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Associate Professor
Brian Owler

Vice President
Dr Stephen Parnis

PRESIDENT'S MESSAGE

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

> "As the political wrangling continues, it is a good time to reflect on why it is important that we respond positively and comprehensively to this evolving humanitarian crisis"

Ebola crisis affects us all

Australia's response (or lack of it) to the west Africa Ebola crisis continues to dominate the political landscape, and featured heavily in the most recent Senate Estimates hearings.

Is Australia ready to handle any cases domestically? Are we doing enough to help international efforts to control and contain the outbreak at its source? The jury is out.

But at least - after weeks of calls from the AMA and others - we are seeing some action on the local front, with protective clothing being delivered to hospitals and health experts having regular planning meetings.

As the political wrangling continues, it is a good time to reflect on why it is important that we respond positively and comprehensively to this evolving humanitarian crisis.

I believe that, as the Ebola outbreak accelerates, first world nations, including Australia, must answer critical questions that will define a generation.

For decades, Western nations have wrung their hands, expressing regret and sorrow for their failure to act in African crises such as Rwanda. In 1993-94, the West stood by as at least 800,000 Africans were killed in 100 days.

UN Force Commander to the Rwandan UN Assistance Mission, Lt. Gen. Romeo Dallaire, documented the humanitarian catastrophe and his frustration at the failure of the West to act in his book, *Shake Hands with the Devil*. This period was salutary for the UN, and for other Western nations such as the United States.

Former US President Bill Clinton and UN Secretary General Kofi Annan record the Rwandan Genocide in their memoirs as one of their great regrets.

Now, 20 years later, a humanitarian disaster of similar proportions is unfolding. The enemy is different and the pace is slower, but the imperative is even greater.

At present, almost 5000 people have died from Ebola virus disease in the west African countries of Sierra Leone, Liberia, and Guinea. However, the number of infections is growing at an exponential rate. There is at present no indication that the outbreak is being contained or controlled.

When senior international health experts use language such as, "the only thing like this has been AIDS", people should take notice. Doctors, particularly public health officials, are trained to be conservative and moderate in language. There is nothing moderate here. The US Centers for Disease Control and Prevention has put estimates of future cases as high as 1.4 million unless there is action.

The leaders of the affected African nations are desperate for international assistance. The World Health Organisation and the UN have appealed to all countries for help. While funding is essential, the assistance must also arrive in the form of physical and human resources. Patients are literally dying in the streets of Monrovia and Freetown. There are not enough beds - not even close, with dying patients being turned away.

Non-government organisations such as the Red Cross and Médecins Sans Frontières, along with the WHO, are providing most of the on-ground support. The US, UK, China, and even Cuba, have committed personnel to go and provide infrastructure and logistical support, as well as health care workers.

Australian volunteers are also doing their bit. Cairns nurse Sue-Ellen Kovack is one such volunteer, providing direct care to patients in Sierra Leone with the Red Cross. She is one of a number of Australians who not only understand the crisis, but who bravely put themselves at risk to provide care for people affected by Ebola.

The commitment and compassion of these volunteers is essential if we are to control the disease.

If the international community, including Australia, fails to act comprehensively now with health care workers and other medical support, hundreds of thousands of lives will be lost. There is a real chance that the disease could become endemic in Africa, meaning that the outbreak will continue indefinitely.

There are other doctors and nurses who are willing to volunteer and provide similar roles. The AMA has been encouraging the Government to resource Australian teams to perform these roles in a coordinated and supported manner.

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Ebola crisis affects us all

... FROM P5

There are concerns about a lack of contingencies to evacuate an Australian health care worker should they become infected. Appropriate arrangements are becoming available. The UK is building a 12-bed facility for infected international health care workers on the outskirts of Freetown, and some European nations have been accepting infected international health care workers for treatment.

It is disappointing that some commentators have focused on whipping up fear and antipathy for Australian health authorities, and even casting aspersions over the motivation of Sue-Ellen Kovack and our other health colleagues even before the negative results were known.

The risk to the Australian public was essentially zero. Health care workers returning from west Africa go into quarantine for 21 days. People are not contagious unless they show physical symptoms such as fever, vomiting, or diarrhoea. Every appropriate precaution is taken.

The international health care workers, including Australians, are essential if we are going to control the Ebola outbreak. There is a clear humanitarian imperative.

However, there are international economic and security consequences if we do not control the outbreak in west Africa.

I recently met with doctors, nurses and other members of the local Sierra Leone community. They all have family and friends at home in Africa. They, too, can see the humanitarian disaster unfolding in slow motion.

The question for the international community, including Australia, is whether we have learnt from history, or whether we continue to accept massive loss of life in Africa as a regular phenomenon. Will it be another episode described in the memoirs of world leaders as one of their great regrets?

This article was first published by The ABC's The Drum on 24 October 2014. Check out the blog at http://www.abc.net.au/news/2014-10-24/owler-will-ebola-be-the-wests-next-big-regret/5838850

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

BY AMA SECRETARY GENERAL ANNE TRIMMER

Better health, member care are AMA goals

> "The new structure gives members more opportunity to contribute to the work of the Council"

With the major governance changes that have taken place within the AMA this year I thought it timely to provide an update on activities.

The new 11-member Board recently spent two days setting its strategic objectives for 2015-17, with a focus on:

- leading on advocacy;
- increasing and valuing membership; and
- ensuring financial security and flexibility.

These objectives are underpinned by organisational capability. Once considered by Federal Council, the one-page statement of strategic objectives will become a public document for members to review.

As part of setting the strategic objectives, the Board formulated the AMA's mission statement as 'Leading Australia's Doctors – Promoting Australia's Health'. This statement echoes the first two objectives set out in the new Constitution.

In addition to setting its strategic objectives, the Board has adopted several governance tools including a Board Charter, which sets out the role of the Board, the Chair, and the Secretary General as the CEO of the company.

The Board is currently reviewing a number of areas of expenditure, the outcome of which will inform the 2015 budget.

Federal Council has also undergone some refreshment, with the establishment of three new committees and two working groups. These are:

- Health Finance and Economics;
- Medical Workforce;
- Medical Practice;
- End of Life Working Group; and
- Defence Health Working Group.

The new structure gives members more opportunity to contribute to the work of the Council. The working groups are designed to draw on the expertise of members for shorter, more focused policy development. All the committees and working groups will meet before the November meeting of Federal Council.

One of the major IT projects underway within the secretariat at present is the redevelopment of the AMA website to make it more user-friendly and relevant to members.

There is a vast amount of information on the current website but it is often hard to find. The new website will have much more effective search tools.

The Council of Doctors-in-Training had a preview at its meeting in mid-October and was enthusiastic about the changes to the DiT section of the website.

The new website should be live before the end of the year.

Many of its offerings will also integrate with doctorportal, and members will be able to get information via either site.

In recent weeks our member services team has been making contact with members who are indicated in some way as being a salaried doctor on the National Membership Register. The purpose behind this is to ensure that all salaried doctors who wish to be designated as such for Federal Council election purposes are captured on the database.

This does not change the way salaried doctors are recorded for other purposes, such as for communications. It is only for voting purposes.

The process is now complete, and voting will be re-run shortly among those doctors to elect a representative to Federal Council. The process was terminated earlier in the year when it became clear that the database did not have a complete record of doctor voting preferences.

COMMENT

Nation's drinking problem focus of AMA National Alcohol Summit

The nation will be urged to reconsider its love affair with the bottle when politicians, doctors, community workers, police officers, public policy experts and industry groups attend a two-day National Alcohol Summit in Canberra hosted by the AMA.

The Summit will be hosted by AMA President Associate Professor Brian Owler, who said a national focus on Australia's drinking problem was long overdue.

"The AMA early this year called on the Australian Government to host a summit at a time when the community was reeling from a series of violent alcohol-fuelled attacks," A/Professor Owler said. "When the Government failed to act, the AMA decided to stage its own Summit, and bring together a broad range of knowledge and experience from across the community."

The harm caused by alcohol has drawn increased attention in the past two years following a spate of high-profile alcohol-fuelled assaults in which several young men were killed, and many others suffered significant injury.

Among the speakers at the Summit will be Ralph Kelly, whose 18-year-old son Thomas died after being king-hit in an unprovoked attack during a night out in Sydney's Kings Cross.

The Kelly family subsequently founded the Thomas Kelly Youth Foundation to campaign for an end to alcohol-fuelled attacks of the kind that left Thomas dead.

Mr Kelly will address the Summit as part of a session on the social costs of alcohol, including street violence and assaults within the family, particularly on women and children.

Other speakers will include AMA Vice President Dr Stephen Parnis, Dr Diana Egerton-Warburton, of the Australasian College of Emergency Medicine, NT Police Association President Vince Kelly, Dr Angela Taft of La Trobe University's Judith Lumley Centre and Mirjana Wilson of the ACT Domestic Violence Crisis Service.

The close association between alcohol and sport will be the focus of another session at the Summit.

Brewers and distillers promote their products heavily at public sporting events, reinforcing strong cultural links between leisure and alcohol.

The AMA is among those who have been lobbying hard for the Federal Government to close a loophole in advertising laws that allow alcohol to be marketed to children as part of the live broadcasts of sporting events.

The pervasive presence of alcohol as part of the national culture will be addressed by speakers including former AMA President Dr Mukesh Haikerwal, Professor Sandra Jones of the Australian Catholic University, and high-profile public health advocate Professor Mike Daube of Curtin University.

On its second day, the focus of the Summit will turn to the devastating effects of alcohol in Indigenous communities. Dr John Boffa of the Central Australian Aboriginal Congress, Aboriginal and Torres Strait Islander Social Justice Commissioner Mick Gooda and Labor Senator Nova Peris will address the harm caused by alcohol and what has and has not worked to curb its abuse among Indigenous Australians.

A particularly pernicious and devastating consequence of alcohol abuse can be Foetal Alcohol Spectrum Disorder, which will be the focus of a separate session to be chaired by former AMA President Dr Steve Hambleton.

A/Professor Owler said the AMA was not pushing for a ban on alcohol, but warned the country needed to urgently address the harm caused by booze.

"We will not be calling for a ban on alcohol or for people to give up alcohol altogether," the AMA President said. "But we will be calling for a national rethink of Australia's historical alcohol culture, and a fresh approach to dealing with alcohol in a safer and more responsible way."

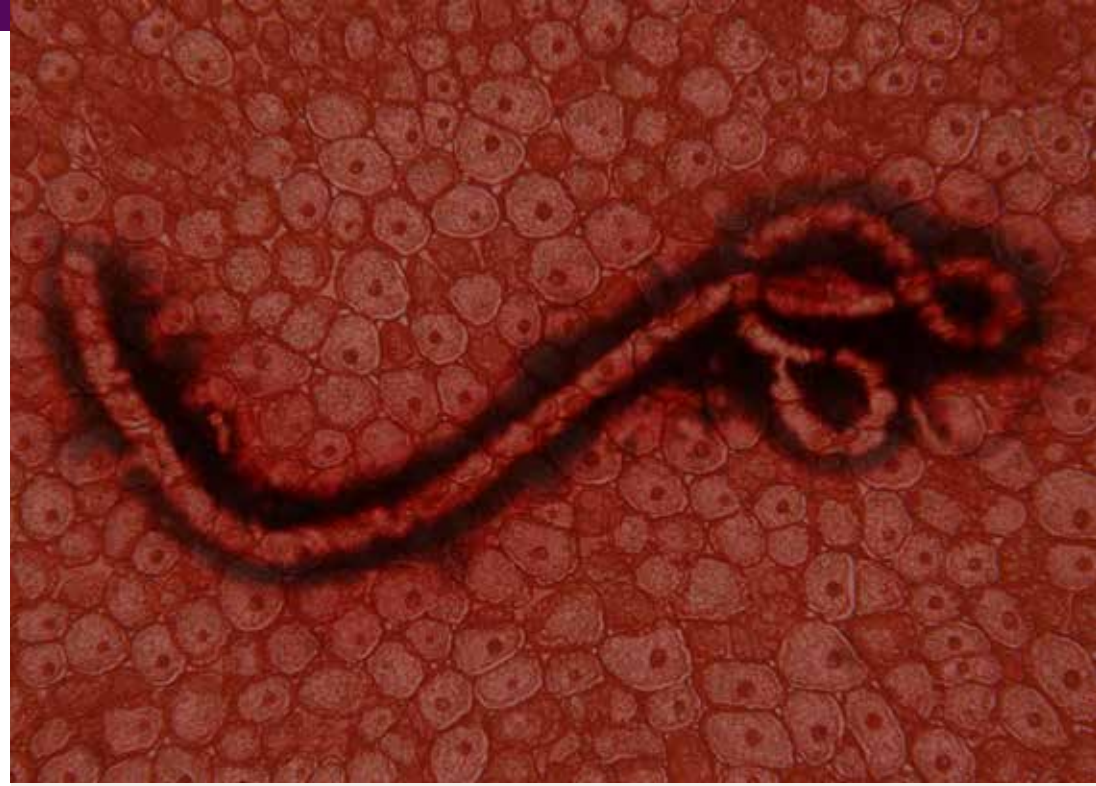
The Federal Government has so far resisted calls for it to become involved in tackling the nation's booze culture, insisting that alcohol regulation is a matter for the states and territories.

But A/Professor Owler said the stance was not tenable, and urged it to "take a strong leadership role in reshaping the relationship between alcohol and the Australian community."

Adrian Rollins

COMMENT

Ebola spreads as Government dithers



The death toll from the world's worst ever Ebola outbreak is set to surge above 5000 as the Federal Government continues to ponder mounting local and international calls for it to do much more to help stem the epidemic.

Prime Minister Tony Abbott has said the Government is "continuing to talk" with other countries about what further contribution it could make, amid conservative estimates that more than 10,000 have been infected with the deadly disease, fuelling fears the international community will struggle to bring the epidemic under control.

AMA President Associate Professor Brian Owler, who for weeks has been urging a much more vigorous response by the Commonwealth, lashed the Government for what he described as its shambolic approach to the international humanitarian crisis.

Late last week the Government insisted that a 20-member medical team was being assembled for possible deployment overseas, but A/Professor Owler said neither the AMA, the Chief Medical Officer Professor Chris Baggoley nor the Australian Medical Assistance (AUSMAT) team in Darwin knew anything about this group, including what sort of training and other preparations it had undergone.

There had been hopes on the weekend that an official announcement on the deployment of Australian medical teams to west Africa was imminent, but in Parliament yesterday Mr Abbott sought to tone down such expectations, indicating that the Government's focus was on Australia and its immediate neighbourhood.

"We have a ready reaction team that can deploy at a moment's notice in our region," the Prime Minister said. "That is our priority, in our region."

Mr Abbott said the Government would nonetheless continue to talk with other governments about Australia's contribution, adding that "I don't rule out doing something more".

But A/Professor Owler said the Ebola outbreak, in which 10,141 people had been infected and 4922 had died as at 25 October, was a major humanitarian emergency that required a much more substantial response by the Australian Government.

"Patients are literally dying in the streets of Monrovia and Freetown. There are not enough beds - not even close, with dying patients being turned away," he said. "The World Health Organisation and the UN have appealed to all countries for help. While funding is essential, the assistance must also arrive in the form of physical and human resources. If the international community, including Australia, fails to act comprehensively now with health care workers and other medical support, hundreds of thousands of lives will be lost."

The Federal Government has steadfastly resisted calls for Australian medical teams to be deployed in west Africa, citing concerns about repatriation arrangements for health workers who might become infected.

But Department of Foreign Affairs and Trade officials revealed last week that foreign governments are willing to treat Australian health workers that fall ill with the deadly disease.

In a startling admission at a Senate estimates, DFAT Secretary Peter Varghese said the US and British governments had both appealed directly to Australia to send

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Ebola spreads as Govt dithers

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medical teams and equipment, and had indicated they would give Australian health workers access to care, either on-site or possibly through evacuation, in the event that they became infected with the Ebola virus.

"In recent days some of our discussions have been much more positive about what access Australian health workers might have," Mr Varghese said.

Though Mr Varghese was at pains to emphasise that the assurances given fell short of a guarantee, they appear to remove the one major barrier standing in the way of the official deployment of Australian health teams to help out in the desperate international effort to halt the spread of Ebola in west Africa and further abroad.

The mathematics of the outbreak are ominous.

Modelling suggests 70 per cent of all those who are infected must be isolated in medical centres if the rate of infection is to slow.

Without effective intervention, the WHO warns that there could soon been 10,000 new infections a week, and the US Centers of Disease Control and Prevention has warned 1.4 million might have the disease by December.

But, as *The Economist* has pointed out, the dirt-poor countries at the centre of the outbreak – Guinea, Liberia and Sierra Leone – do not have anything like the resources needed to bring the epidemic under control, which instead must come from outsiders.

In recent weeks, frenetic work has been undertaken by the US, the UK, and others to build medical centres in the stricken countries – Liberia's Ebola treatment capacity has more than doubled in the past three weeks, and the US military is building 17 100-bed facilities in the area.

But, *The Economist* has said, given the head start that the disease has, and the exponential rate of its spread, even doubling the treatment capacity every few weeks will not be enough to ensure 70 per cent of the infected are isolated, meaning a much greater response is needed.

Meanwhile, Mr Dutton told ABC radio the Government was "weighing up whether or not we can have the safeguards in place if we send health workers into that country".

"We're obviously looking at every scenario and the Prime Minister, [Immigration] Minister [Scott] Morrison and myself met [Sunday] afternoon with the chiefs of our respective departments and senior advisors otherwise on just gaming through, if you like, different scenarios and ways in which we can respond very quickly, both domestically and internationally if that's required," he said. "I think it's prudent for us to go through all of the options that might be available."

So far, the Australian Government has committed $18 million to the international effort.

Mr Varghese said any extra funds to help fight the outbreak would have to come from the aid budget, and the Estimate hearing was told there was currently just $80 million in the aid emergency fund.

The United Nations has estimated that the international community will need to commit at least $US1 billion to bring the outbreak under control, but that figure is seen is too conservative by some, who warn the exponential growth of the outbreak mean it might take up to $US2 billion a month.

A/Professor Owler demanded Mr Abbott "show some leadership" on the intensifying Ebola health emergency amid mounting international concerns about the disease's spread.

The Ebola debate last week threatened to spiral out of the Government's control after confusion about what work had been done to prepare Australian health workers for deployment in the Asia-Pacific region in the event that Ebola appeared nearby.

Chief Medical Officer Professor Chris Baggoley told a Senate Estimates hearing that no health workers had yet been trained to deal with Ebola.

But he was later contradicted by Mr Dutton and Health Department Secretary Martin Bowles, who claimed that a first-response team of 20 health workers had been "fully trained" to tackle the disease should it appear in the country's neighbourhood.

"The National Critical Care and Trauma Response Centre in Darwin has trained clinical staff in Ebola-specific PPE equipment, and they are able to be deployed at short notice," Mr Dutton said. "On stand-by are infectious diseases and emergency specialist doctors and nurses who could be deployed from Darwin. They are vaccinated and heat acclimatised for a four-week deployment."

Adrian Rollins

COMMENT

Cash-strapped hospitals falling short of treatment targets

Public hospital emergency departments are falling well short of national treatment targets despite recent improvements, deepening doubts that they will be able to achieve substantial improvements in performance without a major boost in Commonwealth funding.

Figures compiled by the Australian Institute of Health and Welfare show that 73 per cent of emergency department patients were admitted, referred or discharged in four hours or less in 2013-14, up from 64 per cent in 2011-12, but far short of the 90 per cent target set for 2015 by governments under the National Partnership Agreement.

The best performing State, Western Australia, has to achieve an 11 percentage point improvement in little more than 12 months if it is the reach the target, while New South Wales has to deliver a larger 16 percentage point lift and the ACT and the Northern Territory, the nation's two worst performers, face an even more improbable 28 percentage point gain.

While the National Emergency Access Target is expressed in terms of calendar, rather financial, years, the results underline warnings from the AMA earlier this year that recent improvements in emergency department performance were being put at risk by Commonwealth finding cuts, and that hospitals would struggle to reach the national performance benchmark.

In the Budget, the Federal Government stripped $20 billion from public hospital funding in the next five years by disavowing funding guarantees made under the National Health Reform Agreement in 2011 and scaling back the indexation of its contributions from mid-2017 to the consumer price index and population growth rather than the higher efficient growth dividend.

The Commonwealth cutbacks come despite relentless growth in demand for public hospital services.

There were almost 7.2 million presentations to public hospital emergency departments in 2013-14, a 7 per cent jump from the previous year, and equivalent to almost 20,000 presentations a day.

The health system's ability to respond effectively to medical emergencies was demonstrated by the fact that virtually 100 per cent of patients in need of resuscitation received immediate treatment, while 82 per cent of emergency patients were cared for within 10 minutes.

But this responsiveness has come at a cost for patients with health problems that demand less immediate attention - less than three-quarters of urgent and semi-urgent cases were seen on time.

Overall, patients faced a median waiting time of 18 minutes to be seen, and the median stay in emergency departments was two hours and 40 minutes.

AMA President Associate Professor Brian Owler said the gains that had been made in giving attention to patients more quickly and freeing up beds in other parts of hospitals to enable admission from emergency departments, had been as a result of the hard work of health workers and specific payments from the Commonwealth to the states and territories.

"The improvements reflect the efforts of the dedicated and hardworking doctors and nurses working around the clock in our emergency departments and in the other areas of the hospitals that need to work efficiently to allow patients to be admitted from emergency," A/Professor Owler said.

But he said prospects for any further improvement had been undermined by the Commonwealth's cut to funding.

"There has been a significant reduction in funding guaranteed for public hospital services in the National Health Reform Agreement," he said. "This means that there is no certainty that hospitals will be able to maintain capacity to reach the four hour target of 90 per cent by 2015. Public hospitals are a vital part of our health system. They must be properly supported, and that means more funding, not less."

While emergency departments have improved their performance, elective surgery waiting times have stagnated.

The Institute has reported that half of all patients listed to undergo elective surgery in 2013-14 were admitted within 36 days – the same proportion as in 2010-11.

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Cash-strapped hospitals falling short of treatment targets

... FROM P11

The speed of admission has remained steady despite a 4.2 per cent jump in the number of people listed for undergoing elective surgery last financial year to almost 700,000 patients, though the increase has been driven by population growth, as evidenced by the fact that the rate at which elective surgeries are being performed has remained unchanged at around 30 admissions for every 1000 people for the last five years.

Patients waiting for coronary artery bypass surgery faced the shortest average wait (18 days), while those listed for treatment to correct a deviation or dislocation of the septum of their nose encountered the longest average delays (221 days).

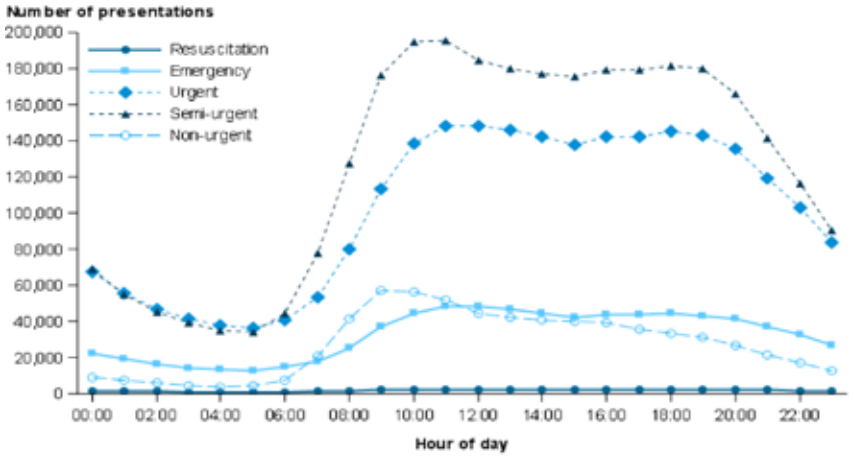
There has been a slight reduction in the proportion of patients facing very long waits for elective surgery – the proportion experiencing a delay of more than a year fell from 3.4 to 2.4 per cent between 2009-10 and 2013-14.

Overall, 90 per cent of patients on waiting lists were admitted within 262 days in 2013-14, a slight improvement from 265 days the previous financial year.

Adrian Rollins

COMMENT

Get in (very) early to skip the ED crush



Emergency department presentations, by hour of presentation and triage category, public hospital emergency deparements, 2013-14.

Patients trying to avoid the crowds in public hospital emergency departments will need to get up very early, or stay up very late.

An analysis of emergency department presentations has found that late mornings and early afternoons are the worst times to arrive, with almost 13 per cent of patients bowling up between10am and noon, and more than 12 per cent coming in between noon and 2 pm.

By contrast, the quietest time is between 4am and 6am, when just 2.5 per cent of all daily presentations are made.

The analysis by the Australian Institute of Health and Welfare shows that patients surge into emergency departments from 8am, and the pace of arrivals does not really tail off until after 10pm.

The greatest fluctuation is among patients with conditions classified as urgent and semi-urgent – most of such presentations occur between 8am and 8pm.

By contrast, there is little daily variation in when patients in need of resuscitation – the most urgent level of care – arrive, while the number of emergency cases fluctuates between less than 20,000 and more than 40,000 every two hours, depending on the time of day.

While demand for emergency department care fluctuates during the day, the Institute figures show any quiet time during the week is likely to be brief.

The influx of patients during the week is remarkably even. The busiest days are Sundays and Mondays, when slightly more than 15 per cent of total weekly presentations will arrive each day, while during even the quietest days (Wednesday, Thursday and Fridays) still 13.7 per cent of total weekly presentation will come through the door each day.

But for those concerned about the extent of alcohol-fuelled violence and harm in the community, the figures shed little light.

Though they show a small increase in emergency department presentations in the early hours of Saturdays and Sundays, the rise is slight, and the data do not disaggregate presentations by diagnosis.

Adrian Rollins

COMMENT

Watchdog could be by-passed in drugs review

Medicines accepted for use in other countries may get automatic approval in Australia under changes to be considered as part of review of drug and medical device regulations.

Just a month after Prime Minister Tony Abbott unexpectedly unloaded on the nation's system of medicine regulation, Health Minister Peter Dutton has appointed an expert panel to put the operations of the Therapeutic Goods Administration and the medicines approval process under the microscope.

The review, to be led by Emeritus Professor Lloyd Sansom with the assistance of Professor John Horvath and Will Delaat, has been asked to "benchmark" TGA regulatory arrangements against those of "trusted international authorities", to examine how assessments made by "trusted regulators" offshore could be used more extensively, to assess greater opportunities for cross-border collaboration between regulators, and to suggest ways to streamline approvals processes.

Mr Dutton said the TGA regulatory framework provided important protection in ensuring the safety and effectiveness of medicines and the way they were promoted, but it was time to assess its operations and identify opportunities for improvement.

"We need a modern regulatory framework to ensure Australians can access the latest treatments in a timely manner," the Minister said, in a none-too-veiled hint that the Government was keen to move to a system that drew more heavily on the work done by regulators offshore.

The announcement has come after the Prime Minster argued that a drug approved for use in comparable overseas countries should be available in Australia.

"If a drug is needed for a valid medicinal purpose, and is being administered safely, there should be no question of its legality," Mr Abbott said. "And if a drug that is proven to be safe abroad is needed here, it should be available."

The Prime Minister condemned the current system of medicines regulation as a "thicket of complexity, bureaucracy and corporate and institutional self-interest."

But AMA President Associate Professor Brian Owler has urged that any changes to the system of medicine regulation should be approached with caution.

A/Professor Owler said it was an important arrangement that protected the public from useless or harmful drugs.

"The way that we regulate medicines in this country for clinical indications is through the TGA, and I think we need to keep using those mechanisms, having experts look at the evidence that exists, whether there's a gap, conduct a clinical trial," the AMA President said.

The review is being conducted as part of the Government's productivity and competitiveness agenda.

In its terms of reference, the review panel has been told that the regulatory framework should "balance safety and market access priorities to the benefit of patients and industry, and align with the Government's commitment to increase productivity and competitiveness".

It has been directed to make recommendations that ensure "there is an appropriate balance between risk and benefit in the regulation of [medicines and medical devices]".

It has also been asked to look at simplifying and streamlining the approvals process, including by "fast tracking approvals, [looking to] opportunities for working together with trusted regulators in other jurisdictions… exploring how risk assessments, standards and determinations of trusted regulators can be used more extensively by Australian regulators [and] streamline approvals that cross regulatory categories".

But the Government declared that the Pharmaceutical Benefits Scheme would be off-limits for the review.

The review is due to report by 31 March, 2015.

Adrian Rollins

COMMENT

Telstra's health plan a cynical commercial ploy: Owler

Quality health care would be undermined by a "cynical and inappropriate" push by telecommunications giant Telstra into primary care, AMA President Associate Professor Brian Owler has warned.

In a major expansion of its 18-month-old thrust into health care, Telstra has unveiled a service which would enable people to seek health advice over the phone or through the internet, claiming it would potentially save a trip to the GP or hospital emergency department.

The telecoms giant said its Tesltra ReadyCare service, developed in consultation with Swiss-based telemedicine provider Medgate, would give callers round-the-clock access to a GP.

In the past year, Telstra's health division has spent $100 million buying up health software platforms that have been used to develop the ReadyCare service, which is expected to begin operations in mid-2015.

Under the model, patients can call in by phone or video. The initial contact will be with an operator who will determine if the inquiry needs to attention of one of the service's medical staff. Callers may be asked to send photos or videos as part of the diagnostic process.

Once information has been provided, doctors are expected to call back with their recommendations within half an hour. Where medicines are prescribed, the doctor would fax a prescription to the nearest open pharmacy, where it can be collected by the patient.

Tesltra said that in more complex cases, the patient would be referred to conventional clinic, but the telecommunications company expects more than half of all inquiries to be resolved by the ReadyCare service.

But A/Professor Owler was scathing about Telstra's plan, describing it as a recipe for bad medicine.

The AMA President told the AAP news service that that Association supported the use of telemedicine, but only where it complemented and supported a strong doctor-patient relationship, and warned that the ReadyCare service was completely at odds with proper models of care.

"We want people to maintain a regular contact with their GP, not just ring someone out of the blue," he said. "[Through ReadyCare], they can just ring up a number and get a doctor on the other end that they have no knowledge of or relationship with, and get scripts and other treatments prescribed. This is not the sort of vision we have for general practice and primary care."

A/Professor Owler said he had made his objections clear to Telstra when he was briefed on their plans early this month, and pledged the AMA would lobby the Federal Government to ensure there would be no Medicare rebate for ReadyCare services.

"This is a really cynical and inappropriate way for Telstra to be engaged in health care," the AMA President said. "It's a commercial solution dressed up as a health solution."

Health for Telstra head Shame Solomon insisted that the ReadyCare service would be a complement to, rather substitute for, regular GP consultations.

He said all information from ReadyCare consultations would, subject to patient consent, be shared with a patient's regular GP, to ensure continuity of care.

But A/Professor Owler said that did not obviate the fundamental problem that ReadyCare was inconsistent with the strong doctor-patient relationships fundamental to quality health care.

Adrian Rollins

COMMENT

Hambleton honoured by his peers

Immediate-past AMA President Dr Steve Hambleton has been made an honorary Fellow of the Royal Australian College of General Practitioners in recognition of his outstanding service to the profession.

Dr Hambleton, a Brisbane GP, said he was gratified by the "high honour" conferred on him at the recent RACGP conference.

In his acceptance speech, the former AMA President recounted the beginnings of his career, and his love for the work as a family GP.

"My vocation as a GP started in 1986 when I worked as a medical superintendent with the right of private practice in Texas, Queensland," he said. "For the first time I was directly serving my patients and their families from the cradle to grave. I was welcomed and embraced by the communities, and it was then that I realised that general practice was my future."

Dr Hambleton became a member of the RACGP in 1988 when he joined the staff of a 24-hour medical centre, and "before long" bought into the partnership.

Initially, the practice bulk-billed its patients, "but the economics of a high quality health care home and the Medicare rebate were incompatible," he said.

"After 26 years I am still working in that same practice, treating often the same patients and the same families. I now see the children of children that I have treated, adults growing old and I have had the privilege of sitting on the bedside as lives have slipped away," Dr Hambleton said. "I love my profession and I have worked to preserve family general practice and I hope I have helped to make sure the rewards that I have had are available for my future colleagues."

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Medical tourism summit

Virtually unheard of a decade ago, medical tourism is becoming an increasingly common aspect of modern medical practise.

Cheap air travel and the spread of medical knowledge and technology has meant more people than ever before are willing to seek treatment overseas, lured by lower costs or cutting edge expertise and techniques.

The Medical Tourism 2014 Summit is being held next month to explore rapid growth in medical tourism and its impact on the Australian health system.

It will look at factors driving Australians to seek treatment offshore, as well as the flow of patients coming to Australia.

Speakers will include NIB Health Fund CEO Mark Fitzgibbon, Melbourne IVF medical director Lyndon Hale, Epworth Group medical director Professor John Catford and Global Health Travel, Thailand managing director Cassandra Italia.

The Summit is to be held on 20 and 21 November at Rendezvous Grand Hotel, Melbourne.

For details, visit: http://www.informa.com.au/conferences/health-care-conference/medical-tourism-summit

AMA IN THE NEWS

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

Print/Online

Doctors seek drug 'education' ban, *Sydney Morning Herald*, 10 October 2014

A rebel group of doctors is lobbying colleagues to ban drug company representatives from their surgeries. AMA Chair of General Practice Dr Brian Morton said doctors benefited from learning about drugs, and were capable of making independent decisions.

Fear spreads as fast and dangerously as virus, *Courier Mail,* 10 October 2014

Fear has gripped the US following the death of the first person in the country to be diagnosed with Ebola virus – a situation Australian experts want to avoid here. AMA President A/Professor Brian Owler said it is not a time for panic or overreaction.

Checks in place at airport for people with Ebola links, *Sydney Morning Herald*, 11 October 2014

Fewer than 200 people have arrived in Sydney from Ebola-affected countries in west Africa, including Cairns registered nurse Sue-Ellen Kovack, who received negative test results for the virus after reporting a fever on her return to Australia. AMA President A/Professor Brian Owler appealed for the Government to do more to support the work of people like Ms Kovack.

Patient alert: Big Pharma could win over your doctor, *Sydney Morning Herald*, 11 October 2014

Doctors are being encouraged to ban pharmaceutical companies from their practices. AMA Chair of General Practice Dr Brian Morton said doctors will hear what drug company representatives have to say with a sceptical mind, and would always put the interests of their patients first.

Dr. Debt, Medical degree fees could hit GP ranks: AMA, *Sunday Canberra Times*, 12 October 2014

Doctors have warned that the Federal Government's planned changes to university fees could send the cost of six-year undergraduate medical degrees to $250,000 or more. AMA Vice President Dr Stephen Parnis said the proposed fee changes would have enormous impacts on the future health workforce.

Africa needs our doctors to fight Ebola: Plibersek, *Canberra Times*, 16 October 2014

Labor will increase pressure on the Government to do more to help fight the Ebola outbreak in west Africa by publicly calling for the Government to deploy medical assistance teams. The AMA has criticised the Government for so far refusing to send personnel to Africa to support international efforts.

Aussies with Ebola might not be helped, *Australian Financial Review*, 17 October 2014

A dozen European countries and the United States have rejected approaches by the Abbott government to guarantee treating Australians infected by the Ebola virus – leaving the Government unwilling to deploy personnel to west Africa. AMA President A/Professor Brian Owler said he understood the reluctance of Prime Minister Tony Abbott to send people to help, but added that if their safety could be guaranteed, there would be no need to send them in the first place.

We need a proper plan, *The Daily Telegraph*, 17 October 2014

The Australian Medical Association has called for a review of the nation's ability to tackle an Ebola outbreak. AMA President A/Professor Brian Owler said it is timely that we review our preparedness.

60 days…or else, *Herald Sun*, 17 October 2014

Serious questions are being asked about Australia's ability to fight an Ebola outbreak as the United Nations warns that the world has just 60 days to control the epidemic. AMA President A/Professor Brian Owler admitted the AMA has concerns about the preparedness of Australia.

Ebola crisis demands a united global effort, *Courier Mail*, 17 October 2014

Ebola is no longer a problem Australia or the rest of the world can largely ignore or offer just token support in the effort to combat it. AMA President A/Professor Brian Owler said we need to be thinking about this problem as an international global emergency.

Ebola failures in the US a cause for concern here, *Weekend Australian*, 18 October 2014

As the US experiences failures at their top-tier Texas Health Presbyterian Hospital in Dallas, with two nurses being infected with Ebola, concerns are raised in Australia. AMA President A/Professor Brian Owler said people are going to be looking closely at the way the treatment was conducted in Dallas to make sure that procedures here are up to scratch.

State housing set aside for Ebola cases, *Weekend Australia*, 18 October 2014

Queensland will commandeer government housing to quarantine Ebola patients under contingency planning for an eruption of the lethal disease in Australia. AMA President A/Professor Brian Owler doubted whether

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AMA IN THE NEWS

... FROM P16

mandatory quarantine for health workers and regular travellers to west Africa was practical.

ACCC wants doctors' fees disclosed, *Sun Herald*, 19 October 2014

The competition watchdog has demanded pharmaceutical companies publicly declare the names of doctors who are paid to speak at or attend conferences. The AMA welcomed the ACCC's recommendation, and said it was consistent with its submission for greater transparency measures in the code.

Confronting a health crisis 'over there', *The Age*, 20 October 2014

West Africa is enduring a crisis of biblical proportions, and the world's response has been deplorable. The AMA said the Ebola epidemic was an unprecedented humanitarian crisis.

Radio

A/Professor Brian Owler, ABC Ballarat, 10 October 2014

AMA President A/Professor Brian Owler talked about a Queensland nurse being cleared of Ebola and the facts about the disease. A/Professor Owler said people should be concerned about Ebola, but not about the idea that a health care worker could return to Australia and pass it on to others.

A/Professor Brian Owler, ABC NewsRadio, 16 October 2014

AMA President A/Professor Brian Owler talked about the Ebola crisis. A/Professor Owler said the AMA is encouraging the Government to support other health care workers to volunteer and, unless there is a global response, the infection will continue to spiral out of control.

A/Professor Brian Owler, 666 ABC Canberra, 16 October 2014

AMA President A/Professor Brian Owler is concerned hospitals in the developed world are not equipped to cope with Ebola and is calling for a review after a second health worker in the US contracted the virus.

Dr Stephen Parnis, 3AW Melbourne, 17 October 2014

AMA Vice President Dr Stephen Parnis discussed concerns raised by Health Minister Peter Dutton about the difficulty of repatriating health workers infected with Ebola. Dr Parnis said everything possible should be done to treat such patients in the country in which they became infected.

A/Professor Brian Owler, 4BC Brisbane, 17 October 2014

AMA President A/Professor Brian Owler discussed the AMA's criticisms of the Federal Government's response to the Ebola crisis. A/Professor Owler said there were many Australian health workers ready to travel to west Africa to assist in bringing the massive outbreak under control.

Television

Dr Stephen Parnis, Sky News Sydney, 9 October 2014

AMA Vice President Dr Stephen Parnis discussed a nurse in Cairns who may have picked up the Ebola virus while working in Sierra Leone. Dr Parnis said the AMA believed the Government was not doing enough to help resolve the crisis.

A/Professor Brian Owler, Sky News Sydney, 10 October 2014

AMA President A/Professor Brian Owler held a press conference regarding the Ebola case in Cairnes and the global response to the Ebola epidemic.

A/Professor Brian Owler, ABC News 24, 16 October 2014

AMA President A/Professor Brian Owler held a press conference in Melbourne regarding the latest local and international developments in the Ebola crisis.

A/Professor Brian Owler, Channel 7 Sunrise, 18 October 2014

The World Health Organisation said unless Ebola was contained, there could be as many as 10,000 new cases a week by December. AMA President A/Professor Brian Owler said the Prime Minister needs to show some leadership on the issue.

Dr Stephen Parnis, Channel 9 Today Show, 18 October 2014

AMA Vice President Dr Stephen Parnis discussed the Ebola crisis on The Today Show. Dr Parnis said Australia needs to help other nations tackle the Ebola outbreak at its source in West Africa.

Dr Stephen Parnis, Sky News Sydney, 20 October 2014

AMA Vice President Dr Stephen Parnis participated in a debate with Independent MP Bob Katter regarding the Ebola crisis and Australia's current approach to the virus.

COMMENT

NOVEMBER HEALTH EVENTS

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

Sun	Mon	Tue	Wed	Thur	Fri	Sat
26	27	28	29	30	31	**1** National Movember Month National Lung Awareness Month National Prematurity Awareness Month National Alpha-1 Awareness Month
2	**3**	**4**	**5**	**6**	**7** National Sunnies Day Walk to Work Day	**8** International Day of Radiology
9 National Phycology Week National Food Safety Week Spinal Cord Injury Awareness Week Walk to d'Feet MND - Sydney	**10**	**11** National Thank U NICU Day	**12** World Pneumonia Day	**13**	**14** World Diabetes Day	**15**
16	**17** World Prematurity Day National Cervical Cancer Awareness Week National Skin Cancer Action Week National DES Awareness Week World Antibiotic Awareness Week	**18**	**19** World Chronic Obstructive Pulmonary Disease Day World Toilet Day	**20**	**21**	**22**
23	**24** National Australian Mesothelioma and Asbestos Awareness Week	**25** National Disability Awards National White Ribbon Day	**26**	**27**	**28**	**29**
30	28	28	28	28	28	28

Device makers need just one tick of approval

Locally-made hearing aids, joint implants and other medical devices could become available more quickly under a Federal Government move to streamline regulatory approvals.

Assistant Health Minister Fiona Nash has announced that Australian medical device manufacturers will no longer have to have their products approved by both the Therapeutic Goods Administration and its European counterparts if they are to be sold in both markets.

Under the new arrangements, to come into effect by the end of the year, any device that conforms to TGA or European standards will automatically be approved for use in the other jurisdiction.

"With these changes, Australian manufacturers can choose to either have conformity assessment conducted by the TGA or an alternative conformity assessment body, such as a European notified body," Senator Nash said. "This will cut red tape, provide more flexibility for local device manufacturers and, in many cases, enable devices to get to market more quickly, which will benefit the public."

But the Minister said the streamlined arrangement would not extent to devices considered to be high risk, such as those containing medicines, in vitro diagnostics, or tissues with animal, biological or microbial origins, which would still require TGA approval, regardless of established conformity in other jurisdictions.

While the change only applies to medical devices, it has encouraged calls for similar streamlined processes to be applied to medicines.

Prime Minister Tony Abbott appeared to give succour to calls for drugs approved overseas to be automatically given the go ahead in Australia when he launched an extraordinary attack on the nation's system of medicine regulation last month.

Speaking in the context of the debate over the use of medicinal cannabis, Mr Abbott condemned the regulatory system as a "thicket of complexity, bureaucracy and corporate and institutional self-interest", which should be by-passed if necessary.

"If a drug is needed for a valid medicinal purpose and is being administered safely, there should be no question of its legality," the Prime Minister said. "And if a drug that is proven to be safe abroad is needed here, it should be available."

The medicines industry has seized on Senator Nash's announcement to urge that it be extended to include non-prescription drugs.

"There is no compelling reason why the Therapeutic Goods Administration should re-assess non-prescription medicines where they have already been assessed by comparable overseas regulators," the Australian Self Medication Industry said.

Executive Director Dr Deon Schoombie said the Government move was a "great opportunity to re-visit those areas where the TGA is out of step with the rest of the world, such as down-scheduling of certain prescription medicines to non-prescription, advertising of non-prescription medicines, scheduling of combination products, and regulation of the lowest risk complementary medicines".

But there is no indication that the Government is considering extending the change to encompass medicines, at least at this stage.

See also Watchdog could be bypassed in drug review, p13.

Adrian Rollins

COMMENT

Hip replacement success rate up

The success rate of hip replacements is improving, with just one in 10 requiring follow-up work, reducing risk and discomfort for patients and saving the health system millions of dollars.

In evidence of significant improvements in surgical techniques and the design and manufacture of medical devices, figures compiled by the Australian Orthopaedic Association's National Joint Replacement Registry show that just 10.6 per cent of hip operations in 2013 were procedures to rectify problems with implants, down from 12.6 per cent in 2010.

Association President Professor Peter Choong said the result was particularly pleasing given the steady rise in the number of hip replacement operations being carried out.

Professor Choong said 40,180 hip replacements were conducted in 2013, almost double the number carried out in 2003.

In all, more than 850,000 hip and knee replacements have been recorded by the Registry since 1999.

Professor Choong said the relatively low revision figures reflected the "outstanding success" of hip replacements in Australia because of the use of devices and techniques know the provide good outcomes.

In helping guide improvements in practise, Registry figures show that total hip replacements where the femoral head is small (28 millimetres or less) are much more likely to result in revision surgery than those where the head is large (32 millimetres or greater).

The Registry shows that using larger femoral heads has resulted in a halving of hip replacement dislocations – the most common complication – between 2003 and 2013.

"Using this data, combined with the individual circumstances of the patient, arms a surgeon with information that can be used to ensure the best outcome for the patient is achieved," Professor Choong said. "With data like this, the Registry is making a difference to the lives of Australians."

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Doctor Portal: the doctor's complete online resource

All the resources and information a busy practitioner needs is now just a click away following the launch of the AMA's Doctor Portal website.

Doctor Portal brings together all the tools and resources doctors look for on a daily basis – the GP Desktop Toolkit, the Find a Doctor feature, the CPD tracker, the Fees List, policy guidelines, position statements, practice advice and support – as well as access to AMA publications including the *Medical Journal of Australia* and *Australian Medicine*, all in one convenient location.

No more wasted time digging around through the entrails of the web to find the information you need – Doctor Portal is your one-stop information hub.

Not only does Doctor Portal give you ready access to the information and resources you need, it gives you a way to connect with colleagues near and far through public and private forums.

Click on the Doctor Portal link to check out these and other features:

- Content sharing – Doctor Portal allows you to securely share information and ideas with colleagues, providing public and private forums that only other registered medical professionals can access and participate in;
- Find a Doctor – locate practitioners using the Find a Doctor feature, which gives you access to Medical Directory of Australia information, including current practice contact details and a scalable map – perfect for when you are referring patients;
- All in one convenience: Doctor Portal features a refreshed MJA Bookshop, careers and jobs resources and the GP Desktop Toolkit, all at one site;
- Free access: Doctor Portal is a free service, and includes features exclusive to AMA members.

Doctor Portal is continually updated, ensuring that all information is current and you are never left out-of-date.

To explore all that Doctor Portal has to offer, visit: http://www.doctorportal.com.au/

Pharmacists intensify health care push

A vaccination training course for pharmacists has achieved national accreditation as the industry's peak body has intensified its push for chemists to provide a range of GP-type services.

The Australian Skills Quality Authority has given formal accreditation to a Pharmaceutical Society of Australia course on the delivery and administration of immunisations, which is included in the Graduate Diploma of Applied Pharmacy Practice.

The course was used in the controversial Queensland pilot program under which pharmacists were given permission to provide vaccinations, such as for the flu.

The development came as the PSA intensified its push for an expanded role for pharmacists in primary care.

The Society wants the next five-year Community Pharmacy Agreement to incorporate a broader scope of practice for pharmacists, including providing vaccinations, conducting health checks and treating minor ailments.

Negotiations on the next Agreement, which is expected to cost taxpayers about $15 billion, are due to begin soon, and the PSA is keen to secure an expanded role for pharmacists because reforms to pharmaceutical pricing and other developments had dented earnings.

Already, major pharmacy chains Chemmart, Amcal and Guardian are offering skin cancer checks, and some conducts tests for coeliac disease.

But the Society is facing stiff resistance from the AMA, which has warned that community pharmacies were a totally inappropriate setting in which to try and deliver quality health care, and allowing pharmacists to provide GP-style services would fragment care and could put lives at risk.

AMA President Associate Professor Brian Owler said that it was unacceptable to try and conduct health checks between shelves stacked with "toilet paper and toothpaste", and said pharmacists did not have the training to accurately diagnose and treat health problems.

AMA NSW President Dr Saxon Smith, a dermatologist, said it was "irresponsible and inappropriate" for pharmacies to offer in-store skin cancer checks.

Nonetheless, the Government has left open the possibility that it might agree to a wider scope of practise for pharmacists.

Health Minister Peter Dutton has flagged that he was open to suggestions about arrangements that would improve access to care.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

Indigenous doctors double

The number of registered Indigenous doctors has doubled in the past decade, boosting efforts to improve the health of Aboriginal and Torres Strait Islander communities.

The Australian Indigenous Doctors' Association has reported that 204 Indigenous medical doctors are now registered to practise – up from 90 in 2004 - and there are currently 310 Indigenous students studying medicine.

Training more Indigenous doctors is seen as crucial to improve Aboriginal and Torres Strait Islander health both because they are considered more likely to practise in Indigenous communities, and are better able to provide culturally-appropriate care.

But although the Indigenous medical workforce is expanding, AIDA President and GP Dr Tammy Klimpton said it needed to become much bigger.

Dr Klimpton said that to reach population parity of around three Indigenous doctors for every 100 Aboriginal and Torres Strait Islander people, the Indigenous medical workforce would have to reach 2895.

"It's great to see our numbers grow, but we need more than 10 times this amount [204]," she said. "An increase in Indigenous doctors, along with a focus on Australia's Indigenous health workforce, will help address the ill health and burden of disease in our communities, and respond appropriately to the continuing crisis in Indigenous health."

Following a visit to several Aboriginal and Torres Strait Islander communities in the Northern Territory in August, AMA President Associate Professor Brian Owler said there were encouraging signs of progress in improving Indigenous health, but warned much more needed to be done.

While some communities were achieving success in tackling domestic violence and other problems linked to alcohol abuse, malnutrition – particularly among the very young – remains disturbingly common, which many children suffering anaemia, scabies and other conditions usually associated with poverty.

AIDA Chief Executive Officer Kate Thomann said training more Indigenous doctors was essential to achieving improvement.

"There is a vital need for the Australian health system to be culturally safe, high quality, reflective of need, and one which respects and integrates Aboriginal and Torres Strait Islander cultural values," Ms Thomann said. "This can only be increased by the employment of more Aboriginal and Torres Strait Islander health professionals, including Indigenous doctors, throughout the health care system."

One small hurdle has been removed after the Aboriginal and Torres Strait Islander Health Practice Board of Australia announced that Indigenous practitioners are now able to renew their registration online.

The Board said the registration fee had been frozen at $100 for the coming year, and urged all practitioners to renew their registration by the 30 November deadline.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Time for med students to bone up on nutrition

Australia is at the forefront of a worldwide push to tackle diet-related health problems by improving nutritional understanding among trainee doctors.

As the nation's waistline continues to bulge, with around two-thirds of adults considered to be overweight or obese, researchers have developed an online resource that will enable medical schools to integrate nutrition in their teaching programs.

Leader of the Web-based Nutrition Competency Implementation Toolkit, Deakin University academic Professor Caryl Nowson, said doctors were at the frontline in dealing with patients with diet-related health problems, and many medical students were graduating with significant gaps in their knowledge of nutrition and related health problems, adding to the nation's health bill from chronic disease.

"Currently, medical graduates are ill-equipped to identify and appropriately manage nutritional issues of patients, which contributes to increased complication rates and hospitalisation time," Professor Nowson said. "The inclusion of nutrition within medical degrees across Australia at present is haphazard and uncoordinated, and course infrastructures do not support the delivery of a sustainable nutrition curriculum within courses."

Internationally, diet-related health problems such as heart disease, diabetes and stroke are increasingly rapidly in scope and severity, and Deakin University Pro Vice Chancellor Brendan Crotty said there was global interest in work being done by Professor Nowson and her team.

The Toolkit, developed by Professor Nowson in collaboration with academics and researchers at Monash University, University of Queensland, University of Tasmania and the Dietitians Association of Australia, provides resources so that medical students can be taught to identify patients at nutritional risk and address associated health problems.

It also includes ways to review and map nutrition components in entry-level medical courses, an assessment tool and other web-based resources.

"Australia has the chance to lead thw world in this area by equipping medical students with nutritional skills that will bridge the gap between medical training and applying nutrition competencies to patient management," Professor Cotty said.

"We believe that evidence-based nutrition knowledge to manage and prevent chronic diseases should be integrated into every medical course in Australia."

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

AMA LIST OF MEDICAL SERVICES AND FEES

The 1 November 2014 edition of the AMA List of Medical Services and Fees will soon be available, both in hard copy or electronic format.

A hard copy of the fees book will be sent to AMA members listed as being in private practice or with rights of private practice, as well as salaried members who have requested a copy. Dispath will commence from 15 October.

The AMA Fees List Online **(http://feeslist.ama.com.au)** will be updated on 1 November. To access this part of the website, simply enter your username and password in the box provided on the screen. Members can view, print or download individual items or groups of items to suit their needs.

Electronic versions (PDF or CSV) of the AMA List will also be available for free download from the Members Only area of the AMA Website (www.ama.com.au/feeslist) [https://ama.com.au/node/4597] from 22 October 2014.

A Fees Indexation Calculator is also available for members to calculate their own fee increase based on their individual cost profile.

To access this part of the website simply enter your username and password in the box on the top right hand side of the screen and follow these steps:

1) once you have entered your login details, from the home page hover over **Resources** at the top of the page;
2) a drop down box will appear. Under this, select **AMA Fees List**;
3) select the first option, **AMA List of Medical Services and Fees - 1 November 2014**;
4) download either or both the **CSV** (for importing into practice software) and PDF (for viewing) versions of the AMA List;
5) for the Fees Indexation Calculator, select option **15. AMA Fees Indexation Calculator**.

Members who do not currently have a username and password should email their name, address and AMA member services number to memberservices@ama.com.au requesting a username and password.

If you do not receive your hard copy of the 1 November 2014 AMA List of Medical Services and Fees or would like one, please contact the AMA on 02 6270 5400 or email feeslist@ama.com.au

PUBLIC HEALTH OPINION

Summit a chance to end nation's decades-long drinking binge

BY PROFESSOR STEPHEN LEEDER

> "Full marks to the AMA for convening a summit about alcohol"

I had heard about but not seen the Todd River in Alice Springs, with its small encampments of quiet and inactive Indigenous people in its dry bed. But about 30 years ago I had my chance.

I was, irony of ironies, attending a meeting of Australian health ministers in a nearby comfortable motel to discuss health goals and targets for Australia. In the dust of the Todd I saw innumerable discarded empty casks of Coolabah wine, and discarded people. You can guess the rest.

Whatever goals we set as a nation back then for alcohol have not been met, and the shambles associated with its misuse - violence, road crashes, liver disease, mental chaos, cardiovascular disease and diabetes, impaired pregnancy and so on - continues pretty much unabated.

Full marks to the AMA for convening a summit about alcohol.

Summit may seem an odd word to use in relation to alcohol, but it is the right word. Alcohol is at the top of current public health problems in Australia, especially in our Indigenous communities, and deserves the quality debate that occurs at international meetings convened to resolve wars and prevent major threats such as Ebola and economic collapse.

That there are many interested parties when discussion and decisions are made about alcohol is a good reason for such a summit. All voices need to be heard, and conflicting arguments for and against an uncontrolled market need to be considered.

But the medical nature of this summit moves it well beyond a talkfest: the health problems to which alcohol contributes are multiple and devastating, especially in our Indigenous communities.

The National Health and Medical Research Council has moved in an increasingly conservative direction in the past two decades in determining the risks posed by alcohol. A little bit of radiation, a touch of small-particle air pollution, a small amount of asbestos were all once regarded as no bad thing. We now know that one cigarette a day increases the risk of heart disease to the same extent as all the modern genetic markers put together. That's the direction we are moving in with regard to alcohol.

Many and varied are those interested in alcohol. We should not expect harmony, and consensus is an unlikely outcome.

Like the problems that necessitate international summits, ideology will probably trump facts most of the time. There will be those who will argue that any form of limitation on the availability of alcohol in any of its many forms needs to be targeted only to vulnerable groups. Others will seek more radical control through taxation, following its demonstrable success in cutting smoking rates wherever it has been applied worldwide.

Yes, of course, tobacco and alcohol are different, but the same arguments about individual freedom and not wanting a nanny state interfering with the market will probably be heard at the summit on alcohol.

The summit may well hear good-news stories that should serve to encourage others to action. Indigenous communities that have taken control of the availability of alcohol point to the importance of community education and community development. In our richly multicultural society, we can easily find national and religious groups who exemplify healthy behaviour in relation to alcohol from which lessons can be drawn.

But the environment also matters, and availability of alcohol deserves attention.

A year ago I met with a senior planning politician to discuss how new housing estates might be designed with health in mind. He asked expressly about shops. I suggested, based on depressed communities we both knew, that it would be great if there were more outlets for fresh food than there were for alcohol. The door closed. I was told this would need to be determined by the market.

The summit will contribute to a continuing conversation. We should not expect Harry Potter will to turn up with his wand and convert all present to a lasting preference for non-alcoholic butter beer.

But if recommendations emerge that focus less on individual responsibility and more on creating a disciplined and supportive environment that decreases the health risk of alcohol, then it will have served a useful purpose.

COMMENT

GENERAL PRACTICE

Integration, not duplication, the way ahead for better care

BY DR BRIAN MORTON

At a time when the AMA has been working with the Pharmaceutical Society of Australia (PSA) on developing a model for integrating pharmacists into general practice, it was disappointing recently to read of them making a bid to independently provide GP-type services.

> "The AMA is not opposed to the greater involvement of pharmacists in providing health care services to patients, but it must be as part of a GP-led team"

The proposal, currently up for discussion, is expected to be included in the PSA's submission regarding the 6th Pharmacy Agreement.

It seems illogical to me that proposing to pay pharmacists a consultation fee, paid at the same rate as GPs, would do anything more than significantly increase the Government's expenditure on primary health care services. It is, after all, not that long since the Home Medicine Program provided for under the current 5th Pharmacy Agreement had to be amended to rein in a three-fold blow-out in costs.

What it will do is fragment patient care, undermine quality, threaten patient safety, create inefficiencies and service duplications, and add to the cost of health care in this country. The AMA will not support any scheme or proposal that threatens the quality and continuity of patient care.

The AMA is not opposed to the greater involvement of pharmacists in providing health care services to patients, but it must be as part of a GP-led team.

There are significant limits on the extent to which tasks can be taken out of the hands of medical practitioners or away from their supervision. These limitations include the inability of lesser-trained groups to appreciate the complexity of medical decision-making and treatment options.

The GP is the only clinician who operates in the nine levels of care: prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease, management of disease, management of disease complications, rehabilitation, terminal care and counselling.

The AMA Council of General Practice in November will be considering a draft incentive model for integrating pharmacists into general practice. The model will enable general practices to engage a pharmacist to provide services such as:

- medication management reviews;
- advising patients on medication and medication management;
- patient education sessions;
- updating GPs on new drugs; and
- quality assurance and prescribing support.

The model up for consideration would provide practices with the flexibility to best utilise pharmacists skills as part of a GP-led multidisciplinary team. The benefits would include improved use of medicines, fewer adverse drug events and improved coordination of patient care.

Rather than pouring more funding into the 6th Pharmacy Agreement in a way that will lead to the fragmentation of health care, the Government would be better off investing in general practice by supporting integrated, collaborative and coordinated care.

COMMENT

DOCTORS IN TRAINING

Challenge to continue planning despite Health Workforce Australia loss

BY DR JAMES CHURCHILL

> "Doctors-in-training continually raise training capacity and workforce planning as the most important issues affecting their current and future practice. With the loss of HWA, where to now?"

With the closure of Health Workforce Australia in August, Australia is at risk of losing significant momentum in understanding, measuring and planning for development of Australia's future medical workforce.

Health Workforce Australia, established in 2010 as an agency reporting to the Council of Australian Governments but beholden to none of them, had been providing useful policy advice on medical workforce planning.

Created with a mandate to produce a National Training Plan to end the boom-bust swings in medical school intakes on the basis of short-sighted politics, the agency was making good progress in shaping workforce development, such that all stakeholders in this complex system play to a similar (even if not always the same) score.

Although medical workforce planning will always be an imprecise science, not least because of the significant assumptions involved, the *Health Workforce 2025* reports released in 2012 are considered the most robust national workforce planning data produced for the Australian health system. Initially slated for annual reviews, however, the *Health Workforce 2025* reports are now showing some signs of age, and are well overdue for refreshed data.

Since the budget announcement, the AMA has been warning of the need to retain the medical workforce planning expertise built within Health Workforce Australia during the past four years. We have been continually reassured that the National Medical Training Advisory Network is to continue with its work plan, and that this would be appropriately supported in its new home at the Commonwealth Department of Health.

Sadly, it is emerging that much expertise has not been carried across from Adelaide to the Department in Canberra, which now bears responsibility for national coordination of medical workforce planning alongside its many other responsibilities and priorities.

Doctors-in-training continually raise training capacity and workforce planning as the most important issues affecting their current and future practice. With the loss of HWA, where to now?

It's clear that coordination of our medical training pipeline is poor, with little known about the number and intentions of doctors completing their prevocational training. It's unbelievably difficult to source public data on how many prevocational doctors work in Australia, and how many prevocational training posts they are competing to fill.

Collecting and analysing this prevocational workforce data must be a priority, not just for the Commonwealth, but for all jurisdictions so they can better understand the risk they face as the crunch of increased graduate numbers and limited vocational training capacity hits the prevocational space.

A large number of issues arise from the complexity and lack of coordination of prevocational position offer and acceptance systems across and within states. There is an increased churn of offers and acceptances that jurisdictions and trainees both find expensive and tiring. Coordination of these systems exists for the internship year, at low cost, and should be examined for other prevocational years.

The next meeting of the National Medical Training Advisory Network is scheduled for 3 December in Melbourne. At this meeting, we need to see significant progress on a work plan for NMTAN, including further development of a meaningful National Training Plan with measurable benchmarks and specific guidance on training numbers that can influence sensible training expansion and reform.

Ultimately, in the wake of the loss of such a large organisation with responsibility for medical workforce planning, governments and stakeholders alike cannot afford to lose momentum on this work, which is of great importance to doctors-in-training and our future Australian health system.

COMMENT

SPECIAL REPORT

THIS STORY HAS BEEN PROVIDED BY MÉDECINS SANS FRONTIÈRES.

Tragic loss, and hope: death and life on the Ebola frontline

October 6, 2014 - Alexander James (l) back at work as an MSF health worker following his son Kollie's (r) discharge from the MSF's Ebola management centre in Foya, northern Liberia. Copyright: Katy Athersuch/MSF

Since the beginning of the Ebola outbreak in West Africa, Médecins Sans Frontières (MSF) has admitted more than 4,500 patients to its treatment centres. Young Liberian Kollie James was among them. Here, his father Alexander recounts his story.

Sunday, the twenty-first of September, is a day I will never forget in my life.

I was out working with MSF as a health promotion officer, visiting villages and telling people about Ebola—how to protect themselves and their families, what to do if they started to develop symptoms; and I made sure everyone had the MSF hotline number to call. When I was finishing up the day, I got a call from my wife's number but it was not her. I answered the phone but nobody spoke. She was staying in the capital, Monrovia, with three of our children while I was working in Foya, in the north of Liberia.

At that time, Ebola had come to Liberia so I tried to talk to my family about the virus and to educate them, but my wife did not believe in it. I called my wife begging her to leave Monrovia and bring the children north so we could be together here. She did not listen. She denied Ebola.

Later that night, my brother called me. "Your wife has died." I said, "What?" He said, "Bendu is dead." I dropped the phone. I threw it away and it broke apart. We were together for 23 years. She understood me. She was the only one who understood me very well. I felt like I'd lost my whole memory. My eyes were open, but I didn't know what I was looking at. I had no vision.

Later that same week, I received another call from Monrovia. My brother, who was working as a nurse, had been taking care of my wife. But he became infected and died too. Then my two youngest children were taken to the centre in Monrovia, but my girls were very sick and they died. I felt

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Tragic loss, and hope: death and life on the Ebola frontline

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even more helpless. I was breaking in my mind. I couldn't make sense of anything.

My eldest son, Kollie James, was still in Monrovia, in the house where our family had been sick, though he was showing no signs of illness. He called me and said, "Everyone got sick, I don't know what to do." I told him to come here to Foya to be with me.

When my son arrived, people in the village would not accept us. They told us that our family had all died and to take Kollie James away. I was angered by their reaction. I knew he wasn't showing any symptoms and was not a threat to them, but because of the stigma they wouldn't let us stay. We had to move on.

The next morning, though, I noticed my son looking more tired than usual. I was worried about him. He didn't have any symptoms like vomiting or diarrhoea, but he just looked tired. I called the Ebola hotline and MSF brought him to their Ebola care centre here in Foya to be tested.

When the test came back positive, it was a night of agony for me. I didn't even shut my eyes for one second. I spent the whole night just crying and thinking about what would happen now to my son.

The next day the psychosocial counsellors at MSF calmed me down. They told me to wait. To hold my peace. I sat with them, and we talked and talked.

I was able to see Kollie in the care centre from across the fence, so I called out to him, "Son, you're the only hope I got. You have to take courage. Any medicine they give to you, you have to take it." He told me, "Papa, I understand. I will do it. Stop crying Papa, I will not die, I will survive Ebola. My sisters are gone, but I am going to survive and I will make you proud."

Every day, the counsellors made sure they saw me, and they sat with me so I could talk. The way the counsellors talked to me helped me relax. They knew it's not a small blow that I am receiving in life. I didn't want to see my son in there. When I saw him in there, I thought about his mother. I already lost her—I wanted him to survive. I wanted him to be strong.

After some time, my son started doing much better. He was moving around. I prayed that he would be free of Ebola and test negative, but I was worried that his eyes were still red. I just wanted us to be together again. Then something amazing happened, something I could not actually believe until I saw it.

Until that moment I saw him coming outside, I could not truly believe that it would happen. I've seen people with Ebola start to look strong and then the next day, they're just gone. So I was also thinking, maybe Kollie will be one of those who will be gone the next day. When finally I saw him come out, I felt so very, very happy. I looked at him and he said to me, "Pa, I am well." I hugged him. Lots of people came to see him when he came outside. Everybody was so happy to see him outside.

Then MSF told me that Kollie is the 1000th patient to survive Ebola. This is a great thing, but I was wondering, how many more people have we lost? How many have not survived? Of course I am so happy to have Kollie still, but it's hard not to think of all those who are no longer with us.

When I took him home with me, he actually had a smiling face. And me too, I had a big smile on my face. I had a very good smile that day. I decided to have a little party for him. Since then we do everything together. We sleep together, we eat together, and we have been conversing a lot. I asked him, "What's your ambition after you graduate from high school?" He's a tenth-grade student. He told me that he wants to study biology and become a medical doctor. That's what he told me!

So now I'm going to try every way I can to meet his needs and succeed in life, so that he should not feel so bad about the pain he has suffered losing his mother. I told him, "Now I am your mother and your father. I am serving as both for you now." And he told me, "I will do everything for you as my father." He is so pleased I called him to be with me. The care that was given to him here was 100 percent.

Now that my son is free of Ebola we will make a life for ourselves. He is 16 now, so I will make him my friend. Not just my son, but my friend, because he's the only one I have to talk to. I cannot replace my wife, but I can make a new life with our son.

Kollie James is the 1,000th survivor cared for in MSF's Ebola treatment centres across Guinea, Sierra Leone, and Liberia since MSF began responding to the Ebola outbreak in West Africa in March 2014.

Close to 3000 MSF staff are working in the region, including some 250 international staff.

COMMENT

Health on the hill

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Primary health ambitions central to Medibank's sales pitch

Medibank Private's push into primary health care and its efforts to screw down on payments to private hospitals are at the centre of its sales pitch to investors as the sell-off process enters its final stages.

In its Share Offer prospectus released to the market last week, the insurer flagged an increasingly aggressive approach to containing growth in costs, including through a controversial plan to intervene in the provision of primary health care.

More than 750,000 people, including almost 279,000 Medibank Private policyholders, have pre-registered their interest in the float, with shares expected to be sold for between $1.55 and $2 each, suggesting the privatisation could raise between $4.3 and $5.5 billion for the Commonwealth.

But demand for the shares will be heavily influenced by the extent to which management plans to drive down costs and boost profits are deemed credible by the markets.

The insurer's task has been made harder by Private Health Insurance Administration Council figures which show the sector is struggling to contain rising benefit costs.

According to PHIAC, before tax profits across the industry fell 2.2 per cent last financial year because a 7.5 per cent lift in revenue was overshadowed by an 8.1 per cent jump in payouts.

In its sale prospectus, issued on 20 October, Medibank Private's management team predicted a 10.5 per cent jump in operating profit this financial year, primarily due to higher health insurance revenue and continued success in pushing down costs.

Overall, the insurer predicts its gross operating profit will rise to 4.9 per cent, from 4.4 per cent last financial year and 3.4 per cent in 2012-13.

To achieve this improvement, the fund expects to do better at holding down costs, including by becoming much more involved in the provision of primary care and through striking better deals with private hospitals and other health service providers.

In a statement of intent that has underlined warnings from AMA President Associate Professor Brian Owler about the ambitions of health insurers to intrude on the doctor-patient relationship and move the country toward a US-style system of managed care, Medibank said a key focus was to limit claims growth.

"Medibank Private, like many other funders in the Australian health care industry, is increasing its focus on managing the growth in claims expenses through a number of strategies, including those aimed at supporting primary care givers such as GPs to better prevent chronic diseases," the insurer said.

Medibank said it was particularly looking at those it described as "high-needs" policyholders, reporting that about 2.2 per cent of all those it insured accounted for 35.2 per cent of all claims between 2010 and 2013.

"Medibank Private is starting to work with these policyholders, initially with a small group, to provide them with support to improve their health," the insurer said. "By supporting these policyholders and their primary care givers to achieve better health outcomes, Medibank Private intends to reduce related claims expenses."

In July, A/Professor Owler warned that the stage was being set for managed care, in which health funds would seek to intervene in the doctor-patient relationship and try to influence or dictate clinical care – something that insurers publicly deny.

On the management side, Medibank Private's executive team led by Chief Executive George Savvides, has achieved some success in recent years in driving down the cost of its operations. Management costs as a proportion of net asset value, while still above the health industry norm, have shrunk from 10.2 per cent in 2011-12 to 9.2 per cent in 2012-13 and 8.7 per cent last financial year – compared with 8.4 per cent for the rest of the industry.

But the insurer has also got big ambitions to rein in claims expenditure, particularly payments to private hospitals, which amounted to around $2 billion last financial year.

In its prospectus issued last week, Medibank Private indicated it will take an increasingly hard line approach in its dealing with private hospitals, which constitute the bulk of its business relationships.

The insurer said that, when negotiating arrangements with private hospitals, it will not only look at the price it pays for services, but also the quality of patient care provided and the extent of demand for the services provided by a particular hospital.

The fund is also expected to look closely at offering more slimmed-down insurance cover, such as policies with a low claim limit and restricted range of services provided through its budget policy arm ahm.

The float is expected to draw considerable interest because of Medibank Private

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strategic position as the nation's largest health insurer – it has 29.1 per cent of the market, with 1.9 million policyholders and 3.8 million people insured – and the long-term growth prospects for the health sector.

Retail investors have until 14 November to bid for shares, with the final allocation announced on 25 November, when conditional trading will commence on the Australian Securities Exchange. Normal, unconditional trading is due to commence on 5 December.

Adrian Rollins

COMMENT

Medibank struggles to make a buck out of Defence deal

Medibank Private has barely turned a profit out of its controversial $1.3 billion contract to provide health services for Australian Defence Force personnel.

As preparations advance for the sale of the Government-owner insurer, it has been revealed that the fund's Complementary Services arm (which includes the former Medibank Health Solutions) suffered a $3.6 million loss in the first year of the Defence Force contract, and a bare $1.6 million profit the following year.

The lacklustre result has been detailed in the Medibank Private Share Offer prospectus sent out to potential investors last week, ahead of the company's planned float.

So far, it is a meagre return for a contract that Medibank boasted "leveraged its core capabilities".

In fulfilling the terms of the ADF Health Services contract, Medibank said it managed and coordinated more than 1100 on-base health workers (a task subcontracted to Aspen Medical Services), as well as a network of 4300 specialists, 254 hospitals and more than 8300 allied health practitioners to serve 60,000 permanent and 20,000 reservist uniformed personnel.

The contract has been dogged by controversy. Many specialists who had provided long-standing care to Defence Force personnel refused to agree to service provision requirements set in place by Medibank, and late last year there were widespread complaints of late payment for services provided.

In its prospectus, Medibank admitted it incurred more than $13 million in management expenses to implement the contract, but claimed a major improvement last financial year with a $5.2 million turnaround in financial performance to deliver the $1.6 million profit.

Time is running thin for the insurer to realise a significant profit out of the four-year contract, which expires in October 2016, unless the Commonwealth invokes a clause allowing for up to two one-year extensions of the deal.

Adrian Rollins

COMMENT

Govts back historic cannabis trial

Medicinal cannabis should be subject to the same safety and efficacy tests as any other drug before being made available on the Australian market, according to the AMA.

As the New South Wales Government works through the details of the nation's first-ever clinical trial of medicinal cannabis, the AMA has warned against the legalisation of the raw dope plant, or any oils and tinctures made from it, and urged that only fully-tested cannabis-based medicines should be considered for use.

In a significant development for those who argue cannabis is effective in alleviating chronic pain and providing relief from symptoms including nausea and muscle spasms and should be legalised, the NSW Government has secured the support of the Commonwealth and its State and Territory counterparts to trial the use of cannabis for medicinal purposes.

"NSW wants to better understand if and how medicinal cannabis can help improve quality of life for seriously ill patients," NSW Premier Mike Baird said.

The issue of medicinal cannabis was discussed at a Council of Australian Governments meeting on 17 October following a long-running campaign by advocates who claim it has been effective in helping many patients including those with cancer, terminal illness or conditions such as multiple sclerosis.

Prime Minister Tony Abbott has voiced support for the use of cannabis for medicinal purposes, and has instructed Health Minister Peter Dutton to be "as helpful as he can be" in supporting the NSW trial.

"No one will be tougher on drugs than I will be," Mr Abbott said. "But, just as we have long used various opiates for medicinal purposes…they play a very important part in pain relief…let's see what we can do with medical marijuana."

AMA Victoria President Dr Tony Bartone told the ABC's *Background Briefing* program the AMA was not opposed to the use of cannabis for medicinal purposes, but only in forms and applications proven to be effective.

"We are in no form ... looking at the crude plant and legalising the plant for medicinal

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purposes," Dr Bartone said, warning that there were great variations in the composition of leaves not commercially grown and harvested that could expose users to harm.

"What we are seeking to do is exactly what any other new medicine would be required to do coming onto the market," he said – to be tested by the Therapeutic Goods Administration.

The NSW Government has formed a Working Group to advise by the end of the year on the design and scope of the clinical trial, as well as the best way to make safe and effective cannabis products available.

"NSW is playing a leadership role, but our historic agreement to work collaboratively on this significant issue means we have a far greater chance of success," Mr Baird said.

The AMA has urged that trial focus on cannabis-based pharmaceutical products already being used commercially in overseas markets.

These include medicines that contain a synthetic version of Tetrahydrocannabinol, the main mind altering molecule in cannabis, and the drug Sativex, made from an extract of the cannabis plant. Sativex is already approved by the TGA, but only for use in the treatment of spasticity in muscular sclerosis.

Dr Bartone said the clinical trials could include testing the application of Sativex to a range of other medical conditions.

But the cautious approach urged by the AMA has been criticised by those who claim it is denying relief for thousands unnecessarily.

Australian Greens health spokesman Dr Richard Di Natale said extensive international experience demonstrated the benefits of medical cannabis.

"I welcome the fact that every Government in the country now recognises that we need to change our approach to medicinal cannabis, but a trial alone is not enough," Senator Di Natale said.

The Senator said that while it made sense to subject anecdotal claims made for medicinal cannabis to clinical tests, there were many instances where its efficacy was well established and should be approved immediately.

"There is already overwhelming international evidence that medicinal cannabis can provide relief from conditions like nausea, pain and muscle spasms," he said. "Medicinal cannabis should be made available for those conditions where it has been proven to be effective now, without delay, without trial."

His urgings appear to have the backing of the Prime Minster, who last month questioned the need for Australian authorities to clinically test medicines already approved by medicine watchdogs in countries such as the US or Europe.

Adrian Rollins

COMMENT

Getting high a bad trip for young minds

Young people who regularly light up a joint are putting themselves at risk of serious mental health problems that could devastate their lives, researchers have found.

As the nation begins preparations for its first-ever clinical trial of medicinal cannabis, two separate studies have underlined the potential dangers posed by recreational use of the drug, finding that teenagers who are regular users are more likely to drop out of school, become dependent on it or other drugs later in life, and be at far greater risk of developing psychotic disorders or attempting suicide.

An Australian-led inquiry by the Cannabis Cohorts Research Consortium, published in T*he Lancet Psychiatry*, has found that the more teenagers regularly smoked cannabis, the greater the chances they would leave school early, flunk a degree, develop an illicit drug habit or try to kill themselves.

The investigation, which aggregated data from three large longitudinal Australia and New Zealand studies involving between 2500 and 3765 subjects each, looked at the frequency of cannabis use among teenagers younger than 17 years, and how they fared up to the age of 30 years.

The researchers, led by Dr Edmund Silins, found "clear and consistent associations…between the frequency of adolescent cannabis use and all adverse young adult outcomes".

In particular, they found those who were daily users were little more than a third as likely to finish school or complete a degree as those who abstained, were almost 18 times more likely to be drug dependent, and seven times more likely to attempt to commit suicide.

In further evidence of the potentially devastating effects of cannabis on young brains, a separate study by Professor Wayne Hall of King's College London linked cannabis use to long-term mental health problems as well as a range of other serious effects.

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Professor Hall's study, published in the journal Addiction, found that cannabis use doubles the risk of developing psychotic disorders such as schizophrenia, as well as impairing intellectual development, substantially increasing the chances of a car accident and making the development of cancer, bronchitis and heart disease more likely.

Researchers said the findings showed that any change to laws regulating the use of cannabis should be carefully considered.

"Prevention or delay of cannabis use in adolescence is likely to have broad health and social benefits," Dr Silins and his colleagues wrote. "Efforts to reform cannabis legislation should be carefully assessed to ensure they reduce adolescent cannabis use and prevent potentially adverse developmental effects."

Mark Winstanley, of the UK charity Rethink Mental Illness, told the Adelaide Advertiser that "too often cannabis is wrongly seen as a safe drug but…there is a clear link with psychosis and schizophrenia, especially for teenagers".

Adrian Rollins

COMMENT

Less-than-local replacement for Medicare Locals

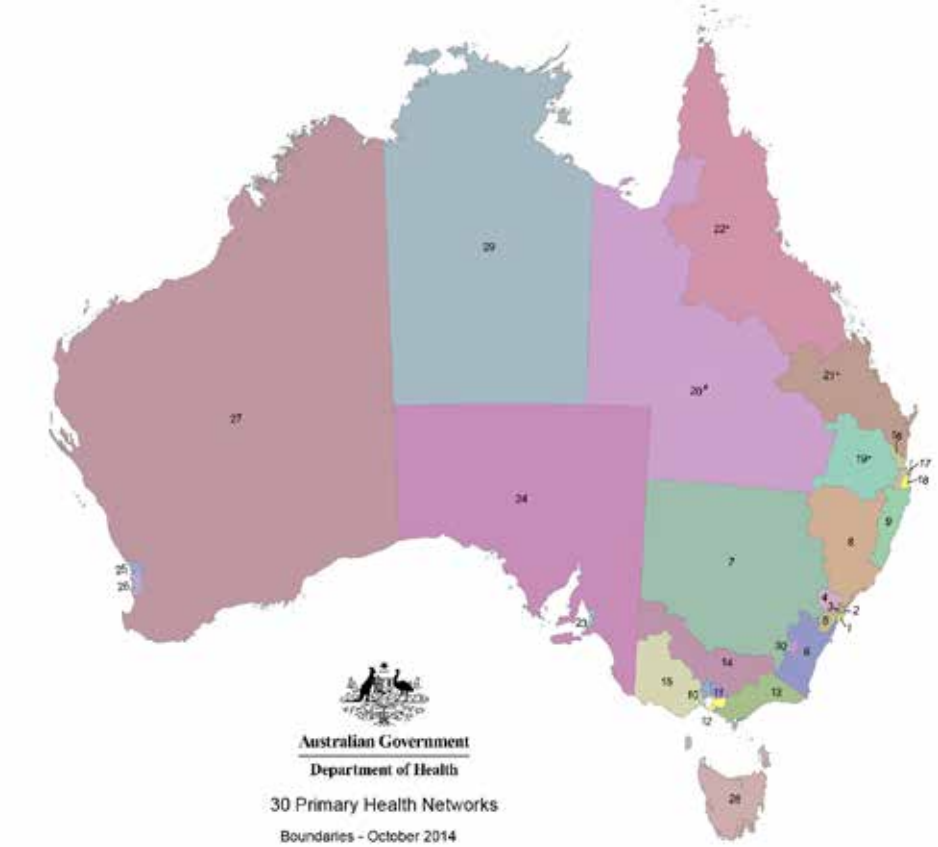
One of the Federal Government's new Primary Health Networks will span a massive 2.2 million square kilometres under boundaries drawn up by the Health Department.

Federal Health Minister Peter Dutton has announced that 30 Primary Health Networks will be established to replace 61 Medicare Locals as part of the Government's overhaul of arrangements to support primary health services nationwide.

The overhaul was prompted by widespread dissatisfaction among GPs with the operation of Medicare Locals, and Abbott Government claims that the system established by Labor was top heavy and consumed funds in administration rather than being directed to frontline care.

The AMA has welcomed the move to dump Medicare Locals, and said it was prepared to work closely with the Government to ensure the PHNs were an effective replacement.

"What we're trying to do in primary care is actually have coordinated primary care with the GP at the centre," AMA President



Associate Professor Brian Owler said. "That is the whole role of the Primary Health Networks that have been established. The AMA wants PHNs to be better targeted and more driven by family doctors at the local level."

The Government announced the establishment of PHNs from 1 July 2015, in line with the recommendations of the Horvath Review, which examined the performance of Medicare Locals.

The Horvath Review found that the performance of Medicare Locals had been highly variable, had generally failed to engage with local GPs, had tended to duplicate existing services, and had failed to resolve problems with fragmented and disjointed primary health care.

The AMA has proposed that that PHNs focus on identifying community health needs and gaps in service delivery and improve the capacity of general practices to provide care by providing IT support, education and training assistance, support for e-health use and facilitate engagement with Local Hospital Networks.

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A/Professor Owler said that evidence from countries such as New Zealand showed that GP leadership and input was vital for PHNs to be effective.

"GPs are generally the first point of call in the health system and they can provide high quality clinical input as well as first-hand knowledge of where improvements in the health system need to be made," A/Professor Owler said.

"While some Medicare Locals have clearly done a good job in improving access to care, the overall Medicare Local experiment has clearly failed – largely due to deliberate policy decisions to marginalise the involvement of GPs," he said. "We can't afford to get it wrong a second time, and the AMA stands ready to work with the Government to ensure that PHNs are an effective and integral component of the health system."

Mr Dutton said the PHNs would align with Local Hospital Networks and deliver efficiencies that would free up resources for service providers.

"Primary Health Networks will deliver better health outcomes for Australians over time by improving the links between local health services and hospital care, and through the better targeting of available funding on effective health programs," the Minster said.

With the new boundaries, 17 Medicare Locals in NSW will be replaced with nine PHNs, while in Victoria 17 Medicare Locals will be replaced by six PHNs. Queensland will have seven PHNs, Western Australia's eight Medicare Locals will be collapsed into three PHNs, and South Australia will have two PHNs, down from five Medicare Locals. The smaller jurisdictions, Tasmania, the Northern Territory and the ACT will each have a single PHN.

Some PHNs will encompass vast territory – in both WA and South Australia, there will be one PHN covering all areas outside the state capitals, and in both NSW and Queensland a single PHN will be responsible for each State's enormous western expanses.

The huge swathe of ground these PHNs will have to cover has sparked concern in some regional areas.

Deputy Chief Executive Officer of Western New South Wales Medicare Local, Steven Jackson, told the ABC he was worried the vast size of the PHN covering most of the central and western areas of the State would pose serious logistical challenges and might exacerbate chronic problems regarding access to care.

"Six different Medicare Locals are affected into that one area, so we're in discussions about all six of those and three local health districts so we have to get in discussions there," Mr Jackson told the ABC.

He said there was disappointment about the abolition of Medicare Locals in the area "because that's what we've been working towards and we believe making a good job of".

In Western Australia, local rural primary health care organisations have already been in discussions in anticipation that there would be one PHN to cover the entire non-metropolitan area of the huge State.

Kimberley-Pilbara Medicare Local Chief Executive Officer Chris Pickett told *Medical Observer* operating a single PHN to serve such a vast area would be a huge practical challenge.

"It will be about 2.2 million square kilometres, so it is going to be extremely challenging logistically, and in terms of getting from A to B, but we will make a fist of it," Mr Pickett said.

Together, his and other rural WA primary health organisations have formed the West Australian Regional and Remote Health Association, which will bid to operate the PHN in the hopes of ensuring it will have strong rural governance.

Aside from the scale of some PHNs, there is also uncertainty about what they will do.

"We're still waiting for the details of the PHN to outline just how they will function so there's been discussion but there isn't any concrete paperwork to give us guidance of how it's going to work," Mr Jackson said. "So, at the moment we have boundaries and we can make assumptions."

According to the Federal Government, PHNs will have five primary roles, including analysing and planning for the health needs of their local communities; assisting general practices in keeping their patients out of hospital; supporting general practices in improving safety and quality of care; helping them establish and operate e-health systems; and purchasing or commissioning clinical services for population health issues such as chronic disease and mental illness.

"Primary Health Networks will be clinically focused, with general practice at the heart of improving the delivery of primary health care in Australia," Mr Dutton said.

Assistant Health Minster Fiona Nash told the ABC that PHNs would be given a clear set of guidelines, including that they would not operate as service providers except on rare occasion.

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"They're going to be regional purchasers of health services, and providers only in the exceptional circumstances," Senator Nash said. "What we saw under the Medicare Locals was the fact that, from the outset, there was no clear picture for them.

"A lot of the Medicare Locals were saying to me they didn't know what they were supposed to be doing. [Primary Health Networks are] going to have a really clear picture of what we expect."

Tenders to operate PHNs will be invited later this year, with the successful applicants to be announced next year in time for them to be given around three months to set themselves up. They are due to begin operations on 1 July 2015, when Medicare Locals will be officially abolished.

Senator Nash said it was anticipated that several Medicare Locals will tender to operate PHNs.

"There will be some of the existing entities that put in a bid, I've been talking to some people that are putting a consortia together," the Minister said. "I think we'll see some really innovative ways to make sure we've got that regional health delivery."

Adrian Rollins

COMMENT

Dust flies over PM's coal comments

A group of doctors have lambasted Prime Minister Tony Abbott over his endorsement of coal as "good for humanity".

The group, Doctors for the Environment Australia, has written to Mr Abbott to voice its strong objections to the comment, which it said ignored a mountain of evidence that burning coal to produce energy poisoned the atmosphere and was contributing to climate change.

Opening a $3.9 billion coal mine in central Queensland, Mr Abbott said that "coal is good for humanity".

"Coal is good for prosperity, coal is an essential part of our economic future, here in Australia, and right around the world," the Prime Minister said. "Coal is essential for the prosperity of the world. Energy is what sustains our prosperity, and coal is the world's principal energy source, and it will be for many decades to come."

Mr Abbott's endorsement of coal as an energy source has drawn a sharp rebuke from environmentalists and others who accuse his Government of undermining local and international efforts to tackle climate change.

Earlier this year the Abbott Government succeeded in ditching the unpopular carbon tax introduced by Labor, and has sought to wind back support for renewable energy.

Doctors for Environment Australia Chair Dr Kingsley Faulkner said the Prime Minister's comments about coal directly contradicted "all available public health evidence".

In a letter to Mr Abbott, Dr Faulkner said there was "ample evidence" about the harm caused by coal, including estimates in the United States that 23,000 people a year die prematurely because of air pollution from burning coal.

He said coal had been "incontrovertibly linked" to climate change, which "is now recognised as the greatest threat to our health this coming century".

"If we are genuine about acting in the best interests of humanity, then our focus must be to assist developing countries with renewable energy technology and rapidly de-carbonise our economy.

"In light of these facts, it was very disturbing to health professionals to hear the statements made by you regarding coal," Dr Faulkner's letter to Mr Abbott said. "It is unacceptable to trade Australia's public health for short-term economic benefit…Yet this is exactly what your Government is promoting."

Adrian Rollins

COMMENT

PM admits thousands to forego tests because of co-payment

Thousands of potentially deadly illnesses may go undetected until they are well advanced because of the Federal Government's $7 co-payment for diagnostic imaging services and other Budget measures, it has been claimed.

As the Federal Government continues to struggle to secure the support it needs to introduce its co-payment, Prime Minister Tony Abbott has admitted that there are likely to be a million fewer diagnostic imaging tests each year, many of them for potentially fatal conditions such as breast cancer and liver metastasis, by 2017.

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Health on the hill

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Asked by Opposition Leader Bill Shorten in Question Time last week whether he was aware of estimates there would be 680,000 fewer such tests in 2015-16 and about one million less by 2017, the Prime Minister said that "the short answer is yes and yes".

"We were advised in the lead-up to the Budget that, as a result of the decision by the Government to…seek to have a modest co-payment for visits to the GP and visits to the diagnostician, there could be a 1 per cent reduction in the total usage of these services," Mr Abbott told Parliament. "At the moment, there are well over 100 million GP visits a year, and about a 1 per cent reduction to these services was the estimate we were given."

The AMA and other groups including the Australian Diagnostic Imaging Association have for months warned that the introduction of a $7 co-payment, together with other changes including $5 cut to Medicare rebates, the axing of bulk billing incentives and an end to subsidies for high cost PET and CAT scans, will push the cost of some diagnostic imaging tests out of the reach of many patients, putting lives at risk.

The ADIA has warned that patients may have to stump up $380 for a CAT scan, up to $160 for a mammogram, $190 for an ultrasound and up to $1000 for a PET scan.

Asked in Parliament by Shadow Health Minister Catherine King about ADIA estimates that general patients might be charged up to $2207 for a liver metastasis diagnosis, Mr Abbott responded that "in the end, what people are charged is a matter for the doctors".

Ms King said the Government's policy could have potentially disastrous consequences for patient health.

"Mr Abbott has confirmed that, when announcing the GP tax, he was well aware that for many general patients, those sorts of costs will be unaffordable, and they will be forced to skip crucial tests and treatments," she said. "Those who do miss important scans are likely to get sicker, require even more extensive treatment, and end up costing the health system much, much more."

The Government so far withheld legislation for its co-payment model as it tries to negotiate support for the measure from key crossbench Senators. Its plan has been rejected by Labor, the Australian Greens and the Palmer United Party.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

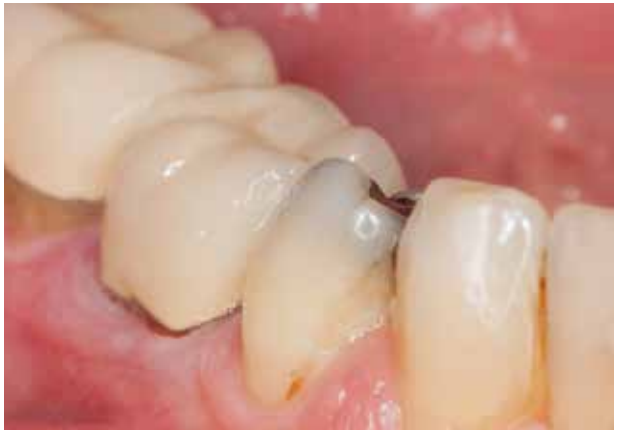
In addition, there is a State/Territory tab, with information and forms specific to each jurisdiction, such as WorkCover and S8 prescribing.

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

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

Research

The dirty secret behind the winner's grin



The next time you see an elite athlete beaming from the top of a podium, try to get a close look at their teeth.

Chances are, their mouth will be in a lot worse shape than their abs.

A high-level investigation has found that top athletes suffer from disturbingly high rates of tooth decay and gum disease, to the extent that it has hampered their sporting performance.

A review of 39 published studies on the oral health of elite or professional athletes has found that three-quarters have tooth decay, up to 15 per cent experience moderate to severe gum disease and up to 85 per cent suffer enamel erosion.

The findings complement the results of a survey of competitors at the 2012 London Olympics where 18 per cent reported that at some point in the past their athletic performance had been affected by problems with their teeth.

Co-leader of the research, University College, London Professor Ian Needham, said dental problems could hamper sporting achievement by causing pain and inflammation, disturbing sleep, affecting eating and undermining confidence.

While the could be many causes of such poor oral health, Professor Needham and his co-authors said sports drinks, high-carb diets and intense training regimens were at least partly to blame.

Sugary and highly acidic energy drinks are notoriously bad for teeth, while high-carbohydrate diets can boost decay-causing bacteria. These problems are compounded by the fact that athletes often operate at the edge of dehydration, limiting the production of tooth-protecting saliva.

"We do not want to demonise energy drinks, and are not saying that athletes shouldn't use them," he told Agence France Presse. "However, people should be aware of the risks to oral health, and can take simple measures to mitigate these."

The researchers said athletes who consume a lot of energy drinks should brush regularly, preferably with a high-fluoride toothpaste, and spit rather than rinse after teeth cleaning.

"Oral health could be an easy win for athletes, as the oral conditions that can affect performance are all easily preventable," Professor Needham said. "Simple strategies to prevent oral problems can offer marginal performance gains that require little or no additional time or money."

The study has been published in the *British Journal of Sports Medicine*.

COMMENT

Adrian Rollins

INFORMATION FOR MEMBERS

Compulsory super increase

Employers have been reminded of an increase in the compulsory minimum superannuation contributions they are required to make on behalf of eligible employees.

The Australian Taxation Office has issued an alert that the first quarterly contribution following the mid-year increase in the Superannuation Guarantee rate from 9.25 to 9.5 per cent is due by 28 October.

"Employers must pay super guarantee contributions for each eligible employee at least four times a year, and the first contribution needs to be paid by 28 October," ATO Assistant Commissioner Emma Haines said.

Adrian Rollins

Golden Grampians a journey into Australia's rich wine history

BY **DR MICHAEL RYAN**

If you venture a little further past the 'dress circle' of Melbourne wineries, you start to discover the intertwined pathways of rural development, gold discovery and grape growing. One such area is the Grampians, some two-and-a-half hours west of Melbourne, and which includes towns like Ararat, Great Western and Stawell.

It is an area I know well, given my wife's family has a sheep farm in the region. The early days of travel from Queensland to Victoria seemed such a drudge until I discovered the area, with its many great wineries, in relatively close proximity to Melbourne. VB and Carlton Draft were quickly replaced by Best Bin 0 Shiraz, Seppelts St Peters Shiraz and others.

The wines in the area vary according to the micro-climate and locale.

Having said that, Grampians Shiraz is somewhat consistent, with well-developed dark fruits – though it has white or black pepper notes, depending on vintage conditions. Among the whites, aromatic Riesling is probably the most consistent variety, and exhibits lovely florals and acidity.

Some of the oldest vines exist in these areas and are quite diverse; including, for example, Vermintino, Dolcetto, and Menieur.

The more recognized wineries in the area, such as Seppelts, Bests, Mt Langhi Ghiran and Montarra, produce top shelf table wines. But there are also a number of emerging stars, such as Mt Cole Wineworks, Grampian Estate and Michael Unwin wines.

Seppelts, with 150 year-old vineyards, is best known for benchmarking Australian sparkling wines, and has won many accolades overseas. They practically invented sparkling Burgundy.

It is rumored Dame Nelly Melba wanted to take a bath in champagne, so the boys at Seppelts obliged by filling a tub up with 213 bottles of fizz. It is rumored that when she had finished the wine was too good to waste so it was rebottled, and they ended up with 214. Work that out.

There is a palpable sense of history at Bests of Great Western, established in 1893.

It's semi-retired winemaker Viv Thompson is a true gentleman of the industry. He has handed the reins to the fifth generation of the family to run the place, his son Ben Thompson. When Viv takes you on a guided tour of the winery, it is akin to a mother hen tending her developing hatchlings.

For accommodation, the renowned Royal Mail Hotel in Dunkeld stands as a beacon to the weary traveler. High class rooms, degustationmenus and a 100-plus page wine list that always ranks top five in Australia.

It's a great place to use as a base for your travel in the region which, if you want to do something quirky, can also include a visit to Ararat's notorious J Ward, which at one time served as an asylum for the criminally insane. While in Ararat, there are plenty of good eateries to check out.

COMMENT

RECOMMENDED WINES

1. **Best's Great Western Bin 0 Shiraz 2012**
   Colour - deep red to purple
   Nose - spicey plums and floral notes, with French oak influences and hints of leather
   Palate – big, juicy wine from fruit oak and tannin integrated. A splendid drink now, but leave seven to nine years to peak. Have with steak tartare.

2. **Mt Cole Fenix Rising Shiraz 2010** - Owned by colleague Dr Graham Burtuch, this is an award-winning wine.
   Colour - deep red/purple
   Nose - dark berries, savoury notes and white pepper
   Palate – luscious, with a lingering tannic finish. 10 year keeper. Have with game pie.

3. **Seppelt Great Western St Peter Shiraz 2012**
   Colour - very dark purple
   Nose - savoury dark fruits, more spicy and peppery than most local Shiraz
   Palate - controlled fruit expression. Tannins and oak effect a balance of fruit flavors. Still very young. Leave at least five years to make full sense of this wine. Have with smoked beef strips.

4. **Michael Unwin Tattooed Lady Shiraz 2012**
   Colour - medium red
   Nose - more cherry and lighter fruits, but elegant rose petal nuances with white pepper
   Palate – abundant fruit that is balanced well with its own medium body structure. Quite a velvety and 'drink now' wine. Have with crispy skin Vietnamese duck.