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PRESIDENT'S MESSAGE

BY AMA PRESIDENT
DR STEVE HAMBLETON

> "Making policy on the run is no way to equip the health system to meet future needs"

Time for serious health policy

There has been an epidemic of crazy health policy proposals floated in the media and political circles in the first few months of 2014.

There has been speculation ahead of the Budget about GP co-payments, freezing Medicare rebates, means testing, and a charge for patients who go to emergency departments with minor ailments.

Many of these thought bubbles have been raised by so-called health experts. They get discussed and dissected in the media, and they attract supporters and detractors. The AMA hopes they never see the light of day, let alone make it into Government policy.

The big problem is that these bad policy proposals are not going away. They linger. The Government should be killing them off, dismissing them outright. But, for some reason, the various Health portfolio Ministers are letting these ideas emerge again and again in Budget conjecture.

We urgently need the Government to engage in meaningful consultation with the medical profession about health policy. There are significant challenges ahead for our health system. We need solutions, and soon.

It is not possible to develop significant health policy that works without first consulting with the people who work in the front line of the health system every day.

Making policy on the run is no way to equip the health system to meet future needs.

First, we must remove the policies that we know won't work from discussions. The AMA has been in the media explaining why these things won't work.

The reports of a possible charge for 'low acuity' patients treated in emergency departments suggest that policymakers have been more focused on budget savings than patient care.

Category 4 and Category 5 emergency department patients are not necessarily GP patients – they are the patients who can safely wait for care.

They are not clogging up the emergency departments, so the proposal is trying to solve a problem that does not exist.

The problem in emergency departments is lack of capacity in the hospital to move sick people out of the emergency department into inpatient beds.

The Government must also clarify its position on primary care, especially general practice.

The GP co-payments idea could actually lead to increased costs to the health system, and should be ruled out immediately.

Freezing Medicare rebates would have a compounding effect on patient out-of-pocket costs, creating another disincentive for people to see their doctor.

Targeting GP services for savings is a false economy that would lead to greater costs down the track.

General practice is a very efficient part of the health system, helping minimise the number of people who end up needing far more expensive hospital or chronic care.

There is not a significant problem with supposed unnecessary use of GP services. This is a furphy. The greater concern is putting barriers in the way of people seeking relatively inexpensive GP treatment for health complaints.

Forcing people to avoid seeing the doctor for minor ailments is a dangerous and expensive policy direction. Minor ailments become major ailments if not treated early.

The international evidence shows that the key to a sustainable health system that delivers high quality outcomes for patients is to ensure the barriers to accessing primary care are low.

Rather than looking to make savings in general practice, the Government should be investing more in primary care and prevention.

We need to keep people out of hospital, where care is much more expensive. We do not need to keep them away from their GPs by adding new price barriers.

Fee-for-service should remain as the cornerstone funding source for general practice.

But we need to reshape current systems to meet the challenge being thrown up by the major cost drivers of an ageing population with chronic and complex health needs, and the sheer volume of services capable of being delivered to those suffering the impacts of non-communicable diseases.

The solution is in how we can provide longitudinal, continuous and coordinated care, not necessarily in changing the way we get paid.

Wellness maintenance, chronic disease management, and appropriate end-of-life care are the key.

More comprehensive care could be better encouraged if GPs were better supported to spend more time with their patients, and to make better use of the clinical teams that are beginning to build around them.

The imbalance in existing patient rebates for GP services rewards high throughput and discourages longer consultations and team-based care.

This is the serious policy discussion the Government should be having with the medical profession.

COMMENT

BY AMA SECRETARY GENERAL ANNE TRIMMER

AMA: it's for the members

Members are the heart of every membership organisation, and the AMA is no different.

The Constitution to be put to members at the Annual General Meeting on 23 May frames the centrality of members in the AMA through two fundamental objects of the Association – to protect and advance members' interests, and to influence health policy and health debate in the society in which members live and work.

All AMA activities can be sourced back to these objects.

Beyond the work of the AMA in supporting its members and their interests through medico-political advocacy, the AMA is constantly evaluating the services it provides to members.

The membership profile of the AMA (and the profession more broadly) is changing.

There has been a rapid increase in the number of doctors graduating from medical school, faced with the immediate challenge of finding training places.

Half the graduates are women, many of whom will be looking for more flexible working models which balance professional practice with young families as, indeed, will many male doctors.

More members work in group practices.

And there is a cohort of doctors who have been very loyal long-term members who are now approaching retirement, but who don't want to lose the connection with their Association.

The AMA has to be relevant to all of these members and support them in their professional lives.

In late 2013 the national AMA leadership (State Presidents and the Federal Executive Council) met over a weekend to develop a strategic roadmap for the Association.

Membership was a key part of the discussion, examining ways to ensure the ongoing relevance of the AMA, its activities and its services to the diverse interests of its membership.

A national Membership Taskforce has been established under the chairmanship of Christine Kane, Executive Officer of AMA WA. The Taskforce has evolved from an earlier iteration, and has been given the brief to work with me in identifying member needs and delivering programs to meet those needs.

For the first time, a national survey of AMA members will be undertaken in 2014, with the expectation that the results will inform member engagement strategies.

While corporate benefits are not the primary driver for a doctor to become a member of the AMA, we want to ensure that the benefits that are offered are meaningful to members. We also want to know that the information that we provide to members, and the way we communicate, is useful.

Very shortly, the AMA and its subsidiary company, Australasian Medical Publishing Company Pty Limited (AMPCo), which publishes the *Medical Journal of Australia* and the *Medical Directory of Australia*, will be launching an online platform to be known as Doctor Portal.

> "For the first time, a national survey of AMA members will be undertaken in 2014, with the expectation that the results will inform member engagement strategies"

The platform will hold a wide range of information, tools and resources which are of use to doctors. The platform will only be open to doctors (medical students will be given access in a later version).

Apart from resources, the platform will enable online forums to be created between groups of doctors. It won't be limited to AMA members, but there will be benefits that only members receive (or receive at reduced or no cost).

Look out for the launch!

Revised offer raises hope of end to Qld contracts dispute

Substantial progress is being made toward resolution of the damaging Queensland public hospital contracts dispute following significant concessions and changes from Health Minister Lawrence Springborg.

In a development that has fuelled hopes the industrial feud is nearing settlement, all parties to the dispute – including representatives from the AMA, Government, the Australian Salaried Medical Officers Federation and the Together union – were late last week engaged in face-to-face discussions on the fine details of a revised offer from Mr Springborg.

AMA President Dr Steve Hambleton, whose efforts to keep open lines of communication during the depths of the industrial battle have been instrumental in achieving the recent progress, said the Minister's "significantly revised offer" presented a "real chance to settle this dispute".

"With good will from all sides, we are in a good position to resolve this dispute to the satisfaction of all parties," Dr Hambleton said.

On 8 April, Mr Springborg unveiled a series of concessions and changes he said should resolve outstanding concerns about the contracts.

Among the changes, the Minister agreed to incorporate the draft addendum (which, among things, removed the right of the Queensland Health Director-General to unilaterally alter contract terms) into the contracts.

He also announced references to "profitability" would be removed from clause 25(5) of the core contract; that an advisory committee that included doctor representatives would be formed to guide future contract developments; and that devising of key performance indictors would be put in the hands of the State's Clinical Senate.

Under the terms of the Government's offer, public hospital Senior Medical Officers have until 30 April to sign the contracts without incurring a penalty, and they are due to come into effect from 7 July.

"These changes remove the remaining doubts," Mr Springborg said. "They provide reassurance that any continuation of the damaging campaign by unions is unnecessary."

But Dr Hambleton cautioned that, while in principle the revisions appeared to address outstanding concerns, the detail of the changes would need to be examined and thrashed out before doctors could feel confident.

"The new offer has the potential to rule out the need for mass resignations by disaffected doctors across the State," the AMA President said. "However, both sides still need to work cooperatively over the finer details of the contracts to ensure everything is in order. The devil will be in the detail, which we now need to get right."

The original contracts offered by Queensland Health were met with outrage by senior hospital staff, who were particularly concerned by provisions that stripped away basic employment rights and protections including fatigue provisions, rest breaks, limits on hours, and unfair dismissal and dispute resolution procedures, as well as allowing managers to unilaterally alter shifts and reallocate doctors to different hospitals without consultation.

As the dispute escalated, hundreds of doctors warned they might be forced to resign from the Queensland public hospital system, creating an enormous vacuum of skills and expertise that the Government would find extremely difficult to fill.

Dr Hambleton said the revised offer from the Government did appear to address the key issues and concerns raised by the AMA and others.

Many doctors had been concerned about a reference to profitability in a section of the contract relating to termination of employment.

Mr Springborg said the intention in including the phrase had been to "promote respect for, and the protection of, public health resources".

"But I recognise that phraseology has caused concern among some doctors and, following a review of other provisions in the contract, the Government has agreed to delete any such reference," the Minister said.

Another point of contention had been the lack of opportunity for input from the medical profession in the future development of contracts.

Mr Springborg said that, following consultation with doctor representatives including the AMA, Queensland Health Director General Ian Maynard would establish a nine-member Contracts Advisory Committee – including an independent chair, four doctor representatives elected by secret ballot, three Hospital and Health Services representatives, and a Queensland Health representative.

The Minister said that, to address doctor concerns, the development of key performance indicators (to come into effect from 2016) would be put in the hands of the State's Clinical Senate, which comprises representatives from all clinical specialties and is chaired by Dr David Rosengren.

Mr Springborg said the change would help ensure that KPIs worked to advance clinical practice, and to build cooperation between hospitals, health services and local clinicians.

Adrian Rollins

COMMENT

Emergency co-payment a bad idea: AMA

The AMA has attacked suggestions that patients who turn up at hospital emergency departments looking for treatment for minor conditions be charged an up-front co-payment.

Criticising what he said was "crazy" speculation about what would be in the Budget, AMA President Dr Steve Hambleton said the idea that charging such a fee would relieve pressure on emergency departments was ill thought out and misconceived.

News Limited papers last week cited an anonymous "senior Government source" as confirming the proposal for an emergency department co-payment as part of moves to introduce a $6 GP co-payment.

"If you do something around GPs, then you would have to do something around the emergency departments," the source was quoted as saying. "People need to be discouraged from going to the hospital with a stubbed toe."

Former Coalition Government health policy adviser Terry Barnes, who proposed the GP co-payment in a submission to the National Commission of Audit, said the emergency department co-payment would need to be set at $36 if it was to encourage patients to see their GP instead.

But Dr Hambleton said the proposal was wrong-headed.

"Category 4 and Category 5 emergency department patients are not necessarily GP patients – they are the patients who can safely wait for care," the AMA President said. "They are not clogging up the emergency departments, so the proposal is trying to solve a problem that does not exist."

Dr Hambleton said the problem emergency departments faced was a lack of beds within hospitals, which blocked the movement of patients out of emergency and into inpatient beds.

The idea has been given short shrift by some State governments, who are responsible for public hospitals and would need to implement the charge.

South Australian Health Minister Jack Snelling said the key to reducing demand for hospital services was to improve access to GPs, and he told *The Australian* "I'm not interested in colluding with the Commonwealth Government on its plans to implement a GP tax – I don't think that is the answer to dealing with the problems that our health system is facing".

Queensland Health Minister Lawrence Springborg told the *Courier Mail* his State would not charge an emergency department co-payment.

"We remain committed to a free public hospital system, and fixing the problem is about more than a co-payment," Mr Springborg said.

Federal Shadow Health Minister Catherine King said she was "deeply concerned" that an emergency department co-payment might deter people from seeking needed medical treatment.

Greens Senator Dr Richard Di Natale said putting price barriers in the way of patients looking to see their doctor or go to hospital would "cost us more in the long run".

And Dr Di Natale questioned who would determine which ailments were legitimate reasons to seek emergency department treatment, and what criteria would be applied.

"As a doctor, I don't want a bureaucrat with a mandate to find savings in charge of making that call," he said.

The office of Health Minister Peter Dutton has refused to comment on the speculation.

Adrian Rollins

COMMENT

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Alzheimer's Australia Western Australia (AAWA) is WA's only dementia specific organisation. AAWA is planning to build its new 3,000sqm headquarters and service centre on its site in the heart of Perth's western suburbs in Bedbrook Place, Shenton Park. The site which has the capacity to accommodate 12,000sqm of medical/health related consulting, research and office space.

Aawa is seeking through this EOI process to develop their land holding with like minded partners to create a nationally recognised leading community based brain and general health precinct.

In addition, medical operators outside the areas of brain health will compliment and complete the precinct. AAWA would encourage all potential partners to review the EOI information and express the interest they may have in leasing, buying strata office or investing in this exciting project.

To engage in this process, view and download the EOI documents by emailing: hayley.pinch@sheffieldproperty.com.au with the subject line AAWA EOI Request, or call Mark Clapham from Sheffield Property on 0409 070 807.

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GP capitation payments: the New Zealand experience

There has been no discernable increase in preventive care services by GPs paid an annual fee to look after the health of their patients, according to the New Zealand Medical Association.

As Federal Health Minister Peter Dutton mulls the merits of introducing so-called capitation payments for GPs – under which they would be paid an annual fee for each patient on their books – NZMA Chief Executive Lesley Clarke said the introduction of such a system in her country more than a decade ago had improved access to primary care.

But Ms Clarke, who visited Australia earlier this month, told *Australian Medicine* there was as yet no evidence the change had driven an increase in preventive health activity, such as more regular health checks or increased monitoring of diet, exercise and other lifestyle factors.

Under arrangements introduced in New Zealand in 2002, GPs derive half their income from capitation payments, with the remainder fee-for-service payments which, under the Kiwi system, include hefty patient co-payments of around $45 to $50 per visit ($17 for disadvantaged groups).

Ms Clarke said most of her members appeared comfortable with the split in sources of income: "Overall, it has been a positive thing for GPs in terms of certainty of revenue and flexibility of funding."

Mr Dutton has indicated he is looking favourably upon what he calls New Zealand's "blended" approach.

"I think there is an opportunity for us to perhaps look at doctors and other stakeholders in the conversation about blended payments," the Minister told a General Practice Registrars conference last month. "There are international examples. New Zealand is perhaps the closest relevant example to us about the way in which they provide support to their GP network, which is a system of blended payments, probably skewed more towards capitation [that] fee-for-service."

AMA President Dr Steve Hambleton has flagged that although the Association was not opposed in principle to changes in the way GPs were remunerated, the focus should not be on this as a way to control health spending upfront, but rather as a way to improve care and lead to lower costs in the long-term by reducing the incidence of obesity, smoking, drinking and other lifestyle-related illnesses.

"We have to think about what is driving costs," Dr Hambleton said. "Chronic disease management is the key, and we have to ensure we do that well."

Ms Clarke said that, so far, the NZ experience with capitation funding in terms of health prevention and chronic disease management activities was inconclusive.

Officially, through capitation payments, the Government purchases what is defined in New Zealand as first level services, which include health promotion, health monitoring, health maintenance and care co-ordination.

Ms Clarke said the introduction of capitation payments had increased Government funding to primary care – it surged from $400 million in 2005 to $750 million in 2011 – and it had improved access.

"The Government has expected primary care to deliver in all these [level one] areas," she said. "Capitation has primarily meant that New Zealand patients look to go to the GP more than they did under the old system."

But to date there is no clear evidence it has affected overall population health.

"It has not achieved a change in the way GPs deliver services," she said.

Data on rates of avoidable hospital admissions are also inconclusive.

"You would hope to see fewer avoidable hospital admissions, and it [the measure] has flatlined since the introduction of capitation – it has not gone up," Ms Clarke said. "But if you look at the Maori, who make up 15 per cent of the population, their avoidable admissions have gone up."

Adrian Rollins

COMMENT

Doctors – stewards of the health care dollar

AMA President Dr Steve Hambleton sat down with Michelle Grattan from the Conversation early in the month to discuss all things health. (You can listen to their full conversation at http://michellegrattan.podbean.com/2014/04/02/dr-steve-hambleton/).

Dr Hambleton talked about the speculation surrounding health care in the upcoming Budget, arguing that the nation was able to sustain current spending on health care despite concerns about managing an ageing population and increases in the cost of new technology.

The AMA President said primary health care – generally coordinated by GPs – was already an efficient way to spend health dollars, and providing access to GPs was important and should not be restricted.

Dr Hambleton argued that the health system as it currently stood was not free – expenses were already built into the system, it was just free at the point of delivery. He said in areas where people had the capacity to pay for their health care, bulk-billing rates were low, and he did not believe there was systemic overuse.

Dr Hambleton highlighted the fact that, generally, people on higher incomes already paid for much their health care through private insurance premiums, and that the barriers to primary health care should not be increased by asking people to make co-payments, because this would result in higher downstream costs, particularly in hospitals.

Dr Hambleton said there was a need to resolve the Federal-State funding blame game, especially when it came to hospitals, and to join up the system by measuring where and why things were happening. He said there was a need to close the gap between what we know and what we do, and e-health technologies would go a long way toward achieving this.

Currently Australia has a shortage of Australian trained doctors, as the numbers being trained are not sufficient to cope with the increase in population. Dr Hambleton said there was a need for long-term planning to ensure there were the resources and means to train Australian doctors.

Dr Hambleton emphasised the importance of the social determinants of health, particularly among Indigenous Australians, saying education, access to health services and safety were important. He said a new funding system was desperately needed, and that Medicare alone was not going to achieve the outcomes to close the gap. He said investing in Indigenous health was cost-effective, as it would set up families for life and encourage them to gain an education and participate in the economy.

Dr Hambleton also touched on lifestyle interventions, saying there was a need to make it easier to make healthy choices, especially around the use of alcohol and the consumption of junk food.

Dr Hambleton completes his term as AMA President in May, and provided some words of advice for the next AMA President.

He said the AMA must always engage with Government and the Opposition to assist them in making better decisions. It must also look at how the health system is structured, especially if doctors were to be stewards of the health care dollar, and that the profession must closely examine environmental and global health.

Kirsty Waterford

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

When disaster strikes, who are you going to call?

Doctors have been warned that during disasters they may face the agonising decision to withhold treatment from a gravely ill patient in order to treat someone with better survival prospects.

As climate scientists warn of the risk of increasingly severe bushfires, floods, cyclones and other natural calamities, the AMA has advised doctors they need to consider the ethical dilemmas they are likely to confront in the event they are called on to help treat people injured or made ill by natural or man-made disasters.

In an update to the 2008 Position Statement *Ethical considerations for medical practitioners in disaster response in Australia*, the Association said that, in addition to causing mass deaths, injuries and serious disruption to community life, disasters can also confront medical practitioners with situations and decisions that challenge strongly-held ethical principles and can bring the multiple responsibilities of doctors into conflict.

In the normal course of practice, the duty of care for a doctor to look after the health of a patient does not generally compete with other responsibilities, such as seeing to the wellbeing of themselves, their family, other patients, staff, colleagues and the general public.

"During a disaster, however, these multiple duties may come into conflict," the Position Statement said.

"For example, in ordinary clinical circumstances, those who are sickest or most severely injured generally receive treatment first. During a disaster, there may be limited resources immediately available [and a] large number of sick and injured individuals.

"The doctor has to prioritise which individuals receive treatment over others. This may involve a decision not to actively treat a gravely ill or injured individual who cannot be saved in the specific circumstances…in order to treat others who can be saved."

AMA President Dr Steve Hambleton acknowledged this was a tough decision, and said the Position Statement provided a guide to a doctor's duty of care in emergency situations.

Dr Hambleton said doctors and other medical professionals were regularly called upon to help out when disaster struck, and most responded willingly and with great commitment.

But he said the Position Statement pointed out that, while helping others, doctors also had a duty to look after themselves and their families, colleagues and other health workers.

"In these situations, doctors have a duty to protect themselves from significant harm, so they should not be expected to exceed the bounds of reasonable personal risk," the AMA President said.

Among the issues and challenges confronting doctors in responding to emergencies and disasters were the assumption of greater professional duties, increased occupational risk, physical and emotional stress, loss of income, risk of professional liability, and the possible exposure of their family to risk.

To ensure the medical profession's readiness to respond, Dr Hambleton said it was important that it be included in the development, implementation and review of disaster response protocols.

This should include the development of standards for triage, the allocation of resources, treatment, quarantine, the giving of consent, and the protection of privacy and confidentiality.

In addition, the Position Statement said, employers, governments, and the community must acknowledge and act on a reciprocal obligation to protect and support doctors and other health workers who respond in times of disaster and emergency.

The Position Statement *Ethical considerations for medical practitioners in disaster response in Australia* can be viewed at: https://ama.com.au/position-statement/ethical-considerations-medical-practitioners-disaster-response-australia-2008

Adrian Rollins

COMMENT

End funding uncertainty for Aboriginal-controlled health care: AMA

The AMA has called for reform of funding for Indigenous health following the release of a report showing that Aboriginal community controlled health services deliver substantial economic and health benefits.

The report *Economic value of Aboriginal Community Controlled Health Services* found that, in addition to their effectiveness in improving health care, Indigenous-operated health organisations deliver significant economic benefits to the communities they serve, providing well-paid jobs for 3200 Aboriginal people, boosting education with on-site training and offering valuable career paths.

The study was commissioned by the National Aboriginal Community Controlled Health Organisation, and Chair Justin Mohamed said the contribution made by his member organisations should not be underestimated.

"Aboriginal Community Controlled Health Organisations are major contributors to closing the appalling health gap between Aboriginal and non-Aboriginal Australians by providing culturally appropriate primary health care to Aboriginal people," Mr Mohamed said. "We now know that they are even more valuable – providing employment and training opportunities to our people, which in turn boost local economies and tackle some of the huge barriers to Aboriginal people achieving economic independence and quality of life."

He said that, ultimately, this resulted in lower health and other costs.

"The ripple effect of healthy Aboriginal communities cannot be overestimated," Mr Mohamed said. "Healthy communities keep our kids in school, keep our adults in the workforce and provide a greater opportunity for participation in broader society. Ultimately, that means reducing welfare dependency, reducing criminal justice rates and diverting people from the need for more expensive health care."

The current $300 million funding commitment to Aboriginal community controlled health services expires at the end of June, prompting calls for more robust funding arrangements.

Mr Mohamed wants the funding quarantined from any cuts in the forthcoming Federal Budget, and AMA President Dr Steve Hambleton urged sufficient Commonwealth investment "to secure the future of these important services".

Dr Hambleton said there was an urgent need for reform of how the sector is funded.

"The AMA believes that an analysis should be conducted to determine needs in Aboriginal and Torres Strait Islander health at a regional level," he said. "Based on that analysis, Aboriginal community controlled health services should be established and appropriately funded l areas of need, according to the demand for services.

The AMA President said differences in funding between jurisdictions should also be reviewed to ensure there was an equitable distribution of resources, according to need.

The Shadow Parliamentary Secretary for Indigenous Affairs, Warren Snowdon, said it was "unacceptable" that decisions on the future funding of Aboriginal community controlled health services had been left so late in the financial year.

Mr Mohamed lamented the insecurity of funding for the sector, and the fact that often funds earmarked for Aboriginal health were diverted into mainstream services, "which simply don't have the same runs on the board with Aboriginal health as our services do".

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

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

Divided system concerns over primary care changes, *Australian Financial Review*, 26 March 2014

It is expected that Abbott Government changes to primary care remuneration will stop short of allowing private insurers to cover out-of-pocket GP fees. AMA Chair of General Practice Dr Brian Morton said there would be privacy concerns about sharing patient information.

Wealthy parents evading vaccines, *Adelaide Advertiser*, 27 March 2014

Parents from some of our most wealthy suburbs are refusing to immunise their children. AMA President Dr Steve Hambleton said the failure of so many parents on the NSW north coast to vaccinate their children was a major disappointment.

Customers miss out in Medibank float, *The Age*, 27 March 2014

The planned sale of Medibank Private next year has sparked concerns about possibility of increased private health insurance premiums. AMA President Dr Steve Hambleton said he was reassured by Finance Minister Mathias Cormann's comments that a scoping study into the sale had found no evidence that premiums would rise as a result.

AMA denies wind farms, *The Australian*, 27 March 2014

The AMA has rejected claims by DLP Senator John Madigan that its finding that there was no evidence of any health effect from wind turbines was politically motivated.

Abbott's premiums promise, *Courier Mail*, 27 March 2014

The Abbott Government has denied the planned multibillion dollar sale of Medibank Private would push up health insurance premiums. The AMA had previously raised concerns about the possible impact of the sale on premiums.

Size of or stomachs speeds up, *Adelaide Advertiser*, 27 March 2014

Australians are gaining weight so rapidly they have exceeded predictions on rates of obesity made just four years ago. Obesity Australia wants the AMA and the Federal Government to recognise obesity as a disease.

Limit energy drinks plea, *Adelaide Advertiser*, 28 March 2014

A Country Women's Association of NSW petition calling for a ban on the sale of energy drinks to kids has the backing of doctors. AMA President Dr Steve Hambleton said he was concerned about the alarming increase in the number of adolescents suffering caffeine toxicity from energy drinks.

AMA boss seeks end to bitterness, *Courier Mail*, 28 March 2014

A group formed to fight the Newman Government's doctor contracts says it is stockpiling pro-forma letters of resignation from medicos until it reaches a critical mass of public hospital staff. AMA President Dr Steve Hambleton has distanced himself from the tactic and has called for a ceasefire in the dispute.

Call for innovative outlook to combat doctor shortages, *Weekend Australian*, 29 March 2014

Health Workforce Australia said one quarter of working doctors in Australia obtained their first medical qualification overseas. AMA President Dr Steve Hambleton said this proportion is much higher in regional and rural Australia.

Cheap chemist shots escalate flu jab price war, *Adelaide Advertiser*, 29 March 2014

A flu jab price war is underway, with discount chemists offering cheap shots and doctors urging patients to go to medical centres. The AMA has previously criticised any move to allow jabs in chemists, based on privacy concerns and the risk of adverse reactions.

Medical tourism plan bugs AMA, *Northern Territory News*, 29 March 2014

Medical and security concerns have been raised about the new medical tourism business run by NIB, which offers offshore plastic surgery packages. AMA President Dr Steve Hambleton warned even if the medical care was vetted and guaranteed, increasing numbers of people who travel overseas were returning home with multi-drug resistant bacteria in their bowels.

Health crisis alert, *Sunday Herald Sun*, 30 March 2014

Doctors have warned elective surgery and emergency department waiting times will be hit by a $560 million Abbott Government funding cut to hospitals. AMA President Dr Steve Hambleton said if there was less money in the system, frontline services would be affected.

Shot in the arm for health, *Sunday Telegraph*, 30 March 2014

News Limited claims its 'No Jab No Play' campaign has encouraged more parents to immunise their children, even in areas

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AMA IN THE NEWS

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traditionally opposed to vaccinations. AMA President Dr Steve Hambleton said a 4 per cent increase in vaccination rates was the difference between effective and ineffective herd immunity.

Don't act your age, feel it, *MX Melbourne,* 31 March 2014

Priceline Pharmacist Justin Withers said findings showed that Australians could be doing more to improve their health, and pharmacists could offer guidance and advice. AMA President Dr Steve Hambleton recommended a visit to the family doctor instead.

Push to stop union advice a grim prognosis for nation: AMA, *Sydney Morning Herald*, 31 March 2014

The AMA said it feared the Queensland Government's unprecedented attempt to stop unions from providing advice to members, and its introduction of individual contracts for public hospital doctors, could embolden other states to follow its lead.

Are we really that chewless, *Courier Mail*, 31 March 2014

Obesity Australia has put the blame for the country's obesity problem on parents who feed their children a high carbohydrate and high sugar diet in the first three years of life. AMA President Dr Steve Hambleton said targeting this age group was a key strategy to beating national obesity.

House calls can ease $1bn hospital burden, *Adelaide Advertiser,* 2 April 2014

Patients with minor illnesses such as ear aches, gastroenteritis and rashes who clog hospital emergency departments are costing tax payers up to $1 billion a year, and could be treated more cheaply with house call medical services. AMA Chair of General Practice Dr Brian Morton said many of the doctors working for such services were overseas trained.

Doctors ordered to take a chill pill, *Courier Mail*, 2 April 2014

Doctors battling the State Government over new contracts are unlikely to win any further concessions as the LNP stands by its proposed solution to the crisis. AMA President Dr Steve Hambleton released a statement hosing down speculation of a rift between the AMA and other groups over the issue.

Can we talk? *Courier Mail*, 5 April 2014

Doctors have declared negotiations with the State Government over new contracts are nearly there, but several sticking points remain. AMA President Dr Steve Hambleton said he believed doctors were close to reaching an agreement with the State.

Chiropractor spruiking dangerous diet plan, *Adelaide Advertiser,* 8 April 2014

Chiropractor Robert Marin was suspended and fined in 2008 for exaggerating people's conditions, and has a long list of conditions imposed on him by the Australian Health Practitioner Regulation Agency. AMA President Dr Steve Hambleton said he had never seen a list of restrictions like it.

Exclusive Not-for-profit to end doctors' war, *Courier Mail*, 8 April 2014

Health Minister Lawrence Springborg will attempt to end the war with public hospital doctors by making further concessions in the contract dispute. AMA President Dr Steve Hambleton said the changes were headed in the right direction.

Radio

Dr Steve Hambleton, Radio National Canberra, 26 March 2014

AMA President Dr Steve Hambleton discussed the Coalition's announcement it would proceed with the sale of Medibank Private. Dr Hambleton believed the sale could affect private health cover.

Dr Steve Hambleton, ABC Capricornia, 27 March 2014

AMA President Dr Steve Hambleton talked about the dispute over new individual contracts for senior doctors. Dr Hambleton said both sides need to calm down before continuing negotiations.

Dr Steve Hambleton, ABC Central Victoria, 28 March 2014

AMA President Dr Steve Hambleton discussed the renewed call by the CWA to ban the sale of energy drinks to people younger than 18 years. Dr Hambleton said research suggested such drinks could harm young people.

Dr Steve Hambleton, ABC Wide Bay, 31 March 2014

AMA President Dr Steve Hambleton discussed the State Government's action to launch legal action against the AMA and unions over claims they were distorting facts in their dispute. Dr Hambleton said the legal action was disappointing.

Dr Steve Hambleton, ABC Gold Coast, 3 April 2014

AMA President Dr Steve Hambleton discussed the Queensland doctor contracts dispute. Dr Hambleton said there had been some refinement of how clauses in the contracts would be delivered.

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AMA IN THE NEWS

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Dr Steve Hambleton, 666 ABC Canberra, 5 April 2014

AMA President Dr Steve Hambleton talked about the death of Sydney jockey Nathan Berry. Dr Hambleton said the condition Nathan Berry developed, Norse Syndrome, is a rare condition that becomes impossible to reverse.

Dr Steve Hambleton, 612 ABC Brisbane, 7 April 2014

AMA President Dr Steve Hambleton discussed the Queensland doctor contracts dispute. Dr Hambleton said he was concerned about clauses in the contracts that might allow financial considerations to overrule clinical need.

Dr Steve Hambleton, 702 ABC Sydney, 8 April 2014

AMA President Dr Steve Hambleton talked about news that the Federal Government has suspended funding to three GP Super Clinics. Dr Hambleton said GPs had been squeezed by cutbacks and rebate freezes under the last government.

Dr Steve Hambleton, 774 ABC Melbourne, 9 April 2014

AMA President Dr Steve Hambleton discussed a possible Government plan to charge people who present to public hospitals with conditions or injuries that should be treated by a GP. Dr Hambleton expressed concern about the plan, saying it would deter patients from seeking help.

TV

Dr Steve Hambleton, ABC1 Brisbane, 27 March 2014

AMA President Dr Steve Hambleton discussed the impact of the Queensland contracts crisis on junior doctors. Dr Hambleton said there had been a significant loss of trust.

Dr Steve Hambleton, ABC1 Darwin, 27 March 2014

AMA President Dr Steve Hambleton talked about parents choosing not to immunise their children. Dr Hambleton said there was a small proportion of conscientious objectors, but they were difficult to convince of the merits of vaccination, even with the best of information.

Dr Steve Hambleton, ABC1 Brisbane, 29 March 2014

AMA President Dr Steve Hambleton talked about Queensland Health lodging an application to put a stop on what it claimed was misinformation being delivered by unions, medical organisations and doctors. Dr Hambleton said the application was a major setback following progress made in the preceding days.

Dr Steve Hambleton, Channel 10 Melbourne, 31 March 2014

AMA President Dr Steve Hambleton talked about reports showing half a billion dollars was being cut from Australia's hospitals. Dr Hambleton said they need to make sure there are sufficient doctors to treat patients and deliver services.

Dr Steve Hambleton, ABC News 24, 9 April 2014

AMA President Dr Steve Hambleton discussed a Federal Government proposal to charge people who present hospital emergency departments with minor ailments. Dr Hambleton said that such patients were not clogging emergency departments and the real problem was hospital bed capacity.

COMMENT

2014 AMA National Conference

23 - 25 May

National Convention Centre, Canberra

Conference session highlights include:

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

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

AMA

Find out more about the Conference:

www.ama.com.au/nationalconference

Conference Enquiries: natcon@ama.com.au

AMA IN ACTION

Dr Hambleton at the World Health Day 2014 breakfast with other invited speakers

AMA President Dr Steve Hambleton started his fortnight in Brisbane appearing on Channel 10's morning program Wake Up. He attended to patients in his GP practice before flying to Melbourne to have a joint meeting with Australian Health Practitioner Regulation Agency and MDA National. Dr Hambleton made a brief stop in Sydney to talk with SBS TV Host Patrick Abraham about medical tourism, and to attend a breakfast for World Health Day, which was also attended by Health Minister Peter Dutton. Dr Hambleton attended the National Press Club Address by National Aboriginal Community Controlled Health Organisation Chair Justin Mohamed in Canberra. While in Canberra, Dr Hambleton was interviewed by veteran political journalist Michelle Grattan from The Conversation. You can listen to what Dr Hambleton had to say here: http://michellegrattan.podbean.com/2014/04/02/dr-steve-hambleton/

Dr Hambleton finished his fortnight with a face-to-face meeting with the AMA Executive team in Canberra.

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

FEATURE

Joining the dots between global health and medical education

BY DR ROB MITCHELL, PAST CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

In recent decades, global health (GH) has achieved recognition as an academic discipline in its own right.

Defined as an area for study, research and practice that places a priority on improving health and achieving health equity for all people worldwide, it emphasises transnational health issues and synthesises population-based prevention with individual-level care.

Doctors working in GH require knowledge and skills beyond those captured in traditional medical curricula.

Although Australian junior doctors are heavily engaged in global health learning and networking activities, there is no defined training pathway for those aspiring to careers in international health and development. In particular, there are limited opportunities for vocational trainees to undertake accredited rotations in resource poor environments.

While a number of Australasian colleges are involved in regional development activities, few have taken explicit steps to prepare fellows for GH practice.

It is timely, therefore, that a policy session at this year's National Conference will explore the links between global health and postgraduate medical education.

The Integrating global health training and postgraduate medical education in Australia session will examine the barriers and enablers to trainees undertaking rotations in resource poor settings, highlight contemporary approaches to GH training, and provide recommendations for integrating GH education with postgraduate medical curricula. Panellists will also discuss Australia's responsibility to produce doctors who are equipped to engage in regional health challenges in a global context.

The session will be facilitated by Dr Lloyd Nash, a consultant physician and global health practitioner with a long history of promoting social accountability in medical education. He will be joined by a panel of experts, each of whom brings a unique perspective to the discussion.

Associate Professor Rosemary Aldrich is Director of Medical Services at Newcastle's Calvary Mater Hospital. A public health physician, Associate Professor Aldrich has recently led the development of a global health curriculum for the Faculty of Public Health Medicine at the Royal Australasian College of Physicians (RACP). This is the first project of its type in Australia.

Dr Georgina Phillips is an Emergency Physician at St Vincent's Hospital in Melbourne, and has led numerous capacity building projects in international emergency medicine. In particular, she has helped establish a permanent rotating position for an emergency medicine advanced trainee to work at Divine Word University and Modilon General Hospital in Madang, Papua New Guinea. Dr Phillips has also developed a relationship with Australian Volunteers International (AVI), so that trainees working in Madang are supported through the Australian Volunteers for International Development program.

Dr Vincent Atua will bring a host community perspective to the panel. An emergency physician trained in Papua New Guinea, Dr Atua is presently Director of Medical Services at Modilon General Hospital. He has hosted numerous Australian registrars and consultants, and will be able to reflect on the value of the long-term relationship that has developed between his facility and the Australasian College for Emergency Medicine.

Dr Suman Majumdar is an infectious diseases physician currently working at the Burnet Institute's Centre for International Health. Dr Majumdar has worked in a variety of international contexts, including in tuberculosis control projects with Médecins Sans Frontières. Some of this work was accredited towards his speciality training with the RACP, and he has an ongoing interest in developing career pathways in global health.

Several of these panellists have contributed articles to this edition of Australian Medicine. They have been published to help 'set the scene' for the global health training discussions at AMA National Conference. I would encourage you to read them, and consider what questions and comments you might like to contribute to the session on Saturday 24 May.

Australian clinicians are well placed to help tackle major challenges in global health.

To contribute safely and effectively, however, specialist skills and practical experience are required. This exciting session at National Conference will consider how we can join the dots between global health and medical education and, in doing so, develop Australia's capacity to promote sustainable development in the Asia-Pacific.

COMMENT

FEATURE

Satisfying the clamour of interest in global health

When Lloyd Nash, fresh from medical school, went looking for opportunities to pursue a career in global health, he was given the brush off.

"Wherever I turned, I felt that people were sending me away rather than welcoming me with open arms," the general physician said. "They were saying, 'Go away, and come back when you have done some volunteer work and some additional training'."

So that's what he did, gaining a Masters in Public Health and becoming a director at the Royal Australasian College of Physicians.

But while Dr Nash's experience of being forced to make his own way is typical for those who have sought, up to now, to establish a career in global health, he believes it is time to take a more systematic and structured approach.

With several like-minded colleagues, including former Chair of the AMA Council of Doctors in Training Dr Rob Mitchell and emergency registrar Dr Jenny Jamieson, Dr Nash founded the Global Ideas Forum (http://www.globalideasforum.com/) as a way to help medical graduates and other young people to tackle health inequity.

Firmly of the view that there is great interest in global health among medical students and those just embarking on their medical careers, Dr Nash is also working with the RACP on the development of global health training opportunities.

"I really believe there is a genuine demand for this kind of training and work, particularly among young doctors," he said.

Dr Nash said it was "not so long ago" that the International Medicine elective became almost ubiquitous in medical school courses and this, combined with increased first-hand experience of yawning health inequities through travel and the greater flow of information, has fuelled a hunger for global health training and work.

He said Colleges such as the RACP were interested in catering for this demand, but typically had three main concerns about how to organise and oversee global health education for trainees working in resource poor countries, which could be categorised broadly as educational support, professional support and personal support.

In Dr Nash's view, each of these concerns could be relatively easily addressed and overcome.

He said the internet made the task of supplying educational materials and supervision to trainees in remote locations practicable.

Regarding professional support, Dr Nash said global health training placements typically required a qualified local supervisor and "someone at home that you can turn to professionally".

In the region, this was not as unlikely or difficult as some might think, because most senior medical staff in countries like PNG, Fiji or Vanuatu would have trained overseas, such as in Australia or New Zealand, and were well qualified to provide the necessary supervision, supplemented by support from a supervisor in the home country.

One of the biggest concerns for Colleges is that they lack the systems and expertise to provide the necessary personal support for trainees going to remote or resource-poor countries, including basic measures such as arranging for health insurance and appropriate vaccinations through to on-the-ground expertise in securing safe accommodation and transport.

Dr Nash said that, rather than try to develop their own expertise or capacity in this area, the Colleges could look at partnerships with organisations like Australian Volunteers International and Medicins Sans Frontieres which have extensive experience in arranging for the safe and effective placement of staff in countries with limited resources and challenging political and physical environments.

He urged Colleges to embrace the opportunity to tap into the interest and enthusiasm of young doctors for global health training, saying the experiences gained would enhance the skills and professional competence of trainees while also providing a benefit for the health and well-being of those living in the region.

Adrian Rollins

COMMENT

FEATURE

Global health training: the consultant supervision perspective

DR GEORGINA PHILLIPS, EMERGENCY PHYSICIAN AND COORDINATOR OF INTERNATIONAL PROGRAMS, ST. VINCENT'S HOSPITAL, MELBOURNE; DEPUTY CHAIR, INTERNATIONAL EMERGENCY MEDICINE SPECIAL INTEREST GROUP, AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE

Interest in global health (GH) and providing health care for those living in countries where medical services are often limited and basic is an ethical and educational imperative for doctors concerned with justice and equity.

Enabling junior doctors to have meaningful and rewarding experiences in such environments can lead to a lifelong commitment to global health practice and advocacy that benefits both resource rich and poor partners alike.

An example of a successful partnership for GH practice and training is the Visiting Clinical Lecturer Program (VCLP) at the Divine Word University (DWU) and Modilon Hospital in Madang, Papua New Guinea (PNG).

The program was set up in 2010 during a six-month sabbatical I had at DWU, and it drew on a longstanding network of emergency medicine (EM) support between Australia and PNG.

It enables advanced emergency medicine trainees to live at DWU and provide academic, clinical and bedside teaching for rural health students, and to work alongside PNG colleagues in the emergency department of the hospital.

The VCLP has been recognised as a valid site of training in emergency medicine by the Australasian College for Emergency Medicine (ACEM) when the placement lasts at least three months.

So far, six advanced trainees with the ACEM have completed accredited rotations to Madang, and a seventh is there now, prompting the ACEM to contemplate the possibility of more permanently acknowledging this PNG placement as an accredited site of EM training.

Of course, undertaking rotations in resource poor settings such as PNG comes with plenty of challenges.

Below are some of the key principles and lessons learnt in establishing and maintaining the VCLP, and how they relate to contemporary approaches and recommendations regarding global health practice and education.

Long term partnerships are crucial

One of the most significant aspects of the VCLP is the fact that the ACEM has recognised the hospital's PNG-trained emergency medicine specialist as appropriate local supervisor of Australasian advanced trainees.

This acknowledgement of, and respect for, the local specialist has arisen out of a long-term relationship that has formed between the PNG and Australasian academic and emergency medicine communities, and which includes peer support, professional development, EM teaching and training, clinical exchange, research support, conference participation, exam preparation and co-assessment.

For the VCLP, the local PNG EM specialist co-supervises each trainee in conjunction with a remote Australasian FACEM, who has weekly web-based input.

The VCLP program is also a long-term capacity-building project, with a clear framework that trainees can contribute to over time.

Trainees benefit from clinical exposure, enhance their teaching and leadership skills, and gain crucial insights within a clear structure. For their part, the host organisations appreciate the practical assistance, the fresh educational exposure, and a growing body of teaching tools provided within a sustainable and consistent framework.

The importance of trainee selection, preparation and supervision

Careful selection of trainees, through recommendations, references and interviews, is crucial to ensure a successful placement.

Briefing should include not just practical information, but should also stimulate self-reflection, challenge preconceived notions, and refresh attitudes, to ensure an informed, compassionate and open-minded approach.

Structured learning objectives and a clear plan for local and remote supervision are essential, and in the VCLP these have been refined over time.

Trainees are regularly challenged clinically, professionally and personally when practising and living in PNG. Careful and thoughtful supervision is paramount to ensuring meaningful outcomes and an overall positive learning experience for the trainee.

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FEATURE

Personal networks aid complex logistics

Investment in relationships at DWU and the Modilon Hospital with regular visits is crucial to obtaining necessary logistic support.

Practical considerations such as securing accommodation, transport and other matters consume time and energy, yet questions of lines of responsibility and risk management can remain difficult. For example, if ACEM is accrediting the rotation, who is responsible for an adverse event?

Recently, a three-way partnership has developed between the ACEM, the PNG hosts and Australian Volunteers International, which has incorporated the VCLP into an Australian Volunteers for International Development-supported position. This provides a far greater structure of support, administration, cost-bearing and risk management than was previously available, and has addressed some of the more difficult logistic issues.

Appreciation of global health educational value and outcomes

Trainees learn about global health through the direct experience of working and living in PNG.

Often more questions than answers arise out of a VCLP placement, stimulating deep, reflective thinking. Emergency medicine trainees who have come through the VCLP have acted to enhance their global health skills and knowledge through self-directed learning and by participating in international emergency medicine (IEM) networks. Providing a structured framework of global health learning around the actual, practical experience is the next step for the ACEM in curriculum development and IEM training.

Increasing opportunities for trainees to participate in meaningful, sustainable global health activities while ensuring there is support for appropriate preparation, as well as safe environments for effective practice and frameworks for valuable educational outcomes, is the challenge for all Australian professional training institutions in the future.

Filling global health training gap began with a phone call

When Rosemary Aldrich's phone rang one day in late 2010, she had no idea it would lead to the development of a world-first training program for public health specialists interested in global health.

"The caller said, 'Here is a bucket of money, can you think of something to do with it?'," Associate Professor Aldrich said.

The timing of the call was fortuitous, coming soon after the public health physician drew a blank when looking at opportunities to train in global health.

After years working as a public health physician while also raising a young family, by late last decade Associate Professor Aldrich was finally in a position to begin pursuing her interest in global health in earnest.

But, while serving as Chair of the Workforce Committee of the Australasian Faculty of Public Health Medicine (AFPHM), it became apparent that there was nothing in place for experienced specialists like her to undertake formal global health training.

"There was a gap in training for people like me," she said, and this realisation, combined with the funding offer, led her to suggest the development of a global health practice curriculum for AFPHM Fellows.

Associate Professor Aldrich, who is Director of Medical Services at the Calvary Mater Newcastle hospital as well as Conjoint Associate Professor in the School of Medicine and Public Health at Newcastle University, bent to the task with a will, organising several workshops bringing together global health practitioners from across Australia and New Zealand as well as undertaking extensive consultations across the field, and with other medical Colleges.

The result, by mid-2012, was the development of a draft Global Health Practice Curriculum which has been endorsed by the AFPHM and is being considered by the Royal Australasian College of Physicians.

It has not been a simple or straightforward process, but Associate Professor Aldrich said that what has been readily apparent is the enormous interest in global health among her specialist colleagues, and a ready demand for opportunities to engage in the area.

"There are many, many specialists who have or are doing this off their own bat already, but there has not before been this formal process in place," she said.

Associate Professor Aldrich said she felt "nowhere near the end of my working life", so "having global health training is just another avenue for pursuing work in the service of others".

She said she felt "very chuffed" that her proposal for a global health curriculum was not only the first of its kind in the world, but had attracted such interest and support from colleagues, both in Australia and internationally.

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FEATURE

Earlier this month she addressed a workshop in Singapore attended by global health specialists from around the world keen to hear about the curriculum and its development.

"At the start, I had no idea it would lead to this," Associate Professor Aldrich said. "You can tell how small this started, from my own little office in regional Newcastle. It goes to show, if you see a gap, do it."

Adrian Rollins

Global health training: the graduate perspective

BY DR RAMONA MUTTUCUMARU, MEDECINS SANS FRONTIERES/ALFRED HEALTH INFECTIOUS DISEASES FELLOW, UZBEKISTAN

After completing the marathon that was the basic physician training exams, I was resolved to pack my bags and embark on something different.

I was fortunate enough to stumble into a position working with Medecins Sans Frontieres (MSF) treating multi-drug resistant tuberculosis (MDR-TB) in Uzbekistan.

This position had been set up a few years earlier, and is accredited for the non-core component of Infectious Diseases (ID) training, with supervision through the Alfred Hospital in Melbourne and the Manson Unit of MSF in London.

For me, it was the perfect opportunity to gain experience in a resource-limited setting with MSF, a non-government organisation I'd always dreamed of working with, while also making strides towards my goal of completing ID training.

Up to then, I had only seen a handful on TB cases, all in a Melbourne tertiary hospital and had never encountered MDR-TB, so I felt no small amount of trepidation about what was awaiting me.

Supporting the local Ministry of Health, our role was to provide resources and training in diagnosing and treating TB.

The burden of MDR-TB in the region was significant, accounting for up to 40 per cent of new cases of tuberculosis, and up to 80 per cent of re-treatment cases.

The challenges of managing MDR-TB, a disease whose horror is matched only by that of its treatment, was compounded by the deficiencies and dysfunction of the local health system. The medical aspects turned out to be the easier part.

Other than the invaluable experience in treating a drug-resistant TB, an entity that remains mercifully rare in Australia, I honed many other skills during my time in Uzbekistan, all of which I expect will prove useful in future.

In the absence of ready access to expensive tests, we had to rely heavily on clinical skills and judgment.

Non-clinical skills turned out to be equally as valuable.

Trainees in Australia rarely have the opportunity or expectation that they will manage and train staff, barring perhaps medical students and junior members of their team.

In contrast, this is an important role of expat medics working in developing world settings.

Additionally, the difficult task of choosing between multiple important and competing priorities was something we were often faced with as a project team.

It's very clear to me that spending time working in a resource-limited setting has a lot to offer trainees.

But what about the flip side of the equation? Should we not ask what trainees can do for the developing world?

Other than the bringing their energy and enthusiasm, trainees, I am certain, are more likely to actually uproot their lives and seek experience overseas. In my experience, many of the needs of the health system and its patients were so basic, that quite often not a great deal of specialist expertise was required to address them.

When more complex problems arose, MSF's internal hierarchy enabled escalation to obtain advice from in-country or overseas experts. Links to my supervisors in Melbourne and London meant that I had an added degree of support.

Readjusting back to a metropolitan hospital setting in Australia has also had its challenges, and it was with mixed emotions that I left Uzbekistan.

There was some degree of guilt for not having done more, but the overwhelming feeling has been a sense of privilege for having being a part of something so important.

The Alfred MSF Infectious Diseases Fellowship is co-supervised by Dr James McMahon at the Alfred Hospital in Melbourne and Dr Philipp du Cros from the MSF Manson Unit in London.

Dr McMahon can be contacted via email: j.mcmahon@alfred.org.au.

COMMENT

FEATURE

Global health training: a recipient's perspective

BY DR VINCENT ATUA, DIRECTOR, EMERGENCY DEPARTMENT MADANG (MODILON) GENERAL HOSPITAL

For the past five years there has been a number of Australian registrars in training who have come to Madang, Papua New Guinea, for three to six months at a time, and were able to get their time in PNG recognised towards their Fellow of the Australasian College for Emergency Medicine (FACEM) specialist training.

The registrars have contributed immensely through their participation and collaboration with their national colleagues, and with the Divine Word University as visiting lecturers in Emergency Medicine.

This has been a mutually beneficial exercise for both Paua New Guinea and the ACEM trainees. The Australian registrars have come away with valuable experiences in tropical medicine, and have personally grown in their time in PNG.

This has come about due to great efforts on the part of the Australasian College of Emergency Medicine's International Emergency Medicine Special Interest Group (IEMSIG), and a few individuals who had a passion for providing such a training opportunity.

Background

From 1995 there had been a desire to establish a specialist emergency medicine program in PNG. But the idea was left on the backburner for several years until Australian and American support came on board in 2002 with support for resident and visiting emergency physician practitioners and instructors.

The first locally-trained specialist Emergency Physician (EP) graduated in 2007, and since then PNG eight more have graduated in what has become an ongoing specialist pathway for junior doctors.

Financial contributions from AusAID helped support and encourage the program, which has seen a number of Australian EPs visit Port Moresby General Hospital and, more recently, Madang (Modilon) General Hospital and Divine Word University, to provide teaching as well support to the onsite registrars.

However, much of cost has been borne by the individuals involved.

Benefits to PNG

Huge improvements have been made in the way emergency medicine is practised in the country, most notably in a better organisational culture and improving patient outcomes.

Ongoing technical support has seen a major emergency department redevelopment at Port Moresby General Hospital, and plans are afoot to redevelop all emergency departments nationally. Courses in emergency medicine have been developed at the University of Papua New Guinea and Divine Word University, in particular, to improve capacity.

A major spin off of the ACEM involvement has been the introduction of the Primary Trauma Care course, which has gained huge popularity, and has attracted domestic funding to train a large group of primary health care workers.

To date, more than 50 PTC Courses have been delivered to over 500 participants. In addition, the Emergency Life Support Course (ELS Course) has been delivered to more than 100 doctors and Health Extension Officers and nurses in the last six years.

Conclusion

As many specialists have spent training time in Australian hospitals, there is a very pro-Australian culture in the PNG medical profession to build on concerning training opportunities for Australian registrars.

This depends, however, on the Australian specialist medical colleges recognising PNG specialists who are suitably experience or qualified to provide this supervision. The benefits to the specialty concerned are immense for a developing country like PNG, and it is hoped that the registrars will be able to get funding as well as professional recognition for their time abroad in a not so parallel medical system.

COMMENT

PUBLIC HEALTH OPINION

Top sales pitch needed for investment in prevention

BY PROFESSOR STEPHEN LEEDER AND SHAUNA DOWNS

> “One problem with investing in prevention is that nothing very visible happens, at least immediately, if it works”

I was once asked by Malcolm Turnbull, serving on a Parliamentary committee inquiring into health care, what I would do if today I had awoken to discover that I was the Minister for Health.

I replied that I would immediately have closed the blinds, taken to my bed and tried to go back to sleep on the assumption that this was just a ghastly nightmare.

Consider your dilemma, if you were Minister, between investments in prevention versus investments in hospitals. The demand for more and better hospitals is relentless. To under-invest in emergency departments, for whatever reason - including prevention - is to court electoral backlash.

One problem with investing in prevention is that nothing very visible happens, at least immediately, if it works.

If you are a prevention professional or politician supporting prevention there will be no crates of Champagne on your doorstep on Christmas morning from grateful people who have not had an accident or not become ill because of your preventive efforts. They, and you, will likely never meet: the preventive transaction is anonymous.

It is surprising that we invest in prevention at all, and even more surprising when you see that we do so at a level higher than many people think.

Consider successful prevention programs, and the social and political contexts in which they occurred. Take as examples tobacco smoking, seat belts and immunisation. Three common features stand out in relation to these examples as having contributed to their success.

First, the community needs to be worried. They may be worried about a disease, but less convinced about how to prevent it. Think about lung cancer. As R.N. Proctor from the History Department at Stanford University put it last year,

> *“Lung cancer was once a very rare disease, so rare that doctors took special notice when confronted with a case, thinking it a once-in-a-lifetime oddity. Mechanisation and mass marketing towards the end of the 19th century popularised the cigarette habit, causing a global lung cancer epidemic. Cigarettes were recognised as the cause of the epidemic in the 1940s and 1950s, with the confluence of studies from epidemiology, animal experiments, cellular pathology and chemical analytics. Cigarette manufacturers disputed this evidence, propagandising the public … As late as 1960 only one-third of all US doctors believed that the case against cigarettes had been established.”*

But now, concerned and informed communities and professionals in economically advanced nations are convinced, and effective tobacco control has won political support and legal action. Cigarette smoking rates have fallen to less than 20 per cent in parts of the US and Australia.

Second, for preventive programs to win support, it helps if they can be shown to work. In 1968, I worked in the western highlands of Papua New Guinea. My predecessors had introduced immunisation, so that when a whooping cough epidemic ignited, the children in our valley were spared. Neighbours were deeply impressed and wanted to know our magic.

Similarly, with seat belt and breathalyser legislation, results followed rapidly, securing these preventive programs in the minds of the public and politicians alike.

MORE P23

PUBLIC HEALTH OPINION

Top sales pitch needed for investment in prevention

... FROM P22

Third, because preventive programs are for the well population, we need to ensure that they are scrupulously safe. As the late Geoffrey Rose, an eminent London epidemiologist, used to say, side-effects are tolerable when you are treating a person with a severe illness – witness chemotherapy – but never when you are seeking to prevent illness in a well community.

Concerns are expressed about the exposure to ionising radiation during mammographic screening. This risk may be very low (a lifetime additional risk of cancer of between I in 10,000 to 1 in 100,000 per year), but when applied to large populations, the risks add up. Indeed, many forms of screening, especially if disconnected from general practice, have been shown to carry serious risks: screening is an ambiguous preventive enterprise – seductive, but often a health hazard. If the preventive step is not incredibly safe – think pink batts – the program will not be sustainable. Best to be rid of the glitches before scaling up and applying to the population.

“If the preventive step is not incredibly safe – think pink batts – the program will not be sustainable. Best to be rid of the glitches before scaling up and applying to the population”

So, if we are keen on prevention, we should be alert to the community context and the political interpretation of what we are proposing.

We will need all the insights we can find to help us with the big preventive challenges that have to do with the way we live, the food we eat, the cities we design and the transport systems we devise.

This is not the time for the faint-hearted! No rushing back to bed, thanks minister!

COMMENT

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

GENERAL PRACTICE

Breaking down the barriers to GP training

BY DR BRIAN MORTON

With recent increases in medical student numbers and the flow-on effect through the training pathway, there is a growing need to increase the number of GPs who teach.

Currently, only 10 to 20 per cent of vocationally registered GPs teach, or are accredited to teach.

This low uptake highlights the need to address a range of barriers that stand in the way in order to encourage GPs and general practices get more involved in this crucial role.

AMA advocacy has directly resulted in the new Government committing $119 million to increase the Practice Incentive Program Teaching Incentive (for medical students), and $52.5 million in GP Infrastructure Grants to support, among other things, improved facilities for teaching and training.

The AMA Council of General Practice has identified a number of barriers to teaching in general practice, and is working on further policy initiatives to address these barriers.

Your views on which barriers are the most significant will help inform this work.

The AMA will shortly survey GPs about this issue, and I encourage you all to participate. The findings of the survey will be released during Family Doctor Week (21-27 July 2014).

Despite the need to expand the number of teaching practices, it is concerning to hear from colleagues about their frustration at not being selected for a GP registrar placement, particularly when nearby practices are being pressured to take on more registrars.

Is this due to some problem with the allocation processes of the Regional Training Provider (RTP)? Or, is it due to practices and GPs not being given the level of support required from the RTP to be a training practice of choice?

According to General Practice Education and Training (GPET), RTPs have the responsibility to manage the supply and demand issues associated with registrar training and practice placements.

However, it doesn't make sense to me that some are being denied the opportunity while others are being pressed to do more.

We also need to ensure that those who want to become involved in training do not face an overly bureaucratic application process.

Recently, a colleague told me of a training provider who wanted certified copies of his medical degree. I would have thought a search of the Australian Health Practitioner Regulation Agency's (AHPRA) Register of Practitioners would have provided suitable confirmation of qualifications.

> "We also need to ensure that those who want to become involved in training do not face an overly bureaucratic application process"

With support for teaching in general practice a priority area for the AMA Council of General Practice, we will certainly be looking into these matters further.

I would be interested in hearing more about your experiences with GP registrar and student placements, so please do not hesitate to email me your views at gpnn@ama.com.au.

COMMENT

Do you know what to do when disaster strikes?

BY DR ELIZABETH FEENEY

> “In certain circumstances, the doctor may have to decide not to actively treat a gravely ill or injured individual”

At the time Hurricane Katrina made landfall, Lindy Boggs Hospital in New Orleans had 126 patients in addition to staff members, family members, pets, and families from the surrounding neighbourhood sheltering in place. Firefighters arrived from north Louisiana on August 31, 2005 to evacuate the hospital. The patients were previously triaged into three groups: A (ambulatory), B (wheelchair), and C (critical). It was intended that the most critical patients would be evacuated first; however, in accordance with triage in a mass-casualty event, the medical staff was told by the rescuers that critically ill patients would be evacuated last, when more help arrived, so that those deemed able to survive could be evacuated quickly. The pronouncement was emotionally difficult for both physicians and firefighters, but it was the physicians, not the rescuers, who were responsible for relaying this information to the patients and their family members.

Dr Anna Pou’s recent article (“Ethical and legal challenges in disaster medicine: are you ready?” in the *South Medical Journal*) describes the unimaginable experience she and her colleagues went through caring for patients at an isolated hospital during Hurricane Katrina in the United States in 2005.

The intense heat; lack of food, water, and electricity; lack of security for those who stayed at the hospital; and only sporadic communication with the outside world; made the situation truly harrowing.

The most heart wrenching aspect of this story is the triaging of patients, not according to who was the most critical, but according to who was most likely to survive.

This seems anathema to those of us who have not been involved in a disaster (or armed conflict) situation – where urgent medical care is required for a large number of sick and injured individuals with limited resources.

Dr Pou argues that the public, the medical community, and government agencies were unprepared for the disaster caused by Hurricane Katrina. In particular, although most doctors were not responsible for formulating disaster plans, they were the ones left to address the plans’ inadequacies, caring for patients with few resources.

Dr Pou wrote that: “The public was grossly uneducated regarding standards of care during catastrophes, which led to feelings of betrayal and abandonment, and these in turn led to public distrust and legal action.”

Fortunately, Australia has not experienced a domestic disaster on the scale of Hurricane Katrina, the Boxing Day tsunami, the earthquake that struck Haiti in 2010 or the tsunami and nuclear disaster that hit Japan in 2011.

But many of our colleagues have responded to Australian floods, bushfires, and storms, providing health care to the local communities during and after these events. A disaster can happen anytime, anywhere - it’s essential that we’re all prepared to respond at a moment’s notice.

As such, the AMA recently updated the *Position Statement on Ethical Considerations for Medical Practitioners in Disaster Response in Australia 2008. Revised 2014.*

The Position Statement outlines a doctor’s duty of care in disasters, including natural and man-made disasters, pandemics, and terrorist activities.

It highlights the personal and professional challenges faced by doctors, and stipulates the reciprocal obligation of employers, governments, and the public to protect and support doctors responding to a disaster.

The updated Statement provides a greater focus on triage during disaster response, explaining that during a disaster there may be limited resources immediately available in relation to a large number of sick and injured individuals in varying states of health.

In certain circumstances, the doctor may have to decide not to actively treat a gravely ill or injured individual who cannot be saved in the specific circumstances, in order to treat others who can be saved.

It’s imperative that the public are aware of, and support, disaster response protocols so they understand the process, rationale, and justification for clinical decision-making before a disaster actually occurs.

In order to ensure the medical profession is ready to respond to a disaster, we must continue to be involved in the development, implementation, and review of disaster response protocols, including standards regarding, amongst others, triage, resource allocation, treatment and quarantine, and consent, privacy, and confidentiality.

The *Position Statement on Ethical Considerations for Medical Practitioners in Disaster Response in Australia 2008. Revised 2014* is available on the AMA’s website (at https://ama.com.au/position-statement/ethical-considerations-medical-practitioners-public-health-emergencies-australia), along with two related statements, the *Position Statement on Supporting GPs in the Immediate Aftermath of Natural Disaster 2012 and the Position Statement on Involvement of GPs in Disaster and Emergency Planning 2012.*

COMMENT

The internet and our children's health

BY PROFESSOR GEOFFREY DOBB

> "These younger years are crucial for the development of the brain, as well as social, interpersonal and language skills"

The use of the internet and its impact on the health of children and young people is a fairly recent addition to the Public Health and Child & Youth Health Committee's agenda.

During a recent meeting we were pleased to have as a guest speaker Dr Kate Highfield of Macquarie University, who is an expert on the issue. Her presentation was very informative and affirmed that the internet and its associated activity is having an increasing impact on the health of the next generation.

There is little doubt that technology has had a monumental impact on all our daily lives. Many carry with us three or four internet-enabled devices, and spend many hours each day communicating with colleagues, friends and family using them.

Internet-enabled devices have become an essential part of our workplaces, education institutions and our home lives.

They are also changing childhood quite dramatically.

Today's children, sometimes referred to as the iPad generation, have access to unprecedented amounts of interactive and engaging forms of technology.

While this exposure will equip children with skills for the future, there is increasing concern that there may be some potentially negative implications for health and development if use is not moderated.

According to research undertaken by Nielson (2013), Australian children are the largest users of social media in the world.

Issues such as cyber bullying are topical and very much in the news and in talk back radio discussions.

However, a focus solely on adolescents and their interactions with technology may be far too late.

Dr Highfield suggested the focus should be on children younger than five years, and perhaps even children younger than three years, where technology devices are often used as a form of 'digital pacifier'.

Constant use of technology displaces important activities such as active play and social interaction, and there are concerns about reduced motor skills, postural anomalies, eyesight problems (due to back-lit screens), disrupted sleep patterns and reduced attention levels.

These younger years are crucial for the development of the brain, as well as social, interpersonal and language skills.

This is not to suggest that technology is all bad. Quality educational games and apps are available, and computing skills are an essential part of all our futures.

Games that encourage play with parents and other caring adults can be a very positive experience for children.

Nonetheless, excessive amounts of solo time on devices may increase social isolation and reduce social skills.

Dr Highfield told the Committee that some primary schools have recently had to provide toys in the playground in order to assist their kindergarten students to interact with one another.

Along with problematic impacts on socialisation, many games and apps aimed at children have unnecessary references to gambling, while others promote unrealistic physical images that can contribute to the development of poor body image among younger girls and boys.

Children are also exposed to large volumes of advertising online, and other content that is unsuitable for children can be only a click away, or may be delivered to their screen inadvertently by the unexpected outcome of a Google search.

So far in Australia there have been few recommendations made about the use children make of technology.

The recently renewed National Physical Activity Guidelines make reference to sedentary behaviour (including screen time) and the need to limit this to two hours a day in children older than five years, and one hour for children aged between two to five years, (with a recommendation of no exposure for children aged less than two years).

MORE P27

The internet and our children's health

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These recommendations may be easily dismissed by parents because they are made solely in the context of physical activity.

The recommendations do not make a distinction between more active and educational forms of screen time and passive screen time, such as watching television.

This leads us to the issue of screen time in the educational setting.

Laptops and tablets are common educational tools, with many children engaging in computer-based learning as part of their education experience.

Understandably, curriculum policies tend to highlight the benefits of technology rather than any potentially negative impacts.

Dr Highfield made it clear that many parents are uncertain how to manage the time spent on the internet, social media and using technology devices within their families, and she and her colleagues are regularly contacted by parents who are desperately seeking assistance. Many parents have problems regulating their own use of technology.

As yet there is no definitive evidence about levels of exposure that are excessive, but exposure should be considered in the context of both time and quality.

As with many areas in public health, the precautionary principle provides us with guidance about the need for caution.

In practical terms, a recent survey of 800 general practitioners found that more than half had concerns about overuse of media and obesity among their patients, and most did not feel confident in identifying appropriate referrals for the problematic use of technology such as the internet.

The Public Health and Child & Youth Health Committee has agreed that this area warrants continued attention from the AMA.

A policy motion around internet use among children and young people will be put to the upcoming meeting of Federal Council.

We recognise that it is impractical to actively prevent children from using technology, but Committee members agreed that, as medical professionals, we should be promoting a message of balance and seek to assist children to engage with technology in the safest possible way.

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

Lyme disease not a local-grown problem: pathologists

The peak body of pathologists has dismissed controversial claims that debilitating Lyme disease is endemic to Australia, and has warned patients and doctors to be wary of positive diagnoses based on tests carried out by non-accredited laboratories.

In a Position Statement bound to incense those who insist people in Australia are catching Lyme disease from native ticks, the Royal College of Pathologists of Australasia (RCPA) has declared there is no evidence that the disease-causing bacteria Borrelia spp is carried by local ticks.

"There is considerable misinformation regarding Lyme disease in Australia, sparking an ongoing debate as to whether the disease is present both here and in New Zealand," RCPA spokesman Dr Stephen Graves said. "So far, research has failed to prove the presence of Lyme disease-causing Borrelia in ticks native to Australia and New Zealand."

Lyme disease is the most common tick-borne disease in the northern hemisphere and is caused by Borrelia bacteria entering the body through a tick bite. Initial symptoms include headache, fever and fatigue, and around 70 per cent of those infected develop a rash.

The infection responds to antibiotics, but if left untreated it can lead to more serious problems in the heart, joints and central nervous system.

Until recently, the only diagnosed cases in Australia involved people who had returned to the country after being bitten by a tick in countries where the disease in endemic.

But several local doctors claim to have diagnosed the disease, including in patients who have never left the country.

Both Bellingen GP Dr Trevor Cheney and Melbourne GP Dr Geoffrey Kemp told ABC radio, in a show broadcast in May 2013, that they had diagnosed cases of Lyme disease in their patients.

"The bottom line is these are very sick people, they have been turned away, nothing was working, and they got better," Dr Cheney said. "I don't have any particular commitment to the L-word, Lyme, I don't give a damn. What I do know is that I've been in general practice of 15 years and I am motivated by a deep sense of guilt and shame for failing so many people."

Dr Cheney's colleague Dr Gull Herzberg told the ABC he was seeing an increasing number of patients presenting with Lyme disease-like symptoms.

"I can't tell you that it's because they have Lyme," he said. "It looks like Lyme, they've got Lyme in the laboratory, I give them a Lyme treatment and they get better. I would like someone to come and pull that apart and show me well, why else is this person getting better."

But so far no National Association of Testing Authorities-accredited lab has diagnosed Lyme disease in patients who have never left the country.

Instead, doctors have controversially used laboratories overseas to confirm the Lyme diagnosis, and the RCPA has warned these results cannot be relied upon.

Many of the tests performed by non-NATA/RCPA-accredited laboratories have not been validated for use in diagnosing Lyme disease, as evident in consensus documents published by European and North American professional bodies, pathologists cited by the RCPA said.

"Until advised otherwise, no confidence can be attached to the results of tests undertaken by non-NATA/RCPA-accredited laboratories," Dr Graves said. "The referring doctor and their patients must be advised that the results of these tests may result in inaccurate diagnoses."

The ABC reported that many Australian samples have been sent to testing at California laboratory Ingenex, which claims to be able to detect Lyme disease when other laboratories cannot.

But University of Western Australia infectious diseases expert Professor Miles Beaman said he was sceptical.

"The reason why enthusiasts of Lyme disease send specimens overseas is because Australian laboratories who participate in quality assurance schemes supervised by national bodies have not been able to detect any positives," Professor Beaman told the ABC. "So they refer the tests overseas, at great expense, to laboratories which are not subject to the same stringent licensing controls as Australian laboratories have."

He said proven clinical cases of Lyme disease were "actually very recognisable. There are very clear primary, secondary and tertiary phases of the disease".

"So the vague symptoms that patients who use overseas tests to diagnose their problems are not typical of Lyme disease, they are just typical of any other condition. In fact being alive really is what they are consistent with."

Aside from the actual diagnosis of the disease itself, one of the big concerns is that often the treatment prescribed is a sustained course of antibiotics.

Infectious disease physician Professor Peter Collignon warned that prolonged use of antibiotics such as ceftriaxone, considered a 'last-line' antibiotic, could increase resistance in the broader population, reducing their effectiveness.

Dr Graves said such treatment was not recommended.

"Long-term antibiotic treatment for Lyme disease is considered inappropriate by expert European and North American bodies, and is not advocated in Australia and New Zealand," he said. "Any beneficial effect a patient experiences from such treatment is unlikely to be a result of the antibacterial activity of the antibiotic."

The nation's Chief Medical Officer Professor Chris Baggoley has established a Clinical Advisory Committee on Lyme Disease to investigate the possibility that there is a local variant of the infection, but Dr Graves said that so far there was no evidence this was the case.

"If a definitive, endemic Australian case of Lyme disease can be confirmed by culture or PCR in a patient who has never left Australia, the issue of endemicity of Lyme disease in Australia will have been settled," he said. "As of January 2014, there is no evidence of Lyme disease borne endemically in Australia or New Zealand."

Adrian Rollins

COMMENT

Not even a trace of evidence for homeopathy

The nation's peak medical research organisation has found that claims homeopathic treatments work are groundless, underlining concerns that patients turning to homeopathy to treat ailments are putting their health at risk.

In a heavy blow for the nation's 2000 homeopaths, the National Health and Medical Research Council has issued a Draft Information Paper (http://consultations.nhmrc.gov.au/files/consultations/drafts/nhmrcdrafthomeopathyinformationpaper140408.pdf) which examined research on homeopathic treatments for 68 different health complaints and found "there were no health conditions for which there was reliable evidence that homeopathy was effective".

"Evidence from research in humans does not show that homeopathy is effective for treating the range of health conditions considered," the paper concluded.

The findings were based on a world-wide examination of systematic reviews of studies that compared homeopathy with placebo and other treatments, conducted on the NHMRC's behalf by professional research group Optum.

The Council said the 57 systematic reviews used for the paper only included studies that were prospectively designed and included controls.

It admitted that the quality of the evidence was "generally low", but concluded "there were no health conditions for which there was reliable evidence that homeopathy was effective".

The Council said several studies that reported homeopathy was more effective than placebo were "not reliable" because they were not well designed or did not have enough participants.

Lead author of the study, Professor Paul Glasziou of Bond University, told *The Australian* the results, if confirmed in the final report, suggested homeopathic treatments were a waste of money, and could lead to harm.

"There is not only the financial cost, but also the potential for an opportunity cost, that you are missing out on something effective," Professor Glasziou said.

The Draft Information Paper, which is open for public comment until 26 May, could deliver a hefty blow to the homeopathy industry.

Homeopathy is a treatment based on the belief that substances that cause symptoms or illness in healthy people can, if administered in very small doses, provide relief from those symptoms. Part of its ethos is that highly diluted substances retain a 'memory' of the original substance.

Homeopaths typically charge between $80 and $100 for an initial consultation, and prescriptions cost around $10. The World Health Organisation estimated that Australians spent around $8 million on homeopathic medicines alone in 2009.

The NHMRC's draft findings come at an awkward time for the complementary and alternative medicine industry, with a review being conducted by the Chief Medical Officer Professor Chris Baggoley into the eligibility of so-called natural therapies for private health insurance rebates.

The Australian Traditional Medicine Society voiced concern about the possibility the NHMRC's report could send practitioners out of business.

The Society's Chief Executive Officer Trevor Le Breton said the "results and potential implications of the Draft Paper threaten the livelihood of hundreds of practitioners who rely on their current health fund status to make homeopathy accessible to their clients and the general public".

Mr Le Breton said the Paper's main finding was the lack of quality evidence available, and this highlighted the need for Government-supported clinical studies to "establish compelling scientific evidence so that homeopathy is afforded the same level of opportunities and recognition as other modalities".

Adrian Rollins

COMMENT

Talk about complementary medicine, doctors urged

Many patients may be at risk of unintended consequences and adverse drug reactions because they have not disclosed that they are using a complementary therapy or medicine, the National Health and Medical Research Council has warned.

The NHMRC said more than two-thirds of Australians use complementary medicine, spending around $4 billion a year on such treatment, often without their GP being aware.

The Council has produced a guide for GPs, nurses and other clinicians to help them broach the topic with patients, discuss evidence and effectiveness, and consider potential risks.

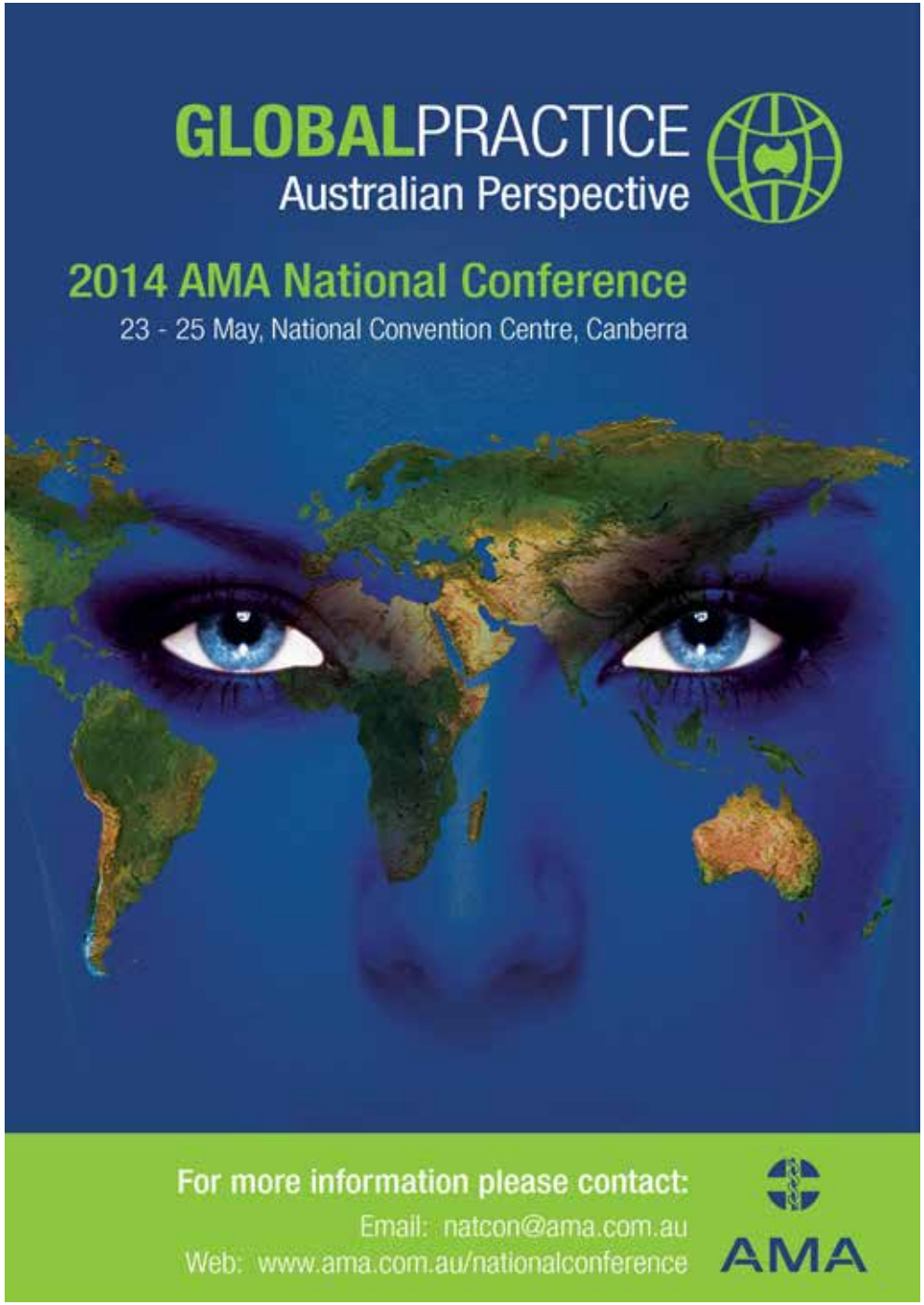
The guide, *Talking with your patients about Complementary Medicine* (http://www.nhmrc.gov.au/guidelines/publications/cam001), reported the results of a 2008 survey which found that only half of patients using complementary medicine discussed this with their doctor, often because their doctor had not asked them about it.

The NHMRC said it was important for doctors to have a full understanding of their patients' health practices, and to achieve this it was necessary to initiate discussions about complementary medicines.

The guide provides tips on how to begin such a conversation, and how to broach potentially sensitive and complicated discussions about evidence, efficacy and potential risks.

Adrian Rollins

COMMENT



Health at centre of climate change action

There has been a rallying call for doctors to be at the forefront of action to combat climate change following the release of an United Nations report highlighting the dire health effects of a sustained rise in global temperatures.

In a strongly-worded editorial, the *British Medical Journal* said the latest report from the Intergovernmental Panel on Climate Change (IPCC) confirmed the conclusion of the Lancet/UCL Commission that climate change was "the greatest threat to human health of the 21st century".

"Those who profess to care for the health of people perhaps have the greatest responsibility to act," the *BMJ* editorial said.

"If we are to avoid catastrophic climate change and bequeath a sustainable planet worth living on, we must push, as individuals and as a profession, for a transformed, sustainable and fair world."

In its report, the IPCC found that in the next 40 years the main health effect of climate change will be to exacerbate existing health problems, including to extend the range of diseases such as food-borne infections and increase rates of malnutrition through more intense droughts, storms and other climatic events.

It warned that if projected climate change scenarios proved accurate, there was a very high likelihood of more deadly and destructive heatwaves and fires, increased malnutrition, and greater incidence of food, water and vector-borne disease.

The Panel said these effects might be partially offset by a fall in deaths due to cold temperatures and geographical shifts in food production, but added that "these positive effects will be increasingly outweighed by the magnitude and severity of the negative effects of climate change".

It warned that, left unchecked, climate change would eventually push temperatures in some parts of the world beyond the capacity of the human body to thermoregulate, making outdoor manual labour virtually impossible at the hottest times of the year.

The *BMJ* said there had already been an estimated average temperature rise of 0.89 degrees Celsius since 1901, and on current trends carbon dioxide concentrations in the atmosphere will more than double to 936 parts per million by the end of the century, with a 50 per cent chance this will result in a temperature increase of more than four degrees Celsius.

"This is an emergency," the *BMJ* said. "Immediate and transformative action is needed at every level."

Promisingly, the IPCC said that action that would help lessen the extent and severity of climate change would also improve health.

Activities with such "co-benefits" included cutting air pollution, providing universal access to reproductive health services, shifting consumption away from animal products, particularly red meat, and reducing reliance on cars and other motorised transport and promoting walking, cycling and other physical activity.

The Lancet said "the health co-benefits of action on climate change could be very large. For instance, a reduction of emissions of methane and black carbon might directly prevent two to two-and-a-half million deaths per year worldwide".

The IPCC's latest report came as health experts called for tougher vehicle emissions standards in Australia.

In a report released in late 2012, the AMA highlighted the health effects of air pollution, especially very fine particulate matter, and a Senate committee was told last year that the country needed to urgently tackle to threat posed by particulate in diesel exhaust.

European countries will adopt strict new Euro 6 standards in September that require a five-fold reduction in fine diesel particles in exhaust, whereas Australia has only begun to adopt the current Euro 5 standard.

Adrian Rollins

COMMENT

Country women invigorate energy drink ban idea

The influential Country Women's Association has joined calls for a ban on the sale of energy drinks to children and teenagers.

In a major fillip for campaigners concerned about the long-term health effects of drinks high in sugar and caffeine on developing bodies and minds, the Country Women's Association of New South Wales has submitted a petition with 13,600 signatures to Federal Parliament calling for a ban on energy drink sales to everyone younger than 18 years.

"Energy drinks contain high amounts of caffeine mixed with ingredients like taurine, guarana, glucoronolactone and ginseng, which elevate the heart rate and blood pressure, and disrupt sleep," CWA NSW President Tanya Cameron said. "Who knows what damage, over time, this causes a developing body and mind?"

Ms Cameron said society already shielded children from alcohol and tobacco, and energy drinks should be added to the list.

AMA President Dr Steve Hambleton said doctors shared the CWA's concerns, noting an "alarming" number of cases of young people suffering caffeine toxicity following the consumption of energy drinks.

"We are very concerned about the number of teenagers being adversely affected by energy drinks," Dr Hambleton told *Medical Observer*. "The dangers of over-consumption are significant, and I think many parents and teenagers are unaware of the risks."

The AMA and the CWA have highlighted inconsistencies in food standards that limit the amount of caffeine in soft drinks to a maximum of 145 milligrams per kilogram but impose no similar limit on energy drinks.

The petition was presented to Parliament by Parkes MP Mark Coulton, who said the CWA had a "good understanding" of issues and concerns important to the community.

But peak industry group the Australian Beverages Council dismissed calls for a ban on energy drink sales to children as "misguided and lacking evidence".

The Council said its members abided by a strict policy of only marketing energy drinks to adults, and cited the results of a Government study which it claimed showed that less than 4 per cent of the caffeine consumed by teenagers came from energy drinks, with the greatest proportion coming from coffee, tea and chocolate milk.

But Ms Cameron said sales of energy drinks were growing strongly, and in 2013 they comprised more than 35 per cent of all drinks sold in convenience stores – eclipsing soft drink sales (31.5 per cent).

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

Gloomy pharmacists plan to slash staff because of drug price cuts

The nation's pharmacies are planning to shed around 10 per cent of their staff in the next 12 months as medicine price cuts slice into revenue, according to an industry survey.

In its latest pronouncement on the effects of the Pharmaceutical Benefits Scheme (PBS) price disclosure regime, the Pharmacy Guild of Australia has warned that the results of a national survey it has conducted imply almost 9000 jobs will go in the coming year, including about 2230 pharmacists and 4400 pharmacy assistants, as businesses are forced to cut costs.

"This survey paints a worrying picture," Guild Executive Director David Quilty said. "While the Guild and pharmacies strongly support the Government getting maximum value for money from the PBS, recent changes to price disclosure are having a very real impact on hard-working pharmacy professionals and the patients they serve."

Under the price disclosure rules, pharmaceutical companies are required to submit sales information to the Federal Government, which accordingly adjusts the amount it pays for medicines subsidised through the PBS to more closely reflect the price at which they are supplied.

The regime has resulted in multi-million dollar savings to the PBS and to consumers, but has eaten into the margins that pharmacists make on prescription medicines.

The industry has repeatedly warned that the margin squeeze is hurting pharmacies and will force many to dump staff. It has also helped spur efforts to expand the scope of pharmacist practice, including the push for pharmacists to administer vaccinations and to conduct health checks.

Mr Quilty said Guild estimates showed pharmacy gross profits would fall by an average of $90,000 in 2014-15 as a result of price disclosure.

He said the survey found that, as a result, around half of all pharmacies would reduce pharmacist hours, and more than two-thirds would cut pharmacist assistant hours.

The Queensland Government has sanctioned a trial under which 60 pharmacies are administering flu vaccines, and Federal Health Minister Peter Dutton last month declared the Government was "open to discussions" about the future scope of pharmacist practice.

The AMA has voiced strong objections to giving pharmacists authority to give flu shots, warning the health of patients could be put at risk because pharmacists did not have the required knowledge and training to safely administer vaccines, and cautioning that the move would also fragment care.

But the Pharmaceutical Society of Australia said the prospective job cuts indicated by the Guild's survey underlined the need for the industry and profession to develop new roles and opportunities.

It said it was working with the AMA and other organisations "to identify new areas where pharmacists can work and apply their skills and knowledge, including in palliative care, dementia, wound care, in the delivery of professional programs and in the use of non-dispensing pharmacists – to name a few".

"An example of this is having pharmacists working in GP practices, where they can add great value to patient outcomes, and to the services being offered to patients," Society President Grant Kardachi said.

The AMA is currently conducting a survey of GP members to gauge interest in, and concerns about, the integration of non-dispensing pharmacists with general practices. The survey can be found at: https://ama.com.au/survey/pharmacists-general-practice-survey.

The pharmacy sector's claims about the heavy burden being borne by pharmacists as a result of price disclosure have been contradicted by consumer groups including the Consumers Health Forum and CHOICE, who argued that, despite the pricing regime, Australian patients continued to pay some of the highest prices in the world for some medicines.

Prominent health economist Professor Stephen Duckett, Director of the Grattan Institute's Health Program, released a report last year claiming taxpayers were over-paying $1.3 billion a year on medicines because of poor deals struck by the Government with manufacturers.

Adrian Rollins

COMMENT

Desperate infertile willing to take big risks to have kids

Infertile women and couples are willing to take significant risks and to enter into offshore surrogacy arrangements in their efforts to have children, according to fertility experts.

In their desperation to have children, women experiencing infertility are five times more likely that their male partners to contemplate potentially serious complications such as multiple pregnancies, premature and low birth-weight births, and a higher incidence of conditions such as cerebral palsy, an Asia Pacific conference bringing together fertility specialists from across the region has been told.

Monash IVF Research Director Associate Professor Luk Rombauts told the Fifth Congress of the Asia Pacific Initiative on Preproduction said a study of 320 infertile couples and a similar number of fertile couples showed the women in infertile couples were far more willing to take on extra risks of complications than their partners.

Associate Professor Rombauts said that couples who had been trying to achieve pregnancy for a long period often asked for multiple embryo transfer.

“Multiple embryo transfer only marginally improves the chance of achieving a pregnancy, but it significantly increases the potential for complications, including possible lifetime health problems for resulting twins, compared with singeltons,” he said.

Associate Professor Rombauts said a comparison of risk perceptions among infertile couples showed women were far more willing than their male partners to undertake extra risk to achieve pregnancy.

“This is significant when you consider that women predominantly drive decisions making in assisted reproduction, even though the burden of infertility is equally shared between male and female partners,” he said.

The Congress also heard that a number of infertile Australian couples have used commercial surrogacy services in other countries to have a child.

Dr Nayana Patel, Medical Director of India-based commercial surrogacy operator Akanksha Infertility, said his clinic had delivered more than 760 babies through surrogacy to couples from 38 countries, including Australia.

Official figures show that in 2011-12 there were just 23 surrogacy births recorded in Australia, while in the same year more than 300 children were born in India to Australian citizens, many of them the result of commercial surrogacy arrangements.

Commercial surrogacy is illegal in Australia.

Dr Patel said couples paid about $24,000, of which the surrogate mother received $9000.

The surrogate mothers are required to remain in a guarded residential facility for the duration of their pregnancy, but Dr Patel said they gained significant benefits from the transaction.

“These surrogates are compensated for their services, as a homeowner would pay a maid,” she said. “It can change the lives of surrogates, because the money they earn may allow them to buy a home for their family, start a small business or educate their own children.”

Demand for such services is unlikely to abate. The World Health Organisation estimates there were about 48.5 million infertile couples worldwide in 2010.

Adrian Rollins

COMMENT

Health on the hill

Political news from the nation's capital

Govt acts to staunch GP Super Clinic funds flow

The Federal Government has acted to stem the flow of funds to the troubled GP Super Clinics program, suspending payment for three clinics that are yet to be built and assessing its options regarding a further dozen facilities.

In a development welcomed by the AMA, the *Daily Telegraph* has reported that about $25 million earmarked for planned GP Super Clinics in Darwin, Brisbane and the outer-Perth locale Rockingham, has been withheld by Health Minister Peter Dutton as the Government assesses how to scale down the controversial program.

According to the newspaper, work was yet to commence on any of the three clinics, and the Government plans to audit progress on a further 12 facilities to determine how advanced they are in construction, and what opportunities exist to axe or wind down the projects.

The previous Labor Government had committed $600 million to build 64 clinics which it claimed would fill gaps in primary care services in particular communities.

But the program has come under heavy criticism from the AMA, including for the fact that several clinics were established in areas already served by privately-run GP practices, and that the large sums involved in setting up the Super Clinics could be used far more efficiently and effectively by increasing support for general practitioners.

"The GP Super Clinics have proved to be anything but super," AMA President Dr Steve Hambleton said. "They have absorbed huge amounts of valuable health funding that would have been better spent in other ways in the health system."

Dr Hambleton said they were supposed to provide primary health care services in areas where patients had limited access to GPs, but many had been built in places where they were directly competing with successful, long-established practices.

The AMA's concerns were borne out by an Australian National Audit Office report which found that the program has been dogged by serious cost overruns and lengthy delays, and many of the clinics had been built in areas already well served by doctors and other health professionals.

The Auditor-General found that only three of the 36 clinics promised in 2007 were completed on time, and as at mid-2013 seven were still not operational, while just one of the 28 announced in 2010 was fully functional.

Mr Dutton told the *Daily Telegraph* the program was a shambles: "When you think of Super Clinics, think pink batts, cash giveaways and NBN."

The Minister said that not only had the scheme chewed up hundreds of millions of dollars, it had "cannibalised existing doctor practices and undermined the opportunity for young doctors to buy into those practices".

Mr Dutton told The Australian the flawed design and implementation of the program limited the Government's ability to retrieve much of the money committed to the scheme.

He said the program's design meant the Government did not own the clinics, and instead paid upfront for services to be provided at the clinics under 2-year service contracts.

The Minister said because all of the money was paid upfront it meant there was no mechanism for the Government to enforce service standards such as through on-going performance-based payments.

And the terms of the contracts meant they could only be altered with the agreement of both signatories, limiting the scope to alter terms or withdraw altogether.

Chair of the AMA Council of General Practice Dr Brian Morton told *The Australian* the program had been an inefficient use of scarce health funds.

Dr Morton said the enormous sums invested in the scheme could have been used far more effectively by providing infrastructure grants and other support for GPs to upgrade technology and expand access to allied health care.

Under the Primary Care Infrastructure Grants program, $117 million has been allocated over four years to upgrade 425 GP facilities. By contrast, the Auditor-General found that two GP Super Clinics alone had cost taxpayers $50 million, and several more had needed substantial top-up funding.

Dr Morton said it would be good to see program wound up immediately, and any unspent funds redirected to boost general practice.

Adrian Rollins

COMMENT

Health on the hill

Political news from the nation's capital

Mental health programs face uncertain future

The long-term outlook for 150 mental health programs remains uncertain after the Federal Government injected just enough extra funds to keep them afloat for the next 15 months.

Health Minister Peter Dutton has provided $170 million to allow the programs to continue operating while the National Mental Health Commission undertakes a review of all existing services, but the funding will not support them beyond mid-2015.

Mr Dutton said the funding injection reflected the Government's commitment to mental health.

"It is essential to ensure the continuity for mental health services, suicide prevention and postvention [sic] programs while the …Commission undertakes its review of all existing services," the Minister said. "People who experience mental ill health need to know that services are available to support them."

Mr Dutton said that providing notification of the continuation of funding now would help providers effectively plan their work for the forthcoming financial year.

But prospects beyond June next year are unclear, with all future funding decisions suspended while the Commission undertakes its work.

The Minister indicated the review was likely to result in changes.

He said the review was important to ensure that services were being properly targeted, and that funds went to those programs that were proven to be most effective.

Adrian Rollins

COMMENT

International agreement on treatments for rare diseases

Patients with rare diseases may get quicker access to advanced treatments under an agreement struck between the Australian medicine watchdog and its European counterpart.

The Therapeutic Goods Administration and the European Medicines Agency have agreed to share their assessments of so-called orphan drugs, which are medicines developed specifically to treat a rare medical condition.

Developing and testing treatments for conditions that may only affect a small fraction of the population present special challenges, including the lack of a large market to offset the cost of research and development, and the fact that there may not be sufficient people with the condition to meet the typical quota required for a scientifically robust clinical trial.

The agreement between the TGA and the EMA is seen as a way to help lower the barriers to orphan drugs while still ensuring they meet safety and efficacy standards.

The TGA said that where a manufacturer simultaneously seeks marketing authorisation in both Australia and Europe, there is an opportunity for "scientific exchange" that could facilitate the evaluation of the medicine concerned.

But, indicating the limits to cooperation, "both regulators will still reach their own conclusions about the suitability of each medicine to be authorised in their respective markets," the TGA added.

Nonetheless, the regulator said, "the agreement will reinforce collaboration and work-sharing between the two regulatory authorities, and will contribute to accelerating access to new medicines for patients with rare diseases in Europe and Australia".

It said such collaboration was particularly important "in view of the small number of patients worldwide, and the need for the limited number of studies performed to benefit patients, regardless of where they live".

In addition to the agreement on orphan medicines, the two regulators have also reached a mutual recognition agreement on good manufacturing practice for medicines.

Adrian Rollins

COMMENT

Health on the hill

Political news from the nation's capital

Anti-vaccination parents could face welfare cut

Parents who object to the vaccination of their children on ethical grounds could be stripped of family tax benefits under a plan being considered by Federal Health Minister Peter Dutton.

The nation's Health Ministers, who met in Brisbane late last week, are facing calls to do more to boost child vaccination rates after it was revealed that more than 75,000 young children were not fully immunised – with coverage in some areas as low as 67 per cent, well below the level considered necessary to ensure herd immunity.

A significant proportion – 15,000 – had not been vaccinated because of the conscientious objections of their parents, according to analysis by the National Health Performance Authority.

A loophole under which parents who conscientiously object to vaccination for their children can still claim an immunisation bonus worth $2100 has drawn the ire of health experts.

The Australian Virology Society, the Australasian Society for Immunology and The Australian Society for Microbiology have urged that the loophole be immediately closed.

Queensland Health Minister Lawrence Springborg flagged his intention to put the issue of parental conscientious objections to vaccination on the agenda of the Health Minister's meeting, telling the *Courier Mail* it was a term that was being "abused and misused".

Mr Dutton said he was looking at the issue closely, including the option of withholding the $726 Family Tax Benefit A payment from parents whose children were not vaccinated.

"There is an argument for them to lose it, and I'm considering that," the Minister told the *Courier Mail*. "We've got pretty good coverage at the moment – about 90 per cent of children aged one, two and five are fully immunised – but there is this issue around conscientious objectors."

AMA President Dr Steve Hambleton said other states should consider following the lead of the NSW Government, which has given child care centres the authority to block the enrolment of unvaccinated children.

"Recent analysis has looked into areas that had poor vaccination rates, and prior to the 'no jab, no play' campaign it was below the threshold for herd immunity, and after this campaign it was above," Dr Hambleton told the *Courier Mail*. "That is the difference between measles going wild and not going wild."

Adrian Rollins

COMMENT

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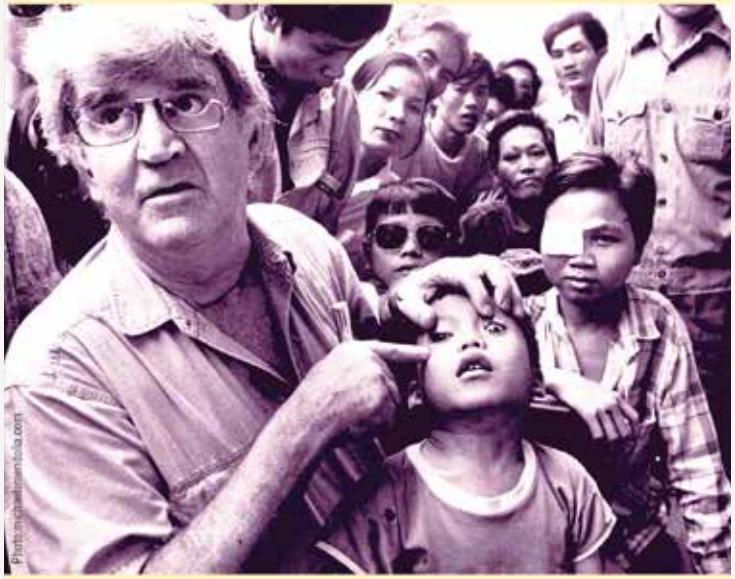

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OPINION

The health system sustainability myth

BY PROFESSOR STEPHEN DUCKETT, DIRECTOR, HEALTH PROGRAM, GRATTAN INSTITUTE

This story first appeared in The Conversation on 8 April 2014, and can be viewed at: http://theconversation.com/rationing-care-vs-increasing-taxes-the-health-system-sustainability-myth-24774?utm_medium=email&utm_campaign=Latest+from+The+Conversation+for+9+April+2014&utm_content=Latest+from+The+Conversation+for+9+April+2014+CID_4bbd0a6f6eeb3c8a3d8719978ad1547f&utm_source=campaign_monitor&utm_term=Rationing%20care%20vs%20increasing%20taxes%20%20the%20health%20system%20sustainability%20myth

In the lead-up to the May budget, the seemingly inexorable rise in health spending has unleashed a "sustainability panic": rhetoric that health system costs are out of control and drastic measures are needed to make the system affordable.

Sustainability panic is often used to justify shifting the burden of controlling health spending from the wider society to a vulnerable few – people with poor health who frequently go to doctors and hospitals, for example, or those with high needs and potentially shortened life expectancy. Proposals to limit access to care or to introduce co-payments for doctor visits would fall heavily on these groups.

Rationing health care is seen as a potential solution to the presumed cost explosion; the alternative being tax increases or some other unpalatable solution.

Lists of rationing targets abound, but typically they include dialysis for over 75s, hip replacements for the elderly, and tailored cancer treatment. The generic description is interventions that are high-cost but have a "low return". The policy question is phrased as whether society at large is prepared to keep paying for them.

These discussions are generally framed in terms of a false dichotomy: rationing or increased taxes. But there are other options. Policymakers should direct their attention to eliminating waste and respecting patient choices about their end-of-life care for a more cost-efficient and equitable health system.

Health rationing

Rationing of health care already exists both implicitly and explicitly. Language is vital in this area: one person's rationing may be another's priority setting.

At the system level, rationing is explicit. Australia has led the world in trying to ensure that new, publicly subsidised treatments – both new drugs and new medical interventions – meet standards of cost effectiveness. In other words, the costs of new interventions need to show commensurate benefits in terms of additional quality-adjusted life years or costs averted elsewhere in the system.

Rationing also occurs in public hospital care. In 2011-12, over 600,000 people were admitted to public hospitals for elective surgery, with wildly varying waiting times. Half were admitted within 36 days of going on the inpatient list, while 10% waited more than 250 days, with significant differences among states. In Tasmania, 10% of patients waited almost a year (348 days).

Some patients wait years for elective surgery.

These inpatient waits were on top of waiting for out-patient appointments, the so-called "hidden" waiting list. No data are publicly available, but media reports suggest this can add two years to

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The health system sustainability myth

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the wait for care.

Implicit rationing decisions are made in the options put before patients. Clinicians in England and the United States have very different perspectives on what options patients should be given. At what age is it legitimate to start a person on dialysis for example? Australian clinicians are probably somewhere between the two.

Implicit rationing is often informed by clinical judgements about the risks of surgery, and different clinicians will weigh up these judgements differently.

What advocates of rationing rightly suggest is that implicit rationing should be made explicit and that the criterion be changed from a clinical judgement to one based on cost effectiveness.

Eliminating waste

The first priority for ensuring the health system is affordable should be that all necessary care is provided efficiently. This is not the case – previous Grattan Institute reports have shown that billions of dollars are wasted in the health system every year.

First, we pay too much for pharmaceuticals, way in excess of what is paid in other countries. Negotiating better deals with drug companies for medicines listed on the Pharmaceutical Benefits Scheme (PBS) could save A$1 billion a year.

Second, not all public hospitals are equally efficient. Avoidable costs are endemic in the hospital system and eliminating those could save at least a further billion dollars a year.

Third, not all care is necessary. Rates of admission to hospital vary substantially, with the variation not able to be explained by either underlying differences in the health of the population or in health outcomes. Superseded treatments are still being provided.

Finally, best-practice guidelines are not being followed and high out-of-pocket costs are leading patients to defer needed care. Both situations may lead to higher downstream costs. One paper has even suggested that if only evidence-based care was provided, there would be no need to discuss rationing at all.

Better end-of-life decision making

Even if the nirvana of a waste-free health system were achieved, there will be cases in which people might question whether certain treatments are worth the cost. After all, any decision about whether to subsidise new pharmaceuticals or medical treatments is a form of explicit rationing.

Outside this systemic level of evaluation, however, the health system fails patients at the level of individual treatment choices – and it fails society.

Drawing on the experiences of their mother's treatment in the United States, medical historian Jackie Wolf and her brother Kevin, an actuary with health-care experience, tell a harrowing tale of interventionist cancer treatments. The cancer specialists all offered hope, recommending many more interventions and giving above-average prospect of survival. Only their mother's general practitioner was honest enough to tell her that her condition was terminal.

We should focus on whether a patient is being treated with dignity in the choices he or she is being offered.

The rationing frame questions interventions where the treatment costs are high and the benefits low. This is the wrong frame. The broader challenge should be to ensure patients' treatment choices are respected.

We all die. Medical intervention will not change that, but it can change whether a person dies as a result of a particular injury or illness during the current episode.

The health system will better serve patients who are likely to soon die if it discusses more realistically the chance of death and the benefit health-care interventions can offer. Will the patient be restored to "perfect health" or will he or she live with significant disabilities, and if so, of what kind?

"We all die. Medical intervention will not change that, but it can change whether a person dies as a result of a particular injury or illness during the current episode"

We should focus on whether a patient is being treated with dignity in the choices he or she is being offered. Are the treatment choices being made in an environment of collaborative decision-making or are they based on medical hubris that avoids discussions about whether the treatment is likely to prolong both life and quality of life?

If these discussions were held with the right balance of sympathy and candour they would probably reduce costs, as fewer high-cost-low-benefit treatment options would be pursued.

Even so, some patients and their families may still want to pursue all options, and that's okay. It would be a sad day for health care in Australia if treatment choices were made based on a taxi meter ticking by the bed.

COMMENT

Research

Poor diet can increase asthma risk

Eating a poor quality diet high in saturated fats and refined sugar can increase the risk of symptoms in asthmatics, according to a new study.

University of Newcastle researchers studied the diets of a group of subjects using the Dietary Inflammatory Index (DII), based on their potential to either cause inflammation linked to overactivity in the immune system, or to protect against it.

Inflammatory foods included those high in saturated fats and refined sugar, while anti-inflammatory foods included fruit and vegetables and those high in soluble fibre, such as oat bran and lentils.

Lead researcher Associate Professor Lisa Wood said that, after studying the diets of 99 asthmatics and 61 people without asthma symptoms, asthmatics who participated in the study were more likely to eat inflammatory diets, increasing their risk of asthma attacks.

For every one unit increase in the DII score, the odds of having asthma increased 62 per cent.

The researchers also found that lung function was significantly associated with DII score.

Lung function was found to reduce by about 10 per cent in the third of patients with the highest DII score compared with the third of patients with the lowest. Levels of the inflammatory marker interleukin-6 were also positively associated with the DII score.

Associate Professor Woods said the usual diet consumed by asthmatics in the study was pro-inflammatory relative to the diet consumed by healthy controls, and that eating a single high-fat meal could cause inflammation in the airways of people with asthma.

She explained that the body responds to excess dietary fat the same way as it would an invading pathogen, so that those who regularly ate fatty food had a chronically activated immune system.

In addition, researchers found that the effectiveness of ventolin – the most common inhaler-based treatment for asthma, also known as salbutamol – can become compromised by the consumption of fast food or sugary drinks.

Associate Professor Woods, with Dr Mehra Haghi, found that the amount of salbutamol transported through the cell membrane was significantly higher in the presence of polyunsaturated fatty acids compared with saturated fatty acids or no fats at all.

“Incubation with polyunsaturated fatty acids appeared to reduce the stiffness of the cell membrane,” Dr Haghi said. “Our findings suggest that the presence of polyunsaturated fatty acids is essential for membrane fluidity.

“Our findings also demonstrate that, if saturated fatty acids are present, then this effect is lost and drug transport is prohibited.”

She said it was particularly important for people who already had asthma to eat a diet high in fruit and vegetables.

The studies were presented at the Thoracic Society of Australia and New Zealand’s annual meeting.

Kirsty Waterford

COMMENT

Working on the land is backbreaking

Farmers are four times more likely to develop work-related lower back pain than workers in any other profession, according to new research.

University of Sydney researchers led an international team to assess the occupational exposure to ergonomic risk factors of lower back pain.

They found that a major cause of disability worldwide was lower back pain developed from ergonomic exposures at work.

More than 25 per cent of Australians between the ages of 18 and 44 years take 10 or more days off a year with lower back pain, costing the health system annually around $4.8 billion. On any given day, one quarter of Australians suffer back pain, and nearly 80 per cent of adults will experience back pain at some point in their lives.

Lead researcher Professor Tim Driscoll said that ergonomic factors linked to lower back pain included lifting, forceful

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movement, awkward positions and vibration, all of which are commonly experienced in farm work.

The people most at risk were those who work in the agricultural sector, and those aged 35 to 65 years," Professor Driscoll said. "However, low back pain is a problem for people in many occupations.

"Based on published research, agricultural sector workers were almost four times as likely to develop low back pain disability as any other group of workers."

The researchers also measured disability adjusted life years (DALYs) – the years of life lost due to premature death and years of life lived with disability.

"The calculations showed that, in 2010, there were nearly 22 million DALYs worldwide caused by workplace-related low back pain," Professor Driscoll said.

"The burden was considerable in all regions, all age groups, and both genders, with 13.5 million DALYs in men and 8.3 million in women.

"The highest rate of DALYs occurred in Asia, Oceania and parts of Africa – places where employment in agriculture is more common, but rates were considerable in all regions.

"Lower back pain arising from ergonomic exposures at work is a major cause of disability worldwide.

"There is a need for improved information on exposure risks, particularly in developing countries, to help better understand the burden," Professor Driscoll said. "This should lead to better prevention of back pain and injury, as well as decreased lost work time due to back pain."

The study was published in the *Annals of the Rheumatic Diseases.*

The study was undertaken as part of the Global Burden of Disease 2010 study, which assesses ill health and disability arising from all conditions in 187 countries for 1990, 2005, and 2010. The study was funded by the Bill and Melinda Gates Foundation.

Kirsty Waterford

COMMENT

Is surgery the answer to type 2 diabetes?

Bariatric surgery has been hailed as the most effective treatment for type 2 diabetes following the findings of a study.

The study, by the Cleveland Clinic, examined 150 overweight patients with poorly controlled diabetes.

The patients were divided into three equal sized groups: in the first group, 50 patients received intensive medical therapy only; in the second group, 50 patients underwent Roux-en-Y gastric bypass surgery and received medical therapy; and in the third group, 50 patients underwent sleeve gastrectomy and received medical therapy.

The effectiveness of treatment was gauged by the percentage of patients who achieved blood sugar control, defined as haemoglobin HbA1c levels of less than or equal to 6.0.

After three years, more patients in the gastric bypass group – 37.5 per cent – achieved blood sugar control without the use of any diabetic medications compared with the other two groups – 5 per cent of the patients in the medical therapy group and 24.5 per cent of patients in the sleeve gastrectomy group.

The study found that patients who underwent bariatric surgery experienced an improvement in quality of life, and a reduction on the need for cardiovascular medications to control blood pressure and cholesterol compared with those receiving medical therapy.

As a result, patients in the surgery group used less cardiovascular and glucose lowering medications – 5 to 10 per cent were on insulin, compared with 55 per cent of patients in the medical therapy group.

One of the lead researchers, Dr Sangeeta Kashyap, said patients who underwent bariatric surgery lost five to six times more weight than those in the intensive medical therapy group.

"We see patients whose lives are ravaged by diabetes," Dr Kashyap said. "At the three-year mark, this study shows that bariatric surgery is more effective, with persistent benefits noted up to three years, for treating type 2 diabetes in moderate and severely obese patients, when compared to medical therapy.

"More than 90 per cent of the patients who underwent bariatric surgery were able to lose 25 per cent of their body weight and control their diabetes without the use of insulin and multiple diabetes drugs."

The researchers also evaluated the impact of diabetes and obesity on a patient's quality of life.

They found significant improvements in five of eight mental and physical domains for patients in the gastric bypass group, compared with improvements in two of eight domains for patients in the sleeve gastrectomy group. There was no improvement in the medical therapy group.

Another lead researcher, Dr Philip Schauer, said the three-year data confirmed that bariatric surgery maintained its superiority over medical therapy for the treatment of type 2 diabetes in severely obese patients.

"We looked at quality of life, because ultimately it is about helping our patients live a healthier, happier life," Dr Schauer said. "When compared to sleeve gastrectomy and medical therapy, gastric bypass patients achieved greater weight loss, were on fewer medications, and had a higher success rate in controlling their diabetes and an improved quality of life."

The study was part of the Surgical Therapy And Medications Potentially Eradicate Diabetes Efficiently trial and was published in *Diabetes Care*.

Kirsty Waterford

COMMENT

Tobacco plain packaging works: UK review

A British Government Minister has announced she is "currently minded to proceed" with the introduction tobacco plain packaging following an upbeat appraisal by a leading paediatrician.

In his review, Sir Cyril Chantler concluded that although there were limitations to the evidence about the effectiveness of tobacco plain packaging laws, the signs were that they had an effect on smoking rates.

"The evidence base is modest, and it has its limitations, but it points in a single direction and I am not aware of any evidence pointing the other way," Sir Cyril said in his report.

In late 2012, Australia became the first country in the world to introduce plain packaging laws for tobacco products, and is fighting legal challenges to the rules from a number of countries.

Both the New Zealand and Irish governments are closely considering introducing similar laws, and British Prime Minister David Cameron has indicated in the past an interest in such legislation, though late last year he appeared to take a step back from this position, rousing accusations that he had been 'got at' by the tobacco industry, which has had links with Australian-born Conservative Party political adviser Lynton Crosby.

But British Public Health Minister Jane Ellison told Parliament Sir Cyril's review made a compelling case that plain packaging would be "very likely to have a positive impact on public health".

"I am therefore currently minded to proceed with introducing regulations to provide for standardised packaging," Ms Ellison said.

The Minister said around 200,000 children aged between 11 and 15 years start smoking in the UK every year, about 600 a day, and that even a 2 per cent cut in the rate at which smoking was taken up would mean 4000 fewer children a year with the deadly habit.

She told Parliament she would publish draft regulations for final consultation, and promised changes before the next general election is due in May next year.

But the Minister's assurances have not satisfied health groups and the Opposition.

While welcoming Ms Ellison's statement, the British Medical Association said there should be no further delays to introducing legislation.

"As doctors, we see first-hand every day the devastating effects of tobacco addiction, and we call on the Government to make a decision quickly and to introduce standardised packaging at the earliest possible opportunity in order to help put an end to a life-long addiction that kills and destroys health," Deputy Chair of the Association's Board of Science, Dr Ram Moorthy, said.

Shadow Health Minister Luciana Berger urged the immediate introduction of legislation banning company branding on tobacco packaging.

"There is an overwhelming body of evidence in favour of standardised packaging, and there can be no excuse for a further delay," Ms Berger said.

In his review, Sir Cyril found that "branded packaging contributes to increased tobacco consumption".

The paediatrician said Australia's experience did not constitute a trial of tobacco plain packaging because of the confluence of a number of changes, including an increase in the tobacco excise.

"Disentangling and evaluating these will take years, not months," he wrote.

But the expert stressed other research and studies meant he was confident in his conclusion.

Sir Cyril said it was notable that Japan Tobacco International attempted to sue the Australian government for taking possession of its mobile "billboards".

He also found there was no evidence of increased counterfeiting following the introduction of plain packs in Australia.

His finding contradicts claims by British American Tobacco Australasia that the black market's share of tobacco consumption has increased from 11.8 to 13.3 per cent since the introduction of plain packaging.

The company claimed the illegal tobacco market in Australia now amounted to 2.7 billion cigarettes, with an additional 400 million smuggled into the country since the introduction of plain packaging.

Adrian Rollins

COMMENT

Seven million sign up to cement Obamacare

The risk that Obamacare will be repealed has diminished after a late influx of applications pushed the number of enrolments above seven million, solidifying the controversial scheme.

Buoyed by the enrolment numbers, President Barack Obama declared early this month that "the debate over repealing this law is over".

Political commentators think it highly unlikely that the Republicans, who have been implacably opposed to the Affordable Care Act since its introduction, will be willing to follow through on their threat to repeal President's Obama's signature social reform because of the likely backlash from more than seven million policy holders.

The last-minute rush of people to sign up before the 31 March enrolment deadline was greeted with relief by White House officials and Congressional Democrats after a series of technical breakdowns and website crashes late last year raised fears the scheme would collapse, delivering a huge blow to the authority and prestige of President Obama and the Democrat Party.

The number of enrolments not only means that, politically, Obamacare's future seems increasingly assured, but that it has a sufficient spread of enrolees to make the system financially viable. One of the chief concerns has been that only the sick and the elderly would sign up to Obamacare, forcing insurers to charge high premiums in order to make the system work.

But President Obama declared that the number of participants in the scheme assured its political and economic future.

"The Affordable Care Act is here to stay," the President said on 1 April. "The bottom line is this: the share of Americans with insurance is up, and the growth in the cost of insurance is down. There's no good reason to go back."

Triumphant senior Democrat Senator Dick Durbin told Obamacare's Republican critics, "You're not going to turn away 7 or 10 million people from insurance coverage. Doesn't work anymore."

But, while the basic Obamacare scheme may be cemented in place, Los Angeles Times columnist Doyle McManus is among those who expect it will undergo significant changes to attract more enrolments and reduce the burden on business.

Among the possible amendments is to introduce a fifth tier of coverage involving lower up-front premium costs in exchange for higher co-payment and excess charges, a move being touted as a way to attract the many put off by what they see as the expensive range of policies currently on offer under the scheme.

The Obama Administration may also attempt to widen Obamacare's political appeal by changing the threshold under which it is mandatory for businesses to offer health insurance to their workers from those firms with at least 50 employees to those with at least 100. The change is being touted as an important step in reducing the administrative burden of the scheme.

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.

Ebola clinic attacked by fearful locals

Medical charity Medicins Sans Frontieres has suspended work at an Ebola treatment centre in southeast Guinea after it came under attack from locals who believed health workers had introduced the deadly disease to the area.

As the death toll from the Guinea outbreak reached 95 people, MSF revealed it had put a 'patient awareness team' in place to try and inform locals about the virus, though emergency coordinator Henry Gray said it was "very difficult" to simultaneously inform locals while trying to do everything possible to halt the outbreak.

MSF reported that locals threw stones at buildings and vehicles at a treatment centre in Macenta under the mistaken impression the charity had brought in the disease, forcing operations to be suspended, though no-one was injured in the attack.

In a promising development, several patients being treated for the virus have been discharged, and the World Health Organisation reported that the fatality rate in the Guinea outbreak was less than 63 per cent – well below the 90 per cent death rate typically attributed to the virus.

While the outbreak appears to be concentrated in Guinea, the WHO reported seven suspected cases in neighbouring Liberia, as well as three in Mali. Up to 15 people in Sierra Leone who have died from the disease are thought to have caught it while in Guinea.

MSF has 60 international staff working in Guinea to help contain the epidemic, and has flown in more than 40 tonnes of medical supplies.

Child charity Plan International said the appearance of the disease in the Guinean capital Conakry marked a new and dangerous phase of the outbreak, with more than two million people living in "very challenging" conditions in the city, including its slums.

Plan said it was the first time the virus had appeared in the country, and locals were fearful.

Adrian Rollins

COMMENT

Woman 'frozen alive' in hospital morgue

The family of an elderly woman who was "frozen alive" in a Californian hospital morgue has had its lawsuit revived.

The woman, Maria de Jesus Arroyo, 80, was pronounced dead at White Memorial Medical Centre after suffering a heart attack in July 2010.

But, according to a report in the *Los Angeles Times*, when morticians removed her body from the hospital morgue a few days later, they found her body face down, her nose was broken, and there were cuts and bruises to her face.

In a subsequent examination, a pathologist concluded that the injuries most likely occurred while Ms Arroyo was alive – that is, that she had mistakenly been declared dead.

In his testimony at a District Court hearing in 2011, the pathologist said it appeared the elderly woman had been "frozen alive", and when she had eventually woken up she had "damaged her face and turned herself face down as she struggled unsuccessfully to escape her frozen tomb", according to court records cited by the *Los Angeles Times.*

At the time, the judge hearing the case dismissed the action brought by Ms Arroyo's family because it came more than 12 months after they had discovered her injuries.

But early this month the 2nd District Court of Appeal overturned the decision, finding that the family could not have known that Ms Arroyo had been prematurely declared dead and frozen alive until the pathologist delivered his expert opinion in December 2011.

The case will now be heard by the Los Angeles County Superior Court.

Adrian Rollins

COMMENT

Criminal history checks

AMA members will know that when they renew their medical registration in September each year they have to make a declaration about their criminal history

At the same time, they are authorising the Medical Board to obtain a written report on their criminal history (e.g. a CrimTrac agency report).

Different jurisdictions have different laws prescribing what constitutes a criminal offence.

Members may have had their renewal delayed if they have not declared an offence that is minor, but which nevertheless constitutes a criminal offence in their State.

Criminal history checks are an integral part of the assessment of a medical practitioner's suitability to practice medicine in Australia.

A criminal history includes:

- every criminal charge made against a person for an offence;
- every conviction (including spent convictions); and
- any plea of guilty or finding of guilt by a criminal court, whether or not a conviction is recorded for the offence. Any criminal matter that goes before the courts, no matter how minor (even a challenge to a traffic infringement), is relevant to a criminal history declaration, and will show up on a CrimTrac agency report.

Civil matters, such as contract disputes or debt matters, do not form part of your criminal history.

When you apply to renew your registration, you are only required to declare any change to your criminal history during the preceding year of registration.

If your criminal history has changed in any way over the preceding year, you must tick 'Yes' on the renewal form and provide details of the offence.

When AHPRA processes your renewal application, a 'Yes' response will prompt them to obtain a report from CrimTrac to verify the details of your criminal history. AHPRA will then conduct an assessment of the information and a decision will be made about whether the offence is relevant to your practice.

The factors the Board will consider in deciding whether a health practitioner's criminal history is relevant to the practice of their profession are set out in the Criminal History Registration Standard, which is available on the Medical Board of Australia website.

To reconcile the variation between jurisdictions about what constitutes a criminal offence, the Medical Board recently authorised AHPRA to make direct assessments when a criminal history shows a minor offence and there is no demonstrable connection with the profession. Minor offences include, but are not limited to, low-level speeding, failure to wear a seatbelt, driving while unlicensed, driving an unlicensed or unregistered vehicle, parking offences, public nuisance, trespass and fishing offences.

The risk of failing to declare your criminal history is that it will subsequently show up on a CrimTrac report during one of AHPRA's regular audits, triggering an investigation into a false declaration.

Medical practitioners who have been found to have made false declarations will be asked to submit a written explanation to the Medical Board. The Board will then decide how to deal with the practitioner, including the relevance of the criminal history to the practice of medicine.

We remind members it is important to declare your criminal history on the registration form, no matter how minor the offence.

You will not normally incur any delays to your registration renewal, as you will continue to be registered while AHPRA makes an assessment, and you will also be protected from inadvertently making a false declaration.

COMMENT

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

The 1985 Mercedes 280E – slowing the speed of depreciation

BY **DR CLIVE FRASER**

1985 Mercedes 280E	
For	Reliable, and ownership lasts longer than most marriages.
Against	Modern engines use less fuel.
This car would suit	Retired psychiatrists.
Specifications	2.7 litre 6 cylinder petrol 136 kW power @ 5,800 rpm 240 Nm torque @ 4,500 rpm 4 speed automatic 16.7 l/100 km (city) 11.4 l/100km (highway) $1000 - $3000 trade-in $3000 - $5200 private sale
Fast facts	Mercedes built 2.7 million W123 cars. This model was always popular with Arab taxi fleets

MOTORING

As fuel prices keep climbing, motorists endlessly complain about what they pay at the pump.

Independent fuel retailers have always had the lowest prices, but the four cents a litre discount from shopper dockets have almost wiped them out.

The grocery duopoly have agreed to step back from 30 cents per litre discounts, but that still doesn't stop them from having very deep pockets when it comes to sending the opposition broke through very aggressive pricing.

But, by my calculations, fuel is one of the lesser expenses when it comes to motoring.

The biggest expense by far is still there even when you're not driving your car: depreciation.

As it is a cost you don't find out about until trade-in time, it sits in the blind spot of most motorists.

Anyone who has divorced will know just how much it costs to trade up to the new model.

An average Holden Commodore SV6 would have cost you $43,790, plus on-road costs, in 2011.

In the past three years, you would have spent $6400 buying 4275 litres of unleaded petrol, assuming that you'd driven an average of 15,000 kilometres a year.

But, after three years, your beloved Holden Commodore is only worth $17,000 as a trade-in.

Allowing for the on-road costs at purchase, you've lost $30,000 in three years, or $200 per week, or 67 cents per kilometre, in depreciation alone.

Your Commodore is dropping in value by 26 per cent each and every year, and depreciation is nearly five times whatever was spent on fuel.

This explains why accountants are very frugal when it comes to buying cars, as they don't like to spend money on depreciating assets.

The tax man does help generously if your vehicle is used for business, by offering a deductible depreciation allowance of 30 per cent.

But is there a way to avoid that hefty depreciation?

The answer is, "yes".

In 1985 a trusted colleague shelled out $65,000 for a Mercedes 280E.

At the time it was a lot of money for what was a lot of car.

It was the last of the W123 series, which had been introduced in 1976.

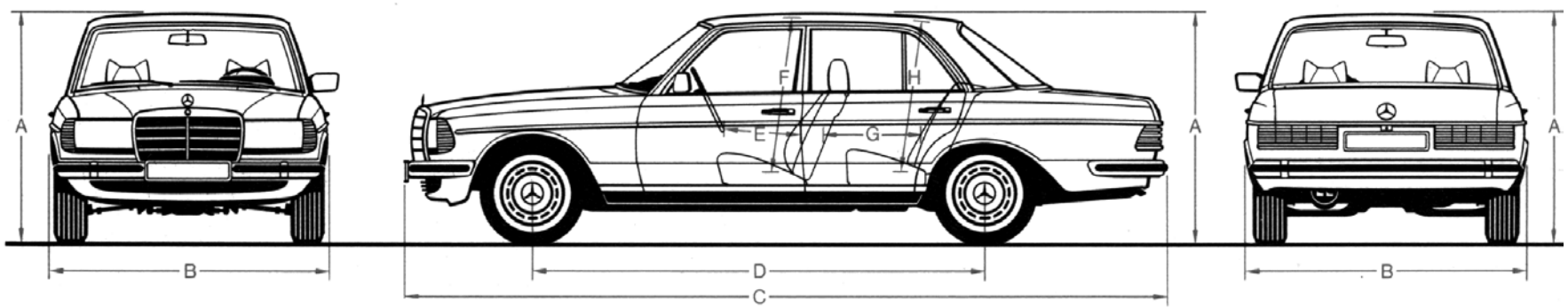
My colleague knew that Mercs had a reputation for longevity, but he did not know that nearly 30 years later that he'd still be driving his 280E.

He's now done 417,000 kilometres, enough to circumnavigate the Earth more than 10 times.

COMMENT

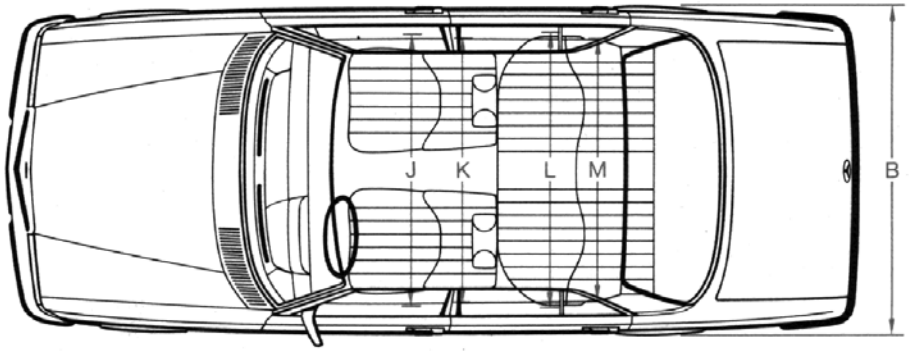
The 1985 Mercedes 280E – slowing the speed of depreciation

... FROM P40



Merceds-Benz 280, 280E

A	max. hoogte onbelast	143,8 cm
B	max. breedte	178,6 cm
C	max. lengte	472,5 cm
D	wielbasis	279,5 cm
E	afstand stuurwiel-rugleuning zitplaatsen vóór [5])	48,4 cm
F	zithoogte vóór onbelast	97,3 cm
G	afstand rugleuning zitplaatsen vóór-rugleuning achterbank [5])	65,2 cm
H	zithoogte achter	94,8 cm
J	breedte over zitkussens vóór	147,6 cm
K	breedte op schouderhoogte vóór	142,2 cm
L	breedte over zitkussen achter	148,0 cm
M	breedte op schouderhoogte achter	141,6 cm
spoorbreedte voor		1488 mm
spoorbreedte achter		1446 mm
draaicirkel		11,25 m
inhoud kofferruimte		ca. 0,50 m³



His car hasn't needed any major mechanical repairs, and costs only $180 for each service every six months.

He's only replaced the brake pads twice, an alternator and one radiator hose.

The paintwork and upholstery are as new, and it gets along very well thanks to its free-revving136 kilowatt six-cylinder engine.

Fuel consumption, by modern standards, is not that great: 16.7 litres per 100 kilometres around town, and 11.4 l/100km on the highway.

The 280E runs happily on normal unleaded petrol.

Safety was ahead of its time, with ABS and a driver airbag available as options on overseas models.

My colleague estimates that his old Mercedes is only depreciating at about $50 a year at present and, who knows, maybe in the future it might just start going up in value!

Safe motoring,

Doctor Clive Fraser

Email: doctorclivefraser@hotmail.com

COMMENT