AUSTRALIAN
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# Budget takes aim at health

## Universal health care in Government sights, p8


INSIDE



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**ISSUE 26.09** - MAY 13 2014


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# In this issue

**Managing Editor:** John Flannery
**Editor:** Adrian Rollins
**Production Coordinator:** Kirsty Waterford
**Contributor:** Sanja Novakovic
**Graphic Design:** Streamline Creative, Canberra



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





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BY AMA VICE PRESIDENT
PROFESSOR GEOFFREY DOBB

# It is governments, not doctors, who need to change archaic practices

> "Australia is failing to reap the potential rewards of modern information and communication technology"

The *Better Bang for your Buck* issue of *Health Voices*, the magazine of the Consumer Health Forum, includes articles from a range of commentators on health policy as well as contributions from the Coalition, Labor and Greens.

The underlying theme is that it is possible to reduce waste and improve efficiency in our health system - and it's hard to argue with that.

Some of the articles just say what you expect them to say.

For example, Terry Barnes pushing his $6 co-payment plan again, David Baker highlighting the potential savings from greater use of generic medicines, and Jeremy Sammut resurrecting personal Health Savings Accounts. Others, including the Shadow Health Minister Catherine King and Greens health spokesman Richard Di Natale, point to the potential savings from investments in general practice and preventative health.

Nevertheless, the most interesting article comes from Federal Health Minister Peter Dutton, because it provides some insight into the current thinking of Government on health policy, and there has been little external indication of that since the election.

Given recent media coverage though, it is not surprising that it is written from the "Growth in spending on health is unsustainable" perspective, even though Australia is in the middle of OECD countries in the percentage of gross domestic product we spend on health, with predictions it will increase by only about 1 per cent in the next decade.

Key points made by the Minister include suggestions of change to Medicare now that it is 30 years old. He uses a comparison between the Kingswood and the cars of today as a way to mount his argument for change, as well as a focus on the 10 per cent of patients who account for 46 per cent of Medicare costs, and potential roles for private health insurance in primary care.

Missing from the article is any acknowledgment of the world leading health outcomes enjoyed by the average Australian, or the role that successive Commonwealth and State Governments have played in contributing to current inefficiencies.

Australia is failing to reap the potential rewards of modern information and communication technology. The Personally Controlled Electronic Health Record languishes as we wait on the outcome of the Government initiated review.

After spending more than $1 billion, there is little evidence at the point of health care delivery of its existence.

Health care is information rich, and the benefits from the secure sharing of information are clear, from increased patient safety to reduced duplication of investigations. This Government project has still to deliver its potential efficiencies.

The other great opportunity is in telehealth.

While there has been some take up, particularly for consultative services, telehealth remains greatly under-utilised, especially for a country with such a dispersed population as Australia. In particular, the potential for improved access to general practitioners for those in rural and remote communities has still to be realised.

More fundamental are the inefficiencies that arise from our Federal funding system.

Much was made of the 'blame game' under our previous Government but, make no mistake, duplication of services or worse - service gaps - continue.

Whether it is under-provision of aged care services (a Commonwealth responsibility), leaving elderly people in our public hospitals while they wait for a place to be available, or the interface between Local Hospital Networks and Medicare Locals, many areas of clear responsibility for funding and health service delivery still need to be resolved.

Peter Dutton's article is titled, "Change imperative to end archaic practices".

MORE P6

# It is governments, not doctors, who need to change archaic practices

... FROM P5

Here he must be referring to the public hospital sector because general practice has changed drastically over the last three decades - as small to medium size businesses, there has been no other option.

Any archaic practices - such as making a telephone call to confirm a prescription under the Authority system - are those forced upon general practice by the bureaucracy.

But even the public hospital system has made great improvements in efficiency over the three decades of Medicare.

This is reflected by much shorter hospital lengths of stay, increased used of day case admissions, implementation of hospital-in-the home and rehabilitation-in-the-home systems and, more recently, reductions in the time patients spend in our emergency departments.

Almost every clinical process has been subject to clinical service redesign, from waiting list management to the admission pathway for our unplanned admissions.

It is often forgotten that some of the 'inefficiency' relates to the role our public hospitals play in the teaching and training of future generations of health professions, not just medical, but also nurses and allied health.

Public hospital culture comes from the top, and there is still too much old fashioned bureaucracy here. Endless forms and documentation in a largely information technology poor environment are a familiar overhead for those working in our public hospitals. Forms needing up to six signatures for an approval are still a reality.

Well done to the Consumer Health Forum for bringing a broad range of views on health reform together. It's a shame the AMA was not included. The AMA has a lot to contribute to the debate.

Certainly, we would always wish to contribute to Government policy positively and proactively rather than having to respond to ill-conceived policies after their public announcement.

But we reserve the right to defend both doctors and patients against poor public policy when quiet advocacy is not enough.

COMMENT

# Federal Budget a dramatic prelude to AMA National Conference

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "For those delegates coming to Canberra for National Conference, I look forward to welcoming you to what will be a great event. May in Canberra is both colourful and cold, so come prepared"

May is the time of year in the life cycle of the AMA when many different activities come to a peak.

May brings the National Conference and the Annual General Meeting. With National Conference comes the election of the President and Vice President, both of which are contested this year with the end of Dr Steve Hambleton's three years in office.

Much will be said elsewhere of the enormous contribution made by Dr Hambleton but, as someone reasonably new to the role of Secretary General, I express my great admiration for the load that he carried during a period when the AMA was without a Secretary General, albeit with the support and input of the secretariat. For all that he has done, both in contributing to the running of the organisation and in his wide-ranging engagement on health policy issues, I add my acknowledgement, thanks and best wishes.

The 2014 National Conference, to be held in Canberra, begins next Friday, 23 May.

This week, Canberra is again centre stage as the Treasurer hands down a challenging Federal Budget. Health Minister Peter Dutton has said on many occasions that he wants to start "a new conversation about health". The shape of that conversation will become clearer tonight, Budget night.

Both Mr Dutton and the Shadow Health Minister Catherine King will address the National Conference, and this will provide an opportunity for delegates to hear more about the Government's objectives.

The National Conference includes several policy sessions that will inform debate within the medical profession on topics as diverse as the global challenge of non-communicable disease; variation in medical practice; the challenge of caring for those who serve in overseas conflicts; and disaster relief. There will also be a session which deconstructs the Federal Budget as it relates to health.

In addition to the policy sessions, National Conference recognises and awards outstanding contributions in several ways. There is a ceremony to acknowledge the outstanding contribution made by members added to the AMA Roll of Fellows. The AMA's flagship research publication, the *Medical Journal of Australia* will provide an award recognising excellence in medical research. The recipient of the AMA Indigenous People's Medical Scholarship will also be announced.

The Annual General Meeting will take place on Friday 23 May, at which voting members of the AMA (not just delegates to National Conference) will have an opportunity to vote on the new Constitution for the AMA. This will bring to conclusion a long campaign to modernise the governance of the AMA and lay the groundwork for a more efficient structure for the future, something I have written about previously in Australian Medicine. Those members who have not yet sent through a proxy form are encouraged to do so. It can be found in the member only section of the AMA website.

For those delegates coming to Canberra for National Conference, I look forward to welcoming you to what will be a great event. May in Canberra is both colourful and cold, so come prepared!

COMMENT

# Health care on the frontline of painful budget cuts


The AMA has warned that plans to radically overhaul health funding arrangements such as imposing a GP co-payment and allowing insurers to charge the less healthy with higher premiums would push health care out of the reach of families and undermine the principle of universal access.

AMA President Dr Steve Hambleton said changes recommended by the National Commission of Audit, including a $15 upfront charge for GP visits and an extra $5 for each prescription, would push more of the responsibility and cost of health care on to individuals and families, raising the risk that many would defer or decline to seek the treatment they needed, undermining health and leading to a higher national medical bill later on.

"It is clear that the Commission's recommendations have been put forward by business leaders and bureaucrats with no input from people with health and medical expertise," Dr Hambleton said. "It is a health system designed by bean counters for bean counters. It puts saving money ahead of saving lives."

While the Abbott Government has said it will not adopt all of the Commission's recommendations, tonight's Federal Budget is expected to include a raft of its proposed measures.

## GP co-payment

The Government has all but confirmed it will introduce a patient co-payment. Both Mr Hockey and Health Minister Peter Dutton have talked approvingly of the need to get those with the capacity to make a greater contribution to the cost of their health care.

The Commission has recommended patients be charged a $15 co-payment for their first 15 visits to a GP each year ($5 for concession card holders), and $7.50 ($2.50 for concession card holders) for every visit after that.

In addition, the co-payment for PBS medicines should be raised by $5 to $41.90, and the general patient safety net should be lifted by almost $200 to $1613.77, the Commission said. Concession card holders would be liable to a $2 co-payment once the safety net threshold of $360 was reached.

Speaking in justification of the co-payment, Commission of Audit Chair Tony Shepherd implied that many people were going to the doctor unnecessarily: "All Australians, on average, go to the doctor now 11 times per year. I just don't think we're that crook".

But the AMA and other health experts have taken issue with the claim, which they argue is a gross exaggeration. The Royal Australian College of General Practitioners said a recent report by the Family Medicine Research Centre found an average of 5.3 visits per capita, while a crude calculation dividing the annual number of GP consultations (129 million) by the population (23.4 million) yielded an average of 5.5.

Dr Hambleton said the proposed changes would shift "more and more health costs on to patients, including the most vulnerable – working families, the elderly, and the chronically ill."

"The new high co-payment proposal for GP visits would see sick people abandon or delay visits to the doctor, which would ultimately cost the health system more, as these patients would eventually require much more expensive hospital treatment," he said.

The AMA President said there was particular concern about how it would affect the vulnerable, including Indigenous people, the elderly, those on very low incomes and people with mental illness.

"Whatever the Government comes through with, we need to make sure that we do not increase the barrier to primary health care for these four groups," he said. "We have great concerns that if the bar is raised, it could actually cost us more, not less, in the long term."

Dr Hambleton also voiced concern that the co-payment would create even more red tape for GPs, constraining them from spending more time with their patients and undermining preventive care.

MORE P9

# Health care on the frontline of painful budget cuts

... FROM P8

Since the idea of GP co-payments was most recently revived late last year, there has been mounting speculation that private health funds might offer policies to cover the extra cost, but the Commission explicitly called for such a move to be prohibited.

The AMA and other health policy experts have also warned of the risk that a GP co-payment might force more patients to seek treatment in public hospital emergency departments.

To address this, the Commission suggested that the States be "encouraged" to introduce a system of emergency department co-payments for "less urgent conditions".

In addition, the Commission has recommended that GPs who want to bulk bill patients be prevented from waiving the co-payment.

In measures that would specifically hit higher income households, the Commission proposed that the better off be blocked from Medicare subsidy for "basic" health services, be precluded from access to the private health insurance rebate, and that the General Extended Medicare Safety Net threshold be raised to $4000.

## Community rating

In a radical break with the principle of not allowing health insurers to cherry pick members, the Commission said community rating should be relaxed to allow health funds to charge higher premiums for members who are smokers or have some other lifestyle-related health risk factors.

"The community rating of health insurance products means unhealthy lifestyle choices made by some force up premiums for all," the Commission said. "Consideration should be given to relaxing rules relating to 'improper discrimination' that prevent health funds from charging different prices based on a person's individual characteristics."

But Dr Hambleton said community rating was an important principle, and weakening it to allow insurers to charge bigger premiums for people with lifestyle-related issues such as obesity was a "slippery slope".

He said obesity could be due to a whole range of factors out of a person's control, including the nutrition of the mother during pregnancy, low birth weight and other epigenetic factors, health and nutrition literacy, education and family stability.

"It's too simplistic to say that if we charge people more, all of a sudden the problem will go away," Dr Hambleton said. "We support community rating. It's the fairest way to deal with these issues and there are other things we should do to decrease the impact of obesity on health care costs."

## Increased competition between professions

Just as controversial, the Commission has recommended a series of measures that would intensify competition within and between health professions, as well as merging or axing a string of health agencies.

It has called for greater competition in pharmacy by scrapping the industry's ownership and location rules, and has urged that the scope of practice for occupations such as nurses and pharmacists be extended – both recommendations which are highly controversial and likely to trigger a strong backlash.

Dr Hambleton said the extension of nurse and pharmacist practice was a serious concern for the AMA, as were a number of other proposed measures including:

- a merger of Health Workforce Australia and GPET with the Department of Health and Ageing, which would undermine the capacity to undertake essential medical workforce planning to ensure the community has access to the right number of doctors in the right places;
- winding back changes to the medical indemnity insurance industry that were implemented by Prime Minister Tony Abbott when he was Health Minister; and
- scaling down and delaying the National Disability Insurance Scheme.

Other recommendations include giving the Health Minister the authority to add and remove medicines from the PBS schedule and allowing drugs approved by "certain overseas agencies" to be added to the PBS without obtaining separate TGA approval.

Dr Hambleton urged the Government to reject the Commission's recommendations and instead talk with the medical profession about reforms that would make the best use of available health funds.

"The only good thing about the Commission's health recommendations is that they will be easy for the Government to reject them – and the AMA will be urging the Government to do so," the AMA President said.

**Adrian Rollins**

COMMENT

# Public hospitals stretched by rising demand

Public hospitals are not keeping pace with the growth in demand for their services, underlining AMA concerns that they be spared from any cuts in tonight's Federal Budget.

Australian Institute of Health and Welfare figures show there has been a steady decline in public hospital capacity in recent years, particularly in the face of increasing demand from an ageing population.

Analysis of the data by the AMA shows that the number of public hospital beds available for every 1000 people in the crucial 65 years and older age group – where demand is greatest – has tumbled by almost 43 per cent past two decades, from more than 30 in 1992-93 to 17.8 in 2012-13.

Total bed numbers fell by 234 last financial year and, across the population as a whole, the number of beds per 1000 people slid down to 2.59. The ratio has not improved since 2009-10.

AMA President Dr Steve Hambleton said the results showed public hospitals were being starved of the resources needed to meet the growth in demand.

"We have maintained roughly the same bed to population numbers over recent years, while there has been increasing demand for hospital services," Dr Hambleton said. "This is why public hospital waiting times are long. Our public hospitals need greater support and funding, not cuts."

The Institute's figures show that the public system still provides the bulk of hospital care – almost 60 per cent of the 9.4 million hospital admissions in 2012-13 were in the public sector, and more than two-thirds of the 28 million patient days reported by the nation's hospitals were in the public system.

But growth in demand for private hospital services is outstripping that for the public system, particularly for elective and non-acute care.

Between 2008-09 and 2012-13, private hospital admissions for palliative care, rehabilitation, health maintenance and other subacute and non-acute services grew by almost 14 per cent a year, compared with 8.2 per cent in the public system.

Over the same period, private admissions for non-surgical and non-emergency care grew by 6.4 per cent, compared with 4.2 per cent in public hospitals, and same-day admissions in private facilities increased by 5 per cent a year, compared with 3 per cent in the public system.

Furthermore, almost 1.4 million of the 2 million elective surgery admissions in 2012-13 were in private hospitals.

Dr Hambleton said that, in contrast to public hospitals, the private system had increased its bed capacity since 2009-10 to keep pace with the growth in demand.

The difference was highlighted by AIHW figures showing that total recurrent spending on public hospitals (in constant price terms) grew by an average of 4.7 per cent a year between 2008-09 and 2012-13, compared with an annual average of 12.2 per cent among private hospitals.

The surge in private hospital care has caused some to warn that a two-tiered health system is developing in which those that can afford it are able to circumvent lengthy queues for surgery in public hospitals by getting treatment in the private system.

Consumers Health Forum spokesman Mark Metherell told the *Sydney Morning Herald* that the majority of people who did not have private health insurance were unable to avoid waiting for elective surgery.

**Adrian Rollins**

COMMENT

# Indigenous health gets temporary lifeline

The Federal Government has been urged to extend its 12-month funding lifeline for Indigenous-run health services to give them financial certainty for at least an extra five years.

AMA President Dr Steve Hambleton said confirmation from Health Minister Peter Dutton that the nation's 150 Aboriginal Community Controlled Health Services will receive $333 million in the Federal Budget to enable them to keep operating until mid-2015 was welcome, but added longer-term financial security was required, urging the Abbott Government to guarantee funding for at least the next five years.

"Aboriginal Community Controlled Health Services deliver the highest quality, culturally appropriate health care to the Aboriginal population," Dr Hambleton said. "These services make a huge difference to people suffering serious health conditions."

His comments were supported by the results of a report that found marked improvements in the performance of health services treating Aboriginal and Torres Strait Islander people.

Using data from more than 200 primary health care organisations that mainly treat Aboriginal and Torres Strait Islander people, the Australian Institute of Health and Welfare found that there had been a jump of between 5 and 9 percentage points in key health services, including detailed health assessments of adults, developing team care arrangements for patients with type 2 diabetes and recording baby birth weights.

Nationally, the Institute found, 58 per cent of Indigenous babies born in the 12 months to mid-2013 had had their birth weight recorded by a primary health care provider.

"Government investment in Aboriginal Community Controlled Health Services is money well spent," Dr Hambleton said. "There is clear evidence that it saves lives and improves quality of life for Aboriginal peoples. It closes the gap."

> "Aboriginal Community Controlled Health Services deliver the highest quality, culturally appropriate health care to the Aboriginal population"

Delivering the annual Commonwealth Closing the Gap report in February, Prime Minister Tony Abbott said the gap in rates of child mortality between the Indigenous and non-Indigenous community had halved in the past decade, but admitted there had been almost no progress in narrowing the gap in life expectancy – currently around 10 years – between Indigenous Australians and the rest of the community.

In addition to the 12-month funding lifeline for Aboriginal Community Controlled Health Services, Mr Dutton also approved $98 million to fund five specific Indigenous health programs – Primary Health Care, Healthy for Life, Australian Nurse Family Partnership, New Directions: Mothers and Babies, and Stronger Indigenous Health Services – being delivered by 90 organisations across the country.

A spokesman for the Health Minister told *The Australian* that "extending the funding to June 2015 provides the continuity for these organisations to deliver important services to Indigenous people over the next 12 months".

National Aboriginal Community Controlled Health Organisation Chair Justin Mohamed said the extra funding was recognition of the significant contribution Indigenous-led health services were making in closing the health gap.

But Mr Mohamed warned that, welcome though the funds were, more was needed.

"The Aboriginal population is growing, and demand for our services is increasing at a rate of more than 6 per cent a year," he said. "We need to have surety that we will have the resources to continue to improve the health of our people over the long term to meet this growth."

Mr Mohamed said funding should grow in line with inflation and should be guaranteed beyond the next financial year.

"We are only now starting to see the results of programs put in place five years ago," he said. "As such, we need to move to a more secure funding model, moving from the current three-year agreements to five-year agreements."

It was a call backed by Dr Hambleton, who urged the Government to move to a five-year funding agreement "as soon as possible".

**Adrian Rollins**

COMMENT

# Close 457 loophole for junior doctor positions: AMA

Hospitals and health departments should be forced to prove they attempted to fill junior doctor vacancies locally before being allowed to hire practitioners from overseas, according to the AMA.

Urging a shake-up of current 457 visa arrangements, the AMA said the recruitment of large numbers of doctors from overseas to fill junior doctor positions in hospitals was no longer tenable given the pressure on training places for local medical graduates.

Even as swelling numbers of domestic medical graduates struggle to secure internships and prevocational training places, official figures show many health authorities and hospitals continue to recruit heavily from overseas, potentially displacing locally trained junior doctors and preventing them from undertaking the additional training they need to complete their qualifications.

In its submission to the Independent Review of the 457 visa program, the AMA cited official figures showing around 2000 doctors entered Australia on 457 visas last financial year, and said it was aware that 916 resident medical officer (RMO) positions were filled by 457 visa holders in the same period.

"While some of these RMOs will be temporary residents that studied medicine in Australia and may seek permanent residency, it appears that many have been recruited directly from overseas," the AMA said. "This is potentially limiting employment and training opportunities for domestic medical graduates."

The pressure on medical training places is intensifying. Last year, just 3125 intern places were available to meet the needs of 3300 domestic and international full fee paying medical graduates, and the number of such graduates is projected to reach 3824 by 2017.

Health Workforce Australia predicts there will be a shortage of 450 first-year advanced vocational training positions a year from 2016, placing even more pressure on RMO positions, forcing junior doctors to wait even longer to enter vocational training.

Under current immigration arrangements, employers can sponsor medical practitioners from overseas on 457 visas - including international graduates of Australian medical schools – without having to demonstrate that they have tried to recruit locally first.

The AMA said this exemption from labour market testing was not justified, and should be scrapped.

"It is untenable that substantial numbers of doctors continue to be recruited directly from overseas into intern and RMO positions when a ready supply of local graduates appears to be available," the Association said.

It said some State and Territory health departments and hospitals did not appear to be using the 457 visa as intended.

"The 457 visa is intended to fill workforce gaps, not displace locally training and highly skilled junior doctors…particularly at a time when domestic medical graduates are struggling to get access to essential training places," the AMA submission said.

The Association said it valued the contribution that international medical graduates have made, and continue to make, but added that it was incumbent on State and Territory health departments and hospitals to help build a sustainable domestic medical workforce.

"The number of domestic medical graduates is projected to grow even further and, in these circumstances, the current exemption [from labour market testing] cannot be justified," the AMA said.

The Review is due to report by the end of June this year.

**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



NEWS

# Budget, global health key items on National Conference agenda

The impact of the Federal Budget on health and the global challenge of non-communicable diseases will be major themes of the looming AMA National Conference.

The National Conference, which is expected to draw hundreds of AMA members from across Australia to Canberra in the last weekend of May, is shaping as an important opportunity to gauge the medical profession's reaction to what promises to be one of the most significant Budgets for health in many years.

Already the Federal Government has flagged it is likely to introduce a patient co-payment for GP services, and its Commission of Audit has suggested a range of other radical changes that would fundamentally alter the structure of the health system, including relaxing the principle of community rating in private health insurance, increasing the scope of practice of pharmacists, nurses and allied health professionals, and lifting restrictions in the pharmacy industry.

AMA President Dr Steve Hambleton said the timing of the Conference, coming just 10 days after the Budget was handed down, was extremely fortuitous.

"It is a unique opportunity, in the week after the Budget, for AMA leaders from all around the country to provide their input for our response to the Budget," Dr Hambleton said.

Conference debates on the Budget and health policy will be informed by first-hand information from the Government, with Health Minister Peter Dutton (and his Labour rival Catherine King) due to address the meeting on Friday, 23 May.

There are also several policy sessions related to the Conference's overarching global health theme, including the global challenge of non-communicable diseases; the challenges of practising medicine internationally; integrating global health training into postgraduate medical education; the challenge of caring for defence force and emergency personnel who serve overseas; and variation in medical practice between Australia and other countries.

Delegates will hear speeches and presentations from a wide range of international and local experts including World Medical Association President Dr Margaret Mungherera; former Defence Minister and AMA President Dr Brendan Nelson; National Preventative Health Taskforce Chair Professor Rob Moodie, and gastroenterologist Professor Anne Duggan.

In addition to policy sessions, the National Conference will be asked to make decisions crucial to the future direction of the AMA.

On Friday 23 May, the AMA's Annual General Meeting will be held, at which delegates will be asked to vote on a proposed overhaul of the Association's constitution. The key proposed change would see operational and corporate compliance responsibilities devolved to a governance board, freeing the Federal Council to focus on its prime policy formulation role.

On Sunday 25 May there will be a vote for the new AMA President and Vice President, with current President Dr Steve Hambleton stepping down from the role.

More information about the National Conference is available at: https://ama.com.au/nationalconference

**Adrian Rollins**

COMMENT

# Leeder honoured for life of achievement

The enormous contribution made by eminent public health expert and *Australian Medicine* columnist Professor Stephen Leeder was recognised at a special event hosted by the University of Sydney early this month.

Current and former health ministers, senior health officials and leading health academics and experts were among a distinguished list of speakers who addressed a day-long forum organised to honour Professor Leeder's valuable contribution to public health policy over many decades.

Among the speakers were former Federal Health Minster Dr Neal Blewett, NSW Health Minister Jillian Skinner, World Heart Foundation President Professor K. Srinath Reddy, Emeritus Professor John Hamilton, NSW Ministry of Health Director General Dr Mary Foley, Sydney Medical School Dean Professor Bruce Robinson, Deeble Institute Director Dr Anne-marie Boxall and Dr Henry Greenberg of the Mailman School of Public Health.

Reflected the breadth and depth of Professor Leeder's work, topics covered in the one-day forum included health policy, the international epidemiology of chronic disease, medical education and public health education and training.

Organisers said the event had been held to celebrate the enormous contribution made by Professor Leeder in public health research, educational development and policy during a long career studded with achievements.

Professor Leeder, who is professor of public health and community medicine at the University of Sydney, was instrumental in the development of the Menzies Centre for Health Policy, set up to inform health policy and knowledge by providing high-quality analyses of health issues.

In addition, Professor Leeder is Editor-in-Chief of the *Medical Journal of Australia*, is Chair of the Western Sydney Local Health District Board, academic coordinator of the University of Sydney's Master of Health Policy degree and is Director, Research Network, Western Sydney Local Health District.

Professor Leeder's latest *Australian Medicine* column, on the health implications of the Federal Budget, '*Now, if pigs would fly?'* is on page 27.

**Adrian Rollins**

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.**

# Senior medicos contest AMA Presidency

For the first time in five years there will be a ballot for the AMA Presidency after Vice President Professor Geoffrey Dobb and AMA New South Wales President Associate Professor Brian Owler both nominated for the position.

The vacancy has been created by the imminent departure of current President Dr Steve Hambleton, who is stepping down from the post he has occupied since 2011.

Both Professor Dobb, who is Head of Intensive Care at Royal Perth Hospital, and Associate Professor Owler, who is a Consultant Neurosurgeon at The Children's Hospital at Westmead, are members of the AMA Executive Council.

Professor Dobb has been nominated by former AMA President Dr Mukesh Haikerwal and AMA Queensland President-elect Dr Shaun Rudd, while Associate Professor Owler has been nominated by AMA Council of General Practice Chair Dr Brian Morton and former AMA Queensland President Dr Alex Markwell.

The election for the AMA Presidency will be held on Sunday, 25 May – the third day of the AMA National Conference in Canberra.

The new President will serve for two years if a proposed new Constitution for the AMA is adopted by the AMA Annual General Meeting to be held on the first day of the National Conference, Friday 23 May.

Under the overhauled structure, the operational and corporate compliance responsibilities will be devolved to a governance board, freeing the Federal Council to focus on its prime policy formulation role.

AMA Secretary General Anne Trimmer said the change would allow the AMA to become a more effective and agile organisation, raising the possibility the new-look Federal Council could appoint small working groups and task forces to develop contributions to health policy debates, drawing on the expertise of AMA members as needed.

There will also be a ballot for the position of Vice President, which is the subject of a three-way contest between Brisbane GP Dr Richard Kidd, AMA Victoria President and Emergency Department specialist Dr Stephen Parnis and Victorian anaesthetist Dr Roderick McRae.

Dr Kidd has been nominated by former AMA President and political aspirant Dr Bill Glasson and AMA South Australia President Dr Patricia Montanaro, while Dr Parnis was nominated by Dr Haikerwal and Dr Morton, and Dr McRae was nominated by Dr Gary Speck and Dr Robert Conyers.

It is possible either Professor Dobb or Associate Professor Owler may also join the runoff, as National Conference Standing Orders give unsuccessful President candidates the option to stand for election as Vice President.

While the positions of President and Vice President will be contested, two other Executive Officer posts, Chairman of Council and Treasurer, have been filled without contest.

Ms Trimmer, who is also the AMA Returning Officer, reported that Canberra-based ophthalmologist Dr Iain Dunlop was the sole nominee for Chairman of Council, a position he currently fills, while current AMA Treasurer and anaesthetist Dr Elizabeth Feeney was confirmed in her role uncontested.

While both have been declared elected, their renewed tenure could be exceedingly short – both positions would be made redundant under the proposed new Constitution.

**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.

# Print industry heavyweight to head AMPCo Board

Former print industry high flyer Richard Allely has been appointed to Chair the Board of the AMA's medical publishing arm, Australasian Medical Publishing Company (AMPCo).

Mr Allely, a former senior Fairfax executive, was credited with reviving the fortunes of print industry heavyweight PMP Limited during a period of major disarray in the printing and distribution group.

The transformation plan he oversaw as Chief Executive Officer from early 2009 was seen as instrumental in achieving big improvements in the company's performance in subsequent years..

He announced his resignation from PMP in September 2012, but his contract with the company does not expire until 30 June this year. He will take up his position as AMPCo Chair on 1 July.

Current Chair, AMA President Dr Steve Hambleton, is stepping down from the role, but will continue to serve on the AMPCo Board as an AMA representative, as will the other AMA representative Dr Elizabeth Feeney, who also serves as Treasurer of the AMA – a position that may be abolished at the AMA Annual General Meeting on 23 May if proposed changes to the Constitution are adopted.

They will be joined on the Board by columnist Rowan Dean, who has a background in advertising and commercial film-making.

The new appointments, approved by the AMA Federal Council, were triggered by the retirement of three existing Board members, Dr John Kessell, Dr Peter Ford and Dr Roderick McRae.

AMA Secretary General Anne Trimmer paid tribute to the many years of service provided by Dr Kessell, Dr Ford and Dr McRae: "Their support for, and interest in, AMPCo over this time is recognised and appreciated".

Ms Trimmer said the Federal Council has decided to hold a fifth AMPCo Board position vacant until early next year, to allow the new Board to operate for a few months "in order to identify which, if any, additional skills might be needed to complete the Board".

**Adrian Rollins**

COMMENT

# AMA IN THE NEWS

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

## Print/Online

### Doctors fear cut will hit 100 jobs, health planning, *Adelaide Advertiser*, 26 April 2014

Health Workforce Australia, the independent body that ensures there are enough doctors, nurses, and other health care workers to meet the nation's needs, could be axed in the upcoming Federal Budget. AMA Vice President Professor Geoffrey Dobb said the state of the board and executive staff was concerning because it indicated the Government was intending to cut it.

### $6 bulk-billing fee hits poor, spares rich, *Sun Herald,* 27 April 2014

A $6 fee for visits to bulk billing doctors would fall most heavily on Sydney's poorest residents, an analysis shows. AMA President Dr Steve Hambleton said that $6 was enough to convince people to defer treatment.

### Death of free care, *Herald Sun*, 2 May 2014

Medicare as we know it would end, with bulk billing scrapped and those earning more than $80,000 denied benefits under a health revolution proposed by the National Commission of Audit. AMA President Dr Steve Hambleton slammed the recommendations and said it would put health, medical, and pharmaceutical care out of reach for Australian families.

### An end to universal health coverage, *Australian Financial Review*, 2 May 2014

The middle class would be required to cover their own health costs and Medicare would be left as a basic safety net under a National Commission of Audit plan. AMA President Dr Steve Hambleton said such payments would be a powerful disincentive, and could stop people going to the GP when needed.

### Visit a pharmacist, not your doctor: audit boss, *Courier Mail*, 3 May 2014

People who need medical certificates should be heading to their local pharmacy or nurse rather than crowding doctors' waiting rooms, Commission of Audit Chair Tony Shepherd said. AMA President Dr Steve Hambleton said it was important that people be encouraged to see their doctor when ill.

### Scare over anaesthetics, *Sunday Mail*, 4 May 2014

Doctors said a national recall of two batches of the most widely used anaesthesia drug probably would not affect scheduled surgery. AMA Vice President Professor Geoffrey Dobb said the recall would not delay surgery because hospitals held sufficient supplies in reserve.

### Overweight people could pay more for health cover, *Sydney Morning Herald*, 5 May 2014

Overweight people could pay more for health insurance if the Abbott Government adopts a National Commission of Audit proposal to allow health funds to charge some customers higher premiums because of their lifestyle choices. AMA President Dr Steve Hambleton said there were better ways to help people improve health than charging them higher health premiums.

## Radio

### Dr Steve Hambleton, 4BC Brisbane, 21 April 2014

AMA President Dr Steve Hambleton discussed a program called SmartVax, which sends clients a text following a vaccination, asking whether they have experienced any side effects. Dr Hambleton said it will help with adverse event reporting.

### Dr Brian Morton, 3AW Melbourne, 21 April 2014

AMA Chair of General Practice Dr Brian Morton discussed a selective leak in the lead-up to the Federal Budget suggesting that doctors may be required to make final assessments for people to keep the disability support pension. Dr Morton said that arm's length assessments would be better.

MORE P18

# AMA IN THE NEWS

... FROM P17

### Dr Steve Hambleton, SBS Ethnic Radio, 22 April 2014

AMA President Dr Steve Hambleton discussed a major review of homoeopathy in Australia which could lead to stricter industry regulation and changes to private health insurance coverage of homoeopathic treatments.

### Professor Geoffrey Dobb, 2SM Sydney, 22 April 2014

AMA Vice President Professor Geoff Dobb talked about co-payments for GP visits. Professor Dobb said the AMA is concerned people will be deterred from seeing their GP and attend hospital emergency departments instead.

### Dr Steve Hambleton, ABC NewsRadio, 23 April 2014

AMA President Dr Steve Hambleton discussed the treatment of elderly patients. Dr Hambleton said the way the elderly were cared for in facilities needed to be reviewed in discussions involving doctors, patients, and families.

### Dr Steve Hambleton, 2SER FM, 23 April 2014

AMA President Dr Steve Hambleton discussed end-of-life issues. Dr Hambleton said a lot could be done in intensive care to extend life, but the questions needed to be asked about the quality of life afterwards.

### Dr Steve Hambleton, 2UE Sydney, 24 April 2014

AMA President Dr Steve Hambleton talked about the problem of addiction to codeine. Dr Hambleton said codeine was an analgesic related to morphine and pethidine narcotics.

### Dr Steve Hambleton, Triple J Sydney, 29 April 2014

AMA President Dr Steve Hambleton talked about medicinal cannabis. Dr Hambleton said scientifically speaking, cancer patient Dan Haslam's testimonial as to its benefits did not help determine the real efficacy of medical marijuana.

### Dr Steve Hambleton, 666 ABC Canberra, 30 April 2014

AMA President Dr Steve Hambleton discussed the latest snapshot of Australia's hospital system from the Australian Institute of Health and Welfare, which indicagted that hospitals were an increasing cost to the economy. Dr Hambleton said to have fewer patients, medical techniques needed to be improved.

### Dr Steve Hambleton, 4BC Brisbane, 1 May 2014

AMA President Dr Steve Hambleton talked about the decision to stand down a Rockhampton surgeon found to have removed the wrong kidney from a patient. Dr Hambleton said it was a serious offence and there was a five-step procedure to follow in considering disciplinary actions required.

### Dr Steve Hambleton, 2GB Sydney, 1 May 2014

AMA President Dr Steve Hambleton talked about possible GP co-payments and other impacts on the health system if Commission of Audit recommendations would adopted in the Federal Budget.

### Dr Steve Hambleton, 6PR Perth, 5 May 2014

AMA President Dr Steve Hambleton talked about the Commission of Audit proposal that insurers be allowed to vary prices based on lifestyle choices. Dr Hambleton said encouraging a healthy population would deliver the health savings the Government was looking for.

## TV

### Dr Steve Hambleton, SBS Sydney, 21 April 2014

AMA President Dr Steve Hambleton discussed Australians going overseas for cosmetic surgery. The AMA is concerned a package offered by insurer NIB gave the illusion that offshore surgery was safer than it actually was.

### Dr Steve Hambleton, Sky News Sydney, 2 May 2014

AMA President Dr Steve Hambleton commented on the Commission of Audit report. Dr Hambleton said it is a major attempt to shift costs onto patients at every income level.

### Professor Geoffrey Dobb, ABC1 Adelaide, 3 May 2014

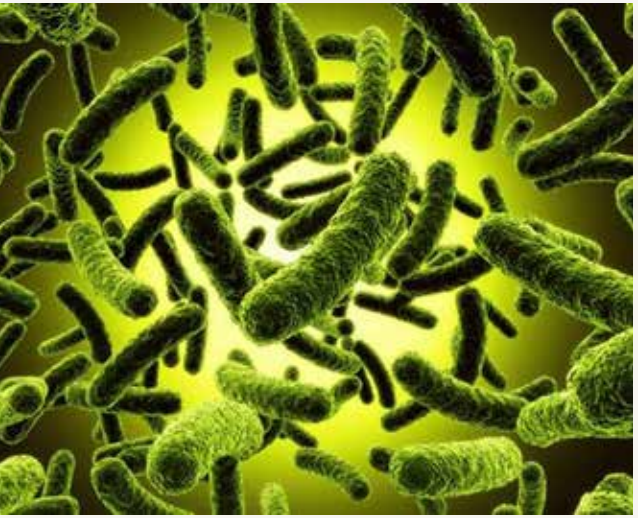
AMA Vice President Professor Geoffrey Dobb talked about two batches of the anaesthetic propofol that had been quarantined. Professor Dobb said this was the first time a problem had occurred with the drug.

### Dr Steve Hambleton, Channel 9 Perth, 5 May 2014

AMA President Dr Steve Hambleton talked about high health premiums for smokers and people who are overweight. Dr Hambleton said if insurers were allowed to cherry pick healthy people, it will make insurance for less healthy people unaffordable.

COMMENT

# Post-antibiotic world almost upon us



The World Health Organisation has warned that humanity is headed for a post-antibiotic era in which even minor injuries and infections could be deadly unless nations, groups and individuals begin immediately to work together to track medicine use and resistance.

In its first global assessment of antibiotic resistance, the WHO has found that in large parts of the world commonly used antibiotics have been rendered virtually useless, meaning that for the first time in generations many people face the risk of dying from infections and injuries that would have been considered minor for their parents or grandparents.

"Without urgent, coordinated action by many stakeholders, the world is headed for a post-antibiotic era in which common infections and minor injuries which have been treatable for decades can once again kill," WHO Assistant Director-General for Health Security Dr Keiji Fukuda said.

The WHO survey of 114 countries discovered antibiotic resistance has spread alarmingly and was now a feature in most regions of the world.

The agency revealed that resistance to cabapenem antibiotics – considered the treatment of last resort for infections caused by the common intestinal bacteria *Klebsiella pneumonia* – is now found in every region of the world. This is particularly concerning because *K. pneumonia* is a major cause of hospital-acquired infections including pneumonia and sepsis.

In some countries, the WHO found, resistance has meant that carpabenem antibiotics were not effective in more than half the patients being treated for *K. pneumonia* infections.

Resistance to one of the most common treatments for urinary tract infections, fluoroquinolones, was also found to be "very widespread".

Furthermore, Australia's relative geographic isolation did not confer immunity from these disturbing trends, according to the WHO.

The agency found that the Western Pacific Region, of which Australia is a part, had high levels of E. coli resistance to fluoroquinolones, and there was also widespread resistance by *K. pneumonia* to third generation cephalosporins.

"In some parts of the Region, as many as 80 per cent of *Staphylococcus aureus* infections are reported to be methicillin-resistant (MRSA), meaning that treatment with standard antibiotics does not work," the WHO reported.

In addition, it named Australia as among a handful of countries including Japan, the UK, France and Canada, where the last resort treatment for gonorrhoea - third generation cephalosporins – had failed.

Earlier this year, AMA President Dr Steve Hambleton warned of the threat posed by drug-resistant bacteria, including those carried by travellers infected while overseas.

"No longer do our borders protect us from multi-resistant organisms," Dr Hambleton said. "These are a major threat to our health system, so it does mean that we need to engage internationally to act on multidrug resistance.

"We simply do not have a new antibiotic up our sleeve to treat some of these conditions."

The WHO said its report would be used to kick-start a global effort, led by it, to address drug resistance, including the development of shared tools and standards, and better international collaboration to track drug resistance, measure its impact, and design effective solutions.

In the Western Pacific Region, the WHO said it would reinvigorate region-wide networks to track antibiotic resistance that had been established in the 1980s but had since withered.

In addition, it has urged patients to use antibiotics only when and as prescribed, and has called on health professionals to be diligent in applying infection control measures, and only to prescribe and dispense antibiotics when they are truly needed.

Dr Fukuda warned that "unless we take significant actions to improve efforts to prevent infections and also change how we produce, prescribe and use antibiotics, the world will lose more and more of these global public health goods, and the implications will be devastating".

**Adrian Rollins**

COMMENT

# Cervical test to go viral

The dreaded biennial Pap smear could be dumped and replaced with a more effective five-year cancer screen test if the Federal Government adopts the recommendations of an expert advisory panel.

In a move that could increase the extent of cervical cancer screening and save more lives, the Medical Services Advisory Committee (MSAC) has proposed that the current two-year Pap smear test be replaced with a similar procedure that only has to be carried out every five years.

But relief for women could still be some time off, with the Federal Government warning the change was unlikely to be implemented before 2016.

The proposal has come amid evidence that less than 60 per cent of women targeted under the National Cervical Cancer Screening Program have Pap smear tests.

The *Cervical screening in Australia 2011-12* report from the Australian Institute of Health and Welfare found that around 58 per cent of women aged 20 to 69 years participated in the screening program between 2009 and 2012, equivalent to more than 3.7 million people in a two-year period.

The Institute found participation was uneven, with those who were wealthier or living in cities significantly more likely to have a regular Pap smear than those less well off or living in remote areas.

But, even though only six out of 10 women in the target group participate, the figures suggest the screening program has saved many lives.

The Institute found that, in the 10 years following the introduction of the screening program in 1991, the incidence and fatality rate of cervical cancer halved, and have since held steady at around nine new cases per 100,000 women diagnosed each year, and two deaths per 100,000.

"In 2012, for every 1000 women screened, eight had a high grade abnormality detected, providing an opportunity for treatment before possible progression to cancer," the Institute said.

According to evidence presented to MSAC, the new five-year test will be even more effective.

While the procedure is the same as that used to collect a Pap smear, the sample of cells collected will be tested for the human papillomavirus (HPV), "which we now know to be the first step in developing cervical cancer," the Federal Health Department said.

"MSAC found that a HPV test every five years is even more effective than, and just as safe as, screening with a Pap test every two years," the Department said. "MSAC also determined that a HPV test every five years can save more lives and women will need fewer tests than in the current two yearly Pap test program."

While millions of women and girls have been and are being vaccinated against HPV, the Health Department advised they would still require cervical screening because the vaccine did not protect against all forms of the HPV that cause cervical cancer.

Not only will the HPV be less frequent, women can also commence it later in life.

Current advice is that women undergo regular Pap smears between 20 and 69 years of age, but MSAC recommends that the HPV test not commence until a woman turn 25 years, with a final test to be conducted between 70 and 74 years.

The Federal Government said the MSAC reommendation "will now be considered after extensive consultation with State and Territory health authorities, medical and pathology experts and community stakeholders," adding that "it is anticipated that changes will not be implemented prior to 2016".

**Adrian Rollins**

COMMENT

# No longer just boy or girl

The Australian Capital Territory has become the first jurisdiction in the country to allow people to be registered on their birth certificates as neither male nor female.

In an amendment that come into force late last month, a new category of Intersex/Indeterminate/Unspecified will be included in all ACT birth certificates, and can be nominated by people who are intersex or who identify as having an indeterminate or unspecified gender.

Executive Director of the ACT Government's Office or Regulatory Services, Brett Phillips, said the amendment also dropped the requirement that those who wanted to change the sex on their birth certificate had to have undergone sexual reassignment surgery.

Instead, he said, "a person born in the ACT who wishes to change their sex must provide evidence that they are either an intersex person, or that they have received appropriate clinical treatment for alteration of the person's sex".

In addition, the amendment has extended to time allowed for parents to register a birth, from 60 days to six months, to "reduce pressure on parents of babies who are not clearly male or female, by allowing additional time to make complex decisions about the registered sex of their child", Mr Phillips said.

The changes coincided with a landmark High Court ruling that quashed an attempt by the NSW Registry of Births Deaths and Marriages to register an androgynous person called Norrie as either a male or female.

In an earlier hearing, NSW Court of Appeal ruled in support of Norrie's application, declaring that "as a matter of construction ... the word sex does not bear a binary meaning of 'male' or 'female'."

The High Court ordered that Norrie's applications be sent back to the Registrar for determination in accordance with its reasons, and dismissed the Registrar's appeal.

**Adrian Rollins**

COMMENT

# DNA test no substitute for faecal bowel cancer screening

The Cancer Council has urged people to continue using faecal occult blood test to screen for bowel cancer, warning that a recently-developed blood test is only a third as effective in detecting the disease.

Cancer Council Australia Chief Executive Officer Professor Ian Olver said the faecal occult blood test (FOBT) remained the "gold standard" for bowel cancer screening despite the development of a DNA test by a team of Flinders University researchers.

The new test involves the detection of two genes that 'leak' into the blood when bowel cancer is present.

Using blood samples from more than 2000 hospital patients in Australia and the Netherlands who were scheduled for colonoscopy or for bowel surgery, the researchers found the test could detect bowel cancer in 65 per cent of cases, and the detection rate rose to 73 per cent for cancers that were at stage two or higher.

Presenting the findings at the Digestive Diseases Week conference in Chicago earlier this month, Professor Graeme Young, of the Flinders Centre for Innovation in Cancer at Flinders University, said the test could be used in future as an adjunct to the current FOBT screening program.

"A blood test is likely to overcome some of the barriers to screening with faecal tests," Professor Young said. "It might prove to be acceptable to those failing to participate in screening using established methods, which at the moment are primarily based around faecal tests."

But he warned that the test should not be seen as a replacement for the faecal test.

"If this test becomes available in the future I think the message would need to be that the faecal test is the best place to start for people who are due for screening. Then the plasma test would be for those people who can't or won't screen with a faecal test," he said.

Professor Olver said there had been mixed messages about the blood test, which he said was only a third as sensitive for advanced adenomas and stage one cancer as the FOBT test.

"New biomarkers for major disease usually attract media coverage, but it is important to remain focused on the evidence," he said. "As the developers of the DNA test have noted, it could have a role as an adjunct to FOBT."

Professor Olver said the "outstanding" results achieved by the FOBT screening program confirmed it as the best population screening test: "We cannot risk having this message confused".

The Cancer Council has urged GPs to continue to encourage asymptomatic patients 50 years and older to screen for bowel cancer with a FOBT test.

Gastroenterologist Professor James St John said the national FOBT program, when fully implemented, had the potential to prevent 70,000 bowel cancer deaths in the next 40 years, and the main focus needed to remain on rolling out the full biennial FOBT screening program.

"We would welcome the addition of a blood-based test if it assists with surveillance, but the focus has to be on what works best to save the most lives, and that is FOBT," Professor St John said.

Australian biotechnology company Clinical Genomics co-developed the test with CSIRO, and the new test has been clinically validated in collaboration with the Flinders Centre for Innovation in Cancer at Flinders University.

> "We would welcome the addition of a blood-based test if it assists with surveillance, but the focus has to be on what works best to save the most lives, and that is FOBT"

Clinical Genomics Chief Executive Officer Dr Larry LaPointe said the evaluation results "give reason to be optimistic about the prospect of improving screening rates by providing another option for people who can't or won't screen for bowel cancer using home-based tests".

Dr LaPointe said the test could become available in Australia on a "user pays" basis as soon as early spring.

"These results show the test has the potential to underpin a cost-effective blood test that identifies those with a curable bowel cancer. This has the potential to save many lives by complementing existing screening programs," added Dr LaPointe.

**Adrian Rollins**

COMMENT

# Prove you are worth it, drug companies told

The nation's chief medicines advisor has approved the publicly-subsidised supply of two extremely expensive drugs, on condition that they prove to be as effective as claimed.

The Pharmaceutical Benefits Advisory Committee (PBAC) has recommended that the $300,000 a year cystic fibrosis medicine Kalydeco, and the $500,000 a year treatment for atypical haemolytic uremic syndrome (aHUS), Soliris, be listed on the PBS through the Managed Entry Scheme, which provides provisional listing subject to proven performance.

If agreed to by the drug companies, the arrangement would see patients pay as little as $6 a prescription to use the extremely costly drugs.

In return, the sponsors of the medicine would commit to reimbursing part or all of the cost of their drugs if they did not achieve the promised improvements in patient health.

PBAC Chair Dr Suzanne Hill told News Corporation newspapers the Managed Entry Scheme had been in place since 2010 and was already being used to trial the melanoma treatment Yervoy, which costs more than $120,000 for a typical four dose treatment.

"There has been an agreement in place with Medicines Australia since 2010 where the [Health] Minister will agree to list medicines under Managed Entry Schemes where the pharmaceutical companies collect data that shows they perform in the real world the same way they perform in the clinical trials," Dr Hill said. "If the patients don't improve, you don't get the subsidy."

There is mounting international concern about very high prices being charged for some medicines.

In the United States there is a mounting backlash against spiralling prices for new and existing medicines, and the American Society of Clinical Oncology is working on an algorithm to rate the cost effectiveness of expensive medicines, and will urge physicians to use the system to discuss the costs with their patients.

Global spending on cancer drugs alone jumped by almost 30 percent to $US91 billion between 2008 and 2013, according to a report by the IMS Institute for Healthcare Informatics, and a review of drug prices by news service Bloomberg found that in the US the cost of dozens of medicines for ailments ranging from cancer to multiple sclerosis, diabetes and high cholesterol had doubled or more in price since late 2007.

But manufacturers argue such price increases are justified by the high cost of developing new treatments. Forbes magazine reported that the average cost of developing a single drug was $US350 million, and could be far higher for big companies that are simultaneously developing several products, only a fraction of which will ever reach the market.

Explaining the decision to recommend the listing of Soloiris, PBAC said that "despite the extremely high price requested, the medicine could be cost-effective if the sponsor agreed to participate in a Managed Entry Scheme that would require the pharmaceutical company to rebate part or all of the price of the drug, depending on how well the patient responds to treatment".

In its submission to the PBAC, the company estimated that supplying the drug in the first five years would cost the PBS up to $200 million.

But, while the manufacturers of Yervoy have agreed to participate in a Managed Entry Scheme for their drug, the makers of Kalydeco, Vertex, have strongly objected to the PBAC recommendation.

In a statement issued late last month, Vertex said it was "extremely disappointed" with the conditions the PBAC had imposed.

"These conditions fail to reflect the substantial clinical benefits recognised by the PBAC, and would result in limiting the number of eligible Australians who would be able to receive Kalydeco," the company said. "We believe that physicians are in the best position to make treatment decisions, based on what is most relevant to individual cystic fibrosis patients."

Vertex said it was particularly unhappy with PBAC conditions that it said would exclude the sickest patients from receiving Kalydeco, and with discontinuation criteria which it believes would result in patients being taken off treatment despite benefiting from the drug.

"Unlike any other country, Australia is seeking to impose strict eligibility and discontinuation criteria to limit the number of patients who could benefit, or are showing benefit, from this medicine," Vertex said, signalling it was unwilling to enter into the proposed Managed Entry Scheme arrangement.

"We hope the Government will reject the unreasonable conditions recommended by the PBAC and list Kalydeco so all eligible Australians can benefit," it said.

**Adrian Rollins**

COMMENT

# Flood of drugs fuelling pursuit of body beautiful

Steroids, peptides and other performance and image-enhancing drugs are being detected at the border in record amounts, underlining fears that many young people are putting their health at risk in the pursuit of idealised body types.

Indicating massive growth in the trade, more than 10,350 shipments of anabolic androgenic steroids, beta-2-agonists, peptides and other hormones were intercepted by customs and border agents last financial year – a 19 per cent jump from a year earlier and a huge increase from around 1000 interceptions a decade earlier, according to an Australian Crime Commission report.

As investigations continue into the use of supplements at Australian Rules and rugby league football clubs, information in the *Illicit Drug Data Report 2012-13* suggests the market for performance and image enhancing drugs (PIEDs) is growing fast and goes far beyond professional athletes.

There was a 36 per cent jump in the number of steroids seizures in 2012-13 to 331, and arrests of both suppliers and users surged 30 per cent to 661 people.

The growing popularity of steroids, peptides, clenbuterol and other performance and image enhancing drugs was highlighted by an Australian Needle and Syringe Program Survey of 2400 people conducted last year.

The Survey found 74 per cent of those who started injecting illicit substances in the previous three years had sought out steroids and other performance and image enhancing compounds, up from just 27 per cent a decade earlier.

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

The increased popularity of performance and image enhancing drugs is being fuelled, in part, by its ready availability.

The Crime Commission said the uncontrolled production and trafficking of such substances in some parts of the world meant there was a virtually unlimited supply available online.

“Due to the varying legal status of PIEDs internationally, producers can manufacture and stockpile PIEDs in countries where they are unregulated, and utilise online websites to reach the global market,” it said.

This is borne out by data showing that the vast majority (88 per cent) of performance and image enhancing drugs detected coming into the country were being imported through the postal system, compared with 7 per cent coming in as air cargo and less than 5 per cent being carried in by plane passengers or air crew.

The AMA has for several years raised concerns that people, particularly young men, are putting their health at risk by taking steroids and other PIEDs in trying to achieve an idealised body shape.

AMA President Dr Steve Hambleton said the evidence showed a disturbing trend among young people to pursue some idealised image of physical perfection.

AMA Vice President and Chair of the Public Health and Child & Youth Health Committee, Professor Geoffrey Dobb, said using PIEDs could have serious health consequences, and there were particular concerns about the composition and safety of hormones and supplements bought online or obtained illicitly.

“Hormones may be requested from medical practitioners but should, of course, only be prescribed when clinically indicated,” Professor Dobb said. “Much more often, hormones and supplements are obtained at gyms or over the internet. Anything from these sources is dubious in terms of both content and safety. For example, Dinitrophenol, which is promoted as a fat loss supplement, has caused severe illness and death.”

Problems associated with the use of steroids, peptides and other PIEDs include extreme mood swings can occur, possibly resulting in paranoid jealousy, extreme irritability, delusions and impaired judgement, Professor Dobb said.

The physical consequences of steroid abuse for men include kidney impairment

or failure, liver damage, cardio vascular problems, and the commonly reported testicular atrophy, reduced fertility, gynaecomastia and an increased risk of prostate cancer. For adolescent male users, additional effects may include stunted growth and accelerated puberty.

In its Position Statement *Body Image and Health*, updated in 2009, the AMA called for action to address the issue of unhealthy body image, including a code for the media industry around the portrayal of body images and role models and the establishment of a national network of researchers, educators, policymakers and industry representatives to coordinate practices addressing the incidence of unhealthy body image.

Professor Dobb said his Committee was likely to review the Position Statement to expand reference to issues of male body image.

**Adrian Rollins**

COMMENT

# Type 1 diabetes rate high, but not getting worse

Australia has so far proved immune to the international trend toward rising rates of type 1 diabetes.

While the prevalence of type 1 diabetes in Australia is well above the developed country average, the national incidence of the lifelong condition has remained broadly stable since the turn of the century, unlike the experience in many other countries.

Type 1 diabetes data collated and analysed by the Australian Institute of Health and Welfare show that 2367 people were diagnosed with the disorder in 2011 – half of them aged 18 years or younger.

The rate of incidence in 2011 was 11.1 cases per 100,000, just a little above the annual average of 10.9 recorded between 2000 and 2011.

Institute spokeswoman Susana Senes said type 1 diabetes developed when the immune system destroyed insulin-producing cells in the pancreas. Researchers believe this is the result of an interaction between genetic and environmental factors, though it is still not known exactly what causes this to happen.

The AIHW figures highlight the extent to which the affliction, which requires regular doses of insulin to manage, appears in the early years of life.

Between 2000 and 2011, 22 per cent of all type 1 diabetes diagnoses were in people aged 19 years or younger, and a further 12 per cent were in people in their 20s.

By comparison, less than 9 per cent were diagnosed in their 30s, and little more than 4 per cent were 40 years or older.

The peak age group for diagnosis was the 10 to 14 years age group, where the rate of incidence reached 32 per 100,000 – a rate five times greater than that experienced among those in their early 40s, Ms Senes said.

While the rates of diagnosis have remained relatively stable, they are still high by international standards.

According to the AIHW, the average annual incidence of type 1 diabetes diagnosis among children aged 14 years or younger between 2000 and 2011 was 23 new cases per 100,000 children, compared with the OECD average of 17 per 100,000 – though the Australian rate was comparable to that in the United States and Canada.

The Institute's analysis showed type 1 diabetes, like its type 2 cousin, is more common in men that women (incidence of 13 per 100,000 in males compared with 8 per 100,000 in females).

But it is less common among Indigenous Australian than the general population, and the incidence is greater in cities and large towns than in remote areas.

**Adrian Rollins**

COMMENT



INFORMATION FOR MEMBERS

# Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

NEWS

# Common anaesthetic in contamination scare

Health authorities have warned doctors and hospitals to suspend use of a common anaesthetic following concerns it may have become contaminated, causing blood poisoning in at least three patients in South Australia.

The Therapeutic Goods Administration has advised health professionals to avoid administering the widely-used intravenous anaesthetic propofol, marketed as Provive and Propofol Sandoz, because of suspicions that batches of the drug have become contaminated with the Gram-negative bacteria Ralstonia pickettii.

Concerns were aroused last month when three patients at two South Australian hospitals developed sepsis after receiving propofol.

The extent of the possible contamination has been narrowed to two batches of the Provive MCT-LCT 1 per cent emulsion for injection in 20 millilitre vials: A030906 and A030907.

Drug company AFT Pharmaceuticals has quarantined both batches, and tests are being conducted by the TGA to confirm whether or not contamination has occurred.

The TGA said propofol was only used in hospitals and "certain health facilities", and advised that it should only be used if no alternatives were available and "the benefits outweigh the risks to the patient".

The health scare has raised concerns that planned operations may need to be postponed.

But AMA Vice President Professor Geoffrey Dobb said the incident was unlikely to delay treatment because there were sufficient alternatives and back-up supplies on hand.

**Adrian Rollins**

COMMENT



INFORMATION FOR MEMBERS

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

## Notice of Annual General Meeting

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

Business:

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

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

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

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

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

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

***Ms Anne Trimmer***
Secretary General
21 March 2014

# MAY HEALTH EVENTS

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

| Sun | Mon | Tue | Wed | Thur | Fri | Sat |
|---|---|---|---|---|---|---|
| 26 | 27 | 28 | 29 | **1**<br>World Asthma Day;<br>National Heart Week;<br>NSW PKU Awareness Day;<br>National Jelly Baby Month;<br>National Crohns & Colitis Awareness Month;<br>National Tracky Dack Day | **2** | **3** |
| **4**<br>National Motor Neurone Disease Week | **5**<br>International Midwives Day | **6** | **7** | **8**<br>World Ovarian Cancer Day | **9** | **10**<br>World Lupus Day |
| **11** | **12**<br>International Nurses Day;<br>International ME/CFS Day;<br>National Food Allergy Week | **13** | **14**<br>National Schizophrenia Awareness Week | **15** | **16** | **17**<br>World NF Awareness Day;<br>World Hypotension Day |
| **18**<br>National Walk Safely to School Day | **19** | **20**<br>World Autoimmune Arthritis Day | **21**<br>National Myeloma Day;<br>National Medicines Symposium 2014 | **22** | **23**<br>National Macular Degeneration Awareness Week;<br>National Palliative Care Week;<br>Australia's biggest morning tea | **24** |
| **25**<br>National Kidney Health Week | **26**<br>National Multiple Sclerosis Awareness Week | **27**<br>National Kidney Health Week | **28**<br>World MS Day | **29** | **30**<br>NSW Gold Week | **31**<br>World No-Tobacco Day |

PUBLIC HEALTH OPINION

# Now, if pigs would fly

BY PROFESSOR STEPHEN LEEDER AND SHAUNA DOWNS

When you glance at this column this morning you may be looking for something to take your mind off the budget to be brought down this evening - a distracting word-picture about the crocuses whose delayed but recent arrival in New England this year signals the end of an especially deep and long winter.

Well, sorry, for as Nanki-poo said in *The Mikado*, "The flowers that bloom in the spring, / Tra la, / Have nothing to do with the case." The best I can do is to offer you my budget. Here it is.

"Madam Speaker, in presenting the Budget this year, I wish to begin by affirming the commitment of this Government to the support and growth of two of our central national services, health and education.

"Contrary to the accusations of our armchair critics, this Government is determined to conserve the values that have made this country great, and to manifest that commitment in the way we fund health and education.

"Recent rumours have unsettled the community, and tonight I want to reassure you and them that we understand how important both health and education are for the expression of our deepest national values - values including humane concern for the less well off, of giving people at the margins of our community a hand up, and ensuring everyone - everyone - in our community that our health service is to be paid for by all, and be available to all, whenever and wherever they need it.

"So I say to you, Madam Speaker, and to the community, there will be nothing in this Budget that will decrease access to necessary care for those not able to afford private care by choice. There will be no additional co-payments for items on the Medical Benefits Scheme, including visits to general practitioners. There will be no disruption to bulk billing.

"We accept that the steady rise in health care costs needs to be addressed, and we will be proposing major reviews of the efficiency of our services. We will not be moving to establish Medicare only as a safety net. We will do nothing further to make superior quality care available only to those who can afford it privately. And, because we will retain the concept of universal contribution to health care, we will also maintain universal access to it - of all Australians - and not deny wealthier Australians access to it, especially if they need it for catastrophic illness or major surgery.

"However, Madam Speaker, we accept that our overall Budget situation needs action in relation to the rate of increase in health spending. I have mentioned already our search for efficiency, and so we will be asking the states and territories to join with us, and our partners in the private sector, to determine a way forward in achieving efficiency targets that we will agree upon. We will be consulting with the specialist medical colleges to discuss ways in which useless treatment can be removed from the register of services paid for by Medicare. We will be discussing monopolies with specialty services. We will be examining pharmaceutical pricing.

"Madam Speaker there are two health service arrangements that I believe we need to consider critically, and they are the Australian National Preventive Health Agency and Medicare Locals.

"The disease challenges we face as a nation make a strong claim for the enhancement of both these organisational entities. We need strong leadership to take us out of the epidemics of obesity, diabetes and heart disease, and prevention must provide that leadership. We need to see evidence of a strong strategic intention in the next year from the Agency.

"Medicare Locals are aggregates of general practitioners and other community health workers that, in theory, could provide a critical element in the long-term care of people with chronic illnesses who, by default at present, too often end up in hospital. The name itself does not help these entities to function, and they will be rebranded and their mission clarified over the next 12 months.

"Madam Speaker, these are my preliminary comments about health and I shall speak later about details. And now I turn to education..."

Feeling better? Good! Stand tall and face the day.

"Madam Speaker, there are two health service arrangements that I believe we need to consider critically, and they are the Australian National Preventive Health Agency and Medicare Locals"

COMMENT

GENERAL PRACTICE

# What's ahead for Chronic Disease Management?

BY DR BRIAN MORTON

Given the ageing population and the increasing incidence of chronic disease, Health Minister Peter Dutton has sent some strong signals that there may be a funding announcement in the Federal Budget on this topic.

The AMA has been calling for additional support for patients with chronic disease, targeting those with higher levels of clinical need.

The AMA has been in regular discussions with the Government and the Department of Health over several years, with the Department floating a range of options including restructuring the Chronic Disease Management (CDM) MBS items, the concept of the medical home, patient enrolment, capitated payments and so on. In addition, the Diabetes Care Project has been running now for a couple of years, and is due to conclude on 30 June this year.

On Budget night, I would hope to see a move to a model of care such as the DVA's Coordinated Veterans' Care Program, which provides for GP-led comprehensive and coordinated care for patients with complex and chronic disease who are at significant risk of hospitalisation. It retains fee-for-service, but provides extra funding for proactive management of these patients. It avoids the risks of capitation and patient enrolment and represents an up-front investment in primary care, leading to better patient outcomes and lower downstream hospital costs.

There is no doubt that existing chronic disease management items could be improved. Data on CDM item claims show us that the current structure sees almost every GP Management Plan result in a Team Care Arrangement, and that very few reviews are undertaken.

There could be a number of reasons for the low number of reviews. Perhaps the patient has passed on or moved away. Perhaps, rather than contending with the red tape requirements of billing the review item, GPs are doing the reviews and just claiming a consultation. Perhaps the current structure places undue emphasis on the front end of the chronic disease management process rather than across the care continuum.

With quality chronic disease management more about longitudinal and ongoing monitoring, review, management and care, this data indicates that something needs to be done to ensure that patient progress against the plan is reviewed.

The AMA has been prepared to discuss the restructure of items with the Government in the past, highlighting that any changes should focus on funding high quality longitudinal general practice care, cutting red tape and supporting streamlined access to GP referred services.

The AMA has also highlighted that private health insurers (PHI) need to work more closely with general practice to improve care for PHI members with complex and chronic diseases, including through the provision of funding for GPs.

> "We do not know what is in the Budget, but if the Government is looking to improve health outcomes for patients with chronic disease, reforms will need to focus on better supporting GPs in caring for patients"

We do not know what is in the Budget, but if the Government is looking to improve health outcomes for patients with chronic disease, reforms will need to focus on better supporting GPs in caring for patients.

I will certainly be looking to see whether the Government has been listening to the AMA, and judging any reform proposals in the context of the type of ideas outlined above.

# It's a fact: DHS just keeps us hanging on the telephone

BY PROFESSOR GEOFFREY DOBB

If getting through on the PBS Authority prescription service seems to be taking even longer than ever, the AMA can confirm this is not a figment of your imagination.

After months of badgering, the Department of Human Services (DHS), which is responsible for operating the phone line, finally provided us with updated statistics regarding call waiting times, so that we could compare performance over time.

We can confirm what many doctors have suspected, that call waiting times did get a lot worse between October 2013 and February 2014.

During this period, just 50 per cent of calls were answered within 30 seconds, compared with 67 per cent during the same time a year ago.

Not only that. The DHA figures show that 16 per cent of callers were forced to wait more than two minutes to talk with someone, up from 12 per cent a year earlier.

Even worse, this drop in performance occurred despite a 12 per cent decline in the number of calls because an increasing number of medicines were moved to streamlined approval arrangements.

The good news is that DHS has introduced a new telephone scheduling tool to help it anticipate peak call periods. As a result, it reports that in March and April, 73 per cent of calls were answered within 30 seconds.

AMA President Dr Steve Hambleton wrote to all AMA members on 10 April to report on ongoing action by the AMA to eliminate the red tape caused by the PBS Authority system, and the Association had a productive meeting with DHS officials last month.

The Department is now reviewing the questions phone line clerks are required to ask, to ensure each one is actually necessary.

It will review five authority medicines 'questions sets' each month in consultation with its medical and pharmaceutical advisors, with the aim of cutting down the time required for each phone call. For example, in April DHS reviewed and updated questions sets for multiple sclerosis medications, as well as for terbinafine, atomoxetine, ivabradine, adrenaline and imiquimod.

DHS also reported that around 5 per cent of calls to the Authority service were for medicines that are now covered by streamlined arrangements and no longer require Authority approval over the phone.

The Department believes that keeping up-to-date with PBS medicines that require phone authority will cut down the number of unnecessary calls and help free up operators.

"AMA President Dr Steve Hambleton wrote to all AMA members on 10 April to report on ongoing action by the AMA to eliminate the red tape caused by the PBS Authority system, and the Association had a productive meeting with DHS officials last month"

If you see 'Authority Required (Streamlined)' marked against a medicine in the PBS, click on it to find the four digit code for the relevant clinical indication and include it on your prescription.

Already, 95 per cent of doctors are doing this.

The top ten streamlined authority medicines for which the Department receives unnecessary calls are:

MORE P30

# It's a fact: DHS just keeps us hanging on the telephone

... FROM P29

- smoking cessation related drugs: Nicotine, Nicabate P, Nicot Step 1 and Nicotine Patch;
- anti-dementia drugs: galantamine and donepezil;
- anti-thrombotic agents: rivaroxaban and clopidogrel;
- pregabalin; and
- quetiapine.

Those who use prescribing software provided by Best Practice and Medical Directors should also note that the Department has received some reports from prescribers that this software may not be providing prescribers with the streamlined authority code alert for some streamlined medicines.

If you notice your practice software does not reflect the latest PBS information, contact your software vendor and advise the Department on customer.feedback@humanservices.com.au.

Moving more medicines into streamlined approval arrangements is an encouraging development, but we need to keep the pressure on DHS to allocate proper resources to the phone line service.

As always, the AMA welcomes member feedback.

But also make sure you report any delays or other complaints about the phone line and its service quality directly to the DHS by sending an email to: customer.feedback@humanservices.gov.au

This email address also appears in the right hand column of the AMA homepage (www.ama.com.au) for your reference and ease of use.

You can make sure Health Minister Peter Dutton and Human Services Minister Marise Payne have a clear picture of the impact on doctors by copying them into your email: Minister.Dutton@health.gov.au and minister@humanservices.gov.au

The AMA knows just how frustrated doctors are with the PBS Authority system, and is pushing hard for action. The system should either be scrapped or, at the least, drastically overhauled to minimise the inconvenience and time wasting it causes for doctors and their patients.

COMMENT



INFORMATION FOR MEMBERS

# First-ever nationwide palliative care survey

GPs have been asked to participate in the first-ever attempt to identify and map the availability of palliative and advance care planning services nationwide.

A survey being conducted by a consortium of leading national health, academic and aged care organisations aims to tap into the local knowledge of GPs to provide an accurate picture of the palliative and advance care planning services available in each area.

The information collected will be used to help fill service gaps around the country, and to develop a dedicated 24 hour hotline to provide specialist palliative care and advance care planning advice.

GPs who decide to take part are asked to complete online survey of existing palliative care and advance care planning arrangements in their practice. Completing the survey is expected to take around 15 minutes.

Project leader, Associate Professor Bill Silvester, said the survey seeks to capture the knowledge of GPs, so that an accurate picture of services can be obtained.

"GPs and managers of aged care services have a good understanding of the palliative care and advance care planning services currently available in their local area, so it is really important that as many as possible participate in the survey, because the results will determine how program resources can be targeted to those in most need," Associate Professor Silvester said.

Findings from the survey will be incorporated into the first-ever national scan of the sector, with the information used to develop a suite of programs under the Specialist Palliative Care and Advance Care Planning Advisory Services Project.

These will include the 24 hour hotline, as well as education, training and web-based resources for health and aged care professionals to enhance their skills in palliative care and advance care planning.

To participate in the survey, go to https://www.surveymonkey.com/s/GeneralPractitioner1

The survey closes on Friday, 23 May.

For more information about the survey or the Advisory Services Project, contact Palliative Care Australia on 02 6232 4433.

# Win a $50 iTunes/Google Play gift card

## AMA survey of GP registrar and hospital-based specialist trainees


There are nearly 16,800 vocational trainees undertaking a recognised training program in Australia.

During May, the AMA will be surveying hospital-based specialty trainees and GP registrars on their experiences in order to guide the AMA's advocacy efforts and provide medical colleges with independent feedback about their training programs.

The AMA Specialist Trainee and GP Registrar Surveys are confidential online surveys that ask trainees about various aspects of their training, including the course curriculum; college assessment and examination processes; the flexibility of the training program; and training costs.

The first AMA Specialist Trainee Survey, conducted in 2010, showed a high level of satisfaction with work and training. It also highlighted several areas that attracted less positive results, including appeals processes, recognition of prior learning, responses to bullying and harassment, and costs. The full results of the 2010 survey can be viewed at: https://ama.com.au/2010-ama-specialist-trainee-survey-report-findings-october-2011.

The AMA plans to use the results from this year's surveys to highlight the strengths and areas for improvement in individual medical college training programs, and to identify emerging issues and trends in vocational training.

AMA Council of Doctors in Training Chair Dr James Churchill said the surveys were an important way of monitoring the experiences of trainees undertaking vocational training programs, and the findings would provide the colleges with important feedback.

"The AMA strongly supports the Australian model of medical vocational training, which does a great job in preparing doctors for independent practice," Dr Churchill said. "But it's important that colleges are aware of where they are doing well, and where the overall training experience for trainees could be improved.

"Most colleges already make commendable efforts to get the views of their trainees. Our surveys will cover some aspects of training that the colleges do not necessarily seek feedback on from their trainees.

"The ultimate goal of the surveys is to assist the colleges to maintain the high quality of specialist medical education in Australia."

In addition to publicly reporting on de-identified survey results, the AMA will communicate survey findings to the medical colleges to assist them with their quality assurance processes.

AMA Council of Doctors in Training has developed and refined two parallel questionnaires for general practice and hospital-based specialist trainees in consultation with college trainee representative groups and the colleges themselves. The questions take into account the Australian Medical Council's standards for accrediting specialist medical education and training.

**The anonymous, ten-minute surveys are open to AMA members and non-members until 30 May 2014**. All trainees are encouraged to participate. Complete the survey by the due date to go into the draw to win one of 10 iTunes or Google play gift cards valued at AUD$50 each. *

**Go to www.ama.com.au/trainee-survey to complete the Specialist Trainee or GP Registrar Survey.**

* In the Australian Capital Territory, only AMA members are eligible for entry into the draw. View the Competition terms and conditions at https://ama.com.au/terms-and-conditions

# AMA Trainee Forum 2014: DiTs focus on regional training, telehealth, accreditation and doctors' wellbeing

BY DR JAMES CHURCHILL

> "...valuable insights were gained from presenters and attendees during the final session regarding doctor mental health, wellbeing and suicide prevention"

The AMA Trainee Forum, held each March, is critical in shaping the advocacy agenda of the AMA's Council of Doctors-in-Training (CDT).

It is the premier forum for CDT's direct engagement with prevocational and vocational trainees from a wide range of specialties on national issues important to DiTs.

This year's Trainee Forum set out to push the boundaries of AMA policy, with discussion of innovative models for enhancing the capacity, distribution and delivery of medical training.

Fittingly, the session dedicated to use of telehealth for teaching and training was conducted via videoconference, with panellists dialling in to Melbourne from as far as Cairns, Mount Isa and rural Tasmania -- and not without its routine share of technical challenges.

Forum attendees discussed the value of opportunities via telehealth to expand the access of trainees in remote areas to clinical encounters with specialists based in major centres, provide innovative educational experiences for trainees and improve the standard of medical care able to be delivered by trainees in rural and remote sites.

The Forum also heard from a panel with significant experience in establishing and managing regional training networks -- networks of health services delivering high-quality generalist and specialist training, allowing trainees to be based in regions where training in single-site settings may not be viable.

While it's clear that a one-size-fits-all approach may not be appropriate, further development of regional networks and hubs shows significant promise for improvement in regional training and the distribution of the medical workforce.

The Trainee Forum discussed and agreed upon valuable outcomes regarding both of these innovative models of delivery of medical training, which have already influenced the formation of new AMA policy in the short time since.

Given the primary reason for the forum's existence is to allow for discussion on important issues for everyday DiTs, the 'trainee soapbox' is always a valuable and entertaining session.

This year, DiTs passionately affirmed their support for their junior and senior colleagues in Queensland, calling for resolution of the Senior Medical Officer contracts dispute amid threatened mass resignations of trainees' supervisors. Thankfully, in recent weeks there have been significant concessions from the Queensland Government, and the negotiation of a revised agreement has largely defused tensions.

The soapbox session also saw discussion of the results of the AMA's recent survey into trainee working hours.

The survey was commissioned to investigate concerns that quality of training for procedural specialties is being threatened by the imposition of rosters with strictly-limited working hours.

While the survey results demonstrate that the average procedural trainee continues to work approximately 60 hours per week, generally consistent with trainees' expectations and recommendations from training bodies, it is clear that protecting the quality of vocational training must continue to be a significant focus for CDT.

The Forum also gives the CDT an opportunity to seek trainee feedback on significant upcoming issues on which AMA advocacy is planned.

In light of the Australian Medical Council's impending review of the accreditation standards for specialist medical education, the forum discussed the current standards and areas on which advocacy should focus.

Similarly, valuable insights were gained from presenters and attendees during the final session regarding doctor mental health, wellbeing and suicide prevention.

With the *AMA-beyondblue Mental Health Roundtable* coming up on 6 June in Melbourne, the discussions made it clear that trainees are ready to build upon work already completed, and to determine a solid plan for addressing the health of the profession.

*Many thanks to all Trainee Forum presenters and attendees for their participation, and to AMA Victoria for hosting the event at AMA House, Parkville.*

COMMENT

# Health on the hill

## Political news from the nation's capital

### Medicare crackdown falls short

A Federal Government crackdown on Medicare rorts has raised a fraction of the expected revenue and has ended up costing the Commonwealth rather than saving health funds, according to a damning audit report.

Intensified checks of compliance with Medicare rules were expected to deliver $70 million in savings between 2008-09 and 2012-13, but an investigation by the Australian National Audit Office has found that the Department of Human Services bungled the process, conducting far fewer reviews and audits than expected, and recovering far less money.

The-then Rudd Government provided the Department with almost $77 million to conduct an additional 8000 Medicare compliance audits and reviews over a four-year period. The extra effort was expected to result in the recovery of more than $147 million, providing a net saving of $70 million.

But the ANAO found that in four years debts worth just $49.2 million were identified and, of this, just $18.9 million had been recovered – meaning the crackdown resulted in an additional cost to the Government of $58 million, rather than a saving.

"The available Human Services' data shows that there was a $128.3 million shortfall in the savings achieved by the Department, in the form of monies actually recovered, against the target set by the Budget initiative – some 87 per cent less than the $147.2 million expected savings," the ANAO report said. "Even if all the debts raised ($49.2 million) were recovered, the result would be a shortfall of $98 million, or 66 per cent less than the expected savings."

When the crackdown was initiated in 2008, the Expenditure Review Committee of Cabinet asked the responsible Ministers to report back on progress in 20011-12, but the Audit Office found "Human Services did not develop or implement its proposal to monitor and report on savings – an opportunity missed, given ministerial expectations of a significant return on the Government's investment".

Instead, the ANAO found that the Department tried to fudge reports on the extent to which it increase audit and compliance activity.

According to the Audit Office report, just once – in 2011-12 – did the Department reach its key performance target of completing 2500 audits and reviews each year.

It found that in 2012-13 Human Services, on its own initiative and without ministerial input, changed the mix of activities that counted toward compliance activity to include less rigorous actions, such as 'targeted feedback letters'. Including such actions bumped reported compliance activity for the year up to 2819 cases, whereas the ANAO found the actual number of agreed compliance actions was 2073.

"While acknowledging the Department's advice that targeted feedback letters were a valid compliance treatment intended to encourage voluntary compliance, their inclusion resulted in inaccurate performance reporting for the budget measure, as well as inaccurate and inflated internal reporting of its compliance coverage rate," the Audit Office said.

In addition, the ANAO found significant deficiencies in the consistency and quality of compliance data collected by Human Services.

In a review of 359 Medicare audits completed by the Department between March and June last year, the Audit Office found that 33 (almost 10 per cent) "contained data inaccuracies that resulted in compliant claims being incorrectly recorded and reported as non compliant".

Responding to the findings, the Department accepted the ANAO's recommendations to strengthen and refine its risk management frameworks and to develop a methodology to monitor and report on the effectiveness of Medicare compliance audits.

But it defended its decision to include feedback letters, education programs and other activities in its compliance work.

"While risk management, the completion of audit work and achievement of savings is key to the Department's compliance activities, the Department is also pleased that the ANAO has noted the additional objectives of the Compliance Program, including education and reinforcing health professionals' awareness of compliance obligations. Prevention and positive behaviour change are a very important part of the department's Compliance Program," Human Services said.

**Adrian Rollins**

COMMENT

# Health on the hill

## Political news from the nation's capital

### Incentives to keep patients health in health fund sights

Health funds are pushing to be allowed to pay doctors incentives to keep patients healthy and out of hospital as part of an expansion of private insurance to cover primary health care.

As experts warn that a Commission of Audit proposal to force higher income earners off Medicare and into private cover would drive a massive increase in premiums, peak industry group Private Healthcare Australia is planning a major expansion into primary health.

According to the *West Australian*, PHA is preparing to submit a reform blueprint to Health Minister Peter Dutton that will include allowing health funds to pay GPs to provide preventive care services to their patients.

Under current arrangements, private health funds are banned from providing cover for GP services, but Mr Dutton has expressed interest in an expanded role for insurers, including in primary care.

The PHA's plan would see doctors paid an incentive by health funds to help improve the health of their members, including by providing advice on diet and exercise, the *West Australian* reported.

They might also receive payments for treating patients in accordance with clinical guidelines.

PHA Chief Executive Michael Armitage told the *West Australian* that often, the first health funds knew that a member had a serious condition was when they were presented with a large hospital bill.

Mr Armitage suggested the incentive arrangement could improve the quality of care while reducing health fund costs.

But an analysis by health insurance actuary Brent Walker suggests private health cover might be pushed out of the reach of many if recommendations from the Commission of Audit are adopted.

In recommendation 17, the Commission suggests that higher income earners be excluded from Medicare and required to take out private health insurance, which would then have to cover GP visits, pathology and pharmaceuticals.

Mr Walker told the *Adelaide Advertiser* that to extend private health insurance to cover all the expenses that currently fell under Medicare would force premiums up by around 150 per cent, putting the cost of a typical health plan at $13,500 a year.

The warning came as it was revealed that some health funds are charging up to $2772 a year for insurance that only covers patients for public hospital care – an entitlement they already have under Medicare.

The *Sunday Herald Sun* said there were 15 such policies on offer in Victoria alone, and they did not confer any advantage in terms of treatment priority or getting access to a single room. Policy holders may get a choice of doctor, but only of those who have practicing rights at that particular public hospital.

A spokesman for insurer NIB admitted to the *Sunday Herald Sun* that its public hospital-only product was aimed at higher income earners who were trying to avoid the tax penalty on those without private health cover.

**Adrian Rollins**

COMMENT

### Plain packaging laws at centre of world trade storm

Australia's breakthrough tobacco plain packaging laws have become the centre of the biggest trade dispute in the history of the World Trade Organisation as worried countries tussle over the protection of intellectual property rights and the ability of countries to take public health measures.

As at late last month, 35 countries had asked to join the dispute as third parties, including the United States, the European Union, China, India, Brazil and Japan.

In a major advance in the progress of the trade stoush, the WTO last week appointed a three-member panel to begin hearings on the dispute and finalise a report within six months.

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# Health on the hill

## Political news from the nation's capital

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The panel, to be chaired by former South African Trade Minister Alec Erwin and including international intellectual property expert Professor Francois Dessemonted and distinguished Barbados politician Dame Billie Miller, will investigate complaints from five countries – Ukraine, Indonesia, Cuba, the Dominican Republic and Honduras – that Australia's plain packaging laws breach international trade obligations regarding the protection of intellectual property rights (in particular, trademarks) and are detrimental to their tobacco industries.

Among the arguments, Cuba has complained that the laws mean that its premium tobacco products, particularly cigars, cannot be differentiated from other products in the Australian market, while the Dominican Republican argued they were detrimental to fair competition in the marketplace, and were therefore inconsistent with Australia's international trade obligations.

The dispute has attracted huge international attention because of its implications for the marketing of tobacco products and, more broadly, the capacity of countries to enact public health measures.

Tobacco companies and producer countries are particularly worried that if Australia's plain packaging legislation stands, many other countries will follow suit, undermining the global market for their products.

So far, governments in Ireland and New Zealand have flagged their intention to introduce similar plain packaging legislation, while the British Government has indicated it will introduce plain packaging laws following a review.

Evidence about the effect of the measure so far is mixed. A University of Sydney study found there had been a jump of almost 80 per cent in calls to the national Quitline since the laws were introduced, but tobacco companies claim there has been no impact on the overall consumption of their products.

The Australian laws have the strong backing of the World Health Organisation.

The WTO dispute is not the first legal challenge the Australian Government has faced to the plain packaging laws.

In 2012 it successfully defended the plain packaging legislation when the High Court of Australia dismissed a challenge from the major tobacco companies, who had argued that the laws breached their intellectual property rights.

A spokesman for Trade Minister Andrew Robb told *The Australian Financial Review* that the Government would vigorously defend the plain packaging laws at the WTO.

"WTO members have a right to take measures to protect public health," the spokesman said, adding that a number of countries including Brazil, Canada, New Zealand, Norway and Uruguay had expressed their support for Australia's case.

If the dispute settlement panel rules that Australia's plain packaging laws do breach WTO trade rules, the country will have 60 days to challenge the decision before it becomes formally adopted.

If there is an appeal, it has to be heard within 90 days by the WTO's permanent seven-member Appellate Body, and the Dispute Settlement Body has to accept or reject the appeal decision within 30 days – and rejection is on possible by consensus.

**Adrian Rollins**

COMMENT

LETTERS

# Keep an open mind on Lyme disease

Dear Sir or Madam

I was alarmed by your recent publication of a piece named 'Lyme disease not a local-grown problem: pathologists'.

I wonder whether Dr Graves swore an oath to 'first do no harm' when he was given the title before his name. And I wonder if he has the faintest idea just how much harm his premature and inappropriate comments are doing. His comments about testing perpetuate myths which help no-one. And especially concerning to me is his advice about treatment at the end of the article - surely treatment decisions are made about individual patients by their medical practitioners.

Likewise, Professor Beaman's statement that the symptoms of Lyme disease are 'consistent with being alive' is breathtakingly ignorant. This description could not be further from the truth. And it is a comment that is profoundly insulting, in particular to those sickest patients who exist daily feeling they are the living dead.

History is littered with examples of diseases which were once dangerously misunderstood. Examples such as H. pylori should not be too far from the memory of current practitioners.

Medical practitioners may not have the time, or inclination, to follow the debate in detail as the evidence related to Lyme disease in Australia builds, but they owe it to their patients to keep open minds. And you owe it to your members to give information that supports an open-minded and productive dialogue, particularly taking into consideration that the CMO's investigations into Lyme disease in Australia are far from concluded. It is also worth noting that NSW Health has recently updated its information on Lyme disease to advise that 'Clinicians should keep an open mind about the possibility of locally-acquired Lyme disease'. The highest price a medical professional may pay for ignorance about this disease is a blow to their ego. But patients are paying with their lives.

The AMA does not serve its members and their best practice by publishing this article. It does nothing to advance the understanding of a very serious disease. I hope that your intention is to publish another article which gives a more complete and updated overview.

First do no harm. Please keep those words at the forefront of your minds.

Yours sincerely,

**Kirsten Smith**

COMMENT



INFORMATION FOR MEMBERS

# Medical claims for diagnostic imaging and pathology provided to patients in public hospital emergency departments

Diagnostic imaging and pathologist specialist members should be aware they are legally responsible for all services claimed under Medicare that are billed under their provider number or in their name, even if the billing was done by hospital administration.

Pathology and diagnostic imaging services for patients in public hospital emergency departments are covered by Australian Government funding arrangements and are not eligible for Medicare benefits.

Emergency patients are to be treated as public patients until a clinical decision to admit has been made and the patient has elected to be admitted as a private patient.

More information about this is available from the Medicare website: https://www.medicareaustralia.gov.au/provider/business/audits/public-hospital-emergency-depts.jsp

The AMA provides the following advice to members about the use of provider numbers in public hospitals:

- where medical services claimed against Medicare are being rendered in public hospitals under a medical practitioner's name and billing provider number, the practitioner must be made fully aware of, and be prepared to accept responsibility for, that billing;
- where services claimed are being rendered in a public hospital, medical practitioners should seek a written guarantee from the hospital that the arrangement is not in breach of the relevant Australian Health Care Agreement; and
- public hospitals must provide doctors with full records of all medical accounts raised in their name.

If you believe your provider number may have been used in ways that contravene the relevant provisions in the Health Insurance Act, the AMA recommends you contact your State AMA Office. As this issue affects employment contracts, State AMAs will be able to coordinate representation for affected members.

The AMA will keep abreast of Medicare compliance matters through its participation on the DHS Compliance Working Group.

# Research

## Cholesterol gives cancer a free ride

Cholesterol's already badly tarnished image has just got a whole lot worse.

A team of researchers have found that the substance, long linked to heart problems and clogged arteries, also plays a major role in helping cancer spread through the body.

In a finding set to intensify the focus on links between elevated cholesterol levels and the incidence of cancer the researchers, led by Sydney University Associate Professor Thomas Grewal, found that low density lipoprotein (LDL) – often referred to as bad cholesterol – regulates the machinery that controls the migration of cells through the body.

Associate Professor Grewal said cells in the body typically stick to each other with the help of Velcro-like molecules on their surface known as integrins. Cancer cells typically have more of these integrins, which help cancer cells that have broken away from a tumour to take root elsewhere in the body.

"Our study identified that bad cholesterol controls the trafficking of tiny vessels which also contain there integrins, and this has huge effects on the ability of cancer cells to move and spread through the body," he said.

"Our research found that having high amounts of bad cholesterol seemed to help the integrins in cancer cells to move and spread.

"In contrast, we found that high levels of good (high density lipoprotein) cholesterol keeps integrins inside cells, and may therefore protect against cancer cell spread."

The discovery, published in the journal *Cell Reports*, may shed new light on cancer therapy.

Associate Professor Grewal told the *t*that people with common cancers such as those of the breast, prostate, lung and liver, often had low levels of LDL cholesterol because it had been absorbed by the cancer cells to help them grow and spread.

"Our findings advance the theory that knowing how to manipulate and lower bad cholesterol could significantly help to reduce the ability of cancer cells to spread.

Associate Professor Grewal has been working on the link between cancer and cholesterol for the last 15 years in collaboration with Professor Carlos Enrich from the University of Barcelona, and the latest paper was the result of five years' work involving researchers from the University of Sydney, the Garvan Institute, and from universities and research centres in Brisbane, Hamburg and Barcelona.

**Adrian Rollins**

COMMENT

## Your money or your life

What price a life? In the romanticised view, every life is priceless.

But, as unpalatable as it may seem, every day governments, insurers, urban planners, hospital managers and many other routinely make decisions that put a finite value on life.

In Britain, the Department of Transport is willing to spend up to $3.25 million on safety measures that would prevent a death, while the National Health Service judges that treatments that can deliver an extra Quality Adjusted Life Year for up to $54,000 could be considered good value for money.

In Australia, the Pharmaceutical Benefits Advisory Committee uses the benchmark of up to $50,000 for each extra Quality Adjusted Life Year when assessing the efficacy of a medicine.

Now a team of academics from the University of Warwick have set out to determine what price can be put on a life, in an effort to give policymakers a more coherent and consistent guide to valuing life.

Behavioural Science Professor Graham Loomes and his team have embarked on a four-year study into how governments and others arrive at a value for life.

"Putting a monetary value on life and health and safety is difficult, and the answers can be pushed around by the way the question is framed," Professor Loomes said.

"At the end of four years it is unlikely we will have a simple model to be used in every situation. But what we hope to have is a model that can be adapted and used in different areas."

He said the figure that people arrive at may be influenced by considerations such as how the money is raised, and the number can also change according to considerations of fairness, which "can be a trick thing to measure".

"Should the same value be placed on old people as opposed to children?" Professor Loomes asked. "Or pedestrians over motorists, as they are more vulnerable. How much allowance should be made for personal responsibility?"

He said the hope was that, by understanding how people currently arrive at a figure, "we may be able to reduce bias and error and get at figures that better reflect people's underlying values".

**Adrian Rollins**

COMMENT

# Inmate suffers slow death in latest botched US execution

The United Nations has renewed its call for a moratorium on the death penalty in the United States amid outcry over the botched execution of a convicted murderer and rapist.

The United Nations' High Commissioner for Human Rights has warned the execution of Oklahoma death row inmate Clayton Lockett may have breached may have breached international law.

The comments came as details emerged of Lockett's final hours, including evidence that he took almost 45 minutes to die after being injected with an untested cocktail of drugs, many of which appear to have leaked directly into his body after an intravenous line failed.

Witnesses said Lockett convulsed violently during the execution and tried to lift his head, even after a doctor declared him unconscious. He died of an apparent heart attack, 43 minutes after the execution had begun.

"What happened in Oklahoma is deeply troubling," US President Barack Obama said when asked about international condemnation of US application of the death penalty following Lockett's case.

Mr Obama said Attorney General Eric Holder would be asked to "get me an analysis of what steps have been taken, not just in this particular instance, but more broadly in this area".

The President said the death penalty's application in the US was problematic, with evidence of racial bias and the eventual exoneration of some death-row inmates.

"All these, I think, do raise significant questions about how the death penalty is being applied," Mr Obama said, "and this situation in Oklahoma I think just highlights some of the significant problems there."

A timeline of the execution released by Oklahoma authorities shows that it took a phlebotomist almost 50 minutes to find a vein after checking the prisoner's arms, legs, feet and neck.

Finally, the IV was inserted into a vein in Mr Lockett's groin and a dose of Midazolam was administered.

The attending doctor declared Mr Lockett unconscious 10 minutes later, though witnesses reported that the prisoner continued to move his head, fight against his restraints and attempt to speak for a further three minutes.

Once Mr Lockett was declared unconscious, the doctor administered vecuronium and potassium chloride through the IV.

But, 10 minutes later, the doctor checked the IV and found that the vein had collapsed and the drugs had leaked out and been absorbed in the surrounding tissue.

The doctor then contacted the warden and informed him that not enough drugs had been administered to cause death, that there were not enough drug left to complete the execution and that there was no vein to inject them into even if there was.

The doctor reported that, at that time, Mr Lockett was unconscious but still had a faint heart beat.

The execution was officially called off 33 minutes after the Midazolam was administered, and Mr Lockett was declared dead of a heart attack 10 minutes after that – one hour and 44 minutes after the prisoner was first strapped into the gurney.

Mr Lockett was convicted in 2000 and sentenced to death for the kidnap and murder of a 19-year-old woman during a home invasion. The woman survived the initial assault, and Mr Lockett ordered two accomplices to bury her alive, and raped one of her friends. His accomplices are serving life sentences.

The families of his victims expressed satisfaction at his execution, but the manner of his death had appalled the UN High Commissioner for Human Rights.

Spokesman Richard Colville said "the suffering of Clayton Lockett during his execution in Oklahoma on Tuesday 29 April, may amount to cruel, inhuman and degrading treatment according to international human rights law".

Mr Colville said that the execution also appeared to run counter to the US constitution, which bars "cruel and unusual punishment".

"The prolonged death of Clayton Lockett is the second case of apparent extreme suffering caused by malfunctioning lethal injections reported in 2014 in the United States," he added, referring to the case of Dennis McGuire, executed in Ohio in January with an allegedly untested combination of drugs.

"The apparent cruelty involved in these recent executions simply reinforces the argument that authorities across the United States should impose an immediate moratorium on the use of the death penalty and work for abolition of this cruel and inhuman practice," he said.

Authorities in many of the 32 states that still have the death penalty have been scrambling to find a supply of drugs to carry out executions after European pharmaceutical companies, their usual source, placed an embargo on the use of their products for capital punishment, in line with European Union laws.

**Adrian Rollins**

COMMENT

# Polio a ‘global health emergency’

The World Health Organisation has declared a global health emergency over the spread of polio, heralding the unwelcome return of a devastating disease recently pushed to the brink of extinction.

The WHO has taken the rare step of issuing a worldwide alert following evidence that wild poliovirus is spreading internationally during what is traditionally a period of low transmission for the disease, raising concerns infections could become much more rapid and wide ranging when conditions conducive to high transmission kick in during the northern hemisphere summer.

“During the 2014 low transmission season there has already been international spread of wild poliovirus from three of the 10 states that are currently infected,” the WHO said. “If unchecked, this situation could result in failure to eradicate globally on of the world’s most serious vaccine preventable diseases.”

It is only the second time the UN agency has declared an international public health emergency: the first was in 2009 during the global influenza pandemic.

AMA President Dr Steve Hambleton said the disease’s re-emergence was “extremely disappointing” given the decades of effort put into eradicating the disease.

“The only disease we have eliminated is small pox, and we wanted polio to be number two,” Dr Hambleton said.

Polio remains endemic in three countries, Pakistan, Syria and Cameroon, and conditions of conflict and regional instability have helped the disease spread to adjoining nations including, in central Asia, Afghanistan; in the Middle East, Iraq and Israel; and in Central Africa, Equatorial Guinea, Ethiopia, Somalia and Nigeria.

The WHO said that, as at the end of 2013, 60 per cent of all polio cases were as a result of the international spread of the virus, with mounting evidence it was often being carried by adults traversing borders.

“The international spread of polio to date in 2014 constitutes an extraordinary event and a public health risk to other states,” the WHO said. “The current situation stands in stark contrast to the near-cessation of international spread of wild poliovirus from January 2012 through the 2013 low transmission season for this disease.”

After reaching a record low of 223 cases in 2012, the number of polio cases jumped to 417 last year and so far this year 74 cases have been notified, including 59 in Pakistan.

Dr Hambleton said conditions in the Pakistan had led to local outbreaks of the disease, and conflict in surrounding countries had helped its transmission, a view shared by the WHO.

“The consequences of further international spread are particularly acute today given the large number of polio-free but conflict-torn and fragile states which have severely compromised routine immunisation services and are at high risk of re-infection,” the UN agency said.

The polio vaccination program in Pakistan, where the disease has its strongest toehold, has been severely disrupted by violence and misinformation. Almost 30 polio vaccination workers and their police offer guards were assassinated in the country last year. Suspicions about the vaccination program have also been heightened in the wake of revelations the US Central Intelligence Agency used a fake vaccination program as cover to help hunt down Osama bin Laden.

The polio virus, spread through faeces and contaminated water, attacks the central nervous system and can cause paralysis within hours. It is fatal in up to 10 per cent of cases, and there is no cure.

The WHO said a coordinated international response was essential to prevent the spread of the disease. It said unilateral action would likely be ineffective.

**Adrian Rollins**

COMMENT