

Hopes are mounting for an imminent boost to GP training after Health Minister Peter Dutton declared the Abbott Government was "implementing" an election promise for increased teaching incentives.

Hinting that the May Budget will include an increased allocation for general practice training, Mr Dutton told the General Practice Registrars Australia conference that the Government was working to deliver on its election commitment to provide a $119 million boost to GP teaching payments under the Practice Incentive Program.

Despite what Mr Dutton warned would be a "tough" Budget, he said the Government was "implementing that promise".

It would mean that rural and remote GPs providing training would receive an additional benefit in recognition of the "additional challenges" they face, the Minister said, adding that these practices would also be eligible for an extra $52.5 million of infrastructure grants to help upgrade their training infrastructure.

MORE P21

Health on the hill

Political news from the nation's capital

... FROM P20

Mr Dutton said the infrastructure grants would be provided on the basis of a matching commitment from the practice: "This will leverage private investment and help ensure the most efficient and productive use of the taxpayers' dollars".

He said the changes were part of efforts to improve the medical training system, which is coming under increasing strain from a surge in the number of medical students.

The Minister said the Federal Government was working with the private sector and its State and Territory counterparts to better manage the system through the development of national medical training plans.

He said the focus should not only be on improved public sector efficiency, but also tapping into innovative ideas from the private sector.

"We should be leveraging the private sector, not just for services, but also to meet workforce training challenges," he said, citing as an example the Commonwealth Medical Internship initiative.

The Minister said that the initiative, through public-private partnerships, had provided training for an additional 76 doctors this year alone.

"Priority for new training positions will be in rural and regional areas to help bolster the medical workforce in communities who need them most," Mr Dutton said. "And each Commonwealth-funded intern has a rural return-of-service obligation."

Adrian Rollins

COMMENT

Aged care reforms on their way

Professor Peter Shergold has been named as Chair of the new Aged Care Sector Committee, which will work with the Government in implementing aged care reforms.

The Committee will be responsible for developing the Aged Care Sector Statement of Principles, which replaces the five-year aged care agreement.

The Committee replaces the abolished independent Aged Care Reform Implementation Council which was previously chaired by Professor Shergold. The Council was disbanded in January along with the Ageing Expert Advisory Committee to avoid duplication of roles and responsibilities.

Senator Mitch Fifield, who announced the appointment, said the Committee will provide guidance to help the aged care sector adapt to the new demands and would have a greater consumer focus.

"The Australian Government understands the need to work in partnership with the aged care sector and aged care consumers," Mr Fifield said

"Committee members have been drawn from peak bodies representing providers across residential and home care; for profit and not for profit providers; consumers and workforce representatives."

The AMA was not invited to join the Committee, but AMA President Dr Steve Hambleton and AMA Queensland representative Dr Richard Kidd recently met with Senator Fifield to discuss key issues affecting appropriate care for older Australians. Dr Hambleton and Dr Kidd discussed with Senator Fifield the ongoing access to medical care for residents of residential aged care facilities, community aged care services that cater for the medical needs of older Australians, and carers of older Australians.

Senator Fifield said the Committee will provide important advice, including identifying where to start the critical task of cutting red tape in aged care and practical steps that can be taken to reduce administrative burdens and compliance costs.

A date for the Committee's first meeting is yet to be set but the Statement of Principles will be completed in the second half of 2014.

Shadow Minister for Ageing Shayne Neumann welcomed the announcement of the new Committee but criticised the Government for taking six months to establish it and for only including one union representative.

Kirsty Waterford

COMMENT

Activity based funding starts in July

The Independent Hospital Pricing Authority (IHPA) has released the National Efficient Price (NEP) and the National Efficient Costs (NEC) determinations for Australian public hospital services for 2014-2015.

MORE P22

Health on the hill

Political news from the nation's capital

... FROM P21

The NEP and NEC determine the amount of Commonwealth funding given to public hospitals according to either hospital activity levels or, in the case of small rural hospitals, an allocation of block funding.

For the first time, from 1 July 2014, Commonwealth funding for most public hospital services will be directly determined by Activity Based Funding. Under the new system, public hospitals are paid for the number and mix of patients they treat.

The NEP for 2014-2015 is set at $5007 per national weighted activity unit. Each service hospitals provide is allocated a complexity weighting, which reflects the cost of delivering that service. The weighting is multiplied by the NEP to calculate the total efficient price of the service.

For example:

- A tonsillectomy has a weighting of 0.7058, which equates to $3534 per admission; and
- A hip replacement has a weight of 4.1855, which equates to $20,957 per admission.

The NEC is used when activity based funding is not suitable to determine funding, which is often the case for small rural public hospitals. For small rural hospitals, funding is allocated based on size and location. The NEC for 2014-2015 is $5.725 million.

For example, a small rural public hospital has an efficient cost of approximately $2.9 million, compared to a larger public hospital in a city that has an approximate efficient cost of $5.7 million.

The NEC funding is applied to 436 small rural public hospitals, which are listed in the NEC determination.

For more information visit http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/national-efficient-price-determination-lp

Kirsty Waterford

COMMENT

Autism Cooperative Research Centre to tackle issues head on

A new $104 million Autism Cooperative Research Centre (CRC) launched in early March will aim to tackle some of the biggest issues facing people with autism, their families, and the community.

Officially launched by the Minister for Industry Ian Macfarlane, the CRC's research will focus on diagnosis, education, and supporting people with autism as they move to the workforce.

The Centre will receive $31 million in Commonwealth funding over the next eight years.

Located at the University of Queensland, the CRC will bring together occupational therapists, educators, biologists, psychologists, governments, international organisations, community groups, and industry.

Mr Macfarlane said the work of the CRC will focus on the full range of issues that affect people with autism.

"Importantly, the CRC will work to build new links between science, industry and Government, with the ultimate goal of generating practical outcomes to improve the lives of people with autism and their families," Mr Macfarlane said.

The CRC is developing new behavioural tools to ensure that at least 70 per cent of autistic children are correctly diagnosed by the age of three, and at least 50 per cent by the age of two.

Mr Macfarlane said ensuring that children are diagnosed correctly at a young age can make a huge difference, not only to the child, but also their family.

A web portal with assistance programs and modules for use by employers, health care professionals, educators, carers, and family members will also be developed.

Currently, only a third of adult Australians with autism have jobs compared to more than half of people with other disabilities. There are only five employment agencies specifically for people with autism in the world, and only one in Australia.

Professor Torbjorn Falkmer, who is leading the Adult Research Program at the Autism CRC told *The World Today* program that low employment rates of people with autism shows Australian employers are missing out on highly skilled workers. He said that in certain work conditions people with autism perform much better in a workplace than people without the condition.

Chair of the CRC Judy Brewe said the establishment of the Autism CRC is a turning point in how we work together to better understand this complex condition and best support those living with it and the wider community.

"We're taking a whole-of-life view of living with autism, from diagnosis and the toddler years through to school education and adult-life issues such as employment and participation in community life," Ms Brewe said.

Kirsty Waterford

COMMENT

GENERAL PRACTICE

Keeping the wolf from the door

BY DR BRIAN MORTON

With the weather cooling down, it won't be long until the waiting room is full of patients suffering from influenza – a misery that could largely be avoided with one jab.

The 2014 Seasonal Influenza Vaccination Program gets underway on 15 March 2014. Now is the time for us to assert ourselves in our preventative health role, as family doctors, and as patients' vaccination provider of choice. We need to be proactive and discuss with every patient, but particularly those most vulnerable, the availability and benefits of the 'flu shot'. Not only will we be providing patients with the opportunity and information to protect themselves from sickness, we might also be keeping the wolf from the door.

Increasingly we are seeing our role as primary vaccination providers being encroached upon by those seeking to expand their scopes of practice and enhance their access to government funding. With the Queensland Pharmacist Immunisation Pilot going ahead, there is a real chance that it won't be long before Australia follows New Zealand's lead and introduces pharmacist vaccinators.

I believe this poses a serious threat to patients' continuity of care, jeopardises the currency of their medical record, and puts patient safety at risk.

This increasing philosophy permeating through government when it comes to health care of 'close enough is good enough' is not good enough in my opinion. Something as important as vaccinations should be performed by appropriately trained and accredited health professionals in an appropriate location.

> "It remains up to us though to ensure that our patients value the service and care they receive from their family doctor and make us their vaccine provider of choice"

The AMA, for one, has a number of concerns with the trial, which is why it has called for it to be ceased. As a rule, pharmacists are not set up to provide clinical services. There is no privacy for patients in a pharmacy. Administering injections must be part of pharmacists' core training if they want to expand their scope of practice. Short add-on courses for the purpose of the trial don't cut it in my view. Having the skills to recognise and manage anaphylaxis is a must.

Where vaccinations occur outside of general practice, they must be subject to the same proficiency and quality requirements as those provided in a general practice.

It remains up to us, though, to ensure that our patients value the service and care they receive from their family doctor and make us their vaccine provider of choice.

How can we do this? By making sure we know which patients are eligible for the seasonal influenza vaccine under the National Immunisation Program. By ensuring we are fully across any restrictions on vaccine use, ie no Fluvax® for under fives. By being up to date on the composition of the 2014 trivalent influenza. By being aware of and discussing with parents the risks of co-administration of trivalent influenza and Prevenar 13® vaccines. By discussing with patients their vaccination needs.

For information on the Immunise Australia Progam and for information on administration of the 2014 trivalent seasonal influenza vaccines, visit http://www.immunise.health.gov.au/internet/immunise/Publishing.nsf/content/ATAGI-advice-TIV.

COMMENT

Doctors' health and wellbeing: talking about our mental health

BY DR JULIAN GRABEK

> "While many questions can be asked of the profession as whole, why in particular are doctors in training more vulnerable?"

Ward rounds, clinics, family discussions, studying for exams, sitting exams, and failing exams all comprise some of the potential strains on our time as junior doctors. The workload and type of work can create significant stress and, among the day-to-day work, the preparation for, and outcome of exams adds further strain on a stressful situation.

In October 2013, beyondblue showed through the National Mental Health Survey of Doctors and Medical Students that, as a profession we have a higher rate of severe psychological distress and attempted suicide compared to the Australian population and other professionals. The rate of suicidal ideation among health practitioners was a staggering 28.5 per cent in females and 22.3 per cent in males compared to the 15.0 per cent and 11.5 per cent respectively in the Australian population. Young training doctors appear to be a more vulnerable group with higher levels of burnout than their older colleagues as measured by rates of emotional exhaustion 47.5 per cent (compared to less than 35 per cent for over 30 years of age), cynicism 45.8 per cent (compared to 36.5 per cent or less for over 30), and lower professional efficacy 17.6 per cent (compared to 16.3 per cent in the 31-40 age group).

While many questions can be asked of the profession as a whole, why in particular are doctors in training more vulnerable? Previous articles have cited the nature of junior doctors' work, studying for exams, and the difficulties maintaining work-life balance. Mental Health services for practitioners exist such as the Victorian Doctors Health Program (VDHP), but often they are consulted by practitioners late when high stress has already had a significant impact on the wellbeing of an individual. When surveyed, junior doctors have cited fear of stigma, concerns regarding anonymity when seeking help and the prospect of being reported to the Medical Board. Among junior doctors, in particular, the feeling of "letting the side down" and concerns regarding the negative connotations of not coping with the workload on the overall assessment of their training performance.

In response to the concerning figures raised in the National Mental Health Survey of Doctors, beyondblue, together with the AMA, has created a forum involving major stakeholders in medical training and doctor wellbeing. The roundtable discussion is aimed to generate models for addressing workplace stress – not just at the individual level, but also at an institutional and training college level. Ideally, prevention is the goal and we applaud the work of medical schools including personal development and stress management as teaching modules within training. At the institutional level, hospitals such as the Royal Melbourne have implemented additional programs that help identify at-risk individuals but also to review rostering practices and ensure safe hours and adequate work-life balance. More can still be done to address the problem and ensure the right balance of safe, enjoyable practice with adequate training exposure that produces trainees with the skills to cope with a wide variety of workplace stress.

The Council of Doctors in Training hopes to generate further discussion regarding the area of reducing the risk of trainee suicide and stress management at our upcoming Trainee Forum on the 15th of March.

COMMENT

Pharmacy vaccinations - trials and tribulations

BY PROFESSOR GEOFFREY DOBB

> “We are interested in engaging with the pharmaceutical industry to learn about new medicines but we do not advocate for pharmaceutical companies or a particular brand or product”

Pharmacists and vaccines have been two prominent themes in the Therapeutics Committee’s work over the last few weeks.

The AMA has opposed a trial by the Queensland Health Department of community pharmacists providing influenza vaccinations because the trial will proceed before pharmacists receive accredited training to perform safe and effective vaccinations – and the details of the training are still unknown. Similarly, AMA NT has raised concerns about recently introduced State legislation that will allow pharmacists and other non-medical health practitioners to immunise patients.

The Pharmacy Board of Australia stated in a communiqué on 5 December 2013 that work on competencies and training is required before vaccination by a pharmacist is able to occur. This means that competencies and standards must first be established; then training programs developed and accredited; and the Board must approve programs of study and set a registration standard for endorsement for scheduled medicines.

AMA Queensland President Dr Christian Rowan and I wrote to the Queensland Chief Health Officer in January about the AMA’s concerns. Dr Young replied that pharmacists in the trial will undertake training in CPR, first aid, and the recognition and emergency management of anaphylaxis. I have since written to the Pharmacy Board of Australia asking whether it considers pharmacists participating in the trial will be practising outside their scope of practice and without completing an accredited education and training program approved by the Board. I am awaiting a response.

Still on the theme of vaccinations, several medicine sponsors have been lobbying the AMA to support submissions they have made to the Pharmaceutical Benefits Advisory Committee (PBAC) to be considered at its meeting in March.

The sponsor of the shingles vaccine, Zostavax, is one of these pharmaceutical companies. Zostavax was recommended by PBAC for subsidy under the National Immunisation Program some five years ago but issues with supply meant that it did not proceed.

The arguments for and against Government subsidy of a medicine are always complex. PBAC has a difficult task in assessing cost effectiveness as well as comparative effectiveness. The AMA takes the position that PBAC, as an independent body of experts, should be supported to make its recommendations without the interference of government or the influence of specific interest groups.

We are interested in engaging with the pharmaceutical industry to learn about new medicines but we do not advocate for pharmaceutical companies or a particular brand or product.

For this reason, we are also leaving the TGA and PBAC to determine how they wish to respond to a bid by OxyContin’s sponsor to have the new ‘difficult-to-crush’ form of this drug, which makes it less prone to misuse, either recognised as a new drug with a new patent period, or to require any generic version of OxyContin to mimic the ‘hard-to-crush’ characteristic.

Back to the theme of pharmacists, the Department of Health and the Pharmacy Guild of Australia announced changes to the Home Medicines Review (HMR) program from 1 March, including a cap of 20 per month for each service provider and a timeframe of 24 months between repeat or additional HMRs for each patient. It appears that, without the cap, the funding for HMRs under the current Community Pharmacy Agreement would either run out before the end of the Agreement or money would have to be taken from another patient program to fund it.

In the lead up to the 2015 Community Pharmacy Agreement negotiations, the AMA will keep a watch on how the cap impacts on general practitioners and patient care. The AMA is also represented by Dr Richard Kidd on an advisory panel, which is overseeing a research project conducted by the Guild on HMR patient eligibility criteria. The findings of this project and the broader review of the medicines management component of the Agreement will inform how these programs are managed in the future.

You can let me know of any negative impact on your patients from the HMR caps by emailing ama@ama.com.au

COMMENT

The good oil – or not, as the case may be

BY PROFESSOR STEPHEN LEEDER AND SHAUNA DOWNS

> "With the rising tide of diabetes attributable to changing dietary practices as part of the prosperity that the oils bring, our attitudes toward these commodities needs serious rethinking"

Think oil – the sort you dig out of the ground and the sort that grows on palm trees. The extraction and processing of both is big business. Big business and health are joined at the hip. Look first at the fossil fuel variety.

Doha, a city of 200,000 in Qatar, a peninsula that pushes into the bottom left of the Arabian Gulf, rises from the desert sands like a gleaming massive space ship recently arrived from an exoplanet or from the set of Star Wars. Its prosperity derives from its oil exports. GDP per head of population (2 million) is the highest in the world. Like other Gulf Nations, especially the Emirates, its politics are plutocratic and the sheiks have immense, if frequently benign, power. Qatar spends hundreds of millions of dollars a year sending citizens abroad, often to Europe and North America, for complex care for cancer and other serious disorders, although heavy investments in new hospitals will soon enable Doha to become a magnet for medical visits itself.

What the Gulf nations face by way of a health challenge is familiar to those who have watched with horror as the Pacific nations have moved away from traditional diets rich in fish and root foods to highly-processed foods that are rich in fat, salt and carbohydrate. The resulting increase in obesity and diabetes is like a macabre psychodrama in which entire populations are coerced into eating their ways towards metabolic chaos. Rates of type 2 diabetes in the Pacific, and now in the Gulf, are around the 20 per cent mark. We are not talking here about a mild 'touch of diabetes' with little consequence but the real McCoy – with the immense hassle of treatment, a natural history of slow but steady deterioration, and vascular, ocular and renal complications. We sell mutton flaps, so fatty that there is no market for them in Australia, to Fiji and Tonga. The commercial drive rides over concerns about health. We do not do ourselves proud with this behaviour.

The Gulf States have prospered immensely from their oil and the pace of development has been deeply impressive. But the consequent downturn in physical activity needed to secure food and the quality of what is sold on the food market is deeply troubling. A visit to a gleaming supermarket in Abu Dhabi will reveal that you can buy almost anything known to you from Australia, but you will struggle to find 'lite' products and few carry any kind of nutritional label. Oil, one may conclude, is good for lots of things, but developing economies struggle with the health consequences of that prosperity both in terms of physical activity and food supply.

Fly from Doha to Delhi. Here you will not find the achievements and excesses of oil that have enabled the air-conditioned luxury of Doha. The food supply is fragmented and chaotic, with many small producers and food supply chains that are so challenged by inefficiency and lack of refrigeration that 50 per cent of all food produced does not get to the table. Of that that does, the oils used in its production often contain trans fat, a form that is now known to be a serious cardiovascular hazard. The trans fat comes from palm oil, the most widely consumed oil for food on the planet. Malaysia, Indonesia and several South American nations have prospered mightily by planting oil palms where once rainforests flourished. Palm oil is easy to produce and transport and finds its way, supported by government subsidies, into many common foods in India and other countries.

In economically-advanced nations such as the US, serious efforts are being made to change the supply of oils away from trans fat in favour of mono-unsaturates, including canola. The regulatory responses to trans fat in the US have created market opportunities for enterprises such as Dow Chemicals to develop productive and profitable crops such as canola. Farmers are rising to the new challenge. On estimate, 700 million tons of trans fat has been removed from the US diet between 2005 and 2012. Michael Bloomberg, former Mayor of New York City, who introduced bans on trans fats, must have a sense of achievement.

The risk, as we have seen with tobacco and mutton flaps, remains that commercial enterprises that are challenged by rising health awareness in developed economies, quietly move their activities off shore, with no concern about the health consequences for millions of people.

Oil out of the ground and oil from a palm are huge commercial successes. With the rising tide of diabetes attributable to changing dietary practices as part of the prosperity that the oils bring, our attitudes toward these commodities needs serious rethinking. That need not lead us towards punitive, restrictive and profit-diminishing behaviours. As the example of Dow and canola shows, smart negotiation can create winners all round. We need intelligence, lateral thinking and commitment. As Bloomberg showed in New York, it helps greatly to have leading politicians on your team.

COMMENT

Medical tourism in Asia goes under the knife

BY DR NEIL LUNT, UNIVERSITY OF YORK*

This article first appeared in the East Asia Forum, and can be viewed at: http://www.eastasiaforum.org/2014/02/13/medical-tourism-in-asia-goes-under-the-knife/

Medical tourism in Asia is booming. People from both Asia and the West are being attracted to cities and 'hubs' of medical excellence in a number of countries, such as Malaysia, Thailand, India, Singapore, Taiwan and South Korea. This tourism is a reversal of medical travel's historic trend of being from low- to high-income countries. But the travel for cheaper treatments, including cosmetic, dental and transplantation surgery, has risks as well as benefits for the host countries.

Surgical techniques and patient safety knowledge have spread alongside the circulation of clinicians with overseas experience. This has led to the internationalisation of techniques previously confined to Western nations. Medical tourism across Asia has developed customer care strategies and large facilities akin to corporate five-star hotels — with strong clinical specialism. And countries seeking to develop medical tourism have the option to grow their own health service or form partnerships with large multinational players.

This development — effectively the internationalisation of private health care aimed at travelling patients — has seen national governments promote their countries' services.

National governments anticipate many benefits from medical tourism. There are financial benefits generated from health services and associated visitor spending. Human resource benefits can be gained by using medical tourism to attract back health workers who have emigrated — reversing the 'brain drain'. Positive spillovers may include the expansion of health-sector infrastructure and also roads and telecommunications. Equity benefits are potentially created by hospitals cross-subsidising care for domestic patients, or helping to fund capital investment. Capital investments, such as MRI scanners, can then be used by all patients in the hospital or health system. And finally, there are symbolic dividends — ascension into the elite club of trading nations through domestic high-tech service industry development.

So do these anticipated benefits occur? The truth is that we simply do not have enough data on country indicators.

The involvement of transnational corporations may result in profits from medical tourism and ancillary activities being remitted overseas. While some evidence suggests medical tourism generates modest contributions to GDP, there are concerns about human resource migration to the private sector, with professionals lured by better salaries and work opportunities. It is possible resources will be taken away from the domestic population and instead invested into private hospitals, where foreign patients benefit from a high staff-to-patient ratio and expensive, state-of-the-art medical equipment. Such private activity is further supported by tax breaks and public subsidies for the training and education of health workers.

Another possibility is that investment is directed towards urban tertiary care rather than more appropriate domestic-population needs in rural primary care centres. The implications clearly vary depending on whether international patients are using spare capacity or competing with domestic patients.

But there is a curious gap in research and policy analysis. System-level evaluation of medical tourism policy and impact is absent. There is also a lack of independent government-funded work examining the pros and cons of medical tourism, and how benefits are distributed across the population. Medical tourism initiatives are launched as national policy platforms with much fanfare. But it becomes difficult to distinguish aspiration from reality given the veneer of country promotion strategies, provider rhetoric, and industry grandstanding. And one may question the political will that exists to grapple with the nature of system-level impacts.

Deeper empirical understanding of these impacts could inform policy and the regulation or stimulation of private sector activities. This may include ways to ensure human resources are made available to the domestic population — benefitting the domestic health system. Certainly medical tourism has the potential to influence the distribution of healthcare resources to the poorer local population. But it remains to be seen whether universal health coverage in East Asian countries and medical tourism development can go hand in hand.

National strategies must understand the risks within medical tourist markets. It is necessary to engage with the evidence when considering the benefits and demand for medical tourism globally. There is no simple upward curve: travel to particular countries may be volatile, reflecting their own political, climatic and economic events. There are also shifts in consumer preferences and exchange rates. To date there has been relatively limited success by medical tourist providers in tapping revenue streams from private and workplace insurance systems or outsourcing from western public health systems. It is difficult to ensure that regulatory interest and public investment is prevented from being captured by the private sector and that the interests promoting medical tourism development are adequately countered.

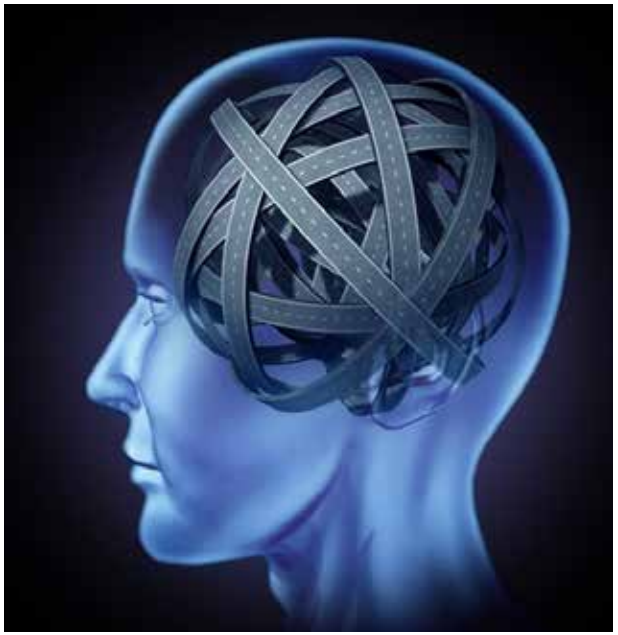
Medical tourism may benefit individual patients, treating clinicians and the private providers. But it is time to ask — do the benefits add up?

* Dr Neil Lunt is Reader in Social Policy and Public Sector Management at the University of York.

COMMENT

Research

New blood tests can detect Alzheimer's



A blood test that can detect Alzheimer's disease with 90 per cent certainty has been developed by scientists from Georgetown University Medical Centre in Washington, who believe that it could lead to the early diagnosis of progressive dementia in elderly people.

As the test is only 90 per cent accurate in its current form, it raises ethical concerns that one in ten people could be wrongly diagnosed.

Nevertheless, researchers believe that a blood test for Alzheimer's could help search for a therapy or cure by identifying those people who are at a high risk and who could benefit most from experimental treatments.

"The accuracy for detection is equal to or greater than that obtained from most published CSF studies," the researchers wrote in *Nature Medicine*.

The study involved blood samples from 525 healthy volunteers, over the age of 70, who were monitored over five years, to see whether they went on to develop mild dementia or Alzheimer's.

The blood test is centred around analysing the fatty chemicals, known as lipids, circulating in the bloodstream, which then begin to change as a result of a breakdown in the membranes of the brain cells associated with Alzheimer's.

The team of researchers, led by Dr Howard Federoff, identified 10 lipids in the blood that can be used to discover early signs of Alzheimer's or other forms of dementia.

Scientists have known that Alzheimer's disease begins long before the diagnostic symptoms start showing, such as memory loss or confusion, and have tried for many years to find ways of detecting these changes with simple tests that could be used in clinics.

Dr Federoff said the blood test offers the potential to identify people at risk for progressive cognitive decline and can change how patients, their families, and treating physicians plan for and manage the disorder.

"We consider our results a major step toward the commercialisation of a pre-clinical disease biomarker test that could be useful for large-scale screening to identify at-risk individuals," Dr Federoff said.

"We're designing a clinical trial where we'll use a panel to identify people at high risk for Alzheimer's to test a therapeutic agent that might delay or prevent the emergence of the disease."

Sanja Novakovic

COMMENT

Statin links to diabetes overestimated

Two new Australian studies suggest the increased risk of diabetes associated with statin treatment has been overestimated, and may have more to do with weight gain than a metabolic effect of statins.

Statins are used extensively to treat dyslipidemia and have been associated with significant clinical benefit that increases with dose. However, recent studies have associated statins with an excess risk of developing diabetes mellitus, which may offset the clinical benefit to patients

Researchers from the University of Queensland found that the risk of developing diabetes among those on high dose statins was much lower than the nine per cent claimed by other studies.

In a meta-analysis of five statin trials, the researchers found the difference in diabetes risk between users of moderate and high doses of statin was extremely low, at around one per cent.

This linked to one new case of diabetes for every 237 patients, treated for two years, with a high dose statin.

MORE P29

Research

... FROM P28

Lead study author, Associate Professor Dr Suhail Doi from the University of Queensland, said the findings suggest that the increased risk of diabetes may not be large enough to counter statin benefits.

"Given the treatment effect in terms of cardiovascular prevention in previously reported studies is large and statin intervention has been well documented to reduce cardiovascular events and prevent death, this benefit will not be offset by the very small risk of onset of diabetes."

In a separate study, researchers from NSW showed that weight gain was a significant part of the increase in risk of diabetes in people taking statins.

Data from a five-year trial was analysed by 7595 patients consuming a low dose of 10mg, and a high dose of 80mg, of atorvastatin. They found that patients gained about one kilogram in weight in the first year of the study.

About 8 per cent of patients developed new-onset diabetes, and change in body weight was an independent predictor of diabetes.

"Our study indicates that a small weight loss, which can be achieved readily, can result in substantial reduction of new onset diabetes risk in both men and women," the researchers said.

Sanja Novakovic

COMMENT

Patient Googling could flag disease epidemic

The modern habit of patients consulting 'Dr Google' at the first sign of illness is sometimes bemoaned by the medical profession, but new research has shown that internet searches for an online diagnosis can provide early warning of an infectious disease epidemic.

The study, published in *The Lancet Infectious Diseases* medical journal, found that internet-based surveillance has been found to detect infectious diseases such as Dengue Fever and Influenza up to two weeks earlier than traditional surveillance methods.

But the study authors, from the University of Queensland's School of Population, Health and State, led by Dr Gabriel Milinovich, warned that internet-based approaches do not have the capacity to replace traditional disease surveillance systems, and should be viewed as an extension of such systems, rather than an alternative.

Senior Research Fellow at QUT's Institute for Health and Biomedical Innovation, Dr Wenbiao Hu, was one of the paper's authors.

He said there was often a lag time of two weeks before traditional surveillance methods could detect an emerging infectious disease.

"This is because traditional surveillance relies on the patient recognising the symptoms and seeking treatment before diagnosis, along with the time taken for health professionals to alert authorities through their health networks," Dr Hu said.

"In contrast, digital surveillance can provide real-time detection of epidemics."

Dr Hu said the study used digital surveillance through search engine algorithms such as Google Trends and Google Insights.

Using those online methods, the researchers concluded that it would have been possible to detect the 2005-06 avian influenza or 'Bird Flu' outbreak between one and two weeks earlier than official surveillance reports.

"In another example, a digital data collection network was found to be able to detect the SARS outbreak more than two months before the first publications by the World Health Organisation," Dr Hu said.

"Early detection means early warning, and that can help reduce or contain an epidemic, as well as alert public health authorities to ensure risk management strategies, such as the provision of adequate medication, are implemented."

The study also found that social media, including Twitter and Facebook, could be effective in detecting disease outbreaks.

"There is the potential for digital technology to revolutionise emerging infectious disease surveillance," Dr Hu said.

Dr Hu said the study had looked retrospectively at the effectiveness of digital surveillance systems, but Australia was well-placed to take the lead in developing a real-time infectious disease warning system.

MORE P30

Research

... FROM P29

"The next step would be to combine the approaches currently available, such as social media, aggregator websites and search engines, along with other factors such as climate and temperature, and develop a real-time infectious disease predictor," he said.

The study found it was important that future research explore ways to apply internet-based surveillance systems on a global scale.

"The international nature of emerging infectious diseases, combined with the globalisation of travel and trade, has increased the interconnectedness of all countries, and means detecting, monitoring and controlling these diseases is a global concern," Dr Hu said.

Debra Vermeer

COMMENT

Treatment rates for mental disorders

The treatment rates for mental disorders in Australia has risen sharply, according to a new study, with experts attributing the jump to the introduction of a Federal mental health initiative giving patients access to a Medicare rebate for psychological treatment.

The study, led by Professor Harvey Whiteford of the University of Queensland's Centre for Mental Health Research, found the population treatment rate for mental disorders in Australia rose from 37 per cent in 2006-07 to 46 per cent in 2009-10.

The authors concluded that the introduction of the Commonwealth's Better Access initiative, giving patients a Medicare rebate for mental health treatment, was the driver for the increased treatment rate.

"The increase in the population treatment rate for mental disorders in Australia from 37 per cent in 2006-07 to 46 per cent in 2009-10 is remarkable by international standards," their paper, published in *Australian Health Review*, said.

"No other country of which we are aware has demonstrated such an increase within three years."

The authors ruled out GP over-referral as a cause of the jump in treatment rates, saying that data on the severity of symptoms reported by people treated under the Better Access initiative showed that their treatment was genuine.

They said that, based on the current trend, they expected treatment rates to continue to rise unless there was some change to the Commonwealth-funded programs for mental health care.

"We also recognise that increased access to services is not sufficient to ensure good outcomes for those with mental disorders," they said.

"It is also important to ensure that evidence-based treatment is provided to those Australians accessing these services."

The paper said that mental disorders such as anxiety, depression and substance use are a leading cause of disease burden in Australia, but available evidence up to date had suggested that only a third of people with such disorders accessed treatment.

"Untreated disorders incur major economic costs and personal suffering," the authors said.

Up until now, it had been challenging to estimate the proportion of people with mental disorders who receive treatment for them.

With this study, Prof Whiteford and his team used survey data to estimate the number of Australians with a mental disorder in any year; a combination of administrative data on people receiving mental health care for the Commonwealth, States and Territories; and epidemiological data to estimate the number receiving treatment. They also used uncertainty modelling to allow for sampling error and assumptions on the estimates used.

The Australian Psychological Society welcomed the study, saying that, as well as improving access to psychological treatment, the Medicare rebate had contributed to a significant destigmatisation of seeking help for mental health problems.

"The availability of Medicare rebates for psychological treatment in private settings via GP referral has clearly resulted in many individuals using these services where previously they would not have done so," said APS executive director Professor Lyn Littlefield.

"The inclusion of mental health psychology services under the nation's funded health system has begun to promote interventions for mental health to a similar standing to physical health services funded under Medicare, which is an extremely important development."

Professor Littlefield noted, however, that the study shows that 54 per cent of people with mental disorders are still not accessing treatment and she warned against any further government cuts in the mental health area.

"We have already begun to see an erosion of the effectiveness of Better Access since funding cuts came into effect last year," she said.

"We need to protect the remarkable gains that have been made in treatment rates for mental illness since the Better Access initiative was introduced, and ensure the appropriate level of funding to provide these direct psychological services to people in need."

Debra Vermeer

COMMENT

Uganda anti-homosexuality law challenged

The World Medical Association (WMA) has written to the President of Uganda to express its concerns about anti-gay laws introduced by the African nation, urging him to reverse the measures.

President Yoweri Museveni signed an anti-gay Bill in February that some are condemning as among the toughest laws against homosexual people in the world.

The Bill punishes gay sex with up to life imprisonment, a measure likely to send Uganda's beleaguered gay community further underground.

The Ugandan law calls for first-time offenders to be sentenced to 14 years in jail. It sets life imprisonment as the maximum penalty for aggravated homosexuality, defined as repeated gay sex between consenting adults and acts involving a minor, a disabled person, or where one partner is infected with HIV.

President Museveni said scientists had written a report that found there was no proven genetic basis for homosexuality, citing it as a reason for the introduction of the Bill.

Chair of the WMA and former AMA President Dr Mukesh Haikerwal and the Secretary General of the WMA Dr Otmar Kloiber said that the science and ethics on which the Ugandan legislation is based is incorrect and that the new law will detract from the many advances in health care made in Uganda.

The letter states that WMA leaders met Uganda's Minister of Health early in March and appeared on Ugandan TV to voice their concern and state clearly that they believe the new law is violating what is now being seen across most of the world community as a basic human right.

Dr Haikerwal wrote that "the heinous crimes of child abuse and pedophilia are abhorrent and totally unacceptable but have nothing to do with sexual orientation but criminal actions". He said that "...it is correct to state, clearly and unequivocally, we are not aware of any medical reason or fault for bi-sexual or homosexual behaviour. Further, it is highly questionable that homosexuality poses a public health risk."

Dr Haikerwal said ultimately the Ugandan legislation must be reversed.

Late last week, Ugandan right's activists and politicians filed a legal challenge to overturn the law.

The Civil Society Coalition on Human Rights and Constitutional Law, which represents about 50 groups, filed the petition in the Constitutional Court, asking for the law to be annulled.

Since the introduction of the law the World Bank has postponed a $90m (£54m) loan to Uganda to improve its health services, and several European nations - including Denmark, Norway, the Netherlands and Sweden - have cut aid to Uganda to show their opposition to the law.

The sponsor of the law, MP David Bahati, insists that homosexuality is a "behaviour that can be learned and can be unlearned".

Kirsty Waterford

COMMENT

Cut sugar intake - WHO

The World Health Organization (WHO) has released updated guidelines encouraging people to halve their daily sugar intake as a means of combating obesity and tooth decay.

The UN health agency said that sugar should contribute only five per cent of an individual's daily energy intake, which is almost half their previously recommended daily amount.

The recommendation means that adults with a normal Body Mass Index should consume less than six teaspoons of sugar each day. This limit includes all sugar added to food and beverages as well as natural sugar found in things like honey, syrups, and fruit juices.

The WHO estimates that half a billion people are affected by obesity worldwide. At least 2.8 million adults die each year as a result of being overweight or obese.

The WHO's Director of Nutrition for Health and Development Dr Francesco Branca said the recommendation is part of the global fight against obesity.

"It is definately worsening. We calculate there's half a billion people that are affected by obesity, and that is on the rise," Dr Branca said.

"We see more and more kids, even from early ages such as before five years, getting more and more overweight and obese, even in low and middle-income countries."

"Much of the sugars consumed today are hidden in processed foods that are usually not seen as sweets."

The WHO warned that a single can of sugar-sweetened soda contains about 40 grams – or 10 teaspoons – of sugar.

The Public Health Association of Australia and the Obesity Policy Coalition have welcomed the recommendations.

Kirsty Waterford

COMMENT

Vitamin D testing rates fall in New Zealand

The rates of unnecessary vitamin D testing in New Zealand have dropped by a staggering 70 per cent since 2010, thanks to the implementation of new testing guidelines, a leading pathologists' group says.

The Royal College of Pathologists of Australasia's Dr Michael Crooke says the rapid decline in unnecessary vitamin D testing in New Zealand is a direct result of the new recommended clinical guidelines.

"The recommended clinical guidelines on vitamin D testing have led to an extremely positive effect on the way in which these tests are requested in New Zealand," Dr Crooke said.

"Seeing this dramatic reduction first-hand has confirmed our views on the excessive nature of a large proportion of these requests.

"I would suggest that, over time, it is highly likely that vitamin D tests will continue to decrease further."

A study released last year in the British Medical Journal found that the rate of vitamin D testing in Australia increased 94-fold from 2000 to 2010. Eighty per cent of the tests were ordered by GPs and 20 per cent by specialists.

The study's authors concluded that the rate of testing for vitamin D was increasing "exponentially at an unsustainable rate" and that the consequences of such over-testing were widespread in terms of costs and effectiveness.

The RCPA released a position statement on the measuring and monitoring of vitamin D in May 2013 in which they recommended against routine screening for deficiency.

The rate of testing increased following concerns that many cases of vitamin D deficiency were being missed.

Australian Medicine previously reported that research conducted by the Baker IDI Heart and Diabetes Institute estimated that 31 per cent of Australian adults had a vitamin D deficiency, which was assessed as severe in 4 per cent of cases, while a separate NSW-based study reported that up to 58 per cent of adults might have a deficiency of the vitamin.

The consequences of deficiency can be severe, according to the Department of Health and Ageing. It says prolonged deficiency could cause rickets in children and osteoporosis and softening of the bones in adults. It can also be associated with chronic kidney disease, Crohn's disease, and cystic fibrosis.

Speaking on the latest drop in testing rates in New Zealand, RCPA spokesperson, Dr Paul Glendenning says routine testing for vitamin D is unnecessary for people with an active lifestyle.

"The previously seen increase in vitamin D testing is unsustainable," Dr Glendenning said. "The RCPA recommends that vitamin D testing is not performed as routine screening.

"As the main source of vitamin D is UVB sunlight exposure, vitamin D levels are correlated with time spent outdoors, exercise and other aspects of a healthy lifestyle, including body weight. For healthy adults, infants and pregnant women who don't have any other risk factors for vitamin D deficiency, we do not currently recommend routine screening."

Dr Glendenning added, however, that people at particular risk of vitamin D deficiency should be tested on a case-by-case basis

"It's justifiable to test those individuals who have a higher risk for vitamin D deficiency. Routine screening is not currently justified, so a case-finding strategy is appropriate."

Clinical guidelines in New Zealand differ slightly to Australia in this area, with some patients in the high risk category for deficiency being routinely supplemented without undergoing vitamin D testing.

Debra Vermeer

COMMENT

It's a mirage!

BY **DR CLIVE FRASER**

Mitsubishi Mirage ES	
For	Economical, lots of fruit, good value, NRMA "2013 - Cheapest car to own and run".
Against	Plenty of great second-hand cars for the same money.
This car would suit	Medical students.
Specifications	1.2 litre 3 cylinder petrol 57 kW power @ 6,000 rpm 100 Nm torque @ 4,000 rpm 5 speed manual 4.6 l/100 km combined $12,990 drive-away (without dents)
Fast facts	The Mitsubishi Mirage is built at Laem Chebang (25 kilometres north of Pattaya) in Thailand.

Chinese-made cars have been on Australia's roads since 2009.

Their only selling point is that they are cheap to buy, but that does not mean that they are good value.

We have all heard stories of how Chinese manufacturing will keep bringing prices down and we have all seen over the last few months how un-competetive Australian car manufacturing has been driven into the ground.

It is entirely logical to believe that cars will always be more cheaply made overseas in countries where there is no annual leave, no superannuation, no workers' compensation, and where wages are low.

When Australian workers' conditions drift downwards to be similar to those in China we'll then be able to compete with the Chinese on price.

Will Australian workers be happy to give up their hard fought conditions? I think not.

But Campbell Newman is testing the water in Queensland where he's asking 3500 senior medical officers to sign contracts which are simply unfair.

Doctors in Queensland, most of whom have been very devoted to the public system throughout their careers, face a very uncertain future.

The contracts provide no protection for unfair dismissal and can be changed by Queensland Health any time after being signed by the doctor.

Signing a contract with Queensland Health is like signing a blank cheque.

While public hospital doctors have been told that they can trust the government "to do the right thing", experience in Queensland suggests otherwise.

And, in a State with no Upper House, no proportional representation and only one major newspaper (controlled by an American), Queenslanders will always have to fight for fairness.

My own recent experience with Queensland Health may serve as a warning of what lies ahead.

I have worked for Queensland Health ever since graduating, 32 years ago.

I have been a loyal employee. I have always put the patients' interests first. I have always enjoyed teaching and the collegiate atmosphere of the public hospital. I also have a busy private practice.

Suffice to say that, in September 2013, I was given three hours notice of a meeting where my "position" was going to be "discussed".

When I complained that three hours was not enough notice, I was really left with no option other than to go to the meeting where I was told that my VMO position had been "abolished".

I had worked as a VMO at the local public hospital for 24 years.

I was told that I had three options.

The first one was to seek a transfer, but there were no other VMO positions to transfer to.

The second option was that I could appeal against the decision to abolish my position, in which case I would be given three months notice in writing and my employment would be terminated anyway.

MORE P34

It's a mirage!

... FROM P33

The final option was to accept a redundancy package.

And if I decided to accept redundancy I would also have to waive my rights to receive 14 days written notice of the offer and I would have to sign all the paperwork some time in the next 24 hours.

It all seemed very hasty and disorganised, but most of all it seemed very unfair.

On my first day of absence, the patients arrived, but no doctor was rostered to be at my clinic.

Just as well that it was an ECT Clinic, and not brain surgery.

This is the sort of experience that I think my public hospital SMO colleagues can expect if and when their conditions of employment change.

Just like there are more people who believe in God and attend Church after experiencing an earthquake, there will be many more doctors who will become AMA members simply because collective negotiation is really the only thing that gives workers any hope of being represented.

So I have been waiting for quite a while for Chinese cars to flood the Australian market.

It does not seem to have happened, though there are plenty of cars coming to Australia that are made in Thailand, Malaysia, and South Africa.

Without import tariffs on cars, we were all given the prospect that you might be able to buy a car in Australia for under $10,000 on the road.

While cars have never been cheaper, I have struggled to find that deal.

That was until two weeks ago when I saw that you could buy a brand new Mitsubishi Mirage ES Manual for $9,990 on the road drive-away.

A colleague had just bought an automatic Mirage LS for $14,200 including on-road costs, but his car was an automatic and had additional features such as a Sports Kit, 15 inch alloy wheels, climate-control air-conditioning and automatic headlamps and wipers.

Either way, all Mitsubishi Mirages come with 5 doors, 5 seats, 5 years roadside assistance, and a 5 year warranty.

I rang him to tell him that I finally found a new car for sale in Australia for under $10,000 on the road.

I was excited. It was almost like the day I graduated.

He was disbelieving. He said to me, "Are you sure that's the right price?"

I said, "It's there in black and white, it's right in front of me, it's $9,990 drive-away".

It was then that I realised that I had failed to read the fine print.

While the car was "brand-new", there was a note next to the picture of the car that said there was "slight hail damage".

This note was not actually in fine print and I could never complain about the advertisement being misleading.

I had just seen the price and forgotten to look at the rest of the page.

I think there is a lesson in this for all the doctors who are being asked to sign the Queensland Health contracts.

There will always be a catch, and one should not trade off hard-earned employee entitlements simply because the government has such a large majority and believes that it can bully its workers into submission.

Safe motoring,

Doctor Clive Fraser

Email: doctorclivefraser@hotmail.com

PS There is, of course, one Chinese-made car for $9,990 drive-away.

It's the Chery J1.

While it does have four cylinders, it prefers PULP, and uses 46 per cent more fuel than the Mirage.

It's also heavier, slower and less safe (only 3 stars on ANCAP) than its competitor.

For my money the Mitsubishi Mirage is better value, even with the dents!

COMMENT