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AUSTRALIAN

Medicine

The national news publication of the Australian Medical Association

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PRESIDENT'S MESSAGE

The Year of the GP?

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

"This is supposed to be the year of the GP. Maybe it is – but for all the wrong reasons. It is GP Apocalypse Now!"

Buoyed by the Coalition's pre-election commitment that general practice would remain the cornerstone and leader of primary care in Australia, my predecessor Dr Steve Hambleton declared last year that 2014 would be the year of the GP – and, on the evidence at the time, he had every right to say so.

And there was no need to doubt that commitment in the early part of this year.

In March, Health Minister Peter Dutton told GP registrars – the next generation of GPs – that:

> *I can say unequivocally that general practice will be at the front and centre of our plan. The Australian Government is committed to rebuilding general practice and putting GPs back at the centre of our health care system.*

It wasn't long before things started to unfold, with the Federal Budget in May unleashing a torrent of attacks on general practice.

There had been warning signs just weeks earlier when the Government released the Commission of Audit report, and certain commentators had been promoting GP co-payments since before Christmas 2013 – but nobody expected the massive cuts and changes to primary care in the Budget.

There was the $7 co-payment for GP services.

There were new co-payments for pathology and radiology.

There was permission for States to charge co-payments for emergency departments.

There were higher co-payments for medicines.

There was the $5 cut to Medicare patient rebates.

And MBS patient rebates for specialist services were frozen.

On top of this, there were cuts to Indigenous health services.

The Government is also reducing public hospital funding by $1.8 billion over the next four years, and reneging on the guarantee of $16.4 billion additional funding under the National Health Reform Agreement over the next five years.

All of these acts will have a devastating negative effect on primary care. They will hurt GPs and their patients.

And now, in the past week, we have seen extraordinary mismanagement of the arrangements for GPs to conduct health assessments.

First there was a statement from the Department of Human Services declaring that GPs could no longer count the time spent by their practice nurses in completing health assessments – an accepted practice since 2010.

Then the Department of Health issued a clarification that was not a clarification, with the result that general practices were unsure of what they could do when processing health assessments, practice nurses were left wondering if they would still have jobs, and vulnerable patients such as the elderly, children, and the disabled had their access to quality primary care threatened by bureaucratic bungling.

The AMA stood firm in its calls on the Government and the Department to sort out this mess – and with results. There will be a meeting later this week to produce sound unequivocal advice on health assessments.

But how did we get to this? This is supposed to be the year of the GP. Maybe it is – but for all the wrong reasons. It is GP Apocalypse Now!

There is some light, however.

When I met recently with Prime Minister Tony Abbott, I believe he saw the wisdom of the AMA's ways in opposing the GP co-payment and other measures as proposed by the Government.

The PM's political antennae could detect the harm to vulnerable people in the community, especially the elderly, the disadvantaged, the chronically ill, and Indigenous Australians.

Within 48 hours, the Government publicly acknowledged they should revisit the co-payment for people in aged care.

The Prime Minister has asked us to come back to the Government with some other changes – changes that could possibly make some of the Budget reforms palatable to the AMA and the community.

There are no guarantees, but it is a start.

The Government is in no doubt that the AMA is totally opposed to the proposed co-payments as they stand.

We still have six months in 2014 to go. Our aim is to still make this year the Year of the GP, but for all right reasons.

SECRETARY GENERAL'S REPORT

BY AMA SECRETARY GENERAL ANNE TRIMMER

The future of the AMA taking shape

As I approach the end of my first year in the role of Secretary General I have sufficient tenure to reflect on some significant changes in the organisation over that time.

Members and readers will be well aware that one of the major projects for 2014 was to steer the adoption of the new Constitution for Australian Medical Association Limited. Members whole-heartedly embraced the new structure for the AMA at the Annual General Meeting in May, and since then I have been using the time to focus on a gradual transition to the new arrangements.

The short meeting of the Federal Council which followed the close of National Conference elected Dr Beverley Rowbotham as Chair for the next 12 months. Dr Rowbotham will steer discussion on the operations of the Council and its committees - now that its role is focused on medico-political development and debate - at the next full meeting of Federal Council to be held in late August.

The more focused role of Federal Council provides an opportunity to engage the wider membership of the AMA in policy development through the use of working groups and task forces set up for specific purposes, rather than the more formal standing committee structure which was used when the Federal Council was also the corporate Board of the company.

An interim Board has been managing the affairs of the company during the process laid out in the Constitution for the establishment of the permanent Board. The members of the permanent Board have now been notified, with the first meeting to be held on 31 July. In addition to the President and Vice President, the Board members (together with their initial term of office) are:

AMA ACT	Dr Iain Dunlop (2016)
AMA NSW	Dr Elizabeth Feeney (2016)
AMA NT	Dr Leonie Katekar (2015)
AMA Q	Dr Richard Kidd (2015)
AMA SA	Dr Peter Sharley (2016)
AMA TAS	Dr Helen McArdle (2015)
AMA VIC	Dr Tony Bartone (2015)
AMA WA	Prof Geoff Dobb (2016)
Council of Doctors in Training	Dr Kathryn Austin (2015)

The new Board will have a full agenda in its first few months, with a strategic planning meeting scheduled very early in its life. These deliberations will guide the organisation at a corporate and strategic level over the next few years.

One of the key sources of information to guide discussions is the results of the first national member survey which is out with the membership at present.

"The new Board will have a full agenda in its first few months, with a strategic planning meeting scheduled very early in its life"

If you haven't yet completed the survey, I encourage you to do so. It seeks your views on a wide range of matters, from the AMA's advocacy to member benefits and communications. The information collected will help inform AMA activities at both the Federal and State levels.

This month the *Medical Journal of Australia*, published by AMA's subsidiary, Australasian Medical Publishing Company Pty Limited, turns 100.

A celebration was held on 4 July at the University of Sydney, including a symposium on the future of medical publishing. A fantastic achievement. Congratulations to Editor-in-Chief Emeritus Professor Stephen Leeder and the team.

NEWS

Cracks opening in co-payment wall

The Federal Government has flagged that aged care home residents may be exempted from its planned $7 co-payment following a meeting with AMA President Associate Professor Brian Owler.

In the first sign that the Government is prepared to give ground on one of its key Budget measures, Health Minister Peter Dutton told News Corporation journalist Sue Dunlevy that he accepted AMA concerns that collecting a co-payment from aged care residents – many of whom do not have access to money – was impractical.

"There are issues that we've agreed with the AMA that we can work on, particularly around aged care," Mr Dutton said. "I think there's more we can do to try to provide GP and nursing services into aged care, and they're the discussions we're having with AMA President [Associate] Professor Owler."

The Minster made his comments a day after a meeting with A/Professor Owler, at which the AMA President argued that aged care facility residents should be exempt from the impost because "it's very impractical to actually collect a co-payment [from them]".

The concession is widely viewed as a significant development in the political debate around the Budget, indicating that the Government is finally prepared to countenance changes to its controversial co-payment policy after staunchly defending it for the past two months in the face of widespread criticism.

Nobel Laureate economist Joseph Stiglitz condemned the co-payment as an "absurd" policy during a visit to Australia last week.

Professor Stiglitz told Fairfax Media he was befuddled why any Government would try to make one of the best health systems in the world more like the US's shambolic, inequitable and expensive health arrangements.

"Why would anybody make reforms to try to make your system like the American system?" he asked. "People don't make a decision about medical tests and procedures on price…but for poor people, price signals price them out."

Senate battles co-payment

The Government appears to have little prospect of having the co-payment passed by the Senate in its current form. It is opposed by Labor, the Greens, the Palmer United Party and independent and minor party senators including Nick Xenophon, the Democratic Labour Party's John Madigan, Family First Senator Bob Day and Australian Motoring Enthusiast Party Senator Ricky Muir, who between them muster 42 out of 76 votes in the new Senate.

A/Professor Owler described the meeting he had with Mr Dutton and Prime Minister Tony Abbott at Parliament House on 25 June as "very constructive".

"The Prime Minister and the Minister made it fairly clear in the meeting that they were willing to look at alternative models and consider those on their merits," he said. "[There was] an indication at last that there's a willingness to revisit the model that they've put forward in the Budget."

The AMA has been at the forefront of objections to the co-payment ever since speculation about its introduction began late last year, and has been a strong and consistent critic of the measure as laid out in the May Budget.

A/Professor Owler said he told Mr Abbott and Mr Dutton that although the AMA was not opposed to co-payments per se, it did not support the model adopted by the Government in the Budget.

In particular, he said, the AMA objected to the fact that it included a $5 cut to the Medicare rebate, was likely to deter many vulnerable and disadvantaged people such as Indigenous and elderly patients from seeing their doctor, would discourage people from taking preventive health measures such as vaccinations and would impose unacceptable costs on families and the chronically ill.

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NEWS

Cracks opening in co-payment wall

... FROM P7

A/Professor Owler said it was reasonable to expect that people who could afford to make some form of co-payment should do so, adding that already almost 20 per cent of GP services involved a co-payment.

But he said the $5 cut to the Medicare rebate was completely unacceptable because the current $36 rebate for a standard GP consultation already grossly undervalued the quality care provided by general practitioners.

Not only that, the AMA President said, “we need to make sure that we have the ability to bulk bill those people in society that are not able to contribute further to the costs of their health care, and that promotes things like prevention and allows people to look after patients with chronic diseases”.

Just a couple of hours after meeting A/Professor Owler, Mr Abbott told Parliament the Government’s determination to introduce a co-payment was undiminished, though he was “perfectly happy” to discuss with the AMA what precise form it should take.

“This Government is committed to a modest price signal for GP services,” the Prime Minister told Question Time. “If it is right and fair and proper to have a modest co-payment for the Pharmaceutical Benefits Scheme, how can it be wrong to have a modest co-payment for Medicare?

“The AMA knows that modest co-payment would improve our Medicare system, and that is why I am perfectly happy to work with the AMA to ensure that Australia has the best possible Medicare system.”

Co-payment claims don’t stack up

The Government has argued that the co-payment is a key part of its strategy to rein in what it considers to be unsustainable growth in health costs, and Mr Dutton seized on an Australian Institute of Health and Welfare report showing health spending had climbed 70 per cent in a decade.

“By asking people to make a modest $7 contribution to the cost of their own health care, we’re in a much stronger position to safeguard our health system from collapsing under its own weight,” the Minister said.

But A/Professor Owler said the AIHW figures “don’t actually support a model for a co-payment, and certainly not a co-payment in general practice”.

He said the figures reflected all health spending by governments, insurers and individuals, and the data on Commonwealth expenditure showed that actually health’s share of total Federal Government spending had dropped from 18.1 per cent in the middle of last decade to 16.1 per cent last year.

Underlining the depth of opposition to the co-payment within the medical profession, at a meeting late last month the AMA Council of General Practice reiterated its objection to the policy, including the $5 Medicare rebate cut.

“We don’t accept the rebate cut is fair or viable for practices,” Council Chair Dr Brian Morton told Medical Observer. “The previous rebate has been inadequate and fallen behind over many years from what the proper fee should be. We call on the Government to actually talk to the profession because it really is a whole-of-profession issue involving diagnostic imaging and pathology, and that goes to other specialists as well.”

Adrian Rollins

INFORMATION FOR MEMBERS

APAC 2014

‘Leading Healthcare transformation’ is the theme of the three-day Asia Pacific Forum (APAC) to be held in Melbourne in September.

The event, which is attracting speakers and delegates from across Australia, New Zealand and the region, will feature more than 40 workshops, master classes, panel discussions and presentations on health care delivery and transformation.

The Forum will be held at the Melbourne Conference and Convention Centre from 1 to 3 September.

For more details, visit: www.apcforum.com

NEWS

Co-payment a $200 blow to families

Young families face an increase of almost $200 in their medical bills as a result of the Federal Government's controversial $7 co-payment, while self-funded retiree couples will on average pay an extra $244, according to a detailed analysis of the effect of the policy.

In an assessment likely to intensify the pressure on the Federal Government to re-think its co-payment proposal, researchers at the University of Sydney's Family Medicine Research Centre estimate the policy will, at the least, leave a young couple with two children on average $184 a year worse off, while retired couples will be hit even harder.

They warned the cost would be even higher if, as seems likely, bulk billing rates fall and providers switch to private billing.

The figures, which take into account the cumulative effect of co-payments for GP, pathology and radiology services, underline the political risk the Government is running with the measure, which will inflict significant financial pain across the electorate.

Underlining AMA concerns that the policy is likely to hit the old, the disadvantaged and the chronically ill particularly hard the researchers, drawing on consultations with GPs and Bettering the Evaluation and Care of Health data, warned that while people on average saw a GP between six and seven times a year, among the elderly the average was closer to 11 visits, and for some with chronic illnesses it was above 16 visits.

"It is the high users, usually the older, sicker people in our community, who will be the most affected," the researchers said.

They estimated that a typical type 2 diabetes patient, who on average sees their GP 13.5 times a year, undergoes around three pathology tests and at least one diagnostic imaging test, would incur an extra $120 in co-payments – a bill that would go up to $148.50 for the quarter who need to see their GP more than 17 times a year.

Even patients with concession cards face a painful hit to the hip pocket. A couple on an aged pension would have to pay an extra $199 a year.

The researchers acknowledged AMA concerns that that the co-payment could deter people from seeking treatment and reduce rates of bulk billing.

A COAG Reform Council report found that 5.8 per cent of people put off or avoided seeing their doctor because of cost, though in some areas the rate was as high as 13 per cent.

"It is likely that the increased costs due to these policies would deter more people from seeking early treatment or from taking necessary medications," the researchers warned, noting international evidence that co-payments had resulted in higher long-term health costs as deferred care led to more serious illness and greater rates of hospitalisation.

"Discouraging people from using primary care health services flies in the face of all international evidence," they said, a point highlighted by the release of OCED advice to the Czech Republic last week in which the agency said strengthening primary care and preventive health services was key to stemming the country's "growing tide of diabetes and other chronic health conditions".

"A COAG Reform Council report found that 5.8 per cent of people put off or avoided seeing their doctor because of cost, though in some areas the rate was as high as 13 per cent."

On bulk billing, the researchers said that, given the loss of bulk billing incentives and the outlay involved for practices in setting up systems to charge the track co-payments, "many providers may choose to charge general patients privately, allowing them to charge more than $7 to recoup their expenses".

While under the Government's model practitioners will be free to waive the co-payment for concessional patients, the BEACH researchers said this would come at a significant cost – a loss of $11 in the case of a standard GP consultation. "This suggests it would not be financially viable to regularly waive the co-payment," they said.

Adrian Rollins

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AMA moves in to sort out practice nurse mess

The AMA is meeting with Government officials later this week to resolve the mess created by the Health Department over arrangements for GPs to conduct health assessments.

AMA President Associate Professor Brian Owler accused the Department of "extraordinary mismanagement" of the issue, which cast doubt on long-standing health care arrangements and potentially put the jobs of practice nurses at risk.

Early last week the Department caused alarm when it advised that the time spent by practice nurses on health assessments would no longer be included in the Medicare Benefits Schedule item – only the time spent by the supervising medical practitioner with the patient would be covered.

The change fundamentally undermined an arrangement that had become standard in general practices across the country since 2010.

A/Professor Owler warned the alteration could have a "devastating impact" on the practice nurse workforce and undermine the cooperative work between doctors and supervised practice nurses in providing health assessments.

He said many practices had hired nurses specifically to conduct health assessments, and the rule change threatened what was a vital service, including visits by practice nurses to elderly patients in residential aged care facilities and those still living at home, as well as assessments for young children and the disabled.

Uncertainty about the status of practice nurses deepened later in the week when the Department issued a clarification that only added to the confusion.

The Department issued advice that "a practice nurse may assist a GP with performing the health assessments".

But A/Professor Owler said the update was vague and unclear, and the Department needed to state in plain English that GPs were allowed to include the time spent by practice nurses in completing health assessments.

He said the Department's attempt at a clarification had only made things murkier, leaving general practices unsure of what they could do when processing health assessments and keeping practice nurses on edge about their future.

A/Professor Owler said just a simple re-wording of the latest advice from the Department was needed to allay fears and give doctors, practices and nurses much-needed certainty.

He said that in its advice the Department should state that: 'The time spent by the GP and the practice nurse is one consideration, but not the only consideration'.

"This change will ensure that general practice can continue to provide high quality preventive health care," A/Professor Owler said. "It will also provide greater job security for practice nurses and ease the administrative burden on practice managers."

Senior AMA officials will push for the clarification to end the confusion and uncertainty when they meet with Department officials later this week.

A/Professor Owler said the episode was an unnecessary and unwarranted distraction for GPs, practices and nurses from what they were there to do – look after their patients.

"GPs need greater support, not greater hurdles, to provide care for their most needy patients," he said.

Adrian Rollins

COMMENT

NEWS

Sport told: time to turn off the drinks tap

The AMA has stepped up its call for a ban on alcohol ads and promotions during live sports broadcasts amid evidence that industry self-regulation has failed.

Launching the second annual report of the Alcohol Advertising Review Board (AARB), AMA Vice President Dr Stephen Parnis said it was clear that many major alcohol companies were ignoring concerns young people were being heavily exposed to alcohol marketing and promotion, and could not be relied on their own to act responsibly.

"Children are being heavily exposed to alcohol promotion, often in association with their sporting idols," Dr Parnis said, pointing out that so intense and prevalent was alcohol marketing during the rugby league State of Origin series that it "would leave most people thinking VB [Victoria Bitter] defeated XXXX rather than New South Wales beat Queensland".

"The Government should act now to introduce strong regulatory controls on the content, placement and volume of alcohol advertising and promotion," he said.

Dr Parnis's appeal followed an update from the World Health Organisation showing that Australians were heavy drinkers by global standards.

The WHO, which reported that harmful levels of drinking caused 3.3 million deaths worldwide in 2012, found that Australians drank about double the international average – 12.2 litres of pure alcohol per capita, compared with 6.2 litres per capita – and consumption was increasing.

The WHO warned that "more needs to be done to protect populations from the negative health consequences of alcohol consumption".

Public health campaigners argue the warning especially applies to alcohol advertising in Australia.

During 2013-14 the Review Board, established by the McCusker Centre for Action on Alcohol and Youth and chaired by renowned child health researcher Professor Fiona Stanley, received 209 complaints about alcohol advertising and promotion, 86 of which were upheld in full, and a further 44 upheld in part.

Carlton and United Breweries (CUB) was the most common and consistent source of complaints – accounting for almost 20 per cent of all complaints lodged in the past two years – earning it the dubious distinction of being the first recipient of the Worst Offender Award "for exposing children and young people to extensive alcohol advertising of AFL, NRL and cricket, and for attracting the most complaints to the AARB".

Dr Parnis said CUB's performance was nothing to be proud of, and showed that the current system of industry self-regulation was not working and needed to be replaced.

"Health authorities agree that exposure to alcohol promotion contributes to young people's attitudes to drinking and their drinking behaviours," he said. "That is why strong, independent regulation is needed as part of a comprehensive approach to reducing harm from alcohol."

In 2012 the AMA highlighted how alcohol companies were increasingly turning to social media to promote their products, including through competitions, promotions, videos and music, and last year pointed out how a loophole in advertising regulations exempting live sports broadcasts from child advertising restrictions left young people exposed to heavy alcohol promotion.

Last month, the AMA expressed dismay the major retailer Woolworths was planning to stock Duff Beer, a product based on the beer consumed by popular *The Simpsons* cartoon character Homer Simpson.

The AMA urged the retailer to reconsider its decision, noting that the program had great appeal among children and young adults.

Professor Stanley warned that alcohol advertising had never been as pervasive and inventive as it was now, and "the association between sport and alcohol in Australia must end".

Adrian Rollins

COMMENT

NEWS

Get off the (minimum) floor and hit the vino

Scrapping or reforming the infamous wine equalisation tax could deliver a bigger boost to national health than the introduction of a minimum floor price for alcohol, according to the Federal Government's former chief preventive health adviser.

In one of its final reports before being shut down at the end of last month, the Australian National Preventive Health Agency found little evidence on health grounds to support the establishment of a minimum floor price for alcohol.

Instead, it raised concerns that the wine equalisation tax (WET) – which is levied according value rather than alcohol volume – may actually promote drinking, and should be overhauled.

It found that the way the WET worked meant that the cheaper the wine, the less it would be taxed, irrespective of alcohol content.

"The effective preferential treatment of wine under the WET results in price distortions in the alcohol market; in particular, in favour of cheap wine," the Agency said. "Preferential treatment of wine, particularly at the lower value end [of the market], is likely to be contributing to social and health harms."

By comparison, it found that imposing a minimum floor price would simply add to alcohol company profits without any discernable public benefit.

"A regulated minimum price increase would lead to profit increases flowing to the private sector from the monopoly rents created," ANPHA said. "This significantly reduces the available public benefits which could be used to further reduce or treat alcohol-related harm, or be redistributed by Government for other purposes."

"The loss of major offsetting benefits makes it very difficult for this policy to result in net benefit to the community."

Adrian Rollins

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NEWS

Health checks don't belong on shopping list

Conducting health checks in supermarkets was highly inappropriate and could put the health of customers at risk, AMA President Associate Professor Brian Owler has warned.

Supermarket giant Woolworths is hiring pharmacy students, graduate pharmacists and entry-level nurses to conduct basic health checks of shoppers using its stores in the latest attempt by major retailers to establish in-house health services.

A spokesman for Woolworths told the ABC that the scheme had so far been trialled in six stores in New South Wales and Queensland, and was set to be rolled out nationwide.

Through the scheme, the retailer offers basic health checks including blood pressure and cholesterol, and any customers found to have readings outside the normal range are advised to see a doctor or pharmacist for medical advice.

But A/Professor Owler condemned the scheme, which he said dangerously undermined quality health care and could put patients at risk by giving them misleading diagnoses or a false sense of security about the state of their health.

He said that not only was it greatly concerning that health checks would be conducted by people without appropriate training or qualifications, but they would be carried out in an environment totally at odds with the delivery of quality care.

"In the proposed Woolworths environment, there would be no access to patient history and there would be no privacy," A/Professor Owler said. "The people conducting the checks would not have the knowledge or experience to advise people about lifestyle factors, medications, side effects, or related conditions."

He said the scheme raised the risk that people who had had a health check would think that they did not have to see their doctor.

The AMA President also noted the irony of conducting health checks cheek by jowl with aisles full of products that contribute to ill-health in the first place, such as alcohol, cigarettes, sugary drinks and high-fat foods.

"This is a dangerous idea that should be stopped before it gets off the ground," A/Professor Owler said. "Good health is not something that you can pick off a supermarket shelf."

The Woolworths scheme is the latest in a series of manoeuvres by retailers to expand into the provision of health services, and comes amid efforts by some health professions to increase the scope of their practice.

Supermarkets have so far found their efforts to establish in-store pharmacies stymied by Government, and Health Minister Peter Dutton has indicated that that stance is unlikely to change.

But the ability of pharmacists to administer vaccines is being trialled in Queensland, and there has been a drive to expand the range of practice for nurse practitioners.

While pharmacists are pushing for authority to vaccinate, they are fighting a rearguard action against the Woolworths health check scheme.

The Pharmacy Guild of Australia condemned it as an attempt by the retailer to "hoodwink consumers into believing they can get professional pharmacist advice and products from a supermarket".

The Guild told the ABC it was concerned that staff recruited by Woolworths to conduct health checks were suitably qualified and whether they had training in privacy requirements.

"It's a hypocritical and, frankly, a public disservice that a supermarket giant which profits so heavily from retailing tobacco and alcohol products - which are the biggest preventable causes of ill health and death - is claiming to be interested in health care," Guild President George Tambassis told the ABC.

Adrian Rollins

COMMENT

NEWS

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

AMA wants GP fee gone, *Sydney Morning Herald*, 19 June 2014

The AMA has demanded Tony Abbott scrap his proposed $7 GP fee, accusing the Coalition of treating health care as an ideological toy. AMA President A/Professor Brian Owler branded the proposed fee as unfair and unnecessary.

AMA cannot claim moral high ground on co-payments, *The Australian*, 20 June 2014

AMA President A/Professor Brian Owler has savaged the Coalition's plan for a $7 co-payment on general practitioners, pathology, and radiology.

My children's GP didn't know, *Sunday Mail Adelaide*, 22 June 2014

The head of the Australian drug company which has developed a vaccine against a deadly strain of meningococcal has revealed a doctor was unaware of the potentially life-saving treatment. AMA Chair of General Practice Dr Brian Morton called for better methods of circulating information to GPs.

Legalise cannabis for the ill, *Adelaide Advertiser*, 23 June 2014

A Greens Senator has said it is cruel to deny the ill access to medical cannabis because of the stigma associated with it. The AMA has acknowledged that cannabis may have therapeutic potential.

Doctors to meet PM on fee plan, *Courier Mail*, 25 June 2014

Doctors were due to meet with Prime Minister Tony Abbott in Canberra to urge the Government to dump the $7 Medicare co-payment for concession card holders and children. The AMA was set to tell Mr Abbott that he should change the co-payment because of the fear many lower socio-economic people will put off visits to their GP.

Abbott to AMA - $7 GP fee may go, *Adelaide Advertiser*, 26 June 2014

Prime Minister Tony Abbott has told doctors he is prepared to compromise on the controversial $7 GP fee. AMA President A/Professor Brian Owler said the fee would prevent the chronically ill from accessing health care.

Aged care shift signals GP fee compromise, *Hobart Mercury*, 27 June 2014

Residents of aged care homes could be exempted from the $7 GP fee in the first sign the Government is prepared to compromise on the controversial measure. AMA President A/Professor Brian Owler said it was a good sign.

Flu drug warning ignored, *Sunday Telegraph*, 29 June 2014

Doctors are wrongly administering the banned Fluvax vaccine to young children, prompting health experts to call for a change in its name. AMA President A/Professor Brian Owler said the instructions on the box said 'not for children under five', so it was frustrating that so many have been given it.

GP anger at Woolies tests, *Australian Financial Review*, 2 July 2014

Two lobby groups criticised a plan by Woolworths to offer health checks to customers. AMA President A/Professor Brian Owler said there would be no access to patient history and no privacy.

Radio

A/Professor Brian Owler, 6PR Perth, 19 June 2014

AMA President Associate Professor Brian Owler talked about the health problems exacerbated by sitting down all day. A/Professor Owler said working at a computer is not conducive to a healthy lifestyle.

A/Professor Brian Owler, ABC Ballarat, 19 June 2014

AMA President Associate Professor Brian Owler discussed the GP co-payment. A/Professor Owler said the GP co-payment proposed by the Federal Government risked harming the most vulnerable and the chronically ill.

A/Professor Owler, 774 ABC Melbourne, 20 June 2014

AMA President Associate Professor Brian Owler talked about the $7 GP co-payment. A/Professor Owler said the fee also applied to pathology and diagnostic imaging services, noting that it was uncertain whether the fee would apply to each individual test or each group of tests.

A/Professor Brian Owler, ABC NewsRadio Sydney, 25 June 2014

AMA President Associate Professor Brian Owler talked about his meeting with Prime Minister Tony Abbott regarding the $7 GP co-payment. A/Professor Owler said the Government had indicated a willingness to reconsider some aspects of the measure.

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AMA IN THE NEWS

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Dr Stephen Parnis, 2HD Newcastle, 26 June 2014

AMA Vice President Dr Stephen Parnis talked about the AMA's meeting with Prime Minister Tony Abbott about the GP co-payment. Dr Parnis said the Prime Minister is prepared to review some of the aspects of the model that have been put forward in the Budget.

Dr Brian Morton, ABC Northern Tasmania, 26 June 2014

AMA Chair of General Practice Dr Brian Morton discussed doctors in the UK voting to support a permanent ban on the sale of cigarettes to anyone born after the year of 2000. Dr Morton said it would be difficult to enforce a ban on a substance that would remain legal in other ways.

A/Professor Brian Owler, ABC NewsRadio Sydney, 1 July 2014

AMA President Associate Professor Brian Owler discussed Woolworths conducting free health checks in its stores. A/Professor Owler said it was cynical for Woolworths to be conducting health checks, given that supermarkets were stocked with unhealthy products.

Television

A/Professor Brian Owler, Sky News Australia, 25 June 2014

AMA President Associate Professor Brian Owler commented on Prime Minister Tony Abbott's commitment to reconsider the Medicare co-payment model.

A/Professor Brian Owler, Channel 9 Perth, 1 July 2014

AMA President Associate Professor Brian Owler discussed Woolworths' move to offer free health checks to customers. A/Professor Owler said if Woolworths was serious about health, it would not sell tobacco and promote alcohol in the way it does.

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.

JULY HEALTH EVENTS

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

Sun	Mon	Tue	Wed	Thur	Fri	Sat
29	30	1 National JulEYE Month	2	3	4	5
6	7 National ASK Y Awareness Day	8	9	10	11 World Population Day	12
13 National Diabetes Week	14 National MDS Day	15	16	17	18	19
20	21 National Pain Week	22 World Fragile X Awareness Day National Stress Down Day	23 World Sjogrens Syndrome Day	24	25	26
27	28 World Hepatitis Day	29	30 Cerebral Palsy Awareness Week	31	1	2

Independent Hospital Pricing Authority

Pricing Framework 2015-16

Public comment invited

Members of the public and all interested parties are invited to comment on the Independent Hospital Pricing Authority's (IHPA) *Pricing Framework for Australian Public Hospital Services 2015-16*.

IHPA's Pricing Framework is fundamental to the National Health Reform Agreement and underpins the annual National Efficient Price (NEP) and National Efficient Cost (NEC) for Australian public hospital services.

Feedback gathered in this public consultation process will be used to help inform IHPA's final Pricing Framework for 2015-16.

Submissions should be emailed as an accessible Word document to submissions.ihpa@ihpa.gov.au or mailed to www.ihpa.gov.au

PO Box 483, Darlinghurst NSW 1300 by 5pm on Sunday 27 July 2014.

The Pricing Framework 2015-16 is available at www.ihpa.gov.au

IHPA

www.ihpa.gov.au

PUBLIC HEALTH OPINION

Moving on from the Medicare Local muddle

BY **PROFESSOR STEPHEN LEEDER**

The recent Federal Budget has provoked strong reactions, many of them negative. The proposals in the Budget are, appropriately, concrete – a $7 co-payment and major changes to the extent to which the Commonwealth finances health care more generally.

What has caused so much angst is that the budgetary process is ill-equipped – in part because it is so concrete and allows no space for the contest of ideas – as a platform for social policy debate.

Yet many of the proposed changes represent big shifts in public policy. For example, after a confusing series of pre-budget sound bites equating the $7 co-payment with a rescue package for an unsustainable health system, it appeared on Budget night dressed up as a way to raise money for a Medical Research Future Fund. These two explanations contradict one another and reveal a lack of policy debate and clarity.

The more likely explanation was neither enunciated nor contested – that the Government believes, as part of its ideology, that paying a fee at the point of use of publicly-funded health care 'sends an important price signal'. If this had been revealed and not hidden, a policy discussion could have followed (as a functioning democracy deserves) as to why a price signal is considered important, and to whom. The possibility of signalling the price of health care at the time of taxation through the Medicare levy and general revenue was not raised.

> “ the Government believes, as part of its ideology, that paying a fee at the point of use of publicly-funded health care 'sends an important price signal' ”

In the case of the abolition of the Medicare Locals, also presented as a fait accompli in the Budget, the circumstances were a little, although not much, better. Few people were knowledgeable about contents of the recent review of Medicare Locals or the reasoning that led to the cut to their budget. There was no opportunity to discuss, with evidence and informed opinion, why the new structure proposed for that purpose, with indeterminate budgets, would be likely to work better than the old. That would have been a good place to start.

At their simplest, the recommendations of the review of Medicare Locals were that a few large primary health care networks should replace the 61 regional Medicare Locals.

Although it is said that these should align with the boundaries of local hospital networks, that cannot be easily achieved. There are many more such hospital networks, especially in Victoria, than there are Medicare Locals. It appears that what is intended is that each primary care network would have within it two councils – one clinical and one community – for each hospital network, assuming that each network would serve several groups of hospitals.

The central recommendation regarding these councils is No. 7, which reads:

> *The government should establish a limited number of high-performing regional [[primary health care networks] whose operational units, comprising pairs of clinical councils and community advisory committees, are aligned to [local hospital networks].*

By some indeterminate means, these councils would empower local general practitioners to work with their hospital colleagues. But, as has been seen with Medicare Locals, the financial management of these partnerships is difficult because the hospital networks are funded by the States, and general practitioners by fees and the Commonwealth's Medicare system. Evidence from studies conducted by McKinsey and Co., a consultancy, reveals that integrated care requires several elements for success, one being that a common budget covers both hospital and community care. This is not possible in Australia

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PUBLIC HEALTH OPINION

Moving on from the Medicare Local muddle

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at present without substantial changes to health care financial management that goes a long way beyond Medicare Locals or primary care networks.

The financial management of integrated care is already difficult in this country. But with vague allusions to the management of the new networks being up for tender, private health insurers are circling, apparently considering applying to manage whatever it is that the new networks will do. Were they to be awarded contracts along this line it would introduce a third source of financing into the equation – publicly-subsidised private health insurance - and commercial imperatives, rather than a strictly service motivation.

What then would the new networks actually do?

The report explicitly excludes provision of services - except in defined default circumstances, and so the principal function will be planning, commissioning, coordination and management and, presumably, developing integrated care programs for people with chronic illness.

Continuing education for general practitioners, which was part of Medicare Locals, appears to have suffered the same fate as several other Commonwealth programs agencies in the Budget, including a raft of preventive services – again, untouched by policy and debate.

Several matters deserve speedy resolution, both for the sake of Medicare Locals struggling with demoralised and departing staff and for their successors, and for the sake of democracy.

First, the Commonwealth should effectively communicate what functions it intends the new primary care networks to fill, and invite informed discussion. It should cease using shouts and murmurs via the Budget as a substitute for informed policy debate.

Second, it should explain the financial and management arrangements it proposes for the conduct of the new primary health care organisations – which pays for what.

Third, and most important from the perspective of patient care, the role of these new entities in the provision of integrated care needs urgent attention.

We need clarity of policy to rid us of this unhealthy medimuddle.

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.

Health on the hill

Political news from the nation's capital

Star-crossed food rating system gets go-ahead

The costs of implementing the five-star food rating system are likely to be outweighed by improvements in the nation's health within the next five years, according to a cost-benefit analysis commissioned by the Federal Government.

Delivering a verdict that has reinforced the commitment of Australia and New Zealand food ministers to introduce the Health Star Rating (HSR) System, consultancy PricewaterhouseCoopers has found that the $60 million it will cost industry and government implement the scheme in the next five years will be more than offset if the expansion of the nation's waistline slows by just 0.04 per cent a year – meaning that after five years there would be 7565 fewer people overweight or obese than would otherwise be the case.

The PricewaterhouseCoopers report concluded that "there is clear evidence that interpretive front-of-pack labelling schemes like the HSR system are an effective tool to assist consumers to make healthier food choices".

"In PwC's view…the aggregate benefits of the HSR system, in the context of multiple public health initiatives, will pay back aggregate costs over [a] five year implementation period," it said.

The positive report card has buttressed the arguments of health advocates, including the AMA, who have campaigned hard for the adoption of a simpler front-of-packet guide to food nutrition for many years.

While the HSR achieved unanimous support from the nation's food ministers more than a year ago following two years of exhaustive consultation and negotiation involving the medical profession, health advocates, government and industry, its implementation was thrown into turmoil soon after the Federal Government changed hands last year.

Newly-elected Assistant Health Minister Fiona Nash, who became Chair of the ministerial Forum, late last year successfully argued for the need to subject the HSR to a cost-benefit analysis.

Then early this year, Senator Nash's then Chief of Staff Alastair Furnival – who it was later revealed co-owned a lobbying firm that worked for major food manufacturers - sensationally interfered in the implementation of the HSR and directed the Health Department to take down the system's website just hours after it had been made live.

Mr Furnival was later forced to resign after his links to the food industry were revealed.

It was against this turbulent background that the Legislative and Governance Forum on Food Regulation agreed at its 27 June meeting to the immediate commencement of the HSR, to be backed by a website and education campaign.

But the announcement came with several concessions to the food industry that had been thrashed out in a series of meetings and negotiations involving Senator Nash, the Australian Food and Grocery Council (AFGC), public health advocates and consumer groups.

Food manufacturers have been given five years – up from the original two – to voluntarily implement HSR labelling, and health groups have conceded to demands that existing labels including the Heart Foundation Tick and the industry's own Daily Intake Guide can continue to be used on food packaging.

In addition, the Forum has set up a process to consider "potential anomalies" arising from the application of HSR rating criteria, such as "where a star rating may be inconsistent with the Australian Dietary Guidelines, or when its use to make comparisons within a food category or across comparable food categories…may mislead consumers".

Public Health Association of Australia Chief Executive Officer Michael Moore said the Forum's decision to back the HSR and reinstate its website now put the onus on manufacturers to implement the scheme.

"Since the demise of the HSR website there have been ongoing negotiations, including a number of meetings with Senator Nash, to ensure that the system is as user friendly for industry as possible," Mr Moore said. "It has been a difficult negotiation, with compromises on both sides. There were many private hiccups, and a very public one when the HSR website was pulled down."

"It is now over to industry."

Industry representatives said negotiations overseen by Senator Nash and her department had resulted in "significant improvements" in the scheme, including increased implementation time and agreement that the HSR could co-exist with the Daily Intake Guide.

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But AFGC Chief Executive Gary Dawson warned that it was up to individual manufacturers to decide whether they would participate in the scheme.

"Ultimately, it will be up to food companies to assess the scheme and determine whether or not they adopt it," Mr Dawson said.

On this front, advocates of the scheme have been encouraged by the announcement of two major industry players, Woolworths and Sanitarium, that they would adopt the HSR across their entire range of products.

Mr Moore said the HSR gave food companies a "clear opportunity…to assist in tackling the obesity epidemic", and Chair of Cancer Council Australia's Nutrition and Physical Activity Committee Kathy Chapman said better labelling was an important weapon in helping combat the incidence of cancers linked to being overweight.

The scale of the nation's problem with food was revealed in an Australian Institute of Health and Welfare update on population health which showed that poor nutrition was a major contributor to chronic disease – which in turn accounted for 90 per cent of all deaths.

The Institute reported that almost two-thirds of Australians were overweight or obese, less than 10 per cent were eating enough vegetables and more than half were not eating enough fruit.

Adrian Rollins

Hambleton appointed to pivotal e-health role

Immediate-past AMA President Dr Steve Hambleton has been appointed to a pivotal role in the development of the nation's e-health system as Health Minister Peter Dutton considers a major overhaul of the troubled $1 billion electronic health record scheme inherited from the previous Government.

The National E-Health Transition Authority has announced the appointment of Dr Hambleton as Chair of the organisation, replacing David Gonski, who occupied the position for six years.

In a statement announcing the appointment, NEHTA said Dr Hambleton brought to the role "clinical expertise and leadership... [which] will be vital in ensuring that e-health becomes widely adopted in clinical settings across Australia".

The former AMA President has a long-standing interest in e-health, and was a member of the three-person panel appointed by Mr Dutton to review the Labor Government's Personally Controlled Electronic Health Record (PCEHR) system.

The PCEHR has been the subject of sharp criticism from the medical profession, which argued that the ability of patients to alter their health record fundamentally compromised its clinical usefulness, because doctors could rely on it to contain all medically relevant information.

Adoption of the scheme has been underwhelming. Since it was launched in mid-2012, little more than one million people have registered an interest in having a PCEHR record, and only a handful of medical practices have created records for their patients.

But Dr Hambleton told *Australian Medicine* that, despite the flaws in the PCEHR, the basic building blocks for an e-health system had already been put in place by NEHTA, and it was a matter of improving on what was already there rather than scrapping everything and starting again.

He said NEHTA had overseen the creation of individual health identifiers, standard terminology and coding for prescriptions and descriptions of diseases, and protocols for secure messaging.

Dr Hambleton said what was need was to get e-health record system built on these foundations right, and the Government was committed to getting a fully- functioning e-health system established.

"The future is uncertain for this particular entity [the PCEHR] but it is not for e-health," the former AMA President said. "The Minister is fully supportive of e-health."

The appointment of Dr Hambleton is seen as significant in light of criticism of NEHTA and the PCEHR that both suffered from lack of engagement with clinicians, a view underlined by the mass walk-out of clinical advisers from NEHTA in August last year, led by clinical lead Chair and former AMA President Dr Mukesh Haikerwal.

The walk-out rocked the organisation and reflected deep frustration with the limited voice clinicians and other key stakeholders were given in the development of the PCEHR.

Dr Hambleton said engagement with clinicians was "critical".

"We need to make sure we engage with all clinicians – GPs, public hospitals, private hospitals, surgeons, emergency physicians, pathologists, radiologists and so on to make sure the system is as streamlined and simple as possible to use," he said.

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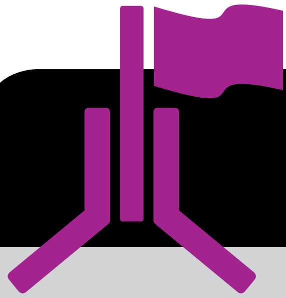

Health on the hill

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He said Australia's health system was "way behind" other countries in terms of electronic communication with patients and between clinicians.

"We need to make sure we deliver," Dr Hambleton said.

The PCEHR review, the findings of which were released by the Government in May, has called for a major overhaul of the system, including a change in the name to My Health Record and making it an opt-out system.

Significantly, in light of Dr Hambleton's appointment, the review also recommended that NEHTA be dissolved and replaced by an Australian Commission for Electronic Health, which would be advised by committees that included clinicians.

Changing the system to an opt-out arrangement is seen as a critical change that would make electronic health records more clinically useful, because knowing every patient had a record would encourage doctors to use the system.

The Federal Government has committed $140 million to continue the roll-out of the PCEHR while it considers the findings of the review, though it appears likely there will be a fundamental overhaul.

Mr Dutton said last month that the Government "fully supports the concept of a national e-health record system, but it needs to be effective, functional and easy for all Australians to use, while being clinically relevant to our doctors, nurses and other frontline health care providers".

Adrian Rollins

Fears co-payment, Budget cuts could widen Indigenous health gap

Many Indigenous people are putting off seeing their doctor because of cost, contributing to extraordinarily high rates of preventable hospitalisation and premature death among Indigenous Australians, the peak adviser to the nation's governments has warned.

In a finding that has added fuel to the debate over the Federal Government's controversial $7 co-payment, the COAG Reform Council's final report card on Indigenous health showed that 12.2 per cent of Indigenous adults delayed or cancelled a trip to their GP because of cost – an outcome linked by Council Chair John Brumby to higher rates of ill health, preventable hospitalisation and premature death.

"When you avoid going to a primary or community care provider because of cost or other reasons, you often end up in hospital," Mr Brumby said. "And we've found that rates of preventable hospitalisations for Indigenous Australians are three to four times higher than for non-Indigenous Australians."

AMA President Associate Professor Brian Owler said the finding underlined doctor concerns about the impact of the proposed $7 co-payment.

A/Professor Owler said the fact that a significant proportion of Indigenous people already put off seeing their doctor when the national bulk billing rate was around 82 per cent did not bode well for when the co-payment came into effect and the bulk billing rate dropped.

The AMA President said it showed how important it was to recognise that Indigenous health was not just a matter for targeted programs and services, but was also affected by broader developments in the health system.

Aboriginal and Torres Strait Social Justice Commissioner Mick Gooda said the proposed co-payment was a cause of "great anxiety" about Indigenous health.

"Aboriginal and Torres Strait Islander people access Medicare services at a rate which is almost one third lower than what is required on a needs basis," Mr Gooda wrote on the ABC's *The Drum* blog. "Our people need encouragement to access medical services, not more barriers."

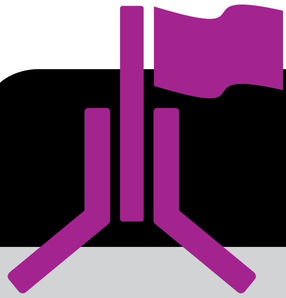
The Federal Government's commitment to improving Indigenous health has been called into question following funding cuts to health programs, as well as the introduction of the $7 co-payment.

The Government has rejected such criticisms, and late last month Assistant Heath Minister Senator Fiona Nash announced that work was to begin on implementing the National Aboriginal and Torres Strait Islander Health Plan as part of efforts to raise the health standards of Indigenous Australians and bring them into line with the broader community.

"The Health Plan provides a useful framework to guide policy and program development," Senator Nash said, adding that it would recognise the links between health, education, employment and community safety. "The Government is committed to closing the gap by ending the cycle of disadvantage which starts with poor child health. Indigenous health will only be improved by concrete action on the ground."

But a $165.8 million cut to funding for Indigenous health programs in the May Budget has undermined the Government's message and raised questions about the seriousness of its intent to close the health gap.

In highlighting the size of the task confronting governments, the COAG Reform Council found that while substantial progress had been made in reducing child mortality rates, there remained formidable disparities in health outcomes.



Health on the hill

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The rate of preventable hospitalisations was three times higher among Indigenous people than the national average, while a shocking 75 per cent of deaths of Indigenous people younger than 75 years could have been avoided through preventive care or early treatment.

Adding to the disturbing picture, the Australian Institute of Health and Welfare has reported that Indigenous adults were twice as likely to die from coronary heart disease as the broader population, and three times as likely to succumb to chronic obstructive pulmonary disease. The rate of COPD in the Indigenous community is more than twice that of the national average.

The stark figures have contributed to the yawning gap in life expectancy – on average, Indigenous men are likely to die 10 years earlier than their non-Indigenous countrymen, while among women the life expectancy gap is greater than nine years, according to the COAG report.

In a disappointing assessment, the COAG Reform Council warned that the goal to close the large life expectancy gap by 2031 was unlikely to be met.

"These things scream out that change is needed," A/ Professor Owler said. "We have got lots of information on what the problems are. We now need to act and make changes."

A/Professor Owler said there were already many examples of local health services that had achieved significant improvements in Indigenous health in their areas through innovative and targeted programs, and groups like National Aboriginal Community Controlled Health Organisations (NACCHO) were working hard on ways to adapt and apply such successes in other areas.

He said any cuts to program funding in the name of efficiency had to be very carefully considered and evaluated, and should only be made in close consultation with those providing Indigenous health services.

Mr Brumby delivered the findings of the COAG report to the NACCHO annual summit on 26 June.

NACCHO Chair Justin Mohamed said that although there were some signs of improvement in Indigenous health, Federal Budget cuts and health policy changes put further progress at risk.

"We are really worried that the millions of dollars being cut from across Aboriginal affairs at the Federal level, plus the introduction of new arrangements in accessing primary health care and changes to unemployment benefits, could potentially push the closing the gap targets even further from reach," Mr Mohamed said.

The NACCHO Cahir lamented the abolition of the COAG Reform Council, in whose absence there would be "no independent umpire able to evaluate progress - or the lack of it – and hold governments accountable".

Adrian Rollins

Govt accused of serving up a shandie

The Federal Government has been accused of ripping more than half the promised $20 million out of a plan to tackle foetal alcohol spectrum disorder.

Assistant Health Minister Fiona Mash came under sustained attack in the Senate after she announced that $9.2 million had been committed to develop a national FASD Action Plan.

Senator Nash, who paid tribute to the work of Coalition backbencher Dr Sharman Stone in pushing for action on FASD, said the plan would "promote consistent messages though primary care providers about the risks of consuming alcohol during pregnancy…and continuing activities through awareness of the risk of FASD".

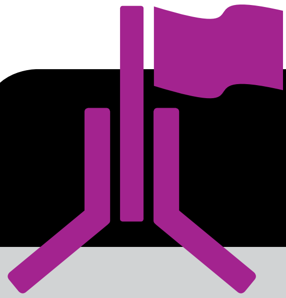
Dr Stone said some Australian communities had the highest rates of FASD and FAS in the world, with many babies born with irreversible disabilities including cognitive impairment and physical, behavioural and learning disabilities.

"The culture of drinking is so deeply entrenched in Australia that it is often very hard for women to get the message that all they have to do is abstain from drinking…for the nine months of their pregnancy," Dr Stone said. "That seems to me a very small price to pay to ensure your baby is not born with permanent brain damage and other physical consequences."

The FASD Action Plan will include $4 million for the New Directions: Mother and Babies Services program, FASD research grants, and resources to help GPs and other health professionals to promote abstention from alcohol among pregnant women.

But Labor condemned the Government for stripping funds away from the effort to prevent FASD.

Shadow Health Minister Catherine King said in mid-2013 the previous Labor Government had allocated $20 million for the FASD Action Plan.



Health on the hill

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Ms King said the Government's funding announcement was welcome, but called on Senator Nash to explain why the amount allocated had been halved.

The debate coincided with the release of research showing for the first time that babies born to mothers who drank excessively during pregnancy not only had impaired cognition and behavioural problems, but were also three times more likely to suffer gross motor skill abnormalities.

The Sydney University and George Institute study found that alcohol during pregnancy can harm the development of motor skills, leading to impairments with movement, balance and co-ordination.

The research found that exposure to just one drink a day of alcohol during pregnancy caused damage to the brain, peripheral nerves and neurotransmitters.

"Mums may come home and have a drink or two and think they're fine, but the advice is that alcohol may cause harm and we don't know the safe level," study co-author and Sydney Medical School researcher Barbara Lucas told the *Daily Telegraph*.

The findings came amid evidence that 80 per cent of expectant mothers consumed at least some alcohol during their pregnancy, and around 20 per cent of health professionals were ignorant of official guidelines advising women to abstain from alcohol during pregnancy.

Launching a national campaign to encourage doctors and other health professionals to discuss the risks of drinking during pregnancy, Senator Nash said it was important that women be informed of the dangers "in a way which doesn't cause distress or embarrassment, or that turns women away from wanting to receive further prenatal care".

The nation's Health ministers have also expressed concern about low rates of adoption of pregnancy warning labels by manufacturers of ready-to-drink alcohol products (often called alcopops).

The ministers resolved to continue to work with industry to ensure increased use of the label, particularly in alcopop packaging.

Adrian Rollins

Finance could give Halton whip hand on Health

Jane Halton may have officially left the Health Department, but in her new role as Secretary of Finance, her influence on the direction and implementation of health policy will be virtually undiminished.

That is the assessment of seasoned Canberra observers following Prime Minister Tony Abbott's decision to appoint Ms Halton to the pivotal Finance role following a 12-year stint at Health.

Ms Halton, who shot to national prominence early last decade when she was appointed by the Howard Government to head its people smuggling taskforce before assuming the top position at Health in 2002, has been appointed to a five-year term as Finance Secretary.

The promotion means Ms Halton will have a central role in helping develop and execute the Federal Government's Budget strategy, which has the containment of health spending as one of its central goals.

It means that although Ms Halton is no longer formally tied to the Health Department, her influence on the direction and implementation of health policy will continue to be substantial.

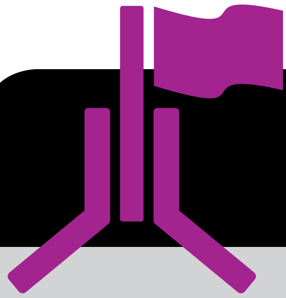
Senior Health official David Learmonth, who has served as Deputy Secretary in the Department for the past eight years, has been appointed acting Secretary following Ms Halton's departure.

Mr Learmonth, who has been a key lieutenant for Ms Halton, has since mid-2006 had oversight of the Department's work regarding medical and pharmaceutical benefits, as well as audit and fraud functions.

The former Defence official has also assumed responsibility for sport functions, including the operation of the Office for Sport and the National Integrity of Sport Unit after responsibility for sport was transferred to Health following the Federal election.

In a statement late last month detailing these and other changes in the senior ranks of the public service, Prime Minister Tony Abbott said he would make an announcement about a permanent replacement for Ms Halton at the Department of Health "in the near future".

Adrian Rollins



Health on the hill

Political news from the nation's capital

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Commonwealth may walk away from health

States may get a slice of income tax revenue or the spoils from an increase in the GST under proposals likely to be considered under Prime Minister Tony Abbott's plans to overhaul the Federation.

Flagging the possibility of a wholesale retreat by the Federal Government from involvement in the delivery of basic services such as health and education, Mr Abbott has raised the prospect of a sharply narrower ambit for the Commonwealth than it currently exercises.

It is a vision strikingly at odds with the centralist policy direction Mr Abbott backed in 2007 when, as Health Minister in the Howard Government, he assumed direct control north Tasmania's Mersey Community Hospital and said "this project, if successful, could validate a new model for running public hospitals, especially in regional areas".

In its May Budget, the Federal Government reignited the health funding blame game with the States after disavowing public hospital spending guarantees negotiated by the Labor Government and reducing the indexation of funding beyond 2017 to CPI plus population growth – effectively slashing $20 billion from public hospitals over five years.

Mr Abbott has followed this up by announcing preparation of a White Paper on the Reform of the Federation, the terms of reference for which explicitly refer to the idea of limiting Commonwealth policy and funding to areas deemed matters of core national interest under Section 51 of the Constitution – foreign affairs, trade, defence, immigration, transport, banking, immigration and industrial relations, but not health, education, aged care, child care and other services.

"We need to reduce and, if possible, end duplication and make interacting with Government simpler," the Prime Minister told the Liberal Party Federal Council. "We need to clarify roles and responsibilities for states and territories so that they are, as far as possible, sovereign in their own sphere. There should be less Commonwealth intervention in areas where states have primary responsibility."

The Federal Government's decision to slice into its contribution to public hospital funding had already fuelled debate about the inadequacies and inequities of current Commonwealth-State funding arrangements.

The states and territories receive revenue collected by the GST – currently around $50 billion – but its growth has slowed in recent years and the states complain that it is insufficient to meet their funding needs. There has been increasing discussion of the need to increase the GST rate above its current 10 per cent, or to broaden its base to include items, such as fresh food, that are currently exempt.

Alternatively, Queensland Premier Campbell Newman has suggested states scrap inefficient stamp duty and payroll taxes in exchange for a slice of personal income tax revenue.

The White Paper review is expected to be conducted over the next two years, raising the prospect that issues around the structure of the Federation and the division of Commonwealth-State responsibilities will loom large in the lead-up to the next Federal election.

Aside from issues of public hospital funding, the prospect of the Commonwealth divesting itself of all health responsibilities raises questions around national variations in the standard of, and access to, care, training standards, accreditation and other quality criteria, as well as coordination on nationally significant health issues such as disease control, immunisation and preventive health policy.

Adrian Rollins

Changes to Labor's health team

Federal Labor leader Bill Shorten has been forced to change the make-up of his Shadow health team for the second time in four months as the Opposition sharpens its focus on higher education policy and plugs holes created by the departure of eight senators.

South Australian Labor MP Amanda Rishworth has been promoted to the Shadow Ministry from Shadow Parliamentary Secretary for Health to the newly-created position of Shadow Assistant Minister for Education and Higher Education to bolster Labor's attack on the Federal Government's moves to deregulate university fees.

Fellow SA Labor MP Nick Champion, a former union official, has been appointed to appointed to Ms Rishworth's position.

The change follows the elevation of NSW MP Stephen Jones to the position of Shadow Assistant Health Minister after incumbent Melissa Parke was forced to withdraw from the Shadow Ministry because of a serious illness in her family.

Mr Champion said "I look forward to fighting the Abbott Government's policy to dismantle Medicare, introduce a $7 GP tax and implement $50 billion in cuts to health and hospitals".

Adrian Rollins

Health on the hill

Political news from the nation's capital

Committee aims to keep health policy an open wound for Govt

The effect of the proposed $7 co-payment on access to care and the hit to public hospitals from Commonwealth funding cuts will be the focus of a Senate inquiry aimed at ensuring health care remains high on the political agenda.

In its second-last sitting day before an influx of new MPs shifted the balance of power in the Upper House, Labor, Green and independent Senators joined forces to back the formation of a Senate Select Committee on Health to inquire into changes to health policy in the Federal Budget, including the imposition of the co-payment, the disavowal of public hospital funding guarantees to the states, and the abolition of health workforce planning and training agencies.

Among the issues the inquiry will consider is the effect of a $20 billion cut in public hospital funding over the next five years on elective surgery and emergency department waiting times, as well as overall hospital capacity, plus the impact of cuts to preventive health programs, Indigenous health care, and Medicare services.

The Committee is not scheduled to deliver its final report until mid-2016, but has been given scope to issue interim reports "as [it] sees fit" – a provision aimed at ensuring the Budget changes to health remain a running political sore for the Government through to the next election, due to be held in late 2016.

The changes to health funding, particularly the imposition of a $7 co-payment on GP, pathology and radiology services, are shaping as a major point of political vulnerability for the Government.

The co-payment is regularly cited as a major factor contributing to voter disenchantment identified in opinion polls. A survey by Essential Research last month found 61 per cent of those sampled supported attempts by politicians to block the co-payment in Parliament.

Adrian Rollins

Medibank sale takes to the road

The roadshow for the planned $4 billion sale of Medibank Private is expected to begin this week when top officials brief institutional investors in Australia before heading offshore.

Chief executive George Savvides and Chief Financial Officer Paul Koppelman will meet potential investors in Melbourne and Sydney over the next few days before embarking on a three-week tour through Asia, Europe and North America aimed at drumming up interest in the sale, according to *The Australian.*

The sale of Medibank Private, one of the biggest public offerings in years, is a key plank in the Federal Government's fiscal strategy and is expected to attract significant interest both at home and abroad.

But although demand may be strong, the sale process is expected to take some time.

The Federal Government expects any sale to be completed this financial year, but only if market conditions are favourable, and there are expected to be several roadshows in order to maximise investor interest and possible returns from the sale.

Joint lead managers of the sale, Deutsche Bank, Goldman Sachs and Macquarie, are likely to closely monitor how another the sale of another major health organisation, Ramsay Health Care-Healthscope, fares.

The prospectus for what could be a $2.6 billion sale was lodged last week.

Adrian Rollins

Price rise for disability services

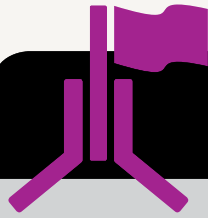
Disability service providers have won an increase in the price the National Disability Insurance Scheme is willing to pay for the support they provide, as operations for the system ramp up.

Service providers have negotiated increases of up to 13.5 per cent in the price the National Disability Insurance Agency, which runs the NDIS, was prepared to pay for services including assistance in self-care and community support.

The agreement goes some way to meeting long-standing concerns among service providers that in many instances the prices the NDIA was willing to pay were inadequate.

"From the first day they started rolling out the NDIS, the disability community knew that the prices the agency was paying for some services didn't reflect the real cost of high-quality support," said Dr Ken Baker, Chief Executive of National Disability Services, which represents 950 disability service providers. "If this had continued, service providers would have gone broke, and people with disability and their

MORE P27



Health on the hill

Political news from the nation's capital

... FROM P26

families would have been left with no, or poor quality, support in the NDIS trial sites."

From 1 July the number of trial sites for the Scheme expanded to include the ACT, the Barkly region of the Northern Territory, the Perth Hills area of Western Australia and the Lake Macquarie area of NSW.

There have been concerns that the Federal Government wants to slow implementation of the NDIS in order to save money, but Assistant Minister for Social Services Mitch Fifield has insisted the Commonwealth remains committed to its timely roll-out.

The scale of demand for disability care has been underlined by an Australian Institute of Health and Welfare report showing that 312,539 people used disability support services in 2012-13.

The greatest demand was for community support (45 per cent of services), followed by employment services (41 per cent), community access (18 per cent), accommodation support (14 per cent) and respite care (12 per cent).

The number of people using disability services has grown significantly, up 12 per cent between 2008-09 and 2012-13, though the rate of growth has slowed in recent years, dropping 2 per cent between 2011-12 and 2012-13.

Most service users required assistance in at least one of through broad aspects of life – independent living (64 per cent), work, education and community living (61 per cent), and daily life (55 per cent).

The growth in demand has driven an increase in expenditure – spending on disability support services rose almost a quarter between 2008-09 and 2012-13 to $7.2 billion.

But although the NDIA has upped its tariffs, Dr Baker said the increases did not go far enough.

"Unfortunately, the agency is still not funding the full cost of quality service provision," he said, noting that in the next 12 months prices will grow at less than the rate of inflation.

Dr Baker has urged that prices be deregulated immediately rather than in 2014-15, as is currently planned.

Adrian Rollins

Independent Hospital Pricing Authority *Work Program 2014-15*

Public comment invited

Members of the public and all interested parties are invited to comment on the Independent Hospital Pricing Authority's (IHPA) *Work Program 2014-15*.

IHPA's Work Program is revised and published each financial year. It outlines IHPA's objectives, performance indicators and timeframes for the coming year.

Feedback gathered in this public consultation process will be used to help inform IHPA's final Work Program for 2014-15.

Submissions should be emailed as an accessible Word document to submissions.ihpa@ihpa.gov.au or mailed to PO Box 483, Darlinghurst NSW 1300 by 5pm on Thursday 31 July 2014.

The *Work Program 2014-15* is available at www.ihpa.gov.au.

N.B. the Work Program has been developed in the context of the recent budget announcement proposing IHPA's amalgamation with other agencies to form a Health Productivity and Performance Commission.

IHPA

www.ihpa.gov.au

INFORMATION FOR MEMBERS

$20,000 immunisation grants

Doctors and nurses with innovative ideas about how to boost vaccination rates in their local community could be in the running for a $20,000 grant.

Applications are being invited for the annual GSK Immunisation Grants program, which aims to encourage innovation and the sharing of ideas among immunisation providers.

Four grants worth $20,000 each will be distributed under the program.

GP vaccination specialist Dr Neil Hearnden, who is on the panel that will assess grant applications, said doctors and nurses working in local communities have can have great insight into gaps in health services and how to engage difficult-to-reach groups, and the grants can help them make a real difference to immunisation rates.

As an example, last year Tasmania Medicare Local used its grant to provide free flu vaccinations for people using crisis support services, while in Queensland the Aboriginal and Torres Strait Islander Community Health Service used the grant to raise awareness of the need for pertussis vaccination for women planning a pregnancy and expectant mothers.

Grant applications need to be submitted by the close of business, Friday, 15 August.

For more information, visit: www.immunisationgrants.gsk.com.au

DOCTORS IN TRAINING

Quality GP training must be safeguarded during time of upheaval

BY DR JAMES CHURCHILL

“GP trainees are rightly concerned about continuity of their training ... protection of the quality of the general practice apprenticeship training experience”

In last month's edition of *Australian Medicine*, I wrote on the impact of the 2014 Federal Budget on medical education and training. Since then, it's become increasingly clear that significant changes to the general practice landscape are pending, and the profession must ensure it is actively engaged to protect the quality of GP training.

Many will be aware that General Practice Education and Training is being absorbed into the Department of Health, ostensibly for cost-savings and efficiency in GP training.

The puzzle pieces of training – the Regional Training Providers and the structures governing them - have been thrown up in the air, with a competitive tender process to take place prior to the 2016 clinical year. It's unclear yet whether the pieces will land in remotely the same place as they started.

Simultaneously, GP training is slated for funding cuts from multiple angles; directly, through reduced AGPT funding per place, and indirectly through loss of Federal funding for the valuable Prevocational General Practice Placement Program (PGPPP). The loss of PGPPP is significant also for a number of internship emergency medicine terms in some states, and for its overall effect on prevocational capacity.

So far, the Department of Health has been consulting widely. However, a number of important questions remain unclear. What structures will exist for professional oversight of the tender process and governance of training? What role will the learned Colleges, the Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine, continue to play? What constitutes appropriate engagement of universities and service providers in GP training?

GP trainees are rightly concerned about continuity of their training, the selection of applicants in 2015 in to an as-yet-unknown system of professional and educational governance and, ultimately, protection of the quality of the general practice apprenticeship training experience.

Above all, trainees seek assurances that reform of GP training will progress with the maintenance of high quality of training its primary goal.

There must be formal governance structures for ongoing professional GP leadership, rather than ad-hoc consultation, to ensure that training providers are not able to 'compete' at the expense of a quality apprenticeship model of training.

Current GP trainees need assurances that they will be able to continue training in the broad model that they began. Many choose their Regional Training Provider based on a relationship with a community or region and, particularly where this is an area of workforce shortage, these trainees must be supported to continue training.

Future GP trainees considering applying in 2015 will require an appreciation of the model in which they will be completing their future training.

For many trainees, it won't be acceptable to apply for GP training on the assumption that models of training, geographic distribution, professional and educational governance may remain similar to the current model. Unfortunately, time is short for resolving these issues – applications open in March 2015.

More urgently, however, the roles of the learned Colleges must be clarified to enshrine their position as custodians of professional standards for the accreditation of training providers.

Now is the time for the Colleges to work together in the interests of GP training, and perhaps even embrace leading roles in areas of training governance that had drifted away from the profession in recent years.

Given these pending changes, and with such potentially wide-ranging reforms, it's critical that the AMA and other stakeholders remain united in their engagement to protect quality GP training.

The Council of Doctors-in-Training is working hard to represent the interests of GP registrars during this challenging time.

COMMENT

OPINION

Life just got worse…

BY DR LUDOMYR MYKYTA AM, CONSULTANT GERIATRICIAN

"If we look at harm, rather than pain, how much suffering will be a direct outcome of the changes in this Budget?"

Life just got a lot worse in the compassionate society with the best health care system in the world. I need to share my dismay.

I have always more than suspected that the concept of political ethics is an oxymoron. In the period prior to the election of this Government, propaganda had replaced reasoned debate, appealing to our fears and basest instincts. I cannot envisage that anyone who practices such deception can be an ethical and moral person.

Political parties may be able to justify their actions to each other on the principle that the end justifies the means. But parties are made up of individuals, many of whom are practitioners of a profession or trade that is guided by a code of ethics. I wonder how they live with their consciences.

I only vote for people and parties that I respect. That leaves me voting for independents and minor parties in the forlorn hope that the winner will have to form a genuine coalition that will "keep the bastards honest".

Professional ethics is very important to me, and I lose sleep over decisions that may potentially cause harm to other people. I hope that that is true of all people who aspire to act as ethical professionals.

There has been much talk of "pain" before and since the recent Budget. It has been expounded on and by experts in macroeconomics. There has been talk of the political and electoral pain that may be experienced by some Coalition politicians.

If we look at harm, rather than pain, how much suffering will be a direct outcome of the changes in this Budget?

As a consultant geriatrician, I specialise in the care of people suffering from dementia and their families. I have bulk billed everyone I see for years.

Most of the patients that I see are very reluctant to seek medical advice for a variety of reasons, including their inability to perceive that they have a problem. Many have to be persuaded that such consultation will not cost them anything.

I have seen millionaires who believe that they are living in abject poverty. I have also seen many, many people for whom a co-payment would be a very significant burden. I will not stop bulk billing, and the co-payment will erode my already relatively modest income.

The Government talks of taking hard and courageous decisions for the sake of future generations. This Budget has dealt the health and aged care systems a lethal blow. Future generations will have nothing to be grateful for.

The ageing of the population is no surprise. It has been more than highly predictable for over a generation.

We had models to study. I, like many people interested in gerontology, made the pilgrimage to Western Europe and Scandinavia, where similar prosperous countries were already coping with the ageing of their populations. Our models of aged care were superficially based on what we saw. No effort was made to understand how these services were organised and funded in these societies.

In retrospect, the introduction of what is now Medicare was a miracle. It could not happen now in the polarised, populist atmosphere that prevails.

We need another miracle. We already fail to meet the needs of our most vulnerable people, the true measure of a compassionate society.

The health and aged care systems are fatally flawed. Tinkering with obsolete and dysfunctional structures and systems can never do anything but fail to meet the needs of more and more people.

Successive governments of both persuasions have failed to make the hard and courageous decisions needed for the benefit of the nation and oblivious of self-interest.

Their only discernible goal is winning an election. They do not risk alienating powerful interest groups and individuals and their idealistic fellow-travellers.

As a profession we must examine our consciences and become more visible and true advocates for our patients.

NEWS

Mental health system 'broken'

The nation's mental health system is "fundamentally broken" and in need of a decade-long overhaul to boost prevention and early intervention and ensure the mentally ill get the care they need, a major health group has said.

In a scathing assessment of current arrangements, peak body The Mental Health Council of Australia has detailed basic flaws in the conception, management and delivery of mental health services that compromise treatment and undermine attempts to improve care.

"There is no such thing in Australia as a mental health 'system' per se," the Council said in a submission to the National Mental Health Commission's Review of Mental Health Services and Programs.

"Instead, the mental health system is shorthand for the many systems and services that consumers and carers may encounter over a lifetime. For the most part, these services and systems are poorly integrated, overseen by different parts of government, based on widely differing organising principles, and not working towards a common goal for improved outcomes," the Council's submission said.

As the Federal Government ponders its role in the delivery of mental health services in the context of a fundamental re-think of Commonwealth-State relations, the Council has argued that there is a role for all levels of government.

While the principle of subsidiarity (that policies and services are conceived and delivered by the level of government closest to consumers, as far as is practicable) has guided the Commission of Audit's view that mental health be fundamentally a State responsibility, the MHCA has taken a more cautious view.

It said that there was "a very strong case" for continued Commonwealth involvement, proposing that it "provide national leadership and hold responsibility for areas…in which national consistency is critical," such as setting and monitoring service delivery standards, workforce accreditation and data specifications.

Alongside questions about the division of responsibilities between different levels of Government, the Commonwealth is also considering what services need to be publicly provided, and which needs can be best met through the operation of market forces.

In its submission, the MHCA argued that mental health care has been characterised by market failure, and people with mental illness are among those who truly need Government protection and assistance.

"Governments must think carefully before using market mechanisms to coordinate and deliver mental health services of one kind or another," the Council said. "The mental health arena has, over time, been characterised by market failure, underinvestment and a chronic absence of services."

It said the solution was not necessarily more money.

"After years of substantial spending by the Commonwealth and states, and increased rates of help seeking, mental health outcomes are not improving at the pace they should be," the Council said. "Structural reforms would not necessarily involve major new spending by Government – in fact, significant progress can be made on a number of important fronts at little cost."

What was needed, it said, was a shared, decade-long commitment to sustained reform that had as its goals improved consumer and career outcomes, priority for mental health promotion and prevention, matching needs with services, and the seamless integration and coordination of programs, policies and services.

"Major gains can be made by ensuring that the right governance conditions are in place, improving coordination within and across governments and service providers, and addressing gaps in services," the MHCA said. "If we can take these steps, we will truly be able to say we have a cohesive 'system' which meets the needs of consumers and carers."

"By contrast," it warned, "if governments only tinker with the present system, but have no vision for a better system in the future or the path to reform, then improvements in outcomes will inevitably be piecemeal and fortuitous rather than far-reaching and deliberate."

The National Mental Health Commission Review, led by Professor Alan Fels, is seen as major opportunity to substantially improve mental health care, and it has so far attracted more than 1800 submissions.

But the Federal Government has been criticised for its handling of the Review. It is yet to release an interim report provided to it by the Commission in February, and is set to receive another interim report early this month.

Shadow Minister for Mental Health Jan McLucas said the review process needed to be honest, transparent and inclusive, and this necessitated disclosing submissions and sharing interim findings.

The Commission is due to deliver its final report in November.

Adrian Rollins

NEWS

Millions wasted on discarded drugs

Millions of dollars are being wasted on expensive subsidised pharmaceuticals that patients never use and instead throw out, an analysis of the nation's medicines disposal program has found.

Costly prescription medicines for treating serious ailments including asthma, chronic obstructive pulmonary disease and high cholesterol are being discarded "in large quantities" despite being well within their use-by dates, according to a Monash University audit of medicines returned by patients to pharmacies for disposal.

In the first study of its kind, the research team gathered and analysed the contents of 686 bins provided to pharmacies under the National Return and Disposal of Unwanted Medicines (RUM) program. There are more than 10,170 bins supplied and serviced under the program, which encourages patients to return unwanted and expired medicines to pharmacies for safe disposal.

The study found that most (85 per cent) of the drugs discarded were scheduled medicines, and of these, the vast majority (81 per cent) were Schedule 4 prescription-only medications (and 2.3 per cent were Schedule 8 drugs whose possession is illegal without authority).

Underlining the extent of waste identified by the survey, almost half (44 per cent) of medicines thrown out through the RUM program had not expired.

The medicines most commonly disposed of included salbutamol, insulin, frusemide, frednisolone, salmeterol, paracetamol, warfarin, atorvastatin, cephalexin and amoxicillin.

While the study did not examine why consumers discarded such medicines, other research found common reasons include concerns about safety or effectiveness, the death of the patient, a change in therapy, or a patient's decision that they no longer needed the medicine or accepted its side effects.

In all, the researchers estimated that just the top 31 medicines alone that were discarded were worth more than $2 million, including more than $270,000 worth of tiotropium, almost $250,000 worth of fluticasone/salmeterol, $173,000 of salbutamol, almost $178,000 of paracetamol and more than $114,000 of atorvastatin.

In a conclusion that could increase the focus on conditions for the public subsidy of prescription medicines, the researchers said the results showed a need for improvements in prescribing.

"The data suggest there may be significant financial wastage with some medicines prescribed under the PBS," the Monash University report said. "Several high-cost PBS medicines were found to be discarded in large quantities, wit5h significant financial loss to the Government."

The study authors said the large quantity of un-expired medicines discarded highlighted the need for more "rational" prescribing and improved patient adherence to treatment regimes.

They said that although there was more the Commonwealth and organisations like the National Prescribing Service needed to do, "pharmacists, together with medical practitioners, will have a pivotal role in optimising how medicines are prescribed and used [by] patients and minimising wastage".

They warned that with an ageing population, the problem of medicine wastage and disposal was only likely to increase, underlining the need for improved prescription practices as well as greater promotion of ways to safely dispose of unwanted drugs.

Adrian Rollins

COMMENT

Managing slow but deadly disease a tough task

Busy western Sydney GP Dr Christopher An understands better than most that simply telling a patient they have potentially deadly hepatitis B does not mean it will be effectively managed.

After 12 years of experience working in immigrant-heavy Bankstown and Cabramatta, Dr An is all too familiar with tendency of patients diagnosed with chronic hepatitis B to let slip what can come to be seen as an unnecessary or onerous system of monitoring and treatment.

The GP diagnoses a fresh case every two to three weeks, and currently has about 100 hepatitis B patients on his books. Typically, each should come in twice a year for blood tests to monitor the development of the disease.

The unfortunate reality, though, is that "how many that come back to see me to follow up is very low," he told Australian Medicine. "A lot of patients get fatigued with the follow-ups and just drop out."

Dr An believes that the best chance of improving patient compliance lies in empowering them – fully explaining the disease and its progress and sharing with them responsibility for its monitoring and management.

"It is very, very important that the patient is empowered," he said.

But in a busy general practice where time with each patient is limited, this can be very difficult to achieve.

Ideally, Dr An said, he would talk each patient carefully through the entire journey of hepatitis B. But in practice, "it is very difficult in my rooms to try to educate a patient about the entire cause and management of hepatitis B".

Adding to the difficulty is the fact that many of his patients with hepatitis B are of Asian background (usually Chinese, Vietnamese, Cambodian or Laotian), presenting linguistic and cultural barriers to treatment.

Which is why he is keen to give PATH B, an on-line guide for patients and health professionals to track the management and progress of hepatitis B, a go.

The program, developed in Europe with support from pharmaceutical company Bristol-Myers Squibb and adapted for Australia in consultation with Hepatitis Australia, provides comprehensive information about the disease as well as tools to manage it, all presented in three key languages – English, traditional Chinese and Vietnamese.

In addition to a detailed explanation about the disease, what it does and how it is transmitted, PATH B also includes an online diary where patients can record test results, medical appointments and a tool to track the progress of their treatment.

Hepatitis Australia Chief Executive Officer Helen Tyrrell told Australian Medicine the fact that PATH B was available in Chinese and Vietnamese as well as English was crucial given the prevalence of the disease among migrants from south-east Asia.

Ms Tyrrell said of the 218,000 Australians with chronic hepatitis B, about 35,000 were from China and 20,000 from Vietnam.

She said in south-east Asia, which was the "global epicentre" of the disease, the blood-borne disease was most commonly transmitted from mothers to their children, and its diagnosis and treatment was hampered by stigma and cultural differences.

As a result, Hepatitis Australia estimates that about half of all adults with hepatitis B are undiagnosed, and only a fifth of those who need treatment are getting it.

The nature of the illness also militates against regular monitoring and treatment. The slow moving nature of the disease, and the adaptability of the liver, means the infected can go for years without symptoms until it escalates. In up to a quarter of all cases it can result in serious conditions such as cirrhosis, liver cancer and liver failure.

"What we have seen as a result is chronic hepatitis B going unchecked, unmanaged and untreated within Australia," Ms Tyrrell said. "We hope a resource like PATH B will empower those living with [the disease] and their families, arming them with the knowledge and understanding they need to better manage their health and tackle hepatitis B."

Adrian Rollins

COMMENT

NEWS

Show the avatar where it hurts

Soon computer-generated human avatars could be used to record and display medical histories as IT companies and researchers expand the application of digital technologies to medical practice, clinical trials and research.

Presenters told the Sydney University Computer Graphics International conference last month that digital graphic technologies used in computer games were now being applied to medical imaging, making it possible to generate lifelike images of patients that incorporate their medical history.

Dr Jinman Kim, an engineer specialising in medical imaging analysis, said vast amounts of data were generated by x-rays, MRIs, CAT scans and other medical images, and the challenge for clinicians was how best to identify and extract useful information.

Dr Kim, from Sydney University's Institute of Biomedical Engineering and Technology, said digital graphic technologies used in computer games provided a way to present and analyse the information provided by medical images.

"The fundamental concepts behind video games, computer graphics or virtual reality are very similar," he said. "They all share foundations and we are now applying them to the development of biomedical imagery."

He said engineers at the Institute were "not far off" developing human avatars that look similar to the virtual characters used in videogames such as Minecraft, Halo or Grand Theft Auto to visually record and present the medical history of a patient.

Working with Royal Prince Alfred Hospital clinicians, they had already developed a three-dimensional 'virtual human body' that could be programmed to reflect a patient's medical history, and which could be viewed on mobile devices.

Digital technologies are also being used to cut the cost of clinical trials and improve their efficiency.

Software company and consultancy Infosys has launched a cloud-based version of its Clinical Trial Supply Management (CTSM) program to reduce barriers to collaboration between pharmaceutical companies and research organisations.

The Federal Government's plans to establish the $20 billion Medical Research Future Fund has heightened the focus on ways to encourage more clinical trials to be conducted in Australia.

As reported in the last edition of Australian Medicine, Commonwealth Chief Scientist Professor Ian Chubb suggested the Fund be used to help finance clinical trials.

Infosys said the cloud-based application of its CTSM program would make managing clinical trials easier and more cost effective.

By integrating information from across the trial process, Infosys said the system would mean enterprises could respond more rapidly to changes in demand based on actual enrolment and patient turnaround, it said, adding that because the system was available on a pay-per-use basis, it circumvented the need for organisations to invest in and maintain expensive dedicated clinical trial management programs themselves.

Meanwhile, a partnership between medical software firm Health Communication Network and UK-based Map of Medicine aims to give practitioners access to the latest evidence and treatment pathways across more than 260 clinical topics.

Map of Medicine, initially developed in 2001 by two doctors at the Royal Free Hampstead Hospital as a way of cutting waiting times by making specialist knowledge available to all clinicians, has developed to become a major international database of clinical pathways based on the latest evidence.

HCN said the Map of Medicine database was constantly revised and updated, and the partnership between the two organisations would give Australian practitioners access to international standards and health care pathways, either as a reference or as a guide for the creation of pathways customised for local conditions.

HCN said the information would help GPs, acute clinicians and allied health professionals to develop agreed care pathways that could reduce waiting times, encourage more appropriate referrals and integrate care.

Adrian Rollins

COMMENT

NEWS

Cancer to become more common

An extra 40,000 Australians a year will be diagnosed with cancer by 2024 as the population ages and the trend toward increasing prevalence of the disease continues.

In estimates developed to help prepare the health system to meet future demand, the Australian Institute of Health and Welfare has projected that cancer diagnosis will grow at an average annual rate of 3.3 per cent in the next decade.

According to the estimate, this means that 169,648 people will be diagnosed with cancer in 2024, up from 129,790 this year.

Historically, the incidence of cancer has been increasing, rising by 0.9 per cent a year between 1982 and 2010.

But, in an encouraging development, the diagnosis is no longer the death sentence it was once regarded to be.

The overall mortality rate dropped by 0.3 per cent a year between 1968 and 2011, while the five-year survival rate has jumped in two decades from below 47 per cent to above 66 per cent.

Despite these developments, cancer remains the nation's second biggest killer, behind cardiovascular disease, and the risk of dying from cancer is one in four in men and one in six in women.

Among the cancers, the most common by far is lung cancer – it claimed 8114 lives in 2011, more than double the next most common cancer, bowel cancer (3999 deaths).

But the incidence of lung cancer, as well as cervical and bladder cancer, is decreasing, while the diagnosis of other cancers, such as breast, prostate and skin cancer, is becoming more common.

Overall, improvements in early detection and treatment mean the proportion of the population who are cancer survivors is likely to continue to grow.

As at 2007, there were around 775,000 cancer survivors – around 3.7 per cent of the overall population.

For those planning future health system needs, the growing number of cancer survivors will be an important consideration.

According to the AIHW, survivors have particular needs and helping care and support for them will be increasingly a challenge.

Not only may they experience physical and emotional aftereffects of their diagnosis and treatment, they can be at risk of developing the same or a different cancer in future years.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

NEWS

Cold ignorance puts all at risk

Widespread ignorance about the causes and treatment of colds and influenza may be contributing to the spread of antibiotic resistance, according to the Federal Government's chief advisor on the safe use of medicines.

Commonwealth agency NPS MedicineWise has commissioned research showing that 65 per cent of workers – including 71 per cent of those aged between 18 and 34 years – mistakenly believe that antibiotics help cure colds and the flu, a disturbing result that raises the prospect of widespread inappropriate use of medicines whose effectiveness is under threat from over-prescribing and overuse.

NPS MedicineWise clinical adviser Dr Andrew Boyden said the research, conducted by pollster Galaxy Research, showed that many people mistakenly believed that antibiotics – which are only effective for bacterial infections – were useful in treating viral infections like colds and influenza, potentially contributing to antibiotic resistance.

"Using antibiotics when they're not needed, like for colds and flu, is contributing to antibiotic resistance," Dr Boyden said. "This is making bacterial infections such as pneumonia and tuberculosis harder to treat, with potentially dire consequences."

Rising antibiotic resistance has been identified as a major global threat to health. There has been a proliferation of bacterial infections resistant to multiple antibiotics. This has coincided in a slowdown in the development of new drugs, leading to warnings that in future many people will die from relatively simple infections because antibiotics have been rendered impotent.

In addition to misconceptions regarding the use of antibiotics, the Galaxy poll also found that most (94 per cent) of employees have gone to work with a cold or flu, 41 per cent believe they have caught the infection using public transport and 42 per cent think have a cold or flu because they have got cold, wet or have caught a chill.

"You can't catch a cold or flu from the weather, yet many Australian workers seem to believe that they have had a cold or flu from getting cold, wet or catching a chill," Dr Boyden said. "Colds and flu are viral infections that are spread from person to person, so good hygiene is paramount.

Dr Boyden said people with a cold or flu should stay at home when unwell, use a tissue when coughing or sneezing, wash their hands after coughing or blowing their nose, avoid sharing cups or cutlery and keep household surfaces clean.

Adrian Rollins

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

NEWS

Rehabilitation help for veterans upgraded

Tablet computers and other technologies have been added to the schedule of equipment available to veterans to help in their rehabilitation from illness and injury.

As the health needs of returning servicemen and women become an increasing focus of Government policy given the recent wind-down of Australia's involvement in several overseas conflicts, the Department of Veterans' Affairs (DVA) has announced the results of a comprehensive review of its Rehabilitation Appliances Program (RAP), including the National Schedule of Equipment and National Guidelines.

The review, conducted by four health professionals and senior RAP staff, recommended changes to significantly streamline the operation of the Program and to update it to meet "the divergent needs of different veteran cohorts, and technological advancements in rehabilitation aids and appliances", the Department said.

The changing health needs of veterans was the focus of a policy session at the AMA National Conference in May, which heard that not only were soldiers now surviving multiple catastrophic physical injuries that would once have been fatal, many were also returning from service with significant mental health problems.

The DVA said that, in addition to streamlining the RAP program, it had created a new category for technological aids to assist with cognition, memory and dementia, and had added tablet computers and speech pathology apps to the National Schedule of Equipment.

The changes follow 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 that since 1999 the ADF 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.

AMA President Associate Professor Brian Owler, who chaired the veteran health policy discussion at the AMA National Conference, 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.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Patient Blood Management Guidelines

The National Blood Authority is inviting submissions on its draft Patient Blood Management Guidelines: Module 5 Obstetrics and Maternity.

The draft Guidelines, the fifth in a series of six modules focusing on evidence-based patient blood management, are being developed to replace the 2001 NHMRC Clinical practice guidelines on the use of blood components.

The other five modules cover critical bleeding/massive transfusion, perioperative, medical, critical care and paediatric/neonatal.

Details on the draft guidelines and how to make a submission can be found at: http://www.blood.gov.au/public-consultation

The deadline for submissions is 25 July.

Research

Stress and obesity a heavy road toll

Anyone stuck behind the wheel for long stretches, battling through city traffic or hauling through the countryside, intuitively knows that all the time spent on the road is unlikely to be boost for their health.

But they might be shocked to discover that spending more than two hours a day driving almost doubles the risk of obesity and inadequate sleep, and substantially increases the likelihood of psychological distress, inactivity and poor quality of life.

In a finding that highlights the human cost of poor city planning and inadequate transport infrastructure, a Sydney University study found that people who drive a lot every day (two or more hours) are more likely to smoke and to be obese, distressed and sleep-deprived.

Showing that people are aware of the dangers inherent in their lifestyle, those who commuted for two or more hours every day reported sub-standard health and quality of life.

"We found a dose-response relationship between driving time and a clustering of health risk behaviours, particularly smoking, physical inactivity and insufficient sleep," lead author Dr Ding Ding of Sydney University's School of Public Health said. "The more time people spent driving, the greater their odds of having poor health and risk factors for poor health.

More than 70 per cent of adults use a car to get to work or study each day, according to the Australian Bureau of Statistics, and private surveys indicate that the average commute time is 27 minutes each way, though for one in five it is regularly more than 45 minutes each way.

Based on responses from almost 40,000 people aged between 47 and 75 years, the Sydney University researchers found that those who drove two or more hours a day had a 78 per cent increased risk of being obese, were 87 per cent more likely to have had insufficient sleep (defined as less than seven hours a day), were almost 60 per cent more at risk of not exercising enough, and were almost a third more likely than the general population to be suffering psychological distress.

Dr Ding said these elevated health risks were independent of age, gender, education and other socioeconomic factors.

But, while the findings were consistent with other studies that linked driving with cardio-metabolic health, causality was yet to be determined.

"This study highlights driving as a potential lifestyle risk factor for public health, [but] further research is needed to confirm causality and to understand the mechanisms for the observed associations," Dr Ding said.

The study was published in the journal *PLOS One*.

Adrian Rollins

Worried about diabetes? Have another cuppa

As if they ever needed it, but coffee lovers have been given an additional excuse to indulge in their favourite beverage.

In a result likely to be hailed in coffee shops and offices across the world, researchers from the Harvard School of Public Health have found that drinking an extra cup or two of java each day improves the chances of avoiding type 2 diabetes.

While the association between coffee and tea consumption and a lower type 2 diabetes risk has been known for some time, research by Dr Frank Hu and Dr Shilpa Bhupathiraju was aimed at exploring how change sin consumption might influence that risk.

Drawing on more than 20 years of data from three major studies involving almost 130,000 subjects, the authors documented almost 7270 type 2 diabetes cases.

Of these, they found that subjects who increased their coffee consumption by an average of one-and-a-half cups a day over four years were 11 per cent less likely to develop type 2 diabetes over the subsequent four years who held their consumption steady, while those who cut their intake by a cup a day or more were at a 17 per cent greater risk of type 2 diabetes.

Changes in tea consumption were not associated with type 2 diabetes risk, and drinking decaffeinated coffee did not change the diabetes risk.

Dr Hu and Dr Bhupathiraju said their findings confirmed prospective studies that had posited an association between increased coffee consumption and reduced type 2 diabetes risk.

The study was published in the journal *Diabetologia*.

Adrian Rollins

Research

Slower and steady the key to fat loss

Forget bursting a boiler if you want to lose weight – regular endurance workouts are better for cutting the flab, according to a University of Sydney study.

While high-intensity interval training (HIIT) – which involves short bursts of vigorous activity such as sprints - has become a mainstay of gym classes and lunchtime workout groups, research by exercise physiologists from the Charles Perkins Centre found that longer but less intense endurance workouts were more effective in reducing body fat among the overweight.

Researcher Shelley Keating said many people were swapping aerobic workouts for high-intensity interval sessions in the belief that it will speed up fat loss, but this was not supported by the evidence.

"High-intensity burst training does deliver important benefits like increased fitness, Ms Keating said, "but it doesn't have a 'fat furnace' effect if you carry weight around the middle."

The study, published in the *Journal of Obesity,* involved 33 overweight adults split into two groups – one which performed 24 minutes of interval training three times a week, the other 45 minutes of moderate exercise three times a week. The former group gained 0.7 per cent of abdominal fat, while the endurance group lost 2.7 per cent of abdominal fat over 12 weeks.

"Forget the claims HIIT workouts can whip overweight people into shape in less time than regular aerobic exercise," Ms Keating said. "The message is [that] if you're hitting the gym to lose weight and trim your waistline, stick with steady aerobic exercise to shift abdominal fat."

Adrian Rollins

Elderly put in danger from over-prescribing

Doctors are over-prescribing anti-inflammatory medication for elderly men and not taking sufficient precautions, increasing the risk of harmful side effects for their patients.

A study involving 1700 men aged 70 years and older found that those prescribed non-steroidal anti-inflammatory drugs (NSAIDS) such as Celebrex were typically on them for around five years – a usage wildly at odds with guideline recommendations that they only be used on an occasional, as-needs basis.

Lead author of the Sydney University study, Dr Danijela Gnjidic, said the result was "alarming".

"Australian and international guidelines suggest NSAIDS should be used for short-term treatment and be taken as needed," Dr Gnjidic said. "This is clearly not what is happening in reality."

The Faculty of Pharmacy researchers found that although NSAIDs were not widely used, where they were they were being taken in a way that put patients at risk.

Older people, in particularly, are at risk of developing serious complications from taking such medication, including developing stomach ulcers, suffering high blood pressure and an increased likelihood of heart failure.

In addition to over-prescribing, the study

found that only 25 per cent of those using NSAIDS were prescribed a proton pump inhibitor to help manage or prevent side effects, despite recommendations that there use should be standard.

"The difference between the guideline recommendations for prescribing NSAIDS and what is happening in the real world is alarming," Dr Gnjidic said, adding there was a need for doctors and patients to work together to ensure safe and appropriate prescribing of NSAIDS for older people.

The research was published in the journal *PAIN*.

Adrian Rollins

Cellar dwellers

BY DR MICHAEL RYAN

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Having a cellar is a one of life's luxuries.

How you do it varies, ranging from under the bed (which has the benefit of easy access) to custom-built rooms that often show that you might be compensating for something: maybe like buying an old E-type Jaguar.

There is good reason to be particular about wine storage. Wine is a living thing, and needs its own version of homeostasis (this is where a bit of second year physiology comes into play).

But, apart from this, why cellar wine?

Generally, wine that is made to last will always cellar well and reward your patience with more complex characteristics. It also allows your event wines, bought for that long-awaited anniversary, to shine and highlight that treasure trove of great memories. Yes, I believe some people even buy divorce wines, although it is usually with the other party's money.

In general, reds will last longer than whites, due to more natural preservatives from the tannins from the red grape skins and usually higher alcohol content. However, acid is higher in white wines and can, surprisingly, aid in helping a white live on.

Temperature is the single most influential variable in cellaring wine. Going past 22 degrees Celsius or, alternatively, below freezing, will kill off this evolving, living thing. Most experts feel a temperature range of between 13 and 14 degrees Celsius is best for a long, slow maturation process. Heat tends to speed up reactions, and can make wines mature more quickly. But above 22 degrees Celsius the wine can literally be stewed.

Another factor is the temperature stability. You don't want more than 0.5 degrees Celsius variation within a 24-hour period, as rapid heating and cooling makes the cork move like a piston, allowing in more oxygen and speeding up the oxidation process. However, the explosion in the use of screw caps means this may not be as important as it once was. In a warm climate like Queensland, a cool place that is 16 degrees in winter and 22 degrees in summer is acceptable, so long as any change in temperature is slow.

Relative humidity is relatively important (and no, this isn't a reference to a bad Tasmanian joke). Corks dry out and let more oxygen in if stored in an environment where the relative humidity slips below 70 per cent. Some people actually place bowels of water in their cellar to aid humidity. Some of these issues are negated by the use of screw caps, but try telling that to a rabid Burgundian wine maker.

Excess light can imply heat, which is not desirable, but UV light itself also contributes to spoiling.

Vibration is probably the least of your worries, but it isn't good form to toss your bottles around.

The other fallacy of cellaring is the need to regularly turn your bottles. This came from the practice in traditional champagne production – riddling – used to collect and consolidate sediment in the wine, and doesn't apply to still wine.

So you can buy yourself a maximum-minimum temperature hydrometer and monitor the cupboard under the stairwell, or you can turn that unused space into a cellar with a wine air conditioning unit.

Fridges designed for wine storage are great and look smart.

I also use my old examination couch at work, with every draw and cupboard filled with wine. There I can comfortably cellar about 80-plus bottles that the missus doesn't know about.

COMMENT

WORTH CELLARING

1. Brockenchack McKenzie William Eden Valley Riesling 2013

beautiful lemon-lime citrus notes, with a hint of spice. The palate is upfront and generous, with a sharp acidity that will ensure a decade of cellaring. Halliday gave it 96 points and, at less than $20, it's a steal.

2. Yalumba FDR1A Barossa Cabernet Shiraz 2010

sensational deep purple colour with an emerging hint of red brick. The nose displays a complex marriage of red plum fruits, chocolate, star anise and roses. The palate is generous, with full and balanced tannins. This is a wine approaching legendary status, and is a treat at about $60. Drink now after decanting for an hour, or cellar for another 12 to 15 years. It's all good.

3. Holyman Tamar Valley Tasmania Pinot Noir 2012

dark cherry colours. Opulent, spicy nose with red currants and some rose petals. Gorgeous fruit balanced by supple tannins and acidity. Yes, you can cellar this Pinot Noir for six to eight years and it will be a complex beast of a pinot: "The iron fist in the velvet glove."