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The national news publication of the Australian Medical Association

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In this issue

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VICE PRESIDENT'S MESSAGE

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

Activity-based funding is here

A system of activity-based funding (ABF) has been in place in some states, Victoria for example, for a while.

Now the momentum is towards a nationally consistent approach to ABF, with the national efficient price and national efficient cost (for small hospital block funding) determined by the Independent Hospital Pricing Authority (IHPA).

The AMA has been involved with the IHPA from the start, providing feedback through its Stakeholder Advisory Committee on such things as the integration of new health technologies and innovation into the ABF model, the implications of rural locations and social disadvantage for health costs, and priority areas for the refinement of ABF, including sub-acute and emergency department care.

The national efficient price for a weighted activity unit (WAU) is determined by IHPA from information provided by jurisdictions, and is approximately $5000. Every hospital admission is then allocated a number of WAU depending on its complexity, comorbidities, complications and so on, as well as taking into account whether they are an Aboriginal or Torres Strait Islander, live in a rural or remote area, or are a child. The Commonwealth then pays the State a proportion of the calculated amount, which in turn is topped up by the states to more or less than the national efficient price before the funds percolate through the health system to the hospitals providing the service.

> "... not all hospital costs are captured by their clinical activity. A good example is the costs of teaching, training and research, which are currently block funded"

While it might appear complex, that is actually a somewhat simplified version of ABF in action.

For a start, not all hospital costs are captured by their clinical activity. A good example is the costs of teaching, training and research, which are currently block funded.

IHPA is working through a process to determine a means, if it can be found, to measure the teaching, training and research activity and cost. Again, the AMA and our Council of Doctors in Training are involved in the group that has oversight of this work.

The effect of ABF is to translate the work done by our hospitals into a single unit price.

The concept is not unique. For example, there is a single national price for delivering an envelope of a given size and weight, no matter where in Australia it is posted or delivered. That works because Australia is treated as a single jurisdiction where the 'winners' and 'losers' are balanced out.

In health, we have eight different jurisdictions for public hospital services, so a national efficient price that assumes similar cost structures, transport costs and so on across them all is bound to have its critics.

An 'efficient price' may work within a relatively small area, but will struggle to be as rational across multiple jurisdictions, even when modified to take into account factors such as location, age and background. Equality of funding is not necessarily equity.

Supporters of ABF suggest it drives efficiency and productivity. A recent Grattan Institute report points to the variations in cost for a hip replacement in hospitals doing more than 200 a year: $9700 in one hospital, $23,400 in another. Costs for a laparoscopic cholecystectomy were similarly found to vary widely, between $4100 and $7900.

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Activity-based funding is here

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The ABF system envisages there will be cost variations between individual patients - people are not a homogeneous product - but assumes that these will be averaged out across the population treated.

The assumption from the Grattan Institute is that cost variations reflect differences in 'productivity' but the alternative, that there are between patient differences that are not explained within ABF, needs to be explored, as does differences in coding between hospitals.

The AMA has always said it should be about having an effective price - one that recognises the need to provide quality individual health care, rather than just an 'efficient' price. An efficient price is touted as driving productivity, but in an industry where significant drivers of costs are labour and length of hospital stay, it is clear that increased productivity may come at a cost to health consumers of inconvenience or reduced quality of care.

Health care has much more in common with running a restaurant than a factory.

Having skilled chefs and wait staff, each with a defined and essential role, is fundamental to the customers' restaurant experience, and cutting the staff-to-customer ratio will lead to complaints. As in health care, increasing productivity by implementing new technology and streamlining processes is possible. But such things as providing information and advising on choices take a finite time, as does the preparation of a dish. To rush risks impairing quality, as it does in health care.

The pursuit of productivity should not come at the cost of dehumanising patients, which is a risk in the search for efficiency.

Sensibly, IHPA have incorporated an evaluation of the effects of ABF into their work plan, and will be taking submissions.

The AMA will be collating advice from our members to inform our submission.

If you are aware of any adverse effects from the wider introduction of ABF, such as a loss of unfunded or under-funded patient services, or any positive effects, such as increased access to patient services, please let me know at vicepresident@ama.com.au.

COMMENT

INFORMATION FOR MEMBERS

Australian Medical Association Limited ACN 008 426 793 ABN 37 008 426 793

Notice of Annual General Meeting

Notice is hereby given that the Fifty-Third Annual General Meeting of members of Australian Medical Association Limited will be held at 4.10pm on Friday 23 May 2014 at the National Convention Centre, Canberra, Australian Capital Territory.

Business:

1. To receive the Minutes of the Fifty-Second Annual General Meeting held in Sydney on Friday 24 May 2013.
2. To receive and consider the Annual Report of Australian Medical Association Limited for the year ended 31 December 2013.
3. To receive the audited Financial Reports for Australian Medical Association Limited and its controlled entities for the year ended 31 December 2013.
4. To appoint auditors for Australian Medical Association Limited and its controlled entities.
5. To consider, and if thought fit adopt as a special resolution, the following motion:

   That the Memorandum and Articles of Association of the Company be repealed and replaced by the new Constitution in the form exhibited to Members at https://ama.com.au/constitution
6. To transact any other business which may properly be transacted by an Annual General Meeting.

A member eligible to vote at the Annual General Meeting may appoint a proxy in accordance with Clause 22 of the AMA Articles of Association. A proxy need not be a member of Australian Medical Association Limited (section 249L Corporations Act). To be effective the proxy form must be deposited at the below place not less than 48 hours before the time for holding the Annual General Meeting.

Proxies are to be deposited with Australian Medical Association Limited by mail or hand delivery to:

Secretary General (Company Secretary)
Australian Medical Association Limited
AMA House
42 Macquarie Street
Barton ACT 2600

A proxy form can be accessed at https://ama.com.au/proxy.

Ms Anne Trimmer
Secretary General
21 March 2014

Pay for GP performance no health solution

AMA President Dr Steve Hambleton has warned the introduction of performance pay for doctors risks compromising care and should only be considered as an adjunct to the current fee-for-service model.

Federal Health Minister Peter Dutton is considering a fundamental shift in the way GPs are paid as part of an overhaul of health funding, and has raised the possibility doctors would be paid an annual fee to care for their patients as part of a "blended" system of payments, often referred to as capitation payments.

The Minister told a general practice conference last month there was "an opportunity for us to perhaps look at doctors and other stakeholders in the conversation about blended payments".

And in a speech to the Australian Private Hospital Association on 24 March, Mr Dutton said it "makes no sense" for taxpayers to foot almost all the bill for primary health care "when the patient is prepared to contribute to their own costs".

"The focus of the Commonwealth should be on getting our primary care response right, particularly for the chronically diseased and aged," the Minister said. "We need to look at the payment models and the way in which we manage the most frequent users."

Mr Dutton voiced keen interest in increasing the involvement of private health funds in the provision of primary care, noting approvingly the Medibank Private trial with several GP clinics in Queensland, the HCF after-hours GP service for members and the deal struck by Bupa with medical centre operator Healthscope.

"I am encouraged to see that health insurers are looking at innovative options in the area of primary health care," he said. "They have been excluded from the primary care space for historical reasons, and if insurers are prepared to work collaboratively with doctors and patients, then we should welcome that development."

The Minister said he would not consider initiatives that would involve patients opting out of the Medicare system, but would entertain ideas that would allow insurers to target "frequent users" of GP services.

The nation's largest health insurer, Medibank Private, has backed the idea of capitation payments to doctors, arguing that they would encourage GPs to keep in

regular contact with patients and to make follow-up calls with specialists as part of efforts to keep high-needs patients out of hospital, so avoiding unnecessary costs.

But Dr Hambleton cautioned pay for performance systems for GPs carried a number of risks without necessarily delivering much in the way of better care.

The AMA President told the International Primary Health Care Reform Conference in Brisbane on 19 March that international experience showed that while pay-for-performance systems changed the way doctors worked, there was little evidence to suggest they saved money or improved the quality of care.

"Cochrane reviews of a range of schemes in a range of countries that use financial incentives to reward performance and quality have determined there is little rigorous evidence of their success in improving the quality of primary health care," he said. "Nor is there much evidence pay for performance is cost effective relative to other ways to improve the quality of care."

Several leading health policy experts, including Grattan Institute Health Program Director Professor Stephen Duckett and UNSW Emeritus Professor of Medicine John Dwyer, have joined the AMA in describing proposals for a $6 patient co-payment for GP visits as a distraction.

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Pay for GP performance no health solution

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Instead, they have urged a more ambitious and holistic approach to reform that directs funding toward tackling the underlying causes of ill health and hospitalisation, particularly the rise of non-communicable diseases associated with poor diet, inadequate exercise, smoking, drinking and other harmful behaviour.

Professor Dwyer said integrated primary health care programs with a focus on education, prevention and early diagnosis would, for an initial upfront investment, save billions of dollars and improve national health, citing as evidence research showing 600,000 hospital admissions could be avoided each year with effective community intervention in the preceding three weeks.

Dr Hambleton said that through the current fee-for-service funding model GPs were providing excellent value for money, and the Government should increase support for them to provide the sort of care needed to maintain help and keep the chronically ill out of hospital.

“Fee-for-service should remain as the cornerstone funding source for general practice,” the AMA President said, accompanied by greater support for longer consultations, more effective support for chronic disease management and “appropriate mechanisms for quality improvement”.

He said the AMA was prepared to consider blended payment models as an adjunct to fee-for-service payments, but was wary of the potential for adverse outcomes.

Dr Hambleton said the risks of performance payment arrangements could not be ignored, and included the potential for doctors to focus only on activities that were rewarded, to cherry pick healthier patients rather than taking on those with chronic and complex conditions, to encounter greater red tape, and to subject them to inappropriate criteria.

He said there was already an imbalance in the existing rebate system that rewarded high patient turnover rather than extended consultations and team-based care, and warned any pay-for-performance system would need safeguards to ensure the quality of care was enhanced rather than undermined.

It should be a supplement to fee-for-service payments, align with clinical practice, be indexed, encourage appropriate clinical and preventive health care services and minimise administrative burden.

“It is all about the right care at the right time in the right place by the right practitioner – the GP,” Dr Hambleton said.

Adrian Rollins

COMMENT

GP co-payment ‘not considered’ by Govt: Minister

A Federal Government Minister has been forced to backtrack after appearing to rule out the introduction of a patient co-payment for GP services.

After declaring to the Senate on 20 March that that “the Government has not considered the introduction of a co-payment for Medicare services”, Assistant Health Minister Fiona Nash notably refused to repeat her assertion when questioned in Parliament four days later.

Asked on 24 March whether the Government was considering a co-payment for GP services, Senator Nash instead said, “My advice was that the Government had not considered the introduction of a co-payment for Medicare services”.

The backflip suggests that a co-payment or some other change to funding for GP services, such as tiered system of rebates based on means testing, remain under active consideration by the Government as it digests the findings of its Commission of Audit and constructs the 2014-15 Budget.

Senator Nash told the Parliament that “to assist the Government to provide subsidies for clinically necessary treatment and services through Medicare, the National Commission of Audit is charged with examining the scope for efficiency and productivity improvements across all areas of Commonwealth expenditure”.

That a patient co-payment for GP services is under examination was confirmed by a senior Health Department bureaucrat during a recent Senate Estimates hearing.

Dr Richard Bartlett, First Assistant Secretary of the Health Department’s Medical Benefits Division, told the hearing on 26 February that, “We have done a range of work over a long period of time about co-payments in the MBS. That work continues.”

Senator Nash’s comments follow months of speculation about the possible introduction of upfront charges for GP visits after former Coalition ministerial health adviser Terry Barnes proposed a $6 patient co-payment as a way to deter people from making unnecessary visits to their doctor.

Mr Barnes suggested the co-payment, matched by a similar charge for emergency department patients, as a way to help control rising health expenditure in a submission presented to the Commission of Audit by the Australian Centre for Health Research.

But the AMA said the co-payment proposal was not credible.

In a devastating critique, AMA President Dr Steve Hambleton said the idea was poorly conceived, simplistic in its analysis, riddled with logical flaws and wildly inaccurate in its conclusions.

In a submission to a Senate select committee inquiring into the Commission of Audit (an edited version of the submission is

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GP co-payment 'not considered' by Govt: Minister

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at: *Flawed co-payment proposal does not stack up, p36*), Dr Hambleton wrote that, among its "very significant flaws", the ACHR assumed that unless there was a policy change, GP service volumes would grow at an annual rate of 3 per cent – well above the annual average gain of 2.24 per cent experienced since the commencement of Medicare in 1984-85.

"By choosing a high-growth rate for the base case," Dr Hambleton said, "ACHR has painted an overly optimistic picture of the scope for budget savings under their co-payment proposal."

The AMA President said ACHR's projections regarding the effect of a co-payment were also flawed.

He said that while imposing a co-payment might have a short-term "shock effect", most households would absorb the cost and see their GP as before because health is regarded as a superior good.

The effect of the co-payment would be most visible and direct on those without the capacity to pay more, and any reduction in GP visits among the financially vulnerable would almost certainly result in a rise in more expensive, and avoidable, hospital stays.

Dr Hambleton said the ACHR managed the extraordinary feat of making co-payment savings estimates that were simultaneously too high and too low.

He said they were too high because of the simplistic assumption that the co-payment would be charged without an up-front reduction in nominal Medicare rebates.

Dr Hambleton said this was not credible, particularly in urban areas, where competition between GPs would make universal application of the co-payment "highly unlikely".

He said the projected savings were too low because they underestimated that savings made from the GP fee freeze that was part of the proposal, and was likely to save the Government $1.1 billion over four years.

"It will be self-evident that rebate cuts of that order would represent a very significant reduction in Government support for patients needing to see a GP," the AMA President warned.

Dr Hambleton said there was no evidence of widespread over-use of GP services and, rather than looking at co-payments, the Government should work with the medical profession on ways to better support GPs in their gatekeeper and preventive health roles.

A Fairfax Media/Nielsen Poll found that voters were evenly split on a GP co-payment, with 49 per cent in favour and 49 per cent opposed – though, as health policy expert Jennifer Doggett pointed out, caution should be exercised in interpreting the result given lack of alternative funding options presented to respondents.

But the Australasian College for Emergency Medicine is the latest to join the chorus of condemnation, arguing a co-payment for emergency department (ED) patients was a poorly conceived idea.

College President Dr Anthony Cross said ready access to emergency care was a fundamental part of the health system, and a co-payment would deter patients from seeking necessary care.

The College said there was very little evidence that patients were seeking emergency care inappropriately, and added that it would be impossible in practice to distinguish between patients who should and should not have attended the ED, for the purposes of charging a co-payment.

Adrian Rollins

COMMENT

Health gets cheaper, not more expensive

Federal Government claims of unsustainable growth in health spending has been undermined by figures showing the share of tax revenue used to cover health costs is declining.

Health expenditure accounted for little more than 20 per cent of the annual Commonwealth tax take during most of the 2000s and, after spiking above 28 per cent during the height of the GFC – when tax revenues plunged – has slid lower, data compiled by the Australian Institute of Health and Welfare show.

According to figures in the AIHW report *Health expenditure Australia 2011-12: analysis by sector*, the ratio of Federal Government health spending to tax revenue eased steadily down between 2001-02 and 2006-07, from 22.3 per cent to 20.5 per cent, before surging to 28.6 per cent in 2009-10 (when the tax take plummeted 7.6 per cent).

It has subsequently resumed its long-term decline, dropping to 26.2 per cent in 2011-12, as tax revenues have recovered.

The analysis belies Government claims of an unsustainable spiral in health costs, which it has used to frame discussion of changes to the funding of primary care.

In a major speech last month, Health Minister Peter Dutton said the health system needed to be fundamentally recast if it was to continue to be effective.

Mr Dutton said there was "an opportunity for us to perhaps look at doctors and other stakeholders in the conversation about blended payments".

The AIHW report found that, since 2001, the Commonwealth has lifted its spending on primary care while scaling back on hospital expenditure, while the states and territories have done the opposite.

Overall, hospitals received around a 40.5 per cent share of total recurrent government spending for the 10 years to 2011-12, while primary care's share has slid slightly, from close to 40 per cent in 2001-02 to 38.2 per cent in 2011-12.

Adrian Rollins

COMMENT

Watch out for the privates

The AMA has signalled qualified support for a bigger role for private health insurers in the provision of primary health care services.

As private health funds intensify their push for a greatly expanded role, the AMA has said it is time for the Government, the medical profession and the industry to look at how to increase their involvement in a way that supports doctors and improves patient care.

AMA President Dr Steve Hambleton said complete deregulation of GP funding by private health insurers (PHIs) was unacceptable, but limited and well-targeted reforms could enhance patient care and save money.

"By supporting a greater role for GPs in private health insurance arrangements, there is the potential for the coordination of patient care to be improved, for care to be provided in the most appropriate clinical settings, and unnecessary hospital admissions to be avoided," Dr Hambleton said. "[But] we do not support any move to completely deregulate the funding of GP services by PHIs, or any changes that would undermine the principle of universal access to health care."

Under the *Private Health Insurance Act 2007*, health funds are blocked from providing cover for out-of-hospital services which are subject to Medicare benefits, such as GP services. Instead, they are allowed to provide cover for a limited range of preventive and allied health services.

In its *Position Statement on Private Health Insurance and Primary Care Services 2014*, released on 20 March, the AMA said there was scope for PHIs to be involved in GP-led wellness programs, the maintenance of electronic health records, supporting hospital in the home services, palliative care, minor procedures and GP-directed hospital avoidance programs.

But it said any such developments would have to be underpinned by recognition of the centrality of the GP in coordinating patient care, and would need to avoid managed care by preserve clinical autonomy and patient choice, as well as recognising the right of practitioners to set their own fees.

"Any move to expand the role of private health insurers should be carefully planned and negotiated with the medical profession to ensure that the outcome is in the best interests of patients, does not compromise the clinical independence of the profession, or interfere with the doctor-patient relationship," Dr Hambleton said.

The AMA President said a key concern about current arrangements was that many procedures covered by PHIs for their members, such as physiotherapy, exercise physiology and dietary services, were provided in isolation from GPs.

"This is a significant problem, with the potential to fragment patient care," he said.

The release of the Position Statement came as Medibank Private unveiled plans to expand a controversial pilot program under which six Queensland medical practices have agreed not to charge out-of-pocket fees for patients in exchange for the fund covering part of their administrative costs. The insurer wants to extend the scheme to a further 20 or 30 clinics this month.

Another large insurer, NIB, wants to be able to pay GPs to provide management plans for diabetes and other chronic diseases, as well as to provide home visits.

The moves have come in a more welcoming environment for private funds, with Health Minister Peter Dutton flagging Government interest in developing a greater role for the private sector in the provision of health services, including primary care.

The AMA Position Statement can be viewed at: https://ama.com.au/position-statement/private-health-insurance-and-primary-care-services

Adrian Rollins

COMMENT

Cutting down on the bulk

The Federal Government has refused to rule out suggestions it is planning to limit access to bulk billing as part of a system of tiered GP rebates.

The *Australian Financial Review* has obtained details of a Department of Health plan under which Medicare rebates for GP services would be paid according to a three-tiered scale.

General practitioners would receive the highest rebate (sufficient to support bulk billing) for treating children and concession card holders; would get a lesser amount for seeing patients who eligible for Family Tax Benefit A; and would receive the lowest rebate for treating all other patients.

According to the *AFR* report, the Department estimated the reform, which was rejected by the former Labor Government, would save $860 million over five years.

A spokesman for Health Minister Peter Dutton declined to comment on the proposal, but the Minister has said Medicare needs to change in the face of spiralling costs.

In a major speech last month, Mr Dutton indicated he was considering a system of "blended" payments for GPs, including an annual fee for each patient rather than the purely fee-for-service model of remuneration used now.

The Health Minister has also expressed concerns about taxpayer-subsidised access to GPs for all patients, regardless of income or assets, expressing the view that it was not unreasonable for the better off to make a greater contribution to the cost of their care.

But AMA Council of General Practice Chair Dr Brian Morton warned many doctors were likely to walk away from bulk billing altogether if the Government adopted the plan.

Dr Morton said the discretion of whether to bulk bill or not should be left with GPs, who were best able to act in the interests of their patients.

A Fairfax Media/Nielsen Poll conducted before revelations of the Health Department plan found any move to means test access to bulk billing for GP services could be divisive.

The poll found that while 52 per cent were receptive to such a move, 46 per cent were opposed – with Coalition voters (55 per cent) the most supportive of the idea.

Adrian Rollins

AMA wins protection for rural GPs

The AMA has achieved a significant advance in protecting the interests of rural GPs working as Visiting Medical Officers after securing authority to collectively bargain on their behalf.

In a decision seen as important in helping to attract and retain doctors in rural areas, the Australian Competition and Consumer Commission has renewed the AMA's authorisation to collectively bargain with State and Territory health departments regarding terms and conditions for rural GP VMOs.

The renewed bargaining authority is for the next 10 years, and covers all states and territories except New South Wales (where AMA NSW already has bargaining authorisation in its own right) and the ACT (which is not classified as a rural area).

AMA President Dr Steve Hambleton said the ACCC's decision was a welcome outcome that would not only make it more efficient and less costly to negotiate conditions for rural GP VMOs, but would help support the rural medical workforce.

"The ACCC accepted the AMA's submission that the ability to negotiate mutually beneficial contracts may also lead to greater attraction and retention of doctors in rural areas, where access to sufficient medical services would otherwise be limited," Dr Hambleton said.

Adrian Rollins

Call for calm as Qld contracts dispute enters dangerous territory

The AMA has called for an immediate moratorium on the controversial Senior Medical Officer contracts being rolled out by Queensland Health as President Dr Steve Hambleton urged the resumption of negotiations to resolve the dispute.

In an unexpected escalation of the dispute, Queensland Health late last week sought a Federal Court injunction to stop the AMA, the Australian Salaried Medical Officers Federation and Together Queensland providing their members with what it said was inaccurate and misleading information regarding to proposed contracts.

Dr Hambleton said the legal action was disappointing, and denied the AMA had been misleading its members.

"I've been attempting to be very careful about presenting the facts to the doctors to make sure they've got a fair opportunity to make a fair decision," the AMA President said.

After signs of progress, the contract dispute descended into acrimony late last month when a mass meeting of public hospital doctors at the Brisbane Convention Centre rejected an offer by Health Minister Lawrence Springborg, prompting a belligerent response by Premier Campbell Newman in Parliament.

In comments that inflamed the dispute, Mr Newman accused the doctors of being motivated by money, and warned the Government would recruit doctors from overseas to replace any who resigned from the public hospital system.

"It is about money and remuneration, it is about pay and conditions, it is about collective bargaining, and not about patients," the Premier said, adding that the doctors involved were not "lowly workers on a factory floor [but people who were] highly trained [and] well remunerated".

"If people do choose to resign, we will have in place arrangements to replace those people, and if we have to recruit people from interstate or overseas, we shall," Mr Newman said. "Do not doubt the Government's resolve. Do not doubt that we will see this thing through."

Dr Hambleton said that the breakdown in goodwill on both sides meant the dispute had entered dangerous and uncertain territory, and called for cooler heads to prevail to get negotiations back on track and avoid serious and long-lasting damage to the State's health system.

"It is not time to put petrol on the fire," the AMA President said. "There is a very real possibility of mass resignations by highly-qualified and dedicated senior doctors who have lost trust in the process to date."

Dr Hambleton said that, contrary to the views of some, any doctors who did resign would not be easily or quickly replaced, and it was time for all involved to take a step back and proceed more calmly.

The pressure of short timeframes for detailed discussions and an unrealistic deadline for an agreement brought things to a head," he said. "There was no time for the doctors to absorb the complexity of the changes being offered by the Government.

"We have now had sufficient time for everybody to vent their emotions and frustrations, and let their cool heads and clear thinking prevail.

"The right thing for the Queensland people is for a return to the negotiations to re-establish the goodwill and momentum that was producing genuine progress."

Prior to the breakdown in talks, Mr Springborg had offered to issue a directive removing the ability of the Queensland Health Director-General to unilaterally alter employment conditions, and to introduce an addendum to the contracts to establish binding dispute resolution procedures, to ban transfers without consultation and to provide for unfair dismissal processes.

In addition, Queensland Health Director-General Ian Maynard said the changes would be backed variations to the Hospital and Helath Boards Act 2011, and the implementation of the contracts would be subject to an independent review after 12 months.

Dr Hambleton said the AMA and senior doctors were not opposed to contracts, but they must be fair and equitable.

He called for a suspension of the roll-out of the contracts to allow for negotiations in good faith.

The Government has demanded that doctors sign the contracts, which are due to come into effect on 1 July, by the end of April or risk forgoing up to 30 per cent of their pay.

The AMA President warned it could be "catastrophic" if the dispute was not settled by the end of the month.

"I really think we have to pull out all stops. The consequences of not getting it resolved are just unthinkable," he said. "It took two years to fix Caboolture Hospital when we couldn't get doctors to attend in that location, and if that happened in more than one location, it would be catastrophic. So it has to be fixed."

Adrian Rollins

COMMENT

Common sense prevails on social media testimonials

Doctors will no longer be held responsible for unsolicited testimonials on social media sites out of their control after the Medical Board of Australia bowed to pressure from the AMA, medical practitioners and the media.

In a move widely welcomed as a victory for common sense, the Board last week announced that Australian Health Practitioner Regulation Agency advertising guidelines will be changed to make it clear that medical practitioners will not be held liable for removing unsolicited testimonials "on a website or in social media over which they do not have control".

The decision came two days after AMA President Dr Steve Hambleton raised the issue directly with the Medical Board Chair Dr Joanna Flynn.

Dr Hambleton pointed out to Dr Flynn that the advice the Board provided to practitioners through its Frequently Asked Questions document was sharply at odds with the requirements as set out in section 6.2.3 of the *Guidelines for advertising regulated health services* under the Health Practitioner Regulation National Law.

According to the guidelines, "a practitioner must take reasonable steps to have any testimonials associated with their health service or business removed when they become aware of them, even if they appear on a website that is not directly associated and/or under the direct control or administration of that health practitioner".

But in its Frequently Asked Questions advice, the Board said that: "Practitioners are not responsible for removing (or trying to have removed) unsolicited testimonials published on a website or in social media over which they do not have control".

Dr Hambleton told Dr Flynn that it was "unacceptable" for there to be such contradictory information, and called for the immediate withdrawal and revision of the guidelines.

The AMA President said the FAQ advice was the most sensible approach to the issue, and the AMA accepted the requirement that doctors should not share or re-tweet patient comments on social media that promoted their practice or service.

The Medical Board had also come under pressure from a coalition of doctors, led by Melbourne reconstructive surgeon Dr Jill Tomlinson and backed by the *Medical Observer*, to change the guidelines.

Dr Tomlinson led the #AHPRAaction campaign, with gathered more than 750 signatures for a petition which warned the guidelines placed "an unreasonably onerous burden on all health practitioners…[and] demonstrate a lack of understanding of the use of social media in Australia in 2014. They restrict consumers' rights to express their positive experiences of health care".

In its announcement, the Medical Board said that it did not have the authority to change the advertising requirements of the National Law, but added that the section 6.2.3 of the guidelines would be altered.

"Until this change is made, AHPRA will be applying the guidelines consistent with information in the FAQs," the Board said.

"This means practitioners are not responsible for removing (or trying to have removed) unsolicited testimonials published on a website or in social media over which they do not have control.

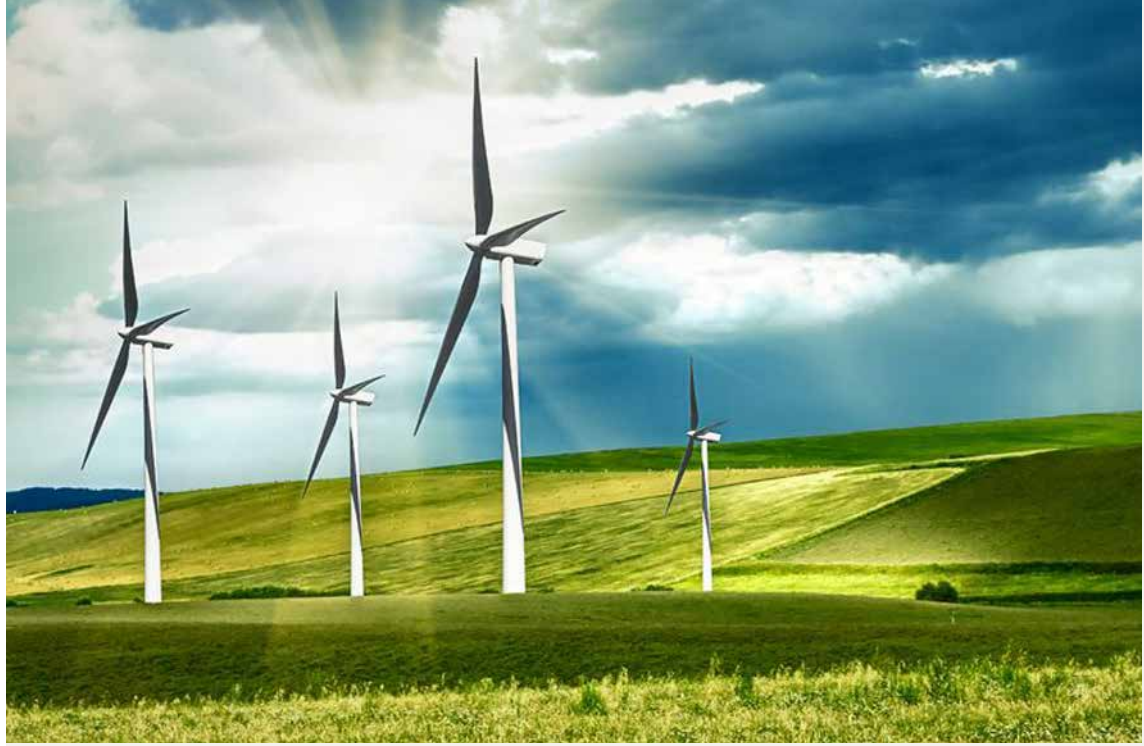
"The Medical Board of Australia will now work with AHPRA and the other 13 National Boards to progress this change."

The Medical Board announcement can be viewed at: http://www.medicalboard.gov.au/News/2014-03-26-mba-to-change-advertising-guidelines.aspx

Adrian Rollins

COMMENT

Wind farm health fears blown away



There is no evidence to back assertions that wind farms cause headaches, dizziness, tachycardia or other health problems, which may instead arise because of anxiety stirred by false and misleading claims, the AMA has said.

While the Federal Government is pushing ahead with plans for a fresh investigation into the impact of wind farms on health, the AMA has issued a Position Statement in which it concludes that "available Australian and international evidence does not support the view that the… sound generated by wind farms…causes adverse health effects".

AMA Vice President and Chair of the Association's Public Health Committee Professor Geoffrey Dobb said that although some people living near wind farms may genuinely experience health problems, these were not directly attributable to wind turbines.

"The infrasound and low frequency sound generated by modern wind farms in Australia is well below the level where known health effects occur," Professor Dobb said. "And there is no accepted physiological mechanism whereby sub-audible infrasound could cause health effects."

Instead, he said, the symptoms of ill health experienced by some living in close proximity to wind turbines may be due to anxiety.

"The reporting of supposed 'health scares' or the spreading of misinformation about wind farm developments may contribute to heightened anxiety," Professor Dobb said, adding that those who experienced adverse symptoms should seek medical advice.

In January, *Australian Medicine* reported a study which found that those who were told wind farms had health effects were more likely to report symptoms than those who were not (see https://ama.com.au/ausmed/answer-blowing-wind).

In its Position Statement, based on extensive research and investigation, the AMA observed that if wind farms did directly cause adverse health effects, there would be a much stronger correlation between reports of symptoms and proximity to wind farms than currently exists.

It said only a relatively small proportion of those living near wind farms reported health problems, and numbers varied greatly between facilities "for reasons not apparently related to the number of residents in the area".

The AMA's conclusions follow the release earlier this year of a systematic review of evidence regarding the health effects of wind farms, commissioned by the National Health and Medical Research Council (NHMRC), which found no grounds to claim wind turbines harmed health.

The 296-page *Systematic review of the human health effects of wind farms* (https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/eh54_systematic_review_of_the_human_health_effects_of_wind_farms_december_2013.pdf), which involved examination of more than 2800 references and 500 documents, concluded that there was "no consistent evidence that noise from wind turbines…is associated with self-reported human health effects".

"Proximity to wind turbines or estimated sound pressure level was associated with annoyance, and often associated with sleep disturbance and poorer quality of life," the study said. "However, it cannot be ruled out that bias or confounding is an explanation for these associations."

But, in a caveat that lends support to the Government's push for further investigation, the study admitted that the "quality and quantity of the available evidence was limited".

Health Minister Peter Dutton told Parliament on 17 March that the shortcoming meant the Government's move to commission an "independent research program" was warranted.

MORE P13

Wind farm health fears blown away

... FROM P12

A number of small but vocal groups including the Waubra Foundation, the Landscape Guardians and Stop These Things have campaigned against wind farms, claiming they are the cause of a range of maladies including headaches, migraines, tachycardia, nausea, tinnitus and hypertension.

The Waubra Foundation has written to the AMA objecting to its Position Statement.

The Foundation's Chief Executive Officer Sarah Laurie accused the AMA of ignorance in coming to its conclusions.

Ms Laurie said the NHMRC itself had admitted there was consistent, if poor quality, evidence of sleep disturbance and poor quality of life among those living near wind turbines, and other studies had linked them to adverse health effects.

The issue is particularly sensitive for the Coalition with its sizable rural constituency, given that wind farms are located in country areas.

Assistant Health Minister Fiona Nash told the Senate last month that "there has been some concern around some of the poor quality relating to that particular report," adding that "we in the Government are well aware of the concerns in the community surrounding this, and we will be putting steps in place to determine that we are fully aware of any impacts that do exist."

And, in a speech to the Senate, DLP Senator John Madigan condemned energy firm AGL for writing to doctors in western Victoria to assert that its Macarthur wind farm had no health effects.

"This is a blatant lie," Senator Madigan said. "It is now on the public record that many residents near Macarthur wind farm have experienced serious health effects and repetitive sleep disturbance since the beginning of operation[s]."

But Greens NSW Upper House MLC Dr John Kaye said both the AMA and the NHMRC showed that "the problem confronted by wind farm residents comes not from the wind farms themselves, but from organisations like the Waubra Foundation, the Landscape Guardians and new organisations such as Stop These Things, which are raising alarm with respect to wind farms".

The Clean Energy Council said the AMA's Position Statement should provide extra peace of mind for those living near existing or proposed wind farms.

"No credible Australian health or acoustic organisations are opposing wind farms, and people should feel reassured by that," Council Policy Director Russell Marsh said, adding that communities had been "caught in the crossfire" of misinformation campaigns waged by opponents.

The AMA has cautioned governments to resist pressure to over-regulate wind farms to address health problems for which there is no evidence.

"The regulation of wind farm developments should be guided entirely by the evidence regarding their impacts and benefits," Professor Dobb said.

He said the health benefits of renewable energy should not be discounted.

"From a public health perspective, it is important to note that electricity generation by wind turbines does not involve the production of greenhouse gases, other pollutant emissions or waste, all of which can have significant direct and indirect health effects," he said.

The NHMRC's Wind Farms and Human Health Reference Group, formed in 2011, has had its term extended until 31 January 2015.

Submissions regarding its draft information paper, *Evidence on Wind Farms and Human Health*, can be made before 11 April. Details can be found at: http://consultations.nhmrc.gov.au/public_consultations/wind_farms

The *AMA Position Statement on Wind Farms and Health 2014* can be viewed at: https://ama.com.au/position-statement/wind-farms-and-health-2014

Adrian Rollins

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

Boozy nation admits there's a problem

A majority of Australians support the AMA's push to close a loophole that allows for the promotion of alcohol during live daytime sports broadcasts amid widespread acknowledgement the nation has a drinking problem.

The Foundation for Alcohol Research & Education's annual Alcohol Poll has found that almost two-thirds of Australians do not believe governments, hoteliers and industry are doing enough to tackle alcohol misuse, and 67 per cent backed a ban on alcohol advertising and promotion on television before 8.30pm.

The results came as a joint VicHealth-La Trobe University study was released showing almost 50 per cent of all alcohol and fast food ads broadcast on television where aired during sports broadcasts, despite the fact that such shows made up just 29 per cent of total programming.

But there are concerns that efforts to curb alcohol abuse are falling victim to Federal Government cost-cutting.

Late last year the Government axed funding for the long-standing Alcohol and Other Drugs Council (see *Axing drug adviser costs taxpayers $1 million, p34*), and the *Sunday Herald Sun* reported last month that a $25 million Labor Government scheme under which sports were offered a grant for forgoing alcohol sponsorship was under a cloud.

Speaking at the launch of the Poll results, AMA President Dr Steve Hambleton said they showed the AMA was far from alone in its concerns about the promotion and advertising of alcohol, particularly to young people.

The AMA has been at the forefront of efforts to address the nation's drinking culture and the harm it causes. It has called for the loophole that allows alcohol to be promoted during sports broadcasts before 8.30pm to be closed, and earlier this year began a push for a National Summit on alcohol misuse and abuse.

Dr Hambleton said the FARE survey gave a timely yet disturbing snapshot of the extent of the country's drinking problem.

The Poll found that almost a quarter drank at least three times a week, one in six drinkers consumed more than six standard drinks in a typical session, around 25 per cent felt unable to stop drinking once they started and more than a third said they drank to get drunk.

While a significant proportion were regular and heavy drinkers, less than 40 per cent were aware of advice that consuming more than two standard drinks in a session increased the risk of long-term alcohol-related harm.

Dr Hambleton said the results pointed to very high rates of alcohol dependency in the community, making it unsurprising that almost 75 per cent reported being adversely affected by someone else's drinking and more than a third indicating they had experienced alcohol-related violence.

Dr Hambleton said there was broad acknowledgement that the nation had an alcohol abuse problem.

He said it was time to curb the main forces driving alcohol consumption – its ready availability, affordability and heavy promotion.

"Alcohol is just about everywhere," the AMA President said. "There are licensed premises and sellers within easy travelling distance to us all. Positive and glamorous images and messages about alcohol are also just about everywhere, thanks to the ubiquitous advertising and marketing of alcohol."

He said the pervasive nature of alcohol promotion was a key ingredient in inculcating the drinking culture in younger people and perpetuating its heavy consumption, underlining the importance of the push to ban promotion during sports programs.

Lead researcher of the VicHealth-La Trobe study, Associate Professor Matthew Nicholson said audiences of sports broadcasts were exposed to substantial amounts of alcohol and junk food branding

while games were in play – much more than in advertisements broadcast during breaks.

Associate Professor Nicholson said that during AFL matches broadcast on television, viewers had 4.5 times greater exposure to alcohol branding on the field than during ad breaks, and around 12 per cent of match screen time was alcohol or fast food-related. He added it reached as high as 61 per cent during broadcasts of cricket matches.

Australians are worried about the nation's drinking habit – the FARE Poll found almost half rate alcohol as the most harmful drug in the community and 78 per cent believe there is a problem with excess drinking.

Dr Hambleton said policymakers and organisations like the AMA concerned about public health had an obligation to take action to start to turn the nation's dangerous drinking culture around.

Adrian Rollins

COMMENT

Every day should be Close the Gap Day: AMA

The nation's government's must immediately begin to act on measures to boost Indigenous health to ensure the momentum built around recent gains is not lost, AMA President Dr Steve Hambleton has said.

In comments to mark Close the Gap Day, Dr Hambleton said the Commonwealth, State and Territory governments should renew their COAG Closing the Gap partnership agreement for a further five years, backed by same level of funding, as well as develop a clear strategy to implement the National Aboriginal and Torres Strait Islander Health Plan.

"Our governments must make every day a Close the Gap Day," Dr Hambleton said. "Consistent and coordinated action is needed to increase the momentum and build on the early successes of strategies to close the gap across the health spectrum."

In a report to Parliament in February, Prime Minister Tony Abbott said the nation was on target to halve the gap in child mortality within a decade, to have 95 per cent of children in remote areas enrolled in pre-school and to halve the gap in year 12 attainment by 2020.

But Mr Abbott said almost no progress had been made in narrowing the 10-year gap in life expectancy.

Dr Hambleton said the existing COAG partnership agreement, which is due to expire in June, had already achieved significant success in reducing smoking rates and improving maternal and child health, and it was important not to let the momentum gained drop away.

He said a renewed partnership agreement needed to be backed by a strategy to implement the Health Plan, including:

- a comprehensive set of measurable targets to be achieved within a decade;
- the development of a service model to achieve those targets;
- the development of a national workforce strategy;
- funding and resources commensurate with the task; and
- clear requirements for governments to work with Aboriginal and Torres Strait Islander health leaders and Indigenous communities.

In an encouraging advance in Indigenous-led health, four Aboriginal GPs have established a joint child and family-focused medical centre on Palm Island.

The Palm Island Children and Family Centre, founded by Dr Raymond Blackman and Dr Vicki Stonehouse in November last year, was set up to fill a glaring gap in medical services on the island.

Dr Blackman said that before the Centre was set up, the only option for islanders in need of care was the local hospital.

He said primary health care, underpinned by an on-going relationship between GPs and their patients, was proven to provide better health outcomes over time.

"We have GP skills, an interest and understanding of Aboriginal and Torres Strait Islander health, and in our clinic we have the necessary support structures to enable better outcomes on Palm Island," Dr Blackman said. "This needs to be replicated throughout the country."

Dr Blackman received the 2014 Wakapi Anyiku Doctor Oomparani Award in recognition of his leadership and commitment.

Adrian Rollins

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

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

APlan for chemists to give vaccines, *Adelaide Advertiser*, 14 March 2014

Health Minister Peter Dutton is considering paying chemists to provide health services such as vaccinations. AMA President Dr Steve Hambleton said pharmacists should not pretend to provide medical care, "that's what doctors do".

AMA warns on health screening, *Sunday Age*, 16 March 2014

AMA President Dr Steve Hambleton launched an attack on health screening services, labelling them a scam targeting the "worried well", charging up to $200 for scans in local RSLs, churches and scout halls.

Let's do a deal, *Courier Mail*, 18 March 2014

Public hospital doctors are on the verge of striking a deal with the State Government in their long-running dispute over contracts. AMA President Dr Steve Hambleton was optimistic a deal was close.

Kiss of life for doctor deal, *Courier Mail*, 18 March 2014

The public hospital doctors' contract dispute was on the brink of resolution after a major breakthrough. AMA President Dr Steve Hambleton said no one wanted to see further damage to the Queensland health system.

Swallow this, *Courier Mail,* 19 March 2014

Health Minister Lawrence Springborg made an eleventh hour bid to sway doctors over public hospital contracts by agreeing to legislative changes to contracts. AMA President Dr Steve Hambleton said the proposed law changes were a strong signal the government wanted to rebuild its relationship with senior doctors.

Secret plan to slash bulk billing, *Australian Financial Review*, 21 March 2014

The newspaper revealed a Health Department plan to means test bulk billing for GP visits and charge an extra $5 for prescriptions, delivering an estimated $2 billion saving.

AMA Chair of General Practice Dr Brian Morton warned GPs could abandon bulk billing en mass if such changes were implemented.

Insurer bid to pay for GP care, *Adelaide Advertiser*, 21 March 2014

Health fund premiums are likely to rise if insurers are allowed to cover GP care. While cautious about the proposal, the AMA has backed the idea of working with private insurers, a position Health Minister Peter Dutton has welcomed.

If doctors quit, we'll get more, *Courier Mail,* 21 March 2014

The Queensland Government has threatened to hire doctors from interstate and oversease to replace those who quit their public hospital jobs over the doctor contract dispute. Australian Salaried Medical Officers Federation President Dr Tony Sara joined AMA President Dr Steve Hambleton in dismissing the solution as out of touch with the reality of recruiting overseas trained doctors.

Diagnosing some ill will, *MX Brisbane*, 21 March 2014

The AMA said that Queensland Premier Campbell Newman inflamed an industrial dispute with senior public hospital medical staff by threatening to hire doctors from interstate and overseas. AMA President Dr Steve Hambleton said the Association was "trying to put this thing back together".

Flying shame of doctor do-little, *Sunday Mail Brisbane*, 23 March 2014

More than 20 Queensland doctors were found to be on non-compliant contracts in an audit of 150 doctors in one of Queensland's Hospital and Health Service areas. AMA President Dr Steve Hambleton said the non-compliant contracts were a damning indictment on the management structure of Queensland Health.

MORE P17

AMA IN THE NEWS

... FROM P16

Radio

Dr Steve Hambleton, 2UE Sydney, 16 March 2014

AMA President Dr Steve Hambleton discussed health screening services. He said if patients had a health concern, they should see their family GP and have targeted screening for their problem.

Dr Steve Hambleton, ABC Far North, 18 March 2014

AMA President Dr Steve Hambleton talked about meetings being held to discuss the controversial Queensland hospital contracts. He said discussions with the Queensland Government had shown progress.

Dr Steve Hambleton, 4BC Brisbane, 19 March 2014

AMA President Dr Steve Hambleton said more than 1000 Queensland doctors had voted to reject the latest offer from the Queensland Government on contracts. He said he wanted to see the issue resolved, and would continue to talk to the Government to get a good outcome.

Dr Steve Hambleton, 891 Adelaide, 20 March 2014

AMA President Dr Steve Hambleton discussed the Federal Government's plans to change the way chemists are paid to dispense generic drugs. He said it was important that consumers and the Federal Government receive the benefits of generic drug discounts.

Dr Steve Hambleton, 4BC Brisbane, 21 March 2014

AMA President Dr Steve Hambleton talked about the conflict between public hospital doctors and the Newman Government over individual contracts. He said the contracts on offer from the Government were one-sided and unfair, and could be interpreted in a way that was unsafe for patients.

TV

Dr Steve Hambleton, Channel 10, 12 March 2014

AMA President Dr Steve Hambleton discussed hospitals preparing for a flu epidemic. He said pregnant women and those with chronic disease were particularly vulnerable.

Dr Steve Hambleton, Channel 7, 21 March 2014

AMA President Dr Steve Hambleton talked about the conflict between public hospital doctors and the Newman Government over individual contracts. He said there was still a chance the dispute could be resolved.

COMMENT

INFORMATION FOR MEMBERS

Recognising and responding to complex trauma

A GP-only forum on how to recognise and respond to patients suffering unresolved complex trauma is being held by the Mental Health Professionals Network.

The online forum, part of the Network's webinar series, will bring together a panel of experts including psychiatrist Professor Louise Newman, GP Dr David Walker and mental health nurse Iggy Kim, to better equip GPs to diagnose and respond to physical, mental and psychosocial presentations that may indicate unresolved complex trauma.

The webinar aims to give participants an understanding of the prevalence, epidemiology and impact of complex trauma, equip them to diagnose the condition and provide tips and strategies for interdisciplinary collaboration to support patients suffering complex trauma.

In preparation for the webinar, participants will need to read the relevant fact sheet and familiarise themselves with the case study that will be the focus of discussion.

The Government-funded webinar has been accredited by the Royal Australian College of General Practitioners for four category 2 points, and accreditation by the Australian College of Rural and Remote Medicine is pending.

The webinar will be conducted on Monday, 7 April, between 7.45 and 9pm AEST.

To register, and for more information, go to http://bit.ly/1gaUA9N

Registration closes at midnight on Sunday, 6 April.

AMA IN ACTION

AMA President Dr Steve Hambleton and other AMA officials have had a busy fortnight representing the profession around the country.

In a speech to the Second International Primary Health Care Conference in Brisbane, Dr Hambleton urged caution in shifting the basis of GP remuneration away from pay-for-service toward pay-for-performance systems, warning that they carried a number of risks without necessarily delivering much in the way of better care.

Dr Hambleton represented the AMA at a meeting of senior doctors in Queensland regarding the hospital contracts dispute. The rally, known as the 'pineapple meeting', saw more than 1000 doctors reject the Newman Government offer of amendments to its controversial senior medical officer contracts.

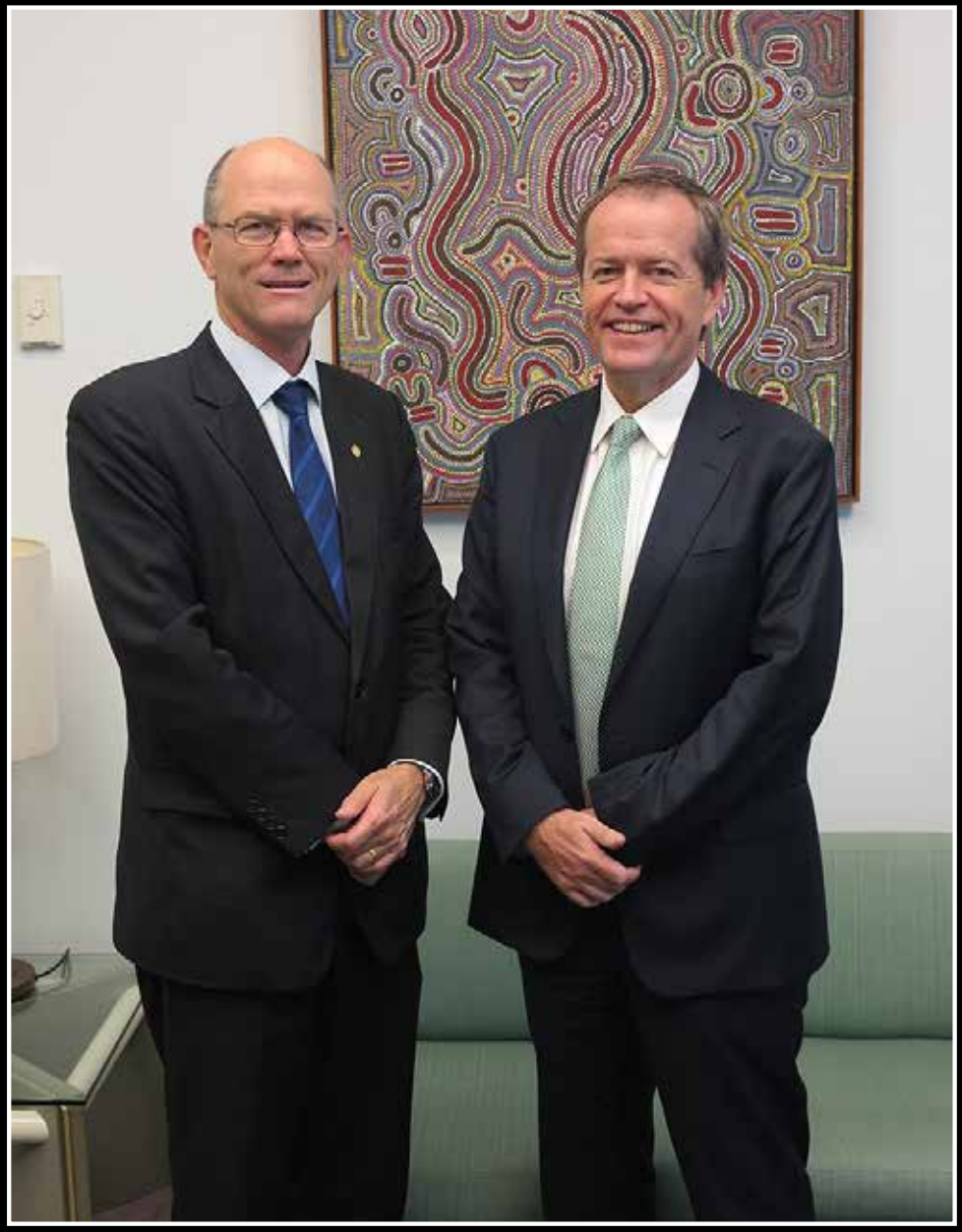
Late last month AMA Queensland hosted their annual event to thank donors, and launched the 'Thank you, Doctor' campaign. Dr Hambleton attended the event to show his support.

Dr Hambleton participated in a panel discussion on expanding role of the private sector in the provision of primary health care at the Australian Private Hospitals Association Conference in Brisbane.

The AMA President also met with a group of parliamentarians to discuss the prevention of Foetal Alcohol Syndrome Disorder, before attending the launch of the Foundation for Alcohol Research & Education's Annual Alcohol Poll in Canberra.

As Federal Parliament finished its last sitting before the delivery of the May Budget, Dr Hambleton had a busy round of meetings, catching up with Opposition Leader Bill Shorten, talking to media about the Government's intention to sell Medibank Private, delivering updates on Queensland Health hospital contract dispute, and commenting on a National Health Performance Authority report revealing that many children in affluent areas of the country were not being fully immunised.

COMMENT



Dr Hambleton with Opposition Leader Bill Shorton

APRIL HEALTH EVENTS

The dates and events listed are major awareness days, conferences, weeks and months related to health. If you know of an upcoming national health event please email the details to ausmed@ama.com.au

Sun	Mon	Tue	Wed	Thur	Fri	Sat
30	31	**1** National April Falls Day National Smile Day World Fabry Diseases Awareness Month	**2** World Autism Awareness Day	**3** 10th Australasian Lymphology Association Conference in Auckland	**4** NSW Orange Hope Day	**5**
6	**7** World Health Day	**8**	**9** National Wear Green Premmies Day	**10**	**11** World Parkinson's Day	**12** VIC ACN Nursing and Health Expo
13	**14**	**15**	**16**	**17** World Haemophilia Day	**18**	**19**
20	**21** National Pre Winter Eczema Awareness Campaign	**22**	**23**	**24**	**25** World Malaria Day	**26**
27	**28** National Pneumonia Awareness Week	**29**	**30** National Osteopathy Awareness Week			

Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
Dr Robyn Langham	AMA Representative for Victoria	Medicine Australia Code Review Panel	11/3/2014
Dr Richard Kidd	AMA Representative for Queensland	Meeting with Minister Fifield, Minister with responsibility for the aged care system, to discuss the medical needs of older Australians	12/3/2014
		DVA Local Medical Officer Advisory Committee meeting	13/3/2014
Dr Steve Hambleton	AMA President	Meeting with Minister Fifield, Minister with responsibility for the aged care system, to discuss the medical needs of older Australians	12/3/2014
		Spoke at International Primary Health Care Reform Conference on driving quality primary care	19/03/14
Dr Omar Khorshid	AMA Federal Councillor	MSAC (Medical Services Advisory Committee) Review Working Group on Arthroscopic Hip Procedures	17/3/2014
Dr Chris Clohesy	AMA Member	MSAC (Medical Services Advisory Committee) Review Working Group on Imaging for Back Pain	18/3/2014
Prof Mark Khangure	AMA Federal Councillor	MSAC (Medical Services Advisory Committee) Review Working Group on Imaging for Back Pain	18/3/2014
Dr Ian Pryor	AMA Member	MSAC (Medical Services Advisory Committee) Review Consultation Committee for Ear, Nose and Throat Services	21/3/2014

Well-off ignore vaccination message, put kids at risk

Parents in some of the country's most affluent suburbs are putting their children and others at risk of sustained outbreaks of serious infections by failing to have their offspring vaccinated, shocking Government figures show.

A report by the National Health Performance Authority has found that more than 75,000 children five years and younger were not fully immunised in 2012-13, with as few as 67 per cent vaccinated in some areas – making local populations vulnerable to outbreaks of potentially fatal diseases such as measles and whooping cough.

According to the NHPA data, there has been a sharp improvement in vaccination rates among Indigenous children, with more than 92 per cent of Aboriginal and Torres Strait Island five-year-olds fully immunised last financial year – a five percentage point improvement from a year earlier.

Overall, 91.5 per cent of five-year-olds were fully immunised in 2012-13, a 1.5 percentage point increase.

But the report identified significant pockets where vaccination rates were well below the level needed to ensure so-called herd immunity.

In Byron Bay, the proportion of five-year-olds who were fully immunised was just 66.7 per cent, the lowest ratio in the country, closely followed by Brunswick Heads (70.2 per cent).

Other areas with poor levels of protection against disease among young children were the well-to-do Sydney suburbs of Manly (80.4 per cent), Paddington (81.8 per cent), and Neutral Bay (83 per cent), as well as Melbourne's affluent South Yarra (82.9 per cent), upper middle class Adelaide suburb Burnside (81.7 per cent) and Riverton in Western Australia (81.9 per cent).

In a sign that a small proportion of parents continue to be misled by the claims of anti-vaccination groups, the NHPA report showed that around 15,000 of the 75,000 one, two and five-year-old children were not vaccinated in 2012-13 because their parents were "conscientious objectors".

AMA President Dr Steve Hambleton said it was a "major disappointment" that so many parents had failed to vaccinate their children.

The AMA and the Australian Academy of Science have been part of an effort, along with the Federal and NSW governments and other public bodies, to overcome ignorance and apathy regarding child immunisation, particularly combating the misinformation spread by groups such as the Australian Vaccination Skeptics Network.

Parents need to ensure their children are fully immunised, or to have an approved exemption, to be eligible for Family Tax Benefit A, and in NSW parents must meet similar criteria in order to enrol their children in child care.

Lobby group The Parenthood has called on governments to close what it considers to be a conscientious objection "loophole" in current laws.

Group Executive Director Fiona Sugden said "it is time for the State and Federal governments to work together to ensure that the recognition of conscientious objectors is finished once and for all".

"Parents do not want to see the return of old-world diseases that wiped out entire generations of families," Ms Sugden said. "It is clear that when herd immunity is compromised by people that don't immunise, it impacts the whole community. This is simply not good enough in the year 2014."

Adrian Rollins

COMMENT

False breast claims end up in court

Two companies face stiff penalties for engaging in misleading and deceptive conduct after giving women false assurances that they were able to diagnose breast cancer.

In a crackdown on operators making unsubstantiated claims about their ability to detect breast cancer tumours, the consumer watchdog has secured Federal Court judgements against Safe Breast Imaging Pty Ltd, its sole Director Joanne Firth, and Breast Check Pty Ltd (now trading as PO Health Professionals Pty Ltd) and former Director Dr Alexandra Boyd.

In its successful actions, the Australian Competition and Consumer Commission alleged that both companies falsely claimed that their procedures, involving the use of a Multifrequency Electrical Impedance Mammograph (MEM), either alone or in conjunction with digital infrared thermographic camera, could provide an adequate scientific basis for assessing whether or not a patient was at risk of developing breast cancer, and the level of that risk, as well as assuring customers they did not have breast cancer.

The Court found that there was no scientific basis for the claims by the companies that scans using the MEM device and/or thermography were a substitute for mammography.

In his judgement regarding Breast Check, Justice Michael Barker said "it would be entirely reasonable for a consumer to conclude that, where a service of a medical nature is being provided, there would be scientific medical evidence of a sufficient quality to support the use of the equipment used…and that the use of breast imaging devices would not be promoted in a way to be contrary to the state of scientific medical knowledge".

ACCC Chairman Rod Sims said the case was particularly concerning because Breast Check had told women its breast imaging services could provide assurances that they did not have breast cancer "when this was not the case".

In addition to misrepresentations about the capability of the MEM device, Safe Breast Imaging was also found to have been deceptive in its claims about the involvement of medical practitioners in its procedures.

The reports the company gave to its customers included the name of a medical doctor, implying they had been prepared by the doctor.

But the court found that, in some instances, the doctors named in the reports had not interpreted the images and had not written the reports. In other instances the people named as doctors were not in fact medical practitioners.

> "…in some instances, the doctors named in the reports had not interpreted the images and had not written the reports"

The court found that Ms Firth knew of the falsity of the company's claims regarding the involvement of medical practitioners, and was knowingly concerned in its conduct.

"Not only did Safe Breast Imaging falsely represent to women that it could assure them they did not have breast cancer…, but SBI also tried to gain greater credibility by overstating the role that doctors played in the service," Mr Sims said.

The ACCC Chairman said the judgement were a clear warning to the medical services industry that claims about procedures and treatments must be accurate and supported by credible scientific evidence.

Penalties in the Breast Check case will be determined at a Federal Court hearing on 20 May, while those in the Safe Breast Imaging case will be decided at a hearing on 10 June.

Adrian Rollins

COMMENT

$200 health screens bad value

The AMA and consumer groups have accused so-called health screening services of preying on consumers and charging up to almost $200 for tests that can be carried out far more cheaply and effectively by GPs.

Operators such as Screening for Life are using venues such as scout halls, RSL clubs and churches to offer screening tests costing around $199 for conditions such as the accumulation of plaque deposits in arteries, osteoporosis, high blood cholesterol and type 2 diabetes.

AMA President Dr Steve Hambleton told the *Sun Herald* such screening services could give patients false assurances, or unnecessarily raise alarm, and were largely targeted at older and more vulnerable people.

“They are preying on the worried well, and they are using the imprimatur of places like the RSL and the Scout halls, which are respected in the community, so people think it must be ok,” Dr Hambleton said.

He said Screening for Life, whose tests are not eligible for Medicare or private health insurance rebates, incorrectly claimed it offered tests not available from GPs.

Dr Hambleton said most of the company’s tests were simple, cheap and could be provided by any GP, where they would be covered by Medicare.

Consumer organisation *Choice* told the *Sun Herald* tests by companies such as Screening for Life could provide people with false hope or cause unnecessary angst.

Adrian Rollins

COMMENT

Robot doctors a solution to health budget woes

Australian hospitals are among the first in the world to embrace a robot doctor developed by British artificial intelligence experts.

The prototype RoboDoc has been created as a fully-functioning, electronic medical practitioner capable of fulfilling all the duties carried out by senior medical officers, registrars, general practitioners and other specialists.

Constructed at a recommissioned British Leyland factory in the English Midlands using materials and ideas borrowed from the British Broadcasting Corporation, the RoboDoc has multiple articulated robotic arms and a high resolution LED screen mounted on a Dalek-like chassis.

Initially developed for the NHS as a means of providing basic hospital medical services and procedures such as amputations and tracheotomies, RoboDoc has been refined and enhanced to provide the whole gamut of services from treating warts to brain surgery.

Developers CyberMed Pty Ltd said their creation embodied all the attributes of a top-class doctor, for a fraction of the price.

“RoboDoc is a huge advance in medicine,” CyberMed chief engineer, artificial intelligence, Dr Dave Bowman said. “It is precise, efficient, knowledgeable and strong and, unlike the human version, it never gets tired or needs a break”.

Dr Bowman said RoboDoc was controlled by a powerful CPU similar to that used for the Space Invaders electronic game, and two servo motors gave it a top speed of eight kilometres an hour.

He added that a vacuum unit modelled on the RoboMaid had been added to RoboDoc’s base to enable it to double as a floor cleaner.

“In these cost-conscious times, RoboDoc is the perfect solution,” Dr Bowman said. “It is on duty 24 hours a day, seven days a week, it doesn’t require shift loadings or overtime, and it even does the cleaning.”

As an extra function, the RoboDoc comes pre-loaded with a selection of tracks from Clannad, Fergal Sharkey and The Coors, and work is underway to expand its musical range to include Air Supply and Richard Clayderman.

Before being approved for commercial release, RoboDoc underwent stringent testing at Edinburgh University Medical School, taking part in numerous revues, drinking competitions and theatre productions, as well as doing volunteer work for a wide array of local charities.

Dr Bowman said RoboDoc had taken the trials in its stride, and proved to be a popular member of the campus community.

He said he was confident its can-do attitude would see it become a successful doctor.

“We’ve loaded it up with all the Wikipedia entries needed to cover basic anatomy, as well as information on the most common ailments, drugs and treatments,” Dr Bowman said.

CyberMed has started mass production of RoboDoc, but it is not known how soon the first units will arrive in Australia.

The company said 1 April was an auspicious day on which to be entering the Australian market.

Adrian Rollins

COMMENT

Self-regulation a bad formula for breast feeding: RACP

The Federal Government is facing calls to ban the promotion of infant formula after it scrapped an independent panel charged with ensuring companies did not spruik their products at the expense of breast feeding.

The Royal Australasian College of Physicians has urged the Government to legislate to block infant formula advertising amid concerns that the abolition of the panel, which was charged with ensuring the promotion of baby formula did not undermine breast feeding, will lead to an upsurge in the use of formula.

President of the College's paediatric and child health division, Associate Professor Susan Moloney, told the *Sydney Morning Herald* that the Government needed to act to prevent the promotion of infant formula, including by offering free samples, gifts or supermarket and pharmacy incentives, particularly to parents of babies less than a year old.

"We're very concerned that if there's no independent oversight, then we need legislation to block advertising of infant formula," Associate Professor Moloney said.

The Infant Nutrition Council, which represents most of the major formula manufacturers, has proposed a self-administered system to monitor advertising by its members, complemented by an arm's length complaints process.

But the Australian Breastfeeding Association told the *Sun Herald* such an arrangement was highly unsatisfactory.

"It's difficult for the industry to be impartial, and there's always that risk they'll act in their own interests," the Association's Chief Executive Rachel Fuller said.

Under the World Health Organisation's International Code of Marketing Breast Milk Substitutes, which has been adopted by more than 80 countries including Australia, infant formula must not be promoted in a way that undermines breast feeding.

According to the *Sun Herald*, Assistant Health Minister Fiona Nash, who was involved in the decision to scrap the independent panel, wrote to a number of concerned organisations late last year to say that Australia upheld its WHO obligations through a "voluntary, self-regulatory code of conduct between manufacturers and importers of infant formula".

A spokesperson for Senator Nash told the newspaper that a decline in complaints and industry compliance meant the independent oversight panel was no longer necessary, and new arrangements were being developed.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

NEWS

Medical tourists should beware the bugs

People contemplating travelling overseas for cheaper cosmetic surgery and other medical procedures have been warned they run the risk of contracting serious antibiotic-resistant infections.

As interest in medical tourism swells, health insurer NIB has broken new ground by offering overseas cosmetic and dental surgery packages that cover airfares, transfers and accommodation, as well as treatment by qualified surgeons and dentists at accredited facilities, backed by a guarantee to cover any medical complications arising from the procedure during the following 12 months.

The offering seeks to tap into rapid growth in the number of Australians travelling overseas, particularly to Thailand, to undergo surgery – including major procedures such as hip and knee replacements, organ transplants and cardiac surgery – and recuperate while staying at a resort or other holiday destination.

But NPS Medicinewise said many were unaware of the risk they faced of being infected with a drug-resistant superbug.

A survey it commissioned from UMR Research found that around half of travellers had not considered the possibility of contracting a serious infection while receiving medical treatment overseas.

NPS Medicinewise clinical advisor Dr Andrew Boyden said this was concerning because of the prevalence of antibiotic-resistant bugs overseas, and the fact that many health care facilities did not have the same infection control standards as their Australian counterparts.

"Australians need to be aware that the over-the-counter availability of antibiotics in some regions of the world, coupled with different infrastructure, policies and practices in overseas health facilities, have contributed to the emergence of so-called superbugs in some health care systems," Dr Boyden said.

"What's more, medical tourism packages are often combined with a vacation. People recovering from surgery may be exposed to a broader range of antibiotic-resistant bugs in the community.

"This is a particular concern where multi-drug resistant organisms are rife."

He said anyone undergoing medical treatment while overseas should have a checkup with their doctor when they return, including telling them of what they had had done.

"You doctor will need to keep in mind that you may be carrying antibiotic-resistant bugs for an extended period after returning from your trip," Dr Boyden said.

Adrian Rollins

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

GENERAL PRACTICE

Making the dollars count

BY DR BRIAN MORTON

> "Preventing illness along with avoidable hospital presentations, admissions and lengths of stay, is where the big cost savings for Government will be made"

It would seem that funding for general practice as we know it is coming to a cross road.

There has been so much speculation about possible changes to how GP services are funded that it is becoming increasingly likely that we will get some related announcements in the upcoming Budget. The challenge for the Government will be to make sure that any changes make every dollar count.

Health Minister Peter Dutton has repeatedly said that Medicare is unsustainable, and that those who can pay for their health care should.

To this end, a plethora of funding ideas have come out of the woodwork. These include the infamous $6 co-payment, means tested Medicare, increasing the Medicare levy, tiered MBS payments with restrictions on who can be bulk billed, block funding or capitated funding for targeted groups, and a greater role for private health insurance in primary care.

At least a conversation has been started about how health care expenditure in this country could be better utilised.

With it has come, I believe, a stronger sense in the Government of the role that general practitioners, who are the foundation of quality primary health care, play in the overall picture of health expenditure.

What needs to be driven home is that general practice consumes a relatively small part of the overall health expenditure and helps to keep overall health system costs sustainable. The Australian Government spent $59.5 billion on health in 2011-12, of which only $7.4 billion (12.4 per cent) was spent on general practice. The recently released AIHW report *Health expenditure Australia 2011-12: analysis by sector* shows that, as a proportion of primary health care funding, medical services has declined from 22.9 per cent a decade ago to 19.1 per cent in 2011-12. More primary health care funding is now spent on pharmaceuticals than on medical services.

General practice is not part of the problem, but part of the solution.

Investing in general practice is a better way for Government to spend its health dollars if it is serious about keeping patients healthier and providing them with the medical care they need, when they need and in the most appropriate part of the health system.

Preventing illness along with avoidable hospital presentations, admissions and lengths of stay, is where the big cost savings for Government will be made.

The only problem is, these savings won't be immediate and, as is all too often the case, immediate impacts are what the Government is looking for, particularly given the current state of the Budget.

The challenge for this Government will be look to the future, and to invest now in primary health care, where it will get better bang for its buck and better outcomes for patients.

The AMA is open to discussions about how general practice can be better resourced to take a more structured and pro-active approach to managing patients, particularly those with chronic and complex conditions. GPs need to be better supported to spend more time with such patients on a long-term basis. The AMA wants to see further investment in general practice through greater support for longer consultations where more problems can be addressed and preventive health issues attended to. More effective funding for chronic disease management is a must.

Any changes to funding arrangements, however, need to be well thought out, targeted and aimed at improving patient outcomes.

Supporting general practice in this way will help make sure every dollar counts.

COMMENT

Are secret negotiations trading away our health?

BY AMSA PRESIDENT JESSICA DEAN

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

Trade and health are intrinsically linked.

This was a major recurring theme at the recent General Assembly of the International Federation of Medical Students' Associations (IFMSA) - the oldest and largest international advocacy body for medical students. The Assembly, held in Tunisia, was attended by almost 1000 medical students from 110 countries.

At the Assembly, medical students expressed collective concern at increasingly stringent aspects of free trade agreements being negotiated around the world, with particular attention drawn to the Trans-Pacific Partnership (TPP) currently being negotiated by a group of 12 Asia Pacific nations including Australia, the United States, Japan, Canada and New Zealand.

The TPP potentially has far-reaching implications for the health of Australians, given that aspects of it threaten to restrict public health policy, push up the cost of pharmaceutical and limit access to essential medicines.

First and foremost on the list of concerns is the inclusion of Investor State Dispute Settlement (ISDS) clauses in the agreement.

ISDS provisions essentially give foreign investors the opportunity to take action against national governments where legislation has an adverse effect on the expected financial returns of an investment.

This prescribed process would bypass normal dispute resolution processes in favour of an international tribunal governed by three arbitrators. Heightening concerns about independence, investors would have a role in selecting these arbitrators.

International examples suggest public health policy will not be immune from the clutches of ISDS.

Under the terms of the North American Free Trade Agreement, which includes ISDS clauses, the Canadian Government has been subject to several lawsuits concerning public health policy. Eli Lilly, for example, sought $CDN 500 million in damages after the Government invalidated secondary patents for Zyprexa and Strattera.

A local example of the impacts of ISDS clauses can be found in Australia's free trade agreement with Hong Kong. Phillip Morris Asia is currently pursuing the Federal Government for compensation for losses incurred as a result of Australia's tobacco plain packaging laws.

Not only will ISDS have local implications for the implementation of health policy, a potential fear of litigation may deter other nations from implementing similar health policy strategies.

The TPP may have further adverse consequences. It includes strict patent law clauses which will effect the production of generic branded medications. This will see medications on the Pharmaceutical Benefits Scheme rise in price, and decrease access to essential medications in developing countries.

Despite the potentially significant impact of this agreement on Australians, citizens themselves have little direct influence on, or input into, negotiations. Neither the public nor Parliament will have access to the text until it has been finalised. Negotiated in secret and subject to little media and public scrutiny, the absence of strong leadership to protect the health of Australians has the potential for disastrous health outcomes.

Through the IFMSA, more than 1.2 million medical students around the world have expressed grave concerns about the health impacts of the Trans-Pacific Partnership. We call for increased scrutiny and transparency and, in particular, urge for greater emphasis to be placed on the potential health impacts of the agreement.

COMMENT

A big bang Budget?

BY DR DAVID RIVETT

I have never considered that the Coalition would be game to radically alter Medicare because of the Australian public's perceived love of bulk billing.

However, the Herald/Nielson poll conducted on March 13-15 and released on March 17 must make one rethink this.

Staggeringly, 52 per cent of the 1400 people polled supported introducing a means test so only needy patients are bulk billed. Some 49 per cent supported a GP co-payment, and 5 out of 10 agreed the government should cut the cost of Medicare.

These are figures supportive of major change by any brave new Treasurer determined to return the Budget to surplus. As to whether Joe Hockey is such a fearless soul we will not know until Budget night.

Personally, I feel the creeping inbuilt annual reduction in Medicare rebates in real terms must see Medicare's inevitable demise. Sadly, the annual 1 or 2 per cent cut in rebates has been so gradual that GPs have worked harder, faster and suffered it without major protestation. Much as the legendary frog in a pot brought slowly to a boil did not leap out to save itself, they have soldiered on. New money from outside Medicare must be found to support quality general practice - if not now, then in the near future.

However, if we are to see a two-tier system, some basic rules must be observed.

Government, not doctors, must decide who is eligible to access bulk billing.

> "Staggeringly, 52 per cent of the 1400 people polled supported introducing a means test so only needy patients are bulk billed"

Rebates for those needing access to bulk billing must be fair and indexed in a manner reflecting practice costs and average weekly earnings increases in the broader community. GPs are not in business to be Robin Hood-like figures hell bent on subsidising second-rate rebates payable for those deemed to need assistance.

Those determined to have sufficient income and assets to make a contribution to their care should be allowed to purchase private insurance to cover up to the AMA fee for GP services.

To avoid a descent into managed care, any such insurance must come without strings, like requiring doctors to use the insurer's diagnostic services, specialists, hospitals or allied health services.

Safety nets will need to be in place for those hit by natural or personal disasters, such as that experienced by the grazier with a $10 million property forced to get by without income during a prolonged drought, or the mother of five whose executive husband suddenly dies. Will Medicare have speedy appeal mechanisms to cater for them, or perhaps loan them funds to continue payment for their existing private insurance for a period until their affairs are resolved, at which time such monies would be paid back?

All interesting conjecture. But I, for one, will be surprised if we see real change come the Budget, as our political masters are generally more focussed on their personal re-election than rebuilding our health system.

COMMENT

Continued concern over Queensland Health contracts

BY DR STEPHEN PARNIS

> “This is a very difficult and stressful time for thousands of Senior Doctors in Queensland”

Late last year I reported on the troubling situation with the Queensland Government, implementing its draconian policy of forcing Senior Medical Officers in the Queensland public health system onto unfair individual contracts.

The policy sees SMOs removed from award coverage, stripped of collective rights and denied access to the Queensland Industrial Relations Commission. It amounts to a blank cheque. The AMA Council of Salaried Doctors has unanimously condemned the decision.

Legal advice indicates that the contracts in their current form utterly favour the employer and put senior doctors at a disadvantage. One of the key aspects of the scheme is that from 1 July private practice arrangements will only be approved for practitioners who sign up to the new contracts.

Of course, more broadly, the concern is that the contracts diminish doctors’ basic workplace rights, and leave them with less time to devote to patient care.

AMA Queensland has been working with the Australian Salaried Medical Officers Federation (Qld) to respond to this situation. Their advocacy has been robust and tireless and they are to be congratulated on what they have achieved to date.

Their efforts have led to some improvements regarding training and education, hours of work, a fatigue clause and clinical autonomy. Several key issues remain, including:

- the absence of a binding arbitration process for dispute resolution;
- enforced shift work;
- arbitrary dismissal;
- the absence of a no disadvantage clause; and
- tier 3 key performance indicators being tied to income.

AMA Queensland is offering support to its members, including a dedicated contract hotline with expert advice. Consistent with the position adopted by ASMOF, the AMA is advising SMOs to politely decline to attend negotiations.

If they do decide to attend negotiations, they should take a professional representative with them, and refuse to sign anything until they have seen and read a final copy of the contract.

So deep is the outrage felt by members that at its forum in November 2013, ASMOF successfully introduced a motion to levy its members to fund an industrial campaign against the contracts.

The campaign has generated a great deal of media attention in Queensland and nationally.

Among other activities, the ‘Keep our Doctors’ website and Facebook page were launched on 19 February. I encourage members to access and explore it.

For those looking at working in the Queensland health system, it seems the new contracts are all that will be on offer. That means that new jobs will be advertised at lower rates, and new employees will be offered lesser terms and conditions.

In March, Federal AMA President, Dr Steve Hambleton, along with Dr Shaun Rudd (President Elect and Spokesman for AMA Queensland) and Professor John Fraser met with the Queensland Health Minister, Lawrence Springborg and the Assistant Minister for Health, Dr Chris Davis, to agree on a pathway to attempt to resolve remaining concerns. This is an encouraging development.

This is a very difficult and stressful time for thousands of Senior Doctors in Queensland. Committed and skilled clinicians are being put under tremendous pressure. They are making difficult decisions which affect their careers, their families, and the patients to whom they dedicate themselves. They should know that the AMA proudly stands with them, and for them.

Further meetings have been scheduled, and we trust that the Queensland Government will see sense on this issue.

Quality patient care depends on committed health staff who do not have to expend enormous amounts of time and resources on industrial battles, or watch their working conditions and basic workplace rights eroded. This situation is unprecedented, and we hope that effective advocacy now will send a clear message to all governments about where doctors stand on quality health care and sensible workplace arrangements.

COMMENT

Meeting with the Minister

BY DR RICHARD KIDD

AMA President Dr Steve Hambleton and I met with Assistant Minister for Social Services Senator Mitch Fifield, in his capacity as the Minister with responsibility for the aged care system, on 12 March.

This was an important meeting.

At the end of last year the new Government moved aged care to the Social Services portfolio, and we needed to ensure that the Minister understood that medical care was a fundamental part of quality aged care and, therefore, part of his remit.

The meeting was an opportunity to highlight the medical needs of older Australians and the integral role played by medical practitioners in the aged care sector, particularly given the Social Services Department had been given the task of implementing the aged care reforms set in train by the previous Government.

We opened the meeting by noting the Minister's recently established an Aged Care Sector Committee. The Committee has been established to support the aged care sector in adapting to new challenges and demands as Australia's population ages. At the time of announcement, the Committee's proposed membership did not include a medical practitioner.

In the meeting we outlined the challenges currently faced by medical practitioners who provide care to older Australians in the community and in residential aged care.

In particular, we highlighted the need for aged care facilities to take more seriously the existing accreditation standard requirement to assist residents to obtain medical practitioner services by providing administrative support.

In terms of community aged care services, we emphasised the importance of involving the treating doctor in Aged Care Gateway assessments in order to direct Home and Community Care Program funding to address the most critical needs of older Australians.

Finally, we discussed the plight of carers and their access to respite services.

To this end, we impressed on the Minister the need for a safety net for older people living in the community and their carers, whereby medical practitioners can authorise urgent access to respite care.

“To this end, we impressed on the Minister the need for a safety net for older people living in the community and their carers, whereby medical practitioners can authorise urgent access to respite care”

The Minister was highly engaged in our discussion about the issues within the sector affecting the provision of medical care to older Australians.

He recognised that good medical care in the aged care sector had consequences for the health budget, and vice versa.

For that reason, the Minister undertook to include a medical practitioner on the newly established Aged Care Sector Committee.

COMMENT

Health on the hill

Political news from the nation's capital

Medibank put on the auction block

The Federal Government has moved to allay concerns that the privatisation of the nation's largest health fund will hurt patients, reporting that there was "no evidence" the move would force insurance premiums up.

In a widely-anticipated decision, Finance Minister Mathias Cormann announced on 26 March that the Government will proceed with the sale of Medibank Private in a transaction that could net the Commonwealth $4 billion.

Senator Cormann said competition in the health insurance sector was strong and, combined with the existing regulatory requirement that all premium increases be approved, meant there was no reasons to expect the sell-off would push up member costs.

"Medibank Private is a commercial business operating in a well-functioning, well-regulated competitive private health insurance market with 34 competing funds," the Minister said. "The scoping study [into the proposed sale] found no evidence that premiums would increase as a result of the sale of Medibank Private."

AMA President Dr Steve Hambleton reacted cautiously to the sell-off plan.

"It's hard to say whether the news is good or otherwise," Dr Hambleton told ABC Radio. "We certainly asked in the scoping study that there be an examination of the impact on premiums. We were concerned that premiums may increase. We note that the Minister says he has no evidence that premiums will increase."

Ever since Medibank Private sale legislation was passed by Parliament in 2006, the AMA has warned of the potential for the privatisation of the fund to lead to a jump in premiums unless the sell-off was managed carefully.

Dr Hambleton said it was difficult to judge the potential impact of the privatisation because the AMA had not seen the results of the scoping study.

"It would be good to know that sort of advice so that we can assure ourselves that [it] will be ok," the AMA President said. "Of course, we won't know until after the sale about what impact the sale might have on the services offered and the benefits to members, but these are some of the unknowns."

Senator Cormann said the Government plan was to sell the insurer through an initial public offering during 2014-15, though "the precise timing and structure [of the IPO] are yet to be determined".

"There is no compelling reason for the Government to own Medibank Private," he said, announcing the appointment of three new members to the insurer's Board: lawyer David Fagan, corporate adviser Linda Nicholls and CSL Director Christine O'Reilly.

But the Government may encounter opposition to its plans.

Shadow Health Minister Catherine King said Labor believed Medibank should be kept in public ownership, not least to act as a "moderator" for fees and premiums charged by health funds.

Ms King said the Government needed to prove its case for selling the insurer off, including its claim that the move would increase competition.

The proposed sell-off comes as the insurer is embroiled in a range of controversial efforts to expand its range of activities.

Through its spin-off Medibank Health Solutions, the fund has run foul of doctors providing health services to Defence Force personnel over the terms of contracts it has offered, and it has also engaged in moves to expand operations into primary health care.

The Federal Government has also mused that Medibank may in future take a role in the management of the National Disability Insurance Scheme.

Adrian Rollins

COMMENT

Govt 'open' to talks about role of pharmacy

Health Minister Peter Dutton has flagged the Federal Government is "open to discussions" about the scope of services that pharmacists can provide.

With negotiations on the next Community Pharmacy Agreement (CPA) looming, Mr Dutton has reassured pharmacists the Government would block any move by retail giants Coles and Woolworths to move into dispensing and left open the possibility of expanding the scope of pharmacy practice.

"I don't believe pharmacists want to be doctors, nor retailers," the Minister told the Australian Pharmacy Professional Conference on 13 March. "[But] the time is right to commence a discussion about the future of pharmacy… so I am open to discussions about an agreement which pays for tangible services and interventions that will provide better patient outcomes."

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Mr Dutton made his remarks as pharmacists braced themselves for a another hit to their profit margins as a result of the latest round of drug price cuts that came into effect on 1 April (see *Billions could be saved as drug prices fall,* following this story).

The Minister admitted that the accelerated price disclosure regime established by the previous Government had added to the financial strain on pharmacies in recent times.

"It has been a tough period for a number of pharmacies over recent years," the Minister said. "People have been caught with the pressures of high rents, rising wages and other input costs and uncertainty and, in some cases, unmanageable levels of debt as a result of the former Government's CPA and accelerated price disclosure."

In their search for more revenue, pharmacists have mounted a controversial and increasingly aggressive push to expand their range of practice to include administering vaccinations and possibly undertake routine health checks.

The Queensland Government is expected this month to authorise the expansion of a pilot program under which pharmacists give flu vaccinations to customers.

And NSW Health Minister Jillian Skinner has given in principle support for pharmacists "being included in immunisation service delivery models", in a letter to the Pharmaceutical Society of Australia seen by the *Australian Financial Review*.

But the AMA and other medical groups have voiced strong objections to the move, which they warn could put the health of patients at risk because pharmacists were not trained to provide such treatment.

Late last month the nurse practitioner Revive Clinic Group took out an advertisement in a Queensland newspaper in which it claimed pharmacists were not legally approved to administer vaccinations anywhere in Australia.

Group Managing Director Louise Stewart told *Medical Observer* the Queensland pilot project, which has expanded to include almost 60 pharmacies, was potentially misleading because patients taking part were not told that the service was a trial.

But the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia have hit back, condemning Revive's statement as "false and misleading".

Pharmacy Guild President George Tambassis said pharmacists taking part in the Queensland trial had been authorised to administer vaccinations, and the Northern Territory had introduced similar legislation.

National President of the Pharmaceutical Society Grant Kardachi said pharmacists were undertaking additional training in administering injections.

While he was careful not to explicitly endorse such an expansion in pharmacy practice, neither did Mr Dutton voice objections.

"Pharmacists should receive a fair and proper return on their capital investment, and financiers should know that is a key objective of the Government," the Minister said.

Mr Dutton made his comments just days after his Government's surprise decision to axe the Pharmaceutical Benefits Pricing Authority, which made recommendations on the prices of medicines on the PBS.

In a surreptitious move, a statement was published early last month announcing that the PBPA would cease operations from 1 April as part of a "new streamlined process to reduce the time taken to list medicines on the Pharmaceutical Benefits Scheme and improve access to medicines".

While the final decision on medicine prices remains with the Health Minister, the Government said the change – which blindsided the pharmaceutical industry – would cut at least four weeks off the time needed to list medicines on the PBS.

"At the same time, sponsors will benefit from having additional time, to the end of week five after the meeting of the PBAC, in which to finalise pricing submissions following a positive PBAC recommendation," it said, adding that there would be no change to current arrangements for sponsors seeking price increases for currently subsidised medicines.

Adrian Rollins

COMMENT

Billions could be saved as drug prices fall

The price of more than 120 medicines subsidised by the Federal Government will drop from today, saving some patients up to $12 per prescription.

Under the terms of price disclosure arrangements introduced by the previous Government, the cost of 121 medicines included in the Pharmaceutical Benefits Schedule has fallen from today, potentially saving the taxpayer up to $20 billion by 2018, according to the pharmaceutical industry.

Among the price cuts, the cost of the widely used cholesterol-lowering drug simvastatin has dropped more

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than $5 a script to $14.99, while the price of anti-fungal treatment fluconazole has fallen by a third, from $36.90 to $24.25.

In addition to the price cuts, 10 medicines used to treat a range of illnesses including cancer, lung infections and arthritis have today been added to the PBS, providing a further financial boost to patients.

The newly-listed medicines include HIV drug dolutegravir (sold as Tivicay), colorectal cancer treatment panitumumab (Vectibix), giant cell bone tumour medicine denosumab (as Xgeva), a drug to treat arthritis in children (toclizumab, sold as Actemera) and the powder form of bacterial lung infection treatment tobramycin (Tobi Podhaler), commonly used by cystic fibrosis patients.

Adrian Rollins

COMMENT

Pharmacists could be valuable support for doctors

The AMA is holding top-level talks with the Pharmaceutical Society of Australia on the integration of pharmacists into general practice.

As collaboration between health professionals deepens, the AMA and the Pharmaceutical Society are working together on how to include non-dispensing pharmacists in GP-led primary health care teams.

In a letter to AMA members, President Dr Steve Hambleton and Chair of the AMA Council of General Practice Dr Brian Morton, said that pharmacists have so far been largely left on the sidelines as nurses and allied health professional have increased their involvement in primary care teams led by GPs.

But the AMA officials said there were good reasons to seek to include pharmacists.

They said integrating pharmacists into primary care health teams could enhance the use and management of medicines, including reducing the number of adverse events.

"Integrating pharmacists into the multi-disciplinary primary care team would enable pharmacists to focus on what they are good at, and ensure that the care of patients is integrated, not fragmented or duplicated," Dr Hambleton and Dr Morton wrote.

In addition to its work with the PSA, the AMA is conducting a survey of general practitioner members to get their views on the integration of pharmacists into GP-led primary care teams, including the contribution they could make, and how their work could be funded. The PSA is simultaneously conducting a similar survey of its members.

Adrian Rollins

COMMENT

Fears NDIS teething problems could slow scheme

The Federal Government has been urged not to use shortcomings in the initial roll-out of the National Disability Insurance Scheme as an excuse to delay its full implementation.

Questions have been raised about the feasibility of current plans to have the scheme in virtually full operation by 2019-20 following a sobering assessment of the capabilities of the Government body charged with overseeing the scheme, the National Disability Insurance Agency.

A review of the NDIA released by Assistant Minister for Social Services Mitch Fifield on 20 March found that the Agency was "like a plane that took off before it had been fully built, and is being completed while it is in the air".

It found that compressed time-frames – the implementation of the scheme was brought forward by a year by the previous Government – had saddled the nascent organisation with an array of significant problems that could undermine its effectiveness in the longer-term if not addressed.

The review, commissioned by the Agency's Board at the behest of Senator Fifield, found that the rush to establish four NDIS trial sites by 1 July 2013, had left the organisation with the legacy of an ICT system that was "not fit for purpose" and a Board without the optimal mix of skills, while the decision to relocate its headquarters to Geelong would entail the wholesale turnover of staff, further disrupting operations.

The review warned that one of the greatest risks confronting the Agency is that it is not given time to consolidate and put in place the systems and processes necessary to derive maximum benefit from the lessons gained from the trial sites.

"Pressure to move faster may compromise the ability of the Agency to learn and to collect the evidence needed

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to inform a successful and sustainable roll-out across the whole country," it said.

The NDIS was proposed by the Productivity Commission and has been hailed as a major social reform that will vastly improve the lives of the disabled and their families and carers, as well as delivering a significant economic boost to the country.

Senator Fifield said the Government was "determined to deliver the NDIS in full", but is awaiting advice from the Agency about whether a "successful" roll-out can be achieved under the current timetable.

So far, the Scheme encompasses just 2500 people at four trial sites in Barwon, the Hunter, Tasmania and South Australia. The plan is that from 2017-18 a further 300,000 people will be added – 93 per cent of those eligible.

The Opposition has raised suspicions that the Government may be soft-peddling on the Scheme.

Shadow Minister for Disability Reform Jenny Macklin, who has responsibility for the NDIS when Labor was in office, said the Scheme was one of the nation's great social reforms and should not be delayed.

The Government inflamed suspicions about its intentions when Treasurer Joe Hockey told Parliament the NDIS was among a "massive tsunami of increases in expenditure" made by the previous Government which had plunged the Budget deep into deficit

"In disability spending, there will be a 125 per cent increase as the NDIS comes into play. And it was not properly paid for," the Treasurer said.

But Ms Macklin condemned Mr Hockey's comments and said the NDIS was fully and sustainably funded by a 0.5 percentage point increase in the Medicare levy.

The review's findings have alarmed proponents of the NDIS concerned about the prospect of delays in its implementation.

Every Australian Counts Campaign Director John Della Bosca said the report should not be used as an excuse for slowing the implementation of the Scheme.

"Rolling out the NDIS is a big job, but it's hardly sending someone to the moon and it should not take a decade to deliver," Mr Della Bosca said. "The starting point for any discussion about the NDIS has to be focussed on the real crisis. Every delay in rolling out the NDIS means Australians with disability and their families will struggle without the supports they desperately need."

Peak body National Disability Services said it would be "premature" to delay the full implementation of the Scheme based on the Review's findings.

"The NDIS is eight months into a six-year marathon," the organisation's Chief Executive Dr Ken Baker said. "We've exerted a lot of effort and ingenuity to get this far so quickly; it's too early to decide that the road ahead is too steep."

He said the problems identified by the Review were "not insurmountable".

Adrian Rollins

COMMENT

Axing drug adviser costs taxpayers $1 million

The Federal Government's shock decision to axe funding to one of the nation's oldest advisory bodies on alcohol and drugs policy will end up costing it close to $1 million, it has been revealed.

Fairfax Media has obtained a leaked report from the administrator appointed to wind up the Alcohol and Other Drugs Council of Australia (AODC) showing the Commonwealth has so far paid out more than $949,000 to cover the cost of shutting the organisation down.

The Abbott Government sent shockwaves through the public health sector last November when it abruptly withdrew funding to the Council, which has been operating since 1966 as the peak body for organisations working to minimise the harm caused by drugs and alcohol.

In a letter sent to the Chair of the National Commission of Audit on 26 November last year, Health Minister Peter Dutton said the decision to discontinue funding had been taken because of "the duplication of roles of peak bodies in the drug and alcohol sector".

The Council, which received $1.6 million a year from the Health Department, provided professional development, information sharing and advocacy services for drug and alcohol organisations, as well as maintaining one of the world's foremost research libraries on drug and alcohol policy.

The decision to axe funding to the body was announced by Assistant Health Minister Fiona Nash, who was embroiled in controversy earlier this year over her intervention to have a website for the new Healthy Food Star Rating System taken down just hours after it went live.

Her Chief of Staff Alastair Furnival was subsequently forced to resign after it was revealed he had links to a lobbying firm which had had a major food manufacturer opposed to the rating system as one of its clients.

Former federal Liberal MP Dr Mal Washer, who was President of the AODC Board, told Fairfax Media the

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decision to axe funding to the organisation was "a bloody tragedy".

"This wasn't subject to any review. It was dumb advising dumber, and dumb won," Dr Washer said.

In his letter to Commission of Audit Chair Tony Shepherd, Mr Dutton said that if the Council was unable to secure funding elsewhere, "it may lead to a wind-up of operations, and the Australian Government will seek to assist with outstanding liabilities".

The leaked administrator documents obtained by Fairfax Media show the Council reached a settlement with the Health Department for $697,790, while a further $250,000 in administrator fees have been sought or approved, so far.

Adrian Rollins

COMMENT

PM dodges senior health card worries

Prime Minister Tony Abbott has tried to sidestep speculation that the subsidised access of seniors to medicine will be restricted under changes being considered for the May Budget.

Responding to reports that the Commission of Audit has recommended that the exemption of superannuation income from eligibility tests for the Seniors Health Care Card be reconsidered, Mr Abbott said the Government would stand by its election commitments.

The Card gives older Australians who do not receive the age pension or a veteran's benefit and who meet income tests, discounts on medicines listed on the Pharmaceutical Benefits Scheme.

In the election, the Coalition pledged to lift the income eligibility threshold in line with inflation, which it estimated would allow an extra 20,000 self-funded retirees access to the Card, at a cost of $100 million over four years.

Mr Abbott said the Government was "carefully considering the interim [Commission of Audit] report".

""The stress that I want to put on everything is we will keep our commitments," he said. "We will do what's necessary to put Australia on a fiscally sustainable path forward. But we will do it in ways that are consistent with the commitments we put forward before the election."

"We made an absolutely crystal clear commitment before the election to index the eligibility thresholds, and we will keep our commitments."

Adrian Rollins

COMMENT

OPINION

Flawed co-payment proposal does not stack up

BY AMA PRESIDENT DR STEVE HAMBLETON

> "The AMA does not believe that there is evidence of widespread over-utilisation of GP services"

This is an edited version of the AMA's submission on the Australian Centre for Health Research's (ACHR) proposal for $6 patient co-payment for GP services. It was presented by AMA President Dr Steve Hambleton to the Senate Select Committee into the Abbott Government's Commission of Audit on 7 March.

The ACHR's proposal for a "modest" GP co-payment has the stated "unambiguous purpose" of finding savings in Medicare outlays.

But we do not believe that ACHR's analysis has any credibility.

The growth in Government spending on GP rebates is very moderate and well able to be sustained. The Productivity Commission's *2014 Report of Government Services* shows that the Australian Government's real expenditure on GPs (2012-13 dollars) has increased from $301.60 in 2006-07 to $304.40 in 2011-12, an average annual increase of only 0.18 per cent.

This rate of increase is fully consistent with the ageing of the population.

The AMA does not believe that there is evidence of widespread over-utilisation of GP services.

Every GP will have a number of patients who are overly anxious about their health and attend more often than they need to, based on physical indications alone.

But, likewise, every GP has a number of patients who turn up at the door long after the appropriate time, and that this under-utilisation of primary care services has a much more costly counterpart in additional tertiary services and avoidable ill health.

The AMA sees very significant flaws in the ACHR analysis.

ACHR has constructed a no policy change scenario that involves growth in service volumes of 3 per cent a year between 2013-14 and 2017-18.

They have not provided any rationale for such a high figure.

Over the entire period of Medicare to date (1984-85 to 2012-13), the average annual growth rate was 2.24 per cent per annum.

By choosing a high-growth rate for the base case, ACHR has painted an overly optimistic picture of the scope for budget savings under their co-payment proposal.

The prime driver of GP consultations is population growth. Australian Bureau of Statistics population projections have population growth slowing gradually from 1.85 per cent in 2012-13 to 1.60 per cent by 2030-31.

The ageing of the population will contribute about 0.2 per cent a year to GP service volumes in the immediate future, and that will slow to nearer 0.1 per cent by 2030 as the baby boomer "shoulder" passes through.

An ageing population will mean more complexity in the mix of services required (more chronic care items, for example) rather than any rise in the number of services per se.

A concerning aspect of the ACHR work is the projected impact of a co-payment.

The 1991 Howe co-payment was very short-lived (December 1991 to March 1992), so it is difficult to see any impact on GP service volumes in the quarterly data published at the time.

The Howe co-payment has also been widely misunderstood (including by ACHR) as a co-payment arrangement whereas it was, in fact, a rebate reduction.

The-then Labor government brought maximum pressure on GPs not to charge the co-payment.

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OPINION

Flawed co-payment proposal does not stack up

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> “It is more likely that the co-payment would be charged in country areas where GP practices are under greater cost pressure”

In the very short term, the scheme caused fear in the population but utilisation rebounded quickly once its demise was known.

The Australian Government has much more experience with PBS co-payments.

The evidence from that side is that they can have a short-term shock effect, but no enduring impact on overall growth rates once households get accustomed to the required contributions.

The reason is simple: health is a “superior good”, and people will meet out-of-pocket costs rather than forego access to health goods and services they see as important.

A rise in co-payments will, of course, have an impact on demand from the most vulnerable members of society, those who do not have any capacity to pay more.

To the extent that a GP co-payment reduces the demand for services from the most vulnerable, then the overall impost on governments would almost certainly rise as there would be an increase in avoidable hospitalisations.

ACHR has managed to conjure up MBS savings projections that are, at once, both too high and too low.

They are too high because they assume very simplistically that a $6 co-payment will be charged notwithstanding no up-front reduction in nominal MBS rebates.

On the basis on this relatively modest impost, ACHR projects quite a sharp reduction in service volumes.

Competitive pressures in urban areas with stronger GP supply will mean that it is highly unlikely that GP practices will universally charge the $6.

If the co-payment is not charged in those areas, the volume reductions will not occur either. And that is where most Australian live.

It is more likely that the co-payment would be charged in country areas where GP practices are under greater cost pressure. They have higher operating costs and less potential to garner efficiencies because the practices are smaller than the practices in the cities.

There is already a city/country divide when it comes to patient out-of-pocket costs and access to health care services more generally.

The ACHR proposal will deepen that divide.

The “announcement effect” only occurs once under the ACHR proposal (in 2014-15), yet in the following three years when the fee freeze progressively tightens the screws, ACHR continues to project large volume savings every year.

Per capita utilisation of GP services is projected to continue falling throughout the forward estimate period. The AMA views this as a highly unlikely scenario given an ageing population.

On the other side, ACHR’s savings projections are too low because the fee freeze component of the proposal would generate savings over four years of more than $1.1 billion additional to any savings resulting from volume reductions.

Rebate cuts of that order would represent a very significant reduction in Government support for patients needing to see a GP.

Were there any credibility in the ACHR volume projections (which we very seriously doubt), then the likely impact of the combined policy of a co-payment and a fee freeze would be savings in MBS outlays of more than $2 billion over four years.

The strong common interest between the profession and the government is to find a formula for GP financing that is most effective in supporting GPs in their gatekeeper/preventive care role.

If that role is performed effectively, there is a dividend in lower downstream health care costs.

In short, great care is needed to ensure that a cost cutting in one part of the budget does not generate additional costs in another part.

COMMENT

FEATURE

Overseas conflicts and disasters: the challenge of caring for those who serve

As the nature of conflict and disaster relief has changed, so has the health issues and challenges faced by those who serve. This will be the topic of an expert-led discussion during the AMA National Conference, to be held from 23 to 25 May at the National Convention Centre, Canberra*.

For all the advances in weapon technology and military tactics that have occurred in the 100 years since World War One broke out, the brutal fact remains that soldiers – and often civilians – continue to die and suffer horrific injuries in battle – as well as away from the battlefield.

The casualty count might have shrunk, but for those at the sharp edge of conflict the threat of death or severe physical or emotional trauma is as real as it ever was.

But, as will be explored in the *Overseas conflicts and disasters, the challenge of caring for those who serve* session at the AMA National Conference in May, though the fact of death, injury and disability as a consequence of war has not changed in the past century, the way this challenge is met has.

For a start, soldiers are now far more likely to survive injuries that for much of the past 100 years would have been considered fatal.

Vast improvements in military tactics and equipment have made a huge difference in ameliorating the danger of combat, but the ability to quickly extract wounded soldiers from the field of combat, combined with advances in medical treatment and technology, has also helped drive mortality rates sharply lower.

In World War One, of almost 226,000 Australian soldiers, sailors and airmen who embarked for overseas service, 58,961 died out of a total enlistment of 416,809, for a mortality rate of 26 per cent. By comparison, of around 28,000 personnel deployed in the Middle East theatre of operations between 2001 and 2013, 42 died – a mortality rate of just 0.15 per cent.

While the huge drop in mortality rates is a great achievement, it has meant that many returning veterans have multiple, severe physical and mental injuries that require sophisticated long-term care, presenting a big challenge for doctors and therapists, as well as families and carers.

Injuries suffered as a result of blasts, such as from improvised explosive devices, were often terrible, including the loss of limbs, hearing, the long-term effects of concussion and PTSD.

A study by the Centre for Military and Veterans' Health (CMVH) found hearing loss was one of the most common complaints of Afghanistan and Iraq War veterans.

> "While the huge drop in mortality rates is a great achievement, it has meant that many returning veterans have multiple, severe physical and mental injuries that require sophisticated long-term care"

Aside from the damage caused by blasts from improvised explosive devices, many reported being exposed to loud noises, often for extended periods, without protection.

The study found that many were also at elevated risk of developing respiratory problems such as asthma, bronchitis, sinus blockages and hay fever because they inhaled smoke, and were exposed to airborne dust, fibres, solvents and fuel fumes.

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FEATURE

Overseas conflicts and disasters: the challenge of caring for those who serve

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Veteran health experts add simple physical wear and tear to the list. Soldiers often develop musculoskeletal problems associated with the physical demands of active service, such as the strain caused by hauling heavy packs and equipment, sometimes weighing more than 70 kilograms, for hours and days at a time.

But, while physical injuries and problems are often visible and readily diagnosed, many soldiers return from active service with mental health problems that are much less obvious, and which they themselves may not acknowledge.

The fact that soldiers suffer mental health problems as well as physical injuries is nothing new.

During World War One and World War Two hundreds of thousands of the servicemen and women suffered what was called at the time shell-shock – what would now in many cases be diagnosed as post-traumatic stress disorder (PTSD).

According to the CMVH study, the risk of developing mental health problems increases up to 15-fold for those involved in combat, and can include PTSD, major depression, panic and other anxiety syndromes, and alcohol misuse.

Unfortunately, many in the past who carried deep mental scars from their war service felt they had few places to turn for help and suffered in silence.

Attitudes toward mental illness among veterans have not helped.

Often, as former Royal Marine Commando Adrian Talbot told the *Sunday Mail*, veterans are not even aware they have a problem until it becomes acute, or are reluctant to seek help.

This reluctance, combined with the hostility faced by many veterans returning from the Vietnam War faced, meant that many from that theatre of battle did not seek treatment, and mental health issues have blighted their lives ever since.

Although soldiers returning from more recent conflicts like East Timor, Iraq and Afghanistan have been welcomed home in a way Vietnam veterans were not, many are still hesitant to seek help with mental health problems for a number of reasons, not least because of fears it may compromise their chances of being included in further overseas deployments.

The challenge of encouraging returning servicemen and women to seek help for mental health problems is set to be a focus of the AMA National Conference session – attention that the CMVH study suggests is sorely needed.

A census of more than 14,000 current and former Defence Force personnel who served in the Middle East conducted by the Centre found ex-servicemen and women suffered "significantly poorer mental health" than those still on active duty, and that its prevalence increased two to three years after the most recent deployment, particularly among those who had left service.

The CMVH said this had particular implications for the Department of Veterans' Affairs, because it suggested ex-servicemen and women were likely to "require considerable support, possibly for many years. Prevalence of PTSD symptoms, suicidal thoughts and alcohol misuse among ex-serving members suggest that there will be on-going need for psychological and psychiatric treatment".

Adding a further complication, the report found the onset of mental health problems stemming from deployment was often delayed, and noted that the DVA could not engage with such people until they lodged a claim.

"Therefore, Defence and the DVA need to work together to provide continuity of service and opportunities for longer-term support… after separation," the study said.

Doctors and the AMA (and its predecessor the BMA) have historically worked in close partnership with the DVA in caring for returned servicemen and women, and this work will continue to be critical as many of the thousands who have been on active service in the past 15 years leave Defence and move to the next phase of their lives.

Adrian Rollins

** This is the first in a series of articles looking at issues that will be the subject of expert-led discussion during the AMA National Conference, to be held from 23 to 25 May at the National Convention Centre, Canberra. Issues to be examined in future editions include the global challenge of non-communicable disease, health funding, practising medicine overseas, and variations in medical practice.*

COMMENT

Research

Teen mental health linked to energy drinks

Regular consumption of energy drinks by teenagers may increase their likelihood of developing mental health problems.

A study by researchers from the University of Waterloo and Dalhousie University found that high school students prone to depression, or who smoke marijuana and drink alcohol, are more likely to consume energy drinks.

Lead researcher Dr Sunday Azagba said it remains unclear why the associations exist, but the trend is a concern because of the high rate of consumption of energy drinks among teenagers.

“These drinks appeal to young people because of their temporary benefits like increased alertness, improved mood and enhanced mental and physical energy,” Dr Azagba said.

The researchers are calling for limits on access to energy drinks by teens, and recommend that manufacturers reduce the amount of caffeine in each can.

The researchers surveyed more than 8200 high school students from Canada, and nearly two-thirds reported they had used energy drinks at least once in the past year. More than 20 per cent said they consumed an energy drink once or more a month.

Dr Azagba said marketing campaigns appear designed to entice youth and young adults.

“It’s a dangerous combination, especially for those at an increased risk of substance abuse,” Dr Azagba said.

Energy drinks have been well documented to be associated with a number of negative health effects, including cardiovascular symptoms, sleep impairment, nervousness and nausea. The researchers said the side effects were caused by the high caffeine levels in the drinks.

AMA President Dr Steve Hambleton has been vocal in warning about the dangers of energy drinks for teens, warning that they were cocktail of addictive caffeine with sugar.

“Energy drinks contain a significant amount of caffeine, and they’re promoted alongside soft drinks,” Dr Hambleton said

“Regulations need to be tightened, as these products are not intended for children or for pregnant women. Even the manufacturers would agree with that.”

Despite the health implications, sales of energy drinks jumped to $US20 billion in 2013 in the United States alone.

Researchers said that, at the very least, steps should be taken to limit the access of teens to energy drinks, to increase public awareness and education about the potential harms of these drinks, and to minimise the amount of caffeine available in each can or bottle.

Dr Azagba said that this would not eliminate the problem entirely, but steps like these could help mitigate the harm that appeared to be associated with consumption of energy drinks.

She said it was something that needed to be taken seriously, and that change wouldn’t happen without a concerted effort.

The study was published in *Preventative Medicine*.

Kirsty Waterford

COMMENT

Sun exposure linked to low folate levels

Women trying to fall pregnant, or who are pregnant, have been cautioned to monitor their sun exposure after new research has linked exposure to the sun’s UV radiation to a decrease in levels of folic acid.

Researchers from the University of Queensland found that UV exposure significantly depleted folate levels.

Nearly 50 women aged between 18 and 47 years were monitored for three weeks by University of Queensland researchers, with each woman given a 500 milligram dose of folic acid to take daily for two weeks.

On the third week, researchers tracked the exposure of each subject to the sun, and measured the folate levels in their blood. They found that the more sun exposure the women had, the lower their folic acid levels.

In fact, researchers found that women who regularly spent time outdoors between 10am and 3pm with little sun protection, had a 20 per cent decrease in folate levels.

Lead researcher Professor Michael Kimlin said that the results were concerning as the benefits of folic acid are well known. He urged young women to take a folic acid supplement prior to and during pregnancy.

“Folate has been found to reduce miscarriage and neural tube defects such as spina bifida in unborn babies,” Professor Kimlin said. “The NHMRC recommends pregnant women, or these planning a pregnancy, take 500 milligrams a day.”

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Research

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Researcher Dr David Borradale said further research, including a controlled clinical trial, was needed.

“We are not telling women to stop taking folate supplements, but rather urging women to talk to their doctor about their folate levels and the importance of folate in their diet, especially those who are planning a pregnancy,” Dr Borradale said.

The study was published in the *Journal of Photochemistry and Photobiology B:Biology*.

Kirsty Waterford

COMMENT

Getting to the heart of a solution

Melbourne scientists are close to producing a new drug to stop and reduce the damage caused by heart attacks, without any side effects.

Professors from the Monash Institute of Pharmaceutical Sciences (MIPS), Arthur Christopoulos and Peter Scammells, led a team of scientists to merge molecular pharmacology and medicinal chemistry, and with this reveal an insight into a specific protein belonging to the family of G protein-coupled receptors (GPCRs).

The team successfully combined the two molecules and now are a step closer to creating a brand new class of drug that is more direct and could have minimal side effects.

GPCRs are in almost every biological process and most diseases, and almost half of all current available medications use GPCRs to achieve a healing effect.

Professor Christopoulos said current GPCR drugs worked either by fully activating or completely blocking receptors, treating the protein like a simple on-off switch.

The new research discovered alternative recognition sites on GPCRs that can be targeted by drugs to fine-tune the behaviour of the protein, an insight that enabled the breakthrough.

“When a heart attack strikes, heart cells die because of a lack of oxygen and nutrients, but even more damage is caused when the blood rushes back to the heart cells due to the release of inflammatory chemicals and damaging free radicals,” Professor Christopoulos said.

An adenosine A1 receptor, a GPCR found in the heart, is activated by current drugs that minimise damage to the heart. However, activating the A1 receptor also slows down the heart, or can even stop the heart completely.

“Correct dosage has been a serious challenge in clinical trials for A1 receptor drugs,” Professor Scammells said.

Professor Christopoulos said the Monash study focused on finding new ways to activate the protein to achieve the beneficial effects, without the side effects.

“The beauty of this protein is that if you activate it effectively, you minimise the heart attack and protect the heart cells, and that’s something that’s never been done before,” Professor Scammells said.

Sanja Novakovic

COMMENT

Simple test for gut wrenching problem

A simple blood test could soon be used to detect stomach cancer, removing the need for invasive endoscopies, according to new research.

University of Adelaide researchers have discovered four proteins that change in concentration in the blood of stomach cancer patients.

The researchers looked at differences in protein levels between serum samples from 37 gastric cancer patients, including 11 early-stage patients, and controls which included healthy and non-cancerous patients with other gastric disease.

They found four proteins – afamin, clusterin, haptoglobin and vitamin D binding protein – were individually superior to current clinical marker CA72-4 in discriminating stomach cancer from healthy controls.

Lead researcher Associate Professor Hoffman said stomach cancer is the fourth most common cancer in the world, and the second-leading cause of death due to cancer.

“Stomach cancer is typically without symptoms in the early stages, so most cancers are not diagnosed until the later stages and the survival rates are therefore low,” Associate Professor Hoffman said.

“Endoscopic investigations are invasive and expensive, and most are generally not conducted until the cancer is at an advanced stage.

“A non-invasive, inexpensive screening technique through a simple blood test for the early detection of stomach cancer would make a huge difference in the survival outcomes for people with this disease.”

The researchers are also investigating whether the biomarkers could be used to detect cancer in other parts of the gastrointestinal system, including the bowel and oesophagus.

The research was published in *Biochimica et Biophysica Acta [2]*

Kirsty Waterford

COMMENT

Biggest fake medicine racket in US history busted

US authorities have cracked a multi-million dollar racket producing fake over-the-counter medicines and treatments such as Vaseline, baby oil, lip salves and cold remedies.

The Long Island-based counterfeit operation, claimed to be the largest pirate goods racket ever uncovered, involved five factories churning out concoctions made from sub-standard and bogus ingredients that potentially put the health of thousands of consumers at risk.

In raids carried out early last month, local authorities and Food and Drug Administration officials seized $2 million worth of fake goods destined for shop shelves across the country.

The scam was detected when a fire broke out at one of the factories last year.

Firefighters became suspicious when they stumbled across what appeared to be fake goods during a follow-up visit following the fire.

Samples sent to manufacturers for testing showed the goods to be fakes. The VapoRub product was found to be a watered down version of the familiar menthol and eucalyptus concoction, while other products were in packages with indistinct expiry dates.

Authorities are testing the seized goods for any hazards to health, though so far there have not been any reported complaints of illness linked to the fakes.

The ringleaders of the racket, brothers Pardeep Mullick, 59, of Plainview, and Hamant Mullick, 60, of Franklin Square, have been charged with felony trademark counterfeiting.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

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

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

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

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

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

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

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

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

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

Email: careers@ama.com.au

Deadly doctor attacks force rethink on China health reforms

A Chinese doctor has been killed by an enraged patient while another had his throat slashed amid a rising tide of violence sweeping China's troubled health system.

A doctor in the north-eastern Heilongjiang province was bashed to death by an irate pipe-wielding patient on 17 February, according to Bloomberg news service, while a day later a medical practitioner in Hebei province was fortunate to survive a savage attack in which his throat was sliced open.

Such horrific assaults are becoming increasingly commonplace in Chinese hospitals and medical clinics as patients and relatives outraged by failed or botched treatments – often caused by fundamental problems in the health system – take out their anger on medical staff.

According to official estimates, more than 10,000 doctors, nurses and other professionals are assaulted each year, while the number of medical disputes has exploded, soaring by an average 23 per cent a year since 2002.

China's CCTV said there were 17,243 medical disputes in 2010 alone, almost 7000 more than in 2005, involving patients and their relatives blockading hospitals, destroying property, attacking medical staff and making demonstrations, such as by displaying the bodies of loved ones at the entrance to hospitals and clinics.

While some of the surge in protests has been put down to greater awareness of patient rights, University of Cambridge researcher Jiong Tu, writing in the *Asia Pacific Memo*, said much was due to deep and widespread anger caused by the nation's malfunctioning health system.

During the 1980s the health system was opened up to market-based reforms which, while benefiting the well-off, left most struggling with rising medical fees, negligible health insurance, and poor access to affordable care, according to Mr Tu.

As the state has retreated from providing health care, patients and their families have been increasingly thrown onto their own resources to cover health costs, leaving many to delay seeking treatment until illnesses have reached an advanced stage.

"Many do not seek health care until their condition becomes serious and, for major illnesses, people can exhaust their life savings," Mr Tu said. "In the absence of a formal institution for dealing with medical disputes, if treatment fails, the despairing patients and their families often direct blame at doctors and hospitals."

He said these problems had been exacerbated by the requirement, under the market-based system, for hospitals and health professionals to become self-sufficient, with underpaid doctors often turning to 'grey' sources of income such as drug kickbacks, bribes and over-prescribing.

"In the process, the image of doctors has gradually changed from benevolent angels to monsters in white cloth, [and] when medical accidents or misfortune happens, doctors often become the direct targets of resentment and revenge," Mr Tu said.

For their part, doctors see themselves as scapegoats for the failings of the health system and Government inaction.

Mr Tu said the Chinese Government had, since 2009, begun work on unwinding some aspects of the market-driven health system, and aim to establish a basic, state-sponsored health system providing universal minimum health care coverage, including access to safe and affordable medicines and health insurance cover for all.

He said the Government viewed these changes as an important "social palliative to reduce rising popular resentment".

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Informed Financial Consent

It's important to keep talking about fees

It is important for doctors to inform their patients about the cost of the care they will be providing, and for patients to ask doctors about the fees and costs associated with that care.

The AMA 'Let's Talk About Fees' material provides straight forward information about '*8 questions patients should ask their doctor about costs before hospital treatment*'.

The 'Let's Talk About Fees' brochures, A5 tear off pads and posters are available to members free of charge. To place an order call Kate Frost on (02) 6270 5428 or send an email to feeslist@ama.com.au

The information is also available on the AMA website at https://ama.com.au/ifc.

Time to improve the air supply

Air pollution has emerged as the single most deadly environmental health risk, causing around seven million premature deaths in 2012, according to the World Health Organisation.

In a grim assessment that underlines recent warnings from the AMA about the need to accurately monitor and control air pollution, especially very fine particulate matter, the WHO estimates that breathing in polluted air caused one in every eight deaths in 2012 – more than double previous estimates.

The finding is unlikely to surprise the inhabitants of major east Asian cities such as Beijing, Shanghai, Bangkok and Jakarta, which are regularly smothered in choking smog that reduces visibility to metres and can linger for days or even weeks.

But the WHO's discovery that more than half of premature deaths caused by smog are due to indoor air pollution is disturbing.

The global health agency has found that 4.3 million people died prematurely in 2012 as a result of breathing in pollution air indoors, a significant proportion of them women, children and the elderly.

"Poor women and children pay a heavy price from indoor pollution since they spend more time at home breathing in smoke and soot from leaky coal and wood cook stoves," WHO Assistant Director-General Dr Flavia Bustreo said.

According to WHO estimates, 34 per cent of indoor air pollution-relate deaths involved strokes, 26 per cent were caused by ischaemic heart disease, 22 per cent were due to chronic obstructive pulmonary disease and 12 per cent were acute lower respiratory tract infections in children.

Of the 3.7 million related to outdoor air pollution (the total of indoor and outdoor air pollution deaths adds up to 7 million because many were exposed to both forms of pollution), 40 per cent were due to ischaemic heart disease, a further 40 per cent were caused by stroke and 11 per cent were due to COPD.

The WHO used 2012 mortality data, combined with improved satellite data and ground-monitoring and better information about the exposure to pollution among the 2.9 billion living in homes using wood, coal or dung as their primary cooking fuel, to arrive at the estimates.

The WHO said it results confirmed that air pollution had become the world's largest single environmental health risk.

"The risks from air pollution are now far greater than previously thought or understood, particularly for heart disease and strokes," Director of the WHO's Department for Public Health, Environmental and Social Determinants of Health Dr Maria Neira said. "Few risks have a greater impact on global health today than air pollution; the evidence signals the need for concerted action to clean up the air we all breathe."

Adrian Rollins

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.

WINE

What's in a name?

BY **DR MICHAEL RYAN**

The outrageous and combustible hotelkeeper Basil Fawlty, with his usual sycophantic arrogance, once told an elitist guest, "Some of these people wouldn't know the difference between a Bordeaux and Claret (tsk)".

That line made me stop and think for a while, as I was unsure myself. Then I realised that in Australia, we haven't used terminology like that for well over a decade.

Claret is an Anglicised version of the French word Clairet, meaning pale, from a dark, Rose-style wine made in Bordeaux. After the 1800s, Bordeaux became known for its more structured reds, with the name Claret sticking.

There is a whole heap of poetic licence that has been used to sell wine.

The French and other Old World producers have bandied together to prevent us upstarts in the infantile New World from cashing in on their heritage.

Take for example Hermitage. I used to love drinking Hermitage for $4 a bottle and, of course, there was Penfold's Grange Hermitage. The name was generic for any bold, heavy red wine, mainly Shiraz, but could have Grenache in it. But the chaps on the Rhone decided to put a stop to this, claiming that Hermitage was their heritage.

Champagne is a classic instance of the practice.

It really is difficult not to call all sparkling wine Champagne, as it is such an entrenched and romantic word.

'Bubbles' is a good euphemism, and serious wine producers have been known to refer to refer to their product as Methode Traditionalle, indicating it has been made in the same way as Champagne.

We Aussies stretched the friendship when any lighter style red got the handle of Burgundy, but Wynns Oven Valley Burgundy was a Shiraz. We even cheekily produced sparkling red wine, often Shiraz-based, and called it Sparkling Red Burgundy.

The whites were confusing in Australia.

Houghton's White Burgundy, a dry table wine, had everything in it but the kitchen sink. Semillon was often called Riesling, Hocks, Chablis or White Burgundy. Hunter River Riesling could contain Semillon, Chardonnay and other varieties, all without any Riesling being present. Tyrrells and Penfolds called this Pinot Riesling.

If your head is spinning, that's ok. It gives a new appreciation for our current wine nomenclature.

The basics of Australian labelling include grape variety, region and year. At least you know that, if you buy a 2008 Barossa Shiraz, that's what you will get! Or is it?

In Australia, the maker doesn't have to declare any added wine if it is less than 15 per cent of the mix.

So, stretching the maths, that Barossa Shiraz could have 14 per cent Cabernet, 14 per cent wine from the Clare Valley, and even 14 per cent of 2001 added to it. So, you are possibly only getting 58 per cent of what you paid for. This is taking it a bit far and good producers nearly always declare their percentages.

For a young wine industry with so many regions and micro climates, I think our labelling system works.

In somewhere like Burgundy, which has been making wine for 1500 years and so is well controlled, their labels allow you to know exactly what style you are getting from a singular grape.

But you have to do the homework to achieve any chance of insight.

This is all too confusing. Just enjoy it.

COMMENT

WINES TASTED

1. **Champagne - 2007 Paul Louis Martin Blanc de Blanc**

   This 100 per cent Chardonnay offers great bread and fresh citrus aromas on a background of yeasty biscuit notes. It has a pleasing full palate with creamy textures, and suits all occasions.

2. **White - 2008 William Fever Grand Cru Chablis Les Preuses**

   This is classic Chablis, with lemon overtones and an almost funky mineral nose. The fruit excites then decelerates in a mid-palate, but the dry minerality lingers. Overall pleasing. I would drink with sashimi tuna.

3. **Red - 2007 David Franz Alexander's Reward Barossa Cabernet Shiraz**

   Impressive dark purple colour, with a cornucopia of aromas typified by dark fruit, plums and hints of spice and cloves, with the perennial leathery notes. A gorgeous, supple fruit palate, with well-structured tannins and oak exposure. While drinking well after an hour of decanting, this will cellar 10 to 15 years. I think game-style meats would suit.