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Medicine
The national news publication of the Australian Medical Association

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Cover: AMA President Associate Professor Brian Owler meets Treasurer Joe Hockey at Parliament House, Canberra, 17 July

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BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Uni fee deregulation a threat to quality medical education

> "Given the prestige of a medical degree and the intense competition for places, future students will pay a lot more for a primary medical degree than is presently the case"

Australian medical schools are world class institutions, and our medical degrees have been an international passport for Australian doctors.

Our medical schools deliver high quality medical education – despite being underfunded in comparison with other developed nations.

In fact, the AMA has long supported calls for an increase in Commonwealth base funding for primary medical education by at least 50 per cent - a necessary investment in our future doctors.

The 2014-15 Budget has delivered a policy prescription that will probably see a lift in funding for primary medical education - via total fee deregulation.

However, it's not the approach that we would have recommended. The fact is the Government is moving to cut its own level of funding by around 20 per cent, and simply further shift the financial burden on to students.

The economic theory might appear plausible – the market will determine the costs of a degree, with students making decisions about what they are prepared to pay based on the level of future earnings that they might expect.

But the fundamental problem with this approach is that university education in Australia can hardly be described as a true market. The normal rules of economics don't always apply and, when it comes to medicine, the Government controls the supply of medical school places.

There is only one direction that the costs of primary medical education will go, and that is up.

Given the prestige of a medical degree and the intense competition for places, future students will pay a lot more for a primary medical degree than is presently the case.

If fees charged to international students are any guide, future graduates are going to be saddled with levels of debt close to the size of the average Australian mortgage.

The Government seems intent on following pro-market policies from the US.

However, we know that the Americans themselves are questioning the wisdom of this approach. It has seen dramatic increases in higher education fees, and yet their higher education system is being outperformed. According to the White House, in 1990, the US ranked first in the world in four-year degree attainment among 25 to 34 year olds. Today, it ranks 12th.

There is also a widening gap in attainment, with students from wealthy families much more likely to enter and complete higher education. Indeed, US President Barack Obama is calling for reforms to make higher education more accessible, affordable, and attainable for all American families.

While the Australian Government will highlight loan schemes that students can take up, this will be no panacea.

There is good evidence that high fee levels and the prospect of significant debt deter people from lower socio-economic backgrounds from entering university.

The Australian medical profession has been a meritocracy for many decades, and it would be tragic to undermine that.

We also know, in relation to medicine, that a high level of student debt is an important factor in career choice – driving people towards better remunerated areas of practice, and away from less well-paid specialties like general practice.

One of the strengths of medical education in Australia is a talented, diverse student population, including those from lower socio-economic backgrounds, rural communities, and other minority groups.

The AMA does not want to see our merit-based system replaced with one where entry to medical school is based on financial capacity. We must have a medical workforce that meets community needs, and the Budget measures put this at risk.

Health Workforce Australia, abolished on 30 June, did some good work on future medical workforce projections.

While we can expect to see the overall medical workforce close to being in balance by 2025, there will be geographic shortages as well as shortages in specific specialties.

Clearly, encouraging doctors to work in these areas and specialties will be much more difficult if they have high levels of debt. This seems at odds with the significant effort that has been made by the Commonwealth since the Howard era to expand doctor numbers and the focus on attracting graduates to work in underserviced communities and specialties.

Like much of the recent Budget, the Government's higher education reform agenda will need to survive an unpredictable Senate.

I hope this process delivers a better policy outcome that replaces a pro-market ideology with a set of fair reforms. These must recognise the importance of quality higher education to the community and the economy, and preserve a sustainable and accessible higher education system.

COMMENT

Government keen to hear AMA ideas on co-payment

The Federal Government has signalled it is keen to work with the AMA on doctor concerns about the $7 co-payment model and other health funding measures in the Budget as it faces a roadblock on changes in the Senate.

In a constructive hour-long meeting with AMA President Associate Professor Brian Owler just before Parliament rose for its five-week winter recess, Treasurer Joe Hockey made it clear that the Government was open to AMA ideas on how to improve key Budget measures.

At the meeting, A/Professor Owler reiterated the AMA's position that, although it was not opposed in principle to patient co-payments, the model proposed by the Government was unacceptable because of its effect on patients, particularly the elderly, those with chronic illnesses, the less well-off and Indigenous patients.

"We talked about a range of issues regarding health funding in the future and AMA ideas about the sustainability of health funding," A/Professor Owler said. "They [the Government] want to stay engaged with the AMA."

The AMA is developing a co-payment model to present to the Government that will protect vulnerable patients and support access to primary care for all.

The meeting with Mr Hockey came two weeks after the AMA President held a similarly promising meeting with Prime Minister Tony Abbott and Health Minister Peter Dutton, following which the Government indicated it would reconsider its plan to apply the $7 co-payment to patients in residential aged care.

The conciliatory noises being made by the Government have come as it has hit a brick wall in the Senate, which has blocked a raft of savings measures in the Budget.

While a Bill to introduce the $7 patient co-payment is yet to be put to a vote in the Upper House, the measure in its current form appears doomed, with the majority of cross-bench senators appearing set to side with Labor and the Australian Greens in opposing it.

The political difficulties it faces in dealing with the Senate were driven home to the Government when it suffered a shock setback in its attempt to ram legislation axing the previous government's carbon pricing regime through the Senate earlier this month.

It finally secured passage of its Bill last week, but only after agreeing to a raft of amendments demanded by the Palmer United Party.

It has now adopted a more conciliatory tone on other measures, including the co-payment and other proposed changes to health funding.

In this spirit, Mr Dutton revealed to the *Australian Financial Review* that he has begun talks with minor party and independent senators on the co-payment.

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Treasurer Joe Hockey meets President Associate Professor Brian Owler: Government wants to hear AMA ideas about the $7 co-payment

Government keen to hear AMA ideas on co-payment

... FROM P6

"My judgement is that there is certainly, in my space, the ability for us to negotiate on the co-payment, and on the measures the Government has in place otherwise," Mr Dutton told the AFR. "We're negotiating in good faith, and I've certainly been encouraged by the level of engagement from those senators so far, and those conversations continue."

The future of the co-payment appears to hinge on the votes of the minor party and independent senators, as both Labor and the Greens appear entrenched in their opposition to the measure.

Last week, Labor leader Bill Shorten and Shadow Health Minister Catherine King presented a petition signed by more than 2500 doctors objecting to the $7 co-payment to back their calls for the Government to change course.

The petition included accounts from doctors about the potential impact of the co-payment.

A Melbourne GP recounted how a 66-year-old pensioner presented at their St Kilda East practice complaining of "a little headache" and checking to see whether they would be charged $7 before agreeing to see a doctor.

Upon examination, the patient was found to have very high blood pressure and needed to be rushed to hospital, where he collapsed and had to undergo emergency surgery.

"I am 100 per cent sure that if the co-payment was already applicable he would have gone home and died," the GP said.

Another doctor from Norwood in South Australia recounted how, in the course of vaccinating a six-month-old infant she checked the baby's weight and found that it was falling away.

She was able to explain to the mother the child's need for more solids and more frequent meals, a diagnosis and intervention the doctor said would be unlikely if the mother, to avoid paying the co-payment, instead took her child to a local council centre for vaccination.

"These are real stories from doctors about real patients – 2500 of them," Ms King said. "The Government needs to listen to these stories and needs to dump its unfair GP tax."

Several health Budget measures were passed by the House of Representatives during the last sitting week before Parliament rose for the winter, including an increase in the co-payment for Pharmaceutical Benefit Schedule medicines and changes in the PBS safety net thresholds.

The changes are due to come into effect from 1 January next year, and the Government plans to introduce them to the Senate when Parliament resumes in late August.

But the Government is more relaxed about the timetable for its proposed co-payment. It is not planned to come into effect until 1 July next year, leaving almost a year to negotiate changes and amendments.

Adrian Rollins

COMMENT

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

Practice nurses kept in limbo

The future of practice nurses remains under a cloud as the Federal Government works to clarify its intentions regarding charging arrangements for health assessments.

The Health Department and the Department of Human Services are understood to be rewording alterations to the way Medicare Benefits Schedule items for health assessments are to be applied following protests from the AMA that the planned changes were unclear and could fundamentally undermine the team-based approach to a vital aspect of primary care.

Under guidelines introduced in 2010, the Government made clear that the time spent by practice nurses in helping a doctor conduct a health assessment, such as by collecting patient information, could be included in the MBS item billed by the practice.

The interpretation has fostered the development of a teams-based approach between doctors and practice nurses to the provision of health assessments, which are considered an important tool in preventive and chronic care.

But, in a change sprung on the profession without prior notice, the Department of Human Services early this month appeared to impose a new interpretation that meant practice nurse time could no longer be counted toward the health assessment item.

In a swift reaction, AMA President Associate Professor Brian Owler condemned the change, warning it could have a "devastating impact" on the jobs of practice nurses, many of whom had been hired specifically to assist doctors in conducting health assessments.

A subsequent attempt by the Government to clarify its intentions failed to end the confusion and uncertainty that had developed around its intentions, and the AMA called for a clear statement.

At a meeting on 9 July, Government officials agreed with senior AMA staff that a clearer statement of intentions was required, and the departments of Health and Human Services have since been working on a form of words.

The episode has exposed the difficulty of balancing the conflicting goals of the departments – Human Services is intent on keeping tight control of Medicare payments and boosting restitution rates, while Health wants to preserve the preventive health benefits of health assessments, including those conducted through cooperation between nurses and doctors.

The AMA has called for a reaffirmation of the interpretation of the MBS health assessments item that has existed since 2010.

But the fact that almost two weeks have passed without a new form of words being produced has observers worried that the Government is intent on a change to current arrangements that will undermine the joint involvement of doctors and nurses in providing health assessments.

Adrian Rollins

COMMENT

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.

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Family Doctor Week celebrates role of GPs in nation's health

The enormous contribution to the nation's health made by more than 30,000 GPs working around Australia is being recognised by the AMA through its annual Family Doctor Week.

This year the Week, which began on 20 July and runs through to 26 July, has as its theme Your Family Doctor – Keeping You Healthy, to underline the central role played by GPs throughout the lives of the patients in safeguarding their health.

AMA President Associate Professor Brian Owler said Family Doctor Week was a special opportunity to acknowledge the hard work and dedication of the nation's GPs, and to highlight just how important is the part the play in the nation's heath.

A/Professor Owler, who will mark the Week with a speech to the National Press Club in Canberra tomorrow, 22 July, said family doctors worked closely with their patients to detect and treat health problems early, improve management of existing conditions and provide advice and guidance for healthier lifestyles.

"Nearly 90 per cent of Australians have a regular GP, and enjoy better health because of that ongoing and trusted relationship," the AMA President said. "The personalised care and preventive health advice provided by GPs about exercise, diet and leading a healthy lifestyle keep people out of hospitals and keep health costs down."

"General practice is the cornerstone of primary health care and the most cost-effective part of the health system."

The AMA's celebration of GPs comes against the backdrop of Federal Budget measures which are seen to undermine general practice and primary care, including the imposition of a $7 co-payment for GP, pathology and diagnostic imaging services, a $5 cut to the Medicare rebate, and cuts to GP education and training.

A/Professor Owler has held meetings with Prime Minister Tony Abbott, Treasurer Joe Hockey and Health Minister Peter Dutton to voice AMA concerns and argue the case for a change in the Government's approach.

The Government has been receptive to the AMA's call. It has indicated that it may examine ways to exclude patients in residential aged care from the co-payment, and has invited the AMA to suggest other changes.

"Family Doctor Week allows the AMA to highlight all that is good about general practice and family doctors, and it also allows us to discuss issues or policies that need to be resolved to allow general practice to provide even better services to Australian communities," A/Prof Owler said.

AMA is concerned that the co-payment will discourage many patients, especially the chronically ill, the elderly and those who are socially disadvantaged, from seeing their GP – leading to more serious and expensive to treat health problems later on.

Researchers at Sydney University's Family Medicine Research Centre estimate the co-payment will add almost $200 a year to the average family's medical bill, while self-funded retirees can expect to fork out an extra $244 a year.

Such increases are likely to deter a significant proportion of patients from seeking timely care, a recent report from the COAG Reform Council suggests. The report found that, even before a co-payment was introduced, almost 6 per cent of people put off seeing a doctor because of cost, and in some areas the proportion was as high as 13 per cent.

Throughout Family Doctor Week the AMA will be making announcements and releasing videos highlighting the importance of the GP-patient relationship and the contribution family doctors can make to getting and staying healthy.

The videos and announcements can be downloaded from the AMA Family Doctor Week website at: https://ama.com.au/familydoctorweek2014

Adrian Rollins

COMMENT

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

AMA mourns MH17 loss

The AMA has offered its "sincere condolences" to the families and friends of those aboard the ill-fated Malaysian Airways flight MH17, which was shot down above eastern Ukraine last Friday.

Members of the international medical community, among them Toowoomba doctor couple Jill and Roger Guard and at least six delegates to the 20th International AIDS Conference in Melbourne, are confirmed to have been among the 298 people – including 28 Australia citizens and nine permanent residents in Australia – who died in the disaster.

AMA President Associate Professor Brian Owler said the attack was a horrific event that had affected many from around the world, including Australia.

"It is hard to comprehend that so many people could suddenly lose their lives in these unpredictable circumstances," A/Professor Owler said. "Many families form many countries, including our own, have been touched by this horrific event."

In the second major tragedy to hit Malaysian Airlines in the last few months, MH17 – en route from Amsterdam to Kuala Lumpur – was shot down by a surface-to-air missile in airspace above separatist areas of eastern Ukraine.

While formal investigations into the circumstances of the attack have barely begun, Prime Minister Tony Abbott and other members of the international community including the United States say the finger of blame points squarely at separatists armed and supported by the Russian Government.

Initial reports had suggested that as many as 100 AIDS researchers, activists and health workers travelling to the Melbourne conference had been on the flight, but that has subsequently been revised down.

At the time of going to press, conference organisers had confirmed six delegates were on the flight, including internationally renowned researcher and clinician Joep Lange, former President of the International AIDS Society, World Health Organisation official Glenn Thomas, Pim de Kuijer of Stop AIDS Now, Lucie van Mens and Maria Adriana de Schutter, both from AIDS Action Europe and Jacqueline van Tongeren of the Amsterdam Institute of Global Health and Development.

Current International AIDS Society President, Nobel laureate Professor Françoise Barré-Sinoussi, said those attending the conference were "in shock" at the loss of life, including that of their colleagues.

"We are all thinking about our colleagues and our friends and all the other passengers as well," Professor Barré-Sinoussi said in an interview at *The Conversation*. "It is a real tragedy."

But she said the organisers were determined that the conference should proceed despite the loss of life.

"It was very important for us, thinking about our colleagues, to show people that we will continue to fight [against AIDS], and that is the best tribute we can do to honour them," Professor Barré-Sinoussi, Director of the Regulation of Retroviral Infections Unit at the Institut Pasteur in Paris, said.

> "While formal investigations into the circumstances of the attack have barely begun, Prime Minister Tony Abbott and other members of the international community including the United States say the finger of blame points squarely at separatists armed and supported by the Russian Government"

A/Professor Owler paid tribute to Dr Lange and other AIDS activists and researchers who had died in the tragedy, adding that the Association was deeply saddened by the loss of all lives on the flight.

"The world has today lost many people who have played critical roles in the global fight against HIV," he said. "The AMA expresses itys profound sadness and sincere condolences to the families and friends of all the victims of this catastrophe."

Adrian Rollins

COMMENT

Looming trade deal could be health hazard: AMA

Australia must reject provisions in the controversial Trans Pacific Partnership Agreement that could undermine the Pharmaceutical Benefits Scheme and compromise the ability of governments to improve public health, according to the AMA.

As secretive negotiations of the TPP drag out, the AMA has voiced fears the proposed trade deal is out of balance and advances commercial interests at the expense of patient health.

The AMA Federal Council has called on the Federal Government to reject "any provisions in trade agreements that could reduce Australia's right to develop health policy and programs according to need".

The Association said it was concerned that aspects of the proposed TPP could be used to attack key health policies and measures including the PBS and the cost of medicine, food labelling and tobacco control laws, restrictions on alcohol marketing, the operation of public hospitals and the regulation of environmental hazards.

The TPP has been the focus of increasing international concern because of ambitious and far-reaching clauses that are seen to serve the interests of major corporations, particularly in the US.

Among the most controversial provisions are investor-state dispute settlement (ISDS) procedures that would enable corporations to mount legal action against government policies and laws they felt harmed the value of their investment or future profits.

Tobacco giant Philip Morris Asia used just such provisions in a 1993 investment agreement between Australia and Hong Kong to challenge the tobacco plain packaging legislation in the courts and seek compensation, arguing that the policy undermined the value of its investment by 'expropriating' its trademarks and branding.

US negotiators are also pushing hard for the TPP to include some of world's most stringent intellectual property protections that would expand and extend patent monopolies, helping hold drug prices high and delay the introduction of generic medicines onto the market.

In addition, the TPP includes proposals demanding the removal of technical barriers to trade – provisions which companies have used to challenge regulations such as alcohol warning labels, alcohol excise, and front-of-packet food labelling.

There are also concerns market access rules in the TPP may be used to restrict government support for public hospitals and other health services by requiring that there be competitive neutrality between such entities and private health providers.

A resolution adopted by the AMA Federal Council said international trade agreements had the potential to hamper governments in acting to protect and promote health.

"Free trade agreements which prioritise investor protections, including through invest-state dispute settlement, allow foreign investors to challenge existing and future Australian health policy measures on grounds that they may constitute 'barriers to trade'," the resolution said. "Trade and investment agreements should not adversely impact on public health or access to quality and affordable health care and medicines."

The Federal Government has so far issued mixed signals regarding its stance on controversial aspects of the TPP.

The Howard, Rudd and Gillard governments all resisted pressure to

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Looming trade deal could be health hazard: AMA

... FROM P12

include ISDS provisions in trade agreements, including the TPP, but the current Government is more equivocal – supporting its inclusion in the preferential trade agreement with Korea but blocking it in the trade deal signed with Japan early this month.

Trade Minister Andrew Robb indicated last November that the Government would oppose provisions that could be used to force consumers to pay more for medicine, but the Government has indicated it will accept an ISDS provision, subject to special exclusions for Australia.

Hopes to conclude the deal by the middle of this year were delivered a massive blow when US Congress did not renew President Barack Obama trade negotiation authority. It is now considered unlikely there will be a Congress vote on the TPP before the mid-term elections in November, effectively delaying progress on the deal until at least early 2015.

Anger and concern about the TPP has been fuelled by the secrecy surrounding negotiations.

TPP talks have been conducted behind closed doors, leaving observers to rely on leaks and ad hoc statements from negotiators for information, an environment that has stoked alarming speculation about the provisions it may contain in its final version.

In its resolution, the AMA Federal Council called for an end to such secrecy, urging the Federal Government to commit to "the utmost transparency in trade negotiations…and to consulting as fully as possible with the health sector, medical practitioners and with wider civil society organisations".

Lead economist at the Asian Development Bank's Office for Regional Economic Integration Jayant Menon said the agreement was falling victim to concerns about the aggressiveness of several of its provisions, combined with the ambition of the TPP agenda and the diversity of the countries negotiation the agreement, which were all conspiring to delay its conclusion.

Dr Menon said the 12 countries negotiating the TPP, including the US, Japan, Australia, New Zealand, Vietnam, Peru, Malaysia, Canada and Mexico, had widely diverse economic characteristics and interests that made it very difficult to establish common ground – a challenge made even more difficult by the agreement's "wide-ranging, highly ambitious agenda".

He said this problem was exacerbated by perceptions among the negotiating countries that the agreement's proposed agenda was heavily skewed in favour of US interests.

"Many see it as terribly skewed in favour of one country, the US," Dr Menon said, warning that the deal might never be concluded.

"Several issues face such stiff opposition from some members that they may never be overcome. In this quagmire, the TPP could easily degenerate into a series of bilateral deals," he said.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

International Indigenous Health Conference 2014

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

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

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

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

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

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

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

Proof anti-smoking measures work

Smoking rates have virtually halved in the last 20 years as Australians shun the deadly habit in record numbers, underlining the success of anti-tobacco measures including excises, smoking bans and plain packaging.

Less the 13 per cent of people aged 14 years or older lit up daily last year, according to Australian Institute of Health and Welfare figures, down from 15.1 per cent in 2010 and virtually half the proportion who lit up in 1991.

In a major boost for the AMA and other health campaigners keen to prevent people from starting the habit, the Institute's National Drugs Strategy Household Survey found that a high and growing proportion of young people have never smoked.

It found that last year 95 per cent of 12 to 17-year-olds had never smoked, along with three-quarters of 18 to 24-year-olds. In addition, the average age at which smokers begin puffing increased to almost 16 years last year, up from 14 years in 1995.

The trends have made smoking increasingly an old person's habit. Those aged 40 to 49 years were the most likely to smoke daily (16.2%), while 50 to 69-year-olds were the heaviest smokers, puffing through an average 120 cigarettes a week, virtually double the amount of smokers in their twenties.

AMA President Associate Professor Brian Owler said the results were a rebuff to tobacco industry claims that smoking had increased since plain packaging laws were introduced.

"The AIHW survey demonstrates beyond question that sales have markedly declined since the introduction of the world-leading plain packaging laws," A/Professor Owler said.

The tobacco industry has sought to sow doubts about the efficacy of plain packaging as part of an international fight to stop the adoption of the laws by other countries.

Last month A/Professor Owler panned The Australian newspaper for peddling discredited industry claims that plain packaging laws were not working. Tobacco companies have claimed the laws have simply resulted in smokers swapping to cheaper brands.

But A/Professor Owler said these claims were not borne out by the evidence, with official figures showing the amount spent on tobacco products had slumped 5.3 per cent since plain packaging was introduced in late 2012.

Plain packaging is just one of a raft of tobacco control measures adopted by Australian governments, including hefty excise charges, advertising bans and public education campaigns.

In its recent assessment of the health performance of member countries, the Organisation for Economic Co-operation and Development lauded Australia's "remarkable success" in reducing smoking rates to among the lowest in the developed world.

The OECD attributed much of the decline to tobacco control measures enacted by government, including being the first country in the world to introduce plain packaging.

Not only are young people smoking less than their forebears, they are also drinking less and take fewer illicit drugs, the AIHW found.

These developments are in line with emerging trends in other countries, including the United States, Britain, Germany, France and Italy.

The *Economist* newspaper has reported that teenagers in these countries are drinking, smoking and taking drugs and significantly lower rates than a decade ago. It speculated that reasons for this may include ageing populations, greater gender equality and ethnic diversity, economic and social pressure for academic and professional attainment, extended cohabitation between children and parents, and changes in the approach to parenting.

Adrian Rollins

COMMENT

AMA IN THE NEWS

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

Print/Online

AMA challenges new MBS rules, *6 Minutes*, 2 July 2014

The AMA is challenging recent advice from the Department of Human Services that GPs can no longer bill for time spent by practice nurses when claiming MBS health assessment items. AMA President A/Professor Brian Owler urged the Government and the DHS to reinstate the former arrangements.

Secret drug payments to doctors stay, *Daily Telegraph*, 3 July 2014

A doctor's identity will be hidden when pharmaceutical companies are forced to reveal how much they spend on overseas trips for individual medicos. The AMA has been worried doctors' reputation could be compromised by publicity about the income they receive from pharmaceutical companies.

Nitschke's actions offensive: Kennet, *The Saturday Age*, 5 July 2014

Euthanasia advocate Philip Nitschke's conduct in helping a 45-year-old man without a terminal illness to die has been criticised by doctors and described as reprehensible by beyondblue chairman Jeff Kennet. AMA President A/Professor Brian Owler said doctors have an ethical and moral obligation to provide suicidal patients with a chance to seek appropriate treatment.

Pensioners hurt most by fees: researchers, *Sydney Morning Herald*, 7 July 2014

New research has backed AMA concerns the Federal Government's proposed Medicare co-payment will hit vulnerable groups the hardest and could deter them from seeking medical care. AMA President A/Professor Brian Owler said it was strong data that lent weight to doctor concerns regarding the planned co-payment.

This won't hurt much, *Australian Financial Review*, 12 July 2014

Health insurers are pushing for a more streamlined approach to patient care, but medical experts are wary. AMA President A/Professor Brian Owler said the AMA is intent on maintaining the independence of the doctor-patient relationship.

Radio

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

AMA President Associate Professor Brian Owler discussed a proposal by supermarket giant Woolworths to conduct 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.

A/Professor Brian Owler, 5AA Adelaide, 2 July 2014

AMA President Associate Professor Brian Owler discussed Woolworths job ads seeking pharmacy graduates for an in store health check program. A/Professor Owler said health checks should be conducted in an appropriate clinical setting by qualified GPs.

A/Professor Owler, 2UE Sydney, 7 July 2014

AMA President Associate Professor Brian Owler talked about Dr Philip Nitschke's euthanasia campaign. A/Professor Owler said the issue is about the wider problem of mental health, suicide, and depression, and how support should be provided for depressed people with suicidal ideation.

Dr Stephen Parnis, 4BC Brisbane, 7 July 2014

AMA Vice President Dr Stephen Parnis talked about people living longer. Dr Parnis said Australians are living longer and healthier lives, but obesity has become one of the biggest public health problems facing the nation.

A/Professor Brian Owler, 666 ABC Canberra, 11 July 2014

AMA President Associate Professor Brian Owler talked about the $7 GP co-payment. A/Professor Owler said the co-payment was a cost shift exercise from the Federal Budget to the states, as the Commonwealth had responsibility to fund Medicare and GP consultations, while the states funded emergency departments, which were likely to see more patients who were avoiding the co-payment.

Dr Brian Morton, 2HD Newcastle, 14 July 2014

AMA Chair of General Practice Dr Brian Morton discussed flu season in Australia. Dr Morton said viruses change every year and that is why having the flu vaccine every year was a good idea.

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AMA IN THE NEWS

... FROM P15

Television

A/Professor Brian Owler, Channel 9 Melbourne, 2 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.

A/Professor Brian Owler, Channel 7 Sydney, 3 July 2014

An internet craze drinking game called punch for punch is blamed for the death of a young dad. AMA President A/Professor Brian Owler is horrified with the punch for punch videos found online, and said one punch can have a devastating consequence.

Dr Stephen Parnis, SBS Sydney, 4 July 2014

AMA Vice President Dr Stephen Parnis discussed calls to have euthanasia advocate Dr Philip Nitschke's medical license revoked after giving a healthy man advice on how to commit suicide. Dr Parnis said doctors have an ethical and moral obligation to those who seek their help.

COMMENT

Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
Dr Chris Moy	AMA Member	NeHTA (National E-Health Transition Authority) Clinical Usability Program (CUP): PCEHR Landing Page Workshop	26/6/2014
A/Professor Brian Owler	AMA President	Meeting with Principal Medical Advisor, TGA	3/7/2014
Dr Andrew Miller	AMA WA Vice President	PBS Authority medicines review reference group	31/07/2014
Dr Ian Pryor	AMA Member	MSAC (Medical Services Advisory Committee) Review Working Group for Percutaneous Coronary Artery Intervention	16/06/2014
Dr Robyn Langham	AMA Representative for Victoria	PCEHR Diagnostic Imaging consultation workshop	9/7/2014
Dr Tony Bartone	AMA VIC President	PCEHR Pathology consultation workshop	8/7/2014
Dr Lawrie Bott	AMA Member	PCEHR Pathology consultation workshop	8/7/2014
Dr Gino Pecoraro	AMA Member	MSAC (Medical Services Advisory Committee) Review Working Group for Lipectomy services	30/06/2014
Dr Brian Morton	AMA Chair of General Practice	Primary Health Networks Stakeholder Meeting	7/7/2014
		GP Roundtable	3/7/2014

Public Health Campaign Manager - AMA

The Australian Medical Association (AMA), as the peak health advocacy organisation, exists to advance the health of the community and the professional interests of doctors.

The Federal Secretariat of the AMA contributes to the achievement of this Mission through reinforcing the AMA's peak status in the development and implementation of health policy and identifying and acting upon the main issues affecting members.

The Role

The Public Health Campaign Manager will work closely with the Secretary General, President and Federal Council to develop and lead on the implementation of AMA Public Health Strategies.

Responsibilities

- in conjunction with the President, Secretary General, and Federal Council prosecute the AMA's Public Health agenda;
- work closely with the President, Secretary General, and Federal Council to devise and implement AMA Public Health strategies;
- proactively develop and lead on the implementation of Public Health campaigns;
- identify key stakeholder groups and coordinate shared campaign activities;
- identify target decision-makers for lobbying activities on Public Health and Indigenous health issues;
- work closely with the Public Affairs team to ensure maximum impact of the campaigns across all media;
- provide briefings and draft correspondence for the President and Secretary General for meetings with parliamentarians, senior officials and public figures, and in response to media inquiries;
- draft formal speeches for the President/Vice President where required as part of a Public Health campaign;
- monitor Public Health policy initiatives within Australia and overseas, including contemporary and emerging research in Public Health areas;
- establish and maintain effective relationships with peak health bodies, government agencies, and other experts and organisations to inform and strengthen the work of the AMA;
- contribute to the success of the team in meeting the AMA's aims and objectives and to undertake other reasonable duties commensurate with the level of this role;
- the duties and responsibilities of the post require the flexibility to travel interstate and work various shifts which may occasionally include weekends, evenings and Public Holidays and this is reflected in the salary.

This position description is not intended to be either prescriptive or exhaustive; it is issued as a framework to outline the main areas of responsibility at the time of writing.

Selection Criteria

- extensive experience in crafting and implementing complex and diverse Public Health campaigns;
- extensive experience in developing and implementing effective strategies to respond to complex Public Health issues;
- understanding of the workings of Federal Government and the ability to identify, build and maintain relationships with key people of influence;
- relevant qualifications or a combination of qualifications and experience relevant to the role;
- excellent people skills – able to build and maintain effective relationships with senior policy makers in the Public Health sector, in Canberra and nationally.
- excellent communication skills both verbal and written;
- excellent presentation skills;
- an enthusiastic and flexible approach;
- the ability to produce high quality accurate work to meet deadlines despite competing demands; good problem solving, decision making and analytical capabilities;
- excellent computer skills with a sound working knowledge of all modern computer software and office systems.

To apply for this position, please submit a cover letter and an up to date resume.

For further information in respect of this position please contact Anne Trimmer, Secretary General via email atrimmer@ama.com.au or on telephone number 02 6270 5460.

Remuneration for this position will be determined after assessment of relevant skills, experience and qualifications.

Closing Date for Applications - Monday 4 August 2014.

Cancer drugs first up in authority prescription review

Doctors and patients could have easier access to vital cancer-fighting drugs affirmed under supply changes being considered by the Federal Government's key medicines advisor.

In the first step in what medical practitioners hope will be swift action to remove most medicines from the burdensome Authority Required PBS Listing, the Pharmaceutical Benefits Advisory Committee has flagged that a review of authority requirements for oncology treatments is the top priority of a meeting to be held in the next few days.

There are currently 447 medicines, including many common treatments, on the Authority Required list, forcing doctors and patients to lose thousands of hours each year because of delays in having calls to the Listing hotline answered and prescription approval given.

While the approval process for the majority of drugs on the list has been streamlined, in its submission to the Commission of Audit the AMA proposed that the system be scrapped.

It cited the results of a survey which found that doctors and patients wasted time equivalent to 25,000 patient consultations each year waiting for calls to the DHS authority free call service to be answered.

The AMA said the pointlessness of the system was underlined by the fact that only 2.8 per cent of calls to the service did not result in prescription authorisation.

The Federal Government has directed that the system be reviewed, and PBAC is due to discuss the Terms of Reference – which were put out for public comment last month, at its July meeting.

The meeting is also due to "give immediate consideration to the existing variations to authority requirements for oncology treatment in public and private hospitals".

The PBAC has undertaken to examine the Authority Required listings in three tranches, beginning with those medicines subject to the highest regulatory burden, including treatments for cancer, multiple sclerosis and rheumatoid arthritis.

Recommendations on the listing of these drugs are due to be considered at PBAC's November meeting.

Listing of second tranche of drugs, including treatments for cardiovascular disease, psychiatric conditions and eye problems, will be considered at a meeting next March, while all remaining drugs on the list – which includes those used in palliative care, will be considered at a meeting in July 2015.

Adrian Rollins

COMMENT

Pregnant women need jab as flu season descends

Infectious disease experts have expressed alarm at evidence that less than half of pregnant women are being vaccinated against influenza as the annual flu season swings into high gear.

The Influenza Specialist Group has cited research showing that fewer than 40 per cent of pregnant women receive the flu jab despite scientific evidence that it is both safe and effective.

The World Health Organisation has designated pregnant women as a high priority for influenza vaccination because of the increased risk of complications from the infection during pregnancy, and because it provides protection for both mother and infant.

But a study of general practitioner attitudes and practices by BMC Family Practice found that a third of GPs did not consider that flu posed a serious risk to either the mother or her foetus.

ISG member, obstetrician Dr Elizabeth McCarthy, said the fact some many GPs had this belief was disturbing.

"Some GPs were under the impression that, outside of a pandemic such as [in] 2009, we needn't worry about pregnant women and the flu. That is wrong," Dr McCarthy said. "Pregnant women's immune system and challenges to their heart and lungs mean that flu is worse for them. If you ask someone who has had flu in advanced pregnancy, she will very clearly remember how terrible she felt."

The warning comes amid evidence that Australia is in the grips of a flu outbreak.

Figures compiled by the National Notifiable Diseases Surveillance System show there were 7881 laboratory-confirmed cases of flu as at 27 June, with 1053 of those occurring in the preceding fortnight.

More than half of confirmed cases involved people aged 25 to 59 years

Nationally, there were 4.6 cases per 100,000 people in the last two weeks of June, but prevalence reached as high at 7.8 per 100,000 in South Australia and 6.6 per 100,000 in Queensland.

A Health Department spokeswoman said the 2014 flu season appeared to have started in late June, but dismissed claims of a 'killer flu' season.

"The current timing of the rise [in cases] and the number of notifications being reported are not unusual, and are not an indication of the potential severity of the season," the spokeswoman said.

The majority of infections involved influenza A, predominantly the 2009 strain of H1N1.

Although the flu season was already underway, Dr McCarthy said it was not too late for people, including pregnant women, to get vaccinated.

Adrian Rollins

COMMENT

Hep C hope comes with a hefty price tag

Regulators have given approval for a potential cure for hepatitis C amid warnings that the nation faces an explosion in the incidence of serious liver disease without major investment in prevention and treatment programs.

The Therapeutic Goods Administration has approved the use of the antiviral drug Sovaldi as part of a combination antiviral treatment of chronic hepatitis C in adults, raising hopes of improved outcomes for the estimated 233,000 people living with the disease.

But the medicine's huge price tag – a 12-week course of treatment costs almost $90,000 in the United States – means it will have to be subsidised through the Pharmaceutical Benefits Scheme if it is to be put within financial reach for many patients.

While viral hepatitis has become increasingly common – the Kirby Institute estimates more than half a million Australians now live with either hepatitis B or C – treatment rates are low.

Fewer than 5 per cent of those with hepatitis B receive treatment, and only around 1 per cent of those with chronic hepatitis C.

Hepatitis Australia has warned this threatens to become a major health burden for the country unless urgent action is taken.

Viral hepatitis damages the liver and, without effective treatment, it can lead to liver cirrhosis, cancer and failure – currently around 1000 a year die from hepatitis-related liver cancer, according to the Institute.

"Without urgent investment in rigorous treatment programs, Australia will continue to fail in its efforts to halt escalating rates of serious liver disease due to chronic hepatitis B or C," Hepatitis Australia said.

There has already been some action on this front.

Earlier this year, the Federal Government allocated almost $22.5 million over four years to fund programs to prevent the spread of sexually transmitted diseases and blood borne viruses including HIV and hepatitis, including $5 million for needle exchange schemes and $4.6 million to boost testing and treatment of hepatitis B.

But Hepatitis Australia said more was needed.

It said hepatitis B and C infections had continued to spiral up despite national strategies aimed at curbing their growth, showing that "Australia needs to redouble its efforts and investment in prevention".

"We know what works – educating the community on the risks of infection and improving access to hepatitis B vaccinations and needle and syringe programs for vulnerable populations," the group said. "It's now time for the investment to make it happen."

While Hepatitis Australia is urging prevention programs, the TGA's approval of Sovaldi has boosted hopes of improved treatment.

Pharmaceutical company Gilead Sciences, which manufactures the analogue polymerase inhibitor, claims that a daily dose of Sovaldi can cure hepatitis C in as little as 12 weeks, at least in some cases.

Clinical trials evaluated by the TGA demonstrated that the hepatitis C virus was undetectable in up to 90 per cent of patients 12 weeks after completing therapy.

Professor Gregory Dore, Head of the Kirby Institute's Viral Hepatitis Clinical Research Program, hailed the drug as "a major advance" in the treatment of hepatitis C because it was able to achieve results more quickly than existing treatments, and with fewer side effects.

But humanitarian organisation Medicins Sans Frontieres has complained that the high cost of the medicine puts it out of the reach of most of the world's poor.

The medical charity said drugs such as Sovaldi had the potential to revolutionise treatment of hepatitis C, but not at current prices.

Sovaldi, is Gilead's trade name for sofosbuvir, which in the United States costs $US84,000 ($A90,000) for a 12-week course of treatment – roughly $US1000 a pill. Even in Thailand, its costs $US5000 for a course.

"The price Gilead says it will charge for sofosbuvir in developing countries is still far too high for people to afford," said MSF Director of Policy and Advocacy Rohit Malpani. "When you're starting from such an exorbitant price in the US, the price Gilead will offer middle-income countries like Thailand and Indonesia may seem like a good discount, but it will still be too expensive for many of these countries to scale up treatment."

Adrian Rollins

COMMENT

HIV home tests come with a warning

Medical colleges have expressed reservations about Federal Government moves to lift restrictions on manufacture and sale of home HIV test kits.

Health Minister Peter Dutton has opened the way for companies to seek approval to supply do-it-yourself HIV test kits in a move which, combined with steps to improve access to antiretroviral drugs, he hopes will assist in the early diagnosis and treatment of the disease.

Mr Dutton said many people were concerned about undergoing a HIV test in a medical setting, and the home self-testing added to the options for diagnosis.

The Minister said this was particularly important given the fact that "we know that there are Australians living with undiagnosed HIV", and early diagnosis was critical to appropriate treatment and helping prevent the spread of the disease.

The initiative follows evidence that HIV is making a comeback in Australia.

The Kirby Institute reported last year that HIV infections jumped 10 per cent in 2012 – the biggest increase in 20 years, prompting concerns about complacency regarding the potentially deadly disease.

Researchers have identified a rise in the number of gay men having unprotected casual sex, particularly among those diagnosed with HIV and those younger than 25 years.

This is despite progress made elsewhere in the world.

A review of the global epidemic co-authored by Monash University research Professor Sharon Lewin and published in The Lancet found that the number of HIV cases worldwide peaked at 3.3 million new infections in 2002, and was down to 2.3 million in 2012, while AIDS-related deaths had dropped from a zenith of 2.3 million in 2005 to 1.6 million in 2012.

Professor Lewin said advances in treatment had not only helped people with HIV to live longer, but had dramatically reduced their infectiousness, making a huge contribution to the reduced spread of the disease.

In addition to allowing the manufacture and supply of home HIV test kits, Mr Dutton has announced to the Pharmaceutical Benefits Scheme, effective from 1 July next year, making it easier to obtain prescription antiretroviral medicine.

The Government has committed $16.2 million over four years to lift restrictions on the supply of antiretrovirals and enable the medicine to be dispensed at any pharmacy.

But health experts have expressed concern about the introduction of do-it-yourself HIV testing.

Royal Australian College of General Practitioners President, Adjunct Associate Professor Frank Jones, warned of the risks of testing positive to HIV at home without access to medical expertise and information.

Professor Jones said that because the dangers of missing a HIV diagnosis were high, home test kits were highly sensitive and had a false positive rate of between 1 and 2 per cent.

"In a low prevalence country like Australia, single rapid tests – such as these at home test kits – are more likely to show a false positive than a true positive," he said. "There is enormous potential for unnecessary patient distress as a consequence of inaccurate results without adequate follow-up with a medical professional."

He said point-of-care testing in general practices, sexual health clinics and other health services was the safest way to improve access to testing and reduce the risks of HIV transmission, a view shared to a point by the Royal College of Pathologists of Australasia.

The College said home and point-of-care rapid tests were not as accurate as laboratory tests, raising questions about their efficacy.

"People who receive a positive result on a HIV self-test will require a laboratory blood test in order to confirm the result," College President Associate Professor Peter Stewart said. "Equally, if a HIV self-test reveals a negative result, this may not mean that the person is free from HIV, as the test is known to produce a concerning rate of false negatives."

He advised people to "think carefully about relying completely in self-testing, especially for such a serious diagnosis as HIV infection".

Adrian Rollins

COMMENT

Shortcut update on drug supply

The medicines regulator has lifted restrictions on the supply of a common anaesthetic just days after the launch of a system to alert hospitals, health professionals and patients of medicine shortages.

Supplies of the widely used intravenous anaesthetic propofol began to flow freely early this month after the Therapeutic Goods Administration withdrew precautionary restrictions put in place following a contamination scare.

While the cause of the contamination, in which several patients developed sepsis after receiving the drug, is yet to be determined, the TGA said the outcome of extensive testing made it confident that the product was safe for use.

The watchdog said both it and three external laboratories had conducted tests for sterility and the presence of bacterial endotoxins on 25 batches of propofol 1 per cent emulsion, involving 1680 vials, and "all samples passed the criteria".

However, in a caveat, the TGA said tests on the outer surface of vial rubber stoppers and the inside of lids had found microbial contamination in a "low number" of cases.

The regulator said that, based on these results and other information, it was "confident that supply restrictions are not necessary".

While the supply restrictions were in place, hospitals and practitioners were directed to avoid using propofol manufactured and supplied by Provive and Sandoz. Instead, they were instructed to secure alternative supplies or, where that was not possible, assess the cost and benefits of using the product.

The decision to lift the supply restriction came soon after the launch, following sustained AMA lobbying, of a website notifying practitioners and patients about medicine shortages.

The AMA has made numerous representations on the need for arrangements to ensure there were clear, consistent and coordinated systems for the timely notification and management of medicine shortages. Immediate-part AMA Vice President Professor Geoffrey Dobb held several meetings with the ministers from both the current and former Federal Governments to press action on the issue.

Announcing the establishment of a website to notify of drug shortages in late May, Assistant Health Minister Fiona Nash said episodes such as the propofol shortage highlighted the importance of getting timely information about supplies of medicines out to the medical community as quickly and clearly as possible.

Senator Nash said it was for this reason that the TGA, in partnership with Medicines Australia and the Generic Medicines Industry Association, had set up a website (http://www.tga.gov.au/hp/information-msi.htm) to alert practitioners and consumers when drugs come into short supply and suggest medicine substitutes or alternative therapies.

Professor Dobb flagged earlier this year that the AMA would have preferred a mandatory notification system for "high impact" medicine shortages, the current voluntary arrangement was still "a considerable improvement on the current ad hoc and uncoordinated approach".

The Minister said shortages can be caused by something as simple as a disruption in manufacturing through to a spike in demand caused by a disease outbreak.

"Whether the shortage affects thousands, hundreds or a small number of people, it can be difficult for the individuals involved," Senator Nash said. "For patients who regularly take a medicine, and then cannot get that medicine, change can have significant implications, even if there is an alternative.

"Up-to-date and consistent communication about medicine shortages is crucial to allow continuity of care."

The website not only provides a single source of information for doctors, pharmacists and patients, but also cuts red tape for drug companies, which will now be able to report shortages by simply completing an online firm.

The Medicine Shortages Information Initiative website is at: http://www.tga.gov.au/hp/information-msi.htm

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.

Private practice increasing target of indemnity claims

In what might be considered a clear case of perverse incentives, medical indemnity payouts are likely to be larger for patients who have suffered a severe injury than for those who have died.

One in five medical indemnity claims involving cases of severe injury that were resolved in 2012-13 resulted in payouts greater than $500,000, compared with just 3 per cent of those where the patient died, reflecting the ongoing financial, physical and social harm suffered by those forced to live with the consequences of severe injury, and their carers.

In its update of medical indemnity claims, the Australian Institute of Health and Welfare found that there has been an increase in claims involving the private sector – up to around 3300 a year in recent years from about 2500 a year late last decade – though there has been little change in the size of payouts, with around two-thirds resolved for less than $10,000.

Unsurprisingly, given their predominance in the medical workforce, GPs accounted for largest proportion of new claims (11.7 per cent) in 2012-13, while general surgery (3.9 per cent) was a distant second, followed by orthopaedic surgery (3.7 per cent).

Over the years, obstetrics has had an unenviable reputation as a particularly litigious specialty, but the Institute's data suggest this status is on the wane – after accounting for 12 per cent of overall claims in 2008-09, the specialty dropped to 8 per cent in 2012-13.

At the same time that the proportion of indemnity claims in obstetrics has declined, it has risen sharply in the field of digestive, metabolic and endocrine system medicine, surging from 10 per cent of all new claims in 2008-09 to 24 per cent in 2012-13 – the highest of any area of practice – followed by musculoskeletal with 20.6 per cent of new claims and mental/nervous system medicine (12.4 per cent). Death accounted for 11.4 per cent of new claims.

In what would be of some relief for insurers and their shareholders, the majority of current claims are for less than $30,000, though a not insubstantial 8.3 per cent are for more than $500,000 (mostly involving public hospitals).

New claims in 2012-13 most commonly arose from procedures (24.1 per cent), diagnosis (17.4 per cent) and treatment (17.1 per cent).

In the public sector, the most common source of claims arising from procedures related to post-operative (8.2 per cent) or intra-operative (5.3 per cent) complications. Other claims arose from the performance of the wrong procedure (15 claims, 1.6 per cent), failure to perform a procedure (25 claims, 2.6 per cent) and, in one instance, a procedure carried out in the wrong part of the body.

Claims arising from treatment primarily concerned delays or the failure of treatments to work, while problems with medication were a relatively rare reason to make an indemnity claim, accounting for just 27 out of almost 950 new claims lodged in the public sector.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

TGA calls for medical expertise

Have you ever wanted to have a say in what drugs or medical devices should be allowed on to the Australian market?

The Therapeutic Goods Administration is currently recruiting medical experts across a range of specialties to advise on the regulation of medicines, therapeutic devices and vaccines.

The TGA is looking to fill vacancies on eight statutory advisory committees covering prescription and non-prescription drugs, biologicals, complementary medicines, therapeutic devices and the safety of medicines, vaccines and medical devices.

The committees provide independent expert advice to the Health Minister and the TGA on specific and technical matters.

The medicines watchdog said it was seeking expressions of interest from experts "who have expertise in relevant clinical or scientific fields, or appropriate consumer issues, and want to contribute to the regulation of therapeutic goods".

Appointments are for up to three years, and are set to commence next year and in 2016.

Applications close at 5pm on Monday, 11 August.

Further information and instructions for submitting an application can be viewed at: www.tga.gov.au/about/committees-expert-vacancies.htm

Doctor delivers $1.2 billion blow to tobacco – and counting

Dr Bronwyn King: Convincing super funds to quit tobacco

In mounting its noisy counter-attack against cigarette plain packaging, the tobacco industry has appeared largely oblivious to the emergence of another potent threat to its long-term viability.

Since 2010 Melbourne-based radiation oncologist Dr Bronwyn King, from the Peter MacCallum Cancer Centre, has been steadily chipping away at the tobacco industry's investor base, so far convincing Australian superannuation funds to unload $1.2 billion of tobacco company shares.

While it sounds like a lot of money, Dr King herself admits that it is small change for the industry.

But the fact that in just four years Dr King's Tobacco-Free Investment Initiative has helped convince 16 major superannuation funds – including the $43 billion First State Super fund, one of the nation's largest - to divest their tobacco holdings is seen as a promise of great potential.

As Dr King tells it, it all began virtually by accident.

Until a chance exchange at the end of an otherwise standard conversation with a superannuation consultant in 2010, Dr King was oblivious to the fact that her super funds were being invested in tobacco stocks.

It was only when the consultant mentioned the option of a fund that did not include shares in mining, tobacco or alcohol stocks that she became aware some of her super funds were being invested in tobacco companies.

"Tobacco?" Dr King recalled saying, to which the consultant replied, "Yes, everyone is investing in tobacco."

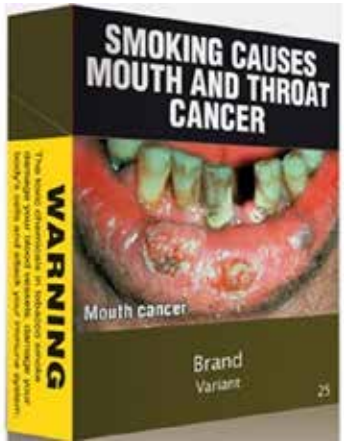
It was a confronting moment for the radiation oncologist, not least because of her early experience at Peter MacCallum working in the lung cancer unit, where she witnessed first-hand the devastating health consequences of smoking.

Her superannuation fund, Health Super, was the default superannuation fund for Peter MacCallum employees, and its investments in tobacco shares were "a terrible fit for me and my colleagues, my hospital and other hospitals around Australia".

The fact that such investments were common in the superannuation industry only added to Dr King's concern.

"From then on I really felt obliged to try to do something about it, that I should at least try," she said.

Dr King raised the matter with the-then Peter MacCallum



Chief Executive Officer, and a day later found herself booked in to make a presentation to Health Super's executive team on the issue.

At the time, the super fund was in the throes of a year-long acquisition by First State Super, and nothing further happened until the transaction was finalised.

Once the transaction was completed, First State announced it had divested itself of all $200 million tobacco company shares it had held.

For Dr King, it was "a great moment. First State showed great leadership, and it started a conversation in the [superannuation] industry".

Soon after, she had a meeting with First State CEO Michael Dwyer at which he agreed to facilitate introductions with key figures in the super industry.

Mr Dwyer arranged introductions for Dr King with key figures in the superannuation industry, and in the ensuing three years she has made numerous presentations to superannuation fund boards, fund managers and peak industry groups pushing the tobacco free investment message – something that five years ago she would never have imagined doing.

MORE P25

Doctor delivers $1.2 billion blow to tobacco – and counting

... FROM P24

While Dr King's motivation to take on this cause is clear – an abhorrence of the enormous, an avoidable, harm caused by tobacco – the reasons why super funds decide to rid themselves of tobacco shares is more mixed.

For funds where a significant proportion of members are health workers, the decision has been reasonably straightforward because such an investment sits at odds with professional ethical standards.

But funds have also divested themselves of tobacco shares because of risk.

The risks confronting investors in tobacco are multiple – governments are increasingly introducing laws and regulations aimed at reducing smoking (such as excise increases and smoking restrictions); there is the risk of litigation against tobacco companies that could involve multi-billion-dollar compensation claims; and there is a reputational risk for those (governments, funds, political parties, individuals) who hold tobacco shares.

There are also less obvious concerns that can lead funds to divest their tobacco shares.

Dr King said reports that children were used to help harvest tobacco in many producer countries was a deal breaker for a fund that had as part of its mandate the exclusion of any investment in child labour.

She said another fund was horrified when she pointed out that the Dow Jones Sustainability Index it used as an investment option included shares in British American Tobacco.

The cause of tobacco disinvestment was given a fillip last year when the $82 billion Future Fund dumped $222 million of tobacco shares under sustained pressure from the Australian Greens and public health groups, citing tobacco's "very particular characteristics including its damaging health effects, addictive properties and that there is no safe level of consumption.

"In doing so, the Board also considered its investment policies and approach to environmental, social and governance issues," then-Future Fund Chairman David Gonski said.

Dr King feels the move toward disinvestment in tobacco is getting to the point where it is becoming a competitive disadvantage for funds to hold tobacco shares, and she is keen to make an even bigger dent in estimated $7 billion of investment the local superannuation industry still holds.

She has been aided in her task by what she considered to be the unique characteristics of tobacco that make it a much clearer and obvious target for disinvestment than other potentially harmful products such as alcohol.

Among these are its proven harmful and deadly effects ("there is no safe level of consumption"), and the fact that the tobacco industry's sole trade is in a product proven to be harmful to health.

Dr King, whose efforts were recognised by the Thoracic Society of Australia and New Zealand when it presented her with the 2014 President's Award, is hoping to eventually take the cause of tobacco industry disinvestment international.

But for now, she said, there was plenty more still to be done in Australia.

Adrian Rollins

COMMENT

Day hospital care grows strongly

Private day hospitals are becoming an increasingly significant and lucrative part of the health system, providing more than one million patient days of care a year, official figures show.

As the Federal Government looks for ways to increase private sector involvement in the provision of health care, Australian Bureau of Statistics data show the number of free-standing private day hospitals is growing strongly, with eight new facilities added in 2012-13 to lift the total complement to 319, compared with 282 private acute and psychiatric hospitals.

Private day hospitals are benefiting from the increasing tendency toward same-day treatment – while there was an overall 4.3 per cent rise in overall hospitalisation rates in the private sector in 2012-13, this included a huge 16.3 per cent jump in the number of same-day patients for day hospitals.

The official figures show private day hospitals were much less costly to operate than their acute counterparts – the average day hospital running cost per patient was $709 in 2012-13, compared with $1188 for private acute and psychiatric hospitals – and their wages bill as a proportion of total expenditure was 41.4 per cent, compared with 49.2 per cent for acute hospitals.

Unsurprisingly, given these results, day hospitals boasted a much better net operating margin than their acute counterparts – 18.7 per cent in 2012-13, compared with 9.2 per cent.

The most common cited reason for attending a private day hospital was the generic 'factors influencing health status' descriptor, accounting for 36 per cent of visits, followed by treatment for digestive system diseases (16.2 per cent) and – reflecting the boom in laser eye surgery - eye procedures (14.1 per cent).

Among private acute and psychiatric hospitals, the most common procedures were non-invasive cognitive interventions (53.6 per cent), followed by digestive system surgery (10.6 per cent) and musculo-skeletal work (6.8 per cent).

Among patients hospitalised for more than a day, the average length of stay was 5.2 days, though the proportion of patients coming in for same-day treatment has grown steadily, from 51.8 per cent in 2002-03 to 59.5 per cent 10 years later.

In a sign that private facilities are running at a reasonably high tempo, the bed occupancy rate is close to 85 per cent, while the number of full-time equivalent staff grew by 4.6 per cent in 2012-13 to up almost 24 per cent from a decade earlier.

Underlining the growing importance of the private sector in the provision of psychiatric care, figures compiled by the Private Mental Health Alliance show it provided 2339 psychiatric beds – spread across 30 stand-alone hospitals and 26 in-hospital psychiatric units - in 2012-13.

In all, almost 32,000 patients were treated during the financial year, with an average length of stay of 19 days.

The most common problem by far was major affective and other mood disorders (48 per cent of overnight stay episodes), followed by problems stemming from abuse of alcohol and other drugs (20 per cent), post-traumatic stress disorder (10 per cent), schizophrenia and psychosis (7 per cent) and anxiety disorders (7 per cent).

Adrian Rollins

COMMENT

Hospital pricing work continues amid uncertainty

The Independent Hospital Pricing Authority is pushing ahead with work on national standards for the cost of hospital services despite the Federal Government's intention to walk away from agreed funding arrangements post-2017.

The IHPA has called for public comment on its proposed *Pricing Framework for Australian Public Hospital Services 2015-16*, which is being developed as part of its work to implement the National Health Reform Agreement struck between the Commonwealth and the States and Territories in 2011.

But the future shape of these relations is clouded with uncertainty because of major changes flagged in the conduct of Commonwealth-State relations.

In its May Budget, the Federal Government abrogated public hospital funding guarantees made by its Labor predecessor and announced it would change the basis of indexation of its hospital funding from mid-2017 to inflation plus population growth.

More fundamentally, the Government has unveiled a review of the Federation which could include a much smaller role for the Commonwealth in the provision of health services.

Regardless of this uncertainty, the IHPA is forging ahead with work which will shape the determination of the National Efficient Price and the National Efficient Cost of public hospital services – both considered fundamental to the national introduction of activity-based funding.

The AMA is considering a submission on the IHPA's Pricing Framework

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

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

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

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

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

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

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

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

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

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

Email: careers@ama.com.au

Baby's death causes rethink of clinical advice

The death of a baby girl soon after childbirth has prompted warnings about the use of prostaglandin gel to induce labour in women who have previously suffered a perforation of their uterus.

An inquest into the death of Aurora Sleep, who died just four days after being born, has found that she would have lived if treating doctors at Mount Gambier Hospital had not tried to induce labour using prostaglandin, and had instead elected to deliver the baby by caesarean section.

Delivering the finding, South Australian Deputy State Coroner Anthony Schapel recommended that clinical guidelines be developed to warn of the risk of uterine rupture in women whose uterus has previously been perforated and who are given prostaglandin to induce labour.

"To my mind, the evidence in this case has demonstrated that the use of prostaglandin gels in the induction of labour in respect of a woman who has experienced a previous uterine fundal perforation that has not required surgical intervention poses a material risk of uterine rupture during labour," Mr Schapel found.

The tragic death occurred when the decision was made to induce baby Aurora at 38 weeks after her mother, Ashlee Brown, 22, developed high and unstable blood pressure during the latter stages of her pregnancy.

But soon after prostaglandin gel to induce labour was applied at 8pm on 17 November, 2011, Ms Brown began to experience frequent and powerful contractions, accompanied by severe abdominal pain.

Little more than two hours later the unborn baby's heart rate shot shot up above 180 beats per minute before dropping sharply, down to 60 beats a minute at 10.36pm.

By then experienced local GP Dr Lucie Walters, who holds obstetric qualifications, had been called and found Ms Brown "significantly distressed", while the baby was experiencing "obvious foetal bradychardia".

Obstetric registrar Dr Kylie Gayford was summoned at 10.52pm, and an emergency caesarean section commenced at 11.30pm. It was then found that Ms Brown's uterus had ruptured and the baby and placenta had been forced into the abdominal cavity – fatally depriving the infant of oxygen.

The baby was subsequently resuscitated and transferred to Adelaide's Women's and Children's Hospital, but the coroner concluded that by then the hypoxic brain injury was irreversible and the baby died four days later.

During the course of the inquest it became apparent that a crucial factor in the deadly chain of events was an abortion Ms Brown underwent in December 2010.

Following the termination it was found that not all material had been removed from Ms Brown's uterus, and two months later her treating obstetrician, Dr George Olesnicky, performed a dilation and curettage procedure, during which her uterus was perforated.

Dr Olesnicky inspected the wound, which he estimated to be about eight millimetres, and found there was no significant bleeding or damage to surrounding organs. He concluded it did not requiring suturing and would heal naturally.

He ordered an ultrasound in mid-March which identified a "thinning/scarring" in the inner and middle layers of the uterus wall. In testimony to the Court, Dr Olesnicky said that he expected the uterine wall to return to full thickness, but said the presence of a scar meant the uterus would not be as strong as it was before the perforation.

Unbeknownst to Dr Olesnicky, Ms Brown soon after became pregnant with baby Aurora.

According to the coroner, the scar turned out to be the site of a fatal weakness for Ms Brown's uterus, giving way under the pressure of the extreme contractions brought on by prostaglandin gel, and expelling baby Aurora and the placenta into the abdominal cavity with deadly consequences.

MORE P29

Baby's death causes rethink of clinical advice

... FROM P28

It became clear during the course of the inquest that there are sharply differing views and clinical advice about the extent of risks posed by perforations of the uterus, particularly in conjunction with the use of prostaglandin.

Dr Olesnicky, who had moved out of the area by the time of baby Aurora's birth, was firmly of the view that uterine perforations of the kind experienced by Ms Brown precluded the use of prostaglandin gel to induce labour.

But Dr Walters, who knew of the perforation of Ms Borwn's uterus that had occurred, did not then – and does not now – believe it prohibited the use of prostaglandin, and pose donly a small and indefinable increase in potential risk.

According to clinical advice and protocols including the South Australian Perinatal Practice Guidelines, Australian College of Rural and Remote Medicine guidelines and the Monthly Index of Medical Specialities, previous uterine surgery is among the list of contraindications for the use of prostaglandin.

But exactly what constitutes uterine surgery was not defined (in her evidence, Dr Walters said she did not consider a small perforation that did not require suturing to be surgery), and there was no indication that a uterine scar was a contraindication for the use of prostaglandin (even though, paradoxically, MIMS listed uterine scarring as a contraindication for the use of Syntocinon, another drug used to induce labour).

The coroner said that "no documentation or medical authority" was tendered to the inquest that suggested prostaglandin was contraindicated or prohibited for a women who had suffered a uterine perforation – regardless of whether or not it required surgical correction.

In testimony at the inquest, retired Professor of Obstetrics and Gynaecology Roger Pepperell put the risk that a previously perforated uterus would rupture during labour induced by prostaglandin gels at between 5 and 10 per cent.

But Coroner Schapel found that the estimate was not "directly supported by literature or by other persuasive evidence".

But he did back Professor Pepperell's recommendation that patients who have suffered uterine rupture – even if it did not require surgical repair – to have explained to them the risks posed by the rupture and any possible future consequences, particularly where the use of prostaglandin gel is being considered.

Coroner Schapel recommended that clinical guidelines be developed and included in the South Australian Perinatal Practice Guidelines, Australian College of Rural and Remote Medicine Rural Clinical Guidelines "relating to the risk of uterine rupture occasioned by the administration of prostaglandin gel in a woman who has had a previous uterine perforation, whether surgically repaired or not".

"To my mind it is obvious that for the guidelines to remain as they are…would be misleading," he said.

Adrian Rollins

COMMENT

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

Nitschke faces registration suspension

Outspoken euthanasia advocate Dr Philip Nitschke has been asked to show reason why his medical registration should not be suspended following widespread condemnation of his conduct regarding a suicidal man who later killed himself.

The Medical Board of Australia is considering whether to take immediate action to limit Dr Nitschke's registration, which expires on 30 September, in the interests of public safety after the campaigner admitted he did not advise the suicidal man, Nigel Brayley, to seek psychiatric help.

It has been asserted that Mr Brayley approached Dr Nitschke following an Exit International workshop and said he wanted to die because his life was falling apart.

Dr Nitschke told Fairfax Media he asked the man 'Why don't you go and talk to someone?', to which he responded by telling him to mind his own business.

"My relationship with him was certainly not a doctor-patient relationship," he said. "He was a person I had scant dealings with. He had obtained lethal drugs before he even talked to me."

"The person made a rational decision, and I'm not going to try and second-guess him on that one.

"If a person comes along and says to me that they've made a rational decision to end their life in two weeks, I don't go along and say 'Oh, have you made a rational decision?' We don't do that."

But his stance has been contradicted by AMA President Associate Professor Brian Owler, who said doctors had a legal, moral and ethical obligation to give appropriate advice.

"Every doctor, when dealing with a patient who expresses some sort of suicidal ideation, does have a duty to provide that patient with appropriate clinical advice, and at least advise them about seeking appropriate treatment," A/ Professor Owler told The Australian. "That's not just a legal issue. That's a moral and ethical issue too."

Chair of the mental health group beyondblue, Jeff Kennett, said Dr Nitscke's stance was inconsistent with the medical profession's Hippocratic Oath and "totally reprehensible".

Mr Kennett, who has strongly supported the legalisation of euthanasia under strict conditions, said Dr Nitchke's actions had set the cause back many years.

The issue erupted just weeks after a euthanasia Bill was introduced to the Senate by Greens Senator Dr Richard Di Natale.

The draft legislation proposes the establishment of a 'dying with dignity' service that would authorise doctors to prescribe, prepare and/or administer a substance that would assist a terminally ill person to end their life in a humane way.

The Bill would indemnify doctors involved against prosecution and calls for the service to be funded by the Commonwealth.

"It's time we put dying with dignity laws firmly on the naiotnal agenda," Dr Di Natale said, adding that he had referred the draft legislation to a Senate inquiry "so that my colleagues have the opportunity to hear the personal stories of individuals who are facing the end of their lives and would be comforted just by having the option of doing so on their own terms".

The issue of assisted death is in the spotlight internationally.

The European Court of Human Rights has blocked the judgement of a senior French court, the State Council, that had allowed for the life support system of a man left in a vegetative state since a vehicle accident in 2008 be withdrawn.

And early this month the British Medical Journal ran an editorial by its senior editors, including Editor in Chief Fiona Godlee, urging that British Parliament pass an Assisted Dying Bill currently before it.

Under the Bill, adults with a terminal illness who are not expected to live more than six months could be legally assisted to end their lives.

Adrian Rollins

COMMENT

Medical training lottery – get set for another round

BY AMSA PRESIDENT JESSICA DEAN

> “Medical students do not necessarily translate into doctors”
>
> - PENNY SHAKESPEARE, First Assistant Secretary, Department of Health, at Senate Estimates hearing, 5 June, Parliament House, Canberra

This quote (left) is from the Hansard of a Senate Estimates hearing, from one of the many occasions where medical graduate numbers and 2015 internship places have been raised as a matter of national importance.

One of the big challenges confronting AMSA in its advocacy on the issue is the stubborn misconception that medical schools produce functioning doctors, and that all that is needed to ward off future doctor shortages is to admit more medical students.

But, as we know, this is far from true, and medical school is only part of the process of training a fully qualified doctor, which also requires the completion of an internship.

The biggest issue currently facing the future medical workforce is not the intake of medical schools, but the bottleneck in internships, prevocational and vocational training places.

SA Medical Education and Training recently announced that the Government’s decision to abolish the Postgraduate General Practice Placement Program (PGPPP) would result in a cut in the number of internships being offered in South Australia for 2015. The PGPPP funded 23 of South Australia’s 278 intern positions in 2014.

Other states have also been using the PGPPP program to fund internship rotations, but have not yet announced whether axing the PGPPP will cause a similar proportionate decrease in the number of internships they offer. In this context, the current projected national internship numbers are somewhat reassuring.

The 2015 numbers

The first round of 2015 internship places have been offered to Category 1 applicants.

Under the COAG agreement, only domestic students in Commonwealth Supported Places (CSP) are guaranteed an internship.

In recent years, domestic full-fee students have often been designated as Category 1 applicants, and have not yet missed out on places. But if the medical graduate numbers continue to climb, and internship numbers fail to grow in proportion, it is quite possible that some will.

This year has seen 3676 applicants for internships. Of these, 3004 are domestic medical graduates, 480 are international full-fee paying medical graduates of Australian universities, and there are 192 other applicants.

As at June 2014, there were approximately 3210 State and Territory intern positions available for 2015 (some positions are still subject to accreditation), and up to 100 Commonwealth-funded intern positions under the Commonwealth Medical Internship (CMI) initiative.

We are working with the Commonwealth Department of Health to identify exactly how many positions will be offered as part of the CMI initiative this year. We are optimistic that it will be more than the 76 offered last year.

Furthermore, experience from previous intern recruitment rounds suggests that not all those who apply for an internship are ultimately willing or able to accept and fill a place. This can be for a number of reasons, including the failure to complete their course, eligibility requirements, or acceptance of overseas offers.

Keeping this in mind, it is difficult to identify which graduates left for overseas preferentially, or left due to the current Australian internship climate.

To provide some perspective, in 2013 there were 3430 Australian-trained graduate applicants and 3190 offers accepted. This left 240 applicants unplaced by state offers. The Commonwealth received 185 applications for the CMI positions, but only 76 were ultimately offered. Therefore, potentially 55 graduates did not apply for the CMI and did not get an internship.

We will continue to work with the states and the Commonwealth, and will provide relevant updates over the coming months.

COMMENT

BY DR DAVID RIVETT

AMA acts to prevent yet another Government shemozzle

What a total shemozzle we have seen from the Department of Health and the Department of Human Services over the right of GPs to bill for nursing input in health assessments.

First the Government issued a clear directive that immediately prohibited such charging arrangements. Then, when challenged by the Federal AMA, it totally flipped and announced that it could continue at a GP's discretion.

What about the rights of all those thousands of practice nurses employed to provide just such services to patients, whose positions could have become financially unviable as a result of the change, putting their jobs at risk?

Any change of such magnitude, with such a severe impact on practice management, should never have been dropped, like it was, as a bombshell with instant effect.

Common decency surely demands there should have been at least 12 months' notice of such a major change, to allow alternative forms of employment to be found for those employees affected.

Thank heavens for the immediate and dogged response from the Federal AMA, through Brian Morton and the AMA Council of General Practice, which resulted in this mad directive being revoked.

One can but ponder who was responsible, what sanction they received, and whether they still have a role in the federal Health Department, and are possibly going to drop more bombs in the future.

All of this uncertainty must make general practice even less enticing to new graduates.

The recent under-indexation of patient rebates, plus the axing of General Practice Education and Training and the confusion surrounding the provision of training for tomorrow's GPs, means many prospective GPs will wonder if such a career is a wise choice. Heavily burdened with HECS debts, they must wonder if general practice is a business model that stands up to rigorous fiscal scrutiny.

Even though the apparently confused directive has been overturned, it has sent shockwaves through the general practice community, and it will now take years for the Department of Health to regain trust and respect.

On the rural front, nothing positive has come from the Coalition except the decision to overturn the Rudd/Gillard Government's cap on tax deductions for self-education expenses, for which we must again be thankful for astute and determined AMA lobbying.

> "Even though the apparently confused directive has been overturned, it has sent shockwaves through the general practice community, and it will now take years for the Department of Health to regain trust and respect"

What the Senate does with the GP patient co-payment remains to be seen.

I, for one, think we are in for a highly entertaining tussle, with the Palmer United Party shoring up its reputation as the guardian of Joe Citizen to ensure it gets another four-plus Senators elected at the next Federal election, and truly put it in a strong position.

OPINION

BY DR MARK MACKAY, SENIOR LECTURER, HEALTH CARE MANAGEMENT, SCHOOL OF MEDICINE, FLINDERS UNIVERSITY, UNIVERSITY OF ADELAIDE PROFESSOR OF MEDICINE CAMPBELL THOMPSON AND 11 OTHERS.

GP co-payment would increase emergency department wait times

> "The introduction of a GP co-payment could see average emergency department visits increase by between six minutes and almost three hours ..."

This article first appeared at The Conversation on 11 July, 2014, and can be viewed at: http://theconversation.com/gp-co-payment-would-increase-emergency-department-wait-times-28658

The introduction of a GP co-payment could see average emergency department visits increase by between six minutes and almost three hours, new modelling shows, as more patients opt for free hospital care rather than paying to see their local general practitioner.

Based on an average emergency department (ED) visit of 5.6 hours, one extra patient per hour would make the visit marginally longer – an average of 5.7 hours, which includes waiting times and treatment, or admission to a bed. An additional four patients per hour, however, would lengthen the queue and result an average visit of 8.5 hours.

The new Senate will soon be asked to vote on legislation for the proposed $7 GP co-payment, but the Department of Health hasn't provided any modelling of its impact.

We've been working on a patient flow simulation model for a large Adelaide hospital with a busy emergency department for almost a year now. We therefore have a ready-developed tool to consider the possible consequences of a GP co-payment shifting activity from the community to hospitals.

While every hospital around Australia would be different, the pattern is likely to remain the same: as patient demand grows without additional resources, small increases soon turn into dramatic spikes in waiting times.

Current waiting times

Patients requiring emergency care are prioritised based on urgency and triaged into five categories. A triage score of one means the patient needs immediate treatment due to a life-threatening issue such as a heart attack, while a triage score of five means the patient requires non-urgent treatment and should be seen within two hours.

People triaged to category five and four are sometimes referred to as GP-like patients. But these categories don't mean the patients shouldn't be there; the triage category is merely a means of prioritising the order in which patients should be treated. And some will require admission into hospital.

Our patient flow model takes triage and whether patients are admitted or discharged from the emergency department into account.

Under the National Emergency Access Target, by 2015 hospitals should be admitting or discharging 90 per cent of patients from the emergency department within four hours. This includes waiting time before treatment, assessment, tests and evaluation.

From October to December 2013, 66 per cent of patients in major metropolitan hospitals were either admitted or discharged within four hours; this compares with 53 per cent of patients during the same period in 2012. So improvements have been made, but there's still a long way to go to meet the target.

Our model

Using our model, we considered the question: what happens to the average queue length and average time spent in the emergency department as additional patients are added to the system?

Clearly, we didn't know exactly how much demand would shift to hospitals, so we had to make some assumptions about what might happen.

For our initial exploration, we assumed an extra patient would arrive at the emergency department each hour between 8.00am and 6.00pm, Monday to Friday, and would be discharged home without admission. One extra patient per hour means ten extra patients per day.

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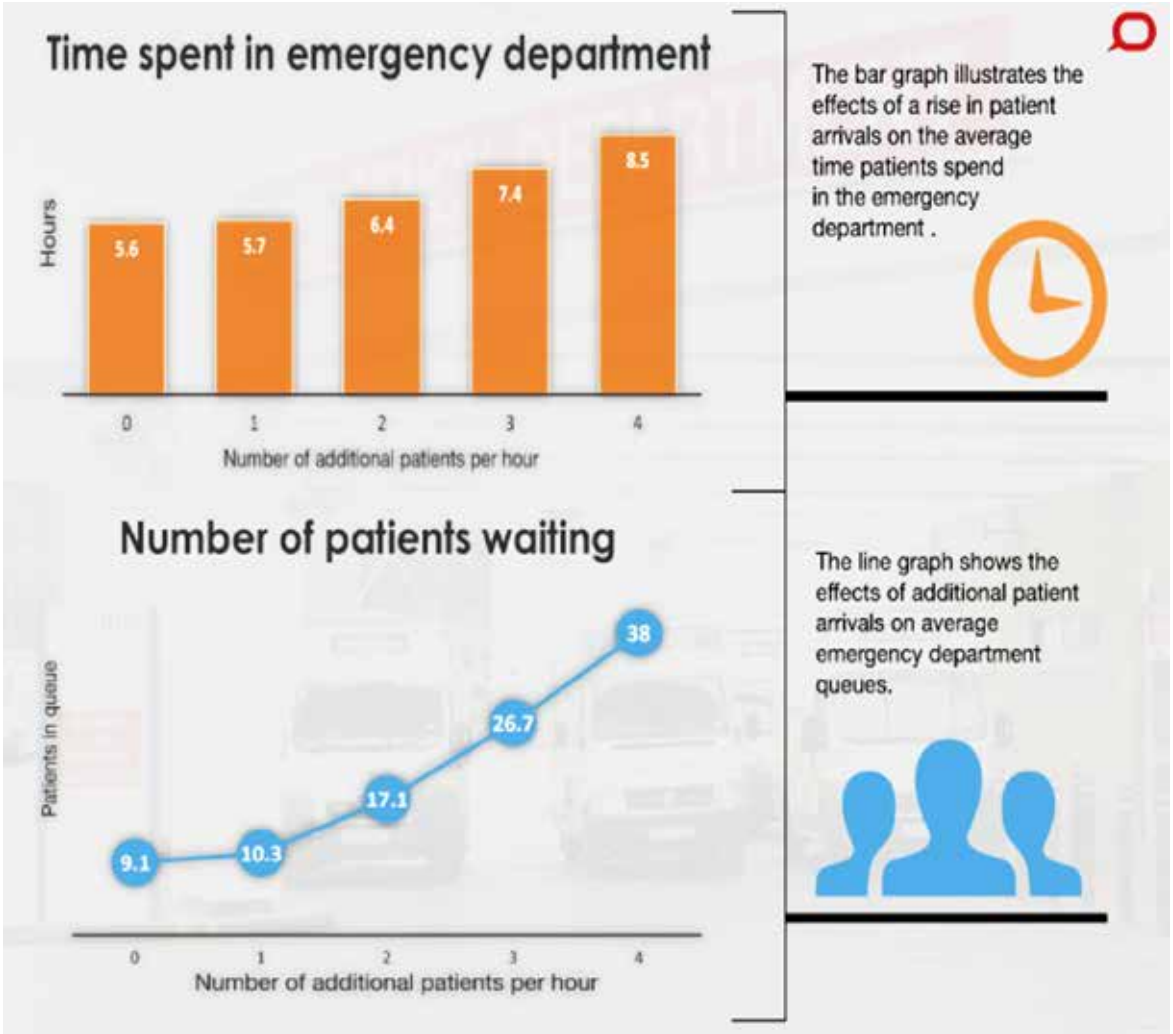
OPINION

GP co-payment would increase emergency department wait times ... FROM P33



This seemed a reasonable assumption, as the hospital's catchment is large and there are an average of 20,000 regular and long GP consultations every day in South Australia. Around 80 per cent of these consultations are currently bulk billed.

One additional patient per hour represents just 0.036 per cent of the total GP consultations, while four additional patients per hour represents 0.143 per cent of consultations.

Finally, we assumed this rate of additional patient arrivals would be sustained. And we've assumed the hospital's level of resourcing doesn't change.

What we found

The following chart shows what happens to emergency department queues and the time patients spend in the ED as additional patients are added to the system.

You can see the addition of extra patients per hour results in a larger increase in average queue length and the average time spent in the emergency department.

Additional time spent in the emergency department means patients wait longer, be it for treatment to commence, or for things like x-rays, blood tests, specialist assessments, and so on.

In this scenario, the average time spent in the emergency department increases for those patients waiting to be admitted into a bed, even though all the additional patients were discharged.

Currently, patients who are admitted to a bed spend an average of 7.6 hours in the emergency department. With one extra patient arriving per hour, this time rises to an average of 7.7 hours, but with four extra patients, this rises to an average of 10.7 hours.

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OPINION

GP co-payment would increase emergency department wait times ... FROM P34

It is important to note that the figures will not't be the same for all hospitals. But the trend will be: at some point average waiting times and average queue lengths will spike.

Flow-on effects

While the federal government has suggested hospitals could charge patients for "GP" attendances to reduce the likelihood of patients deciding to switch service options, such an approach is likely to cost more than it would generate in fees.

Add to this the practical difficulties of determining which patients could have seen a GP instead of visiting an emergency department and whether you'd want emergency department clinicians undertake this task, and it looks even less appealing.

So, what can hospitals do if GP co-payments are introduced and more patients arrive seeking care?

The hospital already deals with variation in patient arrivals and can respond by reallocating resources. But this is done for short bursts and not in a sustained manner, unless there's a planned change to the way in which the emergency department is going to do business.

Clearly, if the introduction of the co-payment results in an additional stream of patients arriving at the hospital, there are two options for the hospital's management: allow patients to wait longer, which may have implications for patient outcomes; or add resources, which invariably involves additional costs.

The health system is complex. Decisions to change a complex system without first understanding both the intended and unintended ramifications creates unnecessary risk. This is precisely where modelling can be of assistance: to analyse various scenarios and understand the outcomes, all without the need to mess up the real system.

In the United Kingdom, the Cumberland Initiative hopes to transform "the quality and cost of [National Health Service] care delivery through simulation, modelling and systems thinking". This, it claims, could "cut NHS costs by 20% while raising capacity and quality".

Our group has just started collaborating with the Cumberland Initiative, with the aim of achieving similar outcomes in Australia.

This article was co-authored by Keith Stockman, Manager of Health Operations Research and Projects in the General Medicine Program at Monash Health.

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

Health on the hill

Political news from the nation's capital

Australians live longer, spend less on health

Australians can expect to live longer than most other people in the world despite spending less on health than the developed country average, challenging claims about the relative inefficiency of the nation's health system.

An international comparison of health spending by the Organisation for Economic Cooperation and Development has found that health accounted for 9.1 per cent of Australia's gross domestic product in 2011-12, below the OECD average of 9.3 per cent and well down from that of the US, where it reached 16.9 per cent. It had risen just one percentage point since 2000.

Yet, in terms of health outcomes, Australia was placed near the top of the table on several key measures. Life expectancy at birth in 2012 was 82.1 years, meaning that Australians, on average, could expect to live two years longer than the OECD average. Only the Japanese, Swiss, Icelanders, Spanish, Italians and French could expect to live longer.

In its analysis, the OECD reported that health spending among its member countries was gradually recovering after falling sharply during the global financial crisis.

The deep recession that followed the GFC in many economies led governments to cut back heavily on spending, including expenditure on health, which virtually stalled among developed countries in 2010.

But in its latest update, the OECD observed that both government and private health spending had since strengthened, reaching an average annual growth rate slightly above 2 per cent in 2012 – though this was still much weaker than the 5 per cent growth recorded in 2008 just before the GFC struck.

Most of the drag on health spending among OECD countries comes from Europe, where deep budget austerity continues to wright heavily - no more so than in Greece, where health expenditure in 2012 was, in real terms, 25 per cent less than in 2009.

Among OECD countries that are still developing economically, growth was much stronger, up by 6.5 per cent in Chile and 8.5 per cent in Mexico due to work on building a system of universal health care coverage.

By comparison with most European countries, Australia's health expenditure has remained remarkably robust during the period of the GFC and its aftermath, and increased by 5 per cent in real terms in 2011-12.

"This strong increase in Australia was triggered by substantial growth in spending on outpatient curative care, administration and public health services," the OECD said, an analysis that lends some support to the Government's ambition to cut down on bureaucratic duplication and administrative inefficiencies in the delivery of public health services.

But in a warning to the Government about the need to intensify preventive health efforts if it was to avoid higher health costs in the future, the OECD found that Australia did not fare well regarding weight control. The measured obesity rate among Australian adults in 2012 was 28.3 per cent, well above the OECD average of 22.7 per cent.

"The growing prevalence of obesity foreshadows increases in the occurrence of health problems such as diabetes and cardiovascular diseases, and higher health care costs in the future," the OECD warned.

Interestingly, the OECD found the public-private breakdown in sources of health funding in Australia were outside the norm among OECD countries, particularly European nations.

While the public sector is the main source of health funding in almost all OECD countries, accounting for an average of 72 per cent of all health spending across the OECD, in

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Australia the public contribution was lower at 68 per cent. In the United States, public spending is less than half of all health expenditure, while in places like the Netherlands, Denmark, Luxembourg and the United Kingdom Germany it is 80 per cent or more.

The OECD reported there had been a major increase in the size of Australia's medical workforce since 2000, and the country now had 3.3 doctors per 1000 people, slightly above the OECD average of 3.2.

Australia also ranked highly in its efforts to curb smoking. Its adult smoking rate of 15.1 per cent was among the lowest among OCED countries, where the average was 20.7 per cent.

Adrian Rollins

COMMENT

Health funds eye off primary care opportunities

The nation's two biggest health funds are eyeing off contracts to operate primary health care organisations being set up to replace the dumped Medicare Local model of primary care.

Both Medibank Private and Bupa have expressed interest in tendering to operate Primary Health Networks (PHNs), which are due to come into operation from mid-2015 when funding for the 61 Medicare Locals runs out.

While the Federal Government is yet to detail the final shape of the PHNs, in the Budget it announced they would be aligned with Local Hospital Networks "to ensure primary health care and acute care sectors work together to improve patient care", and would be advised by Clinical Councils which had significant GP presentation.

The Government is understood to be considering putting the operation of PHNs up for competitive tender.

Both Medibank Private and Bupa told Fairfax Media they were watching the process closely and would consider the opportunity to expand their health service offering.

The possibility that the major private health funds may operate PHNs has arisen as the Government has directed the Health Department to consider ways to partner with private health insurers in the delivery of health services.

Already, Medibank Private is trialling a controversial scheme in Queensland in which it contributes to the administrative costs of GP clinics in exchange for guarantees that its members will receive an appointment within 24 hours and after-hours home visits.

Under current arrangements, private health funds are prohibited from providing coverage for primary health care services, but in the trial Medibank has circumvented the ban by contributing instead to practice administrative costs.

The arrangement has provoked concerns that it could drive up fees and create a US-style two-tier health system.

But Medibank told the Sun Herald its members were not given a priority over other patients, and it was not intended to create a two-tier system.

Health Minister Peter Dutton has indicated he is watching the trial closely, but his spokesman has sought to assure the public that "he supports Medicare and will never go down the path of a US-style health system".

AMA President Associate Professor Brian Owler said the medical profession was open to greater involvement of health insurers in primary care, but it needed to be done carefully in order to preserve the strengths of the current health system.

A/Professor Owler warned that giving private health fund members privileged access to care amounted to a fundamental change in the funding of general practice.

"If people go too far, or the role of private health insurers is unchecked then, yes, it could have very significant consequences and produce greater inequity," he told the *Sun Herald*. "We have a good health care system in Australia and the US model is not one we should be trying to emulate."

Adrian Rollins

COMMENT

Health fund highlights high cost of diabetes

Almost three-quarters of Medibank Private members with diabetes visited hospital at least once last year, figures released by the health fund show.

As private insurers push for an increased role in the provision of primary health care, Medibank Private has revealed that type 2 diabetes has become a significant health problem among its members.

The fund, which is Australia's largest, reported that around 2.8 per cent of its members were identified as having diabetes nationwide, including 3.5 per cent of Victorian members, 2.7 per cent of those in NSW and the ACT, 2.9

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per cent of those in Queensland and 3.4 per cent of those in South Australia.

Of those members identified as having diabetes, 73 per cent visited hospital at least once last year, and the average length of stay was four days.

The most common reason for hospitalisation, accounting for 46 per cent of cases, was diabetic or thyroid-related illnesses, followed by vascular surgery (24 per cent), and eye diseases (21 per cent).

The figures only include private hospital admissions.

In announcing the figures, Medibank Private highlighted data showing the incidence of self-reported diabetes has doubled in the past two decades to 4.2 per cent of the population, and has been accompanied by a growing national weight problem, with two-thirds of adults overweight or obese.

Diabetes Australia has launched a campaign to improve awareness of type 2 diabetes amid concerns that many people underestimate their risk of developing the disease.

The organisation cited a Newspoll survey that found almost 80 per cent of people did not see themselves at risk of type 2 diabetes despite evidence that more than two million already have pre-diabetes and are at high risk of developing the disease.

Diabetes Australia Chief Executive Officer Professor Greg Johnson said many did not take the diabetes risk seriously.

"What many people don't realise is that type 2 diabetes doesn't just affect older people or those who are overweight or obese," Professor Johnson said. "Type 2 diabetes can affect anyone. It is a serious and complex condition."

Medibank's Chief Medical Officer Dr Ian Boyd said that although there was no cure for type 2 diabetes, the condition could be managed through diet, exercise and, in some cases, medication.

The fund's message comes in the context of a controversial push by private insurers for an increased role in the provision of primary and preventive health care.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

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

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

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

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

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

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

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

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

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

Email: careers@ama.com.au

Research

Coffee a great summer sports drink

Athletes sweating it out on a hot day should consider reaching for a nice hot cup of coffee instead of a cold drink.

That is the counter-intuitive discovery made by researchers at the University of Tasmania, who have found that drinking a coffee can deliver a substantial boost to the performance of athletes exercising in hot conditions (35 degrees Celsius).

Previously, caffeine was thought to impair athletic performance in the heat because of its potential to raise the body core temperature, increase the heart rate and cause greater sweating – all adding to the stress of exercising in a hit environment.

But the lead author of the study, Dr Cecilia Shing of the University of Tasmania's School of Health Sciences, said these adverse responses may have been caused by giving athletes too much caffeine.

In her experiment, a group of cyclists was asked to complete time trials in 35 degree heat – some following a moderate dose of caffeine (three milligrams per kilogram of body weight) and some without.

"Our study found that a moderate dose of caffeine was around 85 per cent likely to improve the performance of cyclists in a hot environment," Dr Shing said. "Cyclists who had received a dose of caffeine were completing a time trial on average in approximately 55 minutes, compared to the 60 minutes it took them without the [dose] of caffeine."

She said the results highlighted the potential of caffeine as an aid to improve the performance of endurance athletes not adapted to the heat who are competing in very hot conditions.

The study has been published in *The Journal of Science and Medicine in Sport*.

Adrian Rollins

COMMENT

Fears research fund could cause private donations to dry up

Medical researchers have warned of a worrying decline in private donations to support their work following the Federal Government's announcement of plans to establish a $20 billion Medical Research Future Fund.

Research organisations including the Garvan Institute have reported that private donations have dropped since the Fund was announced in the Federal Budget because donors thought their support was no longer needed.

Garvan Institute Chief Executive Andrew Giles told the *Courier Mail* that since the Budget regular donors had contacted him to say that they would no longer make contributions "when you are already getting money from the Government".

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Research

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He and the leaders of other medical research organisations such as the Walter and Eliza Hall Medical Research Institute and QIMR Berghofer Medical Research Institute have been forced to explain to donors that it will take at least three years for any money from the Fund to begin to flow, and thast they needed their continued support.

Mr Giles described the Fund as a "double-edged sword" which had created the mistaken perception that private donations were no longer required, when the opposite was the case.

The Fund remains mired in uncertainty. Not only is it yet to be established, its prospects remain clouded by the continuing stand-off in Federal Parliament over Budget measures, and key details such as the criteria to be applied to allocate funding had not been finalised.

QIMR Berghofer Director Professor Frank Gannon told the *Courier Mail* he was unsure if any donors had yet withdrawn their funding, but he bemoaned what he said was a "confused situation".

Adding to the complicated picture, the Government expects it to take almost a decade for the Fund to reach its target size.

Ultimately, the Government wants the Fund to be worth $20 billion, enabling it to dispense about $1 billion for research.

But in its first year, it is not expected to hand out more than $20 million of grants, rising to $179 million in 2017-18.

COMMENT

Adrian Rollins

Link between cannabis and psychosis gets more complicated

The causal relationship between cannabis use and schizophrenia has become murkier.

A study of the genetic profile of 2082 healthy Australian adults has found that genes known to be associated with schizophrenia were present in the half who had used cannabis, raising questions about the direction of causality.

The researchers, from King's College London and the QIMR Berghofer Medical Research Institute, suggested that, rather than the use of cannabis being a cause of mental illness, it might be that the same gene was responsible for both cannabis use and schizophrenia.

"This is an important subtlety to consider when calculating the economic and health impact of cannabis use," the researchers said, noting that there might be a causal relationship in both directions - a possibility that required more research.

Dr Matthew Large, from Sydney University's School

of Psychiatry, told *The Australian* there was plenty of evidence that using cannabis precipitated psychosis, and probably caused it in many cases.

But he admitted that this had never explained "why more than half of all people with psychosis smoke cannabis".

"The presence of a shared genetic vulnerability for psychosis could, if replicated, add greatly to our understanding of both addiction and psychosis," Dr Large said.

The release of the research has come amid a push for the legalisation of cannabis for medicinal use.

A group of Federal parliamentarians have called for legislation to allow the sale of cannabis for medical purposes, but medical groups are cautious about the idea, and have called for more research.

Adrian Rollins

COMMENT

Call to use GPs to ease pressure on emergency departments

A debate has erupted in the United Kingdom over calls for GPs to be rostered on after hours and at weekends in public hospital emergency departments.

The UK's College of Emergency Medicine has proposed that all emergency departments have an out-of-hours primary care facility staffed by GPs to help ease the pressure on stretched hospital workers.

The idea has been backed by colleges representing surgeons, physicians and paediatricians amid concerns that existing out-of-hours GP services are not meeting patient needs, causing people to instead go the local public hospital for treatment of what are often relatively minor ailments.

But the British Medical Association warned that the proposal did not take account of the shortage of GPs and risked exacerbating problems around patient access to care.

Chair of the BMA's General Practice committee, Dr Chaand Nagpaul, told The Guardian there were already insufficient numbers of GPs in many areas of the country, which would make it difficult to staff such out-of-hours clinics, and could compromise the access of patients to existing services.

Dr Nagpaul said many primary health services were already struggling to meet patient need because of an inadequate number GPs, and the situation was only likely to get worse because of problems attracting people into the GP specialty and the fact many GPs were considering early retirement.

"If significant numbers of GPs were to work in [accident and emergency departments] rather than GP surgeries, this would contribute to these problems, and could lead to patients not receiving the care they need in the community."

Adrian Rollins

COMMENT

Worst Ebola outbreak on record shows few signs of slowing

More than 600 people have died so far in the worst Ebola outbreak on record, with fears the killer disease is spreading from West Africa into central areas of the continent, putting hundreds of thousands more at risk.

The World Health Organisation has reported that, as at 15 July, 964 confirmed and suspected cases of Ebola in Guinea, Liberia and Sierra Leone, of which 603 people had died.

The previous most deadly outbreak was in the Democratic Republic of Congo, where 318 people died in 1976.

Worryingly, health authorities are struggling to bring the deadly epidemic under control.

While the spread of the disease appears to have slowed in Guinea, where about half of all deaths have occurred so far, in both Liberia and Sierra Leone it continues to spread.

Between 8 and 12 July, Liberia reported 30 new cases and 13 deaths, while in Sierra Leone there were an additional 49 infections and 52 deaths.

The WHO said the epidemic trend was "serious, with high numbers of new cases and deaths being reported".

"This trend indicates that a high level of transmission of the Ebola virus continues to take place in the community."

The WHO is establishing a centre to coordinate actions to tackle the outbreak in Conakry, Guinea, and is working with the governments of the three affected countries to strengthen efforts to track infections.

In addition to being highly infectious, Ebola has an extraordinarily high fatality rate, raising the stakes in action to contain its spread.

Health authorities in Uganda have gone on alert for the disease following unconfirmed reports that it has entered neighbouring Congo.

Despite the scale of the outbreak, the WHO has not recommended any travel or trade restrictions be imposed on the countries where the epidemic has been confirmed.

Adrian Rollins

COMMENT

Queensland a tough place for Easy Riders

BY **DR CLIVE FRASER**

I've always had a fascination with motorcycles for as long as I can remember.

For me, nothing came close to the acceleration and that sense of being part of the machine.

As a medical student, motorcycling also provided me with very affordable transportation and the convenience of parking wherever my bike would squeeze.

I've made some great friends over the years through owning a bike and I've always enjoyed the mateship of going on "a ride" with friends on a Sunday afternoon.

My love affair with bikes was tested by stints in the Emergency Department and orthopaedic wards, where frequently it was a collision with a car that brought the rider to hospital.

I remember very fondly my registrar in the children's surgical ward offering to take the kids for a ride on his motorbike around the hospital (before the paranoia of workplace health and safety rules), and actually doing it!

He's now a prominent surgeon who still rides a bike.

There were those, of course, who rode bikes for a different sort of kinship, in what we now call outlaw motorcycle gangs.

Extortion, violence and all sorts of criminality never seem to be too far away from that group.

But I should point out that our politicians also aren't above the law - my own ex-Queensland Health Minister Gordon Nuttall is still in jail.

In the past 25 years, seven other Queensland cabinet ministers have gone to jail for crimes like misappropriation of public funds, extortion and child sex offences.

While they were all elected representatives, none were bikies and three were Health Ministers.

After some very prominent public acts of violence, culminating in a bikie brawl at Broadbeach and a besieged police station at Surfers Paradise, the Queensland Government enacted the so-called VLAD law.

It is an unfortunate acronym because the other Vlad (aka Dracula) was a Romanian medieval tyrant known for impaling his opponents.

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Queensland a tough place for Easy Riders

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In Queensland "VLAD" stands for the Vicious Lawless Association Disestablishment Bill (2013).

It's an interesting piece of legislation because, for the first time in my memory, you can be convicted of a crime because of who you are, rather than because of what you've done.

And, in another twist, it's also up to the defendant to prove that they are not an office bearer of the organization, rather than the onus being on the prosecution to prove that they are.

And don't think you'll just get a slap on the wrists for having a beer with your mates at the Yandina pub, because the penalty can be up to 25 years imprisonment.

Some very prominent legal figures have expressed concern about the legislation, including its architect and Solicitor-General Walter Sofronoff QC, who has since resigned in protest.

The political storm shows no sign of calming, with a torrent of current and former legal luminaries such as Tony Fitzgerald QC expressing concern about the recent appointment of Tim Carmody as Queensland's Chief Justice.

With nowhere to hide from what is another classic chapter in Queensland's political history, I decided to pay a visit to my local Harley Davidson dealership to see what all the fuss was about.

It was airy and spacious, and my first impression was that it was a retail clothing outlet with a few bikes dotted around as props.

The staff were chatty and courteous, and most of the customers were mums and dads just like me.

In pride of place was a replica of Peter Fonda's Harley from the movie *Easy Rider.*

It's been 45 years since that Harley thundered across the screen to introduce a whole generation to cocaine, LSD and free-love in mainstream movies.

Technology has moved along since the Captain America bike hit the road, with some noticeable components missing.

For starters, there are no indicators or instruments. Also, there's no front brake, and no suspension on the rear of the rigid frame.

The pillion passenger (in the film, Jack Nicholson) did need to keep his right foot off the peg which sat below the swept up exhaust.

But if you wear a football helmet when you ride you won't notice a third degree burn on your calf.

While I felt quite at home at the Harley dealership, I should not neglect to mention that the local chapter of an outlaw motorcycle gang had had its "clubhouse" in an industrial estate only 500 metres away.

But that's not there anymore since it became illegal in Queensland for three or more members to meet.

PS: There was a secret compartment hidden in the fuel tank where Peter Fonda hid the cash.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

Captain America - Harley Davidson Hydra-Glide 1949-1952	
For	Patriotic paint job.
Against	Not too good at stopping.
This car would suit	Queensland cabinet ministers with a stash of money who need to make a fast getaway.
Specifications	73.66 cubic inch twin cylinder petrol (1207 cc) 8.0:1 compression ratio 4 speed manual

COMMENT