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BY AMA VICE PRESIDENT
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Clinical input to health financing proposals

The current proposal for a mandatory $7 co-payment for general practice, pathology and diagnostic imaging services, and increasing co-payments for PBS medications, is a timely and topical example of a long-standing problem: the lack of clinical input to health financing proposals and decisions.

Led by the AMA, most public commentary on the co-payment proposal noted that this is not a health policy; it is essentially a financial policy, driven by financial considerations and with a view to financial gains, not health impacts.

As AMA President Associate Professor Brian Owler has said, the AMA is always willing to work with the Government of the day to come up with solutions, but that hasn't occurred in this case.

A lot of the current co-payment proposal actually goes against the grain of health policy in terms of preventive health care, GPs managing people out of hospital with timely access to diagnostic services, keeping them well and preventing expensive hospital care.

Without genuine clinical input, a purely financial solution for a complex health policy is always a recipe for disaster.

> "Without genuine clinical input, a purely financial solution for a complex health policy is always a recipe for disaster"

Of course, the co-payment proposal is just the most recent example. Health financing proposals and decisions at all levels have rarely benefited from sufficient clinical consideration and input.

The problem is clear. How can clinical care and clinical perspectives be made a central and mandatory consideration in health financing decisions?

The AMA, by virtue of those it represents, is the most recognised and authoritative voice within the medical profession, particularly in bringing a clinical perspective to bear on issues. It is also a trusted and respected participant in public debates, and its views are regularly sought by the media.

The AMA is exploring how it can most effectively use its authority, and the wealth of clinical expertise of its members, to ensure the clinical perspective is taken as the most important reference point for those making health financing decisions.

One way of considering this issue of clinical input is from the focus of sustainability - can expenditure on health care be sustained at affordable levels into the foreseeable future? If decisions about sustainability don't include clinical input, we will be left to deal with the health impacts of financial policies.

The broad area of end-of-life care, and the issue of futile care at the end of life, is one area where the issues of health financing sustainability and the potential for clinical input to financing decisions can intersect.

Work across a range of organisations reflects growing awareness of these issues in end-of-life care, including by the Australian and New Zealand Intensive Care Society (ANZICS) and the Australian Commission for Safety and Quality in Health Care (ACSQHC). It is an area that I have a strong interest in given my specialty of emergency medicine. I have also had the privilege of supporting two close family members, whose final months were spent at home enjoying wonderful palliative care. I am determined that other Australians and their loved ones should benefit in similar ways.

Issues of clinical input are being recognised internationally. Canada's Premiers, meeting as the Council of the Federation, have highlighted the need for a systematic approach to clinical practice guidelines in collaboration with health care providers. They also recognise the need to look at the appropriateness of care, given mounting evidence that some patients receive treatments that may not be best suited to their actual needs. Collaboration between providers and their institutions and organisations can also identify and propose practices that governments may be interested in funding and implementing.

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Clinical input to health financing proposals

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The Charter for the UK's National Institute for Health and Care Excellence (NICE) includes a responsibility to ensure careful and targeted use of finite resources, with NICE guidance setting out an evidence-based case for investment and disinvestment. All NICE guidance and quality standards are developed by independent committees of experts that include lay members and representatives from clinical practice, public health, social care and, where appropriate, from industry.

The current Budget proposals highlight the need for the AMA to be able to assess and provide clinical advice on health financing proposals. This need applies both in terms of reacting to external proposals and proactively identifying and providing clinical input on health financing changes that we see as required – which could include investment and disinvestment proposals.

While other countries are giving more recognition to the need for clinical input and involvement, there is no overseas model that is a perfect fit for our needs and the specific circumstances of our health system (such as our mix of private and public health care).

We need to consider how this should operate in our context: do we want to take charge and manage this within our profession; or do we look to Government to provide supporting infrastructure and processes, and provide our input through them.

I welcome your ideas and suggestions about areas and priorities where your clinical perspective suggests changes to support sustainable health financing.

This could include your views on areas such as futile end-of-life care, unnecessary red tape, better use of e-health, or other areas of clinical care.

Any suggestions, more broadly, about how the AMA can identify and advise on the clinical impact of financing proposals are also welcome.

COMMENT

INFORMATION FOR MEMBERS

Statutory Review of the Personal Property Securities Act

The Personal Property Securities Register (PPSR) is the register where details of security interests in personal property (not real estate) can be registered and searched. A supplier of personal property can register their interest on the PPS Register to protect their right to repossess property if the customer fails to make appropriate payments. This can affect businesses that lease equipment, for example, including medical practices.

The main legislation governing the PPSR is the Personal Property Securities Act 2009 (the Act). The Government is now undertaking a review of the Act, to consider its operation and effects. The review will pay particular attention to the experience of small businesses.

An interim report is due by 31 July 2014 with recommendations on priority actions for the Government to consider, focussing on issues raised in relation to small businesses. The final report is due on 30 January 2015 and is expected to make recommendations on how to improve the Act.

The AMA encourages members affected by the PPSR and the Act to provide comments by email at ppsareview@ag.gov.au. Initial submissions relevant to small business are sought by 6 June 2014, with other submissions open until 25 July 2014.

Full details are available at the Attorney General's website.

Patients face big fee hike for diagnostic services

Patients are set to be hit with a massive hike in out-of-pocket costs for x-rays, CAT scans and MRIs, and the viability of many any pathology practices will be threatened by the Federal Government's push to discourage bulk billing in pathology and radiology.

AMA President Associate Professor Brian Owler warned that the Commonwealth's "ideological approach" to health care funding had resulted in bad policy that would hurt patients and put many families and practitioners under severe financial pressure.

In a major speech defending the Budget on 11 June, Treasurer Joe Hockey said he welcomed the AMA's "in principle" support for co-payments, to which A/Professor Owler responded by clarifying that although the AMA was not opposed to co-payments per se, "we do not support the current co-payment proposal".

While much discussion of the Budget has so far centred on the $7 co-payment for GP, pathology and diagnostic imaging services, A/Professor Owler said associated moves for an across-the-board $5 cut to Medicare rebates and to scrap bulk billing incentives for pathologists and radiologists, could be equally as corrosive for health care.

Currently, pathologists receive a bulk billing incentive of $3.40 per patient, while for radiology it is 10 per cent. Combined with the $5 rebate cut, this means pathologists will be $8.40 out of pocket for each non-concession patient, while radiologists face even bigger losses.

According to the Australian Diagnostic Imaging Association, patients who were previously bulk billed would not only have to pay a $7 co-payment, but also faced an extra charge because of the loss of the bulk bill incentive.

The Association said the extra charge would be $9.72 for a chest x-ray, $34.50 for a chest CT scan and $65.48 for a head MRI, meaning general patients faced paying $90 up-front for an x-ray, $380 for a CAT scan and up to $190 for an ultrasound – money they would have to get reimbursed from Medicare, though the cap on Medicare Safety Net benefits would mean the costs were only partially covered.

A/Professor Owler said these changes were particularly concerning given that the co-payment was charged for each service, so that a patient might be charged multiple times for a single visit.

He said the changes would threaten the viability of many pathology and diagnostic imaging practices, especially given that Medicare rebates for their services have been frozen for the past 14 years.

Currently, around 87 per cent of pathology services are bulk billed, and losing $8.40 for each non-concession patients would be a "real problem" for many practices, particularly in regional areas.

Meanwhile, he warned, "diagnostic imaging practices that provide excellent services in disadvantaged areas will become unviable".

ADIA Chief Executive Officer Pattie Beerens said that in meetings with the Government since the Budget, the clear message had been that "bulk billing is not their priority, and that everyone should pay at least a small amount to the cost of their health care".

Ms Beerens said her members feared for the consequences of the Budget measures.

"In our view, the Government has been too aggressive on patient rebates for diagnostic imaging. Many people will simply be unable to afford diagnostic imaging under the measures announced in this Budget, and many conditions will therefore go undiagnosed," she said. "The measures proposed will not only have significant short-term effects, but the implications for Australia's health care system in

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Patients face big fee hike for diagnostic services ... FROM P6

the long term could be devastating."

A/Professor Owler said the AMA's general practice, pathology and radiology representatives were developing recommendations on how the Government could re-cast its policy to protect the most vulnerable patients – work he said the Government should have undertaken before the Budget.

"The [Budget] proposal went through without consultation with the AMA and, for that matter, any other health group," he said. "It's the sort of work that really should have been done before the Budget proposal was announced."

He said the policy had been misconceived, because health care costs were not growing unsustainably, and general practice was part of the solution, not the problem, to containing cost increases.

Health's share of Commonwealth spending had actually fallen from 18.1 per cent in 2006-07 to 16.1 per cent this financial year, A/Professor Owler said, "so the narrative that's being built up about an unaffordable health care system, [and] that GPs are the ones driving this problem with sustainability, is a narrative not based in the reality of the figures that the Government [itself is] publishing."

His argument was backed by a report from the Commonwealth Fund that compared the performance of health care systems across 11 developed countries, including Australia.

It found that Australia ranked second highest for quality of care (behind the UK) while spending the least on health as a percentage of GDP (8.9 per cent).

A/Professor Owler said one of the areas where Australia did not perform so well was in access to care. The Fund ranked Australia ninth on cost-related problems in getting health care, with 16 per cent of people last year failing to fill a prescription, skipping medical tests, or avoiding the doctor when sick because of cost.

He said this did not bode well for when the $7 co-payment was introduced.

"This is the situation now," he said. "The Government's co-payment will significantly increase the cost barriers to quality health care, especially the poorest and sickest. This will inevitably increase costs in other parts of the health systems as people go to the doctor much later and much sicker."

Adrian Rollins

COMMENT

Anatomy of the co-payment

For all patients

- $5 cut to Medicare rebates for GP attendances and all pathology and diagnostic imaging services
- bulk billing incentives for pathology and diagnostic imaging services axed
- freeze on indexation of rebates for medical services extended until July 2016, except for GP attendances.

Concession card holders and children under 16 years

- $7 co-payment charged for the first 10 GP, pathology and diagnostic imaging services in a year
- exactly $7 must be charged to be eligible for $6 Low Gap Incentive ($9.10 for regional, rural & remote)*
- after 10 services, rebates increase by $5 if no co-payment is charged

*only GP low gap incentive is indexed

Hospital funding cuts risk reigniting short-sighted blame game

AMA President Associate Professor Brian Owler has voiced "very significant concerns" about the Federal Government's decision to strip $20 billion from public hospitals in the next five years.

A/Professor Owler, who works as a neurosurgeon at Sydney's Westmead Hospital, said the move would add to the pressure on hospitals already struggling to meet performance targets.

In its final assessment of the health system, the COAG Reform Council reported that although there had been an improvement in the proportion of emergency department patients receiving timely treatment, elective surgery waiting times continued to grow, as did the wait for important procedures such as coronary artery bypass grafts and cataract surgery.

In all, the Council found that public hospitals had made progress on only three out of eight key performance benchmarks, and no State or Territory had met all their targets for elective surgery or emergency department performance in 2013.

Council Chair John Brumby said the results were concerning.

While emergency departments in NSW, Victoria and Western Australia had partially achieved their targets, no jurisdiction had reached the goals set for treating, discharging or referring patients within four hours, Mr Brumby said.

"In turn, this means it is almost impossible for any State or Territory to achieve the agreed 2015 performance outcome," he said.

Regarding elective surgery, the Council found that several jurisdictions performed well – the ACT achieved eight out of nine benchmarks, NSW seven and South Australia six.

"However, other states and territories did not perform well, and results in Tasmania and Queensland were particularly concerning, with both states achieving just one agreed benchmark," Mr Brumby said.

A/Professor Owler said the results highlighted the stress public hospitals were under coping with growing demand.

"It comes down to the capacity of the public hospital system," he said. "You can't provide the number of services that we need to provide as doctors in the hospitals, because the capacity is not there. More funding and resources are needed."

Under the National Health Reform Agreement negotiated by the previous Federal Government, the Commonwealth, state and territories would share responsibility for funding public hospitals.

But in the Budget, the Abbott Government disavowed public hospital funding guarantees made under the Agreement, and dumped the efficient growth dividend system of payments due to commence in 2017-18, replacing it with a basic CPI plus population growth indexation arrangement.

The AMA has estimated the changes will rip $20 billion out of public hospitals over five years.

A/Professor Owler said the Agreement had ended the hospital funding blame game between the Commonwealth and the states, and its abrogation risked reigniting it.

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Hospital funding cuts risk reigniting short-sighted blame game

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More importantly, he said, the decision to axe $100 million of reward funding and change the indexation formula meant the Federal Government's contribution was "going to be a long way short of the sort of funding that we need to fund public hospitals and provide the sort of capacity that we're going to need to look after a growing and ageing population".

"This is not the time to cut public hospital funding. The hospitals must be funded and equipped to build capacity to meet current and future demand," the AMA President said.

A/Professor Owler said it was also disappointing that the changes meant a move away from the activity-based funding system that had been established.

He said the most significant aspect of the system was the improvements in care that it drove.

"ABF was all about trying to get a more efficient health system," the AMA President said. "It was a system that reduced things like unwarranted clinical variation, that made people look at the efficiencies of the services that they provided to try a drive a sustainable health system."

"To go away from ABF means not only that we have wasted an enormous amount of time and effort in getting that program to where it is now, but we ignore the benefits in terms of sustainability and trying to reduce the requirements for funding for our public hospital system."

He said the decision to abolish organisations like the COAG Reform Council and the National Preventive Healthcare Agency would make it harder in future to make informed decisions regarding health policy.

A/Professor Owler said the sort of information and analysis provided by the Council was what "we actually need to drive health policy in the future, not the sort of ideas that get floated as thought bubbles and then come out as a Federal Government Budget proposal".

Adrian Rollins

COMMENT

$250,000 medical degrees risk undermining health care

Medical students face graduating with debts of more than a quarter of a million dollars under the Federal Government's decision to deregulate university fees and reduce support for course places, undermining the attractiveness of specialities like general practice and exacerbating doctors shortages in rural and regional areas, the AMA has warned.

In a forthright letter to Education Minister Christopher Pyne, AMA President Associate Professor Brian Owler has cautioned that the changes were likely to lead to much higher medical course fees, encouraging aspiring doctors to select specialties and work locations that are better paid, and discouraging many students from lower socioeconomic backgrounds from entering medicine.

Under the Government's changes, university fees will be deregulated from 2016, the Commonwealth's contribution to course costs will be cut by an average of 20 per cent, and interest on student loans will be raised from the current CPI level to the 10-year Treasury bond rate (with a maximum annual rate of 6 per cent). Universities will be blocked from charging domestic students any more than they do international students.

A/Professor Owler said that, given the strong demand for medical school places, it was reasonable to expect domestic students will be asked to pay the same course fees as international students, offset to a reduced extent by the Commonwealth's course contribution.

"This would leave a medical student with a debt of over $259,000 plus interest once they have completed both [a Bachelor of Medical Science and a Doctor of Medicine] degree," the AMA President wrote. "On any measure, this is a significant debt and, no matter what upfront loan assistance is provided, it will deter students from low income backgrounds from entering medicine."

He warned Mr Pyne that, unless revised, the Government's changes would have a perverse effect on the composition and distribution of the medical workforce, undoing years of effort and investment in building a socially, culturally and geographically diverse medical profession well placed to provide care for patients from a wide range of backgrounds and areas.

There has been a significant expansion in medical school places, and Health Workforce Australia predicts that by 2025 there will be enough doctors to meet aggregate demand for care.

But variations in the distribution of doctors by specialty and location mean there are likely to be shortages of particular skills and in specific regions.

"Encouraging doctors to work in these areas and specialities will be much more difficult if they are saddled with high levels of debt," A/Professor Owler said. "We know in medicine that a high level of student debt is an important factor in career choice – driving people towards better remunerated areas or practice and away from less well paid specialties like general practice.

"[High levels of student debt will undermine] the significant effort that has been made by the Commonwealth to expand doctor numbers, as well as attract graduates to work in underserviced communities and specialties."

In addition, the AMA President expressed concern about the future composition of the medical workforce under the Government's fee changes.

He said one of the strengths of Australia's medical education system was the selection of students from diverse backgrounds, given that entry to medical school was based on merit rather than financial capacity.

There was good evidence, A/Professor Brian Owler said, that the prospect of high fees and substantial debt deterred people from lower socioeconomic backgrounds from entering university.

"If we are to deliver a medical workforce that meets community needs, it is important that we strike the right balance in who is selected for medicine so as to ensure that people from different backgrounds are well represented," he said.

The AMA has asked for a meeting with Mr Pyne to discuss its concerns and work on ways to avoid perverse outcomes from the deregulation of fees.

Adrian Rollins

COMMENT

Axing health workforce agency must not come at expense of planning

The decision to axe Health Workforce Australia and absorb its functions within the Health Department must not come at the expense of the considerable momentum and expertise around health workforce planning that has been developed in the past five years, the AMA has said.

The Senate has launched an inquiry into the Federal Government's decision, detailed in the Budget, to abolish HWA at a time when crucial work is being undertaken to improve the planning and coordination of medical training amid concerns of inadequate prevocational and vocational training places.

In a written submission to the Senate Community Affairs Legislation Committee inquiry, AMA President Associate Professor Brian Owler said that, with the Government determined to axe HWA, the focus of effort "must be on ensuring that [its] functions and programs are preserved without any loss of momentum during [the] transition process".

The need for well-informed and coherent health workforce planning becoming glaringly obvious in the late 1990s and early 2000s when the working presumption of policymakers that the country had an over-supply of doctors was shown to be glaringly wrong.

There was a subsequent major ramp-up in medical school places, and focus has now shifted to the later years of medical training and the need for a significant increase in intern, prevocational and vocational places to give medical graduates the opportunities they need to complete their training.

> "...the report warned a significant bottleneck in access to vocational training would develop by 2016, and there would also potentially be a shortage of Residential Medical Officer training places"

In its landmark *Health Workforce 2025* report, HWA projected that by the middle of next decade there was likely to be sufficient doctors to meet overall community demand, though it predicted there would be shortages in particular areas and specialties.

And the report warned a significant bottleneck in access to vocational training would develop by 2016, and there would also potentially be a shortage of Residential Medical Officer training places.

In his submission to the Senate Committee, A/Professor Owler said there was also emerging evidence of a shortage of public sector positions for new Fellows in a number of specialties, such as anaesthetics.

Following the HWA report, the National Medical Training Advisory Network was established last year to identify and address looming bottlenecks in the training pipeline.

The Network is advising on the preparation of a report that will update the HWA's original findings and projections, and is developing a National Medical Training Plan.

A/Professor Owler said the Network had the potential to carry on much of the work that had been undertaken by HWA, but a crunch point in medical training planning was rapidly approaching.

"Its work is taking on an increasing urgency due to the shortage of vocational training posts…and the fact that the advertising of posts and applications for entry to vocational training in 2016 will occur in mid-2015," the AMA President warned. "This leaves only a year for substantial work to be done that can inform vocational training numbers and guide doctors' career choices."

He said the Committee needed to reassure itself that the Health Department had the plans and resources in place to ensure that there was no disruption or loss of momentum to the workforce planning and coordination work that HWA had undertaken.

"We are now in a position where that information, advice and capacity enhancement is being delivered by HWA, and we must not lose this momentum," A/Professor Owler said.

Adrian Rollins

COMMENT

GPs face a Clayton's Medicare increase

The financial pressure on general practitioners will ease a little next month when a two per cent increase in the Medicare rebate for a number of services comes into effect.

The long-awaited increase, which was originally due last November until the previous Government deferred it until 1 July this year, will help go some way to ameliorate rising practice costs.

> "The Government must recognise that the cost of providing medical services increases each year, as practice costs increases, and that the single fee charged by the doctor has to cover expenses"

But AMA President Associate Professor Brian Owler said the modest increase was inadequate and would be quickly overtaken by increasing expenses and cuts – including the $5 reduction in Medicare rebates introduced as part of the $7 co-payment for Medicare services.

"The Government must recognise that the cost of providing medical services increases each year, as practice costs increases, and that the single fee charged by the doctor has to cover expenses," A/Professor Owler said. These expenses include staff wages, rent, utilities, insurance, professional development and accreditation costs and supplies.

The AMA President said that in announcing the rebate increase the Government was engaging in "sleight of hand", because of the $5 rebate cut and the imposition of the $7 co-payment.

He added that Medicare rebates for a range of other services, including specialist, consultant physician and psychiatry consultations, operations and anaesthesia, were last indexed in 2012 and the Government had no plans to index them again until mid-2016.

"That's an almost four-year freeze [on] the rebate the Government will pay towards the cost of specialist medical treatment," A/Professor Owler said, and warned that private insurers might similarly put their rebates on hold, potentially hitting more health fund members with out-of-pocket costs.

The two per cent increase will apply to the following Medicare schedule items from 1 July:

- Group A1 – general practitioner attendances;
- Group A5 – prolonged attendances on a patient in imminent danger of death;
- Group A6 – group therapy;
- Group A7 – acupuncture – only GP items;
- Group A11 – urgent attendance after hours – only GP items;
- Group A14 – health assessments;
- Group A15 – GP management plans, TCA and case conferencing – only GP items;
- Group A17 – domiciliary and residential management reviews;
- Group A18 – GP attendances associated with PIP payments;
- Group A20 – GP Mental health Treatment;
- Group A22 – GP after-hours attendances;
- Group A27 – pregnancy support counselling;
- Group A29 – early intervention services for children with autism or pervasive development disorder or disability – only item 139 for GP management plan;
- Group A30 – telehealth attendances; and
- Group M1 – bulk billed incentives.

The indexation of all other Medicare items will be frozen for a further two years.

Adrian Rollins

COMMENT

Doubt cast on medical research fund claims

The Federal Government has been accused of being removed from reality with its claims that the $20 billion Medical Research Future Fund will ensure the financial sustainability of the health system.

In a major speech defending the Budget, Treasurer Joe Hockey declared the Fund could lead to medical breakthroughs that would improve lives and cut costs.

"We must find new cures and treatment to make our health system sustainable and affordable into the future," Mr Hockey said. "By contributing now through sensible savings in our health Budget, we can become a global leader in medical research."

Under the Government's plan, money raised from the $7 Medicare co-payment and other sources will be directed into the Fund, which will provide around $1 billion a year for medical research from 2022-23.

But AMA President Associate Professor Brian Owler is among sceptics concerned that the Government is taking money from primary health to help pay for research.

A/Professor Owler, who has experience in clinical research, said he had first-hand experience of how difficult it is to attract research funding, having spent "countless hours writing research grants".

"So I understand the problems with research, and the AMA very much supports extras funding for research, but taking money out of primary health care and putting it into tertiary-level research is not the answer to the sustainability of the health care system," the AMA President said.

"To think that, as the Treasurer said, we're going to solve the sustainability of the health care system by coming up with a whole bunch of cures for diseases so that people won't have to go to hospital…is a step out of the reality of what happens in research.

"Research is the hard grind, [it is] the international piece of work where progress is slow, it's hard-fought and it's something that's not going to solve the sustainability of the health care system."

Walter and Eliza Hall Institute of Medical Research Director Professor Douglas Hilton thought that while the way the Fund was to be financed could be debated, putting money into medical research was a good investment for the country.

Commonwealth Chief Scientist Professor Ian Chubb, who said he was not consulted about the creation of the Fund, told ABC television that, to be most effective, the Fund should not be too narrow in its focus.

Professor Chubb said that, instead of spreading the funds thinly over research projects, it should be used to finance the "big things" the country needs to do.

"We need to be able to fund clinical trials on a scale, we need to translate the results of medical research into patient care," he said. "We've not been terribly good at that. We're getting better at it. We start from a pretty low base and this might well be an opportunity to do things in areas and on a scale that we haven't been able to do before. And if we can do that, then it'll be good."

But Associate Professor of Medical Ethics at Flinders University, David Hunter, condemned the Fund as unfair and

unethical, because the co-payment used to finance it would disproportionately hurt the disadvantaged, while most of the research effort was likely to go on treatments that would predominantly benefit the world's wealthy.

In addition, A/Professor Hunter said, it came at the expense of preventive health measures that were likely to be of much greater benefit to the less well off.

He said that, rather than medical research, the Fund should have as its focus health research, particularly on examining ways to improve the health system.

Adrian Rollins

COMMENT

Budget measures add up to bad health policy

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

The health measures in the Federal Budget are almost universally opposed by the people who provide health services in Australia. The AMA is at the forefront of this opposition.

The message is clear: the measures add up to bad health policy.

The health of Australians is too important for health care to be an ideological toy.

While the AMA strongly represents the interests of doctors, we will always put the interests of our patients first. This is our professional obligation. It is why we oppose the Budget measures. They will hurt our patients, especially the sickest and most vulnerable.

Co-payments are the headline item. The AMA is supportive of some co-payments, but not the one proposed by the Government.

The co-payment applies to general practice, pathology, and diagnostic imaging. But there are also two other troubling elements. The first is a $5 reduction in the patient Medicare rebate. The second is the loss of the bulk billing incentives for diagnostic imaging and pathology. These incentives were introduced in 2009 as both fields had been subject to a Medicare rebate freeze for an astonishing 14 years. Unlike in general practice, these bulk billing incentives apply to all patients, not just concession holders.

For pathology, the bulk billing incentive is between $1.40 and $3.40. Not much. The bulk billing rate is around 87 per cent. In around 50 per cent of cases, pathologists never see or have contact with the patient. For outpatients, the specimen may be sent to the lab by the doctor. This makes the copayment logistically impossible and costly to collect. The end result is that the pathologist is now up to $8.40 out of pocket for non-concession patients. This is a real problem - not only for large corporates, but also for small pathology practices that are usually more regionally-based.

In diagnostic imaging, the issues are even more significant. The loss of the 10 per cent bulk billing incentive, as well as the $5 rebate cut, means that radiologists face much greater losses. For a CT scan, that would be $65. The $7 copayment will not make up the shortfall. The patient will have to pay the whole amount for the test and claim the rebate afterwards. Diagnostic imaging practices that provide excellent services in disadvantaged areas will become unviable. This is a big problem for the doctors, their patients, and local communities. It is hardly a small business friendly policy.

Anyone working in health understands the basic premise that prevention is not only better than the cure, but it also makes economic sense. Diagnosing and managing chronic disease properly in general practice keeps patients out of more expensive hospital care. People with chronic diseases are very much affected by the co-payment.

This proposal poses a financial barrier for vaccinations and other preventative health care measures and chronic disease management.

The recent COAG Reform Council report showed that, among the more disadvantaged in society, 12 per cent of people defer or do not see their GP due to cost. That is in the current context of 81 per cent bulk billing. It will significantly increase with a co-payment.

It is already difficult to secure services of GPs for aged care. It is impractical to collect co-payments in this setting, particularly from patients with dementia. It is only likely to drive GPs out of this area. If patients in aged facilities get sick, or can't see a GP, they end up in an emergency department. It's an expensive problem now but would get worse if the co-payment goes ahead.

The gap in life expectancy between Indigenous and non-Indigenous Australians remains high – 9.5 years for females and 10.6 years for males. Indigenous people are three times more likely to die from a potentially avoidable cause. Recent evidence indicates that 12.2 per cent of Indigenous Australians do not access a GP because of cost in the current system. A copayment will hamper our collective efforts to 'close the gap' through Indigenous health care.

The cumulative effects of the $7 co-payment can be significant even for a routine diagnosis.

I have previously used the example of a young woman with a breast lump who needs a biopsy for diagnosis. As the impacts of the co-payment are appreciated, the out-of-pocket costs rise to much greater than $63. Early diagnosis is essential. For some patients, these sorts of costs will deter them from accessing care and completing investigations. The effects

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BUDGETNews

Budget measures add up to bad health policy

... FROM P14

of delayed diagnosis are expensive and often tragic.

What about the common scenario of the patient on warfarin? Not all of these patients will be under the cap of 10 co-payments for concession patients. There is usually a large number of visits, every few days at first, for INR testing to determine whether the blood is too thin or thin enough. That will mean hundreds of dollars in co-payments.

The notion that GPs have the ability to bulk bill is false, especially for practices in more disadvantaged areas. Bulk billing a non-concession patient will mean the GP will be $5 worse off compared to the current situation, and obviously $7 worse off than if they charged the co-payment.

For concession patients - who are least able to pay -the GP will lose $11 per consultation compared to now, or $13 compared to if they decide to charge the $7 co-payment. The Health Minister's suggestion that GPs use the $2 'windfall' from charging the co-payment for standard consultations to offset the losses from bulk billing other patients is not only insulting to the role of GPs, it won't cover the losses.

Another reason for the AMA's response to this proposal is the lack of evidence. Modern medicine is evidence based. We are trained not to accept blind assertions or opinion, or indeed ideology, in determining the best treatment without the supporting evidence.

For months, Australians were pre-medicated for the Budget on the narrative that Australia has a budget emergency, with the finger of blame pointed at an out of control health budget.

The health budget is not out of control. As a proportion of GDP, Australia's health care spending has remained constant. In 2011 it was 8.93 per cent compared to the OECD average of 9.3 per cent. The proportion of this contributed by the Federal Government expenditure remains constant at around 41 per cent. As a proportion of Federal Government expenditure, health expenditure has actually fallen from 18.1 per cent in 2006-07 to 16.1per cent in 2012/13. There is no evidence that health is progressively consuming either Federal or State budgets.

The co-payment is unfair and unnecessary. Ideology has pushed this proposal too far. It is poor health policy. The Prime Minister should step in and scrap this policy. If not, it deserves to fail in the Senate.

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.

Flattery can be costly

When an AMA member recently received a "very assertive and convincing" call that he had been nominated by a colleague for membership of an international association, he was initially flattered, if more than a little suspicious.

The fact that the call came through on his mobile number, which he believed was private, made him cautious, and when he checked with his colleague, they knew nothing about such a nomination.

The member's caution was well-founded.

Doctors and medical practices are regular targets of scams and dubious practices, and in this case it involved an organisation offering grades of membership starting at something low like 'associate', moving up to higher grades such as 'silver' or 'gold'.

They try to pressure and flatter their targets into purchasing a high level, very expensive membership, which they claim is appropriate to the person's professional and personal status. They may be promised inducements like a listing, along with a certificate or a book or other publication.

The AMA has warned that the vast majority of these calls originate overseas and do not involve reputable organisations.

AMA legal officer John Alati urged members not to act on such calls.

"You will normally receive nothing for your money," Mr Alati warned. "At most, you may receive a dubious 'membership' to a meaningless, online 'association'. Further, you will be giving your personal details to an unknown organisation which is unlikely to adhere to Australian privacy laws."

The doctor who contacted the AMA was curious as to how the organisation had obtained his mobile number as well as the name of his colleague.

"We don't know for sure," Mr Alati said. "But web sites which link people are a fairly easy way to get the names of people who know you professionally. Being called on your mobile can lend an air of personal contact and catch you off guard.

"Mobile numbers are not difficult to obtain either. For example, it may be that a mobile app can collect your number and distribute it to unknown destinations."

If members received such calls, Mr Alati said the AMA's advice was to "never agree to anything on the spot".

"Always take time to consider your options, do some research and make a calm, considered decision as to whether the product on offer is worth the price, or indeed anything at all," he said. "You can also ask the caller where they obtained your information, but don't expect a straight answer."

He urged members who have experienced or heard about scams, rip-offs and other dubious business practices to contact the AMA.

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.

Tobacco industry claims snubbed out

AMA President Associate Professor Brian Owler has condemned *The Australian* newspaper for promoting discredited tobacco industry claims that plain packaging laws are not working.

A/Professor Owler called on *The Australian* and other media outlets to stop giving the tobacco industry a "free ride", saying official figures contradicted manufacturer claims that cigarette sales had increased since the introduction of plain packaging laws, and instead showed consumer spending on cigarettes and other products had slumped to its lowest level on record.

Debate about plain packaging laws has been reignited, with two Government backbenchers telling *The Australian* the legislation should be revisited as part of a push against Government intervention in people's lives, and Assistant Health Minister Fiona Nash reserving her judgement on the issue.

In the latest phase of its global campaign to prevent other countries from following Australia's lead and adopt plain packaging, cigarette companies have asserted that the volume of tobacco sales has climbed marginally by 0.3 per cent since the introduction of plain packaging in late 2012, casting doubt over the effectiveness of the measure.

But A/Professor Owler said the smoking debate was "not about politics or ideology, it is about life and death".

He said the latest official gross domestic product data from the Australian Bureau of Statistics told a sharply different story, showing the amount spent on tobacco products had slumped 5.3 per cent since plain packaging was introduced, dropping to $3.298 billion in the first three months of this year – the lowest level since records began in 1959.

Backing his argument, the Health Department last week released figures showing tobacco clearances (which reflect tobacco imports) fell by 3.4 per cent last year, the first full year since tobacco plain packaging was introduced.

Far from being a failure, A/Professor Owler said, the figures and other research demonstrated the effectiveness of plain packaging in helping control tobacco consumption – a point reinforced by the vast resources the tobacco industry was throwing into its campaign to have the laws overturned in Australia and blocked elsewhere.

"The tobacco companies attack plain packaging because it is working, and they do not want other countries following Australia's lead," he said. The ground-breaking tobacco plain packaging laws, which were supported by both sides of politics, put Australia at the forefront internationally in the battle against smoking."

The fight against plain packaging has developed into the biggest trade dispute in the history of the World Trade Organisation.

A three-member panel appointed by the WTO has begun hearings into complaints from five tobacco producing countries that Australia's plain packaging laws breach international trade obligations on the protection of intellectual property. So far, 35 other countries have joined the dispute as third parties, concerned about its implications for the ability of countries to take public health measures.

Among the claims being made by industry is that, instead of giving up the habit, smokers are instead swapping to cheaper brands. A report in *The Australian* cited a report by research firm InfoView showing that the market share of cheaper cigarettes had climbed by 32 to 37 per cent since plain packaging was introduced.

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Tobacco industry claims snubbed out ... FROM P17

But a study of plain packaging undertaken by Sir Cyril Chantler on behalf of the United Kingdom Government found that the phenomenon of smokers trading down to cheaper cigarettes was the continuation of a well-established market trend.

While admitting there were limitations to the evidence about the likely effect of plain packaging on tobacco consumption, Sir Cyril found industry arguments that it would make cigarettes cheaper and drive the market in illicit tobacco unconvincing.

"Having reviewed the evidence, it is in my view highly likely that standardised packaging would serve to reduce the rate of children taking up smoking, and implausible that it would increase the consumption of tobacco. Branded packaging plays an important role in encouraging young people to smoke," Sir Cyril concluded.

"I am satisfied that the body of evidence shows that standardised packaging, in conjunction with the current tobacco control regime, is very likely to lead to a modest but important reduction over time on the uptake and prevalence of smoking, and thus have a positive impact on public health."

Adding to the pressure on the tobacco industry, the Irish Government has endorsed tobacco plain packaging legislation, making it the first country in the European Union to move to adopt the measure, and only the third country – behind Australia and New Zealand.

If enacted, the Irish legislation would remove all forms of branding from tobacco packaging, except for the brand and variant name in a uniform typeface.

Tobacco companies have indicated they will challenge the legislation, but Dr Pat Doorley of the Royal College of Physicians of Ireland told *The Irish Times* the initiative would prevent younger people from taking up smoking.

"A study conducted by the Irish Cancer Society and the Irish Heart foundation indicates that teenagers find plain packaging less appealing," Dr Doorley said.

Adrian Rollins

COMMENT

Let's get rid of the stigma around mental illness: AMA

The AMA is developing a campaign to reduce stigma around mental health issues within the medical profession, and is helping develop a range of support services for doctors and medical students experiencing depression, anxiety and other mental health problems.

The AMA made the commitments following a roundtable discussion on the mental health of medical professionals hosted by the Association and mental health campaign and advocacy group *beyondblue*.

GP Network News reported that AMA President Associate Professor Brian Owler and Vice President Dr Stephen Parnis attended the roundtable, at which *beyondblue* representatives detailed the results of their landmark survey of the mental health of doctors and medical students.

The survey, which drew on responses from 14,000 doctors and medical students, found that many have contemplated suicide or are suffering severe psychological distress and burnout.

In a result with major implications for how workload, occupational demands and resources are managed, the study found 20 per cent of medical students and 10 per cent of doctors had had suicidal thoughts in the preceding 12 months – rates much higher than the broader community - and a quarter of all doctors were likely to have a minor psychiatric disorder, such as mild depression or anxiety.

Significantly, the survey found that although members of the medical profession were far more likely than the general community to be suffering significant psychological distress, they were very reluctant to seek help because of stigma surrounding mental health problems.

As a result of the roundtable, the AMA has committed to developing a campaign to reduce the stigma attached to mental health problems within the medical profession, and to working with the Medical Board of Australia and the Australian Doctors' Network on the implementation of a range of mental health support services.

In addition, the Association will provide a mental health toolkit accessible through its Dr Portal website. Several resources to assist doctors and medical students struggling with mental health issues are already available through the AMA website at: https://ama.com.au/doctorshealth

Adrian Rollins

COMMENT

Medical profession prominent in honours list

Almost 30 AMA members have been recognised for their devotion to their communities and their service to the medical profession in a string of Queen's Birthday honours awarded earlier this month.

The nation's highest honour, Dame in the Order of Australia, was awarded to psychiatrist and New South Wales Governor Dr Marie Bashir for what Prime Minister Tony Abbott described as "a lifetime of achievement".

"She has been an advocate for the disadvantaged and marginalised in the community, particularly those with mental illness," Mr Abbott said. "Her contribution has also lifted the quality of health care in the Asia Pacific region, training and inspiring many medical practitioners to provide life-changing health care to so many."

GPs, medical researchers, specialists and public health experts were also recognised in the honours list.

Florey Institute paediatric neurologist Professor Ingrid Scheffer, who is at the leading edge of research into the identification of epilepsy syndromes and genes, was named as an Officer of the Order of Australia for her decades of work as a clinician, academic and mentor as well as her research.

Deputy Commissioner of the Mental Health Commission of NSW, Professor Alan Rosen, was another recipient of the Officer of the Order of Australia award in recognition of his enormous contribution to the development of the nation's mental health sector.

Medical ethicist and Professor of Medicine at Monash University Paul Komesaroff was made a Member of the Order of Australia for his enormous contribution to the medical community, both in Australia and abroad, particularly his investigations into the social and cultural dimensions of health and health care, and his ability to build multidisciplinary collaboration, both nationally and internationally.

Former AMA Vice President Dr Gary Speck was also made a Member of the Order of Australia for his significant contribution to medicine as an orthopaedic surgeon, for his dedication to the medical profession through his work at the AMA and other professional organisations, and his services to Government.

James Cook University professor of obstetrics and gynaecology Professor Caroline De Costa was another AMA member created a Member of the Order of Australia in recognition of her outstanding contribution to medicine, particularly her work on Indigenous and women's health issues. Among her work, she is researching ways to reduce the incidence of foetal alcohol syndrome in Indigenous communities in far north Queensland.

Other AMA recipients of Queen's Birthday honours for 2014 were:

NEW SOUTH WALES

Professor Barry Baker AM

Professor Peter Fletcher AM

Professor Geoffrey Driscoll OAM

Dr Francis Cheok - AMA OAM

Dr Cameron Henderson OAM

Dr Yusufali Khalfan OAM

SOUTH AUSTRALIA

Professor Peter Charles Blumbergs AO

Professor Leslie Cleland AM

VICTORIA

Dr Jonathan Gareth Burdon AM

Dr David Griffiths Campbell AM

Professor Richard George McLean AM

Professor Henry Miles Prince AM

Professor Jeffrey Szer AM

Professor James Tatoulis AM

Dr James Allan Mawdsley OAM

Dr Andrew David Pattison OAM

Dr John David Scarlett OAM

AUSTRALIAN CAPITAL TERRITORY

Professor Michael Levy, AM

Dr Peter Hughes - OAM (former AMA ACT President and Fellow of the AMA)

WESTERN AUSTRALIA

Dr Alastair Alexander Mackendrick – OAM

QUEENSLAND

Professor Ian Wronski AO

Dr Zelle Carmel Hodge AM

Adrian Rollins

COMMENT

End persecution of colleagues overseas: AMA

The AMA is urging Prime Minister Tony Abbott to bring pressure to bear on the Turkish and Sudanese governments over the persecution of medical professionals, including a young mother of two facing execution.

AMA President A/Professor Brian Owler has written to Mr Abbott calling on him to intervene over the fate of young Sudanese doctor Merian Yeyha Ibrahim, who is being held on death row on charges of apostasy and adultery.

In what A/Professor Owler said was a barbaric violation of human rights, Dr Ibrahim was imprisoned in August last year after being convicted of adultery, apostasy (abandoning a belief or principle), for having married a Christian, asserting that she is Christian, not Muslim, and for refusing to recant her faith.

She was raised by her mother as an Orthodox Christian but under Sudanese law a child must follow the father's religion. It has meant that her marriage to Daniel Wani, a Christian, has not been officially recognised.

Dr Ibrahim was sentenced to 100 lashes for adultery, and condemned to death for apostasy. Adding to the cruelty of her treatment, she was imprisoned while pregnant and recently gave birth to her daughter while incarcerated, A/Professor Owler said. Her 20-month-old son is also in prison with her.

"She is a prisoner of conscience, not a criminal, and should be released immediately," the AMA President said.

Dr Ibrahim's case has already drawn international attention, with numerous governments and organisations including the World Medical Association (WMA) and the British Medical Association demanding that her convictions be overturned and she be released.

Under Sudanese law, a woman sentenced to death is allowed to nurse her child for two years after birth before an execution can proceed, and lawyers are appealing her conviction.

A/Professor Owler has also urged Mr Abbott to pressure Turkish authorities to abandon legal action being taken against two doctors who provided emergency treatment for protestors injured during anti-government demonstrations last year.

The doctors, Selcan Yuksel and Erenc Yasemin Dokudag, were charged with "praising a criminal, insulting religious values and damaging a mosque" after they attended to protestors who had been taken to the Bezm-I Alem Valide Sultan Mosque in Istanbul after suffering contusions and broken bones in clashes with security forces.

A/Professor Owler said the doctors were "doing what they trained to do – care for the injured".

He said the Federal Government should demonstrate support for the principle of medical neutrality by officially requesting that Turkish authorities drop the case against the doctors.

"Throughout the world, in times of peace and conflict, doctors must be allowed to care for those in need, impartially and without discrimination, and without fear of persecution or punishment for complying with their ethical obligations," the AMA President said.

"The AMA and the WMA have particular concerns about a new Turkish health law that criminalises emergency medical care and requires routine reporting of all confidential patient information to state authorities."

Late last month the AMA National Conference unanimously adopted a resolution advocating the right of doctors to render care without fear of persecution and calling on Turkish authorities to drop the legal action against the two doctors and scrap the new health law.

> "Throughout the world, in times of peace and conflict, doctors must be allowed to care for those in need, impartially and without discrimination, and without fear of persecution or punishment for complying with their ethical obligations"

There is mounting international concern over the treatment of Dr Yuksel and Dr Dokudag, which has been the subject of protests from the WMA and 10 other international medical organisations.

A/Professor Owler said that support for the Turkish doctors would "send a strong signal to the world that doctors and other health professionals should not be impeded in their duty of care to the sick and injured".

In addition to its representations to Mr Abbott, the AMA has written to the President of the Republic of Sudan, Omar Hassan Ahmad al-Bashir, about the plight of Dr Ibrahim, and has expressed its concerns about the treatment of the two Turkish doctors directly with the Turkish Ambassador to Australia, Reha Keskintepe.

Adrian Rollins

COMMENT

How to hang out the shingle, ethically

Doctors should be up-front and accountable about any money or other material benefit they get for promoting products and services, and must always put the interest of their patients first, the AMA has said.

Releasing revised guidelines on how to ethically advertise and endorse products and services, AMA President Associate Professor Brian Owler said the overriding duty of doctors was to act in the best interests of their patients, and to do this they must "maintain their professional autonomy, clinical independence and integrity".

In particular, A/Professor Owler said, doctors must not allow relationships with industry to compromise, or be seen to compromise, their professional judgement, their ability to serve their patient's best interests or damage the community's trust in the integrity of the medical profession.

Just how high that standard is was revealed in a poll of 1206 adults commissioned by Reader's Digest survey that found doctors were among the most trusted professionals, just behind paramedics, firefighters, rescue volunteers and nurses.

Significantly, doctors and medical researchers headed the list of the nation's most trusted people. Neurosurgeon Dr Charlie Teo received top ranking as a person of integrity, followed by burns specialist Professor Fiona Wood and immunologist Professor Ian Frazer.

In its *Position Statement on Advertising and Public Endorsement*, the AMA said doctors could advertise their services, but only in a way that did not compromise patient care or the standing of colleagues or the profession.

"The chief purpose of advertising …medical services is to present information reasonably needed by patients, doctors and other health care professionals," the Position Statement said. "For example, factual information about professional qualifications, services and practice arrangements."

It said any advertising should be truthful, factual, should not attempt to make patients apprehensive or fearful about their health, should not exploit a lack of medical knowledge, should not disparage other medical services or products, and should not make claims of superiority.

In particular, the guidelines make clear doctors should not solicit testimonials, and the offer of gifts, discounts or prizes in advertising was "not appropriate".

The AMA said it was not unethical for a doctor to receive money or other material benefit for promoting a product or service, but only as long as they were transparent and accountable about the arrangement.

This could be a particularly sensitive issue in the care of individual patients, and the AMA advised that doctors should only recommend products and services based on the needs of the patient, rather than any commercial interest.

Where the doctor did have a financial interest, the Position Statement said, the doctor had an obligation to disclose it to their patient at the time.

The AMA urged doctors to be careful in promoting products and services, and to avoid endorsing medicines and medical devices directly to the public.

It warned that the public's high regard for the medical profession meant that "commercial entities" would seek out doctors to promote their products and services.

It said doctors should not have any public association with products that clearly harmed health, and should be cautious about promoting health services such as pharmacies, nursing homes or private clinics, as well as products and services not directly related to health care.

The Position Statement can be viewed at: https://ama.com.au/position-statement/advertising-and-public-endorsement-2004-editorially-revised-2006-revised-2014

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.

Govt heeds AMA on veteran health

The health of returning Australian Defence Force personnel and their families will be the focus of a major Commonwealth research effort following calls at the AMA National Conference for improved understanding of, and provision for, the health needs of returning servicemen and women.

The Federal Government has announced the establishment of a $5 million Transition and Wellbeing Research Programme, which will include a study into the mental health and wellbeing of both active and retired ADF personnel, a project examining the effect of combat experiences on personnel deployed in the Middle East between 2010 and 2012, and an investigation of the effect of military service on the families of current and former ADF personnel.

The research program is seen as timely given the recent wind-down of Australia's involvement in several overseas conflicts, particularly in Afghanistan.

AMA President Associate Professor Brian Owler said the ADF had, since 1999, been through an extended period of high operational tempo during which more than 45,000 personnel had seen active service overseas including Afghanistan, Iraq, other areas of the Middle East, South Sudan, East Timor, and Papua New Guinea.

At the AMA National Conference late last month, A/Professor Owler chaired a policy discussion on health care for current and former ADF personnel, and said it was clear that while the country was getting many things right in the care it provided to its troops and veterans, there was room for improvement.

"We must do everything we can to support those who return with service-related injuries," A/Professor Owler said. "The research to be funded by the Government is important because it will allow us to identify emerging health issues and better inform the future delivery of health services."

In addition to the research program, the Government has announced that, from 1 July, a new Medicare Benefits Schedule item will be provided for GPs who use a screening tool in assessing the health of former ADF members for up to five years after discharge, a move long suggested by the AMA.

ADF personnel are often reluctant to disclose injuries, particularly mental health problems, A/Professor Owler said, and may even keep them hidden for many years after leaving the ranks, often making the condition worse.

The AMA President said the new health assessment item was an important initiative that would help encourage veterans to come forward and access treatment earlier.

"We are pleased the Government has taken up the AMA's call for an assessment item to make it easier for veterans to access services," he said. "We need to do as much as we can to look after those who have served. We don't want to see a repeat of the sort of treatment veterans have received in the past."

The Conference was told that changes in the nature of conflict and advances in frontline medical care meant many soldiers were surviving injuries that would once have been fatal.

But, as a consequence, many were returning home with much more severe physical injuries, such as amputations, multiple severe wounds, hearing loss, fractures and traumatic brain injuries.

Immediate-past ADF-Reserves Surgeon General Major General Professor Jeffrey Rosenfeld said the prevalence of bomb attacks in modern warfare could inflict particularly severe injuries.

In addition, the Conference heard that many ADF personnel suffered mental health problems as a result of their service, with around 50 per cent of all ADF personnel expected to experience some form of stress disorder.

Navy psychiatrist Commodore Duncan Wallace said research showed that post-traumatic stress disorder, in particular, was much more common among Defence personnel. The 12-month prevalence of PTSD among ADF members was 8.3 per cent, compared with 5.2 per cent in the broader population, and the incidence of obsessive-compulsive disorder among ADF personnel was more than twice that of Australians in general.

Commodore Wallace said the extent of depressive disorders among ADF personnel was particularly marked – a 6.4 per cent it was more than twice that in the general population.

He and former Army chief Lieutenant General Peter Leahy told the Conference that one of the biggest problems was getting returned Defence personnel with mental health issues to admit they had a problem and seek help.

Lieutenant General Leahy said among soldiers there was a stigma attached to admitting they had a mental health problem, and Commodore Wallace cited research showing that almost 37 per cent delayed seeking help because they feared it would prevent them from being redeployed, 27 per cent felt such an admission would harm their career prospects, 27 per cent were concerned others would treat them differently, and 25 per cent thought it would make them seem weak.

He said that despite improvements in recent years, there remained problems for soldiers leaving the ADF to access Department of Veterans' Affairs services, and there was a lack of support for the families of returned servicemen and women during what could be a difficult transition to civilian life.

A/Professor Owler said the AMA was keen to work with the ADF, the Department of Veterans' Affairs and personnel and veterans themselves on ways to improve the delivery and integration of services, so that all get the care they need."

A resolution passed unanimously by the AMA National Conference called for research to monitor the health of ADF personnel and veterans injured during ADF operations, to identify emerging health issues and better inform the future delivery of health services; the development of seamless health care delivery for ADF personnel and veterans; the development of a unique service/veteran health identifier; and the potential for existing non-liability health care arrangements for veterans to be extended to a broader range of conditions.

Adrian Rollins

COMMENT

EXPRESSIONS OF INTEREST

MEMBERSHIP OF THE ADVISORY COMMITTEE ON MEDICINES SCHEDULING (ACMS) AND THE ADVISORY COMMITTEE ON CHEMCIALS SCHEDULING (ACCS)

Medicines and chemicals scheduling is a classification system that controls how substances will be made available to the public. Medicines and chemicals are grouped into Schedules that require similar regulatory controls over availability to protect public health (e.g. Schedule 4 – medicines only available on prescription; Schedule 5 – substances requiring appropriate labelling and packaging).

The Department of Health is seeking expressions of interest from experts interested in contributing to the work of the national scheduling framework via membership on the Advisory Committee on Medicines Scheduling (ACMS) or the Advisory Committee on Chemicals Scheduling (ACCS).

ACMS and ACCS

ACMS and ACCS are statutory expert advisory committees under the Therapeutic Goods Act 1989. They are responsible for providing advice to the Secretary of the Department of Health on the level of access required for medicines and chemicals.

To be considered for a position on either of these committees, applicants should have expertise in an area relevant to the assessment of substances that warrant restricted access.

Specifically for the ACMS, applicants should have expertise in at least one of the following fields:

- regulation of scheduled medicines in Australia
- toxicology or pharmacology
- clinical pharmacology
- pharmacy medicines
- medical practice
- consumer health issues relating to the regulation of therapeutic goods
- industry issues relating to the regulation of therapeutic goods.

For the ACCS, applicants should have expertise in at least one of the following fields:

- regulation of scheduled chemicals in Australia
- veterinary medicines or veterinary pathology
- industrial or domestic chemicals
- agricultural or veterinary chemicals
- clinical aspects of human poisoning
- occupational health issues, particularly as a medical practitioner
- consumer health issues relating to the regulation of chemicals.

Remuneration and travel will be determined by the Remuneration Tribunal.

Further information on these positions and to receive an EOI application pack, email SMP.committees@health.gov.au.

EOI are due to the department by 22 June 2014.

Physical activity: it's not all about the World Cup

The Australian public's love affair with elite sport should not blind governments to the need to provide significantly greater support for physical activity across the community, the AMA has said.

In an upbeat message on prospects for the nation's health, the Association reported evidence that people, young and old, appeared to be heeding advice to become more physically active.

But it warned much further work was needed to get more people active and realise the great health benefits and cost savings to be derived from having a physically active population.

The AMA's *Position Statement on Physical Activity 2014*, released last week, cited evidence that more than half of adults took part in physical activity at least twice a week, and almost two-thirds reported being physically active at least once in the previous 12 months.

Meanwhile, each day there was a 69 per cent chance that any given child would undertake at least an hour of moderate to vigorous activity. Altogether, 60 per cent of children take part in at least one organised sport.

Despite these promising signs, most adults continue to live predominantly sedentary lifestyles, meaning there was the chance to realise significant benefits from even a moderate increase in activity.

The Position Statement referred to estimates that a 10 per cent boost in participation in physical activity would save $258 million, with a third of this coming of the nation's health bill.

Being physically active not only helps prevent and manage chronic diseases and debilitating conditions such as cancer, cardiovascular disease, type 2 diabetes and depression, but is vital to the cognitive and social development of children, the Position Statement said.

In recognition of these benefits, current national guidelines recommend adults undertake between two-and-a-half and five hours of moderate activity (or between 1.25 and 2.5 hours of vigorous activity) a week.

For infants, the guidelines underline the importance of floor-based play (and no television). For children aged one to five years, the recommendation is at least three hours a day (with no more than one hour of television or electronic media a day), and for children aged five to 12 years at least an hour of moderate to vigorous activity each day.

The AMA said GPs had a role to play in encouraging patients to get and remain physically active, noting evidence that such interventions can increase physical activity levels in patients for up to six months.

But the effort cannot be left to medical practitioners alone, the Position Statement said.

"Governments also have a responsibility to ensure that all sections of the community have good access to safe physical activity opportunities," it said, including by investing in infrastructure and urban plans that make it easy, safe, convenient and enjoyable to be physically active.

This involved the construction and maintenance of walking a cycling paths, parks and recreational facilities, and the promotion of activity through programs and education campaigns.

"Governments must extend their focus on support for elite athletes to support of more physical activity opportunities for all Australians," the AMA said.

The Position Statement can be viewed at: https://ama.com.au/position-statement/physical-activity-2014

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

Warning over two-tier GP visits, *Sun Herald,* 8 June 2014

An Abbott Government push to allow private health insurers to cover GP visits would create a US-style two tier health system and drive up doctors' fees. AMA President A/Professor Brian Owler said it would be a fundamental change in the way that general practice is funded.

Co-payments may hit nursing homes, *Sunday Age*, 8 June 2014

Doctors groups are worried the already small number of GPs who visit nursing homes to see patients will drop even further when the government implements its planned GP co-payment. AMA Chair of General Practice Dr Brian Morton said only 20 per cent of Australia's GPs currently made trips to nursing homes.

SA just snack away from being fattest, *Adelaide Advertiser,* 12 June 2014

South Australia is close to edging out Queensland to become the fattest Australian state. AMA President A/Professor Brian Owler said more needed to be done to help people manage weight problems and associated chronic illnesses.

New hit to the cost of health, *Adelaide Advertiser,* 13 June 2014

Patients will have to pay up to $1000 upfront for medical imaging such as CAT scans, MRIs and X-rays as a result of a hidden budget blow. AMA President A/Professor Brian Owler said there was a danger patients may put off diagnostic imaging tests if the costs are too high.

Doctors' group accuses Canberra of treating healthcare as 'an ideological toy', *Age*, 19 June 2014

The AMA has demanded Tony Abbott scrap his proposed $7 GP fee. AMA President A/Professor Brian Owler branded the proposed fee as unfair and unnecessary and said it deserved to be voted down in the Senate.

Move it or die, *Courier Mail*, 19 June 2014

Australians are working themselves to death by just sitting behind their desks. AMA President A/Professor Brian Owler said physical inactivity was killing Australians, and that employers had to encourage their staff to move throughout the day.

Medical co-payment belongs on scrap heap, *The Age*, 19 June 2014

The health measures in the federal budget are almost universally opposed by the people who provide health services in Australia. AMA President A/Professor Brian Owler said the health of Australians was too important for health care to be an ideological toy.

Radio

Dr Stephen Parnis, 666 ABC Canberra, 10 June 2014

AMA Vice President Dr Stephen Parnis discussed a report on a medical trial in the US which is pushing the ethical boundaries between prolonging life and death. Dr Parnis said the ethics of the procedure were questionable, as patients were unable to opt out.

Dr Brian Morton, 2UE Sydney, 12 June 2014

AMA Chair of General Practice Dr Brian Morton discussed a study which shows only one in four people leave hospital with the best combination of medicine, lifestyle advice, and referrals for rehabilitation. Dr Morton said there were great outcomes in the Australian health system, but there was a need to add "polish" to it.

A/Prof Owler, 5AA Adelaide, 13 June 2014

AMA President Associate Professor Brian Owler talked about COAG Reform Council's health review. A/Professor Owler said the rate of smoking and heart attacks was decreasing, and obesity was a major issue in SA.

A/Prof Brian Owler, 4BC Brisbane, 13 June 2014

AMA President Associate Professor Brian Owler talked about doctor concerns that patients will put off medical tests because of cost. A/Professor Owler said the proposed Budget co-payments did not just affect GP visits, but also pathology and diagnostic imaging services.

Television

A/Prof Brian Owler, Channel 10 Sydney, 8 June 2014

AMA President Associate Professor Brian Owler talked about the health system, warned of the risk it would head toward a harsher, US-style two-tiered system.

A/Prof Brian Owler, SBS Sydney, 10 June 2014

AMA President Associate Professor Brian Owler discussed calls for a new national approach to the problem of alcohol abuse. A/Professor Owler said it was not just about violence on city streets, but also domestic violence and child neglect.

A/Prof Brian Owler, Channel 10, 12 June 2014

AMA President Associate Professor Brian Owler discussed the COAG Reform Council report. A/Professor Owler explained Australians imagined themselves as active, but the report painted a different picture.

COMMENT

AMA IN ACTION

The AMA's new leadership team, President Associate Professor Brian Owler and Vic President Dr Stephen Parnis have been in the thick of national debate on health policy since assuming their positions. Following up on their meeting with Health Minister Peter Dutton earlier this month, the pair again visited Canberra, this time to meet with Assistant Health Minister Fiona Nash and Australian Greens health spokesman Senator Richard Di Natale, where they presented the AMA's position on a range of pressing issues, most particularly the Budget changes to health funding.

Later this week they are due to meet with Prime Minister Tony Abbott and Shadow Health Minister Catherine King, where the deep concerns within the medical profession about the direction of naitonal health policy will be raised.

In between these and other meetings (including those with specialist colleges and medical organisations), A/Professor Owler, Dr Parnis and other AMA officials, including AMA Council of General Practice Chair Dr Brian Morton, have been busy in the media. A/Professor Owler has conducted two major media conference at Australian Parliament House on the impact of the Budget changes on health care and the COAG Reform Council's report on the performance of the health system. He, Dr Parnis and Dr Morton have also conducted numerous interviews with radio stations, television networks, newspapers and industry publications about health issues of the day.

Adrian Rollins

COMMENT

Talking truth to the Federal Government about the health effects of the Budget: AMA President A/Professor Brian Owler and Vice-President Dr Stephen Parnis meet with Assistant Health Minister Fiona Nash at Parliament House, Canberra

Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
Dr Chris Moy	AMA Member	NeHTA (National E-Health Transition Authority) Clinical Usability Program (CUP) Steering Group	12/6/2014
Dr Brian Morton	AMA Chair of General Practice	Budget Measure Consultation Meeting re: GP training changes	25/06/2014
A/Professor John Gullotta	AMA Representative for NSW and ACT	TGA stakeholder meeting on maintaining currency of medicine product information	26/6/2014
Dr Ian Pryor	AMA Member	MSAC (Medical Services Advisory Committee) Review Working Group for Ambulatory Electrocardiogram for Arrhythmias	10/6/2014
		MSAC (Medical Services Advisory Committee) Review Working Group for Paediatric Surgery	27/5/2014
		MSAC (Medical Services Advisory Committee) Review Working Group for Ambulatory Electrocardiogram for Arrhythmias	29/4/2014
Dr Robyn Langham	AMA Representative for Victoria	Medicines Australia Code of Conduct Review Panel meeting	7/5/2014
Anne Trimmer	AMA Secretary General	Medicines Australia Code of Conduct Review Panel meeting	7/5/2014

COMMENT

The nation's health on the improve, but for how long?

Major declines in infant mortality, heart attacks, rates of smoking and lung cancer cases have helped ensure Australian life expectancy is among the highest in the world.

But the AMA has warned the Federal Budget could undermine recent progress and exacerbate the threat posed to the nation's health by rising rates of obesity, diabetes and other chronic conditions by making it more expensive to see a doctor, obtain medicine or undergo a diagnostic test and by reducing the focus on preventive health measures.

In its final update on the state of the nation's health, the soon-to-be-disbanded COAG Reform Council reported that average life expectancy increased almost a year between 2007 and 2012 to reach 79.9 years, supported by a 22 per cent fall in the child death rate, a 21 per cent decline in deaths from heart attack and stroke, and a 6.4 per cent fall in deaths from cancer.

Cancer has overtaken circulatory diseases to be the leading cause of death.

The increase in life expectancy has been underpinned to considerable extent by the success of anti-smoking policies and campaigns, with little more than 16 per cent of adults lighting up daily – down from 19.1 per cent in 200708.

Aspects of health care have also improved – more than 70 per cent of emergency department patients receive timely treatment, rates of hospital-acquired infections have fallen, fewer people with chronic diseases are ending up in hospital unexpectedly and access to mental health care has improved.

But AMA President Associate Professor Brian Owler said the COAG report also revealed worrying signs of stress in the health system, particularly public hospitals, and highlighted the risk that increasing the cost of seeing a GP, getting medicine or having a pathology or radiology test could undo recent health gains – especially given the nation's increasing weight problem.

"The report shows that public hospitals are already stretched to meet demand," A/Professor Owler said. "Waiting times in emergency departments have improved, [but] elective surgery waiting times have increased nationally, from 34 to 36 days, [and] access to important surgery varies significantly by levels of disadvantage."

Indicating the price sensitivity of a small by significant proportion of the population, COAG reported that 5.8 per cent of patients either delayed or avoided altogether seeing a doctor because of cost (more than 7 per cent outside the major cities), while 8.5 per cent did not have a prescription filled for the same reason – a proportion that rose one in every eight people in the most disadvantaged areas.

A/Professor Owler said these findings reinforced the AMA's concern that the Government's decision to impose a $7 co-payment on GP, pathology and diagnostic imaging services would cause an increasing number of people with health problems to delay seeking treatment, potentially turning a condition that could be readily treated into much more serious and expensive issue later on.

MORE P29

The nation's health on the improve, but for how long?

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"Our worries about co-payments is not about co-payments, per se," he told radio 4BC. "Many doctors already charge them for those that can afford it. But we are worried about those most vulnerable in our society, those in aged care, the young, and those that are the working poor for which these sorts of costs are a significant barrier to them accessing healthcare."

A/Professor Owler said the Government's "poorly-designed" co-payment model would hit patients with a rapidly accumulating medical bill if they were referred for diagnostic tests or prescribed medication.

"The rates for not filling scripts in the COAG report can be expected to increase significantly with increased co-payments for PBS medicines," he said. "This would have serious consequences for downstream health care costs. A similar impact will occur with co-payments for pathology and diagnostic imaging services."

Preventive health measures such as vaccinations and measures to improve physical activity and diet have been a focus of health policy through COAG in recent years, but the results have so far been disappointing, and Associate Professor Owler expressed concern that the Abbott Government's Budget would further undermine progress.

The COAG report found hospitalisation rates for vaccine-preventable conditions surged 16 per cent between 2007 and 2012, while the nation's waistline has expanded to the extent that 62.7 per cent of adults are overweight or obese, and more than 4 per cent of people have type 2 diabetes – a chronic disease associated with poor diet and sedentary lifestyles.

"In the future, Australia's high obesity rates suggest a possible increase in the incidence of type 2 diabetes, given the well-established link between the two," the report said.

Of particular concern, according to the COAG report virtually half of all those with type 2 diabetes – which is most prevalent in disadvantaged areas - were not managing the condition effectively, and only around 10 per cent who knew they had the disease maintained a health body weight.

A/Professor Owler said increasing the cost of seeing a doctor would lower vaccination rates, increasing the number of people with vaccine-preventable health problems who end up in hospital, and would likely undermine the diagnosis and effective management of type 2 diabetes, leading to greater health costs in the longer-term.

"The good news in the report about improved health outcomes is overshadowed by the risks of the Government co-payment model," he said. "The rest of the world is lowering barriers to primary care to improve overall health outcomes and make their health systems sustainable. But Australia is moving in the opposite direction."

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

Rich world eating its way to an early grave

The obesity epidemic sweeping through the world's richest countries has left more than half of all adults overweight or obese and shows no sign of abating.

In an alarming assessment, the Organisation for Economic Co-operation and Development has reported that Australia has the fifth highest rate of obesity among its 34 member countries, exceeded only by the United States, Mexico, New Zealand and Hungary.

More than one in every three adults in Mexico, the US and New Zealand are obese, while in Australia the rate is 28.4 per cent – well in excess of the OECD average of 17.9 per cent.

In a particularly worrying development, the OECD found that Australia was one of just a handful of countries – along with Mexico and Switzerland - where waistlines were continuing to expand at a significant pace. By contrast, in Italy, England and the US rates of overweight and obesity have all-but stabilised.

That said, "there is no sign of retrenchment of the [obesity] epidemic," the OECD intoned in its *Obesity Update* June 2014, warning that this was likely the harbinger of accelerating health costs and morbidity.

It said that for much of human history increasing weight was associated with better health and longer lives, but "an alarming number of people have now crossed the line beyond which further gains are dangerous".

The OECD warned that for every extra 15 kilograms above normal weight that people gained, the risk of premature death increased 30 per cent, and obesity was responsible for up to 3 per cent of health spending in most countries (but up to 10 per cent in the US).

In a sobering prospect for the Abbott Government, which has set itself the task of putting health spending on what it considers to be a sustainable trajectory, the OECD has warned that the full impact of the obesity epidemic is yet to be felt: "Costs will rise rapidly in coming years as obesity-related diseases set in".

Governments confronted with such a serious health issue have adopted a range of measures and tactics. In the US, Medicaid co-payments are waived for patients who meet specific 'wellness' targets, while in the UK the Government sets targets and priorities which businesses voluntarily sign up to.

Several countries have looked to taxes, food labelling and advertising regulations to slow weight gain, with varying degrees of success.

In late 2011, Denmark introduced a tax on saturated fats, which saw many shoppers transfer their custom from higher-priced supermarkets to discount stores. The levy was scrapped after a year. In Hungary, a tax on certain food ingredients pushed the cost of some foods up almost 30 per cent, with a consequent plunge in sales, and about half of food manufacturers responded by simply reformulating their product.

Another approach has been to improve food labelling. The UK has introduced a voluntary, front-of-packet traffic light system, and the EU has made information

MORE P31

Employers warned to prepare for new super system

Employers have been urged to prepare for major changes in the way they make superannuation contributions.

The Australian Taxation Office said its new SuperStream system, which will go into operation from 1 July, will make it simpler and cheaper for employers to make super contributions by eliminating unnecessary variation and complexity in the information required and the means of making payment.

"The need for reform of Australia's superannuation system was highlighted in the 201 Cooper Review, which found the existing processes made poor use of technology, and there was no consistency in the data required and how funds deal with contributions," ATO SuperStream National Program Manager Philip Hind said.

Under the system, all contributions will be made electronically and the ATO said employers would increasingly find that they could use a single channel in dealing with super funds, regardless of how many different ones their employees might contribute to.

"The main benefit for employers is that the SuperStream standard will simplify [their] experience," Mr Hind said. "[It will] reduce costs by eliminating unnecessary variation and complexity that has crept into the system over recent years."

The mandatory new system is being introduced in stages.

Large and medium-sized employers are expected to begin implementing SuperStream by the end of the year and complete implementation by mid-2015, while businesses with fewer than 20 employees will not be required to start using the system until July next year, with implementation to be completed by 30 June, 2016.

"All employers need to introduce changes in the way they currently make super contributions," Mr Hind said, "[though] the ATO will provide flexibility and support to employers making a genuine attempt to comply with their obligations under SuperStream. This means you must have in place firm implementation plans."

Adrian Rollins

COMMENT

Rich world eating its way to an early grave

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about energy content, fats, sugars, salt and other ingredients compulsory. Australia's own five-star Healthy Food Rating system was due to begin next month, but has become mired in controversy after a Government staffer who ordered a website for the system to be taken down was forced to resign over links to the food industry.

Marketing unhealthy food to children has also been the focus of action in some countries. Several nations including Slovenia, Iceland, Norway, Turkey and Chile have imposed bans or restrictions on food ads during child programs.

The OECD said the most comprehensive policy action has been taken by the Mexican Government, which has imposed an 8 per cent tax on high-energy food, a levy on soft drinks, food labelling requirements, and a ban on the marketing of junk food on television and radio during child viewing times.

So far, though, evidence on the effect of such measures is only just beginning to emerge, the OECD said.

Adrian Rollins

COMMENT

E-cigarette claims nothing but vapour: experts

Public health experts worldwide have urged the World Health Organisation to ignore tobacco industry claims about e-cigarettes and instead focus on the evidence in assessing their health implications.

Leading Australian public health advocates Professor Stephen Leeder, Professor Alan Lopez, Professor Ian Olver, Professor Mike Daube, Professor Simon Chapman and Associate Professor Freddy Sitas are among 129 international public health physicians and campaigners who have written to the WHO Director General Dr Margaret Chan in support of the organisation's evidence-based approach to electronic nicotine delivery systems (ENDS).

Their call has come amid mounting international concern about the rapid, and largely unregulated, growth in e-cigarettes, which are often being spruiked as a safe alternative to tobacco products and an aid in kicking the smoking habit.

The global market for e-cigarettes – battery-powered devices that vaporise a solution that users then inhale - is growing at a massive rate. A recent US study identified more than 500 brands offering more than 7760 flavours, with an extra 10 brands being added every month. They are often marketed by tobacco companies.

Late last month a group of doctors and academics wrote to the WHO urging it, in the interests of harm reduction, to resist pressure to subject e-cigarettes to significant restrictions contained within the Framework Convention on Tobacco Control. The letter can be viewed at: http://nicotinepolicy.net/documents/letters/MargaretChan.pdf

In particular the group, who identified themselves as "specialists in nicotine science and public health policy", argued it would be counterproductive to ban advertising of e-cigarettes "and other low-risk alternatives to smoking", and said it would be "inappropriate" to apply passive smoking protections to vapour products.

But in their counter letter, sent on 16 June, the public health experts urged the WHO to take a sceptical approach to such claims until such time as they have been subjected to rigorous assessment. The letter can be viewed at: http://tobacco.ucsf.edu/sites/tobacco.ucsf.edu/files/u9/Chan-letter-June16%20PST%20FINAL%20with%20129%20sigs.pdf

In particular, they said the WHO should be wary of the tobacco industry's role moving into and driving the e-cigarette market.

"Manufacturers of ENDS are making a range of false and unproven claims, misleading the public into thinking these products are harmless (they are not) and effective cessation aids (unknown)," the experts wrote.

They said there was insufficient evidence to back the claim they were an effective aid to giving up smoking, and instead there were disturbing signs that young people who had never smoked were using e-cigarettes.

And they warned that there was "good evidence" that e-cigarettes released several toxic substances including ultrafine particles, propylene glycol, nitrosamines, nicotine, volatile organic compounds and carcinogens.

"Proposals to allow EBDS use in indoor spaces like workplaces, bars and transportation could see significant exposure to these substances," they cautioned.

"The absence of detailed evidence on health effects is not evidence that no effect exists. Rather, insufficient time has elapsed to determine what effects exist and their magnitude on a population level."

The WHO said it was currently reviewing the existing evidence around ENDS and preparing a paper for submission to the meeting of the Parties of the WHO Framework Convention on Tobacco Control, to be held later this year.

It said it was also working with national regulatory bodies to look at regularity options, as well as with toxicology experts to understand more about the impact ENDS may have on health.

In Australia, it is illegal to sell e-cigarette liquids that contain nicotine, and the *Sun-Herald* has reported that Supreme Court of Western Australia has effectively banned e-cigarettes outright in the state in a landmark judgement against a company, called HeavenlyVapours, that had been selling the dispensers and nicotine-free "e-juice" through a website.

It had been prosecuted under the Tobacco Products Control Act, which prohibits the sale of anything such as food or a toy that mirrors a tobacco product.

The newspaper added that, in New South Wales, more than a dozen Sydney retailers faced legal action after being caught selling illegal nicotine-laced e-liquids late last year.

Adrian Rollins

COMMENT

Legacy of childhood trauma costs billions

The diagnosis and treatment of adults suffering the effects of childhood trauma needs to be included in GP training and should be incorporated in mandatory national guidelines, according to a child abuse advocacy group.

The group Adults Surviving Child Abuse (ASCA) claims that billions of dollars of scarce health funds are being wasted, and many people are suffering unnecessarily, because of widespread ignorance among health practitioners about the lingering effects of childhood trauma and how to treat it.

Guidelines developed by the ASCA, *The Practice Guidelines for the Treatment of Complex Trauma & Trauma Informed Care and Service Delivery*, have been recognised as an Accepted Clinical Resource by the Royal Australian College of General Practitioners.

The recognition means the resource is considered a useful contribution to general practice, but is not produced to the standard required for it to be adopted as a clinical guideline.

The College advised practitioners that "a degree of clinical interpretation and caution is applied when using [an Accepted Clinical Resource] to guide practice. This is because the evidence base in support of the content is either limited or not clearly described".

Nonetheless, ASCA President Dr Cathy Kezelman said the RACGP's recognition was a significant step toward improving the treatment of people suffering the effects of childhood trauma.

"Unresolved trauma is one of our greatest public health concerns," Dr Kezelman said. "Failures to identify, acknowledge and respond appropriately to trauma costs the public health system billions of dollars."

Dr Kezelman said such trauma, which could include mental, physical and sexual abuse, as well as neglect and domestic violence, was the root cause of many significant mental and physical health problems, as well as substance abuse.

She said the guidelines had been developed over several years based on the best available evidence, and provided a sound basis for training and care.

"The guidelines offer the grounding for the education and training needed for all health professionals, including those in primary health care. Improved practices, as identified in the Guidelines, will help reduce the burden of disease related to unresolved trauma and improve the lives of victims, as well as those of their children," Dr Kezelman said.

She cited evidence from studies overseas showing that patients whose prior trauma is identified and acknowledged made 35 per cent fewer visits to their doctor and had 11 per cent fewer episodes of emergency department care.

ASCA Advisory Board member and RACGP Fellow Dr Johanna Lynch said the significance and prevalence of adults who have survived childhood trauma was currently not acknowledge din general practice training, and GPs needed to become skilled in identifying, managing and caring for those who carry the legacy of such experiences.

Dr Kezelman said that in addition to developing such training, the Federal Government should also ensure ASCA guidelines were embedded as standards for practice in primary care.

Adrian Rollins

COMMENT

The final word on PIP implants

Women have been reassured that ruptured Poly Implant Prothese breast implants pose no greater health risk than any other brand of breast implant.

Delivering its final verdict on the infamous PIP implants, which were the centre of a global health scare following revelations of sub-standard manufacture, the European Commission's Scientific Committee on Emerging and Newly Identified Health Risks found that although the implants were more likely to rupture than those of other brands, there was no evidence they were more harmful.

Monitoring by the Therapeutic Goods Administration has found that, as at 16 May, there were 530 confirmed cases of rupture, with a further 25 yet to be verified.

Around 300,000 women worldwide received PIP implants, including around 13,000 in Australia, and the company founder Jean-Claude Mas was last year convicted of fraud and sentenced to four years imprisonment by a French court, which also imposed a lifetime ban on working in medical services or running a company.

Much concern has centred on the presence of cyclic siloxanes in PIP implants in higher concentrations than in other brands, but the Committee said investigations had shown that such chemicals were common in the bodies of women even without breast implants, as a result of their widespread use in many household products. The chemicals were found to be non-toxic and not an irritant.

The Committee also investigated cases where the rupture of an implant had been associated with inflammation. It found that that neither the rupture, nor the inflammation, has been associated with breast cancer or anaplastic large cell lymphoma.

"While there are differences in rupture rates, there is no reliable evidence that ruptured PIP implants create a greater health risk than a ruptured silicone breast implant from another manufacturer," the Committee concluded.

It strongly advised that where rupture did occur, the implant be removed, and recommended that – because of concern ruptures might go undetected – that women with PIP implants seek regular clinical examinations.

But the Committee said there was no compelling medical reason for women with intact PIP implants to have them removed, except where they were experiencing significant anxiety, and advised that in these circumstances "the decision to remove an intact PIP implant…be based on an individual assessment of the woman's condition by her surgeon or other treating physician".

The TGA said the Committee's findings and recommendations were consistent with its own position regarding PIP implants.

"The SCENIHR report is a comprehensive survey of investigations carried out around the globe on PIP breast implants," the watchdog said. "[It's] recommendations…agree with those made by the TGA, and the report does not identify any matter that requires further investigation by the TGA."

Nonetheless, the regulator said, it would continue to monitor the situation and was ready to take further action if deemed necessary.

Adrian Rollins

COMMENT

International Indigenous Health Conference 2014

Indigenous health agencies, groups and individuals from around the world are set to converge on northern Australia late this year for the inaugural 2014 International Indigenous Health Conference.

The Conference, which had its genesis in last year's Australian National Indigenous Health Conference, aims to bring together more than 300 First Nations speakers and participants from across the globe to share experiences and ideas about how the close the health gap between Indigenous peoples and the wider community.

For the event's organisers, for any such action to be successful it must involve a holistic approach embracing a person's mind, body, soul and culture.

"This gathering will highlight some of the existing Indigenous health programs currently implemented in Aboriginal communities all over the world and provide a unique opportunity for delegates and speakers to see the power of people networking in one place, at one time, with similar goals," the organisers said.

Community-based health programs will be a particular focus, with presentations from community groups to account for at least half of the conference's proceedings.

The conference will be held at the Pullman Cairns International hotel, Cairns, from 15 to 17 December.

For further details, visit: http://www.indigenoushealth.net/submitpaper.htm

Fluvax for young put to the test

Some doctors are continuing to inject young children the Fluvax vaccination despite a long-standing ban imposed after it was found to be linked to convulsions.

Official figures show the vaccine was administered to 43 children younger than five years last year, and 31 so far this year despite the ban, which came into force in 2010, a result that Chief Medical Officer Professor Chris Baggoley told AAP "defies belief".

Professor Baggoley said the cases were a tiny proportion of the more than 48,000 flu jabs given to young children last year, "but for every child that's been put at risk is makes me profoundly cranky".

Meanwhile, clinical trials of modifications to bioCSL's Fluvax vaccine to make it safe to administer to young children are set to begin in August.

The drug manufacturer announced the commencement of trials following the publication of two studies that found the way bioCSL had manufactured Fluvax caused febrile convulsions in several young children who received the vaccine.

Health authorities in 2010 banned the use of Fluvax for children five years or younger, and imposed restrictions on its use for those aged between five and nine years, after it was linked to a significant increase in fever-related convulsions in young children.

The studies, published in the peer-reviewed journal *Vaccine*, found that the way bioCSL manufactured the vaccine was the root cause of the problem. In particular, they found the virus components contained in the 2010 version of the vaccine combined to overstimulate the immune system of some young children, triggering fever and related convulsions.

The studies also found that these effects could be averted by increasing the levels of virus splitting agents used in the manufacturing process.

bioCSL said it had found that increased levels of virus splitting agents used in making Fluvax had not impaired its function and, following consultations with regulators, this had now been incorporated into its standard method of Fluvax manufacture.

But clinical trials are needed before the use of the vaccine for young children is approved.

"The next step is proving our scientific findings through clinical studies and, until that happens, I want to stress that bioCSL's Fluvax must not be used in children under five years of age, and that restrictions also remain in place for the use of Fluvax in those aged five to nine years," bioCSL General Manager Dr John Anderson said.

"We recognise that the events that took place in 2010, and the ongoing uncertainty about the cause, have been very concerning to the public," Dr Anderson said. "The investigations have been extremely complex, and it is of some relief to have reached this point. Our conclusions now give us a clear path forward, which we intend to pursue to the fullest."

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

What makes for a successful public health campaign?

As public health campaigners know, it is one thing to identify a health threat, and something entirely else to actually do something about it.

Many of the nation's most successful public health campaigns, such as deterring drink driving and getting drivers to buckle up, have relied as much on legislative action as education programs to raise public awareness and change risky behaviour. Others, such as the Grim Reaper anti-HIV campaign, captured the community imagination.

But not all health threats are as readily recognised, or elicit the same degree of political and community engagement and support.

Just what makes for an effective public health campaign will the focus of discussion at the 2014 Australasian Symposium on Health Communication, Advertising and Marketing, to be held in Brisbane on 30 September.

The symposium aims to bring together speakers and participants with a ride range of expertise to share ideas and experiences about the design, implementation and evaluation of campaigns intended to change behaviour and improve health.

The event is being organised by the Queensland University of Technology, and speakers include experts in campaigning and communication from across Australia and internationally.

According to the organisers, the intention will be to foster links between people working in the area of health communications, with a special emphasis on "building collaborative links between agencies, researchers and campaign clients".

For more information, visit: www.healthcam2014.com

Medicare spoil sport

Professional athletes injured in the course of playing their sport will no longer be eligible for Medicare rebates as part of a Federal Government crackdown on the claiming system.

The Department of Human Services has written to sporting bodies, player associations and health professionals to inform them that Medicare benefits will not be paid where an athlete is injured in the course of their employment or where their employer is liable for the cost of treatment.

As part of its Medicare review, the Department found that claims have been made for Medicare benefits for the treatment of athletes injured during the course of their sport, in breach of the Health Insurance Act 1973.

Under the Act, Medicare benefits are not to be paid where a patient is injured in the course of their employment, or their employer is liable to pay for medical services.

The Department warned that, as of 24 May, any claims involving people employed to play sport would no longer be processed.

But, in a concession to the "considerable time" taken to review claims submitted by a number of sport organisations, the Department indicated that claims lodged but not processed between 1 August last year and 24 May this year would be honoured.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

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

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

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

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

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

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

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

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

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

Email: careers@ama.com.au

GENERAL PRACTICE

The bell tolls for AMLA and Medicare Locals

BY DR BRIAN MORTON

Medicare Locals, as announced in the new Government's 2014-15 Budget, will no longer be funded by the Commonwealth after 30 June 2015.

From 30 June, Commonwealth funds will also stop flowing to the Australian Medicare Local Alliance. In relation to the latter, it has been the long held view of the AMA that it was just an extra layer of bureaucracy.

The AMA recognised the need for more integrated and streamlined health care and has been supportive of the introduction of a network of Primary Health Care Organisations (PHCOs) to help achieve this goal.

However, the Medicare Local model the former Government introduced was fundamentally flawed – it sought to down play the role of general practice rather than to engage and support it in caring for patients.

The AMA, in its 2011 Medicare Locals Position Statement, laid out the framework and principles under which Medicare Locals could be effective PHCOs. The AMA emphasised the importance of general practice and the need for GPs to be involved in the high level decision making of Medicare Locals.

To be effective, the AMA said that Medicare Locals needed to work with GPs and needed to be accountable to their membership. They also needed to work effectively with Local Hospital Networks. The final point of the Position Statement was that the Government should review Medicare Local operations within three years of their implementation.

On coming to power, the new Government fulfilled its election promise, ordering an independent review of Medicare Locals by former Chief Medical Officer Professor John Horvath.

The findings of the Horvath review reflected in many ways the outcomes of the AMA's GP member survey on Medicare Locals. The performance of Medicare Locals was patchy, they had failed to improve the coordination and delivery of primary care services, failed to appropriately involve or engage with GPs, and were duplicating existing services.

The Horvath Review recommendations, in summary, included:

- that the Government should implement Primary Health Organisations (PHOs) to integrate patient care across the health system;
- that it should reinforce general practice as the cornerstone of integrated primary health care;
- that there be principles for the establishment of PHOs which covered contestability, flexible structures to reflect regional characteristics, engagement, and clear performance expectations;
- that the Government should not fund a national alliance of PHOs;
- that the PHOs should be limited in number and align with Local Hospital Networks;
- that the Government should review the after-hours program and consider how, in time, PHOs could administer additional Commonwealth-funded programs;
- that PHOs should only provide services where the market has failed to do so, or where there are significant economies of scale; and
- that PHO performance indicators should reflect outcomes that are aligned with national priorities and contribute to a broader primary health care data strategy.

Many of these recommendations reflect the concerns expressed by the AMA about Medicare Locals in our public commentary and submission to the Horvath Review.

That said, there are some recommendations, including the potential for for-profit organisations to set themselves up as PHOs, that are of concern. In addition, it will be essential that funds allocated to PHOs are quarantined for primary care use only.

The Government has responded to the Horvath Review by announcing the establishment of Primary Health Networks as part of its first Budget.

The AMA Council of General Practice is discussing the design and implementation of the Government's proposed Primary Health Networks, and will seek to ensure that we don't get the model wrong this time around.

Primary Health Networks offer a significant and important opportunity to support general practice in delivering high quality care to improve patient outcomes, and to ensure that services across the health sector align and work together in the interests of patients.

BY DR DAVID RIVETT

Cost cutting Budget in need of medical advice

Watching Australia's Chief Scientist Professor Ian Chubb on ABC television recently express his surprise and concern that he was not consulted about the Federal Government's $20 billion medical research fund underlined to me what everyone has been saying about the recent budget, which is that with consultation it could have been so much better.

The average rural GP has a lower socio-economic patient demographic, with higher rates of both unemployment and welfare dependence. Making bulk-billing non-viable will hurt rural Australia considerably and serve to make rural practice less attractive as a career option.

Many have asked how the corporate giants will handle the proposed changes. If I was them I would set up a charitable trust to fund the "most needy" $7 co-payment. The total cost per patient would be $70 a year but, as it should be tax deductible as a charity, that could make it more like $35 per annum per patient. It would enable free access to GP consults and pathology and radiology services. Not a huge cost in the scheme of things, and easily recouped by an extra service per annum. Such an arrangement would make a mockery of the proposed changes.

If I was advising Government I would ask Centrelink to classify the truly vulnerable in society and issue them with a "co-payment" credit card with $70 credit on it, able to be used only for the stipulated 10 GP/pathology/radiology services.

GPs do not have access to a patient's financial details, and are not in a position to make decisions about how 'needy' they might be.

We all get regular surprises when elderly retirees who insist on bulk billing turn up for vaccinations for prolonged overseas jaunts. The credit card approach would also enable real-time determination of when the 10 services requiring co-payment have been completed.

It would restrict GPs from gratuitously bulk billing to lure patients, and focus charity (given that bulk billing is a most charitable act) to where it is most needed.

Needless to say, I would ban "charitable bodies" set up by the big end of town to circumvent co-payments.

And what of General Practice Education and Training getting folded into the Department of Health?

This is a major cause for alarm, and seems consistent with the underlying principle on which the Budget seems to have been framed - that maintenance of quality is a low priority when cost cutting is the mantra.

> "The Prevocational General Practice Placement Program has been stopped, despite it being a huge window of opportunity to get doctors to experience rural health before they are locked in to a specialist training scheme"

The Prevocational General Practice Placement Program has been stopped, despite it being a huge window of opportunity to get doctors to experience rural health before they are locked in to a specialist training scheme.

Successful projects such as the "Murray to the Mountains" trial of the intern year in rural Victoria will be no more.

All medical groups, led by the AMA, must fight hard to ensure the training of tomorrow's rural GPs is not compromised and downgraded.

Health on the hill

Political news from the nation's capital

Red Cross bled $5 million

One of the world's most widely recognised and respected medical charities has had its funding slashed by the Federal Government.

The Red Cross, which runs blood collection services and provides humanitarian and medical care and disaster relief, has been caught short after the Abbott Government revealed it will cease paying the annual $5 million General Purpose Grant first introduced by the Howard Government in 2006.

Health Minister Peter Dutton notified the charity the Government would no longer pay the grant, which was continued by the Rudd and Gillard governments.

A spokesman for the Minister told *The Age* that, while the Government was "extremely grateful" for the work the Red Cross undertook, it was "not strongly related to the health portfolio".

Australian Red Cross Chief Executive Robert Tickner told *The Age* the surprise decision was "especially hurtful" given looming celebrations to mark the organisation's first 100 years of service in the country.

The former Labor Minister said the move would leave a "significant but limited" hole in the charity's budget.

"It will inevitably have a significant, but limited, impact on services, programs and support functions, and on staff and volunteers in specific areas," Mr Tickner told *The Age.*

In its newsletter to members in mid-2012, the Red Cross said the grant "makes a critical contribution to our work across Australia, allowing Red Cross to continue delivering humanitarian relief and community support services".

Adrian Rollins

COMMENT

Get children out from behind bars: RACP

The nation's largest specialist medical college has condemned the detention of children in immigration centres and demanded that they be held for no longer than two weeks.

As the Federal Government trumpets the success of its hard-line 'turn back the boats' policy, the Royal Australasian College of Physicians has called for a major rethink of the treatment of child refugees.

The College's incoming President, Professor Nicholas Talley, said the RACP did not support the detention of children and families for any length of time, and was extremely concerned about mandatory detention.

"It is unacceptable that we are locking up more than 1000 children, including unaccompanied minors, for up to nine months at a time," Professor Talley said. "Immigration detention is not a suitable or safe environment for children. [They are] exposed to violence, self-harm, distressed parents and adults with significant mental health problems."

Paediatrician and College member Dr Karen Zwi, who recently visited Christmas Island as part of the Australian Human Rights Commission's inquiry into children in immigration detention, said offshore facilities did not have health services for children with special needs and pregnant women.

"Medical services are not adequately screening children for infectious disease, developmental delay and common problems such as anaemia," Dr Zwi said. "These conditions can be easily treated if detected early, but can cause long-term complications if neglected. Children in detention deserve the same standards of care as we would offer to all children."

Concerns about conditions in offshore detention centres have been heightened by the Abbott Government's shock decision late last year to disband the Immigration Health Advisory Group (IHAG), which included representatives from the AMA as well as general practitioners, psychiatrists, psychologists and other medical professionals, and provided independent advice on the treatment of asylum seekers.

Soon after the decision, information was published showing rates of depression and severe mental stress in detention centres had soared. Figures compiled by contractor International Health and Medical Services and obtained by *The Australian* under Freedom of Information laws showed that almost 45 per cent of detainees were diagnosed with psychological problems in the September 2013 quarter, almost double the 23.1 per cent reported with a similar diagnosis six months earlier.

The AMA has called for the establishment of a "truly independent" medical panel to oversee and report directly to Parliament on health services for asylum seekers being held in detention.

In its submission to the AHRC inquiry, the College echoed the AMA's call and recommended that processing time for children and adolescents be no more than two weeks, after which they and their families must be transferred to a community setting.

Adrian Rollins

COMMENT

Health on the hill

Political news from the nation's capital

Flame lit under medicinal cannabis debate

A push to legalise medicinal cannabis has been launched by a group of federal MPs drawn from each of the major political parties.

The recently-reformed Parliamentary Group for Drug Policy and Law Reform has called for an end to what it sees as the stigma surrounding the use of medicinal cannabis.

The group, convened by Liberal MP Dr Sharman Stone, Labour MP Melissa Parke and Greens Senator Dr Richard Di Natale, is urging members of each of the main political parties to follow several US states and support moves to have the medicinal use of cannabis legalised.

The medicinal use of cannabis was prohibited in the middle of last century, and in recent years calls have mounted to have the ban overturned, including in the unanimous findings of a NSW parliamentary committee.

Dr Stone said "significant numbers of random trials have demonstrated the last resort value of using medicinal cannabis to relieve some of the terrible suffering associated with some terminal cancers and other conditions".

Dr Di Natale said the evidence for the efficacy of medicinal cannabis in relieving the relieving the nausea, pain and weight loss suffered by some with a terminal illness was clear.

"To deny effective medication to someone with a terminal illness simply because of stigma is cruel," the Senator said.

He said that its use would need to be regulated, but there was no reason why it could not be licensed in the same way as poppy growers are now.

In a paper published in the *Medical Journal of Australia* last December, authors including Emeritus Professor Laurence Mather of the Sydney Medical School and Dr Alex Wodak, a consultant at Sydney's St Vincent's Hospital, argued that the time had come to lift the ban.

"It is now clear that cannabis has genuine medicinal utility, but this has been largely overlooked, with research and society's attention being directed towards the hazards of recreational use rather than the benefits of medicinal use," the authors wrote.

In its report, the NSW parliamentary committee said the evidence suggested medicinal cannabis-based treatments would be appropriate "for a small number of people in specific circumstances, and under the supervision of medical practitioners with suitable expertise".

"Those patients would necessarily be people with severe and distressing symptoms that are not able to be addressed by existing medications," it added.

The committee's recommendations were dismissed by the

NSW Government, but Federal Labor MP Melissa Parke said it was "time for Australia to move forward on this issue".

Adrian Rollins

COMMENT

Research

Melanoma scourge may need more than slip, slop, slap

Doubt has been cast over the effectiveness of sun protection campaigns amid evidence that the incidence of melanoma is rising among young people most at risk of developing skin cancer.

Although there was a massive 325 per cent increase in the number of melanomas removed each year between 1982 and 2009, a number of studies have claimed that the incidence of melanoma among young people is decreasing as a result of public health campaigns such as the well-known slip, slop, slap SunSmart campaign.

But, in a study published in the journal *Acta Dermato-Venereologica*, Melbourne-based dermatologist Dr Douglas Czarnecki has argued that such claims have been based on crude population-wide analyses that have not taken account of changes in the composition of the community.

"The authors claiming a reduction in the incidence of melanoma in young Australians [have] failed to mention that the incidence was calculated for the entire population, and not the susceptible population," he said.

Dr Czarnecki said that in the past 30 years the profile of the population has changed markedly, with a big upsurge in the proportion of people from Asia, the Pacific Islands, the Middle East and Sub-Saharan Africa – all regions where melanoma is much less common that in Australia.

He said the crude rate of melanoma in Australia was 526 per million in 2008, compared with two per million in Egypt, three per million in China and one per million in India.

"[There has been] a large number of dark skinned immigrants settling [in Australia]," Dr Czarnecki said. "These people have a low risk of developing melanoma, and if they are included in the total population when calculating incidence, [it] will appear lower than if immigration had not taken place. This apparent change in incidence might be used to support the impression that public health campaigns were working, even if they were not."

Instead, in his study Dr Czarnecki calculated the incidence of melanoma excluding those who were born, or whose parents were born, in regions of low prevalence.

Using this method, he calculated that between 1982 and 2009 the incidence of melanoma in young people susceptible to the condition actually increased from 5.9 per 100,000 to 6.3 per 100,000. If young Maori and Aboriginal people were also excluded, the incidence per 100,000 rose from 6 to 6.8 over the same period.

'The increase…occurred when many public health campaigns were run, and the age group studied was born and raised while these campaigns were in action," Dr Czarnecki said. "Claims that [these] campaigns have been effective at reducing the incidence of melanoma in young Australians cannot be taken at face value."

His warning came as study published in the journal *Nature* indicated that although high-rating SPF 50 sunscreens were effective in preventing sunburn and slowing the onset of skin cancer, they did not negate the cancer risk.

The study found that mice predisposed to developing melanoma took only about 30 per cent longer to develop the cancer when coated with SPF 50 sunscreen.

Adrian Rollins

COMMENT

Young mothers most likely to give their babies herpes

Herpes Simplex Virus (HSV) has emerged as a more common threat to infant health than congenital rubella, syphilis or perinatal HIV, according to a nationwide study.

Data drawn from the Australian Paediatric Surveillance Unit and analysed by University of Sydney researchers has in the past 15 years identified 131 cases of neonatal HSV infection – 24 of which proved fatal.

Though the incidence of neonatal HSV infection is rare, the study's lead author Professor Cheryl Jones, of the Sydney Medical School, said it was significantly more common in children born to mothers younger than 20 years of age, and was more likely in babies of low birth weight and those born pre-term.

The study found that mothers younger than 20 years were four times more likely than the general population to give birth to babies infected with neonatal HSV.

Neonatal HSV, though rare, can be serious and even deadly. Apart from sores and lesions, it can cause encephalitis and, if left untreated, may infect multiple organs and glands, with often severe consequences.

"Without antiviral therapy, death or handicap is almost inevitable after disseminated or central nervous system disease," Professor Jones said, though her study found that the mortality rate

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Research

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from neonatal HSV infection had dropped off in recent years.

Babies typically catch HSV from their mothers during delivery, but they can also be infected through contact following birth.

It has been speculated that caesarean delivery might reduce or prevent transmission of HSV from mother to baby, but Professor Jones' study, published in the journal *Clinical Infectious Diseases*, found that a third of all infected infants were born by caesarean.

The study found that the overall rate of neonatal HSV infections was relatively stable over 15 years, but the prevalence of HSV-1 has increased relative to HSV-2.

Though both are ubiquitous and contagious, historically HSV-1 has been most commonly associated with cold sores, while HSV-2 has been responsible for most cases of genital herpes.

Globally, however, there has been an increase in genital herpes caused by HSV-1, including in Australia, and Professor Jones' study has found that HSV-1 has displaced HSV-2 as the leading form of neonatal HSV infection.

"This increase (in HSV-1 genital herpes infections) has been most marked in young women, and is consistent with our findings of an over-representation of adolescent mothers in this study," Professor Jones said. "The reasons for this increase are unknown, but preventive efforts should include increasing adolescent awareness of sexually transmitted infections like HSV."

Adrian Rollins

COMMENT

Prostate diagnosis may no longer leave men prostrate

An advance in diagnosis could enable men with prostate cancer to avoid unnecessary surgery and its associated complications.

In a development with major implications for the on-going debate about the need to screen for and remove prostate cancers, researchers at Cancer Council Victoria's Cancer Epidemiology Centre and TissuPath Specialist Pathology have identified three biomarkers that can be used to identify those prostate cancer tumours most likely to prove deadly.

The researchers found that men whose tumours contained either of the proteins MUCl or p53 were twice as likely to die from prostate cancer as those without them, while the presence of the protein AZGPI indicated a man was three times less likely to die from the disease.

"Only a minority of prostate cancer diagnoses lead to death but, due to a lack of markers of aggressive disease, many non-lethal cancers are still treated aggressively," study author Dr Liesel FitzGerald told the Herald Sun. "If this preliminary study is validated, this research can inform clinical practice so both doctors and patients understand whether their tumour is likely to progress, and make more informed decisions on how best to treat it."

More than 18,000 men are diagnosed with prostate cancer every year, and many undergo surgery to have their prostate removed – an operation that can potentially cause devastating life-long side-effects such as impotence and incontinence.

Such aggressive treatment has become increasingly controversial given the inability of doctors currently to determine which tumours are likely to turn deadly, and hence avoid unnecessary surgery and its attendant complications.

Adrian Rollins

COMMENT

Malaria diagnosis could take just seconds

Breakthrough devices with the potential to save hundreds of thousands of lives by slashing the time taken to diagnose meningococcal infection and malaria are among the projects being undertaken at a new nano-device research facility.

Researchers at the $1.25 million Ian Potter NanoBioSensing Facility at RMIT University in Melbourne are working on projects to vastly improve the speed, accuracy and sensitivity of diagnostic tools using nano technology.

Among other devices under development are a prototype tool to cut the time taken to detect the presence of the parasite Cryptosporidium in drinking water from five days to five minutes, as well as technologies to improve early-stage diagnosis of cancer and cardiovascular diseases, and for detecting contaminants in food and dairy products.

"Speed is critical – the quicker we can diagnose, the quicker we can ensure a patient receives the right treatment," Facility Director Associate Professor Vipul Bansal said. "The point-of-care nano-devices we're developing are not only inexpensive and simple to use, but also extremely sensitive, so they can give an accurate diagnosis almost instantly."

A/Professor Bansal said the facility would enable the development of nano-devices with a wide range of applications in the detection of diseases and health hazards, including through international collaboration.

Adrian Rollins

COMMENT

Upsurge in deadly virus has world on edge

Australian health authorities are closely monitoring a recent upsurge in infections of a deadly respiratory tract virus that has so far killed more than 200 people in the Middle East.

While no cases of the Middle East respiratory syndrome coronavirus (MERS-CoV) have so far been recorded in Australia, a working group of the Communicable Diseases Network is developing advice in the event that an infection within the country is confirmed.

The disease so far has been largely confined to Saudi Arabia, where more than 85 per cent of the 701 confirmed instances of infection have occurred, though Saudi authorities are understood to be developing revised estimates that could increase the number of cases by 20 per cent and the number of fatalities by almost 50 per cent.

All cases involve people who live in, or have travelled to the Middle East, or who have had contact with those returning from these areas.

In a worrying development, surveillance indicates there was a significant upsurge in cases in April and May, mostly as a result of transmission between patients, staff and visitors at hospitals and health clinics.

The World Health Organisation has warned MERS-CoV has a 30 per cent fatality rate, and is worried about the risk of a major deadly outbreak during the Hajj pilgrimage in October when millions of Muslims are expected to make the journey to holy sites in Saudi Arabia.

Reflecting this heightened concern, the Morocco Health Minister Lahoucine Louardi has advised pilgrims to cancel plans to travel to Saudi Arabia this year because of the risk of infection.

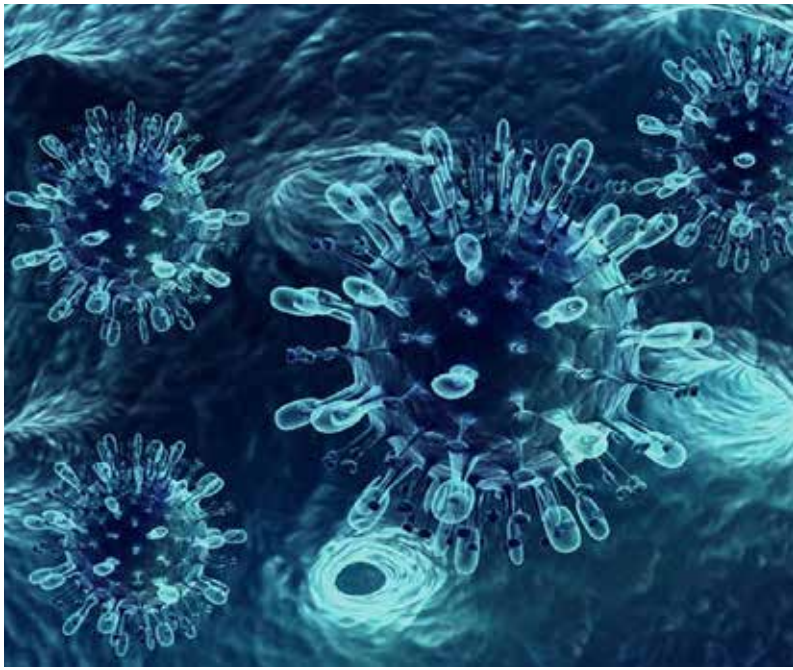
Camels are thought to be the primary source of the virus, but WHO estimates that most cases (up to 75 per cent) involve secondary infections, the majority health workers.

Aside from Saudi Arabia, MERS-CoV infections have also been reported in the United States, Iran, the Netherlands, Greece, Turkey, Malaysia, Egypt, Lebanon, Oman, Yemen and the Philippines, Jordan, Qatar and the United Arab Emirates.

A major concern for health authorities is that much about the infection so far remains unknown, including how it may be transmitted.

“While there is no evidence indicating transmission of MERS-CoV from asymptomatic infected individuals, and no evidence of ongoing community transmission, little detail is available on a large number of the most recently reported cases, so this cannot be ruled out,” the WHO warned.

The WHO’s International Health Regulations Emergency Committee on MERS-CoV, chaired by Australia’s Chief Medical Officer Professor Chris Baggoley, has so far stopped short of the declaring the outbreak an international public health emergency.



But the Committee has expressed concern about systemic weakness in infection control in Saudi Arabia and the United Arab Emirates, and the potential for a major upsurge in cases, “especially given the anticipated increase in travel to Saudi Arabia related to Umra, Ramadan and the Hajj.”

Adrian Rollins

COMMENT

Trust, not torture, key to resolving hunger strike, Israeli Govt told

The Israeli Government has been urged to strike down proposals making it legal to force-feed hunger striking detainees.

In a letter to Israeli Prime Minister Benjamin Netanyahu, World Medical Association President Dr Margaret Mungherera, and WMA Chair Dr Mukesh Haikerwal, have condemned force-feeding as tantamount to torture, and have asked that a proposed law to legalise it be rejected.

The WMA call has come amidst a hunger strike by as many as 125 Palestinian detainees in Israeli prisons that has been going for more than 60 days.

The Israeli parliament, the Knesset, is considering a law that would allow the hunger strikers to be force-fed, a prospect that has alarmed the Israeli Medical Association and the WMA.

The Israel Medical Association (IMA) has urged physicians not to cooperate with the government's plans. "It goes against the DNA of the doctors to force treatment on a patient," spokeswoman Ziva Miral told Al Jazeera America news service. "Force-feeding is torture, and we can't have doctors participating in torture."

In their letter, Dr Mungherera and Dr Haikerwal wrote that "force feeding is violent, often painful and absolutely against the principle of individual autonomy. It is degrading treatment, inhumane, and may amount to torture".

They said it was a "most unsuitable" approach to saving lives, and doctors should not be involved in it "in any way".

Mr Netanyahu has been reported as pushing for the force-feeding legislation to be fast-tracked, with backers arguing it is a safety measure aimed at not only saving the lives of hunger strikers but also heading off a wave of potentially violent protests if a hunger striker dies.

But Dr Haikerwal and Dr Mungherera said there were much better ways of dealing with hunger strikes than force-feeding.

They said evidence showed the best approach was to establish and maintain a trusting and respectful doctor-patient relationship.

"The IMA can help," they wrote. "Our Israeli colleagues are about to deal with the situation, if only they are allowed to establish a real patient-physician relationship without threats and interference from prison authorities. Force-feeding is completely incompatible with this methodology, and it destroys any patient-physician trust."

Adrian Rollins

MOTORING

BY DR CLIVE FRASER

Holden Kingswood HK HT HG HQ HJ HX HZ (1968 – 1980)	
For	Spawned its own TV series (*Kingswood Country*)
Against	Large cars didn't need to be as large as families became smaller.
This car would suit	Anyone who doesn't believe that the age of entitlement is over.
PS	In the sit-com *Kingswood Country*, Ted Bullpit would constantly ask, "Where's the bloody Kingswood" and prophetically said, "No wonder the country's in a mess!"

On Budget!

Regular readers of this column know that I always do my best to steer clear of politics.

After all, this is a motoring column, and I'm not Andrew Bolt.

But since the Federal Budget it's been difficult to think about anything else, particularly its likely impact on those that I regard as vulnerable and less fortunate.

While there are undoubtedly those that will be better off after Joe Hockey's song and dance, I dare not mention their names for fear of being barraged with mail from medical researchers and pregnant company executives.

But I do want to spare a thought for university students, unemployed youth, pensioners, families, the poor, the sick, asylum seekers and any Australian born after 1965.

When university students staged an overly long protest on the ABC's Q&A program recently, Federal Education Minister and Leader of the House Christopher Pyne remained remarkably calm and tight-lipped when he responded by asking the audience to "wait and see" what was in the Budget.

As if he didn't already know.

At the other end of life, we can now expect to officially have the world's oldest retirement age at 70, while workers from Pakistan, India, China, Russia and Ukraine down tools at 60.

Even John Howard retired at 68.

Coming from Queensland, it's not surprising that none of these cutbacks were mentioned in the lead-up to the last election, and we should all just accept that none of this would be happening if it wasn't for that nasty Commission of Audit.

While there have been accusations of broken election promises, I'd simply see what happened as prevarication.

Not that we should expect anything else, they are politicians after all.

But for me, the lowest point of all in the debate was when our Federal Health Minister and Member for Dickson, Peter Dutton, likened Medicare to a Holden Kingswood.

Is Peter Dutton being un-Australian by taking a swipe at our national icon - the Holden Kingswood?

And he might need to watch his words, with the Motoring Enthusiast Party having such a strong voice in the Senate, if not in the media.

I'd dare say that the Holden Kingswood and Medicare have nothing in common.

For starters, the Kingswood was an affordable and popular vehicle targeted at meeting the needs of Australian families.

Replacing a long line of Holden Specials, the first HK Kingswood rolled off the production line in 1968, when John Gorton was Prime Minister.

The HK carried over the 186 cubic inch motor from the much-loved HR Holden but, for the first time in Holden's history, you could order a Kingswood with a Chevrolet 307 cubic inch (5.0 litre) V8.

It wasn't until the next HT model that automatic transmissions came with three speeds (Tri-Matic).

Up till then, autos only had a two speed Powerglide transmission, but the three speeder was prone to failure and came to be known as the Traumatic.

The HG had only minor cosmetic changes until the all-new HQ, which had two new sixes (173 and 202) and a choice of three V8s (253, 308 and 350).

The HQ had coil springs on the rear, but handling was limited by cross-ply tyres.

The HJ went metric, with the engine displacements becoming 2.85, 3.3, 4.2, 5.0 and 5.7 litres.

In 1975, Gough Whitlam gave Australia Medibank and Holden gave us the Kingswood Vacationer, which had radial tyres, carpets and a radio.

Emission controls saw the HX drop the 2.85 litre six, but handling didn't receive attention until the very popular HZ with its radial tuned suspension.

Anyone who has read this far will agree that (unlike the Federal Government and Medicare) Holden made incremental changes to the Kingswood, culminating in a vehicle that is still much loved.

Perhaps the only way I can excuse Mr Dutton for his comments about the Kingswood is to note that he wasn't even born when it was released, and he was only 10 years old when production ceased in 1980.

COMMENT