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Budget drains health

Doctors, patients pay for Government bottom line, p4

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REGULAR FEATURES

This cap doesn't fit

BY **AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB**

It's that time of year again. As depressing as the arrival of winter in a beach resort, the Federal Budget season is in full spate.

There used to be a convention that the contents of the Budget were confidential until the Treasurer rose to deliver the speech. The ritual of the journalist and commentator 'lock up' added to the sense of occasion and aura of expectation.

In recent years the pattern has changed, with any bad news made public through carefully managed leaks, or packaged with other pre-budget announcements to 'soften up' the public and the media. This leaves the opportunity to bask in the light of a positive balance of announcements on Budget night.

One of the worst of these 'bad news' announcements this year has been the $2000 cap on tax deductible professional education expenses.

This came out of the blue, without any prior consultation with the AMA or other professional associations.

It seems unlikely that other government departments could have been aware it was coming, because it seems directly opposed to other policy directions in health, for example. Other professions will also be adversely affected and should also be drawing the government's attention to the inequity of this cap, but the effects on doctors will be particularly severe.

Specialist training in medicine is particularly long and expensive. Most Colleges operate on a cost recovery model from their trainees. The costs for training and mandatory courses can be over $20,000 a year out of the salary of a doctor in training. These are not discretionary costs. They are an essential cost for providing the highly skilled medical workforce Australia needs in the future. The financial burden on trainees is already high, and it is clearly not in the public interest to have perverse incentives that encourage people to cut corners.

In addition to this, trainees are encouraged to attend Colleges or specialist society meetings to present research and hear from those at the cutting edge of their specialty.

The pace of change and innovation in medicine has never been greater, so keeping up with this in an environment that provides peer assessment and the opportunity for questioning is invaluable for professional development and patient care.

No medical education course, seminar or conference comes cheap. Sponsorship is a rapidly diminishing pool. Regulation of pharmaceutical companies severely limits their capacity to provide support.

Registration fees are often $1500 to $2000, or more. To this must be added the costs of travel and accommodation. These fall unevenly on those living in rural and remote Australia or Western Australia.

Specialists working in rapidly developing areas or sub-specialist areas may only be able to keep up to date by attending meetings in the United States or Europe, and it seems incongruous that these essential business inputs would not be considered as a tax deductable expense.

The expense is as essential as the cost of airfares for fly-in, fly-out workers for a mining company or the cost of food for a restaurant.

In introducing this cap, Treasury couldn't have been aware that other areas of government - the Australian Health Practitioner Regulation Agency and the Medical Board of Australia - have made continuing education a mandatory part of maintaining registration as a health professional. It's an unavoidable business cost for health professionals and any consideration of equity with other businesses should see these expenses as tax deductable.

Of course, there are already checks in the system, with the need to be able to substantiate tax claims and the review of claims by the accountants who prepare our tax returns. I can't believe Treasurer Swan is suggesting these professionals are incompetent or not doing their job properly.

Treasurer Swan also suggested the claims for education expenses relate to "first class airfares and five star hotels." I can't imagine his motivation when it is so obviously wrong.

Even if a few claims relate to such expenses, is he suggesting that tax deductibility for first class airfares and five star hotels should be confined to bankers, businessmen, sports stars and entertainers?

Nevertheless, most of us can only dream of the legendary standards of the mining industry's annual Diggers and Dealers conference for our meetings – or am I too succumbing to the politics of envy?

The $2000 cap on claims for professional education expenses appears to be a poorly considered piece of policy - even before the detail is available.

As a consumer, I want to know that my accountant, lawyer, architect and the engineer designing the bridges I am travelling over is up to date.

The Medical Board has indicated by its actions that continuing education is essential for health professionals.

If Treasury had consulted before the announcement, it is hard to believe such poor policy would have been published.

The information they are getting now from the AMA and other professional groups must be telling them it is inequitable.

Sometimes saying you were wrong can make you look better. I hope you get to read this Mr Swan. Please reconsider and change this dumb and dumber change to the tax deductibility to an essential cost of working in medicine.

TO COMMENT CLICK HERE

Govt transplants funds from health to support bottom line

Patients will pay for the Federal Government's $1.8 billion hit to health spending with reduced bulk billing, higher out-of-pocket expenses, less tax relief and fewer medical specialists, AMA President Dr Steve Hambleton has warned.

"... history showed that when the indexation of MBS rebates was frozen or held back, bulk billing rates eventually fell"

Describing the Budget as a "quadruple whammy" on health, Dr Hambleton said measures taken by the Government to rein in health spending would affect every patient, and those with complex and chronic conditions were likely to be hit particularly hard.

The Government has announced an eight-month freeze on the indexation of the Medicare Benefits Schedule (MBS) rebates until mid-2014, saving it $664 million, as well as virtually doubling the upper Medicare Safety Net threshold to $2000 (for a saving of $105 million), phasing out the medical expenses tax offset (a $964 saving) and capping tax deductions for work-related self-education expenses at $2000 a year, for a saving of $514 million.

Despite these cuts, Health Minister Tanya Plibersek claimed the Government was undertaking "record ongoing investment" in health, pointing to an $871 million boost to public hospital funding in 2013-14, an increase in MBS spending to $19 billion and the allocation of an extra $226 million to cancer screening and research.

All up, the Minister said, $79.2 billion would be spent on health next financial year.

But Dr Hambleton said the Government was pushing more of the cost of health care directly onto doctors and their patients.

The AMA President said that, over time, the effect of the Budget savings measures would show up in lower bulk billing rates, higher out-of-pocket expenses, less tax relief and greater difficulty getting specialist care.

He said freezing the MBS rebate put doctors in a very tough position because it meant practice income was held down even as the cost of providing a health service – everything from rents and utility bills to salaries and medical supplies - continued to climb.

"Doctors face three choices," Dr Hambleton said. "They can get out of the business altogether, they can lower the quality of their service, or they can maintain service quality and charge a fair fee.

"Practitioners have shown in the past that they refuse to lower the quality of their service, and that means they will have to charge a fair fee."

Earlier this month the Government hailed figures showing the bulk billing rate for GP services reached a record high of 82.4 per cent in the March quarter, and Ms Plibersek predicted it would remain high despite the deferment of MBS indexation.

"I believe that, given that the pause in indexation is only for eight months, the majority of doctors who bulk bill patients now will continue to bulk bill," the Minister said. "This is a delay of eight months in a pay increase. I know that nobody likes having a pay increase delayed by eight months.

"But it's a very clear and limited period, and I would hope and expect that the majority of doctors who bulk bill now will continue to do so."

But Dr Hambleton said the Minister's "dismissive" comments reflected misplaced confidence.

He said history showed that when the indexation of MBS rebates was frozen or held back, bulk billing rates eventually fell.

"The last time they were frozen or half indexed, it resulted in the lowest bulk billing rates we have ever seen," the AMA President said.

And he warned patients and the broader economy would pay a heavy price for the decision to cap the tax deduction for self-education expenses at $2000.

Dr Hambleton said that the cap was far below the costs incurred by doctors in maintaining their qualifications and keeping abreast of developments in diagnosis and treatment, and it would deter practitioners, particularly those entering the profession, from choosing to go into specialities that required significant initial and ongoing investments in education and training.

"We know that the quality of service will not go down, but doctors will be less inclined to get into those high cost specialties," he said. "It will result in a dumbing down of our health system."

In addition, he warned, it was likely to hit the education sector and the hospitality industry hard.

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AMA backs tighter vax rules for schools

The AMA has backed a Federal Government push to tighten immunisation requirements when children enrol in school.

While not backing a ban on children who are not immunised from entering school, the Association has welcomed plans to make it more difficult for parents to enrol their children without proof they have at least considered vaccination.

Federal Health Minister Tanya Plibersek has written to her State and Territory counterparts proposing uniform national rules requiring that parents produce immunisation documents for their children when enrolling them in school.

Ms Plibersek said that although a majority of the states and territories had immunisation requirement for school entry, but they were often not enforced.

"I am proposing we introduce a rigorous, nationally-consistent policy for schools to assess and document immunisation for all new enrolments as a way of identifying children who have slipped through the immunisation net, or have not yet met the immunisation milestones," the Minister said.

The move follows mounting concern the nation is vulnerable to sustained outbreaks of highly contagious and potentially deadly diseases such as measles because of low vaccination rates in pockets of the community.

Government figures show that although overall immunisation rates among very young children are high, there are areas – including in some well-to-do Sydney suburbs – where they have slumped, leaving pool of vulnerable children of sufficient size to feed a sustained outbreak.

The findings have highlighted fears that anti-vaccination groups spreading misleading information about the risks of inoculations are being heeded by some parents, despite ample clinical evidence about the widespread benefits of vaccination.

AMA President Dr Steve Hambleton backed Ms Plibersek's move, and said the barrier to enrolling children in school and childcare should be lifted to ensure parents consider vaccination for their children.

Dr Hambleton said he did not support calls for children who are not vaccinated to be banned form school, but said parents should be required to provide proof that they had at least made an active choice on the issue, whether it be to vaccinate or not.

"The demand that there be a 'no certificate, no play' rule is something we certainly would support," the AMA President said.

"We applaud the Minister's leadership in this area, and urge the nation's health ministers to take action to get vaccination rates among five-year-olds back up to where they need to be."

Ms Plibersek wants to establish a nationally consistent policy that requires parents seeking to enrol their child at school to present a Child Immunisation History statement.

"Ensuring accurate records are available at schools will assist both in promoting immunisation of children and improving the control of spread of vaccine-preventable diseases by excluding children from school during an outbreak, if they are not immunised," she said.

The Minister said she was encouraged by a South Australian Government program which had seen a lift in immunisation rates among five-year-olds from 88.8 to 91.1 per cent since mid-2012 through the distribution of an information pack to parents.

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Medical registration for doctors holding *occasional practice* registration

"In light of the current Medical Board registration arrangements, the AMA urges all members who are considering transition to retirement that, if they wish to continue to practise in any way at all, they should maintain their registration"

There are a small number of members who are registered in the *limited registration (public interest – occasional practice)* category with the Medical Board of Australia.

As a result of AMA lobbying at the time the national registration arrangements were being developed in 2009, this registration category was created as a transitional measure to accommodate medical practitioners in NSW, Queensland, Tasmania and the ACT who held this type of registration with their respective state medical boards.

These practitioners were advised at the time that they would be able to renew their registration in this category for three consecutive years under the national registration arrangements.

Members who are registered in the abovementioned category will have received a letter from the Medical Board of Australia and AHPRA about their registration options and an application form through which they can:

1. apply for general registration;
2. apply for non-practising registration; and
3. advise the Medical Board of Australia that they do not wish to apply for either category – and in doing so will let their registration lapse.

I have had several conversations with the Chair of the Medical Board of Australia Dr Joanna Flynn to argue for suitable arrangements for affected members.

As a result, the AMA notes that the Board:

- is not charging an application fee for this process (which usually applies when registrants change registration categories); and
- will accept that the practitioner meets the recency of practice hurdle for general registration if the practitioner continues to practice their current scope of practice (i.e. for clarity this may be just prescribing and making appropriate referrals to colleagues).

In light of the current Medical Board registration arrangements, the AMA urges all members who are considering transition to retirement that, if they wish to continue to practise in any way at all, they should maintain their registration. There is no compulsion for any registered medical practitioner to let their registration lapse, just because they are winding back their practice or reducing their scope of practice.

Maintaining registration, in any registration category, means that you can use the protected title of 'medical practitioner'. Medical indemnity insurers already offer reduced premiums for reduced or limited scopes of practice.

The AMA has been, and will continue to, lobby the Medical Board to offer a reduced registration fee as a way to support registrants who may be considering retiring, to maintain their registration in order to remain in the workforce and contribute as an active member of the medical profession.

The AMA Economics and Workforce Committee and the Federal Council have given careful consideration to continuing professional development (CPD) requirements for registered medical practitioners. All registered medical practitioners should meet the minimum CPD requirements - tailored to their scope of practice.

This accords with the AMA Code of Ethics, which advises practitioners to "continue lifelong self-education to improve your standard of medical care". All medical practitioners have a duty, if they continue to provide patient care – diagnosing, treating and prescribing – to undertake CPD.

CPD requirements can be met through a wide range of activities, from attending structured educational courses, to reading journals and undertaking online learning activities.

Medical practitioners who are not a fellow of a college or not on the specialist register, can structure their own CPD, though it must have some practice-based reflective elements such as clinical audit, peer review or performance appraisal.

Dr Steve Hambleton

TO COMMENT CLICK HERE

Bulk billing warning as rebates freeze

Mounting financial pressures on medical practices have prompted warnings that the bulk billing rate for GP services is likely to fall from the record high reached earlier this year.

Government figures show 82.4 per cent of GP services, almost 75 per cent of diagnostic imaging procedures and 87.6 per cent of pathology services, were bulk billed in the March quarter, helping hold the bulk billing rate for all Medicare services at a historically high 76.5 per cent.

But AMA President Dr Steve Hambleton warned the rate was likely to fall in coming months following the Federal Government's decision to delay the indexation of the GP Medicare rebate – currently set at $36.30 – by eight months, from November this year to July 2014.

Dr Hambleton said it was "surprising" that the Government handed down a Budget package that will force bulk billing rates down a day after it lauded figures showing bulk billing had hit record levels.

He said it was becoming increasingly unsustainable for doctors to continue bulk billing as the gap between the rebate and the costs of running a practice widened.

"Wages go up, superannuation is now going up, costs are going up, and the rebate to see the doctor is not going to go up," the AMA President said on 3AW. "You will find that the bulk billing rate, which is relying on the [Medicare] rebate, is likely to start to fall."

But Health Minister Tanya Plibersek has dismissed concerns the bulk billing rate will slide, arguing that the eight month delay in indexing Medicare Benefits Schedule rebates would cost doctors little and be barely noticed by patients.

Ms Plibersek said on ABC's Radio National the impact of freezing MBS indexation until July next year would be minimal, saying it amounted to the loss of 60 cents on a standard GP consultation.

"We think bulk billing rates will stay very strong," the Minister told *The Australian Financial Review*. "The average doctor gets $350,000 a year in Medicare billings. It's a fairly substantial payment."

But doctors said the figure cited by the Minister was grossly inflated, with one declaring that "my gross billings are about a third of this amount, let alone Medicare, which is nowhere near this figure".

The Government has been keen to push high bulk billing rates as a measure of the success of the Government's primary health care policies.

"These historic high rates of bulk billing are a result of concerted effort on the part of this Government," Ms Plibersek said. "We've invested hundreds of millions of dollars into incentives to encourage doctors, pathologists, radiologists and other health professionals to bulk bill their patients."

She said record high bulk billing was "a very strong signal that our health system is both affordable and that numbers of doctors [and] allied health professionals have improved".

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No link between Gardasil and infertility: TGA

The medicines watchdog has found no evidence to link the genital warts vaccine, which has been credited with a dramatic reduction in the occurrence of the illness, to premature ovarian failure and infertility.

In answer to a question on notice, Health Minister Tanya Plibersek said the Therapeutic Goods Administration found that there was no "plausibly biological basis" for drawing a link between the vaccine Gardasil and premature ovarian failure.

The issue arose following a report in the *British Medical Journal* late last year of the case of a 16-year-old Australian girl who suffered premature ovarian failure after being vaccinated against the human papillomavirus (HPV).

According to the lead author of the report, Dr Deirdre Little, the girl's menstrual cycle became scant and irregular following vaccination. She declined to take oral contraceptives, as initially prescribed for amenorrhoea, and suffered premature ovarian failure.

"Although the cause [of premature ovarian failure] is unknown in 90 per cent of cases, the remaining chief identifiable causes of this condition were excluded," Dr Little said in her report. "Premature ovarian failure was then notified as a possible adverse event following this vaccination."

But in her written answer to a question from West Australian Liberal Senator Michaelia Cash, Ms Plibersek said the medicines watchdog had not found evidence of a link between Gardasil and premature ovarian failure, and did not think there were grounds to undertake long-term surveillance of ovarian function among immunised girls and women.

"The TGA has not identified a possible safety signal for premature ovarian failure following Gardasil vaccination," the Minister wrote. "In addition, the TGA does not consider that a plausible biological basis for a causal relationship between the administration of Gardasil vaccine and the occurrence of premature ovarian failure has been established."

In her answer, Ms Plibersek said oligomenorrhoea and amenorrhoea were "common occurrences" in teenaged girls and young women, and could have many possible causes.

Out of 6.7 million doses of Gardasil distributed in Australia between 2006 and the end of last year, the case reported by Dr Little was the only incident the TGA had been informed of involving a possible link between the vaccine and premature ovarian failure.

"The TGA considers there is insufficient evidence of a safety signal with Gardasil to warrant undertaking a specific long-term follow up of ovarian function in a cohort of vaccinated girls and women," the Minister wrote.

In all, the TGA reported it had been advised of 1983 suspected adverse events following vaccination with Gardasil, including 1585 where Gardasil was the sole vaccine administered.

The regulator found that the majority of adverse reactions were mild and well recognised: almost one in five involved headaches, 18.4 per cent involved reactions at the site of the injection, including bruising, pain, swelling or a rash, 15 per cent were for nausea, 14 per cent dizziness, 11 per cent for fatigue and lethargy, and 10.6 per cent involved fever.

There were 167 cases (9.1 per cent) where the recipient fainted, and 19 reported instances of anaphylactic reaction.

The TGA reported that there was no evidence that the incidence of demyelinating disorders such as multiple sclerosis was any higher following Gardasil vaccination than would occur by chance.

The low incidence of reported adverse events following Gardasil vaccination (less than 0.03 per cent) has come amid hopes genital warts could soon be eliminated because of the treatment.

As reported in the last edition of *Australian Medicine* (see https://ama.com.au/ausmed/war-warts-being-won), the incidence of genital wart cases among young women has plunged since the nationwide human papillomavirus vaccination program began in 2007.

A study in the *BMJ* found rates of diagnosis among women 21 years or younger has plummeted from 11.5 per cent in 2007 to just 0.85 per cent in 2011, a fall of almost 93 per cent.

Hopes to eliminate the disease, which can cause cervical cancer, have been boosted by the Government's decision last year to extend the vaccination program to include boys.

Internationally, the GAVI Alliance – a global joint public and private partnership partially funded by the Australian Government – has announced plans to vaccinate 30 million girls in 40 of the world's poorest countries against HPV after negotiating a deal with manufacturers for supplies at just $4.40 a dose, a big discount on its cost in developed countries.

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Dedicated surgeons speed up emergency care

Patients are treated more quickly and discharged sooner from hospitals that have dedicated acute care surgical centres, experience at a major Victorian hospital suggests.

A review of patient records at the Royal Melbourne Hospital has shown that the establishment of an emergency general surgery service has led to a significant improvement in the speed of admissions from the emergency department, as well as markedly shorter hospital stays.

Royal Melbourne Hospital general surgeon Dr Rose Shakerian told the Annual Scientific Congress of the Royal Australasian College of Surgeons that in its first 48 weeks of operation, the emergency general surgery service (EGS) had achieved significant improvements in patient outcomes, even as the number of acute admissions had skyrocketed.

Dr Shakerian said the service treated 4523 patients between its establishment in February 2011 and January 2012, during a period when acute admissions surged by 73 per cent.

She told the Congress that, compared with the 48 weeks preceding the establishment of the EGS, the average length of hospital stay fell from 5 to 4.1 days (an 18 per cent drop), while the proportion of patients admitted from the emergency department within eight hours jumped from 49 to 69 per cent – a 20 percentage point improvement.

The findings underline calls by the College for the establishment of dedicated acute care surgical units in hospitals as a way to boost efficiency and improve care.

They come amid evidence that the nation's hospitals are struggling to reach national benchmarks for timely emergency department treatment.

An audit by the National Health Performance Authority, released late last year, found that most patients are waiting in emergency departments for up to 17 hours for care.

The nation's governments have jointly committed to a goal that by 2015, 90 per cent of emergency department patients will be seen and discharged or admitted within four hours of arrival.

But the first nationwide assessment of emergency ward performance found that just 54 per cent of patients at major metropolitan hospitals left the emergency department within four hours, while an average of 63 per cent were seen in the same time at major regional hospitals.

AMA President, Dr Steve Hambleton, said the results reflected problems afflicting hospitals more generally, rather than just emergency departments, and showed that they simply did not have the capacity to meet demand.

The AMA President called for governments to take joint responsibility to work on solutions.

"It is time for cooperation, not blame," Dr Hambleton said. "There are many reasons for the variance in performance across the states and territories, but a united focus on a small number of key priority areas will help lift hospital performance across the board."

The AMA President said, "whole-of-hospital reform is needed, not just emergency departments".

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INFORMATION FOR MEMBERS

AMA Fee List Update – 1 April 2013

The AMA List of Medical Services and Fees (AMA List) has been updated to include new items for radiofrequency ablation for the treatment of Barrett's oesophagus, cervical artificial intervertebral disc replacement, and testing for germline mutations of the von Hippel-Lindau gene. Changes have also been made to items for the removal of rectal tumours. These items are provided in the Summary of Changes for 1 April 2013, which is available from the Members Only area of the AMA website at http://www.ama.com.au/feeslist.

The AMA Fees List Online is available from http://feeslist.ama.com.au. Members can view, print or download individual items or groups of items to suit their needs. The comma delimited (CSV) ASCII format (complete AMA List) is available for free download from the Members Only area of the AMA Website (www.ama.com.au). To access this part of the website, simply login by entering your username and password located at 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 first option, AMA List of Medical Services and Fees - 1 April 2013; and
4) download either or both the CSV (for importing into practice software) and Summary of Changes (for viewing) detailing new, amended or deleted items in the AMA List.

If you do not have Internet access, the AMA produces the AMA List on CD. If you wish to order a copy of this CD, please complete the following form and return to:

Ms Melanie Ford - AMA. PO Box 6090, KINGSTON ACT 2604

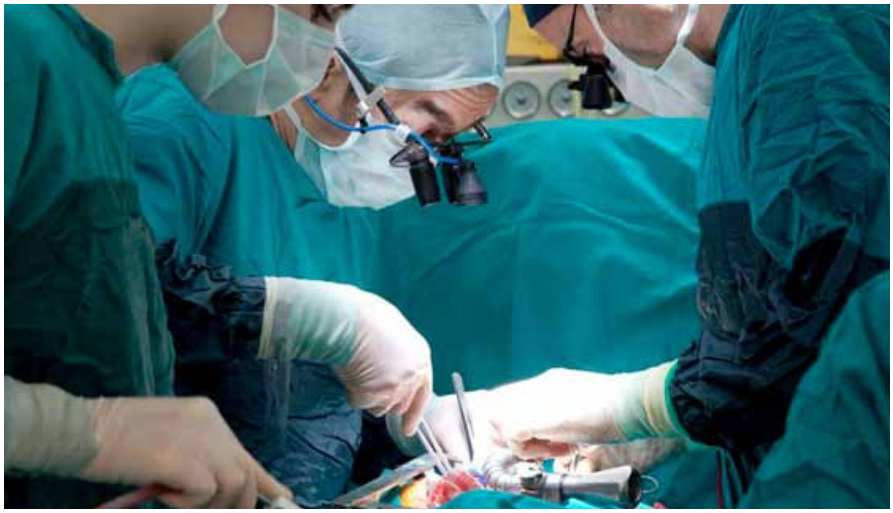
PLEASE PRINT CLEARLY

Name:_____

Address: _____

❑ I wish to order the AMA List of Medical Services and Fees on CD for $52.

Surgeons have choice cut



Surgeons were the nation's top wage earners, and medicine confirmed its status as one of the country's most lucrative professions, according to Australian Tax Office figures.

An analysis of 2010-11 tax collections shows that 3115 surgeons between them earned a taxable income of almost $1.1 billion that year, putting their average annual taxable income at $350,383 – a $17,589 increase from 2009-10.

Surgeons were followed in the earning stakes by anaesthetists, with 2685 practitioners earning between them $902 million in taxable income in 2010-11, for an average annual take of $335,940.

Among other medical specialties identified in the Tax Office data, 2350 psychiatrists between them were paid more than $403 million in taxable income, for an average annual taxable earnings of $171,600, while 20,725 general practitioners collectively earned more than $2.8 billion, for an average annual income of $135,600, and almost 6500 internal medicine specialists together were paid around $1.8 billion, putting average annual taxable earnings at $279,500.

Altogether, medical professions accounted for six of the 10 best-paid occupations, along with chief executives, managing directors, judges, financial dealers and mining engineers.

In terms of the distribution of earnings, anaesthetics was the most top heavy of the specialties: 76 per cent of male anaesthetists earned more than $180,000 a year, compared with 63 per cent of male surgeons, 63 per cent of male internal medicine specialists, and 50 per cent of male psychiatrists.

In all, just 8 per cent of male anaesthetists earned less than $80,000 a year, compared with 12 per cent of male internal medicine specialists, 13 per cent of male surgeons and almost 18 per cent of male psychiatrists.

The spread of earnings among male general practitioners was much more even – 30 per cent were paid more than $180,000 a year, and 27 per cent earned less than $80,000 a year.

The Tax Office figures confirmed a significant gender divide in earnings within the medical profession.

While an increasing number of women practitioners are being paid more than $180,000 a year, they are more likely than their male colleagues to earn significantly less.

Though the bulk of female GP (43 per cent) earned between $80,001 and $180,000 in 2010-11, 43 per cent were paid less than $80,000.

Even in anaesthetics, where 52 per cent of women practitioners earned more than $180,000, 16 per cent had a taxable income of less than $80,000, and among female surgeons the figure was 26 per cent.

Unfortunately, the Tax Office data did not include details of working hours, but an Australian Bureau of Statistics report suggests that at least part of the pay discrepancy between male and female doctors is due to the time spent on the job.

The ABS report A*ustralian Social Trends,* brought out last month, showed that, overall, GPs worked an average of 42 hours in the week prior to the 2011 Census, three hours less than the average for specialists (45 hours).

But it found the hours worked by doctors varied considerably between men and women.

"As in many occupations, female doctors were more likely to work part-time than their male counterparts," the report said. "In 2011, in the week preceding the Census, around a third of female GPs (35 per cent) and specialists (33 per cent) were working part time. In comparison, around one in ten male GPs or specialists worked part-time in that week (both 13 per cent)."

According to the ABS, male doctors were much more likely to work long hours, with 17 per cent of male GPs and a quarter male specialists working 60 hours or more a week. In comparison, 9 per cent of female GPs and 12 per cent of female specialists worked more than 60 hours.

Among male specialists, obstetricians, cardiologists and surgeons (including neurosurgeons, paediatric surgeons, and cardiothoracic surgeons) were particularly likely to be working long hours.

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Australia underperforms on baby and maternal health

Australian mothers and young children are at greater risk of dying than their counterparts in a majority of other industrialised countries.

A report by international charity Save the Children shows that although Australia scores well on overall maternal and child wellbeing, being ranked 10th best in the world, this result owes much to the weighting given to the nation's relative wealth, high levels of education and the proportion of federal MPs who are women.

A breakdown of the Save the Children data shows that Australia ranks just 20th out of 36 industrialised countries in terms of maternal mortality, and 24th for mortality rates among children five years or younger.

According to the report, in 2010 Australian women faced a one in 8100 lifetime risk of maternal death, far greater than the world's best performing country, Greece, were the risk facing women is just one in 25,500.

Similarly, the mortality rate among Australian children five years or younger was 4.5 per 1000 live births in 2011, compared with the international low of 2.5, achieved by Iceland.

But, despite this, the 14th annual *State of the World's Mothers* report shows the prospects for mothers and young children in Australia are far better than for most of those living in other parts of the world.

In particular, the study highlights the gulf in child and maternal health between the world's advanced economies and many developing countries, particularly those in sub-Saharan Africa.

With the exception of Australia, all the top 10 ranked countries identified in the report - headed by Finland, Sweden, Norway and Iceland - are European, while the bottom 12 nations are all in sub-Saharan Africa.

The health divide between the world's top and bottom ranked countries, Finland and the Democratic Republic of Conga, is enormous, according to the study.

"Maternal death is a rare event in Finland: a woman has less than a one in 12,000 chance of dying in pregnancy or childbirth," it said. "But in Congo, one woman in 30 is likely to die of a maternal cause."

There was a similarly confronting contrast in the fortunes of young children in the two countries. One in every 6 Congolese children does not survive to his or her fifth birthday, compared with one in every 345 in Finland.

Save the Children said the report highlighted to need for intensified effort worldwide to improve maternal and child health, particularly in the most impoverished and least developed countries.

The organisation said that although there had been "unprecedented progress" since 1990 in reducing child and maternal deaths, the pace of improvement had been patchy and uneven.

"Nearly all newborn and maternal deaths (98 and 99 per cent, respectively) occur in developing countries," the report said. "Every day, 800 women die during pregnancy or childbirth, and 8000 newborn babies die during their first month of life."

In fact, according to Save the Children, for many children the first days and weeks of life are the most perilous.

It found that three million babies died within their first month of life in 2011 – 43 per cent of all deaths of children younger than five years recorded that year. Furthermore, 75 per cent of these newborns did not survive their first week, and a third did not live through their first day.

The charity said there were three major causes of such newborn deaths – complications during birth, prematurity and infections.

It estimated that the lives of one million babies could be saved each year through the universal availability and use of four common treatments:

- steroid injections for women in pre-term labour to reduce deaths due to breathing problems in premature babies;
- resuscitation devices to save babies who do not breathe at birth;
- chlorhexidine cord cleansing, to prevent umbilical cord infections; and
- injectable antibiotics to treat newborn sepsis and pneumonia.

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National first to track cancer

The Federal Government has moved to fill a major gap in efforts to improve the detection and treatment of cancer.

Cancer control agency Cancer Australia has been awarded $2.4 million over four years to develop and operate a system to collect and report on cancer diagnoses nationwide, in what is seen as a crucial step in improving the detection and treatment of the deadly condition.

Cancer experts said the lack of consistent national data on the diagnosis and treatment of the disease had been a significant shortcoming hampering efforts to boost survival rates.

Further bolstering the early detection of cancer, the Government has unveiled a $56 million plan for free breast screening for all women aged between 70 and 74 years, building on the current program of free breast screens for women aged between 50 and 69 years.

The expansion means an extra 220,000 breast screens will be conducted in the next four years, with estimates an additional 2400 breast cancers will be detected.

Prime Minister Julia Gillard said improved clinical management of cancer and its outcomes depends on the stage at which it is diagnosed, and the lack of national cancer data left a significant gap in knowledge.

"We must fill this gap if we are to continue to lead the world in cancer care," Ms Gillard said, warning that the number of people diagnosed with cancer was likely to swell to 150,000 a year by 2020.

The system to be set up by Cancer Australia will collect, collate and report national data on the stage at which a cancer was diagnosed, the treatments applied at each stage of the disease and the frequency with which cancer reappeared following treatment.

In addition, the agency will develop a set of indicators by which cancer control efforts can be measured against international benchmarks.

Cancer Australia Chief Exective Professor Ian Olver said collecting evidence was instrumental to effective cancer care.

"Cancer survival statistics help provide the big picture. But we need data sets on [the] stage at diagnosis, recurrence and responsiveness to treatment to guide best practice," Professor Olver said.

His comments came as an international cancer detection expert urged the Government to bring forward plans for a comprehensive bowel cancer screening program.

Vice President of Cancer Control at the Canadian Partnership Against Cancer Dr Heather Bryant said "every effort" needed to be made to speed up the frequency and breadth of bowel cancer screening in order to avert thousands of unnecessary deaths.

Speaking at a Cancer Council conference in Adelaide earlier this month, Dr Bryant said the Government was taking too long to increase the frequency of bowel cancer screening in the country.

> "If the program was rolled out faster, Australia could expect a much higher rate of early diagnoses and, in turn, a major reduction in the number of bowel cancer deaths each year"

Under the Government's plan, the current program – under which people are screened every five years between the ages of 50 and 65 years – would be expanded to encompass 50 to 74-year-olds, with screening tests every two years. But the upgraded testing regime would not be fully implemented before 2035.

But Dr Bryant said this rollout was too long, given that bowel disease is a major killer in Australia, claiming an average of 80 lives a week. More than 11,000 cases are diagnosed every year, and there are around 4600 deaths.

"If the program was rolled out faster, Australia could expect a much higher rate of early diagnoses and, in turn, a major reduction in the number of bowel cancer deaths each year," she said.

"We know that screening people who have no signs or symptoms of the disease is extremely important, because bowel cancer often develops from a benign polyp and can be prevented when these polyps are discovered early and removed," Dr Bryant said. "The longer these polyps go undetected, the greater the risk of developing bowel cancer. Checking regularly through screening is out best line of defence against what is a highly treatable disease if caught early."

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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

Let's protect delicate kids from those nasty facts, *The Daily Telegraph*, 7 May 2013

AMA President Dr Steve Hambleton said it should be more difficult for unvaccinated children to enrol in primary school.

Fear cap will slash enrolments, *The Australian*, 8 May 2013

The AMA is fighting against capped tax deductions for self-education expenses.

Backlash may prompt rethink on $2000 cap, *The Australian Financial Review*, 9 May 2013

The AMA has been particularly vocal opponent to a $2000 limit on tax deductions for self-education expenses, and is seeking to convince the Government that medical training should be quarantined from any cap.

AMA in 'hands off Medicare' call ahead of Budget, *Courier Mail*, 10 May 2013

The AMA has called on the Government to keep it "hands off Medicare". The AMA said any short term gain from freezing Medicare rebates to save $1.54 billion over the next four years would have long-term costs if people could not afford to visit a GP.

Vaccine crackdown at schools, *Hobart Mercury*, 11 May 2013

The AMA has urged governments to increase the 'hassle factor' for parents who fail to immunise their children. AMA President Dr Steve Hambleton said he fully supported a crackdown.

Plibersek hails high rates of bulk billing, *The Canberra Times*, 14 May 2013

AMA President Dr Steve Hambleton said more doctors were bulk billing because they cared about their patients, many of whom were "doing it tough".

The sick used to fill Budget black hole, says AMA, *Sydney Morning Herald*, 16 May 2013

AMA President Dr Steve Hambleton said fewer doctors would be able to offer bulk billing because Medicare Benefits Schedule rebate indexation changes would mean government funding would not keep up with rising costs.

Nine months from a national baby boom, *Adelaide Advertiser,* 16 May 2013

AMA President Dr Steve Hambleton said there would be a "surge" in the birth rate in late February 2014 as couple tried to beat the end of the baby bonus, which will be scrapped from 1 March next year.

Radio

Dr Hambleton, 2UE, 6 May 2013

Doctors said they were "furious" anti-vaccination groups were warning parents not to trust their GP's advice on vaccinating their children. The Head of the Australian Vaccination Network said parents should consult books instead, as doctors are not taught about all the risks. Australian Medical Association President Dr Steve Hambleton said the claim was "totally false".

Dr Hambleton, 2CC, 8 May 2013

Australian Medical Association President Dr Steve Hambleton said further booster vaccinations may be required in order to combat whooping cough.

Dr Hambleton, 6PR Perth, 14 May 2013

AMA President Dr Steve Hambleton voiced his concerns that Medicare refunds for GP visits may be frozen in the Budget.

Dr Hambleton, 3AW Melbourne, 15 May 2013

AMA President Dr Steve Hambleton said every year the rebate you get from when you see a GP was increased by the inflation rate, and warned the Budget plan to freeze the rebate would end up costing patients more.

TV

Dr Hambleton.Today on *Sunrise*, 6 May 2013

The AMA criticised the Australian Vaccination Network, which recommended that people not to take the advice of GPs when it comes to vaccination.

Dr Hambleton, Sky News, 10 May 2013

The AMA said patients could pay more to see a doctor by the year's end amid concerns the Government will freeze Medicare rebates to help fill a Budget black hole.

Dr Hambleton, Channel 7 *Sunrise*, 15 May 2013

Labor's major items include the National Disability Insurance Scheme, which will be partly funded by an increase in the Medicare levy. Australian Medical Association President Dr Steve Hambleton said the Government was getting sick people to pay for its Budget black hole.

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AMA in action

Dr Hambleton voices the AMA opinion about the Budget to the media

AMA President Dr Steve Hambleton chaired the AMA Economics and Workforce Committee, which heard a presentation from Dr Tony Sherbon, Chief Executive Officer of the Independent Hospital Pricing Authority. The Committee discussed public reporting of pharmaceutical industry payments to doctors and the handling of complaints made against doctors.

Dr Hambleton was at the forefront of community reaction to the Federal Government's Budget, detailing the AMA's concerns that changes to freeze the Medicare rebate, restrict access to the Medicare safety net, phase out tax offsets for medical expenses and impose a $2000 cap on work-related self-education expenses would reduce bulk billing, leave patients further out of pocket and hamper the ability of practitioners to deliver quality care. For more news and analysis of the Federal Budget, download the Budget Special edition of *Australian Medicine* at https://ama.com.au/ausmed

Dr Hambleton also met with Liberal MP Andrew Laming, who is Shadow Parliamentary Secretary for Regional Health Services and Indigenous Health.

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AMA President Dr Steve Hambleton with Dr Tony Sherbon, CEO of the Independent Hospital Pricing Authority

Dr Hambleton with MP Andrew Laming Shadow Parliamentary Secretary for Regional Health Services and Indigenous Health

Health on the hill

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Teary introduction to disability scheme

An emotional Julia Gillard broke down in tears in Parliament last week while introducing a Bill to help fund the Federal Government's signature DisabilityCare scheme.

The Prime Minister wept as she recalled receiving a thank you card from 17-year-old Sandy Anderson, who suffers from a condition similar to cerebral palsy.

"Sandy has big dreams for his future, like any teenager, but his future also has some big needs: mobility aids that cost tens of thousands of dollars, personal care to maintain his hygiene, physical therapy to maintain his muscles and his health," Ms Gillard told Parliament. "In years to come, DisabilityCare Australia will ensure… Sandy and so many other young people with disability will have the security and dignity every Australian deserves."

The legislation introduced by Ms Gillard and passed by Parliament will increase the Medicare levy by 0.5 of a percentage point to 2 per cent from 1 July next year, raising $19.3 billion by the end of the decade to help fund DisabilityCare.

According to Government projections, the annual cost of the scheme will grow from $200 million next financial year to $10.4 billion in 2022-23. In the next 10 years the cumulative cost is expected to reach $33 billion.

Because the increased Medicare levy will provide only partial funding for the disability scheme, the Government has drawn up a range of other measures to help pay for the initiative.

It plans to raise $6.5 billion over 10 years by indexing and means testing its rebate for private health insurance premiums, and expects to free up a further $6 billion by cracking down on tax exemptions for superannuation earnings and the design of the higher concessional contributions cap.

The health system is also expected to make a contribution.

The Government will phase out the net medical benefits tax offset, freeze Medicare Benefits Schedule rebates for eight months and index the tobacco excise. Together with a jump in import processing charges, these measures are collectively expected to raise an extra $20.6 billion over the next 10 years.

The Coalition has backed DisabilityCare and endorsed the rise on the Medicare levy, but at the time of going to print it was still to commit itself to the other measures outlined by the Government to help fund the scheme.

A key plank in the establishment of the national scheme fell into place days before the Budget when the Queensland Government joined its counterparts in New South Wales, Victoria, South Australia, Tasmania and the ACT in signing up to the initiative.

Under a deal with the Commonwealth, Queensland will more than double its disability funding to $2 billion a year by the end of the decade, and a $200 million funding shortfall will be met from the pool of funds raised by the increased Medicare levy.

The Commonwealth will contribute $2 billion over the same period.

Queensland's acquiescence means the scheme will cover at least 90 per cent of the population, with only Western Australia and the Northern Territory holding out.

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Final wishes go electronic

Doctors will be able to quickly access the treatment wishes of terminally ill patients under Federal Government plans to include advance care plans in electronic health records.

As the Gillard Government pushes ahead with the rollout of its Personally Controlled Electronic Health Record (PCEHR) system, Health Minister Tanya Plibersek has announced $10 million will be spent to upgrade the scheme to include Advance Care Directives that set out patient wishes for treatment as they approach the end of their life.

"Most families want to be true to the wishes of their loved ones as they approach the end of their lives, and Advance Care Directives allow that to happen," Ms Plibersek said. "Including [them] on the PCEHR will mean people will be able to share their end of life plans with any of their chosen doctors, hospitals, family or carers."

The Minister said that including advance care plans on the PCEHR meant that patients and treating doctors could get access to them wherever they were in the country.

The AMA has long urged the increased use of advance care plans as a way for people to ensure that their wishes as to how they are to be treated in their final stages of life, and one of Australia's leading specialists in the area, Associate Professor Bill Silvester, said the move to put the information on the PCEHR was an important and welcome move.

"By putting advance care directives online, it guarantees the patient is at the centre of their health care," Associate Professor Silvester said. "If a patient is admitted to hospital, doctors will be

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able to quickly see exact details of their wishes for end of life care. It ensures that the patient stays front and centre and maintains control of what will be happening to them when they can no longer speak for themselves."

Professor Silvester, who is President of the International Society of Advance Care Planning and End of Life Care, has been awarded $800,000 by the Government to conduct a two-year project on advance care planning.

Chair of the AMA Ethics and Medico-legal Committee Dr Liz Feeney said recently that advance care planning "plays an important role in patient self-determination by giving competent patients the opportunity to think about, and articulate, their goals and values for their health care should they lose decision-making capacity in the future".

"Having an advance care plan greatly reduces stress for the patient, their family and the doctors who may have to make difficult decisions at a particularly challenging time," Dr Feeney said. "Such plans give patients the peace of mind of knowing that their health care wishes have been made clear to others, as well as helping surrogate decision-makers act in ways that reflect the patient's wishes and assisting doctors in preparing clinical care and treatment plans that are consistent with the patient's expressed values, preferences, and goals of care."

While expanding the PCEHR to include advance care plans is seen as a valuable innovation, the introduction of the electronic health records system has been undermined by poor and haphazard support for medical practices.

The AMA has repeatedly warned Ms Plibersek that the take up of the PCEHR by medical practices has been undermined by inadequate arrangements to help them set up the technical and administrative processes needed to join the scheme.

The Government had imposed a 1 May deadline for practices to make themselves 'PCEHR-ready' or lose access to e-Practice Incentive Program payments, and has heavily promoted the system to the general public.

But AMA President Dr Steve Hambleton warned "a serious mismatch is being created between the patients that have signed up and are expecting their general practice to engage with their PCEHR, and the general practices that are actually ready to use the PCEHR".

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Families offered a bridge out of detention

The Federal Government has admitted that children of asylum seekers will be held at the notorious Curtin immigration detention centre, but has stressed that their stay will be kept to "the shortest possible time".

As the Government continues to struggle with the explosive politics of the asylum seeker issue, Immigration Minister Brendan O'Connor has acknowledged that children will be held in detention while mandatory health, security and identity checks are carried out.

"Where there are children in family groups, these detention centres and their services are adapted for families and children," Mr O'Connor said. "The stay in a detention centre for families will be for the shortest possible time, and only while their mandatory checks are undertaken. This will include Christmas Island, Curtin and Wickham Point."

The policy is at odds with mounting evidence that mandatory detention causes long-term harm to the physical and mental wellbeing of asylum seekers, especially children.

The AMA has been at the forefront of public debate on the issue, and President Dr Steve Hambleton warned last year that indeterminate detention "has a serious mental health impact".

"There are currently no specific guidelines for dealing with the health needs of children in detention," Dr Hambleton told the 2012 AMA Parliamentary Dinner at Parliament House. "But there is plenty of research evidence of the harm that detention causes to a child's development. We must do the right thing."

Dr Hambleton called for the establishment of an independent expert medical panel, reporting directly to Parliament, to monitor the quality of health care provided to detainees.

The Government earlier this year appointed a 12-mmeber Immigration Health Advisory Group, led by former Defence Force medical officer Dr Paul Alexander and including AMA Psychiatrist Group member Dr Choong-Siew Yong, to advise on the health needs of asylum seekers.

But Dr Hambleton said the group was constrained in its work and a truly independent expert panel was needed.

A significant increase in the number of asylum seekers coming by boat since the start of the year has not only strained the capacity of detention centres, but added to financial pressure on the Government,

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which has used a policy of mandatory detention – particularly in offshore facilities – to help deter new arrivals.

But Mr O'Connor has announced the Government will allow asylum seeker families which have undergone mandatory identification, health and security checks, to be allowed into the community on so-called bridging visas.

Consistent with the Government's tough rhetoric, the Minister emphasised that public support for those on bridging visas would be kept to a minimum. They would not be eligible for Centrelink support, and would instead receive an allowance equivalent to about 90 per cent of unemployment benefits.

"People released into the community on bridging visas will receive adequate support, but it will not be so generous that it encourages people to come to Australia by boat," Mr O'Connor said.

He added that holding a bridging visa was not a means to circumvent lengthy processing arrangements, and was taken as a measure to help contain the costs of the influx of boat arrivals.

"They [asylum seekers on bridging visas] will not be processed any faster than had they waited in a refugee camp overseas," he said. "[But] the alternative to putting asylum seekers in the community is to detain people while their claims for protection are processed.

"This is not only expensive, it takes a toll on people's mental health and wellbeing."

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Fresh momentum for telehealth push

The Federal Government has unleashed millions of dollars to fund an array of telehealth projects as it tries to promote use of the National Broadband Network.

More than $20 million will be provided to finance nine research programs to investigate and evaluate the use of communications technologies to provide medical services and support, particularly for patients in rural and remote areas.

Among the recipients is the CSIRO, which has been awarded more than $4 million to trial two telehealth technologies using the NBN.

The research organisation will trial a technology providing home monitoring of chronic diseases for elderly patients, and a service to provide eye care for Indigenous communities. The trials will be run for 12 months and involve more than 1300 patients in homes, clinics, hospitals, nursing homes and local health care districts across the country.

Leader of health services for the CSIRO's Digital Productivity and Services Flagship Dr Sarah Dods said the arrival of fast broadband made it possible to explore new ways of delivering health services, particularly in remote areas.

Dr Dods said video-based consultations were already available in some locations, but this was "just the tip of the iceberg" in terms of what broadband could deliver.

She said such technology could reduce the need for travel, provide timely access to services and specialists, improve the ability to detect and diagnose conditions and provide new ways to educate, train and support health workers in remote areas.

"They can also reduce the burden on our health system by helping hospital 'frequent flyers' – such as chronic disease sufferers and the elderly, who accounted for more than 70 per cent of health expenditure in 2007-08 – manage their conditions from home," Dr Dods said.

Other projects include a $3 million trial of virtual nursing services and in-home videoconferencing for 200 elderly and chronically ill patients, a $1.5 million project using telehealth to enable 80 cancer patients in the Hunter-New England region to manage their condition and a $2.4 million program testing the delivery of in-home services to 200 elderly patients using telehealth connections with doctors, including daily monitoring of their condition and wellbeing.

The announcement came as it was revealed by *The Australian* that global telecommunications giant BT is spearheading a push by more than 20 public and private health care organisations to expand the network of telehealth services.

BT is convening a meeting of key players late this month that is expected to bankroll a two-year project developing a framework to fast-track the rollout of telehealth services.

BT Australasia's director of health Lisa Altman told *The Australian* that although telehealth services were being developed in isolated pockets of the country, there needed to be a broader, more ambitious approach.

"This is trying to make it happen at scale," Ms Altman said. "If we can bring the timeframe for telehealth at scale back from five-seven years to three-five years, we will have made a great achievement."

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The initiative is modelled on a project in Britain which aims to rollout telehealth services to three million people within the next five years.

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Insurance rise adds to Budget pressure

Private health insurance coverage has reached its highest point in almost 25 years despite a cut in Government rebates for premiums, increasing the pressure on public finances.

Private Health Insurance Administration Council figures show that 46.9 per cent of the population had private hospital cover in the March quarter, the highest such reading since mid-1988.

According to the data, an extra 52,863 people took out private hospital insurance in the first three months of the year, taking the total number with coverage to 10.8 million people.

Health Minister Tanya Plibersek seized on the results to deride claims that the introduction of a means test on the private health insurance rebate would see hundreds of thousands of people dump or downgrade their private cover.

"Industry 'experts' predicted that introduction of income testing of the private health insurance rebate would cause 1.6 million people to drop their cover," Ms Plibersek said. "In fact, in the three quarters that followed introduction of income testing, an additional 175,354 people took out private hospital cover."

But Opposition health spokesman Peter Dutton said the figures did not tell the full story of the long-term consequences of the Government's private health insurance changes.

Mr Dutton said thousands had pre-paid their premiums for 18 months of more, meaning the full impact of the means test on the rebate was yet to be felt.

He said PHIAC reported that premiums worth $1.2 billion were pre-paid in the June quarter last year, and the Budget Papers acknowledged that a higher number of policy holders chose to prepay their 2012-13 premiums in 2011-12.

"This is a Government that ignores the longer-term consequences of its actions," Mr Dutton said. "The full consequences of their catalogue of broken promises and disastrous policy handling of private health will be felt by our health system in the years to come."

In an interesting development, the industry figures show there has been a sharp 16 per cent rise in the number of private patients being treated in public hospitals – a result that underlines concerns that State governments are increasingly tapping into the lucrative private market to top up their health funds.

The Australian reported earlier this month that new public hospitals are being built with extra private rooms, allowing more to be charged to insurers.

The major insurers, concerned at what is seen as an attempt to shift public hospital costs onto the private sector, have imposed a cap on payments to public hospitals.

The rise in private health insurance cover has increased the pressure on the Budget, with Government forced to upgrade forecasts of how much it will spend on insurance premium subsidies in coming years.

As reported in *The Australian*, the Government had expected the private health cover rebate to cost it around $4.5 billion a year, but in the Budget this estimate has been raised to $5.6 billion this financial year, followed by $5.4 billion in 2013-14, $5.6 billion in 2014-15, $5.7 billion in 2015-16 and $5.9 billion in 2016-17.

According to the Budget Papers, the revised forecasts reflect "stronger than expected growth in the number of people with subsidised private health cover, and more people upgrading their level of health insurance".

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Baby boom on the cards as handout is cut

Doctors have been warned to expect "a surge" in births in nine months' time after the Federal Government announced it will axe the controversial baby bonus.

AMA President Dr Steve Hambleton told *The Advertiser* there was likely to be a spike in the number of babies in February 2014 as couples rush to take advantage of the baby bonus, worth up to $5000, before it is scrapped on 1 March next year.

"If families are considering children and are prepared, there is an opportunity – but it is only open for another two weeks," Dr Hambleton said, predicting "there will be a surge".

The Government expects to save $1.1 billion by abolishing the baby bonus and replacing it with a less generous, one-off $2000 boost to the Family Tax Benefit Part A for the birth of the first child, and $1000 for every subsequent child.

The baby bonus, introduced by the Coalition Government in 2002, has been condemned as poor policy that has had

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little measurable success in achieving its stated aim of boosting procreation.

While the nation has one of the highest fertility rates among developed countries, this has been largely attributed to the relative strength of the economy and a big influx of immigrants attracted by good growth and employment prospects.

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Gates' vaccination drive gets personal

One of the world's biggest philanthropists, Microsoft founder Bill Gates, wants more of Australia's foreign aid program to be devoted to the eradication of malaria and polio.

Mr Gates, who amassed a huge fortune as head of Microsoft, is expected to lobby Prime Minister Julia Gillard to have more aid funds directed to malaria and polio-fighting projects when he meets her during a visit to Australia late this month.

The lobbying is part of efforts to convince wealthy nations to increase joint public-private efforts to reduce and eliminate deadly infections that claim millions of lives every year, especially among small children and women living in developing countries.

Even before stepping down from his Microsoft role in 2008 Mr Gates, together with his wife Melinda, had become a major international force driving advances in research and prevention for some of the world's deadliest diseases, particularly those afflicting the poor.

Through the Bill and Melinda Gates Foundation, the couple have donated billions of dollars to efforts to develop vaccines and other approaches to prevent the development and spread of life-threatening illnesses including hepatitis B, polio, malaria, rotavirus, pneumonia and human papillomavirus.

The Foundation, co-chaired by Mr Gates, has pledged to spend $10 billion between 2010 and 2020 to help research, develop and deliver vaccines to people living in the world's poorest countries.

Part of this is a $2.5 billion donation to the joint public-private Gavi Alliance to support the immunisation of 250 million children in developing countries against deadly illnesses, including a plan to administer the genital wart vaccine Gardasil to 30 million girls in 40 developing countries to help prevent cervical cancer.

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Sports science comes under scrutiny amid doping claims

The Senate has waded into the furore surrounding allegations of widespread doping in the major football codes, launching an inquiry into sports science.

Claims that Australian Football League and Australian Rugby League players have been subjected to treatments and supplement programs that may have breached acceptable medical practice and anti-doping rules has sparked intense scrutiny of the role played by sports scientists at sports clubs.

The Australia Sports Anti-Doping Agency has launched an investigation into training and supplementation regimes at a number of clubs, and the Essendon Football Club earlier this month released a report by former Telstra chairman Ziggy Switkowski detailing a breakdown in the oversight of sports science activities within the club.

Australian Greens Senator Dr Richard Di Natale, who proposed the inquiry, said it was important that the practice and role of sports scientists come under scrutiny.

"The recent doping saga has thrown a light onto the role of sports science in Australian sport, which has exposed some very concerning practices," the senator said. "As a doctor I'm really very concerned about potential health impacts of some of the drugs and supplements that have been reportedly used in our football codes.

"Using drugs that aren't yet approved for human use, or prescription medications for purposes they weren't designed for, is dangerous."

Senate has directed that its Rural Affairs and Transport Committee investigate the current practice and regulation of sports science, the role of club administrators and boards in overseeing the work of sports scientists, the duty of care sports scientists owe to athletes, and avenues for increased regulation of the profession.

Senator Di Natale said one of the key problems was a lack of agreed standards regarding who can call themselves sports scientists, and how they should conduct themselves.

"We need to work out what sorts of safeguards and governance structures need to be in place in order to protect our athletes and players from being used as guinea pigs in a race to find the winning edge," he said. "Australia has some of the world's best sports scientists, and their reputations also need to be protected."

The Committee has been given until 27 June to conduct the inquiry and complete its report.

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The perils of social media rules

BY **DR EDWIN KRUYS**

Last year's draft social media policy by the Australian Health Practitioner Regulation Agency (AHPRA) caused a lot of upheaval. Health professionals expressed concerns it was too prescriptive. Now there's a new version and the organisation is requesting feedback.

It looks like AHPRA has taken the feedback on board, but do we need more regulation in health care?

A 76-page consultation paper has been posted on the AHPRA website, and it includes drafts of the social media policy, revised Code of Conduct, revised Guidelines for Advertising and revised Guidelines for Mandatory Notifications.

It looks like AHPRA has taken the feedback it received on an earlier version on board, because the new draft policy is less prescriptive.

Health professionals have to follow strict professional values, no matter if they're in the elevator at work, at the pub, or on Twitter or Facebook. For that reason, there's no real need for a social media policy, and I'm glad the current draft is only two pages long.

However, social media rules have now been sprinkled throughout the Code of Conduct and Guidelines for advertising (these two documents are mentioned eleven times in the text of the draft social media policy).

What does it say?

Most of it is common sense, but I thought these two changes were worth mentioning:

- health practitioners are expected to behave professionally and courteously to colleagues and other practitioners, including when using social media (Code of Conduct 4.2c); and
- testimonials on Facebook and other social media networks have to be removed by health practitioners (Guidelines for Advertising 7.2.3).

I've read all 76 pages, but it's still not clear to me what exactly a testimonial is and whether I'm now required to remove my LinkedIn testimonials and endorsements by colleagues from around the world. Also, it looks like the practice Facebook page will become a public complaints register, as positive feedback that smells like a testimonial will have to be deleted to avoid litigation. It will need a lot of explaining when removing friendly, unintended testimonials from our patients and, worse, it will put health practitioners off social media. And I won't mention Google testimonials – they are impossible to remove. Let's hope AHPRA can provide some clarification and reassurance here.

Interestingly, an issue that causes heated debates has not been mentioned, namely anonymous posting on social media networks by health practitioners who are identifying themselves as such, but are using a pseudonym instead of their real name. Some say it's important for those such as whistleblowers to be anonymous, while others say health professionals should always have to be identifiable. But perhaps it's a wise decision by AHPRA not to open this can of worms.

Good or bad?

The problem with regulations like this is that they increase the liability for health professionals and practices already operating in a highly regulated industry.

In the light of recent national e-health developments, and the flood of legal issues that health providers are facing when signing up for the PCEHR, we don't need more regulation.

The risks are: less innovation and progress, a defensive attitude by practitioners, higher legal and insurance costs, increased AHPRA fees and, eventually, more costs for patients.

That brings me to the risk management paragraph in AHPRA's draft Code of Conduct, which states that it's good practice "to be aware of the principles of open disclosure and a non-punitive approach to incident management". I wonder if AHPRA is going to follow this advice when a practitioner breaches a social media clause.

Something tells me that we'll be hit with a punitive approach if we forget to delete Mrs Jones' friendly Facebook recommendation or if we're not courteous enough when replying on Twitter.

AHPRA is requesting feedback via guidelinesconsultation@ahpra.gov.au by close of business on 30 May 2013.

**Dr Edwin Kruys is a rural doctor in Western Australia. His blog can be viewed at: http://www.panaceum.com.au/author/edwinkruys*

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We're from the Government...

BY **DR BRIAN MORTON**

"What is particularly galling is that this Government seems to regard the high bulk billing rate as its achievement"

The centerpiece of the health section of last week's Federal Budget was a $900 million (over four years) reduction in MBS rebates, making it all that more difficult for patients to get access to the affordable services they need.

The more GPs try to make things better for their patients, the more the Government frustrates our efforts by these types of measures.

Of that $900 million saving, $664 million of it is achieved under the euphemistic (even Orwellian) title 'Medicare Benefits Schedule – realigning indexation with the financial year'. This was not on our budget wish list. As far as I know, it was not on anyone's budget wish list. The Government could have realigned indexation with the financial year by bringing forward the next 1 November 2013 increase to 1 July 2013. It chose instead to defer it to 1 July 2014.

At the budget lock-up, the Government representatives were asked if they had made any assessment of the impact on patient access and affordability of this decision. The response was that they expected GPs would continue to bulk bill, and that the bulk bill rate had just reached the highest level on record.

The message is clear. The more GPs do the right thing by their patients, the more the Government will exploit this to their advantage.

Although the decision affects all patients for all services across the Schedule, it will have the greatest effect on those doctors who bulk bill their patients.

A Level B consult would normally increase by about $0.60 cents from 1 November 2013, but now that will not happen until 1 July 2014.

What is particularly galling is that this Government seems to regard the high bulk billing rate as its achievement.

The bulk billing rate has been rising since 2004, when the previous Government substantially increased GP rebates.

This has continued despite the best efforts of this Government to stop it: by removing the Practice Incentive Payment (PIP) e-health incentives for GPs not participating in PCEHR (2012-13) and the reduction of incentives for GPs who do participate; increasing GP PIP targets for diabetes, asthma and cervical cancer; removing Tier 1 after hours incentives from 1 July 2011 (subsequently restored until 1 July 2013); removing practice nurse items (partially offset by PNIP); reducing GP Mental Health Plan rebates from 1 November 2011; and the removal of immunisation incentives, to name but a few.

A further $120 million saving over four years is identified for the provocatively titled 'Medicare Benefits Schedule – removing double billing' measure.

This measure will prevent GPs claiming a standard consultation and a GP chronic disease management item for the same patient on the same day.

It comes into effect on 1 November 2014, and saves $42 million in its first full year, so seems to capture about one million consults.

But by far the Budget measure with the greatest significance for GPs - and for long term quality of care - is the decision to cap tax deductions for work-related self-education expenses for health professionals at $2000.

The AMA has had much to say about this already.

The Government has committed to consultation, but the parameters are set in the budget. It is essential the Government listens carefully to our arguments and acts on them.

TO COMMENT CLICK HERE

Medical students campaign for access to essential medicines

BY **FREYA LANGHAM***

Ticking "yes" to generic formulations on a prescription is something most of us take for granted. The majority of medicines we routinely use are now available in generic form, making them cheaper for both the consumer and the Government.

This privilege, however, cannot be taken lightly. The Trans-Pacific Partnership (TPP) is a far-reaching agreement being negotiated between 12 countries, including Australia, New Zealand, the United States and Canada, that threatens both access to essential medicines, and the ability of our government to determine its own health policy.

The negotiations are being conducted, unnecessarily, in secret, but leaked texts reveal aggressive intellectual property provisions. Rather than prioritising access to essential medicines, these provisions will protect the interests of pharmaceutical companies by making it easier to patent medicines, lengthening patent terms, and expanding data exclusivity (reducing the access of generic manufacturers to clinical trial data to register generic versions of patented drugs). The cumulative effect of these provisions is to increase monopoly terms for patented medications, delay the introduction of generics and further hinder access to affordable medicines.

These provisions are an alarming departure from the public health safeguards enshrined in previous international trade agreements.

While they most obviously threaten access in countries with under-developed health systems, they also threaten to raise the cost of Australia's own Pharmaceutical Benefits Scheme. Specific clauses of the TPP text aim to directly restrict national pharmaceutical reimbursement programs, affecting the ability of governments to negotiate affordable prices.

It doesn't stop there.

Proposed clauses in the treaty to settle investor-state disputes would allow corporations to sue governments if the regulatory environment negatively affects their investments. This has the potential to severely restrict the actions governments can take to protect public health by putting them at risk of lawsuits for setting prices for medicines or regulating the sales of harmful products, such as with tobacco plain-packaging legislation.

The latest round of TPP negotiations have commenced in Lima, Peru. Hundreds of negotiators from the participating countries came together in the South American country last week for 10 days of talks on the exact terms of the agreement, with pressure to finalise the text this year.

Stakeholders are blocked from directly accessing the drafts and attending negotiations, though there was an opportunity yesterday [19 May] for those concerned to provide some input.

Australian Medical Students' Association (AMSA) was represented by Monash University medical student Timothy Martin, who joined representatives from a number of other medical students' associations that share our concerns regarding the proposed intellectual property clauses of this wide-ranging multilateral trade agreement.

Medical students are well positioned to campaign on the issue of access to essential medicines – both as future health professionals, who must demand adequate tools to practice our trade and serve our communities, and as students of the universities where considerable drug research and development occurs.

As such, AMSA is taking an increasing interest in this area, following on from the passing of our *Access to Essential Medicines Policy* last year. A copy is available at http://www.amsa.org.au/advocacy/official-policy/

While these concerns may seem distant for many Australians, as future health professionals in an increasingly globalised world, we cannot ignore the implications of such an agreement, both for our own health, and for that of our neighbours.

TPP members include developing countries such as Vietnam and Peru, where public health systems are under-resourced, pharmaceutical reimbursement schemes do not exist, and health insurance is not widespread.

For the most part, individuals are required to pay out-of-pocket for their own medications. The monopoly position enjoyed by many pharmaceutical company products mean prices can be held high, pushing the cost of vital medicines out of the reach of many.

Australia must not only ensure that the final TPP Agreement does not adversely affect our own Pharmaceutical Benefits Scheme and health regulating autonomy, but also use its strong negotiating position within the Agreement to advocate for countries where access to essential medicines truly is a matter of life and death.

** Freya Langham is National Coordinator for the Access to Essential Medicines campaign of the Australian Medical Students' Association, and studies medicine at Monash University. You c an follow Freya on Twitter @freyajl and @ yourAMSA.*

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Keeping abreast of current knowledge

BY **DR DAVID RIVETT**

"So why then does the Federal Treasurer begrudge us claiming the costs of accessing such as a legitimate business expense when we seek to stay abreast of current knowledge? "

I am writing from Melbourne, where I am attending the Anaesthetists Annual Scientific meeting, no doubt much to the disgust of the nation's Treasurer. Not only is such an event an opportunity to attend diverse and stimulating lectures, it also enables me to accrue vital continuing medical education points to permit my ongoing performance of anaesthetics.

An excellent array of speakers and workshops made this task very easy.

We were reminded that, in 1978, Harrison's guide to treatment of myocardial infarction was:

- bed rest for six weeks;
- no toilet privileges for two weeks; and
- no angiography for three months.

I well remember attending a conference in the 1980s when thrombolytics in the form of streptokinase were conclusively demonstrated by multicentre double blind trials to both save lives and lessen cardiac injury.

However, on returning to sunny Batemans Bay, I was told that it would be far too radical for a small rural hospital to be allowed such a 'dangerous' drug. After six months of nagging, we got the go ahead. Today, thrombolytics are administered by paramedics enroute to accident and emergency departments.

Times change and knowledge advances rapidly. Much of our current dogma, outlined in guidelines and protocols, will prove to be wrong in years to come, just as they have been in the past.

Ongoing education is an absolute must to best care for our patients. Surely such an assumption does not require a double blind research paper to be accepted. So why then does the Federal Treasurer begrudge us claiming the costs of accessing such as a legitimate business expense when we seek to stay abreast of current knowledge? Does he truly want a dumber, more dangerous cohort of medical practitioners?

Conference highlights included Professor Edzard Ernst outlining the difficulties of getting 'natural' therapists to accept scientific discipline in assessing their remedies, one of the major problems being that alternative practitioners often exhibited a religious fervour of belief in their therapies, such that any scientific questioning of their validity was regarded as sacrilegious and tantamount to heresy.

Australia, we were told, has more than 10,000 naturopaths, and virtually anyone can set up as such, often with fancy and expensive - but useless - diagnostic machinery, enabling such larks as "blood test typing of diets" and "live blood analysis diagnosis".

Perhaps in Caesar's day, reading of the entrails was a science, but not in this century.

If our Treasurer really wants Australian medicine to be world's best, he should direct his cost cutting attention to mumbo-jumbo medicine.

All country GPs should visit www.anzaag.com, which has set up management guidelines for anaphylaxis occurring during anaesthesia, including outlines for allergy testing referrals, lists of patient testing centres and leaflets of explanation for patients.

Finally, aside from the formal activities, the conference trade display was top notch, with a chance to use and assess very many useful medical devices, and to network with city anaesthetists prepared to provide rural locum relief.

Certainly no junket Mr Swan, and sadly not possible to access for under $2000.

TO COMMENT CLICK HERE

At the end, the toughest decision of all

BY **DR LIZ FEENEY**

It is an unfortunate fact that many patients do not achieve the quality of death they wish to have. What is standing in the way? And what can doctors do to help?

A policy discussion session entitled 'Finding ways to provide the best possible end-of-life care' will be held at this year's AMA National Conference to address these questions.

The session will focus heavily on the role and process of end-of-life decision-making, and how it affects the patient's experience of end-of-life care, as well as the experiences of the patient's family members and the health care team.

The 'best possible end-of-life care' is personal, unique to each individual. Everyone has their own cultural, religious, and other personal experiences that influence and reflect their values and goals at the end of life. Only the individual knows what quality of life (including levels of disability and discomfort) they are willing to live with.

As their doctor, you are there to advocate for your patient, and to use your expertise to clarify and understand their values and goals (which may change over time), to determine what is most important to them at the end of life, and to facilitate medical decisions that are consistent with their wishes.

This requires good quality, culturally sensitive, patient-centred care that emphasises continuous, open, informed communication and collaboration between the patient, the health care team, and, where appropriate, the patient's carers, family members, and/or surrogate decision maker.

Sounds easy? Not always.

Where a patient is competent, the doctor should have informed, frank and honest discussions with them regarding their diagnosis, prognosis, and treatment options, so they can make their own informed end-of-life decisions. But this situation can prove challenging for the doctor to manage where, for example:

- the patient (and/or family members) may not truly understand, or are in denial of, the nature of their illness or injury;
- the patient (and/or their family members) may have an unrealistic expectation of the benefit of particular treatments; or
- the patient's family members appear to be influencing or coercing the patient to make particular treatment decisions.

Many patients experiencing an acute life-threatening medical crisis have impaired capacity, requiring a surrogate (often a family member) to make treatment decisions on their behalf.

Difficulties arise if the surrogate does not know the patient's values, goals of care, or wishes regarding treatment, or they're not readily applicable to the circumstances at hand.

This can result in a variety of difficult situations that the doctor must manage, such as:

- a surrogate who is making end-of-life decisions to satisfy their own values and wishes, not that of the patient;
- conflict and disagreement within the patient's family over treatment;
- conflict and disagreement between the doctor and the patient's surrogate or family members over prognosis and/or treatment;
- making decisions for a patient who has no surrogate, and whose values and goals of care are unknown; or
- conflict and disagreement within the health care team itself over treatment.

These examples highlight just some of the challenges faced by doctors caring for individuals at the end of life.

In the National Conference session, we will hear the views and experiences of Professor Michael Ashby, Director of Palliative Care at Royal Hobart Hospital and Southern Tasmania Health Organisation (THO); Dr Peter Saul, a senior intensive care specialist in the adult and paediatric ICU at John Hunter Hospital in Newcastle, and Director of Intensive Care at Newcastle Private Hospital; and Dr Kate Robins-Browne, a general practitioner with an interest in clinical ethics, who is completing a PhD exploring the way older people, and those they want to be involved in decision-making on their behalf, understand medical decision making where a patient has impaired capacity.

These speakers will provide their own perspectives on end-of-life decision-making, and offer guidance on how to support both patients and their families to ensure the best possible end-of-life care for the individual.

We will provide members with an update of this session following National Conference, and ensure we keep end-of-life care at the forefront of AMA activities.

TO COMMENT CLICK HERE

Doctors integral to aged care reform

BY **DR PETER FORD**

The Senate Community Affairs Legislation Committee is conducting an inquiry into the five aged care Bills placed before the Parliament by the Minister for Ageing, Mark Butler on 13 March.

The AMA has made a submission to the inquiry in which it has highlighted that, while the Bills create a framework for providing aged care subsidies, they make no provision to secure medical and nursing care for older Australians by integrating clinical care into aged care services.

The submission discussed four major areas of difficulty within aged care that need to be addressed. These are:

- medical care in residential aged care facilities – a lack of treatment rooms and access to GP services, an absence of information technology infrastructure, and a lack of qualified nursing staff;
- medical care in the community – recognition of the important role played by GPs in the planning and co-ordinating care for older Australians who elect to stay in their own homes, and the need for more nursing and allied health care services;
- assessments – the current Aged Care Assessment Team assessment times are too long, and make little use of input from treating doctors; and
- respite care – there is a need to streamline access to respite care by allowing GPs to approve such care for older people who are in urgent need of it, in much the same way that a doctor is able to determine the need for hospital admission.

The AMA has continued to advocate the role of the medical practitioner as integral to the aged care sector, and has recommended that the Committee consider amendments of the *Aged Care (Living Longer Living Better) Bill 2013*, including:

- establishing a Ministerial Clinical Advisory Committee; and
- include a review of the extent to which medical and nursing services are integrated into aged care services.

The Senate Committee is due to report on 17 June 2013.

The Committee for Healthy Ageing is monitoring the implementation of the Home Care Packages Program and the Aged Care Gateway to triage patients into community and residential aged care services.

The extent to which the Aged Care Gateway will provide more timely assessments and access to services is unknown.

As medical practitioner input is not fundamental to the application for aged care services on entry to the Gateway, delayed clinical assessment could potentially impede patient access to appropriate services.

TO COMMENT CLICK HERE

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

TO COMMENT CLICK HERE

Members' Forum

Here's a selection of what AMA Members have been saying about the latest issues affecting the profession:

Members continue to express outrage over the Federal Government's decision to impose a $2000 cap on work-related self-education expenses.The AMA has been at the forefront of protests by individuals, professional groups and the higher education sector against the move, warning it will compromise training and undermine quality care.

Expenses debacle

How dare Wayne Swan tell us we are claiming too much, and all traveling first class. He does that all the time and we, as taxpayers, have no say and we pay for it. This is the politics of envy.

Dr Charley Nadin (not verified)

Cap doesnt add up

So it is essential to attend these conferences, because that's how to earn Continuing Professional Development points, which is a pre-requisite to maintain registration. But the cap is $2000. Go figure.

Dr Harry Grunstein

Quixotic

I am flabbergasted at this quixotic decision that is so out of touch with reality. I work as a GP in a Rural, Remote and Metropolitan Area 5 location, and attending workshops and conferences is the only way I can stay updated and in touch with what colleagues in urban areas are doing. I am doing three workshops this year and the registration fees alone for each is $2700, and this does not even include the travel and accommodation expense.

Submitted by TM (not verified)

Cap on education expenses

Most of us that are self-employed incur not only the added costs of conference/workshop registration, travel and accommodation costs, but also the opportunity cost of lost income while on conference leave. Many of the EMST, APLS, ALS, ALSO, Ultrasound courses registration fees are well over $1000.

If the government is in need of dosh, why not tax junk foods? I am sure this would generate more income than capping doctor's medical education costs, while also doing something positive towards improving the health of Australians and reducing the cost of healthcare!!!

Anonymous

TO COMMENT CLICK HERE

Research

Researchers uncover thin gene

It has often been suggested that some people have good genes when it comes to staying skinny.

Now research has found that genes actually do play an important role in explaining how some can chow down on burgers and chips and stay thin while most on a similar diet tend to pack on the weight.

While examining mice genetically modified to have no Kruppel-Like Factor 3 (KLF3) protein – a protein that turns off genes involved in blood production – researchers from the University of Sydney found that the mice remained lean on a high-fat diet. The mice also showed signs of improved glucose metabolism and insulin action.

Dr Kim Bell-Anderson, lead author of the study, said that KLF3 was known to be important for turning off gene expression, but the genes it targeted were unclear.

The research team looked at the gene expression of about 20,000 genes to see which ones were abnormally expressed in the mutant mice. They found that the expression of a gene that produces adipolin – a hormone produced by fat cells that enters the blood and modulates responses to food – was increased in the genetically altered mice.

In general, higher adipolin levels mean less fat because the body is able to better regulate its blood glucose level and prevent extra glucose from turning to added weight.

KLF3's main role is to turn genes off and on — in the mutant mice, production of adipolin skyrocketed when there was nothing telling the body to stop producing it.

Basically, the extra adipolin acted as a glucose moderator, enabling the mutant mice without the KLF3 protein to consume more food without gaining weight.

"The amount of adipolin circulating in the blood of our mutant mice was more than doubled," Dr Bell-Anderson said.

"The roles of KLF3 and adipolin in humans, and their beneficial or harmful effects, are yet to be determined. But therapies aimed at increasing adipolin levels may be a promising target for treatment of type 2 diabetes and obesity,"

KW

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Antibiotics could cure 40 per cent of chronic back pain

More than 70,000 Australians could cure their chronic back pain by simply taking a course of antibiotics, new research suggests.

Danish researchers have found that many of the worst cases of chronic back pain are due to bacterial infections that could be cured with a course of antibiotics, rather than surgery.

More than 40 per cent of patients treated with antibiotics were cured from the pain. Considering hospital costs in Australia for chronic back pain and slipped discs are around $500 million a year, this could result in a huge saving.

The study examined 67 patients with chronic lower back pain following disc herniation, and confirmed five previous studies that found up to half of patients undergoing surgery for a first-time disc herniation had a bacterial infection.

Of those who tested positive for the infection, more than 80 per cent carried the microbe Propionibacterium acnes, known for causing acne.

The bacterium lives in hair roots and crevices of teeth, and can get into the blood stream during tooth brushing.

The microbe does not usually cause problems, but can if the infected person has a slipped disc. In healing the damage caused by the herniation, the body grows small blood vessels into the disc.

Rather than helping, though, the blood vessels can ferry propionibacterium acnes bacteria inside the disc, where they grow and cause serious inflammation and damage to the neighbouring vertebrae.

The researchers treated patients with the common antibiotic Augmentin for 100 days, and found 80 per cent felt much less pain and took fewer sick days following treatment.

"This will not help people with normal back pain, those with acute or sub-acute pain, only those with chronic lower back pain," lead researcher Dr Hanne Albert from the University of Southern Denmark said. "These are people who live a life on the edge because they are so handicapped with pain. We are returning them to a form of normality they would never have expected."

Senior researcher Claus Manniche said the discovery was the culmination of 10 years' hard work. "To find bacteria really confronts all we have thought up to this date as back pain researchers," he said.

Dr Albert said the antibiotics would not work for all back pain, and cautioned that over-use of the drugs could lead to more antibiotic-resistant bacteria.

But, she said, many patients were undergoing ineffective surgery instead of using antibiotics that could alleviate their pain.

Dr Albert said patients who would benefit from antibiotic treatment could be identified with an MRI scan, a physical examination and pain history.

"We have to spread the word to the public, and to educate clinicians, so the right people get the right treatment, and in five years' time are not having unnecessary surgery," Dr Albert said.

The study has been published in the European Spine Journal.

KW

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Doctors call for chance to explain

Doctors want the chance to explain the circumstances in which they receive any payments or support from drug companies as tough new public disclosure rules loom in the United States.

As doctors in Australia work with the medicines industry on arrangements to disclose financial dealings between drug companies and individual practitioners, the American Medical Association has warned that a similar scheme coming into operation in the US must give doctors the chance to provide relevant "contextual information" of such payments.

American Medical Association Chief Executive Officer Dr James Madara has written to the Centers for Medicare & Medicaid Services (CMS) – which will implement the Physician Payments Sunshine Act – seeking a number of alterations and amendments to make the proposed system more "accurate, fair, balanced" and secure.

Under the new rules, which were included as part of the Obama Administration's health reform package, drug companies will begin collecting data on payments they make to individual practitioners from1 August this year, and will be publicly divulged from 30 September 2014.

The American Medical Association is generally supportive of the initial design for data collection developed by CMS, but Dr Madara has "strongly urged" that there be provision made to enable doctors to provide background for any payments made, as well as strict limits on the personal identification information physicians would be required to disclose and provision for practitioners to be able to delegate clerical work required by the Act to practice managers or other administrative staff.

Dr Madara said allowing doctors to provide context for payments received would add to the accuracy and fairness of the system, and help ensure that it was "not undermining those interactions that advance the art and science of medicine".

The American Medical Association sought limits on the data that doctors would be required to divulge, particularly personally identifiable information such as personal email addresses, because of possible identity theft and other security concerns.

"While we urge the agency to increase the information that physicians and industry may voluntarily submit, we continue to have concerns that the public disclosure of personally identifiable information, along with any potential data breaches or overly broad disclosures of information under the Freedom of Information Act, would heighten the possibility of widespread physician identity theft," Dr Madara said.

He added that the Association was also concerned to make sure the new laws did not bury doctors in red tape, warning "the Sunshine Act has the potential to create significant administrative burdens for physicians".

Developments in America have come as the Australian Medical Association and the medicines industry work on arrangements for the disclosure of drug company payments to individual doctors.

There is a push underway for greater scrutiny of the financial relationship between medical practitioners and pharmaceutical firms, including a Bill before Parliament calling for a ban on drug company payments for doctors to attend conferences.

Australian Medical Association President Dr Steve Hambleton told a Senate inquiry last month that doctors did not "shy away" from increased transparency, but said it had to be done in a way that did not undermine patient confidence in doctors.

Dr Hambleton warned the proposed legislation went too far by making the relationship between doctors and drug companies illegal, and any regime of disclosure had to be sensitive to the risk of damaging the doctor-patient relationship.

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US considers welcome mat for overseas doctors

Sweeping immigration law reforms could boost America's intake of doctors from overseas to help plug gaps in the medical workforce, particularly in rural areas.

US lawmakers are debating a bipartisan Bill to overhaul the nation's archaic and restrictive immigration laws which could help smooth the way for more offshore doctors to enter and work in the world's largest economy.

The Border Security, Economic Opportunity and Immigration Modernization Act, which is sponsored by a group of senators including Republicans John McCain and Marco Rubio and Democrat Charles Schumer, aims to toughen border control measures while opening a path to citizenship for the nation's estimated 11 million illegal immigrants.

Medical groups including the American Medical Association and the Association of American Medical Colleges are encouraged by proposals in the Bill revamp J-1 visas and other provisions that would allow more overseas doctors to enter the country and work.

Currently, doctors entering the country with a J-1 visa have a chance to have their two-year residence requirement waved if they agree to work for three years in a specialty or area where there is a shortage of practitioners, are employed on contract at a health facility in that area, have a "no objection" letter from their country of origin and begin work within 90 days of receiving the waiver.

Adding to the difficulties overseas doctors face, the visa waivers are in short supply. Each State receives no more than 30 a year, and the supply is vastly inadequate for many states with large rural populations.

American Medical Association President Dr Jeremy Lazarus said the J-1 visa waiver program was vital in providing much-needed health care to many communities.

"International medical graduates play an integral part in American medicine, often joining physicians in practices serving patients in rural and low-income urban areas," Dr Lazarus said.

The proposed immigration reforms, which may be put to full Senate vote before the August recess, would increase the number of waivers per state, particularly for jurisdictions where there is heavy demand, and would increase the allocation of visas for professionals with advanced education from 28.6 to 40 per cent.

AR

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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.

TO COMMENT CLICK HERE

Jolie has breasts removed to cut cancer threat

Cancer screening providers have reported a jump in inquires after actor Angelina Jolie revealed she has undergone a double mastectomy in an effort to cut her risk of contracting breast cancer.

Ms Jolie, 37, one's of the world's most prominent and recognisable celebrities, revealed in a column in the *New York Times* last week that she had opted to have both her breasts removed after learning that she carried a faulty gene that greatly increased her chances of developing breast cancer.

BreastScreen ACT told *The Canberra Times* there had been a 20 per cent jump in inquiries the day after Ms Jolie's piece was published, with 30 per cent of callers mentioning their action had been prompted by reading Ms Jolie's account.

In the article, Ms Jolie said tests had showed she carried the BRCA1 gene, and doctors estimated she had an 87 per cent chance of contracting breast cancer and a 50 per cent risk of developing ovarian cancer.

"Once I knew that this was my reality, I decided to be proactive and to minimise the risk as much as I could," the actor wrote. "I made a decision to have a preventive double mastectomy."

She completed three months of treatment, involving a two-stage surgical process that included an eight-hour operation to remove breast tissue and insert temporary "fillers", late last month.

As a result of the procedure, doctors estimate her risk of developing breast cancer has been cut to just 5 per cent.

Ms Jolie, whose mother died from breast cancer six years ago aged 56 years, said she had gone public with her ordeal in order to encourage other women with a family history of the disease to seek information and make informed choices.

Ms Jolie sought to reassure other women that the operation had left only minor scarring and had not made her feel any less feminine.

"On a personal note, I do not feel any less of a woman. I feel empowered that I made a strong choice that in no way diminishes my femininity," she said.

The actor said she had decided to tackle the breast cancer risk first, but would also consider treatment to reduce her vulnerability to ovarian cancer.

"I started with the breasts, as my risk of breast cancer is higher than my risk of ovarian cancer, and the surgery is more complex," Ms Jolie said.

AR

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Strong relationships produce Clare Valley gems

BY **DR MICHAEL RYAN**

I sometimes wonder if the Clare Valley is one of the most misunderstood wine regions in Australia.

Technically, it is warm and has something like 1770 heat ripening units - almost 100 more than the Barossa, which is 100 kilometres down the road. Yet it turns up some of the most sought after Rieslings, as well as elegant Shiraz and Cabernet Sauvignons.

Kerri Thompson is one person who understands this region well. She graduated in 1993 from Roseworthy College with her oenology degree and has worked on vintages in McLaren Vale, Tuscany and Beaujolais. She was head wine maker at Leasingham Wines for seven years, and appreciated the concept of building relationships with great growers. This stood her in good stead as she ventured out on her own.

Her growers are loyal, and she reciprocates by turning their well-tended, dry-grown fruit into little bottles of magic. Some organic/biodynamic principles apply, with minimal pesticide use in some vineyards. The toil of being trapped behind a desk in a large company only strengthened her steely resolve to return to the vineyard.

Kerri believes we should be celebrating these unsung growing heroes that have special pockets of land producing exemplary fruit. The growers commitment to their craft is unsung and often beaten down by the corporates.

Kerri makes four Rieslings, and I have found these wines over the years to be consistently high quality, and made with a mantra revolving around a wine that is meant to be enjoyed.

While some classic Clare Valley traits are obvious, the Rieslings are enjoyable as young things that spin my mind, anticipating what they will be like in five to seven years. I think she could single-handedly revive the public's faith in Riesling.

A Tempranillo Granache Rose, a single vineyard Shiraz, a Cabernet, a cheeky blend of Shiraz, Grenache, Tempranillo and Mataro, and a straight Tempranillo, all display her versatility as an orchestrator of wine. She has achieved a most enviable position, with most of her wines selling out shortly after release.

Wines Tasted

2012 Churinga Vineyard Watervale Riesling

This is made in the Clare mould to some degree, with notes of lemon, grass and flinty kerosene characteristics. It tis in its palate that it differs, offering a rich, balanced feel in the mouth, with the acid hitting about a third along the palate, but leaving a lingering

taste. She is not making a formulaic lemon sorbet. I had this with lemon myrtle scallops.

2012 5452 by KT Riesling

Some people would be happy with this as their high-end Riesling, but KT has deliberately kept this as an entry level wine, with a younger palate in mind. I get slightly sweet pickled limes, and some herbal notes like tomato leaves, on the nose. Contributing to the funky nature of this wine is the use of 90 per cent wild yeast ferment. The palate seems to surf on generously, with acidity being restrained. A baked goat's cheese soufflé would suit.

2012 Melva by KT Riesling

I found this wine swimming against the tide in a most delightful way. Honeysuckle aromas float, with Seville orange blossom and a waft of spiced ginger emerging as it warms up and lets go. Wild yeast ferment with 10-year-old French Oak barrel exposure for three months, with some residual sugar, makes this a creamy, succulent food-matched Riesling. I suggest sea urchin pasta.

2010 Churinga Vineyard Watervale Shiraz by KT

Somehow, Clare Valley Shiraz can get overshadowed by its rich Barossa cousin. KT has sourced premium fruit, and has handled the wine with flawless precision. Dark purple hues coat the glass. Warm red and dark fruits abound. Chocolate and background spice float on vanilla tobacco notes. The palate is supple and generous, and tannins guide the flavour experience, but don't dominate. This wine developed in the two days after opening, which indicates great cellar life. Deconstructed beef Wellington with roasted turnip would do me.

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