AUSTRALIAN
# Medicine
The national news publication of the Australian Medical Association



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PRESIDENT'S MESSAGE

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

> "The AMA cannot support the Government's co-payment proposal as it stands because of issues for vulnerable patients, the people who really can't afford to pay the co-payment"

# Co-payment policy in need of surgery

One of the most important roles in health advocacy is to influence governments to change or scrap bad health policy.

Rather than simply saying 'no', the more successful health advocates suggest changes to improve bad policy or produce a whole new policy to take its place. This is the AMA way.

The Federal Government's co-payment proposal, in its current form, is bad health policy.

In fact, it is not a health policy at all. It is an economic policy poorly disguised as a health policy. Its objective is to save dollars, not lives.

So, ever since Budget night, the AMA has been on a mission to have the policy changed or scrapped.

The AMA cannot support the Government's co-payment proposal as it stands because of issues for vulnerable patients, the people who really can't afford to pay the co-payment – the poor, the elderly, the chronically ill, and Indigenous Australians.

There are also issues to do with the viability of some medical practices, not just in general practice, but also in radiology or diagnostic imaging.

The overarching problem is that the Government's proposal goes against the grain of health policy, which should be to encourage people to see their GP for preventive health care and chronic disease management.

We know the problems, but what are the solutions?

The political reality is that the Government is committed to this policy in one form or another. But the Government knows that it will have to make changes to win over the votes of the Senate crossbenchers.

This is where the AMA comes into the equation. We have produced a fairer and more equitable co-payment proposal. After all, the AMA and the profession are not opposed to co-payments, in principle.

We have been upfront with Government and informed them that our proposal will not deliver the revenue they were hoping for with their original policy. Our proposal would, however, deliver better health care for the community.

I have received good hearings in personal meetings with the Prime Minister, the Treasurer, and the Health Minister.

They asked the AMA to put forward an alternative proposal.

We are still involved in negotiations with the Health Minister and his Department, so we are not in a position to make the details of our plan public at this stage. Rest assured, our plan protects the best interests of doctors and patients.

We have talked to members and worked with our AMA Council of General Practice to make sure that they are happy with our alternative model.

Our model still achieves part of the Government's objectives, in that it sends what the Government likes to call a 'price signal', but it is not a price signal that would deter the neediest and sickest from accessing care.

We are placing a greater value on general practice. But we are also providing protections for those that are most vulnerable in our community, while still encouraging people to see their doctor for preventive health care.

Australia's biggest challenge in terms of health care is going to be an ageing population and the burden of chronic disease.

As people get older, they often have more chronic diseases. They need their GP to help manage and coordinate their care.

About 50 per cent of people between the ages of 65 and 74 have five or more chronic diseases that need to be managed.

They are not going to the doctor to fill in time. There is no evidence of a widespread problem with unnecessary visits to the GP. Some are claiming that large numbers of older Australians are going to the doctor simply to have a chat. They aren't. They are getting the best possible care and advice to manage their conditions.

That is why we need to value general practice and primary care, to make sure that we manage people in our communities, keep them well, and keep them out of expensive hospital care.

That is why we need to influence the Government to produce better health policy.



COMMENT

BY AMA SECRETARY GENERAL ANNE TRIMMER

# Members put a premium on AMA advocacy

In a previous column I referred to the first national member survey of members by the AMA. The survey was completed recently and the initial results are in. As with most surveys the results are instructive.

Not surprisingly, members look to the AMA for representation on policy issues. This was followed by workplace relations representation and advice.

The top items nominated for AMA advocacy were ethics and professionalism, followed by doctors' fees. This view has been reflected in the emails and letters received by the secretariat following the speech given by the President, Associate Professor Brian Owler, to the National Press Club on 23 July, in which he laid out the AMA's position on a range of matters - not just those arising from the recent Federal Budget, but also reflecting the changing environment within which doctors are working.

When asked how they would like to receive information from the AMA, members overwhelmingly identified email as the preferred communication. This result will provide a useful benchmark for future surveys as the AMA begins the task of improving the way it engages with its members and the medical profession. Over the coming months members will see an overhaul of the website, making it easier to find content and to navigate the site.

After a soft launch at the AMA National Conference in May, promotion will begin shortly of a new web portal – *doctorportal* – which is available to all registered practitioners. *Doctorportal* is designed to aggregate a suite of tools, resources, products, services and information for medical professionals. Doctors have to register to enter the site to ensure that they are authenticated as a doctor. The platform content will develop over time as more tools and resources are added.

The Board of the AMA meets this week for the first time in its new structure. At the end of August the Board will have a planning meeting to set the strategies for the company. Ensuring that the AMA remains relevant to its members and evolves with the profession are key objectives.

Late in August, the Federal Council will meet for the first time in its new role focusing on medico-politics. The meeting will provide the Council with the opportunity to consider its structure and operations for the future. It has the opportunity to develop more flexible ways of working on policy and political issues, with working groups drawing on the experience and interests of a wider group of members, where appropriate.

"It has the opportunity to develop more flexible ways of working on policy and political issues, with working groups drawing on the experience and interests of a wider group of members, where appropriate"

Federal Council will have the opportunity to engage in the proactive development of policies on issues relevant to members and their interests.

So often, the medico-political agenda is driven by the need to respond to current political events – as has been the case with the need for a well-articulated response to the Budget.



COMMENT

# AMA works on alternative to Govt's massive hit on patients

The Federal Government's wholesale changes to health care funding will dump an extra $10 billion of costs onto patients and put the system itself at enormous risk, the AMA has warned.

As the AMA presses ahead with work on an alternative co-payment model to present to the Government, it has released estimates showing that proposed changes to health spending contained in the May Budget would entail a huge shift in the funding burden onto patients.

In its submission to a Senate committee inquiry into patient out-of-pocket costs, the AMA said the planned $5 cut to Medicare rebates and scrapping of bulk billing incentives would cost patients $3.5 billion in its first three years, while freezing indexation of rebates would cost $1.4 billion, increasing Pharmaceutical Benefit Scheme co-payments and safety net thresholds would cost patients an extra $1.4 billion and the $7 co-payment would add about $1.4 billion to family health costs.

The AMA said that these changes, combined with an immediate $1.8 billion cut to public hospital funding and the dumping of the $16.4 billion Health Reform Agreement funding guarantee, were "driven by ideology" rather than evidence.

"They make no attempt to refine and shape the Australian health care system to position it to deal with future challenges," the submission said. "Structural changes of this magnitude, without any long-term forecasting and analysis of their impact, subject the health of Australians and the Australian health care system to enormous risk."

## AMA's alternate co-payment model

The AMA has warned the Federal Government that it will have to scrap Medicare rebate cuts and shield vulnerable patients from increased costs if the medical profession is to accept the introduction of a co-payment for GP, pathology and diagnostic imaging services.

President Associate Professor Brian Owler cautioned that it would not deliver savings of the magnitude anticipated in the Federal Budget.

Last month Prime Minister Tony Abbott asked the AMA to work with Health Minister Peter Dutton and the Health Department on an alternate form of the co-payment amid widespread hostility to its wholesale changes to health funding, including a $7 charge for GP, pathology and radiology services and a $5 cut to Medicare rebates. The plan in its current form faces defeat in the Senate.


A/Professor Owler, who met with Mr Dutton last Thursday as part of discussions on an alternate model, said the AMA supported the concept of a patient co-payment, but only if it was imposed in a way that protected vulnerable patients and did not take money out of primary care.

"The AMA cannot support a proposal that takes money out of primary health care," he said. "That's not a negotiable option."

He said the AMA's work on an alternative model was guided by three fundamental principles: that there be no Medicare rebate cuts; that vulnerable patients, including children, be protected; and that it include ways to improve the value patients place on GP services.

The peak grouping of GP organisations, United General Practice Australia, last week backed the AMA in its

MORE P8

# AMA works on alternative to Govt's massive hit on patients

... FROM P7

negotiations with the Government on the co-payment.

The AMA President told a Senate committee inquiry into patient out-of-pocket expenses that the Government's proposed co-payment model was "poorly designed and inflexible. It will have unacceptable impacts for vulnerable patients and their doctors, and implications for health care policy."

## Out-of-pocket expenses

A/Professor Owler said the Federal Government's proposed changes to health care amounted to an abrupt U-turn in the thrust of current policies, which encouraged medical practitioners to bulk bill.

He said that, as a result, the "vast majority" of health services were provided at no cost to the patient.

In fact, in the past decade, the proportion of health services involving out-of-pocket expenses has held steady or declined. At the same time, where such costs are imposed, they have increased.

"Importantly, less than 12 per cent of out-of-pocket costs are for medical services," A/Professor Owler said. "This is contrary to the common misperception that all 'out of pocket costs' are for medical expenses."

More than 81 per cent of GP services were bulk billed in 2012-13, and the AMA President warned that increasing the cost of accessing primary care would end up costing the nation more, as people put off seeing their doctor for relatively minor ailments that could eventually become far more expensive to treat.

Director of the Grattan Institute's health program, Professor Stephen Duckett, told the Senate committee hearing that any savings to be drawn from the $7 co-payment would be quickly washed away if many of those who had intended to see their GP instead went to EDs for treatment, where each visit cost the public purse $290.

The Government has estimated that patients will forego one million GP services as a result of the co-payment, and Professor Duckett warned that "if more than one in three of these patients go to an emergency department there will be no saving to the Government".

A/Professor Owler said that, rather than extracting money from primary care, the Government should be increasing its support for GPs.

"We've seen this competitive drive towards six minute medicine and what we need to do is actually reward GPs for spending the time with their patients, for managing their chronic diseases, and keeping them well and out of hospital," he said. "GPs are the answer to the sustainability of the health care system, they are not the problem."

## Bulk billing a political battlefield

Mr Dutton has claimed that one of the biggest threats to the country's system of universal health care has been the growth in bulk billing, which he said the co-payment was intended to address.

"The biggest change to the original intention of Medicare since its inception is not the introduction of a co-pay, [but] the steady growth in bulk billed services…which is undermining the sustainability of the system," the Minister said in an opinion piece in the *Sunday Tasmanian* on 27 July.

> the Government's proposed co-payment model was "poorly designed and inflexible. It will have unacceptable impacts for vulnerable patients and their doctors, and implications for health care policy

"A scheme that was designed to protect those who were unable to support themselves had become, in some cases, a tool with which GPs could gain market share and poach patients from the surgery or clinic down the road."

But Opposition leader Bill Shorten pledged Labor would "fight to the death" to protect Medicare and bulk billing.

"[Medicare is] the rock upon which we built modern Australia," Mr Shorten told the NSW Labor Conference late last month. "It is madness for Australia to go down the American road, just when Americans are finally making a long, exhausting U-turn.

"Medicare doesn't just keep Australians healthy. It makes us more productive and its boosts participation."

**Adrian Rollins**

COMMENT

# AMA sounds alarm on move toward US-style managed care

AMA President Associate Professor Brian Owler has raised the alarm about a strong push by private health insurers into primary health which he warned could pave the way for US-style managed care.

A/Professor Owler used a major speech at the National Press Club to draw attention to recent manoeuvres by private health funds which he said compromised fundamental principles about universal access to health care and could result in insurers interfering in the doctor-patient relationship and dictating treatment.

"Despite the protests of innocence, I fear a concerted effort on behalf of private health insurers to undermine and control the medical profession," the AMA President said. "We have concerns, and both private health insurers and the Government understands that a US-style managed care system is something that the public does not want."

In his speech, A/Professor Owler drew attention to a number of recent developments which he said were cause for alarm, including Medibank Private's trial with general practice provider IPN to give its members priority GP appointments in return for paying administrative fees, the interest of insurers in tendering to operate the new Primary Health Networks being set up to replace Medicare Locals, possible involvement with regional GP training providers and pre-assessment programs for cosmetic procedures.

The health funds have undertaken these initiatives with the tacit support of the Federal Government, which has encouraged their interest in expanding their scope of operations, including into primary care.

In a speech in March, Health Minister Peter Dutton noted with approval the Medibank-IPN trial as an example of the sort of "collaboration" with doctors and patients the Government would welcome.

"I am encouraged to see that health insurers are looking at innovative options in the area of primary health care," Mr Dutton said. "They have been excluded from the primary care space for historical reasons, and if insurers are prepared to work collaboratively with doctors and patients then we should welcome that development."

In an attempt to head off concerns that such developments could undercut Medicare and the principle of universality of health care, the Minister said the Government had no interest in undermining Medicare, nor in supporting changes that would allow insurers to provide gap insurance or bump up premiums.

But A/Professor Owler said he was not reassured.

"I know the Government is engaged very closely with the private health insurers and have asked them for information about how they might contribute," he said. "The stage is being set for a US-style managed care system in both the primary care and hospital settings, [and] I am concerned that the Government is also looking towards such a system."

"The Government has said 'no, we're not going to go down the track of managed care', but managed care has many guises, and we need to keep a very close brief on where we are actually heading with private health insurers and their engagement with primary health care."

Health funds have already been accused of interfering in clinical decision making after claims the Medibank Private was refusing to cover plastic surgery for patients with burns, cancer and other conditions.

The Australian Society of Plastic Surgeons has, according to News Corporation newspapers, raised objections after Medibank refused to cover the cost of surgery to remove both breast implants from women after one of them had burst. Other concerns include a refusal to cover reconstructive surgery for burns victims and patients who have had cancers removed.

A/Professor Owler said the AMA did not totally discount a role for private health funds in primary care, but it should be "at the edges", such as supporting the management of patients with chronic health problems.

He said it needed to be kept in mind that insurers were motivated by profit and the competition for market share.

"While we understand that there are some areas in primary care where private health insurers may have a role, I think we need to be very careful about how that is done," he added.

**Adrian Rollins**

COMMENT

# AMA says no place for 'exorbitant' fees

The AMA has defended the right of doctors to charge "appropriate" fees for their services, particularly given the failure of the Medicare rebate to keep pace with the rising cost of providing care.

Amid claims that some patients are being hit with enormous out-of-pocket expenses as high as $60,000, AMA President Associate Professor Brian Owler said there was no call for specialists to charge "exorbitant" fees.

But A/Professor Owler said the failure of successive governments to ensure the Medicare rebate kept pace with the cost of running a medical practice had left many doctors with little choice but to charge out-of-pocket expenses.

"The AMA does not support any specialist charging any fees that are exorbitant. But I do support the ability of a doctor to charge a fee that they feel is appropriate for their services," he said. "More and more doctors have been charging gaps because the distance between the [Medicare] schedule fee and what it is costing them to run their practices is increasing."

On 1 July the Medicare rebate for a standard level B GP consultation inched higher to $37.05 after being frozen for an extra nine months, but it still almost $36 less than what AMA considers to be a fair payment for GP services.

In the specialties, the gap is even larger. The AMA estimates that the decision by Government to freeze indexation of the rebate for specialist consultations for two years will push the gap out to $97.72 next year.

So far, the vast majority of patients have been shielded from the full effects of the Government's failure to properly index Medicare rebates. In general practice, the bulk billing rate has reached above 82 per cent, while 89 per cent of specialist services are covered by private health insurer no-gap arrangements, and a further 4 per cent are covered by known gap arrangements.

But the Federal Government's plan to slash the Medicare rebate for GP, pathology and diagnostic imaging services by $5 and introduce a mandatory co-payment is expected to drive bulk billing rates down.

The Royal Australian College of Surgeons has expressed consternation at media reports that some patients are being hit with very large out-of-pocket expenses.

The College said that extortionate fees, which were manifestly excessive and bore little relationship to the skills, resources or time used in providing care, were "exploitative and unethical" and in breach of its Code of Conduct.

College President Professor Michael Grigg said revelations of very high charges damaged the standing of surgeons and the health system.

"These stories affect confidence in private health care, private hospitals, the surgical profession and surgeons," Professor Grigg said.

The College said it was working with the Australian Competition and Consumer Commission on ways to increase the disclosure of surgeon fees while still being compliant with the Trade Practices Act.

> "Patients need to understand that they do have the ability to go an seek another opinion, to see whether another doctor might be able to provide a service at a cost that is more appropriate ..."

A/Professor Owler said it was important that all practitioners employed informed financial consent.

"Patients need to understand that they do have the ability to go an seek another opinion, to see whether another doctor might be able to provide a service at a cost that is more appropriate for that particular patient," he said.

A/Professor Owler said doctors needed to be able to charge appropriately to cover the multitude of costs of running a practice – staff, property, equipment, insurance – as well as earn a fair income.

"But, by the same token, [we need to ensure] patients are not put under financial distress from accessing health care," he said.

**Adrian Rollins**

COMMENT

# Macquarie Leasing


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# Drug company disclosure a step closer

Drug companies will be required to publicly disclose substantial gifts, payments and subsidies provided to individual doctors and other health professionals, including air fares, honoraria, conference registrations and accommodation under voluntary rules being considered by the consumer watchdog.

Under a Code of Conduct prepared by peak pharmaceutical industry body Medicines Australia (MA) in consultation with stakeholder groups including the AMA, the details of all "transfers of value" between drug companies and individual health professionals that are covered by contracts will be published.

The Code, which will apply to companies that are members of MA, is the culmination of an extensive and exhaustive year-long process of consultation and revision involving representatives from industry, the medical profession and consumers, including Associate Professor Robyn Langham, who represented the AMA on the Code Review Panel set up by Medicines Australia.

In a submission to the Australian Competition and Consumer Commission (ACCC) in support of the draft Code, the AMA said it embodied a "realistic and common sense approach", particularly in the absence of evidence about whether or how the information might influence patients.

"At this point in time, these reporting requirements are philosophically based," the AMA said. "There is no evidence yet of their positive or negative impact on health care systems or health care decisions."

It said drug companies reporting under the Code would still need to obtain permission from health practitioners before publicly disclosing information about them, as stipulated under the Privacy Act 2008.

A/Professor Langham, who is Head of Nephrology at Melbourne's St Vincent's Hospital, said developing the Code had been a major undertaking for all involved. Since August last year there have been monthly face-to-face meetings of the 12-member Panel, as well as several forums with medical practitioners, consumers and other stakeholders and painstaking assessment of numerous submissions.

While A/Professor Langham was paid by MA for the time she committed to the Panel's work, her involvement stemmed from a long-standing belief in the importance of disclosure to a robust, trusting and ethical relationship between medical practitioners and their patients.

Like GPs and some other practitioners, her line of work has involved developing on-going relationships with her patients – a circumstance A/Professor Langham said underlined the importance of dealing with patients ethically and openly.

"I see it as an important part of the day-to-day work that doctors do," she said. "The concept of transparency is critical to the way patients see us as a profession."

In devising the updated version of the Code, the Panel sought to arrive at a level of disclosure that would reassure patients that they were being treated respectfully and ethically without imposing costs on companies and practitioners that were so great that they would deter them from signing up.

The balance struck in the Code has not satisfied some.

The Consumers' Health Forum, which had direct input into the design of the Code through representation on the Review Panel, has nonetheless heavily criticised the proposal put to the ACCC for approval.

Forum Chief Executive Officer Adam Stankevicius said the Code failed to establish the degree of transparency required to safeguard the interests of patients, and instead embodied the "tendency of the medical profession to avoid disclosing information that may be in their patient's or the public's interest".

Critics have often made reference to the United States, where legislation has been enacted requiring full disclosure of all payments, gifts and other 'transfers of value' made by drug companies to doctors, including transactions as minor as a cup of coffee or sharing a research paper.

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# Drug company disclosure a step closer

... FROM P12

But the situation in the US is different in two critical aspects – the disclosure regime is mandatory, and it is supported by government funding, neither of which applies in Australia.

Instead, A/Professor Langham said, the Review Panel paid close attention to arrangements in Europe, where conditions were much more similar to those in Australia.

Under the revised Code, Medicines Australia members will be required to publicly report 'transfers of value' to individual health practitioners, including speaking fees; sponsorship to attend conferences and courses (airfares, accommodation, registration fees);

consulting payments; fees paid to sit on Advisory Boards; market research fees; and education grants.

The final design of the Code was heavily influenced by the fact that it was voluntary, raising the risk that drug companies and practitioners could simply ignore it if it was too burdensome to implement, and that the nation's privacy laws raised doubts about what could and could not be publicly disclosed.

Working within these constraints, the Code has embraced a level of disclosure below that stipulated in the US but consistent, the Panel believes, with protecting the interest of patients. MA member companies will be required to disclose transfers of significant value covered by a contract, which would typically include travel, accommodation and registration expenses for attending international conferences, as well as honoraria and stipends.

The push to revise the Code came from the ACCC, which in December 2012 gave the MA two years to come up with a framework to improve the transparency of payments made to individual doctors. The MA submitted the draft Code on 2 July and expects the Commission to adjudicate in the next six months, giving time to implement the new transparent reporting requirements from October 2015.

A/Professor Langham said the Code was not the end of the process, but rather an important first step.

She said one of the difficulties confronting the Panel was the lack of international experience and evidence to draw up on regarding what disclosure regimes worked, and admitted to considerable uncertainty how the Code might be adopted and operate in practice.

"Doctors have the opportunity to opt out of public reporting, and it is unknown whether that is going to be widespread practise," she said.

Other hurdles are more technical in nature – how to collate and present the details of doctor payments and sponsorships provided by the drug companies, and devising a unique identifier for each practitioner to ensure transactions are not incorrectly attributed.

Either way, A/Professor Langham remains keen to be involved in developing a robust system of disclosure that will sustain and enhance the trust and confidence that underpins healthy doctor-patient relationships.

The AMA's submission to the ACCC regarding the draft MA Code of Conduct can be viewed at: https://ama.com.au/submission-medicines-australia-revised-code-conduct-and-proposed-industry-reporting-requirements

**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**

# Quality GP training put at risk

The Federal Government has put the nation's ability to sustain a highly-trained GP workforce in jeopardy through its Budget cuts and changes, the AMA has warned.

AMA President Associate Professor Brian Owler said the Government's decision to abolish General Practice Education and Training (GPET) and absorb its functions within the Health Department had, along with the shutdown of the Prevocational General Practice Placements Program (PGPPP) and the decision to abolish regional training providers (RTPs) and put their functions out to tender, raised serious concerns about the future of GP training.

A/Professor Owler used a speech to the National Press Club during Family Doctor Week to highlight medical profession fears about the long-term ramifications of the Budget measures.

"The loss of GPET into the Department of Health…is not simply a cost-saving measure," he warned. "It represents the loss of professional oversight in the coordination of GP training."

The AMA President added that the move to axe RTPs and put their work out to tender risked fragmenting GP training while dumping the PGPPP robbed aspiring family doctors of a valuable apprenticeship opportunity.

"These changes are major setbacks for general practice training," A/Professor Owler said.

"The Budget reforms will dismantle the existing GP training infrastructure that has taken many years to put in place.

"Instead, the Government appears to be resting all its faith in the marketplace to provide a training solution – this is a recipe for chaos."

The impact of the Budget cuts was discussed at a high-level GP Registrar Forum hosted by the AMA late last month.

The Forum, attended by A/Professor Owler, AMA Council of Doctors in Training Chair Dr James Churchill, AMA Council of General Practice Chair Dr Brian Morton, Chair of General Practice Registrars Australia Dr David Chessor and a number of other GP registrar leaders, expressed alarm at the Government's changes.

The AMA President said abolishing GPET would mean the medical profession no longer had control and leadership of GP training, and there was no confidence that the Health Department had the expertise to provide a suitable replacement – particularly in the very short time set by the Government. GPET is due to shut down at the end of the year.

The Forum called for GP Colleges to have an expanded role in GP training, and for the abolition of RTPs to be deferred until there was proper consultation with the profession about the future structure and role of their replacement.

A/Professor Owler said the Budget changes to GP training were particularly regrettable given that the demands on GPs, who were central to the operation of the health system, were becoming ever more acute.

Not only were patients presenting with ever-more complex and chronic conditions to diagnose, treat and manage, but GPs had to keep abreast of repaid developments in medical knowledge and treatments.

"The rate of growth in medical knowledge has become exponential," A/Professor Owler said. "New treatments, new medications, and even new diagnoses come seemingly every day.

"I do not envy the task of the GP in being across the range of medical conditions, medications, and treatments that a GP, or family doctor, must be familiar with.

"It is why it is so important that we have a highly-trained general practice workforce."

The AMA President said the importance of high quality medical education and training was often overlooked, but it was fundamental to the nation's high standards of health.

Australians have among the longest average life expectancy in the world. A boy born in 2012 can expect to live for almost 80 years, and a girl, more than 84 years.

This has been underpinned by sustained declines in death rates caused by major killers such as heart disease, cancer and infections.

"The standard of medicine practised in this country is among the best in the world, whether it be in our general practices or in our hospitals," A/Professor Owler said.

"It is because we have a highly trained medical workforce. We have an established apprenticeship model, with our Colleges maintaining education and training standards.

"That is why it is so important that we continue to invest in training our GPs and our other specialists of the future."

In its Budget, the Federal Government created 300 extra first year GP training places from next year, but A/Professor Owler said the welcome investment was undermined by the other measures that hurt GP training.

**Adrian Rollins**

COMMENT

# Close gaps in HIV detection, treatment: AMA

A rebound in HIV infections has underlined the need for governments to ramp up their investment in prevention programs and treatment, according to the AMA.

As more than 12,000 HIV experts, activists and carers descended on Melbourne late last month to attend the 20th International AIDS Conference, AMA President Associate Professor Brian Owler said a jump in the nation's infection rate to its highest level in 20 years sounded a clear warning that there needed to be a change in the nation's response to the deadly disease.

"In the face of increasing rates of HIV infection, a business-as-usual approach is not enough," A/Professor Owler said. "Testing rates have declined, rates of unprotected sex and high-risk sexual behaviour have increased, and a significant number of those infected with HIV are not receiving treatment."

The AMA President's comments followed the release of a report by the University of New South Wales' Kirby Institute, which showed there were 1235 new cases of HIV diagnosed and reported across Australia last year, virtually unchanged from 2012, when there was a 10 per cent surge in new infections to the highest level in 20 years.

The number of new infections is now 70 per cent higher than those detected in 1999, and a decline in testing rates has led to estimates that around 10,000 people with HIV do not realise they are infected, while more than a third are diagnosed late, delaying treatment and increasing the risk of transmission.

A major concern for health workers is increasing ignorance and complacency about HIV, particularly among younger men, and gaps in care which have meant up to half of those with the disease are not receiving antiretroviral treatment.

At a meeting in June, the nation's Health Ministers committed to rejuvenating the country's HIV effort.

In a joint statement, the Ministers committed to halving new HIV transmissions in Australia by 2015, and their "virtual elimination" by 2020.

Supporting this, the Health Department has announced that from 1 July next year patients in the community who use antiretroviral therapies will no longer have to demonstrate a link to a hospital in order to receive a publicly subsidised supply, and the authority prescription process will be streamlined.

The change means that prescribing doctors will no longer have to provide a hospital provider number.

The nation's Chief Medical Officer, Professor Chris Baggoley, said the country was tackling HIV as part of a broader assault on blood borne viruses.

"We understand in Australia that HIV is not addressed – cannot be addressed – in isolation from other blood borne viruses and sexually transmissible infections," Professor Baggoley said.

He said measures to tackle HIV, hepatitis B and C and STIs had been combined and "together the strategies support a coordinated, holistic effort across all conditions. They respond to the intrinsic links through co-infections, common risk factors and priority populations".

A/Professor Owler said the national strategies were welcome, not least because they included concrete targets that would provide impetus for action.

But he said immediate action was needed to close persistent and growing gaps in testing and access to affordable treatment.

"We urgently need an implementation action plan and government investment if we are to turn aspirational targets into a reality," the AMA President said. "This must include a focus on reducing inequities and engaging with communities experiencing higher infection rates and poorer health outcomes."

Former US President Bill Clinton told the AIDS Conference that advances made in the fight against HV had put the prospect of an AIDS-free generation within reach.

"The AIDS-free world that so many of you have worked to build is just over the horizon. We just need to step up the pace," Mr Clinton said. "We are on a steady march to rid the world of AIDS."

Hopes for improved treatment for HIV were boosted ahead of the AIDS Conference when it was revealed that two Australian patients had had their cancer and AIDS infections virtually eradicated following bone marrow transplants.

Cancer is a common complication among those with HIV, and the discovery has opened up inquiries into the use of stem cell transplants as a HIV treatment.

As medical researchers explore new and better treatments, the AMA has released its *Position Statement on Sexual and Reproductive Health 2014*, in which it has urged governments to do more to educate people about HIV and sexually transmitted diseases and strengthen early detection and treatment initiatives.

The Position Statement can be viewed at: https://ama.com.au/position-statement/sexual-and-reproductive-health

**Adrian Rollins**

COMMENT

# GPs, pharmacists agree: let's work together

GPs and pharmacists will work much more closely together to improve patient care under arrangements being developed by the AMA and the Pharmaceutical Society of Australia.

The AMA and the PSA have announced they are collaborating on ways to integrate pharmacists into GP-led primary care teams to improve the use of medicines and cut down the frequency of adverse drug events.

Already, some GPs and pharmacists are working more closely together with promising results, and the two professional organisations are seeking to draw on these experiences to provide a model for collaboration that could be adopted much more widely.

AMA President Associate Professor Brian Owler said patients were presenting to GPs with increasingly complex and chronic conditions, and closer co-operation and co-ordination between doctors and pharmacists would improve care.

"With the growing burden of chronic disease, we are seeing patients with very complex medication therapies," A/Professor Owler said. "By encouraging pharmacists to practise collaboratively with doctors in GP clinics, we will improve communication and assist in managing these complex medication regimens."

The move toward greater co-operation has come despite occasionally testy relations between the professions as bodies such as the Pharmacy Guild of Australia have pushed for an expanded scope of practice for pharmacists, including conducting health checks and administering vaccinations – both ideas strongly opposed by the AMA.

But A/Professor Owler said it was important that GPs and pharmacists complement, rather than compete with, each other.

Both he and PSA Chief Executive Officer Dr Lance Emerson said that much closer co-operation between doctors and pharmacists would not only improve patient outcomes, but save precious health dollars.

It has been estimated that around 190,000 hospital admissions each year are as a result of adverse drug events that cause patients distress and cost the health system $660 million.

Both A/Professor Owler and Dr Emerson said it was important to ensure that the model for doctor-pharmacist collaboration was viable and sustainable for both, including appropriate funding parameters.

"We are working very closely to develop a model that produces the best outcomes for patients and health profe4ssionals while also providing long-term budgetary benefits for the Government," A/Professor Owler said.

**Adrian Rollins**

COMMENT

# Health assessment items: wait for clear advice continues

The Federal Government is yet to issue a full and clear statement confirming that the time spent by practice nurses assisting in the preparation of patient health assessments can be included in the Medicare rebate claimed by GPs.

While the Department of Health has provided assurances that there was no intention to change existing arrangements when the wording of advice from the Department of Human Services was changed, the AMA is still waiting on clear advice from the Government affirming that this is the case.

In his regular GP column in this edition of *Australian Medicine*, Dr Brian Morton, Chair of the AMA Council of General Practice, said that although the episode appeared headed to a satisfactory conclusion, it emphasised just how easily poor decisions and misconceived ideas could arise when Governments neglected to consult with the medical profession.

"It is hard to understand what the Department was thinking when it decided to change established arrangements without consultation with the profession," Dr Morton said. "Apparently, they didn't think revising the 2010 Health Assessment Factsheet, which made it clear that nurse time counted, was that significant."

Instead, it was left scrambling to try to rectify the error, botching the first attempt at providing a clarification.

"In a classic case of *Yes Minister*, the Department of Health was quick to respond with a clarification that suggested DHS had got it wrong," Dr Morton said.

"However, its advice that a practice nurse may assist a GP with performing the health assessment offered little comfort to GPs around the country. A plain English statement along the lines of 'Yes, nurse time counts', would have provided more comfort."

In a sign that the Health Department had heeded doctor concerns, it issued a statement that "both GP and practice nurse time can be used to decide which Medicare item would be the most appropriate to bill Medicare for a particular health assessment".

Dr Morton said this had provided a welcome assurance that the Department was working to end the uncertainty, and was working hard to "get the wording just right".

"The AMA remains committed to working with these departments regarding the interpretation of MBS items, and this episode should be a clear lesson to them both about the importance of consulting with the profession about how the MBS works before publishing material that overturns accepted practice and interpretation," he said.

**Adrian Rollins**

COMMENT



INFORMATION FOR MEMBERS

# PBAC nominations invited

**AMA members are invited to nominate to medical specialist positions on the Pharmaceutical Benefits Advisory Committee (PBAC).**

PBAC has asked the AMA to nominate suitable members to be considered for future vacancies that may arise over the next 12 months or so.

PBAC positions are challenging, stimulating and provide an opportunity to contribute directly to pharmaceutical benefits policy in Australia.

PBAC is an independent expert committee that advises the Minister for Health on medicines in relation to the Pharmaceutical Benefits Scheme. PBAC is required to consider the clinical effectiveness, safety and cost effectiveness of a medication compared with existing therapies.

AMA members who nominate must be able to interpret the comparative outcomes of therapy involving a medicine and critically appraise clinical evidence. Experience in health technology assessment and/or pharmaco-economic evaluation is also an advantage.

The AMA's executive will assess nominations prior to forwarding them to the Minister for potential appointment.

PBAC meets three time a year for three/four-day meetings and may hold up to three additional one-day meetings. PBAC members currently receive an annual salary of $36,750 and all travel costs are reimbursed. Appointments are for four years.

Further information about PBAC can be found on the PBS website [http://www.pbs.gov.au/info/industry/listing/participants/pbac].

**To nominate, please forward a curriculum vitae no longer than 2 pages (Click here [https://ama.com.au/system/files/sample_cv.pdf] for an example) to gmorris@ama.com.au by Tuesday, 19 August 2013. If you have any questions, please contact Georgia Morris on 02 6270 5466.**

# 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

### Dutton to deal on GP co-payments, *Australian Financial Review*, 18 July 2014

Health Minister Peter Dutton says he has opened negotiations with the minor party Senators on the $7 co-payment for doctor visits. The AMA believes the Government is sympathetic to the objections it has raised and a compromise can be found.

### Medical community shares grief at reported loss of giant in AIDS research, *Canberra Times*, 19 July 2014

Medical researchers and activists were left devastated by reports that dozens of delegates bound for Melbourne to attend the International AIDS conference were aboard downed flight MH17. AMA President A/Professor Brian Owler offered condolences to those who lost loved ones.

### Surgery fee gap soars, *Sunday Times*, 20 July 2014

Surgeons are slugging cancer sufferers up to 10 times the Medicare fee for lifesaving operations. AMA President A/Professor Brian Owler said the AMA had no problem with surgeons charging gaps because the Medicare rebates have not kept pace with inflation.

### Celebrating our family doctors, *Hobart Mercury*, 22 July 2014

Tasmanian general practitioners were feted as part of the AMA's Family Doctor Week. During AMA Family Doctor Week, the AMA is urging people to work with their family doctor on preventive health care.

### Surgery policy 'like US', *Adelaide Advertiser,* 24 July 2014

The nation's largest health fund is refusing to fund plastic surgery for burns and skin cancer victims under a new policy that doctors claim amounts to the introduction of US-style managed care. AMA President A/Professor Brian Owler told the National Press Club there was a fear of concerted effort on behalf of private health insurers to undermine and control the medical profession.

### GP fee would harm system, Abbott: AMA, *Sydney Morning Herald*, 24 July 2014

AMA President A/Professor Brian Owler told the National Press Club the AMA is not against co-payments in principle, but it was opposed to the Government's proposal because it threatened the universality and affordability for health care for the neediest and sickest in the community.

### Doctors urge checks to reduce heart attack risks, *Canberra Times*, 25 July 2014

AMA President A/Professor Brian Owler said people who had high cholesterol or blood pressure, an unhealthy diet, diabetes, and especially smokers, were at increased risk of dying from heart disease.

### Caveman challenge dinosaurs, *Daily Telegraph*, 25 July 2014

Advocates of the Paleo diet have lashed out at the Dieticians Association of Australia after the group slammed their eating habits as a fad threatening to do more harm than good. AMA Chair of General Practice Dr Brian Morton said that there was lack of evidence beyond the anecdotal and experimental.

### Immunisation message still vital, *Canberra Times*, 25 July 2014

The importance of immunisation for preventable diseases is still a relevant community message. AMA President A/Professor Brian Owler said where immunisation levels were low, illnesses such as whooping cough and measles could be spread more easily.

### AMA slams $8b burden of Abbott's 'bad health policy', *Courier Mail,* 29 July 2014

Doctors warn that patients will be slapped with $8 billion in health care costs in just four years because of controversial Abbott Government Budget changes. AMA President A/Prof Brian Owler gave evidence to a Senate inquiry into out-of-pocket costs in Australian health care.

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# AMA IN THE NEWS

... FROM P18

**AMA rejects call for more fee disclosure, *Age*, 30 July 2014**

The AMA has rejected calls for greater transparency on surgical fees, saying it was not possible for patients to compare prices for operations in the same way they might shop around for a dishwasher.

## Radio

**A/Professor Brian Owler, ABC Riverina, 23 July 2014**

AMA President Associate Professor Brian Owler discussed the AMA's opposition to the Federal Government's proposed Medicare co-payment. A/Professor Owler said the AMA was not opposed to all co-payments, but could not support the Government's proposal as it did not include protection for vulnerable patients in the community.

**Dr Brian Morton, 3AW Melbourne, 23 July 2014**

AMA Chair of General Practice Dr Brian Morton discussed how people can stay warm during the night. Dr Morton said hot water bottles were a good option, but recommended not leaving electric blankets on overnight.

**A/Professor Brian Owler, 720 ABC, 24 July 2014**

AMA President A/Professor Brian Owler talked about his concerns regarding the equity and fairness in Australia's health care system. A/Professor Owler said the AMA is concerned the proposed GP co-payment lacks protection for vulnerable, elderly, and chronically ill people.

**A/Professor Owler, 6PR Perth, 30 July 2014**

AMA President Associate Professor Brian Owler talked about chickenpox. A/Professor Owler said people needed to realise that chickenpox could have serious implications for a person's health.

**A/Professor Brian Owler, ABC Riverland, 30 July 2014**

AMA President Associate Professor Brian Owler talked about the AMA's submission to a Senate committee regarding out-of-pocket costs in health care. A/Professor Owler said regional and remote areas that already have limited access to GPs have very low bulk billing rates and will be particularly affected by the proposal co-payment.

**Dr Brian Morton, 720 ABC Perth, 28 July 2014**

AMA Chair of General Practice Dr Brian Morton discussed the trial by Medibank Private to provide faster health care access for their members. Dr Morton said that the benefits to better access to health care is good, but the overall idea is not in the spirit of Medicare legislation.

## Television

**A/Professor Brian Owler, ABC Sydney, 23 July 2014**

AMA President Associate Professor Brian Owler addressed the National Press Club about the Australian health care system

**A/Professor Brian Owler, ABC 7.30 Sydney, 23 July 2014**

AMA President A/Professor Brian Owler discussed the sustainability of the Australian health system. A/Professor Owler said the Federal Government's proposed $7 GP co-payment threatens the very foundations of the system.

**A/Professor Brian Owler, SKY News, 28 July 2014**

AMA President A/Professor Brian Owler talked about the role of health insurers in primary care and GP clinics. A/Professor Owler said once private health insurers get into general practice, they will want to control the cost and dictate the course of management for a patient.

**A/Professor Brian Owler, Channel 10 Sydney, 29 July 2014**

AMA President A/Professor Brian Owler talked about a Senate inquiry into out-of-pocket costs for health care. A/Professor Owler said that we have to make sure the health system takes care of those who are most vulnerable.

COMMENT

# AMA IN ACTION

AMA President Associate Professor Brian Owler ensured the AMA remained at the centre of the national debate about the future of the health system with a strong speech to the National Press Club on 23 July. In his nationally-televised address, A/Professor Owler put the Federal Government's push for a $7 co-payment in the context of broader policy shifts affecting the foundations of the health system, including the universality and accessibility of care, and the threat posed to the sanctity of the doctor-patient relationship by the push by private health funds for greater involvement in the provision of primary care. These were key messages A/Professor Owler took to Tasmania late last month, where he addressed the AMA Tasmania Annual Conference.

Last week the AMA hosted a meeting of United General Practice Australia, which endorsed the AMA's leadership role in pushing the Government to make changes to its co-payment proposal. In the latest of several face-to-face meetings with Government leaders including Prime Minister Tony Abbott, Treasurer Joe Hockey and Health Minister Peter Dutton, A/Professor Owler last Thursday night held talks with Mr Dutton in which he pressed the case for major changes to the Government's co-payment model.

In an important development for the AMA's operations, the newly constituted Board, established following constitutional changes adopted at May's National Conference, held its inaugural meeting last week. The Board takes responsibility for the day-to-day operation of the AMA, allowing the Federal Council to deliberate on policy.

AMA Vice President Dr Stephen Parnis took time out from a private visit to Malta to meet with officials of the Maltese Medical Association.

**Adrian Rollins**

COMMENT


The newly-constituted AMA Board held its inaugural meeting in Canberra on 31 July (from l to r): Dr Peter Sharley (SA), Dr Helen McArdle (Tas), Dr Brian Owler (AMA President), Dr Liz Feeney (NSW), Professor Geoffrey Dobb (WA), Dr Leonie Katekar (NT), Dr Iain Dunlop (ACT), Dr Tony Bartone (Vic), Dr Richard Kidd (Qld)

# AUGUST HEALTH EVENTS

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

| Sun | Mon | Tue | Wed | Thur | Fri | Sat |
|---|---|---|---|---|---|---|
| 27 | 28 | 29 | 30 | 31 | **1**<br>Infant Massage Week<br>World Breastfeeding Week | **2** |
| **3**<br>National EOS Awareness Week | **4**<br>National Dental Health Week | **5**<br>Jeans for Genes Day | **6** | **7** | **8** | **9**<br>Nnternational Day of World's Indigenous People |
| **10** | **11**<br>National Haemochromatosis Awareness Week | **12** | **13** | **14** | **15**<br>Brain Injury Awareness Week | **16** |
| **17** | **18**<br>National Natural Fertility Awareness Week | **19**<br>World Humanitarian Day<br>National Healthy Bones Week<br>Hearing Awareness Week<br>Speech Pathology Week | **20** | **21** | **22** | **23** |
| **24**<br>National Speech Pathology Week | **25** | **26**<br>Daffodil Day | **27** | **28** | **29**<br>National Measles on Wheels Day | **30** |
| **31**<br>International Overdose Awareness Day<br>VIC Parkinsons' Walk in the Park<br>NSW Parkinson's NSW Unity Walk & Run | | | | | | |

PUBLIC HEALTH OPINION

BY PROFESSOR STEPHEN LEEDER

# Anyone seen general practice?

Like trying to find your way when your global positioning device is unwell and you are assaulted with confusing half-messages - *turn left at the intersection you have just gone through* - we are struggling to get a clear sense of direction in general practice and primary care.

Divisions of General Practice made good sense – enable general practitioners to meet, share ideas, pursue continuing education and do things together that can be done best when not in isolation.

Then came Medicare Locals, with a more complex set of expectations, brokering multiple programs for the Commonwealth that were never effectively communicated. Even the name was weird. But before they were fully established to show what they could do – for example, tying care together between hospital and community for patients with chronic problems - they too have been unceremoniously ushered off the stage.

The next player to be auditioned is called Primary Health Networks, of indeterminate size.

What the PHNs are to do, what lines they are expected to speak in the great drama of health care, is not clear enough for anyone to whom I have spoken to tell me. In short, the lines – the policy – are simply not there to speak.

Into this tangle come private health insurers, bidding to fulfil the undefined role of PHNs. Presumably they see money in it. Does this mean that there is a policy for the future of primary care lurking in Canberra, and we have simply not been told what it is?

Or, more likely, are there only a bundle of disjointed tactics – privatise, make users pay, reduce Medicare and so on – that speak of an ideology that favours the private over the public, and so gives comfort to those insurance companies that are angling for part of the action?

So that is one set of confusing messages from our Tom-Tom. There are more. Two are especially troublesome.

First, there is the unsubstantiated belief that a great leap forward in the prevention of non-communicable disease can be achieved by a combination of preventive services offered in general practice and a stiffening of individual will-power and moral fibre as in “turn off the TV with the junk food ads, don’t buy so much alcohol and don’t smoke”. Evidence? None.

The huge gains necessary in food policy, urban design, transport systems, and much else that determine the environment we live in, and set the agenda for health and the decisions individuals make about their lives that prevent non-communicable disease have never had, and do not now, have anything to do with medicine.

“The huge gains necessary in food policy, urban design, transport systems, and much else that determine the environment we live in, and set the agenda for health and the decisions individuals make about their lives that prevent non-communicable disease have never had, and do not now, have anything to do with medicine”

So asserting that a national approach to these new pandemics can be mediated by the health care system – private or public – is not based on evidence.

This is what makes the loss of the Australian National Preventive Health Agency, with its capacity to engage these out-of-health players,

MORE P23

PUBLIC HEALTH OPINION

# Anyone seen general practice?

... FROM P22

such a wanton act of vandalism: it had the independence, the strength and the capacity to do the heavy lifting with industry and portfolios other than health. But it is now neutered and back in the federal Health Department.

Second, there is a touching belief that general practice and community care can save us from the tsunami of chronic illness that is now not far from our shore. Evidence? Next to none. Certainly the potential is there, as demonstrated in other countries, but look further.

Where integrated care works to reduce inappropriate use of hospitals there is one payer. An example is Kaiser Permanents with its managed care for six million Californians. Then there are the many McKinsey-supported projects in the US and the UK involving complete electronic data systems to assess clinical performance and health outcomes, guidelines and a keen interest in professional standards for all practitioners, rewards and sanctions. Pull any of these pieces out of the integrated care structure and the whole thing collapses.

We have none of these necessary arrangements. Like the out-of-health preventive measures needed to achieve non-communicable disease prevention, these qualities of successful integrated care are not within the power of general practice to achieve, whether that practice is embedded in a Commonwealth-funded PHN or a private insurance arrangement. They belong with the major State and Federal health bureaucracies.

Time for a reality check. Or cold shower. Or both.

General practice is too important for this amateurish messing about and having expectations fall on it like a meteor shower that it cannot be expected to meet.

We need an evidence-based social policy (as in P-O-L-I-C-Y) for general practice, fewer expensive consultancies with their glossy and trashy-worded weasel advice, and much greater clarity to protect this precious asset and set it free of bureaucratic tape and political thought-bubbles.

Oh. In case you are unfamiliar with the elements of good policy – the blood and breath of democracy – with its judicious mix of evidence, consumer views, contested ideas, economics and politics, read all about it at http://en.wikipedia.org/wiki/Public_policy.

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:

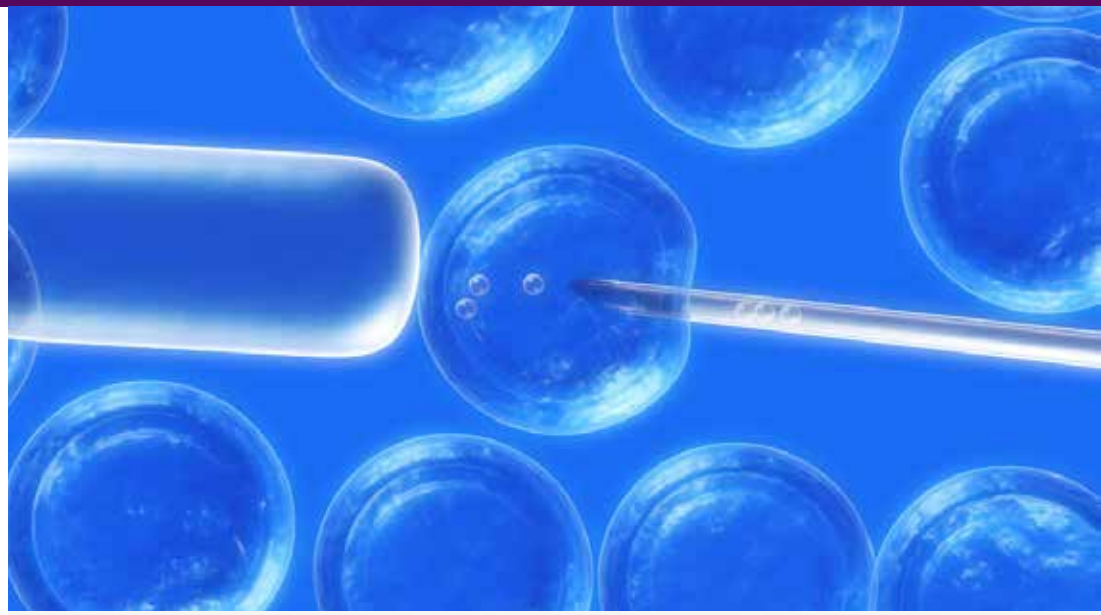
- online practice tools that can be accessed and/or completed online;
- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

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

# Beware stem cell doctors trading on hope



The nation's peak medical research organisation has reissued a warning on the dangers posed by unproven stem cell therapies following reports that an Australian woman died in Russia following treatment for a rare neurological disorder.

The National Health and Medical Research Council has cautioned that although stem cell science offers great potential, the safety and effectiveness of most treatments is yet to be scientifically verified.

"An increasing number of people are travelling overseas for stem cell treatments which are unproven, often referred to as 'stem cell tourism'," the NHMRC said. "Currently, the only stem cell treatment for which safety and efficacy has been scientifically established is haematopoietic (blood) stem cell transplantation for the treatment of certain blood and immune system disorders."

The peak body repeated its warning following a report in *The Age* that Brisbane mother of two Kellie van Meurs travelled to Moscow for stem cell treatment after developing Stiff Person Syndrome, a rare disorder that involves progressive rigidity and stiffening of abdominal and core muscle groups.

Ms van Meurs suffered a heart attack and died on 19 July while undergoing stem cell treatment in Russia, according to *The Age.*

Peak research group Stem Cells Australia has highlighted concerns that people are being lured into undergoing unproven stem cell treatments both in Australia and overseas, putting their health at risk.

It said people were being enticed with promises of cures backed by glowing patient testimonials, and were often being charged very large sums of up to $60,000 per treatment, which they were frequently encouraged to undergo multiple times.

"The doctors offering unproven stem cell treatments are effectively selling hope, with little or no medical or scientific evidence to back up their claims around both safety and actual benefit," Stem Cells Australia said.

While much concern had centred on treatments being provided overseas that were not available in Australia, the organisation warned that an increasing number of doctors and clinics were exploiting a loophole in regulations to provide unproven stem cell therapies here.

"The fact that such treatments are being offered in Australia can make it more difficult to determine if the stem cell treatments are legitimate, especially when the treatments use your cells," SCA said.

It said a controversial loophole excluded unproven stem cell treatments from regulation, as long as they were offered by a registered Australian doctor, used a patient's own cells and was a one-patient treatment.

While treatments using as person's own cells were often marketed as being 'natural' and posing no risk, "it is important for you to know that even treatments using your own cells can be dangerous. There have been reports of cells from fat growing into bone, as well as deaths reported overseas," SCA said.

NHMRC Chief Executive Officer Professor Warwick Anderson said only treatments that had been proven to be safe and effective through clinical trials should be made available to the public, and recommended that those interested in undergoing new stem cell treatments investigate the option of taking part in a registered clinical trial.

According to SCA, there are currently more than 200 trials of stem cell treatment underway internationally.

**Adrian Rollins**

COMMENT

# Doctors put diagnostic tools to good use

General practitioners are ordering almost double the diagnostic imaging tests they were a decade ago as the number of patients and medical problems they treat has increased.

A University of Sydney study has prompted claims of over-servicing after it identified a 45 per cent increase in the number of x-rays and other tests ordered by GPs between 2002 and 2012, from around 8.45 million a year to 12.2 million.

In all the study, based on responses from 9802 GPs, found the rate of tests ordered during the period rose significantly, from 8.7 per 100 patient encounters to 10.2.

But the researchers, from the University's Family Medicine Research Centre, found that in most circumstances the diagnostic imaging tests ordered by doctors were in accordance with clinical guidelines, and other factors were at play in driving growth.

Part of the explanation came from increased reliance of patients on GPs. There was almost a 25 per cent jump in the number of GP visits between 2002 and 2012, from 97 million to 120 million a year.

At the same time, the number of problems patients were presenting to their GP at each visit also increased significantly. The number of problems managed by family doctors rose from 149 per 100 patient encounters to almost 158. The researchers found that for each additional problem, the chance of a diagnostic imaging test being ordered increased 41 per cent.

Changes in technology and medical knowledge also played a role.

The likelihood that a GP would order an imaging test to help manage a medical problem climbed from 5.3 to 5.8 per cent over the period.

But, although doctors were largely medically justified in the diagnostic imaging tests they ordered, there were some exceptions.

The study's lead author, Dr Helena Britt, said GPs were found to be overly quick in ordering imaging tests for patients with back problems. They accounted for more than half of all imaging tests ordered.

For every 100 patients presenting with back problems, 17 were sent off for diagnostic imaging – most commonly x-rays (54 per cent), followed by CT scans (36 per cent) and MRIs (5 per cent).

The authors said the rate at which doctors referred patients presenting with back problems for the first time for imaging was "inconsistent with all established guidelines".

"Expert guidelines advise caution in ordering tests for presenting back problems unless there is a red flag to prompt investigation," Dr Britt said. "Red flags can include issues such as major trauma, unexplained weight loss, unexplained fever, a history of malignancy, inflammatory conditions and neurological issues."

The study's authors also found room for improvement in the use of imaging for patients with knee and ankle sprains and strains.

They found that reliance on x-rays for patients with knee problems could be "significantly reduced" by applying the Ottawa knee rules protocols, while doctors frequently ordered ultrasounds for ankle sprains and strains despite clinical guidelines to the contrary.

Despite these problems, the study concluded that doctors by large made appropriate use of diagnostic imaging tests.

"In general…Australian GPs select appropriate diagnostic imaging modalities for specific clinical problems, given the restraint imposed by restriction of MBS rebates for MRIs ordered by GPs," the study found.

"Imaging ordering behaviour suggests broad compliance with published guidelines."

**Adrian Rollins**

COMMENT

# Medical grads earn top dollar, but face huge debts

Medicine graduates have the second highest starting salary and progress to become the nation's top income earners after 20 years in the job, according to an analysis of lifetime graduate earnings.

As the Federal Government spruiks major changes to the funding of higher education based on projections of future graduate earnings, the peak body representing Australia's top universities, the Group of Eight Australia, has released analysis indicating that, while graduate income grows strongly in the first five years of work, the rate of increase slows thereafter.

Drawing on data from the 2011 Census, the Group of Eight reported that medical graduates earned a starting salary of $64,454, second only to engineers, on $68,175, and well above the average among all graduates of $48,888.

Across all academic disciplines, the fastest period of income growth is in the first five years following graduation, when they grow by an average of 5.7 per cent a year – with law (8.5 per cent) leading the way.

But thereafter the rate of gain moderates to an average of 2 per cent a year in inflation-adjusted terms – though still double that of workers without tertiary qualifications.

In a result that emphasises the relative value of a medical degree, however, the Group of Eight found that over an extended period the earnings of medical graduates outstripped those of graduates in all other fields, including law, engineering and IT.

After 10 years, medical graduates earned on average close to $105,000, compared with $100,000 for lawyers and around 97,000 for engineers.

After 15 years the gap had widened, with those working in medicine earning on average around $115,000, with law coming in second with an average of $105,000.

At 20 years, the average medical graduate earned $117,000, while for law it was $107,000.

But even though the G8 analysis suggests a medical degree offers the best earning potential, the AMA has expressed alarm at planned changes to the funding of higher education that could push the cost of a medical qualification up to $250,000 – a level that AMA President Associate Professor Brian Owler said would discourage many students from lower socioeconomic backgrounds from entering medicine.

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

In a forthright letter to Education Minister Christopher Pyne, A/ Professor Owler warned the changes were likely to lead to much higher medical course fees, encouraging aspiring doctors to select specialties and work locations that are better paid, exacerbating shortages in rural areas and in specialties such as general practice.

**Adrian Rollins**

COMMENT

# Haikerwal to lead Govt health agency

Former AMA President and current World Medical Association Council Chair Dr Mukesh Haikerwal has been appointed to oversee the Australian Institute of Health and Welfare as the Federal Government pushes ahead with controversial cuts to health agencies.

Health Minister Peter Dutton announced late last month that Dr Haikerwal, who was awarded the AMA President's Medal at the 2014 AMA National Conference, had been appointed to a one-year term as AIHW Chair, effective from 19 July.

The appointment puts Dr Haikerwal in the thick of massive changes to institutional arrangements in health as the Abbott Government seeks to cut costs and pare back the regulatory burden by abolishing a number of agencies and statutory bodies.

Under its plans, announced in the May Budget, the Government aims to merge the AIHW with the Australian Commission on Safety and Quality in Health Care, the Independent Hospital Pricing Authority, the National Hospital Performance Authority, the National Health Funding Body and the Administrator of the National Health Funding Pool to create a new health productivity and performance commission.

"Dr Haikerwal is highly respected in medical circles and is also an extremely experienced administrator," Mr Dutton said. "He will be a great asset to the AIHW, Australia's premier source of data on health and welfare."

In the private sector, Catholic Health Australia has appointed experienced Queensland-based lawyer Suzanne Greenwood as its next Chief Executive Officer, following the recent departure of Martin Laverty to head the Royal Flying Doctor Service.

Mrs Greenwood is currently national CEO of the Institute of Arbitrators and Mediators Australia, and before that was corporate counsel and company secretary at the St Vincent's Health and Aged Care, Queensland.

**Adrian Rollins**

COMMENT

# Super-resistant STD found in Australia

Doctors have been warned to be on the alert for the most highly resistant strain of gonorrhoea ever detected in Australia, in the latest worrying evidence that the effectiveness of antibiotics is waning.

The Health Department has urged GPs to refer all cases of gonorrhoea infection for culture-based testing, particularly where treatment has failed, following confirmation of the most highly resistant strain of the disease ever detected in Australia.

In an alert issued last month, the Department said testing at the WHO Collaborating Centre for STD and the Neisseria Laboratory at Sydney's Prince of Wales Hospital had identified a new multidrug resistant strain of gonococcal, dubbed A8806.

It said subsequent analysis at QCMRI and the University of Queensland had found that strain had genetic similarities to the rare ceftriaxone-resistant strain H041, which was identified in a single case in Japan in 2009.

The Department said the A8806 strain exhibited the highest measure of resistance to ceftriaxone "ever reported in Australia".

It advised that non-culture tests, which are increasingly being used for the diagnosis of gonorrhoea infection, did not provide the definitive data necessary for predicting antimicrobial resistance.

"It is vital that GPs continue to use culture-based testing where possible," it said, adding that physicians should collect cultures from patients where the failure of treatment is suspected.

**Adrian Rollins**

COMMENT

GENERAL PRACTICE

# Health assessments fiasco close to resolution

BY DR BRIAN MORTON

> “... the AMA is still waiting on a full and clear statement from Department of Health and the Department of Human Services, which has been promised”

The winter edition of the Department of Human Services’ Forum newsletter caused a furore with advice that practice nurse time could no longer be counted towards the practitioner’s time when claiming for health assessment items under Medicare.

The change was a surprise to the AMA, which in 2009 had been successful in convincing the Department of Health to include the time spent by nurses in gathering and providing information related to health assessments in the Medicare item.

Clear on what had been agreed, the AMA was quick to challenge the advice from the DHS and to call for the previously agreed arrangement to be reinstated.

It is hard to understand what the Department was thinking when it decided to change established arrangements without consultation with the profession. Apparently, they didn’t think revising the 2010 Health Assessment Factsheet, which made it clear that nurse time counted, was that significant.

In a classic case of Yes Minister, the Department of Health was quick to respond with a clarification that suggested DHS had got it wrong. However, its advice that a practice nurse may assist a GP with performing the health assessment offered little comfort to GPs around the country. A plain English statement along the lines of ‘Yes, nurse time counts’, would have provided more comfort.

In an effort to obtain such an assurance, the AMA met with representatives of the Department of Health and the Department of Human Services, who undertook to make it as clear as possible that practice nurse time counted towards the time spent by GPs when claiming a health assessment item, assuming the complexity requirement of the item had been met. Essentially, it means that time is not the only determinant of the item claimed.

To assist the Department of Health in this regard, the AMA asked that the long-standing section in the factsheet’s Q&A that had made this arrangement clear (before being surreptitiously replaced in April) be reinstated.

At the time of writing, the Department of Health is working hard to get the wording just right. In a sign that progress was being made, the Department of Health recently issued a statement to the media in which it said that “both GP and practice nurse time can be used to decide which Medicare item would be the most appropriate to bill Medicare for a particular health assessment”.

While this statement was welcome, the profession clearly requires that the Department of Health and the Department of Human Services to publish definitive advice that resolves any outstanding uncertainty.

The DHS has apologised after providing incorrect information to callers seeking clarification about health assessment item inclusions, and has stated it will be monitoring this issue to ensure there is no recurrence.

Meantime, the AMA is still waiting on a full and clear statement from Department of Health and the Department of Human Services, which has been promised.

The AMA remains committed to working with these departments regarding the interpretation of MBS items, and this episode should be a clear lesson to them both about the importance of consulting with the profession about how the MBS works before publishing material that overturns accepted practice and interpretation.

COMMENT

BY DR JAMES CHURCHILL

# Time to end lucky-dip approach to career choices

For many junior doctors, the choice of vocational training and subsequent medical career is a complex and poorly-understood process.

In fact, it's fair to say that no two junior doctors' career pathways are quite the same, a unique mix of perspective, desires and interests, heavily shaped by mentors and early career experiences.

As described by Anthony Scott and Catherine Joyce in the 21 July edition of the *Medical Journal of Australia*, the medical workforce is undergoing substantial change, and career choices may not be the same for tomorrow's doctors as they are today — or perhaps even yesterday, so to speak, given current training bottlenecks.

A medical training system that demonstrates social accountability should be responsive to community needs, both in terms of location and specialty of training.

The challenge for policy makers and the profession is to sustainably achieve these aims while maintaining an employed and engaged generation of doctors with the high-quality training required to meet Australia's future health needs.

Various policies have been implemented to influence the location of future practice, including bonding schemes. But there is little guiding input into pathways of specialty choice.

"Various policies have been implemented to influence the location of future practice, including bonding schemes. But there is little guiding input into pathways of specialty choice"

With the exception of posts funded by the Specialist Training Program, trainee numbers in each vocational pathway are relatively loosely coordinated and, depending on pathway, remain determined by complex negotiations between health services and accrediting Colleges, service needs and trainee progression.

Given the numbers of prevocational trainees moving through the medical training system, there is a clear need for expansion in vocational training programs.

Ideally, the first targets for expansion should be those specialties and locations with the greatest current and projected workforce needs. The work of the National Medical Training Advisory Network in the coming months will be important to help better define data on the size of the prevocational workforce that will require vocational training in the coming years.

However, medical career pathways will not evolve through the addition of capacity alone, without risking cohorts of junior doctors embarking upon career paths in which they have little interest or engagement. Such an outcome would produce a system that does not meet the standards of excellence expected by the Australian community.

The factors that make fields of practice more or less appealing to trainees are incredibly diverse, but the cross-cutting issue is often a lack of accurate understanding about what really goes on in a particular field.

It's often said that medical students see all of the glamour (and go home on time or early) and residents see all of the paperwork. Is it enough to see the full picture only after beginning vocational training, or worse, only when fully qualified?

There is a critical need for relevant, profession-led and up-to-date resources for junior doctors to assist their effective decision-making. Information on career pathways, application requirements, projected workforce need and future career opportunities must be produced in formats accessible to junior doctors — there are few junior doctors who read lengthy workforce reports in their spare time.

Tools that assist junior doctors analyse their aptitudes, characteristics and preferences are used in the UK and New Zealand as part of resources provided to assist career choices. Professional 'portraits' and formalised, supported career plans developed in the early prevocational years have useful roles.

With the number of junior doctors coming through prevocational training, now is the time to invest in better career planning resources for trainees.

Coupled with sufficient vocational training capacity, there is no better opportunity to produce an engaged generation of doctors with the high-quality training required to meet Australia's future health needs.

# Health on the hill

## Political news from the nation's capital

### Medibank Private deal may be illegal: AMA

The AMA has cast doubt on the legality of a controversial arrangement under which the nation's largest health insurer pays a fee in exchange for preferential access to GP services for its members.

Amid fears that the health system is being set on a path toward US-style managed care, the AMA has told a Senate inquiry that it is apprehensive about the implications of the arrangement being trialled between Medibank Private and the Independent Practitioner Network.

"The AMA is very concerned that this type of program sets a precedent where private health insurers are effectively involved in the poorly targeted funding of a broad range of GP services, and that the principle of universal access to health care is being undermined," AMA President Associate Professor Brian Owler said in his submission to the Senate Standing Committee on Community Affairs.

Under the Medibank Private-IPN arrangement, the insurer pays IPN an administrative fee to enable its members to be guaranteed a GP appointment within 24 hours and have access to out-of-hours care.

The architects of the deal claim it is not in breach of the Private Health Insurance Act 2007 (PHIA) and is in accordance with legislation prohibiting insurers from covering gap payments for GP services – a view support by the Government.

But the AMA questioned the Department of Health's (DoH) view that the arrangement was consistent with existing legislation.

"It is difficult to agree with this assessment, in so far as we understand that participating GPs, who would otherwise charge a gap, will not be financially disadvantaged when they bulk bill Medibank members," A/Professor Owler said.

"This implies some form of compensation paid to participating GPs by IPN and, to that extent, this would be linked to the volume of MBS services.

"If, as the DoH contends, the arrangement is technically compliant with the provisions of the PHIA, it is clearly inconsistent with the spirit and intent of the legislation."

Greens Senator Dr Richard Di Natale has introduced amendments to the PHIA which he said were aimed at removing any ambiguity in the legislation regarding the ability of private insurers to reach deals with medical clinics to provide services not specifically covered by Medicare.

"In order to safeguard the integrity and efficiency of our universal insurer – Medicare – it is necessary to clarify that such arrangements, which create a two-tiered system that favours the insured, are against the spirit and intent of the law," Senator Di Natale said.

"This Bill amends the [PHIA] to make it clear that private health insurers may not enter into arrangements with primary care providers that provide preferential treatment to their members."

A/Professor Owler said there was scope for greater engagement between insurers and GPs, but said most existing arrangements were poorly designed and targeted.

"If this situation is to change, there needs to be much more robust engagement with the profession to ensure that future models are in the best interest of patients and the provision of high quality, equitable and sustainable health services," he said.

**Adrian Rollins**

COMMENT

### New care charges hit the elderly

Elderly patients assigned a home care package or who move into residential care will be hit with charges of up to $25,000 a year under changes that came into effect last month.

As part of efforts to curb growth in spending on aged care, the Federal Government has stipulated that from now on the elderly will have to make an increased contribution of up to $60,000 toward the cost of their care.

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# Health on the hill

## Political news from the nation's capital

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Under the changes, people receiving a home care package will be charged a basic daily fee equivalent to 17.5 per cent of the single Age Pension, while those whose annual income exceeds either the single or couple pension rate (respectively $24,731.20 or $38,344.80 as at March 2014) are now subject to an additional "income-tested care fee".

To help soften the financial blow, the Government has capped the income-tested care fee for part-pensioners at $5000 a year, and $10,000 a year for self-funded retirees, and has set a lifetime limit on fees paid of $60,000.

Those moving into residential care are liable, at the very least, for a basic fee set at 85 per cent of single Age Pension. Depending on their income, they may also be charged a means-tested care fee, an accommodation payment and an extra charge for upgrades such as a higher standard of accommodation, hairdressing services, pay television or other extras.

For those in residential care, the Government has set an annual cap of $25,000 on the means-tested fee, and no-one will be required to pay more than $60,000 in their lifetime.

The changes are controversial and have been hotly contested by seniors groups and aged care advocates.

The Government sought to provide some comfort for those expecting to move into residential care by announcing that the family home would continue to be exempted from aged care assets test "if occupied by a spouse or other protected person".

In addition, it said the changes would not affect people who were already receive home care or who were in residential care when the measures came into effect on 1 July.

"If you are already in residential care or home care, you will continue with your current financial arrangements, unless you leave and re-enter after 28 days of unapproved leave," the Department of Human Services said.

More information can be obtained by calling 1800 200 422 or visiting myagedcarae.gov.au

**Adrian Rollins**

COMMENT

OPINION

# GP co-payments: why price signals for health don't work

BY PROFESSOR JANE HALL, DIRECTOR, CENTRE FOR HEALTH ECONOMICS RESEARCH AND EVALUATION, UNIVERSITY OF TECHNOLOGY, SYDNEY, AND RICHARD DE ABREU LOURENCO, RESEARCH FELLOW, UNIVERSITY OF TECHNOLOGY, SYDNEY.

> "The [$7 co-payment] is fundamentally flawed because it's a crude attempt at fitting an economic concept to an industry for which it's inappropriate"

***This article first appeared on The Conversation on 10 July, 2014, and can be viewed at: http://theconversation.com/gp-co-payments-why-price-signals-for-health-dont-work-28857***

Arguments against health co-payments proposed in May's federal budget will come to the fore again shortly as the Senate considers whether it will pass the necessary legislation.

The government's attempt to introduce a $7 compulsory co-payment for visits to doctors and pathology services has attracted strong criticism.

The measure is fundamentally flawed because it's a crude attempt at fitting an economic concept to an industry for which it's inappropriate.

The health co-payments have been described by the government (and its National Commission of Audit) as a price signal. Both have indicated that they feel it's needed to reduce "unnecessary" visits to the doctor and use of pathology services.

Price signals work by encouraging consumers to think about whatever it is they are about to buy, and whether it's worth the cost. They assume some consumer knowledge of the product, and its value. We rely on prices right through the economy to temper consumption.

But this economic common device is inappropriate for primary care because health care is not a commodity or luxury service; it is an essential service that can create much greater downstream costs if not used at the right time.

## Excluding from care

The aim of modern health funding is twofold: to ensure people have universal protection against the potentially large financial risk posed by sudden illness and that even people who are poor and sick are not excluded from beneficial health care.

That means co-payments have to have at least some exceptions, otherwise they will do what price signals traditionally do and keep some people out of the market. In other words, without exceptions for people who cannot afford this new cost, they will be excluded from care.

This makes health inequitable; the same co-payment will have a larger deterrent effect on low-income groups than it does for high-income groups.

Evidence from Australia and other countries shows that low-income groups are much more likely to rely on general practitioners than visit more expensive specialists. But it is this less expensive and more accessible (and accessed) service that's being targeted by the government's proposal.

## Information asymmetry

The chairman of the National Commission of Audit, the treasurer and the health minister have all claimed that Australians go to the doctor too often. They suggest the introduction of a price signal for health in the form of co-payments will only reduce trivial visits.

This leads to the second problem with the measure: relying on patients to judge which doctor visits and treatments are valuable.

Doctors have a lot more training and knowledge than their patients and so patients rely on them for advice. Thus the aphorism, you need to see the doctor to tell you whether you need to see a doctor.

This is particularly the case with primary care, which often acts as the gate keeper to other health-care services. Patients go to their primary-care provider for many and varied reasons, but the value of those visits is only apparent after the fact.

Co-payments cannot operate as an effective price signal if people can't judge the quality of what they're buying. They will simply stop going if they cannot afford to pay.

The aim of introducing co-payments is to reduce costs to government but repeated studies have shown that lower overall costs do not necessarily follow.

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OPINION

# GP co-payment would increase emergency department wait times

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The combination of being highly price sensitive (or being unable to afford care) and the inability to judge when care is required means people who are less well-off are put off from seeking necessary care. And this just ends up being more expensive in the long run as illness is not prevented from getting worse.

## A better way

One alternative is that people who can afford it should make the co-payment, while the needy are protected by safety nets and other special arrangements. But safety nets require various tests for eligibility, which introduce more "red tape" (or administrative) costs.

Maybe instead of creating new charging procedures and administrative costs, payments could be collected through the tax system, via general taxation or the Medicare Levy.

This levy was first introduced in 1984, and most recently increased to cover the National Disability Insurance Scheme. Perhaps now is the time to increase it or make it more strongly progressive than it is now (that is, have people on higher incomes contribute more) so it provides the health-care budget with greater surety.

Health services are not like other services; going to the doctor can't be compared to a visit to the hairdresser or servicing your car.

What may seem like a simple price signal to some is a financial barrier to effective and timely care for others. The consequences of introducing co-payments are not just a loss of fairness but also a false economy.

Government budgets should be instruments of efficiency and equity. Australia is lauded for exactly these things in its health system, it would be a pity to lose our international reputation because of mistaken understanding of an economic concept.

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

## Schizophrenia hope as genetic secrets revealed

The risk of developing schizophrenia has been linked to genes associated with essential brain functions including memory and signalling, as well as those active in the immune system.

In a major step toward the development of new and effective treatments for the common and debilitating psychiatric disorder, researchers worldwide have collaborated on a project that has led to the identification of 108 locations on the human genome associated with the risk of developing schizophrenia.

The massive undertaking, which involved examining 80,000 gene samples from schizophrenia patients and healthy volunteers, has confirmed earlier findings identifying around 24 genomic regions associated with the condition and expanded knowledge of its genetic basis and underlying biology.

Lead author of the study, Stephan Ripke of the Broad Institute at Massachusetts General Hospital, said the identification of so many genetic loci for schizophrenia meant researchers were able to distinguish patterns, so that "we can group them into identifiable pathways - which genes are known to work together to perform specific functions in the brain. This is helping us to understand the biology of schizophrenia".

The study, "Biological insights from 108 schizophrenia-associated genetic loci", published in the journal Nature, found the disorder was linked to many genes expressed in brain tissue, particularly those related to the function of neurons and synapses.

Some were found to be active in pathways that control the plasticity of synapses - a function essential to learning and memory – while other govern post-synaptic activity, particularly signalling between cells in the brain.

In a discovery that lends some support to theories that schizophrenia may be linked to immunological processes, several of the schizophrenia-linked genes identified by the study are active in the immune system.

Building hope that the study could lead to a new generation of drugs to treat schizophrenia, researchers found that the disorder was also associated with the gene that produces the dopamine receptor targeted by current medications.

"The fact that we were able to detect genetic risk factors on this massive scale shows that schizophrenia can be tackled by the same approaches that have already transformed our understanding of other disease," senior author Michael O-Donovan of the MRC Centre for Neuropsychiatric Genetics and Genomics at Cardiff University said. "The wealth of new findings have the potential to kick-start the development of new treatments in schizophrenia, a process which has stalled for the last 60 years."

Currently, treatments for schizophrenia are primarily to treat psychosis, just one of the symptoms of the disorder, rather than its debilitating cognitive symptoms, and treatment options have been limited by a lack of understanding of the condition's underlying biological mechanisms.

They said the sole target for existing treatments was found serendipitously, and "no medications with fundamentally new mechanisms of action have been developed since the 1950s".

The researchers said their discoveries provided many more possible avenues for therapeutic action and investigation.

**Adrian Rollins**

COMMENT

## Dose alerts help asthmatics breathe easier

Asthmatics who receive personalised alerts are much more likely to take preventive medication and avoid severe asthma attacks, an Australian study has found.

In the first research of its kind, investigators at the Woolcock Institute of Medical Research have

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demonstrated that, over a six month period, asthmatics who received reminders took, on average, 73 per cent of the prescribed daily doses of corticosteroids, compared with less than half (46 per cent) among those who did not receive alerts.

Reflecting this higher compliance rate, only 11 per cent of patients who received reminders reported suffering a severe asthma flare up during the period, compared with 28 per cent of those who did not.

Study senior author, Associate Professor Helen Reddel, said the finding was significant because asthma was often poorly managed, leaving many sufferers vulnerable to potentially life-threatening attacks.

“Asthma is often poorly controlled because people are so busy and don’t remember t use their preventer inhalers,” A/Professor Reddel said. “Finding an easy and effective way to boost usage is a significant step forward.

For the research, published in *The Journal of Allergy and Clinical Immunology*, 43 GPs enrolled 143 patients aged between 14 and 65 years who had frequent asthma symptoms.

The patients were split into four groups. The first received alerts if they missed a dose and had online feedback about their usage, the second had personalised discussions with GPs about improving their compliance, the third received both alerts and had discussions with the GP and the fourth received active asthma care from their GP.

All patients used the electronic inhaler monitor system SmartTrack to record the date and time of dosages.

Overall, the study found that although medication compliance was much greater among patients who received alerts, there was no significant difference in the control of asthma symptoms among the four groups.

A/Professor Reddel said this was possibly because of the “quite high” doses of corticosteroids generally prescribed to asthma sufferers in Australia.

“The modest adherence in the non-reminder groups may have been enough to help control asthma symptoms, so the higher adherence rates in reminder groups could not produce any further improvements,” she said.

But A/Professor Reddel added that if compliance could be improved, there was an opportunity to reduce dosages.

Around two million people have asthma, which killed 394 in 2012 and caused almost 38,700 to be hospitalised. Effective management of the condition has been hampered by poor compliance with medication regimes.

A/Professor Reddel said the fact that those who received dosage alerts suffered half the proportion of flare ups as those who did not was “particularly significant” given that half the patients enrolled in the study lived in disadvantaged communities where medication compliance and the severity of attacks were likely to be worse.

She said longer-term studies were needed to investigate the effectiveness of dosage reminders for periods greater than six months.

**Adrian Rollins**

COMMENT

## Night owl teens not such happy campers

While teens are famous for being morning grouches, parents and clinicians have been put on the alert for those that have trouble getting to sleep at night.

A South Australian study has found that teenagers who habitually delay going to sleep at night are at increased risk of developing insomnia, anxiety and depression, underlining the importance of efforts to encourage changes in sleeping behaviour.

A survey of more than 300 South Australian high school students has found that those more active in the evening were at greater risk of a range of disorders including insomnia, depression, separation anxiety, social phobia and obsessive-compulsive disorder.

Adelaide University researcher, PhD candidate Pasquale Alvaro said that around 11 per cent of teenagers experienced insomnia at some point, and he found that this raised the risk that they could develop depression, generalised anxiety disorder and suffer panic attacks.

“These findings suggest that the ‘eveningness’ chronotype – being more active in the evenings – is an independent risk factor for insomnia and depression,” Mr Alvaro said. “This is important because adolescents tend to develop a preference for evenings, which sometimes becomes a syndrome, whereby they keep delaying going to sleep.”

He said there could be serious ramifications.

“Having insomnia in addition to anxiety or depression can

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further intensify the problems being experienced with each individual disorder.

“It can lead to such problems as alcohol and drug misuse during adolescence.”

Mr Alvaro said efforts to prevent and treat teen insomnia and depression should take into account the links between mental health, sleep and the tendency of teens to stay up late at night.

**Adrian Rollins**

COMMENT

## A genetic discovery that could be a bit easier to swallow

A mysterious disease that causes nerves in the oesophagus to disappear, preventing food from entering the stomach, has been found to be autoimmune in origin.

Researchers have long been confounded about what causes the rare complaint, which afflicts around one in every 100,000 people.

The condition, known as achalasia, causes nerve cells in the oesophagus – including those that control the opening and closing of the sphincter at the opening to the stomach - to gradually disappear. Eventually, the sphincter locks shut, causing food to accumulate in the oesophagus.

Treatments have typically involved either forcing the sphincter open using a balloon inserted endoscopically, or surgically cutting it, but understanding the cause has for years remained elusive.

But an investigation by researchers at KU Leuven in Belgium and Germany’s Bonn University, published in the journal *Nature Genetics*, has provided strong support for long-held suspicions the condition is autoimmune in origin.

Using DNA samples from 1506 achalasia patients and 5832 healthy volunteers, the researchers identified 196,524 tiny differences – single nucleotide polymorphisms (SNPs) – in the immune-related DNA of those with the condition, and compared them with those of the healthy subjects.

As a result, they identified 33 SNPs associated with achalasia, and all were located in the region of the human genome known to be associated with other autoimmune disorders such as multiple sclerosis and type 1 diabetes.

This evidence has led the researchers to conclude the condition is an autoimmune disease.

In the course of their investigations, the scientists pinpointed a string of amino acids inserted in the DNA of those with achalasia, opening a promising avenue for the development of a treatment and possible cure.

**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**

# Big Tobacco hit with $25 billion damages bill

An American tobacco company has been ordered to pay the widower of a chain smoker $US 25 billion in punitive damages in the second-largest such judgement in American legal history.

In a stunning end to a wrongful death lawsuit brought against RJ Reynolds Tobacco Company, a Florida jury awarded Cynthia Robinson $US17 million in compensatory damages and $US23.6 billion in punitive damages over the death of her husband Michael Johnson from lung cancer in 1996.

The judgement came at the end of a four-week trial that heard Mr Johnson, a dock worker and bus driver, contracted lung cancer after smoking between one and three packets of cigarettes a day for more than 20 years. He died when he was 36 years old.

In the case, launched in 2008, Ms Robinson and her lawyers claimed that RJ Reynolds – whose brands include Camel, Kool and Pall Mall - conspired to conceal the health dangers and addictive nature of its products.

In arguing the case, plaintiff lawyer Chris Chestnut presented evidence of the company's aggressive marketing campaigns and promotions, particularly those directed at young people.

"They [RJ Reynolds] lied to Congress, they lied to smokers and tried to blame the smoker," Mr Chestnut said, adding that size of the damages awarded by the jury showed that it had "got it".

"This wasn't a runaway jury, it was a courageous one," he said. "The jury was outraged with the concealment and the conspiracy to conceal that smoking was not only addictive, but that there were deadly chemicals in cigarettes."

The company condemned the judgement as "grossly excessive" and said it would appeal.

"This verdict goes far beyond the realm of reasonableness and fairness and is completely inconsistent with the evidence presented," RJ Reynolds Vice-President Jeffrey Raborn was reported by *The Age* as saying. "The damages awarded are grossly excessive and impermissible under state and constitutional law."

History suggests the company is likely to win a substantial discount on the damages award with its appeal - a $US28 billion punitive damages bill awarded by a Los Angeles jury against Philip Morris in 2011 was slashed to $US28 million on appeal.

But the case has once again highlighted to investors the big litigation risk they are exposed to if they hold tobacco company shares.

**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

# Govts take drastic action to tackle worst Ebola outbreak on record

The World Health Organisation and West African nations have launched a $100 million disease control plan as the worst Ebola outbreak on record continues to spread through the region.

As the death toll from the epidemic reached 729 late last week, officials from the WHO and Sierra Leone, Liberia, Guinea and Nigeria held an emergency meeting to work on ways to halt the disease, which has so far infected more than 1300 people.

Authorities are resorting to increasingly desperate measures to bring the outbreak under control. The Liberian Government has closed all but four of its borders, while Nigeria has placed a major hospital under quarantine.

"The scale of the Ebola outbreak, and the persistent threat it poses, requires WHO and Guinea, Liberia and Sierra Leone to take the response to a new level, and this will require increased resources, in-country medical expertise, regional preparedness and coordination," said WHO Director General Margaret Chan. "The countries have identified what they need, and WHO is reaching out to the international community to drive the response plan forward."

The announcement of the plan came as tragic accounts have emerged of the disease's deadly toll among health workers.

Last week Sierra Leone's top Ebola doctor, Sheikh Umar Khan, who had personally treated more than 100 Ebola patients, died from complications associated with the disease. His death came just days after three nurses who had worked with him perished.

And two American doctors who were infected with Ebola while treating patients, Kent Brantly and Nancy Writebol, remain "gravely ill" with the disease.

The plight of the doctors has underlined World Medical Association concerns that junior doctors and nurses working at the frontline of efforts to tackle the deadly outbreak are being recklessly exposed to the risk of infection because of inadequate equipment and supervision.

The WMA's Junior Doctors Network has expressed alarm that many of its members were treating patients without basic protective gear, putting them at great risk of contracting the disease.

The World Health Organisation has recommended that health workers operating in close proximity to patients with Ebola virus should wear a face shield or a medical mask and goggles, a clean, non-sterile long-sleeved gown, and gloves.

But shortcomings in the supply of essential safety equipment for medical staff have been tragically demonstrated by the fact that physicians and other health workers are among those who have contracted the disease.

"Junior doctors are the most vulnerable health care staff, as they are in the first line contact with the infected and their next of kin," said Dr Nivio Moreira, Chair of the WMA's Junior Doctors Network. "We are appalled by reports that many junior doctors are not provided with protective equipment essential for dealing with such a deadly disease."

In addition to the lack of basic protective gear, Dr Moreira said the Association was also concerned that many junior medical staff were working without supervision, despite the fact that dealing with Ebola required a high level of expertise on hand to support less experienced staff.

"These are major threats to all those working in these situations, and go to the heart of safe working conditions," he said.

While Ebola continues to spread in west and central Africa – 108 cases were reported between 21 and 23 July – Australian health authorities have sought to provide assurances that there was a "very low" chance it could be imported into Australia.

A meeting of the Communicable Diseases Network of Australia has been convened to discuss the Ebola threat, and customs officers and other border protection officials have been alerted to be on the lookout for arriving travellers who may be displaying symptoms of the disease.

But the Health Department said long-standing screening processes in-flight and at the nation's airports meant there was little chance of someone infected with the disease entering the country undetected.

Fears about the possibility it could be spread by plane passengers were fuelled by revelations that a Liberian Finance Ministry official infected with Ebola flew to Nigeria to attend a conference and died days after arriving in West Africa's most populace nation.

**Adrian Rollins**

COMMENT

# Doctors, hospitals in crosshairs in deadly Gaza conflict

The World Medical Association has issued an urgent plea for an end to attacks on all hospitals, ambulances, physicians and other health workers in the Gaza Strip and surrounding areas.

As the death toll from the conflict soars, WMA Chair Dr Mukesh Haikerwal has expressed alarm at reports that Red Cross vehicles and hospitals are being targeted in the conflict.

"Respect for, and protection of, health services is one of the core values of international humanitarian law and the human right to health," Dr Haikerwal said. "It is unacceptable that health personnel and facilities are ever regarded as legitimate targets."

Last week, Gaza's most sophisticated medical facility, Shifa Hospital, was hit, killing at least 10 people, mostly children.

The Israeli Government and Hamas have accused each other of responsibility for the attack.

The WMA Chair condemned those using hospitals to shelter combatants or store weapons, as well as those who allowed attacks on medical facilities as part of armed conflict.

"It is the duty of all of us in the international health community to speak out to protect the non-discriminatory provision of health care to those in medical need," Dr Haikerwal said. "We denounce all attacks on physicians, health care staff, medical facilities and patients, or their abuse as military shelters or human shields."

In addition to the threat from combatants, the Red Cross has also come under attack from civilians.

Last week, its offices in Gaza were ransacked by residents claiming that it had failed to provide assistance in evacuating the dead and wounded.

**Adrian Rollins**

COMMENT

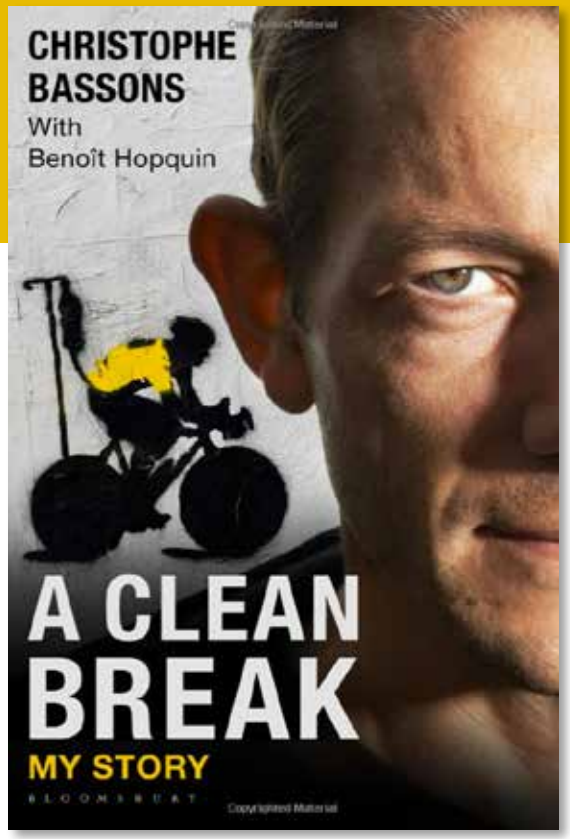
BOOK REVIEW

# A Clean Break

## Christophe Bassons

REVIEWED BY
ADRIAN ROLLINS, EDITOR,
*AUSTRALIAN MEDICINE*

Bloomsbury, 227 pages, $29.99. ISBN 9781472910356




Even before Italian cyclist Vincenzo Nibali rolled across the finish line on the Champs Elysees on 27 July to secure victory in the 101st Tour de France, questions about possible doping were being asked.

The air of suspicion that hangs like an unpleasant smog over every major cycling achievement is virtually inevitable given the revelations in the last two years of industrial-scale doping that pervaded the top echelons of road cycling through the late 1990s and 2000s.

But the fact that Nibali's victory, emphatic though it became, was not achieved by a single, outrageous demonstration of superhuman strength, but rather the dogged pursuit of opportunities to snatch a handful of seconds on major rivals here and there throughout the three-week marathon, should give sceptics some pause.

Where Armstrong's dominance of the Tour between 1999 and 2005 was underpinned by an all-conquering team and fearsome performances in the high mountains and time trials, Nibali was often left isolated as teammates fell away on the big climbs, and his well-timed attacks (he won four stages) were rarely more than a couple of kilometres before the daily finish line.

The convincing nature of Nibali's victory (his nearest rival, French rider Jean-Christophe Peraud, finished 7 minutes and 37 seconds behind) was due in no small part to the fact that his two main rivals – reigning champion Chris Froome and former winner Alberto Contador – both crashed out of the race early on.

Nevertheless, you have to go back almost 20 years to 1997, when doping in the peleton was getting into full spate, to find a similarly emphatic victory. It is an uncomfortable set of facts for those who insist the sport has cleaned its act up.

It is a period that brings back unpleasant memories for former pro cyclist Christophe Bassons who, in his autobiography A Clean Break, recounts how he was essentially hounded out of the sport because of his blank refusal to dope.

Bassons was a very strong athlete who fulfilled his dream to enter the ranks of professional cycling in 1996, and met with some early success.

But as the decade advanced, a depressingly familiar pattern began to assert itself in the race calendar. In the early races Bassons would perform well. But as the Tour de France approached, the pace of the peleton would accelerate and Bassons had to increasingly push himself to his physical limits just to keep up.

During multi-day races, he would come under pressure from team management and medical staff to take "recuperatives". Initially, he was offered vitamin tablets, then it became vitamin injections, and, finally, out-and-out doping with products such as growth hormones, corticosteroids, and Erythropoietin (EPO).

His stubborn refusal angered the team managers and his teammates, who viewed his position as a personal indulgence that undermined the team's competitiveness, robbing them of prize money and putting the team's long-term future at risk.

One of the most disturbing aspects of Basson's experience is the role played by doctors in promoting and enabling systematic doping.

Cycling teams at the time employed doctors knowledgeable about the using of drugs to enhance athletic performance, and who had few qualms in administering them to athletes.

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BOOK REVIEW

# A Clean Break

... FROM P40

Bassons, in his obstinacy, found himself to be increasingly isolated in his chosen profession – particularly after he decided to speak out publicly about the degree of doping in cycling.

Though a series of columns and interviews published during the 1999 Tour de France, Bassons expressed scepticism about the effectiveness of dope testing and doubts that riders were racing 'clean'.

His outspokenness earned him the enmity of Lance Armstrong who, during a stage through the Alps to Alpe d'Huez, sidled up next to him in the peleton and said, "You know, what you are saying to the journalists is not good for cycling".

Basson's replied that he was simply saying that doping was occurring, provoking Armstrong to snarl in reply, "If you're here to do that, it would be better for you to go home and find another job…Get the hell out!"

Bassons comes across as a difficult character, as highly principled people can sometimes be.

But *A Clean Break* is a valuable account of what it was like trying to compete clean in a sport that, at the time, was riven with doping – particularly the enormous pressure brought to bear on athletes to take performance enhancing drugs in order to keep up with the competition, and the questionable ethics of medical professionals who connived in systematic doping.

For the sake of the health of the current generation of cyclists, Basson's experiences are, hopefully, a warning of what can happen rather than something that continues to be replicated to this day.

The former pro cyclist himself, is sceptical that the sport has cleaned up its act.

Asked by the *Sunday Advertiser* last month if he believed the 2014 Tour de France was clean, Bassons said: "Even today, cyclists ride as quickly at the end of Tour de France as at the beginning of Tour de France. Is that normal?"

"Cyclists with very little muscle are very powerful. Is that normal? Some teams dominate the sport. Is that normal? No cyclist wants to talk about doping. Is that normal?" Bassons continued.

"Cycling says it is clean thanks to the biological passport. For me, the biological passport prevents big doping but allows small and constant doping. That's perhaps even more dangerous."

COMMENT



INFORMATION FOR MEMBERS

# Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

**To register for the product, please sign up here.**

WINE

# Trimming the bush




BY **DR MICHAEL RYAN**

Some 5000-plus species of grape vine exist in the world, and about 200 have been used to make consumable wine. About 90 per cent of wines are made from about 10 per cent of these varieties.

Wine styles can vary from region to region, and what the wine maker decides to do with them.

Another permutation is how the plant itself is managed. In particular, canopy management. The leaf of the plant is the energy generator and protector of the vine and its care is a top priority.

The Vitus Vinifera plant (the botanical name for grape vines) can grow like a weed if left untrained. The thing will become a mass of twisted limbs (canes) with scant fruit as the plant focuses instead on growing leaves.

So, if we cleverly trim this plant and limit the number of canes, its focus becomes the production of fruit.

The more fruit, though, the less pronounced flavours can be, so bunch thinning might be required in some planting regions.

Another potential pitfall is that if too much canopy is left, particularly in wet climates, moisture accumulates and disease is rife.

In our clever human way, we have worked out what suits most regions with respect to pruning.

Technically speaking, there is spur pruning and cane pruning. Spur pruning limits new growth to two major canes each year, while the cane pruning allows for a longer arm of bunches to form, with canes typically being two-years-old when pruned.

Spur pruning is used for moderate to highly vigorous species like Cabernet, Merlot and Shiraz, while cane pruning is often used in cool climates and, in particular, for Pinot Noir.

The concept of wild growth without trellising is called Goblet style or “Bush Vine Growth.”

In this method, the plant is trimmed to resemble a shrub. This can suit hot, dry climates with poor soil. The canopy protects the plant from too much sun, but it is not moist enough to encourage moulds. Often the fruit is very concentrated, and some great Barossa Shiraz and Grenache have been grown like this.

There can be other variations such as single trellising and double trellising and so on.

It’s all about air movement and sun exposure. Google is good for images of these techniques.

The wine industry is adept at recycling, and one of the great uses for canes pruned from the vine is to burn them to smoke meat, especially duck. The resulting flavour is less pungent and more elegant that other wood smokes.

Alternatively, you can just burn them and have a big BBQ and drink last year’s vintage for good luck.

COMMENT

## DRINKING WELL

1. **2011 Toolangi Paul’s Lane Yarra Valley Chardonnay** - colour is deep straw with a green hue. The nose is exceptionally alluring, with initial classic white peach and some floral notes. The flinty, funky nose builds and has meaty nuances. The palate builds nicely with some restraint, escalates into stone fruit flavours, but is supported by good acidity. Toolangi make exceptional Chardonnay on all levels. I rate these guys up with Giaconda and other great producers. Will cellar seven years-plus, but enjoy with a three cheese baked soufflé..

2. **2012 “Super Nanny Goat” Central Otago Pinot Noir** - lovely deep ruby colour. The bouquet is a heady mix of plums, strawberries and blueberries with savoury mushroom and spicy notes. The palate is luscious but balanced by supple integrated tannins. A full gustatory experience in a glass. At sub $50, the best value Pinot Noir this year. I enjoyed this, ironically, with roasted goat in an array of herbs.

3. **2011 Craggy Range Gimblett Gravels Merlot (NZ)** - has traces of Cabernet Sauvignon and Malbec. Intense purple colour. The nose is elegantly balanced, with layers of dark fruits, figs, olives, spice and dusty tannins. The voluptuous elegant palate is a delight to drink. Bordeaux style with barrel loads of love. Try with some venison. Cellar for 10-plus years.