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AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

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AMA LEADERSHIP TEAM

President
Associate Professor
Brian Owler

Vice President
Dr Stephen Parnis

VICE PRESIDENT'S MESSAGE

BY AMA VICE PRESIDENT
DR STEPHEN PARNIS

Obesity – a major national health problem

Few things are as confronting or anxiety-provoking as winding up in a hospital emergency department cubicle.

As an emergency physician, I manage medical conditions which cover the entire spectrum – babies with a fever, through to the frail elderly who have had a fall or become confused. A cricketer with a soft tissue injury may be followed by a middle aged man with severe chest pain and a heart attack. It's never boring, and it's always challenging.

An essential part of emergency medicine – and indeed most medical practice – is understanding the factors which led to the presentation. Some are obscure, but many are apparent on a regular basis. I assess risk, and know that some of them are unavoidable, such as getting older or inheriting genetically determined risk factors.

However, there are many risk factors which are environmental. It is a matter of regret that they could have been minimised or avoided altogether – and lead to longer, healthier lives.

Most Australians know that these factors include smoking, alcohol misuse, overweight and obesity, and overexposure to the sun. It is no coincidence that these are recurring themes in the AMA's public health agenda.

Earlier this month, I spoke at a forum on the need for a national strategy to deal with obesity.

More and more, we are seeing people who, for a range of complex reasons, have become dangerously overweight or obese. As a result, they are at a greatly increased risk of major health problems such as diabetes, cardiovascular disease, arthritis, and even a number of cancers.

“Most Australians know that these factors include smoking, alcohol misuse, overweight and obesity, and overexposure to the sun. It is no coincidence that these are recurring themes in the AMA's public health agenda”

The statistics are well known, but bear repeating: two-thirds of Australian adults, and a quarter of children, are overweight or obese.

It has become the exception for Australians to be of healthy weight.

The greatest thing about my work is, quite simply, the opportunity to care for people when they are at their most fragile and vulnerable. I get to relieve pain, make challenging diagnoses, and save life. But my strong preference, whenever possible, is to prevent or mitigate the impact of disease in the first place.

The advice given to patients by their GP can often be a difficult pill to swallow. Advice regarding healthy lifestyles is received in many different ways, and the reasons for success or failure are often elusive. I try to play my part in the emergency department by being objective, empathetic, and practical in what I advise.

At a national level, it is clear that if we continue with increasing rates of obesity, the harms will inevitably follow. We face the very real prospect of life expectancy declining for the first time in centuries.

So what is to be done?

Education and improved health literacy are an obvious part of the equation. But, although people should pay heed to what they do and what they eat, it is all too easy to dismiss the nation's expanding waistline as simply a matter of individual responsibility.

We need programs that educate parents about healthy eating for toddlers and young children. Children need to be taught about healthy food and eating patterns. We need to think about what we can do to help people avoid excessive weight gain during pregnancy. In this era of celebrity chefs, we encounter many who have never learned the basics about food preparation.

MORE P5

NEWS

Obesity – a major national health problem

... FROM P4

Ads for food that is full of sugar and fat, and not much else, saturate the television shows watched by millions of Australian adults and children. This happens because marketing works. But the problem goes well beyond television.

Food production companies, like their alcohol counterparts, are skilled at promoting their products through social media in ways that might astound those of us who are a little older.

We need to target the nexus between sport – particularly professional sport – and junk food. Fast food chains are major sponsors of sport at all levels, building brand loyalty and helping to normalise the overconsumption of their products.

In addition to issues surrounding our relationship with food, Australians have become far too sedentary, and for this we are also paying a price. We should make it easier for people to be active by thinking more carefully about how we plan and build our cities, suburbs and towns.

We need to make physical activity a healthy, life-long habit, and that means encouraging people to walk to the shops, cycle to work, take the kids to the park, to play team sports, and to move around more during their workday by building better workplaces and transport.

It is a sad reality that on weekends, I often see empty playgrounds and overcrowded shopping centre car parks.

So, better marketing regulation, improved health literacy and more effective town planning are just a few important and practical steps we could take right now, to improve health and reduce future health costs.

This year, the AMA has been working hard at ensuring obesity and other major public health issues such as alcohol and tobacco remain high on the national agenda.

Only a month ago, we convened the National Alcohol Summit to focus attention on the country's drinking problem, to highlight the damage being done, and to demand the implementation of a series of solutions.

There will be no let up next year.

The AMA is developing an ambitious public health agenda for 2015 covering all of these areas, as well as extending into road safety and head injury prevention, to do what we must to help build a healthier Australia.

COMMENT

INFORMATION FOR MEMBERS

AMA Indigenous Peoples Medical Scholarship 2015

Applications are invited for the AMA Indigenous Peoples Medical Scholarship 2015.

The Scholarship is open to Aboriginal and Torres Strait Islander people who are currently studying medicine, with the4 successful applicant receiving $10,000 year for the duration of their course.

AMA President Associate Professor Brian Owler said training more Indigenous doctors and health professionals was an important part of closing the health and life expectancy gap between Aboriginal and Torres Strait Islander people and the rest of the community.

"The AMA Scholarship aims to help increase the number of Aboriginal and Torres Strait Islander people in the medical workforce," A/ Professor Owler said. "Previous AMA Scholarship recipients have graduated to work in Indigenous and mainstream health services, and some have spent time providing care in their own communities."

Since 1994, the Scholarship has assisted more than 20 Indigenous men and women to become doctors – many of whom would not otherwise not have had the money needed to study medicine.

"Increasing the number of Indigenous doctors and health workers improves access to culturally appropriate health care and services, and ensures medical services respond properly to the unique needs of Aboriginal peoples and Torres Strait Islanders," A/ Professor Owler said.

Applications for the Scholarship must be received by 30 January, 2015.

To be eligible, applicants must be currently enrolled at an Australian medical school, be in at least their first year of medicine, and be of Australian Aboriginal and/or Torres Strait Islander background.

For more information, including how to apply, visit: https://ama.com.au/ama-indigenous-peoples-medical-scholarship-2015

NEWS

Government sent back to the drawing board on co-payment

Any move by the Federal Government to scrap bulk billing incentives as a way to gouge more money out of the health budget has been condemned by AMA President Associate Professor Brian Owler as a "direct attack on the most vulnerable".

> "Scrapping bulk billing incentives would be a direct attack on the most vulnerable people in our communities … It would be a direct attack on children, on the poorest people in our communities, and it would be a direct attack on Indigenous health. That sort of proposal must be ruled out"

There is speculation the Government is looking to strike a deal with the Palmer United Party to axe Medicare bulk billing incentives as its scrabbles for health savings after admitting defeat and dumping its widely-condemned $7 Medicare co-payment plan last week.

But in a pre-emptive strike, A/Professor Owler publicly called on Health Minister Peter Dutton and PUP leader Clive Palmer to rule out any such deal, and instead engage in considered and well-informed discussion on health policy.

"Scrapping bulk billing incentives would be a direct attack on the most vulnerable people in our communities," the AMA President said. "It would be a direct attack on children, on the poorest people in our communities, and it would be a direct attack on Indigenous health. That sort of proposal must be ruled out."

Currently, patients with a concession card or who are younger than 16 years attract a bulk billing of $6.25 in metropolitan areas, and $9.25 in the bush, when they see their GP. For pathology and diagnostic imaging services, the incentive is worth $6 in the city and $9.10 elsewhere.

With more than 82 per cent of GP services bulk billed, and almost 90 per cent of pathology services, it is estimated scrapping the incentive would save the Government at least $632 million a year, though it would mean children and concession card holders would face increased financial barriers in accessing health services.

A/Professor Owler made his call following an extraordinary two weeks in health policy dominated by contradiction, confusion and discontent within the Government's own ranks about the contentious co-payment policy.

Confusion arose when the Prime Minister's Office briefed journalists that the Government was dumping the $7 co-payment, only to have this directly contradicted by Treasurer Joe Hockey and Mr Dutton, who insisted the proposal remained very much Government policy.

The incident fed rumours of deepening divides within the senior ranks of the Government and brought incipient discontent among the ministers and Government backbenchers over the way the Prime Minister's office operated closer to the surface.

The sense of Government disarray deepened last week when it failed to win Senate support for its signature proposal to deregulate university fees.

In the wake of the humiliating defeat, Mr Dutton surrendered his ambitions to introduce the $7 co-payment and admitted the Government would have to substantially recast its health policy.

"It's clear that there's not support in the Senate for the current version of the co-payment that we put forward in May's Budget," the Health Minister told reporters. "But we continue discussions with the Senators, and we are confident that they will arrive at a compromise position which will help make Medicare sustainable."

Asked to confirm that the co-payment, in its original form, was dead, the Minister said that, "Well in its current form it is clear that the co-payment doesn't have the numbers in the Senate. But we have negotiations in train with the independent Senators, and I believe that we can arrive at a compromised position.

"But I'm not going to publicly canvass those options and those discussions."

MORE P8

Government sent back to the drawing board on co-payment ... FROM P7

The uncertainty is fuelling concerns that the Government will, either through negotiations with cross-bench senators or by regulation, make changes to Medicare that will hurt patients and rip money out of the health system.

"We saw last week the discussions around the co-payment," A/Professor Owler said. "Is it dead? Is it alive? Is it just resting? What I'm very concerned about is reports that there was a deal done between the Government and Clive Palmer to actually scrap bulk billing incentives."

"Clearly, the Government is deeply divided on what is a poorly designed policy measure, which affects general practice, pathology and radiology services," the AMA President said.

He said the AMA had developed an alternative proposal for a $6.15 co-payment backed by protections and safeguards for the most vulnerable so that only those who could afford it would be required to pay, and "I have advised the Government that I remain willing to talk to them about that proposal or other options that provide support for vulnerable patients, and that invests in general practices".

As part of its campaign against the Government's co-payment model, the AMA has urged its members to visit the Doctors4Health website (http://doctors4health.com.au/), which they can use to send a message to their local MP expressing their concerns about the co-payment.

As of late last work, more than 4000 messages had been sent to MPs as part of the campaign.

The AMA President said it was time for the Government to ditch its fiscally-driven approach to health policy and turn the discussion to policies that would improve health and the long-term sustainability of the health system.

"We need to have a much clearer discussion about health policy in this country," he said. "We need to stop talking about co-payments and go back to the drawing board, and start from scratch, and have a proper discussion about how we're actually going to engage in prevention, chronic disease management, and how we're going to keep the Australian community healthy."

University fee deregulation

While the future direction of health policy remains very uncertain, the prospects for aspiring medical students are a little clearer after the Government's proposal to deregulate university fees was rejected by the Senate.

The AMA had warned the policy could push the cost of a medical degree up to $250,000, potentially deterring many students who had the ability but not the financial resources to take on such a hefty debt.

After losing the Senate vote, Education Minister Christopher Pyne made amendments including reducing the interest on accumulated debt from the government bond rate to the consumer price index and stipulating that domestic students must face lower fees than their overseas counterparts.

But the PUP senators and independent Senator Jacqui Lambie, who were instrumental in having the original legislation voted down, indicated that they remained opposed to the legislation despite the amendments, giving the Government little hope of securing its passage.

Medical Research Future Fund

The apparent abandonment by the Government of its $7 co-payment plan has sparked concerns about the $20 billion Medical Research Future Fund.

But A/Professor Owler said this was a furphy because the money raised from the $7 co-payment was never going to go to the Fund.

Instead, under the Government's model, the $3.5 billion that would flow into the Fund's coffers was to have come from the $5 cut to Medicare rebates that was a central part of the co-payment model.

"The co-payment does not actually fund the Medical Research Future Fun," the AMA President said. "What funds the Medical Research Future Fund is actually a cut to the Medicare rebate of five dollars. That is the cut that actually provides $3.5 billion over four years, about five billion or so over the six years."

A/Professor Owler said the AMA supported the MRFF, but not the way it was to be partly funded by "taking money out of the pockets of patients going to the doctor in primary health care and putting it into tertiary-level research".

Adrian Rollins

COMMENT

NEWS

Cost already deterring many from seeing GP

Cost considerations are already deterring tens of thousands of Australians from seeing their GP, underlining fears that imposing a Medicare co-payment or axing bulk billing incentives will force hundreds of thousands to put off seeing their doctor.

An official survey has found that 4.9 per cent of adults delayed or avoided seeing the family doctor in 2013-14 because of cost, while almost 8 per cent put off seeing a medical specialist for the same reason.

The results, reported in the annual *Patient experiences in Australia* survey by the Australian Bureau of Statistics, adds weight to AMA concerns that the Federal Government's proposed $7 co-payment for GP, pathology and medical imaging services, will cause many patients to forego timely primary care, with the likelihood that they will eventually require more complex and expensive treatment – including hospitalisation – by putting off timely treatment.

More than 27,320 people aged 15 years and over were sampled for the survey, which found that 82 per cent of Australians saw their GP in the previous year, while one and three consulted a medical specialist.

Around a fifth reported be forced to wait longer than they felt acceptable to see their GP, while a quarter said they waited too long to see their specialist.

The AMA's concerns that the $7 co-payment could cause many to delay seeking timely treatment were echoed by a Senate Committee inquiring into the health system, which reported almost universal condemnation of the co-payment among medical experts, health providers and consumers.

In its first interim report released last week, the Senate Select Committee on Health said the "overwhelming sentiment of witnesses as that the $7 co-payment will have a negative impact on the health and wellbeing of all Australians".

It cited witnesses including Grattan Institute program director Professor Stephen Duckett, University of Technology, Sydney, academic Professor Jane Hall and Benetas policy officer Stephen Burgess that adding to the financial barriers facing people in accessing primary care would cost the health system more in the long term.

Committee Chair, Labor Senator Deborah O'Neill said the committee had heard submissions that hospital emergency departments would be log-jammed, and people would delay seeking treatment until it was too late, if the co-payment were introduced.

In its majority report, the committee said it was "deeply concerned by the substantial body of evidence it has received regarding the negative effects" of the co-payment, and recommended that it be immediately abandoned.

Adrian Rollins

INFORMATION FOR MEMBERS

Advance care planning service launched

The hopes of elderly Australians to determine how they are treated and how they will spend their final days have been given a boost with the launch of an advisory service for GPs and aged care workers.

The service, Decision Assist, has been developed with Federal Government funding and aims to assist those caring for older Australians, including doctors, nurses, and allied health professionals, by providing them with additional knowledge and skills about advanced care planning and palliative care.

Decision Assist Chair Associate Professor Bill Silvester said that Decision Assist service aimeds to help meet the wishes of older people to avoid hospital where possible, and help them stay in their community.

The service includes:

- a national hotline to assist GPs and aged care workers with information about palliative care and advice on advance care planning advice (**the hotline, 1300 668 908, will operate between 8am to 8pm seven days a week**);
- specialised training and workshops for GPs and aged care staff to enhance their knowledge and skills about advance care planning and palliative care;
- online resources and mobile applications to enable quick and convenient access to up-to-date end of life care information, as well as links to promote the co-ordination of care among service providers; and
- a dedicated website (www.decisionassist.org.au) containing detailed information on advance care planning and palliative care.

Kirsty Waterford

NEWS

Australia joins Ebola fight as epidemic slows

The first contingent of Australian health workers deployed under the Federal Government's contract with private provider Aspen Medical has arrived in Ebola-struck Sierra Leone.

A team of six doctors, eight nurses and three environmental health officers are currently undergoing in-country training and are set to begin working alongside around 200 local staff at a 100-bed British-built Ebola treatment centre at Hastings airfield, near Freetown, late this week.

AMA President Associate Professor Brian Owler, who has been a vocal critic of the Government's tardy response to the Ebola epidemic, which has so far left more than 6000 people dead, said he was pleased that Commonwealth-funded health workers were finally contributing to the international effort to tackle the deadly outbreak.

Australian doctors and nurses working for humanitarian organisations such as the Red Cross and Medecins Sans Frontieres have been in west Africa virtually since the outbreak began, but for months the Abbott Government rebuffed calls from allies and the international community to join the relief effort citing concerns about the logistical challenges of evacuating any Australian health workers who may become infected with the disease.

It eventually acquiesced last month, and engaged private health services firm Aspen Medical on a $20 million contract to staff and operate a 100-bed British-built Ebola treatment centre in Sierra Leone.

A/Professor Owler said he was satisfied with the Government's decision to contract Aspen to undertake the task following meetings with company officials and an inspection of its arrangements.

"I have had several meetings with Aspen officials, and have visited their headquarters in Canberra to get assurances about standards of training, equipment and care and evacuation arrangements should health workers become infected with the virus," he said. "The AMA is satisfied with the organisation of the deployment and the opportunity that has been provided for the hundreds of Australian health workers who want to volunteer to provide care and save lives."

Under an arrangement struck with British authorities, any Australian staff who contract Ebola will be treated at a British-operated hospital in nearby Kerry Town dedicated to treating international health workers

The risk of infection is far from negligible. By early this month, 622 health workers had been infected with Ebola, 346 of whom had died, according to the World Health Organisation.

But, significantly, a substantial proportion of infections did not occur at Ebola treatment centres but at other health facilities, underlining the need to adhere to infection control measures in all health settings, the WHO said.

By the end of last month, Aspen had received 400 expressions of interest from health workers, and 200 had lodged formal applications.

While Australian health workers are expected to comprise only a fraction of the 220 staff needed to operate the treatment centre at any one time, because they will each serve six-week rotations (including two weeks of in-country training), and because the deployment is expected to last months, if not years, Aspen has said it will need a substantial pool of workers to draw upon.

While Aspen is gearing up the Australian effort, other countries, most notably the United States, Britain, China and France, are continuing to build on their contributions.

US President Barack Obama has asked Congress to approve a further $US6 billion in emergency aid to fight the outbreak, while the UK and China are building more Ebola treatment centres – though charity MSF has warned the international effort is still falling short of what is required.

MSF International President Dr Joanne Liu said it was "extremely disappointing" that countries with biological disaster response capabilities had not yet chosen to use them.

Nonetheless, the Australian deployment has come amid signs progress is being made in containing the outbreak, particularly in Guinea and Liberia.

MORE P11

Australia joins Ebola fight as epidemic slows

... FROM P10

Signs outbreak is stabilising

In its most recent update, the WHO struck a cautious but hopeful note in its assessment of the outbreak, reporting that the rate of new infections had stabilised in Guinea and Liberia in the past five to six weeks, though transmission of the virus in Sierra Leone remained "intense", and it has spread to Mali, where at least seven people are confirmed to have been infected.

In Guinea, where 1327 people have died, there were 77 new cases in the last week of November, down from 148 the week before, while in Liberia – where 3145 people have died – there were 48 cases in late November, down from 78 the previous week.

The situation in Sierra Leone remains much more concerning, where there were 537 new cases in the last week of November (up from 385 the previous week), including 202 in the capital, Freetown.

Confidence about bringing the outbreak under control has been boosted by a build-up of resources.

The WHO said each of the three west African countries hardest hit by the disease now had sufficient facilities to isolate and treat at least 70 per cent of all new Ebola infections, to conduct laboratory tests within 24 hours and to safely bury 70 per cent of all who die from Ebola – each of which were considered key benchmarks in stemming the epidemic.

"At a national level, there is now sufficient bed capacity in Ebola virus disease (EVD) treatment facilities to treat and isolate all reported EVD cases in each of the three countries, although the uneven distribution of beds and cases means there are serious shortfalls in some areas," the Organisation said. "Similarly, each country now has sufficient and widespread capacity to bury all reported EVD-related deaths."

Despite this progress, the disease remain deadly for many of those who catch it.

The WHO reported a case fatality rate across west Africa of 72 per cent among all confirmed cases, and it was still a high 60 per cent among patients who were hospitalised.

In addition to those who fall ill, the disease is also taking a heavy social and economic toll.

Almost half of Liberians who had a job when the outbreak started are now unemployed, and the World Bank said the disease had crippled the economies of affected countries.

In estimates released last week, the World Bank said Sierra Leone's growth rate had tumbled from 11.3 per cent before the outbreak to 4 per cent now and a likely minus 2 per cent next year, while Liberia's growth rate had been slashed from 5.9 per cent to 2.2 per cent now and 3 per cent next year, and Guinea's had been cut from 4.5 per cent to just 0.5 per cent, and was likely to drop to minus 0.2 per cent in 2015.

Adrian Rollins

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

NEWS

Doctors asked to look out for victims of violence

GPs and other doctors have been urged to look out for tell-tale signs of domestic violence amid mounting national alarm over the extent to which women and children are being assaulted in the family home.

A series of recent brutal assaults, including the bashing murder of 11-year-old Luke Batty at the hands of his father in February and the stabbing death of Fiona Warzywoda by her estranged partner Craig McDermott in April, have helped focus national attention on violence against women.

Alarming statistics show that, on average, one woman is killed every week by a current or former partner, and a third of all women have been physically or sexually attacked by someone known to them.

To help GPs navigate what can be a difficult issue to broach with their patients, doctors have been urged to refer to the guide *When she talks to you about the violence*, developed by Women's Legal Services NSW with the backing of AMA NSW last year.

The toolkit includes advice on how to ask a patient about abuse, how to respond, support of victims, mandatory reporting requirements and continuing care, and is available as a download at http://itstimetotalk.net.au/gp-toolkit/.

AMA President Associate Professor Brian Owler marked national White Ribbon Day (25 November) by reiterating the medical profession's strong support for measures to stop violence against women.

A/Professor Owler said too many women and children experienced some form of physical or sexual violence in their lives, and they deserved to able to live free from assault.

While rates of domestic violence are particularly high in some communities, such as among Indigenous women, evidence shows that it is prevalent across the community.

"This is unacceptable for a sophisticated nation like Australia," the AMA President said.

A/Professor Owler said that, aside from the direct physical injuries inflicted, domestic violence had effects which reverberated through the lives of those attacked and those around them.

"The most prevalent effect is on mental health, including post-traumatic stress disorder, depression, anxiety, suicidal ideation and substance misuse," the AMA President said, adding that domestic violence was also associated with poor physical health, including somatic disorders, chronic pain, gynaecological problems, gastrointestinal disorders and sexually-transmitted infections.

In 2010, the nation's governments jointly committed to a 12-year national plan to reduce violence against women and children.

Among other things, the plan called for better access to services for women and children experiencing domestic violence and a strengthened justice system to ensure perpetrators are prevented from instigating assaults and are held to account when they do.

A/Professor Owler urged that concrete action be taken to realise the goals of the national plan.

Adrian Rollins

COMMENT

AMA IN THE NEWS

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

Print/Online

Could be mixed blessings, *MX Brisbane*, 21 November 2014

A study indicates a dash of Red Bull with your vodka could reduce your chance of having too wild a night out. AMA Vice President Dr Stephen Parnis said he was sceptical of these findings.

Fund's sneaky cuts cost market punters, *Adelaide Advertiser*, 26 November 2014

Medibank members have profited on the stock market but if they use their health insurance they will now be hundreds of dollars out of pocket as a result of a secret cut to benefits. AMA President A/Professor Brian Owler attacked the fund over the changes.

Split opens on GP tax contradictions, *The Age*, 28 November 2014

Divisions within the Federal Cabinet over Budget policy versus political strategy have raised speculation of tensions between Prime Minister Tony Abbott and Treasurer Joe Hockey. The AMA called on the government to make a clear statement on whether it had shelved or was still pursuing the GP co-payment.

GP payment is still alive, *Northern Territory News*, 28 November 2014

The Government's strategy on its controversial $7 GP fee is in complete disarray, with the senior officials on Wednesday night briefing journalists it was dead only to have ministers back the policy. AMA President A/Professor Brian Owler described the Health Minister Peter Dutton as being petulant for refusing to acknowledge the fee lacks the support of the Parliament, the population, or the profession.

Botched concept, *Australian Financial Review*, 28 November 2014

The government lacked a firm vision of what it wanted when it launched its radical Medicare co-payment. AMA President A/Professor Brian Owler said the final form of the co-payment was a nasty surprise.

Abbott faces $1.3b Budget hit as medicine price hike bid stalls, *Northern Territory News*, 1 December 2014

Health Minister Peter Dutton has argued the price hike for subsidised prescription medicines is necessary because health costs are rising. AMA President A/Professor Brian Owler said this claim was wrong.

Radio

A/Professor Brian Owler, 4BC Brisbane, 24 November 2014

AMA President A/Professor Brian Owler talked about Queensland Government plans to extend smoking bans. A/Professor Owler said they should do so because smoking rates were too high and thousands of people were still dying of lung cancer.

Dr Stephen Parnis, ABC Riverina, 25 November 2015

AMA Vice President Dr Stephen Parnis talked about GPs often being the first point of contact in recognising and reporting domestic violence. Dr Parnis said GPs were well suited for the role, as they had the training, expertise, ethics, confidentiality and trust of the patient.

A/Professor Brian Owler, 5AA Adelaide, 26 November 2014

AMA President A/Professor Brian Owler talked about the Government's move to abandon the GP co-payment policy as part of the Government's effort to knock off the barnacles.

A/Professor Brian Owler, 2UE Sydney, 27 November 2014

AMA President A/Professor Brian Owler discussed the Federal Budget and how a number of journalists were briefed that Tony Abbott would drop the GP co-payment. AMA President A/Professor Brian Owler said the Government's proposal should have been dealt with a lot sooner and that they should be focusing on investing in general practice.

A/Professor Brian Owler, 666 ABC Canberra, 27 November 2014

AMA President A/Professor Brian Owler talked about the confusion over the Government's decision to dump the GP co-payment and the unclear impact the decision would have on the Medical Research Future Fund.

A/Professor Brian Owler, 891 ABC Adelaide, 27 November 2014

AMA President A/Professor Brian Owler discussed the Medical Research Future Fund. A/Professor Owler said the AMA is supportive of the fund, but opposed linking it to the Medicare co-payment as a cynical ploy.

MORE P14

AMA IN THE NEWS

... FROM P13

Dr Stephen Parnis, Radio National, 28 November 2014

AMA Vice President Dr Stephen Parnis talked about a new report revealing high rates of self-harm and suicide among Australian children and teenagers. Dr Parnis said 90 per cent of cases do not come to the attention of doctors.

A/Professor Brian Owler, Radio National, 28 November 2014

AMA President A/Prof Brian Owler discussed the confusion surrounding the Federal Government's Budget policy to charge a $7 GP co-payment. A/Professor Owler accused Health Minister Peter Dutton of being petulant in his refusal to dump the policy.

Television

A/Professor Brian Owler, ABC News 24, 27 November 2014

AMA President A/Professor Brian Owler talked about the Government shelving the GP co-payment. A/Professor Owler said if the GP co-payment was shelved, there could be discussions on chronic disease management, prevention, and investing in general practice to increase quality of care.

A/Professor Brian Owler, Sky News Sydney, 27 November 2014

AMA President A/Professor Brian Owler discussed the likely decision from the Federal Government to dump the $7 GP co-payment. A/Professor Owler said the AMA was not against the idea of a co-payment, but could not support the proposal put forward by the Government.

A/Professor Brian Owler, Sky News Sydney, 4 December 2014

AMA President A/Professor Brian Owler talked about reports of a deal between the Federal Government and Clive Palmer to scrap bulk billing incentives for GPs.

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. Dispatch 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

DECEMBER 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
30	1 National Decembeard Month World AIDS Day	2 RACGP CPR for GPs - Adelaide	3 Bond University Medicine Graduation	4	5 International Volunteer Day	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25 Christmas Day	26 Boxing Day	27
28	29	30	31 New Year's Eve	1	2	3

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/

NEWS

Private Medibank sneaks out cuts to benefits

Medibank Private executives have approved big cuts to benefits for common diagnostic tests including blood tests, x-rays and MRIs without informing policyholders.

In revelations which have taken the gloss off the company's $5.7 billion public float, news.com has reported that, as of 1 September, the nation's largest health insurer slashed the benefit it would pay for radiology and pathology services by up to 30 per cent by reducing cover to the level of the Medicare schedule fee.

The cuts means that, for example, the insurer will only cover $385 of the cost of a $516 CAT scan, leaving patients $131 out-of-pocket.

MP Executive Manager of Provider Networks and Integrated Care, Dr Andrew Wilson, told news.com the change was necessary because benefits for pathology and diagnostic imaging services had been growing at a rate well above that of the Medicare Benefits Schedule.

"If we continued in line with current trends, we believe it would have as adverse impact on premiums and the affordability of private health insurance," Dr Wilson said.

But the decision, taken in the final weeks of Medibank's operation as a government-owned entity, has drawn sharp criticism from AMA President Associate Professor Brian Owler.

A/Professor Owler said private health funds were always eager to highlight gaps between their benefits and doctor fees, but failed to own up to the out-of-pocket costs they created for their members by holding down or cutting benefits.

In a major speech to the private health insurance industry last month, the AMA President said the perception that out-of-pocket costs for medical services was increasing was "only partly true", and that the proportion of doctors charging in accordance with health fund schedules was at an all-time high.

He said that this year 89.7 per cent of privately insured medical services were provided at no gap, and 3.2 per cent were provided under 'known gap' arrangements. Of the 7 per cent that do involve a gap, it is often at or below the AMA rate.

The slug to benefits, which was implemented without informing members, has fuelled concerns that the insurer will be tempted to inflict even deeper cuts now that it is a publicly traded company.

Although Medibank has made gains in reducing administration overheads, its management costs as a proportion of net asset value remain above the industry average, and the executive team is under intense pressure to realise significant improvements in financial performance.

There are concerns the insurer will hike premiums above the industry average and increase the range of policies subject to exclusions, leaving many patients unknowingly short of the coverage they need for important medical procedures.

A/Professor Owler said policy exclusions was one of the most common complaints made by patients about their health insurance, and he urged the industry to rid itself of "junk" policies.

"Sometimes treatment is planned and surgery is booked only to be cancelled shortly beforehand because the hospital's health fund check reveals that the patient is not covered"

"The AMA would prefer to see a private health insurance market that does not have exclusion insurance products," the AMA President said. "Too often my members see patients who think they have cover, but don't, because they purchased a cheaper product several years ago.

"Sometimes treatment is planned and surgery is booked only to be cancelled shortly beforehand because the hospital's health fund check reveals that the patient is not covered," he said. "It is not an unusual scenario."

Adrian Rollins

NEWS

Almost half drink and smoke too much

Australians are cutting down on their drinking and smoking, but almost half continue to consume alcohol, tobacco or illicit drugs in quantities that put their health at risk.

While there is mounting evidence that tobacco control measures like bans on advertising and public health campaigns are working, and the proportion drinking to excess is shrinking, a comprehensive survey of drug use has found that a substantial minority continue to regularly engage in risky behaviour.

The *National Drug Strategy Household Survey detailed report: 2013*, released late last month, found there was significant crossover between dangerous smoking, drinking and drug taking.

Almost half of all daily smokers reported drinking at risky levels, and a third admitted to using illicit drugs in the previous 12 months.

The close association between these behaviours was further underlined by the finding that 60 per cent of illicit drug users regularly drank to excess, and almost a third were daily smokers.

Overall, almost 11 per cent of those surveyed on their smoking, drinking and drug habits reported to have indulged in at least two or more of these risky behaviours, and 3 per cent said they engaged in all three.

The results add urgency to calls from the AMA for more to be done to curb the nation's drinking and smoking habits.

Following the National Alcohol Summit it convened in October, the AMA said the Commonwealth needed to provide national leadership in tackling the nation's drinking culture, including by tightening the regulation of alcohol advertising, severing the links between sport and alcohol sponsorship and upgrading consumer warnings around the dangers posed by excessive drinking and drinking while pregnant.

The AMA has also called on the Government to vigorously defend Australia's ground-breaking tobacco plain packaging laws from legal challenges mounted by the tobacco industry, locally and in international forums.

The Australian Institute of Health and Welfare said the results showed that

risky smoking, drinking and drug taking behaviour was disproportionately high among certain groups, particularly the unemployed, Indigenous Australians and the disadvantaged.

And, contrary to the perceptions of some, those living in the country were more likely to be smoking, drinking to excess or taking illicit drugs than their city counterparts.

The survey found that the national decline in daily smoking rates was largely concentrated in the major cities, and no significant downturn was recorded in the rest of the country between 2010 and 2013.

This was reflected in the fact that more than a fifth of people living in the Northern Territory smoke daily, compared with less than 10 per cent of those living in the ACT.

Furthermore, people living in remote and very remote areas were twice as likely to have used methamphetamines last year as those living in the rest of the country.

Adrian Rollins

COMMENT

NEWS

E-cigs light up among the young

Young Australians are rapidly turning to e-cigarettes despite uncertainty about their long-term health effects, underlining calls for tight control on their marketing and availability.

A major survey of household drug use found that, in 2013, 27 per cent of 18 to 24-year-old smokers had used e-cigarettes in the previous 12 months, highlighting concerns that the new technology is making rapid inroads into the Australian market, even though their safety and efficacy as an aid to quitting smoking has yet to be proven.

In the most substantial examination yet of the extent of e-cigarette use in Australia, the Australian Institute of Health and Welfare for the first time asked about battery operated electronic cigarettes in last year's National Drug Strategy Household Survey, the detailed results of which have just been released.

The survey found that one in seven (14.8 per cent) of smokers aged 14 years or older had used e-cigarettes in the previous 12 months, with younger smokers much more likely than their older counterparts to have tried them out.

While more than a quarter of young adults reported using e-cigarettes, just 7 per cent of those in their sixties had tried them.

E-cigarettes operate by heating up a vial of fluid, sometimes impregnated with nicotine, to emit a vapour which is then inhaled.

They have been marketed as an aid in quitting smoking, though these claims have not yet been substantiated, and health authorities are concerned that not enough is yet known about their long-term health effects and have raised the possibility that they be a pathway to smoking tobacco, particularly among children.

Alarmed by the rapid uptake of e-cigarettes despite the dearth of knowledge about their effects, the Queensland Parliament became the first jurisdiction in Australia to subject the product to the same restrictions as tobacco cigarettes, making it illegal to sell them to minors or use them in no smoking areas.

While evidence is still being gathered on the health effects of e-cigarettes, doctors and public health experts advise people not to use them.

They warn that, because nicotine is highly addictive, people should avoid e-cigarettes that contain nicotine (and which are illegal in Australia).

And they have voiced alarm about the way e-cigarettes are being formulated and marketed specifically to attract children and other young users, with offering including chocolate, lolly and alcohol flavours.

Health experts are demanding that governments crack down on the promotion of e-cigarettes, including by preventing manufacturers and distributors from making unverified claims about their use as an aid in quitting smoking.

They said e-cigarettes must not be confused with proven nicotine replacement therapies, which have been rigorously assessed for their efficacy and safety before being approved for use by the Therapeutic Goods Administration.

The TGA is yet to approve any e-cigarette product as an aid in quitting smoking.

Adrian Rollins

NEWS

Better cars, safer intersections key to cutting road toll

Dozens of lives and millions of dollars could be saved through simple measures to improve road safety such as building more roundabouts, installing more guard rails and lowering speed limits, an official review has found.

Despite major improvements in road safety in recent decades, the Bureau of Infrastructure, Transport and Regional Economics has reported that road crashes not only kill and maim hundreds every year, but cost the community $27 billion annually – the equivalent of 18 per cent of total health expenditure and 1.8 per cent of gross domestic product.

In a study commissioned by the Federal Government, the Bureau assessed a range of measures that could be taken to reach the National Road Safety Strategy target of a 30 per cent reduction in casualties by the end of the decade, including road upgrades, lower speed limits, a crackdown on in-car distractions such as mobile phones and advances in car safety features.

While admitting to significant limitations in trying to quantify the benefits of some measures, the Bureau nonetheless found that installing more roundabouts was likely to be the most cost-effective action governments could take to reduce the road toll, followed by installing more roadside barriers, centre median barriers and shoulder rumble strips.

The Government has seized on the report to back its massive $50 billion infrastructure agenda.

Assistant Minister for Infrastructure Jamie Briggs said the Bureau's findings highlight that "each of our major infrastructure investments will help save lives and reduce road trauma, not only on major highways, but also on nearby local roads".

But the report only provides qualified support for major road building projects, emphasising that relatively low cost measures such as installing roundabouts and guard rails deliver the best value for money in terms of lives saved and injuries averted.

The Bureau reported that converting an intersection into a roundabout typically reduced fatalities and injuries by more than 70 per cent, and the estimated benefit-cost ratio was 11.3.

"Intersection treatments can be very effective," the report said. "Roundabouts can be particularly effective, reducing casualty crashes by over 70 per cent."

By comparison, installing guard rails on 85 per cent of the nation's road in the next 20 years would potentially save 13 lives a year and 353 fewer serious injuries, for a benefit-cost ratio of 5, and building centre median barriers would save about 46 lives annually for a benefit-cost ratio of 3.8.

Overall, such measures were likely to bring only incremental improvements in road safety, and often involved trade-offs – for instance, roadside barriers were more dangerous for motorcyclists, and roundabout were more treacherous for pedestrians, cyclists and those on motorbikes.

Smarter cars

Instead, the Bureau found that improvements in vehicle safety technology, particularly the introduction of autonomous emergency braking systems, may constitute the next big advance in cutting the road toll.

"Vehicle safety technology and standards are set to take over from the three main measures that have reduced road trauma so far (seat belts, blood alcohol testing, and speed enforcement) to deliver further reductions in the road fatality rate," the report said.

MORE P20

NEWS

Better cars, safer intersections key to cutting road toll ... FROM P19

"Autonomous emergency braking (AEB) systems will save lives as they are introduced to the vehicle fleet.

"The technology in light vehicles is expected to save over 1200 lives and prevent 54,000 hospitalised injuries by 2033. Over 400 of these deaths and 10,000 of the hospitalised injuries prevented are pedestrians and pedal cyclists."

Not only is such technology set to make vehicles safer, but also render some of the investment in safer roads and intersections eventually redundant: "AEB will reduce the incidence of collision crashes, and thus reduce the road trauma benefits of intersection treatments, as these also target a subset of collision crashes".

Road safety experts polled by the Bureau in preparing its report also nominated other measures such as cracking down on the in-car use of mobiles, lower speed limits and a more visible police presence on the roads.

It said mobile phone use was probably a factor in around 7 per cent of crashes last year, involving 83 deaths and 2300 instances of hospitalisation.

But it said a lack of specific measures to curb their use meant it was not possible to model their effectiveness.

The Bureau said that speed could be "directly correlated" with road trauma, and cutting speed limits could improve safety. But it warned this would also increase travel times on uncongested roads, and so should only be introduced with care.

"Reductions in speed limits may be warranted on some rural roads. However, whether it would be warranted on any particular stretch would depend on specific crash rates and characteristics."

Adrian Rollins

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

NEWS

Push on for world's first tobacco-free generation

Tasmania could become virtually smoke-free by the middle of the century under a radical proposal to ban its sale to anyone born on or after 2000.

The Tasmanian Parliament is due to debate legislation next year that would make it illegal to sell tobacco products to anyone born in 2000 or later, creating what its supporters hope would the world's first tobacco-free generation.

Tasmanian Upper House MP Ivan Dean has introduced a Private Members Bill, to be debated next year, which would change current laws that make it legal for children born in 2000 to buy cigarettes and other tobacco products once they reach 18 years in 2018. Instead, it would continue to be illegal to sell them tobacco products.

One of the key supporters of the initiative, Kathryn Barnsley, of the University of Tasmania's Centre of Research Excellence for Chronic Respiratory Disease and Lung Ageing, said the reform would see sales of cigarettes and other tobacco products in the island State gradually decline.

"It is important to emphasise that smokers would not be criminalised or penalised," Ms Barnsley said. "It is the commercial sales of cigarettes that would be phased out over the next 40 years, and only the sellers would be subject to penalties."

Smoking rates are declining nationwide, with Australian Institute of Health and Welfare official figures showing just 12.8 per cent of those aged 14 years or older smoked daily in 2013 – half the rate in 1991.

But Tasmanians tend to smoke more than the national average – almost 16 per cent of those aged 14 years or older smoked on a daily basis in 2010, and a 2011 survey in the State found 9 per cent of 12 to 17-year-olds had smoked in the previous week.

Public health experts are particularly concerned about smoking among adolescents because evidence shows about 75 per cent of teenagers who smoke regularly continue with the deadly habit as adults.

Backers of the Tobacco Free Generation initiative said the key goal was to prevent young people from taking up the habit in the first place.

It is estimated that, in its first year of operation in 2018, the legislation would prevent 800 to 1000 18-year-olds from legally purchasing cigarettes.

Backers of the proposal argue that its strength lies in the fact that it does not seek to affect existing smokers, such as with an immediate ban on tobacco sales, which they warned could raise a host of difficult problems.

Because of tobacco's highly addictive properties, they said, people already addicted to its use "cannot deal with an instant ban. Change has to be staged. An overnight ban creates the problem of addicts whose addiction has just become illegal".

Instead, they argue their proposal is much more manageable, and will see demand for cigarettes reduced gradually but inexorably over time.

"It is a very slow phase-in over 20 to 40 years. It allows retailers to have many years to adjust to selling other products," they said.

Adrian Rollins

COMMENT

Optometry Board sees the light on glaucoma care

Thousands of Australians suffering irreversible blindness will receive improved care after the Optometry Board backed down from plans to allow optometrists to circumvent ophthalmologists in the diagnosis and management of glaucoma.

In a major development, the Optometry Board has acceded to pressure and modified glaucoma guidelines that had been the subject of a fierce legal dispute between it, the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) and the Australian Society of Ophthalmologists (ASO).

AMA President Associate Professor Brian Owler said recognition in the guidelines that optometrists should not be able to independently manage glaucoma patients was a major advance in care.

“The revised Optometry Board guidelines will ensure that ophthalmologists will be the leaders of glaucoma management, with collaborative arrangements and clear referral pathways between the patient’s optometrist and ophthalmologist,” A/Professor Owler said. “Glaucoma patients are the winners from this arrangement.”

RANZCO and ASO had taken the Optometry Board to task over its move to allow optometrists to manage glaucoma patients without reference to ophthalmologists.

In a carefully-worded statement, the Optometry Board said that “collaboration and communication between treating optometrists and ophthalmologists after each patient consultation is in the best interest of patient safety and optimal eye health care, and is fundamental to the delivery of safe, high quality health care services”.

National support and education group Glaucoma Australia joined the AMA into welcoming the resolution of the dispute.

National Executive Officer Geoff Pollard said GA “supports an integrated eye-care system, with optometrists, ophthalmologists and other eye-health providers working collaboratively”.

“GA hopes that systems to ensure increased presentations for comprehensive eye tests, including a review of the optic nerves and not just an intra-ocular pressure test, will be strengthened from the renewed collaborative arrangements and result in a higher glaucoma detection rate,” Mr Pollard said.

A/Professor Owler commended the work of RANZCO and ASO “for their efforts on behalf of Australians with glaucoma and other serious eye conditions”.

He said the case underlined the need for clear, robust and transparent processes for assessing proposals to extend the scope of practice of non-medical practitioners so as not to compromise patient care.

Adrian Rollins

Govt turns blind eye on sight-saving work

Hundreds of country Australians will be condemned to blindness by a short-sighted Federal Government decision to axe funding for a path-breaking eye health service for people in remote and Indigenous communities, ophthalmologists have warned.

The Government has ceased funding the Indigenous and Remote Eye Health Service (IRIS), an initiative of the Australian Society of Ophthalmologists that was established with a $5 million outlay by the-then Labor Government.

In its four years of operation, the IRIS Task Force, chaired by former Wallaby captain Dr Mark Loane and involving former AMA President Dr Bill Glasson, has undertaken 12,800 patient consultations, conducted 2100 surgical procedures (mostly restoring sight), and has supported the establishment of 22 ongoing eye health services.

“Large numbers of Aboriginal and Torres Strait Islanders and non-Indigenous Australians are being blinded each year,” the Society said in a statement. “Sadly, though, funding has been cut for the one truly national program that could save their sight. The stark reality is that the gap is being widened, not closed.”

A third of Indigenous people report problems with their eyesight, and the 2008National Indigenous eye health survey (NIEHS) found that low vision was nearly three times more common among Indigenous adults than the broader population.

Overall, 3 per cent Indigenous adults suffer vision loss caused by cataracts, but only 65 of those who need cataract surgery received it.

In addition, eye disease and vision loos linked to diabetes is common, but in 2008 only 20 per cent of Indigenous people with diabetes had received an eye examination in the previous 12 months.

Unsurprisingly, the 2008 NIEHS survey found that blindness was six times more common among Indigenous adults than the general population, with the major causes cataracts, damage to eye nerves, refractive error, and diabetic eye disease.

The Society said the decision not to renew funding for the IRIs program had been taken despite strenuous efforts by the organisation to convince the Government to continue its support.

Adrian Rollins

NEWS

Worldwide action urged to curb overdose deaths

Ten of thousands of lives could be saved every year by ensuring ready access to the drug overdose treatment naloxone, the World Health Organisation has said.

Issuing its first-ever *Guidelines on the Community Management of Opioid Overdose*, the WHO said more than 150,000 people died around the world every year because of drug overdoses, many of them as a result of taking an opioid such as heroin

The UN health agency said that improving access to the opioid-reversal medication naloxone, particularly in countries where there are limited health services for injecting drug users, could save many thousands of lives at minimal cost.

Burnet Institute researcher Professor Paul Dietze, who was on the working group that developed the WHO guidelines, said they gave countries a reference point for the development of effective drug overdose prevention and treatment measures.

"Overdose remains a significant cause of deaths in Australia, with around one person dying every day as a result of injecting opioids such as heroin," Professor Dietze said. "A key message in the WHO Guidelines is that opioid overdose is both preventable and reversible if witnessed by others, as it is on most cases."

In Australia, programs to train drug users and provide them with doses of naloxone have already reported success in saving lives.

Harm Reduction Victoria (HRV), which has so far trained and equipped more than 300 injecting drug users with naloxone in the past 12 months, said it had already received reports of 34 instances where drug overdose had been effectively reversed.

"We know it is making a real difference," HRV Executive Officer Jenny Kelsall said. "We look forward to the day when every opiate user carries naloxone and regards it as an essential item in their tool kit."

Naloxone is a prescription-only medicine that is routinely carried and administered by paramedics and emergency physicians, but it is also being offered in take-home kits for drug users and their families.

Professor Dietze said that, through the National Naloxone Reference Group, organisations such as HRV were sharing information on getting naloxone into the hands of drug users and training them and their friends and family about what to do in case of an overdose.

"Our biggest challenge is getting naloxone out there to everyone at risk of overdose," Dr Ingrid van Beek of the Kings Cross Kirketon Road Centre said. "Naloxone needs to be readily available in all parts of the country to maximise its impact on overdose death rates."

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

National residential medication chart released

A new national medication chart that can be used to prescribe and supply PBS medicines is now available free from the Australian Commission on Safety and Quality in Health Care at http://www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/nrmc/.

Doctors and pharmacists in the ACT, Tasmania, Victoria, Queensland, Western Australia and South Australia can now prescribe and supply most PBS medicines to residents of aged care facilities using this chart without needing to also write prescriptions. (Legislation is yet to be passed in NSW and the Northern Territory to allow the NRMC to be used for medicine prescribing and supply purposes.)

The National Residential Medication Chart (NRMC) has also been designed to provide a central point for information. 'Prescriptions' and the record of medicine administration are co-located, with the resident's details including their photograph and known adverse drug reactions visible from each page. Relevant pathology, doctors' instructions and special considerations are also included.

The NRMC was developed, tested and evaluated in 2013-14 by the Commission in over twenty residential aged care facilities in NSW (specially exempted from current NSW legislative restrictions). AMA members, Dr Brian Morton and Dr Richard Kidd, participated in the expert reference group providing advice.

The Commission found that the NRMC improved medication safety for residents as well as considerably minimising the administrative burden of prescribers, aged care staff, and pharmacists when ordering, administering and supplying PBS medicines.

While NRMC test sites provided very positive feedback and have chosen to continue using it, their experiences indicate that everyone involved initially needs training and support to move successfully to an NRMC model.

The next step is for commercial companies to develop electronic versions of the NRMC to streamline processes even further.

Use of the NRMC is a decision of the residential aged care facilities and is purely voluntary but AMA members may wish to encourage the facilities they work in to investigate its adoption.

Mental health in the medical industry – time for action

BY KAREN STEPHENS, MDA NATIONAL

Doctors in distress

In August this year two recently graduated doctors committed suicide within a week of each other in New York. A fellow graduate doctor wrote in the *New York Times*:[1]

I imagine that they experienced fatigue, emotional exhaustion and crippling self-doubt at the beginning of those residencies – I know I did.

A *beyondblue* survey of Australian doctors and medical students in 2013 found that:

- doctors have a higher suicide rate compared with the general population, with female doctors more than twice as likely to suicide as females in the general population
- one in 10 doctors and one in five medical students had suicidal thoughts in the past year, compared with one in 45 people in the wider community
- 25% of doctors and more than 40% of medical students are highly likely to have a minor psychiatric disorder
- among doctors, 3.4% are experiencing very high psychological distress, much greater than the wider community. [2]

Stressful work experiences

Stressors in a doctor's workplace may include long hours, shift work, exposure to blood-borne diseases, being constantly judged on their performance, dealing with suffering and death, lack of resources in the health system, and the challenges of managing a business and employing staff.

Aggression from co-workers was found to be the cause of greatest harm to doctors' health and happiness, according to new research published in the *MJA*.[3]

The stress of complaints or claims is also known to cause emotional and physical stress. An Australian study[4] found that GPs with a current medico-legal matter had a higher prevalence of psychiatric morbidity, experiencing emotions such as distress, anger, fear, guilt, depressed mood, loss of confidence, feeling ashamed, insomnia and nightmares, loss of reputation and wanting to give up medicine.

Easing the distress

The graduate doctor writing in the *New York Times* opined:[5]

We need to be able to voice these doubts and fears. We need to be able to talk about the sadness of that first death certificate we signed, the mortification at the first incorrect prescription we ordered, the embarrassment of not knowing an answer on rounds that a medical student knew. A medical culture that encourages us to share these vulnerabilities could help us realize that we are not alone and find comfort and increased connection with our peers.

A recent American study found that only half of depressed interns obtained mental health services.[6] Responses for avoiding help include lack of time, lack of confidentiality, a desire to manage their mental health independently, and professional stigma.

Nearly half of the interns in the study believed their colleagues would have less confidence in them as medical providers if they sought psychiatric treatment. Threat of judgment from other physicians serves as one of the largest barriers to seeking psychiatric care.

As a result of the beyondblue survey, a roundtable with key industry stakeholders from the medical profession was held in June 2014 and an action plan is being developed.

Developing a nationally consistent and comprehensive suite of services for doctors and medical students via doctors' health advisory services was seen as one of the most practical strategies to improve access to resources. *beyondblue* plans to develop a national doctors' mental health website.

The AMA recommends that doctors should:

- have their own GP
- make time for activities which nourish them as a person
- know about access to confidential services
- act if they are concerned about a colleague's health.[7]

The RACGP's *Keeping The Doctor Alive* covers coping strategies, lifestyle balance, boundary issues, management skills, personal support, medical support, and peer support. Download a copy at https://www.ranzcp.org/Files/Branches/Victoria/Keeping_the_Doctor_Alive-pdf.aspx

Keeping your grass greener by AMSA is a guide for medical students to maintain their health and wellbeing. Download a copy at http://www.amsa.org.au/projects/wellbeing/keeping-your-grass-greener/

Where to get confidential help

- Your MDO – MDA National has a Doctors for Doctors Program which provides support to our Members.
- Doctors' Health Advisory Service/Peer Support Service – confidential support, information and advice. Help Lines in each state and territory are:
  - > ACT 0407 265 414
  - > NSW (02) 9437 6552
  - > NT (02) 9437 6552
  - > QLD (07) 3833 4352
  - > SA (08) 8366 0250
  - > TAS 1300 853 338
  - > VIC 1300 853 338
  - > WA (08) 9321 3098
- Bush Support Services – support for remote health workers. 24-hour Support Line: 1800 805 391
- Medical Benevolent Societies – support and advice for doctors, medical students and their families:
  - > ACT (02) 9987 0504
  - > NSW (02) 9987 0504
  - > SA (08) 8267 4355
- *beyondblue* 1300 22 4636
- Lifeline 13 11 14

1 Sinha P. Why Do Doctors Commit Suicide? *The New York Times* September 4 2014.

2 National Mental Health Survey of Doctors and Medical Students www.beyondblue.org.au October 2013, available at http://www.beyondblue.org.au/about-us/programs/workplace-and-workforce-program/programs-resources-and-tools/doctors-mental-health-program.

3 Hills D & Joyce CM. Workplace Aggression in Clinical Medical Practice: Associations With Job Satisfaction, Life Satisfaction and Self-rated Health *MJA* 2014;201(9):535-540.

4 Nash L, Tennant C, Walton M. The Psychological Impact of Complaints and Negligence Suits on Doctors. *Australasian Psychiatry* 2004;Sep 12(3):278-81.

5 Sinha Op. cit.

6 McPartland AS. Suicide and the Young Physician *The Atlantic* Sep 16 2014.

7 AMA. Position statement: health and wellbeing of doctors and medical students 2011.

GENERAL PRACTICE

PHNs set to deliver better outcomes

BY DR BRIAN MORTON

The recently released Invitation to Apply for Funding and program guidelines for Primary Health Networks is a material step forward for more integrated and streamlined health care.

Applicants wishing to become Primary Health Networks (PHNs) now have until 2pm (AEST) on 27 January 2015 to prepare and submit their applications.

Prior to the introduction of Medicare Locals, the AMA highlighted that if they were to be successful GPs would need to be involved in any high-level decision making.

Promisingly, it seems that the PHNs, unlike their predecessors, will actively work with GPs to identify and address gaps in local and regional health care services, and will provide support services to general practices.

This suggests the Government has paid close attention to the recommendations of the Horvath review, including that PHNs should reinforce general practice as the cornerstone of integrated primary health care.

PHNs will be governed by a skills-based board, which should not preclude GPs with the appropriate skills, and will be accountable for the PHNs performance.

The Board will be supported by a GP-led Clinical Council and Community Advisory Committee, both of which will report to the Board.

The Clinical Council will be expected to work in partnership with the Local Health Network, and will help with the development of local strategies to improve patient pathways through the health care system. It will streamline and improve the quality of patient care, as well as their health outcomes.

The Community Advisory Committee will ensure that all decisions, investments, and innovations made have the patient at the front of mind, are cost effective, locally relevant and aligned with local care experiences and expectations.

In many instances, the PHN guidelines are aligned with the AMA position on the principals for an effective primary health care organisation, and on what their priorities should be. For example, PHNs and the Clinical Councils will be expected to work co-operatively to ensure that patient care is not restricted or adversely effected where the patient flow crosses boundaries. This will be particular important in localities like Albury/Wodonga and Canberra/Queanbeyan.

The removal of a separate overarching body, such as Medical Locals had with Australian Medicare Local Alliance, has eradicated an unnecessary bureaucratic layer.

This, along with specific streams of funding, will ensure that money is not diverted from front-line services to support excessive administrative operations.

The AMA has advised the Government that it would be concerned if the process for establishing PHNs provided an opportunity for PHNs to be managed by any entity with an inherent conflict of interest.

The PHN guidelines have gone some way to addressing this concern by advising that they should be structured to avoid, or actively and appropriately manage, conflicts of interest, particularly in relation to purchasing, commissioning and providing services.

PHNs will have access to innovation funding from 2015, which will help to support new innovative models of primary health care. This will provide a significant opportunity to develop and trial different models of care to meet identified gaps in health services and to make health care pathways seamless for patients.

While many Medicare Locals didn't seem to know what they were supposed to be doing, this should not be the case with PHNs. The guidelines pretty clearly outline what will be expected of them. The application process similarly is clearly explained.

As a GP, I look forward to seeing just how well PHNs deliver on their objectives.

With evidence from countries such as New Zealand showing that GP leadership is a must if PHNs to be effective.

PHN applicants should have no doubts about what they will be doing as the application documents are pretty clear.

COMMENT

AMSA

BY AMSA PRESIDENT JESSICA DEAN

> "I'm sure many of these prospective medical students breathed a huge sigh of relief when the Federal Government's fee deregulation legislation was defeated in the Senate last week"

Uncertain future clouds outlook for aspiring doctors

This is an interesting time of year for medical students.

For most, exams have just finished and celebrations will undoubtedly ensue.

For some, these celebrations are tempered by the risk of supplementary examinations, or even failure. For these students, this period of time can be really tough.

As the National Vice-Chancellor Tour raps up as part of the 2014 AMSA Mental Health Campaign, representatives from all 20 medical schools are immersed in planning the campaign for 2015.

For just under a quarter of students, this time is filled with a combination of nervous excitement and relief as they walk out of hospital for the last time as a medical student, to return in a few weeks as a junior doctor.

Alas, for a number of international students, this excitement is overwhelmed by growing stress; the clock is ticking. Their student visas will soon expire, yet their future is still up in the air as they await the possibility of being awarded one of the few remaining State vacancies or a Commonwealth Medical Internship (CMI) offer.

As the first round of internships draw to a close at the end of 2014, the CMI initiative itself has been generally well received. It changes the lives of doctors offered a job under this scheme who would have otherwise been lost to opportunities overseas.

The process of applying for a CMI is complicated, however, by the fact that each agency has its own independent application process, with varying timelines and requirements, resulting in round after round of offers being made to students until no vacancies remain.

These State-based application processes have to be almost completely exhausted and the offers allocated, before CMI applications can be made, leaving hundreds of international students in the lurch.

Efforts are being made to better manage late vacancies at a national level but, ultimately, only small gains can be made.

What is needed is a national application process, which would ameliorate most of these concerns.

In the coming months, new students will enter medical school for the first time; starting their journey to become a doctor.

I'm sure many of these prospective medical students breathed a huge sigh of relief when the Federal Government's fee deregulation legislation was defeated in the Senate last week.

AMSA, along with the AMA, has been very active on this front.

After many media releases and interviews, multiple trips to Canberra to lobby on the issue, numerous emails and meetings with the cross-bench Senators, and presentations at two Senate Select Committee hearings, we are all truly stoked with this result.

I would like to thank the AMA, and in particular President Associate Professor Brian Owler, Vice President Dr Stephen Parnis and AMA Council of Doctors in Training Chair Dr James Churchill, for their continued support of AMSA and medical students in general.

At the end of December my Victorian Executive will have finished our term and will hand over to a very competent and enthusiastic NSW Executive, led by James Lawler from the University of Newcastle.

I wish James and his team the very best for 2015.

Jessica Dean is the President of the Australian Medical Students' Association. Jessica is a 6th year Medicine/Law student at Monash University. She is currently completing an Honours Project in Bioethics at The Alfred. Follow on Twitter @ AMSAPresident or @yourAMSA

COMMENT

RURAL HEALTH

Bush outlook brightens with classification overhaul

BY DR DAVID RIVETT

Thanks to robust lobbying by AMA President Associate Professor Brian Owler and the grace of Assistant Health Minister Fiona Nash, the review of the geographical classification systems used to distribute rural incentives is back on track.

This is significant. In all, 48 incentive programs are operated using such classifications, and I was excited to attend the reconstituted Rural Classification Technical Working Group meeting in Canberra on 25 November, where the newly-adopted Modified Monash Model was presented.

The Modified Monash (MM) Model uses town size as a key determinant in arriving at has seven remoteness classifications:

MM1: (formerly Remoteness Area 1);

MM2: RA 2 or 3 with population >50,000;

MM3: RA 2 or 3 with population 15,000 to 50,000;

MM4: RA 2 or 3 with population 5,000 to 15,000;

MM5: RA 2 or 3 with population <5,000;

MM6: RA 4; and

MM7: RA 5

The new classification system recognizes the fact that the facilities a town is likely to have varies according to its size.

The model includes buffer zones at the edge of Urban Centred Locations (UCLs), as delineated by the Australian Bureau of Statistics. This is in recognition of the fact that small towns sitting on the fringes of larger centres are not treated the same as those located more remotely.

For areas with an MM2 classification, this buffer zone extends 20 kilometres out from the fringe. For areas classified as MM3, the buffer zone is 15 kilometres, and for MM4 areas it is 10 kilometres.

When explored in detail this works well, with far fewer anomalies than the existing system, though they still occur.

One stand-out anomaly under the MM system is Kalgoorlie, which deserves a higher score (MM3) than it has currently been allocated.

State AMAs, workforce agencies and medical Colleges are closely examining the outcomes of the new model and will challenge any further anomalies they identify.

One of the oversights in the introduction of the new system has been that there is no mechanism for review or appeal when problems are identified, and this is something that the AMA will push strongly for.

Importantly, the classification accorded to a town or community is not set in stone – they will be regularly updated using information from the National Census.

No model can be perfect, but the Modified Monash Model is a quantum leap forward in more effectively targeting incentives.

In another welcome development, Senator Nash has decreed that Bonded Medical Scholars can serve their bond in towns of less than 15,000, irrespective of their District of Workforce Shortage (DWS) or Area of Need (AON) status – they will no longer be forced to move on just because of a change in their community's DWS or AON classification.

Further, she will strive to simplify the DWS and AON systems by scrapping the current system of quarterly reviews. Instead, status will be determined and set on an annual basis. This will be a blessing for overseas-trained doctors.

In overhauling the existing unsatisfactory system, the Government has not stopped there.

A new Panel is to be set up to review current rural incentives and recommend ways to better support the rural training of junior doctors.

It seems this review is expected to work with lightning speed, because on my return from attending the Working Group meeting in Canberra, I was greeted by a letter stating that one of these incentive arrangements, the John Flynn Placement Program, has been placed on hold pending Ministerial Review.

This program has been around long enough for there to be ample evidence of whether or not it has been effective - hopefully it will be found to have sufficient promise and achievement to justify its continuation.

Health on the hill

Political news from the nation's capital

Tech giants to be held to account over cyber bullying

Major social media sites like Facebook and Twitter could be fined up to $17,000 a day if they fail to comply with orders to take down cyber bullying messages and material, under measures proposed by the Federal Government.

Reflecting mounting community concern about the use of social media to attack, denigrate and intimidate young people, Parliamentary Secretary for Communications Paul Fletcher has introduced legislation that seeks to make social media providers accountable for messages carried on their sites.

The legislation calls for the creation of a National Children's E-Safety Commissioner to oversee and administer a consumer complaints system. The commissioner would have powers to order that cyber bullying messages targeting children be taken down.

Under the proposal, the commissioner would become involved if a site fails to respond to a complaint within 48 hours. Where a provider does not comply with a take-down notice, the commissioner will not only have the power to issue a fine, but also to seek a court injunction and to publicly name and shame non-compliant services.

AMA President Associate Professor Brian Owler commended the Government for taking such a tough stance on the use of social media and the internet to attack, intimidate and harass young people.

"The harm in the community being caused by cyber bullying demanded a strong response," A/Professor Owler. "Too many young people are taking their own lives or inflicting self-harm, and bullying can often be an underlying factor."

Intentional self-harm is the leading cause of death among young people aged between 15 and 24 years, according to the Australian Bureau of Statistics, with 324 teenagers and young adults dying by their own hand in 2012, while six boys and eight girls younger than 15 years committed suicide.

In addition, thousands more entertain thoughts of self-harm and suicide – last year, the national telephone crisis service for the young, Kids Helpline, received calls from almost 16,000 children and young adults who were assessed to have self-injury and self-harming behaviour.

While the statistics do not include a breakdown of how many instances involved bullying, there is evidence that around a quarter of children between Years 4 and 9 are bullied every few weeks.

A/Professor Owler said that although many factors contributed to children and young people harming themselves, the pervasive use of social media and the internet among young people could be a source of vulnerability for some.

"Many children in Australia are happy and healthy, but some children are clearly not, and they are vulnerable and susceptible to bullying," he said. "Not all who are cyber bullied will have suicidal thoughts or engage in self-harming behaviour, but the sad reality is that there are documented cases of suicide resulting from cyber bullying."

The Government's proposed legislation calls for the creation of a two-tiered complaints system, depending on the size and location of the social network provider.

Twitter, Facebook and other large organisations would be accorded tier 2 status, which would make them liable for civil penalties, court injunctions and other 'enforcement undertakings', while smaller providers and those with only nominal corporate representation in Australia, such as Snapchat and smaller niche social networks could apply to be accredited as tier 1.

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Health on the hill

Political news from the nation's capital

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To be accredited, they would have to agree to comply within 48 hours with directions to remove content deemed harmful by the commissioner, but would not be subject to direct enforcement measures. Instead, where they repeatedly refuse to comply with take-down orders, they may have their accreditation revoked.

In addition to regulating providers, it is envisaged that the Children's E-Safety Commissioner will also be able to ask individuals who post cyber bullying material to refrain from any further such activity, and apologise to the child who was the target of the intimidation or abuse.

More controversially, under the Government's legislation the commissioner would have authority to disclose information to school principals, teachers, parents and guardians in order to help resolve complaints.

While this may help incidents escalating, there are concerns that knowledge their complaints may be conveyed to parents and teachers may increase the reluctance of young people to report instances of cyber bullying. Already, there is suspicion it is being underreported by children concerned that if they report they are being bullied, they will have their access to the internet restricted or blocked altogether.

The AMA was among a number of organisations that made submissions to the Government as it developed its cyber bullying legislation, noting that there was increasing concern in the medical profession about the effect of bullying on the health and wellbeing of young people.

A/Professor Owler said the arrangements were a "good start" by the Government in an emerging area of activity and regulation.

Adrian Rollins

Hambleton to advise on rural incentives

Immediate-past AMA President Dr Steve Hambleton has been appointed to advise the Federal Government on incentives for doctors to work in rural and remote areas.

Dr Hambleton is part of a three-member panel, including former Rural Doctors Association of Australia President Dr Paul Mara and Monash University Emeritus Professor John Humphreys, who have been engaged to help overhaul the General Practice Rural Incentives Program (GPRIP).

The appointment of the panel follows the Government's landmark decision to ditch the flawed Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) system and replace it with the more accurate Modified Monash Model (MMM) system to guide the allocation of resources and incentives in regional, rural and remote areas.

Assistant Health Minister Fiona Nash said the appointment of the panel was the next phase in the Government's program of reforms to the rural health workforce.

"We must ensure that workforce programs are targeted to getting the right doctors, with the right skills, to the right places," Senator Nash said.

There are significant imbalances in the distribution of GPs and other doctors around the country. While there are relatively high concentrations of GPs in the major cities and regional centres, many rural communities suffer from a shortage of doctors, forcing patients to travel many hours to receive treatment.

The Minister said the panel would consult with rural doctors and key health organisations on redesigning the GPRIP to use the Modified Monash system to best align incentives with need, and would also look at opportunities to increase the exposure of junior doctors to rural practice.

The move to the MMM classification system has been hailed by the AMA and other medical organisations as a major advance for rural health given the glaring anomalies in the allocation of resources under the ASGC-RA classification system.

There have been numerous perverse outcomes under the ASGC-RA system, such as doctors working in Cairns, a coastal city of 150,000 people, receiving the same incentives as those working in central west NSW towns such as Hay and Deniliquin.

The MMM is based on the current Australian Bureau of Statistics remoteness classification structure, and classifies regional areas according to local town size.

The Minister said that, as a result, under the MMM system Charters Towers would be in a different category to Townsville, Port Fairy will have a different classification to Ballarat, Gundagai will be different to Hobart and Sale will differ from Mildura.

Adrian Rollins

Health on the hill

Political news from the nation's capital

'Hidden disease' focus of parliamentary inquiry

The prevention, prevalence, detection and cost of hepatitis C will be the subject of a parliamentary inquiry amid concern it is a serious but badly overlooked health issue in the community.

The House of Representatives Standing Committee on Health has announced it will hold public hearings with medical experts and community support in Melbourne in late January as part of an investigation aimed at determining the extent and cost of the debilitating illness and gauging the best way of tackling its spread.

Committee Chair, Liberal MP Steve Irons, described chronic hepatitis C as "a hidden disease".

Mr Irons said that around 230,000 people lived with chronic hepatitis C, but only around 1 per cent received treatment, putting many at risk of liver failure.

Chronic hepatitis C can lead to liver inflammation and scarring and, if left untreated, may result in liver cancer and shutdown.

The inquiry will examine the prevalence of hepatitis C and options for its early detection and treatment, as well as the costs it inflicts on the community.

It will hold public roundtable meetings in Melbourne on 21 and 22 January, 2015.

For more details, visit: www.aph.gov.au/HepatitisC

Adrian Rollins

Government shelves Jan drug price hike

Patients have been saved from a $5 jump in the cost of prescriptions after the Federal Government withheld legislation to increase the Pharmaceutical Benefits Scheme co-payment in the face of a hostile Senate.

In a development that has blown a further $1.3 billion hole in the Budget, the Government decided not to introduce a Bill that would have raised the patient co-payment for subsidised prescription medicine from $36.90 to almost $42.70 from 1 January, taking into account indexation. Pensioners and concession card holders faced an 80 cent rise in their co-payment to $6.90.

The planned price hike lacked crucial support from cross-bench senators, and was condemned by AMA President Associate Professor Brian Owler, who said it was an unjustified and poorly conceived measure.

The Government had argued that the $5 co-payment increase was necessary because of what it claimed was an unsustainable increase in health spending.

But A/Professor Owler said the claim was rubbish, with official figures showing health accounted for just 16.13 per cent of the Commonwealth Budget in 2014-15, down from 18.22 per cent in 2007-08.

"The proportion of the Federal Budget going to health is actually falling," he said.

Health Minister Peter Dutton withdrew the Bill calling for the PBS co-payment increase on the last parliamentary sitting day for the year after failing to secure sufficient support for the measure in the Senate.

Both Labor and the Greens are opposed to the increase, as are the two Palmer United Party senators and several other cross-bench MPs.

Unlike the Medicare co-payment, any increase in the PBS co-payment has to be legislated, and the Government quietly pulled the Bill off the Order of Business for the Senate last Thursday, 4 December.

The decision means the co-payment will not increase on 1 January, as planned in the May Budget, adding to the disarray over the Government's fiscal strategy.

Budget measures worth $28 billion are in limbo as the Government struggles to secure the support in the Senate that it needs, including its Medicare co-payment, a 20 per cent cut to university funding, a freeze on Family Tax Benefit payments, a six month delay for dole payments and lowering the indexation rate of pensions.

While admitting the Government had missed its 1 January 2015 deadline for the PBS co-payment hike, Mr Dutton remained hopeful that a deal could be struck with the Senate cross-bench.

"In its current form, it is clear that the [PBS] co-payment doesn't have the numbers in the Senate, but we have negotiations in train with the independent senators," the Health Minister said. "The Government is not ruling in or out other options. I believe that we can arrive at a compromise position, but I'm not going to publicly canvass those options and those discussions."

Mr Dutton said the delay in approving the co-payment increase was costing the taxpayer $20 million a month.

Adrian Rollins

OPINION

BY DR KEAN-SENG LIM
MBBS (SYD),
FRACGP, GAICD

Co-payments and rebate cuts spell death by stealth for quality GP care

As a general practitioner, my first concern is the health of my patients. It's pretty depressing to see health care reduced to talk of "price signals" or "co-payments". This is not what health care is about.

I have worked as a General Practitioner in Mt Druitt for the past 18 years. Our practice is the oldest continuously running practice in the area and has been serving the people of Mt Druitt for 45 years. For those who may not be familiar with the area, Mt Druitt is one of the less well off parts of outer western Sydney, with high rates of unemployment, single parents, indigenous patients, refugees and migrants. It has some of the states highest levels of obesity and chronic disease, especially diabetes and lung problems. This can be a challenging but professionally rewarding place to work,.

Many of my colleagues run traditional solo practices and rely on bulk billing. We are used to the challenges of patients who have to decide whether to spend $5 on medication or the bus fare home. All too often we see patients needing specialist care but know they won't be able to get into the public outpatient clinic at the local hospital for months or years.

As General Practitioners, we develop strong attachments to our local communities and I am proud to work in Mt Druitt. We have a strong community of local doctors in the Mt Druitt Medical Practitioners Association, where many members donate their time to lifestyle improvement programs, such as the SALSA program, in local schools. We see patient and community needs and we try to find a way to improve them.

I am proud of the practice we have built. When the previous government made available grants to improve practice facilities, our practice applied. This allowed us to engage a range of allied health providers to provide better care for our patients. We have a tightly knit and dedicated team, with a dietician, exercise physiologist, psychologist and community pharmacist available to assist in providing care for our patients. With innovative programs developed by local endocrinologists and the Medicare Local, we have access to a visiting diabetic specialist. All this allows our patients to access the services they need and make it less likely they will end up requiring more expensive hospital care. We do charge a private fee for those of our patients who can afford to pay, although we bulkbill many who are less well off. This allows us to spend the time needed to better use our expertise to provide better care.

It has been truly disappointing to see the level of debate around General Practice since the Federal Budget. The total amount spent under Medicare on General Practice is a fraction of the whole health budget and has RISEN BY LESS THAN 1% in the last 5 years. This is hardly out of control. When you hear health reduced to price signals and fiscal restraint, you really wonder why you bother.

General Practice remains the most cost efficient part of the whole health care system. With further investment we would be able to further lift the level of care we could offer. We could engage nurses and assistants to help us follow up our sickest patients and help them navigate their way through the system. We could make sure Mr Smith, who has been in hospital three times this year, is able to receive assistance with his medications, have the regular follow up care and not have to go back into hospital a fourth time. We could have more time to spend with patients whenever it is needed

Unfair copayment proposals, or alternatives such as freezes or cuts to rebates effectively destroy quality general practice care by stealth, and we are all the poorer for it.

We should always strive to make things better, and this is a challenge my colleagues and I are ready to take. We can build a better, more efficient, fairer health system. THIS is what health care is about. Our challenge to the Prime Minister is whether he is ready to talk about health.

COMMENT

Research

Stressing out cancer cells may lead to better treatment

(This article has been supplied by The Lead South Australia, and can be viewed at: http://www.theleadsouthaustralia.com.au/industries/health/stressing-out-cancer-cells-may-lead-to-better-treatment/)

Using metabolic stress to kill cancer cells could open the way for new targeted therapies that won't harm normal cells and have no adverse side effects.

Researchers at the University of Adelaide in South Australia showed that chromosomal instability – which is a hallmark of rapidly dividing cancer cells – makes them stressed and vulnerable to mild metabolic disruption.

Metabolism is the normal process by which the body turns food into energy.

"A common problem in treating cancers is that they don't respond to chemotherapy, or they respond for a while, but then come back," says lead author Dr Stephen Gregory, Senior Postdoctoral Fellow with the University's School of Molecular and Biomedical Sciences.

"One reason this happens is because a tumour is usually not made up of identical cells but rather a diverse population of cells that changes all the time, losing and gaining chromosomes as they divide – so-called chromosomal instability. Sooner or later they change enough to be able to resist chemotherapy drugs.

"Our research has shown that chromosomal instability has some consequences for cells – they get stressed, and it only takes a small metabolic push to kill them."

Current chemotherapy is also very toxic to all dividing cells, particularly affecting cells in hair follicles, the gut lining and blood, often causing hair loss, pain and making patients unwell

"We need to find ways to target cancer cells without affecting other normal dividing cells," says Dr Gregory.

The researchers induced chromosomal instability in small experimental flies, Drosophila, and found that the unstable cells were "on the edge" of how much stress they could tolerate.

"This is significant because a change in metabolism is something people cope with very well normally," says Dr Gregory. "That means that we hope to be able to develop treatments that have no side effects on patients, but are able to kill off the unstable tumour cells that cause relapses."

Dr Gregory says this may give some validity to theories of alternative treatments such as going on a radical diet.

"People who have advanced cancer which isn't responding to chemotherapy often try a range of different treatments such as a radical diet in the hope it may help," he says. "In some situations, it may in fact work; but we hope to be able to point the way to a more targeted approach – finding the most appropriate steps for intervention in the metabolic process that will give the best results."

The research has been published in the journal *Oncogene*. It is funded by the National Health and Medical Research Council and continues with a recent NHMRC project grant of $593,000.

Breast implants linked to cancer

Breast implants commonly used in reconstructive surgery for women following a mastectomy puts them at increased of developing a rare cancer, research has found.

In a cruel twist for women recovering from breast cancer, Macquarie University researcher Professor Anand Deva has found chronic infection associated with textured breast implants – frequently used in reconstructive surgery following a mastectomy performed to treat breast cancer – can activate the immune system and lymphocytes.

In a study published in the journal *Plastic and Reconstructive Surgery*, Professor Deva said the long-term stimulation of these lymphocytes could turn the cells cancerous and give rise to rare anaplastic large cell lymphoma.

Altogether, 170 cases of the cancer have been reported worldwide, and "all have been associated with having implants as some sort of risk", he said, adding that in 90 per cent of cases, the breast implants involved were textured.

Professor Deva told news.com the risk for women with such implants developing the cancer was 30 per cent, but that the risk became "much higher" if the implant was part of reconstructive surgery following breast cancer.

The warning is the latest scare involving breast implants.

Several years ago there was a world-wide alert issued after it was discovered that French-made Poly Implant Prothese (PIP) implants had been manufactured using industrial rather than medical grade silicone.

Subsequent investigations have found that although PIP implants are more prone to rupture, they do not contain toxic chemicals and has recommended that they be left in place unless leaking or rupture is detected.

Adrian Rollins

Research

Herbal remedies may not be all benign

Cancer patients have been warned that commonly used complementary remedies including fish oil, green tea and ginger could increase the risk to the health and undermine the effectiveness of conventional treatments.

In a presentation to the Clinical Oncology Society of Australia's Annual Scientific Meeting, researchers at Melbourne's Peter MacCallum Cancer Centre reported that the 10 most common complementary medicines could interfere with the operation of chemotherapy drugs, unexpectedly increasing their toxicity or reducing their effectiveness.

"These products may increase the effects of chemotherapy and put the patient at risk of toxicity, or decrease the efficacy of chemotherapy," lead author Sally Brooks said. "Those that contain high levels of antioxidants may interfere with both chemotherapy and radiation therapy."

The study was based on inquiries made by doctors and patients to the hospital's Medicines Information Centre over a two-year period, and covered the 10 most common complementary medicnes, including fish oil, turmeric, coenzyme Q10, milk thistle, green tea, ginger, lactobacillus, licorice, astragalus and reishi mushroom.

Ms Brooks said these substances were unlikely to cause problems when they were consumed as part of a normal, healthy diet, but were problematic when they were concentrated in larger amounts in complementary medicines.

She said the complexity of dealing with different types of cancers, and the enormous variety of responses among individuals, meant that much more research was needed.

Nonetheless, she said, "what's safe for one person may not be for another. We need to raise awareness of proven and potential risks".

Clinical Oncology Society of Australia President Associate Professor Sandro Porceddu said the research was an alert for people to be careful about what they took.

A/Professor Porceddu said patients could wrongly assume that anything that was natural and labelled complementary was safe and would complement conventional cancer therapies.

"Although some complementary therapies and medicines may benefit patients, they can also be dangerous and undermine treatment," he said. "Until we know more, it is best to err on the side of caution, and for patients to discuss with the health care provider any complementary or alternative therapies they are using or considering using."

Adrian Rollins

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.

NEWS

Asia getting rapidly healthier, but older too

Life expectancy across the Asia-Pacific region is increasing at one of the fastest rates in the world, but millions are being denied access to affordable, quality care because of weak government investment in health.

Across Asia, average life expectancy reached 73.4 years in 2012 – a jump of seven years since 1990, outstripping an average gain of 5.3 years among developed countries over the same period, according to the Organisation for Economic Co-operation and Development (OECD).

The improvement was underpinned by a dramatic fall in infant mortality (which has halved in many countries since 1990) and big gains in maternal health – the average maternal mortality rate across Asian countries has plunged by 48 per cent.

As a result, a massive demographic shift is underway across the region. The population is rapidly ageing, so that by 2050 more than one in every four people will be 65 years or older.

But region-wide improvements disguise major disparities in health among individual countries, the joint OECD-World Health Organisation report, *Health at a Glance Asia/Pacific 2014*, shows.

While a baby born in Hong Kong or Japan in 2012 could, on average, expect to live for more than 86 years, (and more than 84 years in Australia), average life expectancy in Papua New Guinea was just 64.5 years, and 67 years in Myanmar.

The differences are reflected in wide discrepancies regarding infant mortality between countries in the region. While there was just one infant death per 1000 live births in Hong Kong in 2012 (and three per 1000 in Australia), in Pakistan the rate is a massive 69 deaths per 1000 live births, 54 in Laos and 48 in PNG.

The OECD said that, while the overall improvement in life expectancy and reduced infant and maternal mortality in the Asia-Pacific region was impressive, much more can and should be done in many countries to lift health standards.

"Countries in the Asia-Pacific region need to step up their efforts to give more people access to affordable, quality health care," the OECD said. "Too many people, especially women, cannot get the medical treatment they need due to high costs, difficulties in getting permission to see a doctor, or a lack of health care providers in rural areas."

Part of this comes down to inadequate investment in health, particularly by governments.

The report found that Asian countries spend an average $US730 per person on health (equivalent to 4.6 per cent of gross domestic product), compared with an OECD average of $US3510 (9.3 per cent of GDP).

The shortfall in public spending is even more marked – in Asia, less than half (48.1 per cent) of total health spending comes from the public purse, compared with the OECD average of 72.7 per cent.

The relative lack of investment is obvious in the paucity of health resources available, particularly in poorer rural areas.

Across the Asia-Pacific, there is an average of 1.2 doctors and 2.8 nurses for every 1000 people, well below the OECD average of 3.2 doctors and 8.7 nurses.

There are also fewer hospitals on hand. In Asia, there are 3.3 hospital beds for every 1000 people, while among developed countries the average is 4.8.

While spending on health in Asia is relatively low by developed country standards, individuals and governments have been outlaying more on health as economies have developed and millions have emerged from poverty.

Across Asia, per capita spending on health grew at an annual average of 5.6 per cent in real terms between 2000 and 2012, exceeding the average annual rate of economic expansion of 4.3 per cent.

The growth in spending has been particularly marked in China and Mongolia, where it has been virtually double that of the regional average.

These investments have had marked results in health outcomes.

In most Asia-Pacific countries, more than 90 per cent of one-year-olds now receive vaccination for measles, diphtheria, tetanus and pertussis – on par with global best practice.

These and other investments have helped contribute to sharp declines in infant and maternal mortality and improvements in life expectancy – both China and Mongolia registered a 71 and 70 per cent improvement, respectively, in infant mortality rates between 1990 and 2012, compared with an average gain of 55 per cent across Asian countries.

Adrian Rollins

NEWS

Japan must gear up for 'super-ageing' population

Japan needs to cut the time patients spend in hospital and do better at recognising and rewarding quality care as the ranks of its elderly rapidly swell, an assessment of the Asian country's health system has found.

The Organisation for Economic Co-operation and Development said Japan scored highly on many key indicators of health, including longevity, and stroke and cancer survival rates despite only average health spending.

The OECD's *Health Care Quality Review of Japan* noted that Japan's average life expectancy of 83.2 years was among the highest in the world, as are its five-year survival rates for breast, cervical and colorectal cancer, while its 3 per cent case-fatality rate for stroke is the lowest in the world.

The organisation said this achievement was particularly impressive given that the country spent just $US3484 per capita on health a year – very close to the average among OECD member countries.

"These outcomes are achieved by a health system that is characterised by its flexibility and light-touch governance… [which] makes the system accessible and responsive," the OECD said.

But it warned that changes were needed if the health system was to cope with the increasing array and complexity of demands from the nation's "super-ageing" population.

The OECD said one area where great efficiencies could be realised was in hospital care.

It said the average length of hospital stays in Japan was very long – patients stay, on average, 17.9 days in acute care, compared with the OECD average of 6.6 days.

The organisation said there was potential to provide more care outside of hospitals, cutting costs and treating patients closer to their homes and families.

The OECD said the Japanese health system also lacked sophisticated and systematic quality assurance arrangements.

It said initiatives to assess and reward quality care were often voluntary and public, were applied haphazardly, and did not reward quality in either a sophisticated or consistent way.

The OECD also urged Japan to upgrade its mental health care, noting the country's high suicide rate. There are 20.9 suicide deaths per 100,000 people in Japan, compared with the developed country average of 12.3.

"Japan needs to shift to a more structured health system and strengthen quality governance," the organisation said. "Delivery of the key services of primary care, acute care and long-term care should be better separated to make sure that care takes place in the right setting.

"[Also], the infrastructure to monitor and improve the quality of care must deepen and become embedded at every level of governance."

The OECD recommended that Japan cut the number of hospital beds (there are currently 13.3 for every 1000 people, compared with the OECDE average of 4.8), while expanding nursing home places and providing a wider array of services in the community.

Adrian Rollins

COMMENT

MOTORING

All hail the Howarth elevator

BY **DR CLIVE FRASER**

It's been 20 years since Brisbane was hit by its worst hailstorm ever.

I recall looking up on the afternoon of Friday, 18 January 1985, and seeing a very menacing dark green sky as I left the Royal Brisbane Hospital car park to head home during peak hour.

I didn't get far in the traffic before I had to pull over as the storm struck and visibility was immediately reduced to zero, with the rain (and hail) bucketing down.

The sound of hail stones as big as cricket balls hitting the roof of my 1980 Chrysler GH Sigma was deafening.

Thinking that I might protect my panels with some towels, I bravely ventured out of my vehicle, only to make a hasty retreat after copping a blow to the head from a large chunk of ice.

I might have thought twice about braving the elements if I'd known that 55 millimetres of rain had fallen in 10 minutes, and that wind gusts of up to 187 kilometres an hour were being recorded at Brisbane Airport.

The wind was so strong that the hail was being driven horizontally, and my car was being hit from all angles.

The damage to my vehicle was not immediately obvious that night, but in the morning light my car looked like it had taken hundreds of blows from a hammer.

I recall that it cost $4000 to cut off my roof, replace the bonnet and boot and put body filler in the hundreds of dents all over my $8000 car.

The cost to the community overall was $300 million ($900 million in today's money).

Twenty per cent of Brisbane's cars and 20,000 homes were damaged in the storm, and 2000 homes were un-roofed.

Repairs to vehicles took up to a year, as there were simply not enough spare parts in Australia to fix the thousands of cars that had been damaged.

Automotive repair methods have changed considerably since 1985, with stronger and thinner metal panels and modern flexible paint.

Nowadays there is a fair chance that most, if not all, of the dents to cars caused by hail can be repaired without body filler or re-painting.

One of the techniques used is to pull the dents out by attaching a stick with a dab of glue to the divot and applying a heat gun or freezing gas or compressed air to pop it out.

But the most common high-tech method of fixing a dent is to push it out from behind with a pointy stick.

I should have known that this was possible, because I'd been a surgical registrar and I'd elevated the depressed zygomatic arch many times with a Howarth elevator using the Gillies method.

Of course, these days the pointy stick is a bit more sophisticated than a cut-off garden stake. Modern automotive pointy sticks have a magnetized rotating ball on the end which allows the operator to see exactly where the stick is internally situated by placing a ball-bearing on the outside of the panel.

Repairers have a highly practised technique, with most repairs using a circular motion from the outside to the centre.

All of this is only possible of course if the metal (and paint) isn't stretched (too much).

Late last month (Thursday, 27 November) Brisbane copped another massive hailstorm during peak-hour, and another $200 million dollars' worth of damage.

I'll be out there with my Howarth elevator to lend a helping hand if needed.

Hail facts:

Hail forms when an up-draft of air in a storm causes water to freeze and solidify and fall back to Earth.

A cricket ball weighs 160 gm.

A 7.2 cm (cricket ball) sized hail stone weighs 195 gm, and will fall to Earth at 48 m/sec or 173 km/h.

Being hit by a large hail stone can be deadly.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

COMMENT