Australia's Health System:
What's the treatment?
AMA National Conference 2013

20 pages of coverage inside

AMA

AUSTRALIAN Medicine

The national news publication of the Australian Medical Association

Reverse expenses cap now

AMA demands immediate end to education expense cap, p7

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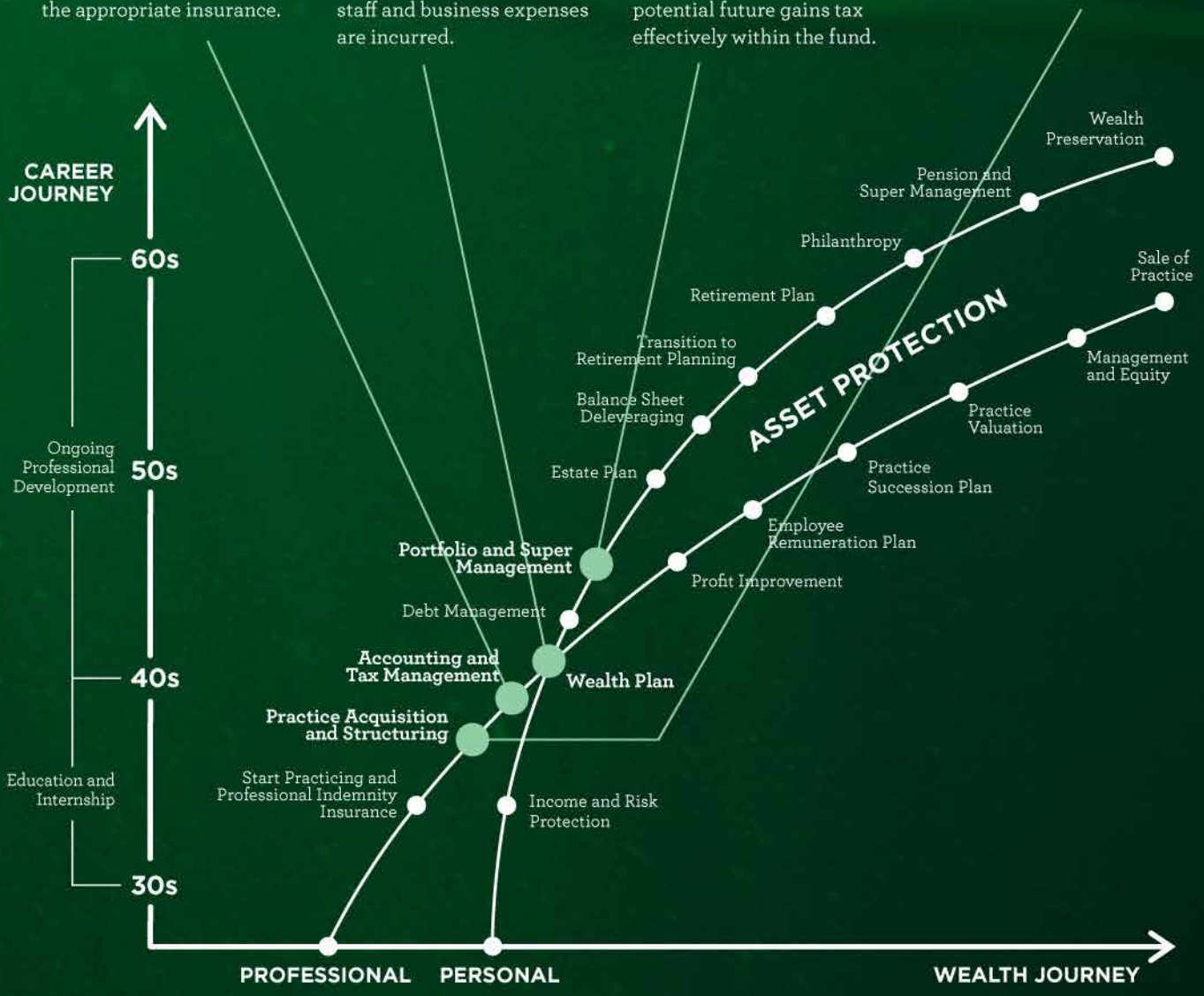

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42 Macquarie St, Barton ACT 2600

Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499

Web: www.ama.com.au
Email: ausmed@ama.com.au

EXECUTIVE OFFICERS

President
Dr Steve Hambleton

Vice President
Prof Geoffrey Dobb

Chairman of Council
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Executive Officer
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Cover: New AMA Executive team (L to R): Dr Elizabeth Feeney, Dr Iain Dunlop, Professor Geoffrey Dobb and Dr Steve Hambleton

Conference Hits New Heights

BY AMA PRESIDENT DR STEVE HAMBLETON

Feedback from delegates to last month's AMA National Conference indicates that the event was a huge success – organisationally, content-wise, and with significant political impact.

National Conference provides the AMA with the opportunity to put the spotlight on how we, as an association, support the entire medical profession, hold governments to account, and support the community to maximise their affordable access to the highest quality health services.

This all came together at this year's Conference, with startling results.

Health Minister Tanya Plibersek and Shadow Minister for Health and Ageing Peter Dutton addressed the delegates against the backdrop of serious unrest in the community and in the profession about the impact of Budget decisions that will make families pay more for their health and make it harder for doctors to improve their skills over their careers.

Both made soothing sounds, but neither provided rock solid assurances or promises that Budget decisions would be reversed. We heard the buzzword of political-speak, "consultation", many times.

We will work to draw out more convincing responses from the Government and the Opposition over the coming months as the 14 September election date draws nearer.

The Chair of the COAG Reform Council, John Brumby, launched the Council's latest health report at the Conference, which was a strong signal from COAG about the AMA's key high-profile role in the health system.

Our policy sessions covered some of the more pressing contemporary issues confronting the profession and the community – and we were graced with some of the best authorities nationally and internationally to share their wisdom with us.

The President of the British Medical Association, Professor Sheila the Baroness Hollins, led an expert panel to discuss revalidation, a matter that is affecting the profession all around the world.

"Our National Conference provided the ideal forum to showcase all theses issues. Our advocacy will help provide the solutions"

Revalidation is the process adopted in the UK by which doctors have to regularly show they are up to date, and fit to practise medicine. The Medical Board of Australia is in the middle of a consultation process as it examines the potential need for and impact of a revalidation model in Australia.

The community debate about end-of-life care is broad and growing in intensity. Our policy session provided an overview of the role and process of end-of-life decision-making and how it impacts on the patient's experience of end-of-life care – a very expensive and emotional time for individuals and families.

The AMA needs to be a leading participant in this community conversation.

Former NSW Health Minister, the Hon John Della Bosca, headlined a lively and entertaining panel discussion of *The Politics of Health*, which was moderated by the ABC's Sophie Scott. It was good to have the political issues of the day discussed openly by experts who make a living creating or discussing the political issues of the day.

The session – *A Market Economy for Health Care* – provided a stark reminder that significant health reform is inevitable. We heard more about the Medicare Select model of primary care that was proposed by the National Health and Hospitals Reform Commission, and the private insurers made it clear that they want a role in primary care.

The very important social determinants of health were given some air in the *Health Has A Postcode* session, with our experts sharing their views about the effect that a person's socio-economic background and place of living influence their health outcomes.

For the first time we had live streaming of content, which enabled many members who were not able to be there to see and hear first hand from our presenters.

You can also review all the policy sessions at https://ama.com.au/live

The single urgency motion from the Conference floor was to do with the Government's decision to place a $2000 cap on tax deductions for work-related self-education, which was appropriate given the broad anger at the decision.

This issue will be a catalyst for the AMA's approach to the Federal election. Along with the Medicare cuts and the MBS freeze, Australian families face paying significantly more for their health care.

Our National Conference provided the ideal forum to showcase all theses issues. Our advocacy will help provide the solutions.

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NATIONAL CONFERENCE FEATURE

Australia's Health System: What's the treatment?

AMA National Conference 2013

24-26 May 2013, Westin Hotel, Sydney

More than 260 delegates from across the country descended on Sydney for the AMA National Conference held at the Westin Hotel from 24 to 26 May.

Proceedings included major speeches by Health Minister Tanya Plibersek and Shadow Health Minister Peter Dutton, as well as policy sessions on hot topics including revalidation, end of life care, health politics and inequality, and health funding.

The conference included the AMA Annual General Meeting and elections, as well as awards.

Online video of the proceedings can be viewed at: https://ama.com.au/live

POLITICAL NEWS:

Major parties lambasted on expense cap

The AMA is pushing for a key Federal Government Budget measure to be challenged in Parliament in a high-stakes gambit to overturn the controversial $2000 cap on tax deductions for work-related self-education expenses.

The AMA National Conference unanimously passed a motion demanding that the Commonwealth "urgently reverse" its decision to introduce the cap from mid-2014, and called on the Coalition and minor parties to oppose the measure when the Budget Appropriation Bills are debated in Parliament.

The motion, moved by AMA Council of Doctors in Training Chair Dr Will Milford and seconded by AMA Victoria President Dr Stephen Parnis, adds weight to action already being taken by senior AMA officials – led by President Dr Steve Hambleton – to have the deeply unpopular decision scrapped.

The resolution echoed warnings sounded by Dr Hambleton that the medical profession, because of its extensive vocational training and continuing professional development requirements, would be hit particularly hard by the tax change, which would compromise the quality of care.

It said the cap would help deter doctors from maintaining their education and training at a time of rapid evolution in medical knowledge; would hit doctors in rural and remote areas particularly hard because of their higher travel costs; was inconsistent with statutory qualification and skill requirements; and failed to recognise existing tax deduction directives.

Dr Hambleton has warned the change has the potential to undermine access to quality care, noting that doctors must learn new technologies, surgical techniques, treatments and pharmaceuticals if they are to provide the best possible care to save lives and improve quality of life for their patients.

Dr Milford told the Conference that passing such a motion would send a strong message, both to politicians and to AMA members, that the tax change was unacceptable and would be vigorously opposed.

"There will be debates over the Budget in the coming weeks and we need to target the participants in those debates – not only government MPs, but those of the Opposition and the minor parties"

"There are those who may consider this to be just another example of the AMA table thumping or chest beating, and being an empty gesture," Dr Milford said. "This is far from the case."

Dr Parnis said the change to the tax deduction, which has drawn outraged comments from thousands of AMA members, had to be made a point of contention in parliamentary debates over the Budget's appropriation bills.

"This is not an issue that we only turn our attention to after [the federal election on] 14 September," he said. "This is a matter for the current Parliament. There will be debates over the Budget in the coming weeks and we need to target the participants in those debates – not only government MPs, but those of the Opposition and the minor parties."

The AMA has already made vigorous representations on the issue to the Government, including with Health Minister Tanya Plibersek and senior officials from the office of Treasurer Wayne Swan, as Ms Plibersek acknowledged at the Conference.

"Steve [Hambleton] was on the phone as soon as any discussion of this started, saying that 'my members are not going to like it'," the Minister said.

But neither Ms Plibersek nor her Opposition counterpart Peter Dutton offered much encouragement to hopes that the tax change would be overturned.

Instead, Ms Plibersek told the Conference the Government would issue a discussion paper "in coming weeks", and there would be opportunity in the next 12 months for work on "carving out" tax deductions for genuine work-related self-education expenses.

Mr Dutton provided even less grounds for hope.

In his Budget Reply speech last month, Opposition leader Tony Abbott indicated the Coalition would accept the savings measures outlined in the Budget, and Mr Dutton indicated that position was unlikely to change.

"I think it is bad policy, [and] if I could reverse the cap today, I would," Mr Dutton said. "[But] it is going to be very hard to reverse this and other taxes. This is the situation we all face, and it is best to be upfront on that."

Dr Parnis described Mr Dutton's comments as "profoundly disappointing".

"I regarded [his remarks] as an abrogation of responsibility," he said.

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POLITICAL NEWS:

Judge us on what we have done: Plibersek

Health Minister Tanya Plibersek addresses the National Conference

Health Minister Tanya Plibersek has forecast the end of the hospital funding blame game and equated the establishment of Medicare Locals with the creation of Medicare in a robust defence of the Federal Government's health policy record.

In a key address to the AMA National Conference as pre-election positioning among the major political parties intensifies, Ms Plibersek acknowledged widespread anger among health professionals about recent Government decisions including the eight-month freeze of the Medicare rebate and a $2000 cap on tax deductions for work-related education expenses.

But the Health Minister called for doctors to judge the Government's performance on significant reforms that she said would deliver far-reaching improvements to health care.

Ms Plibersek predicted the deep tensions over hospital funding that broke out between the Commonwealth and several states late last year would become a thing of the past as hospitals around the country moved to activity-based funding.

"We are going through a transitional period now, [and] this transitional period has allowed a little bit of the old fashioned argey-bargey to continue," she said. "But I don't think this will happen once we are in a position of activity-based funding [because] it will become harder to cost shift and blame shift and obfuscate."

The Minister said activity-based funding meant that, for the first time, states were providing accurate information on how much it cost to provide treatment, making it "very difficult to be engaging in the blame game".

Ms Plibersek also leapt to the defence of Medicare Locals, which she claimed were "as important to the future of the universal health system as the MBS (Medicare Benefits Schedule) and the PBS (Pharmaceutical Benefits Schedule)".

In a speech to the AMA National Conference hours earlier, Shadow Health Minister Peter Dutton – who had previously threatened to abolish Medicare Locals - announced a future Coalition Government would review the Medicare Local program.

But Ms Plibersek said Medicare Locals played an essential role in the health system and accused the Opposition of being "very dishonest" with the electorate about its intentions.

"Medicare Locals have transformed the way we offer primary care services to Australians, to make sure people have primary care services located close to their homes," she said.

Ms Plibersek said that if Mr Dutton's back down from his earlier threat to abolish Medicare Locals was genuine, it would be a welcome move, but if the Coalition's review was just a ploy to delay any announcement about killing off the program until after the 14 September election, that would be "a very dishonest approach".

The Minister defended the introduction of the controversial Personally Controlled Electronic Health Record, which has been dogged by technical glitches and poor support.

Ms Plibersek told the Conference more than 180,000 records had been created – still far short of its initial six-month target of 500,000 records – and that "thousands" of health professionals had also joined the system.

But the Minister was forced to defend Budget savings measures that have sparked an outcry among doctors and prompted warnings that bulk billing rates could soon begin to fall.

In the Budget the Government announced an eight-month delay in indexation of the MBS rebates until mid-2014 and detailed that tax deduction cap on education expenses.

Ms Plibersek said the cap was "not about catching people who have genuine costs in self-education. It's about the first-class airfares and plush hotels. I know that it's a minority."

The Government has promised to issue a discussion paper about the change in the next few weeks, and Ms Plibersek said there would be an opportunity in the next 12 months to "work on carving out what is necessary self-education expenses".

The Minister tried to downplay the significance of the freeze on MBS rebate indexation, which she said had been an "extremely difficult" decision for the Government.

"We have asked doctors that they wait eight months for their next increase in the pay they get from Medicare," Ms Plibersek said. "Nobody likes to wait for a pay rise but, in Budget circumstances where we want to increase services to the public, we have made a tough decision."

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POLITICAL NEWS:

Govt debt means austere times for health: Dutton

Shadow Minister for Health and Ageing Peter Dutton talks to media at the National Conference

The Coalition has pledged to unwind means testing for private health insurance rebates and launch a review of Medicare Locals as part of a pre-election pitch to doctors.

Shadow Health Minister Peter Dutton told the AMA National Conference that a Coalition Government would reverse changes made to private health insurance, most particularly rebate means testing, and would cut health bureaucracy to free up funds for frontline health services.

But the Gillard Government's highly unpopular move to cap tax deductions for self-education expenses at $2000 appears set to stay, after Mr Dutton told the AMA National Conference that it would be "very hard" for the Opposition to reverse the policy if it wins office at the 14 September election.

And, in a move that sits awkwardly with Mr Dutton's pledge to unwind rebate means testing, Shadow Cabinet last week decided to support Government changes to cap indexation of the private health insurance rebate at either the rate of inflation or the annual premium increase, whichever was lower.

The change, to come into effect from April next year, is expected to save $700 million over four years, and Opposition Leader Tony Abbott said it was justified because of the poor state of Government finances.

In a major address to the AMA ahead of the federal election, the Opposition frontbencher – who has held the shadow health portfolio since 2007 – sought to dampen hopes that a change of government would lead to an upsurge in health spending.

Instead, Mr Dutton warned that the Commonwealth's tough financial position meant there would be little new money for health in the next decade, and the focus of a Coalition Government would be to change funding priorities and improve the efficiency and effectiveness of expenditure.

"The biggest threat to our health spending over the next decade is the current state of the Budget," the Shadow Minister said.

In his address to the Conference, Mr Dutton took aim at Labor's performance in Government, attacking what he said was rapid growth in bureaucracy at the expense of funding and resources for frontline health services.

He said health expenditure had soared, surging by 74 per cent in the past decade, with much of this expansion occurring in the Department of Health and Ageing (DoHA) as well as the creation of new agencies and regulators.

"DoHA staffing numbers have grown by 23 per cent in six years. There are now 6000.

"I have been impressed by senior DoHA staff, but we cannot afford for those numbers to be maintained.

"We will need to work with the sector to identify duplication and waste [in the bureaucracy]. This is the only way we will preserve money for frontline services," Mr Dutton said.

The Shadow Health Minister singled out Medicare Locals as a Labor initiative that would come under particular scrutiny if the Coalition were to win office later this year.

Mr Dutton said one of his first acts if he were to become Health Minister would be to initiate a review of the Medicare Local system.

"There remain a lot of unanswered questions about the formal role of Medicare Locals," he said. "Some appear to be doing a good job but in some cases health professionals have expressed their frustration, or indeed indifference, to their existence."

The Liberal frontbencher said the review would be founded on recognition of general practice as the cornerstone of primary care, would assess processes for determining market failure and service intervention to ensure existing clinical services were not disrupted and would examine tendering and contract arrangements.

The proposed review signals a significant softening in the Opposition's position regarding Medicare Locals, after Mr Dutton pledged last year that they would be abolished.

The comments suggest Medicare Locals might survive a change of government, although possibly in much different form.

But while the Shadow Minister provided some chink of light for Medicare Locals, he provided no comfort for medical professionals set to be hit hard by the $2000 cap on tax deductions for self-education expenses coming into effect next year.

"I think it is bad policy, [and] if I could reverse the cap today, I would," Mr Dutton said. "[But] it is going to be very hard to reverse this and other taxes. This is the situation we all face, and it is best to be upfront on that."

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POLITICAL NEWS:

Continuity *and* change at top of AMA

AMA Executive 2013, Dr Elizabeth Feeney, Dr Iain Dunlop, Professor Geoffrey Dobb and Dr Steve Hambleton

The AMA has opted for stability at the top of the organisation in what is likely to be a tumultuous period in federal politics, with President Dr Steve Hambleton and Vice President Professor Geoffrey Dobb re-elected to their positions unopposed at the National Conference.

Dr Hambleton, a Brisbane GP, and Professor Dobb, Director of Critical Care at Royal Perth Hospital, were each confirmed at the Conference for a third annual term in their respective roles.

But there were changes in other AMA executive positions, after Canberra-based ophthalmologist Dr Iain Dunlop successfully challenged Dr Rod McRae as Federal Council Chairman.

Following his loss, Dr McRae contested with Anaesthetist Craft Group representative and fellow executive member Dr Elizabeth Feeney for the Treasurer position, vacated by retirement of long-serving member Dr Peter Ford. Dr Feeney won the election.

Dr Hambleton praised by Dr Ford and Dr McRae for the dedicated service they have provided to the AMA executive over many years, helping assure the Association's position as one of the nation's most respected and influential voices on medical issues and health policy.

In other personnel changes at the AMA, it was announced on the eve of the National Conference that prominent lawyer and director Anne Trimmer has been appointed AMA Secretary General.

Ms Trimmer joins the AMA after serving as Chief Executive Officer of the Medical Technology Association of Australia – a position she held following an extensive career in the legal profession, practising law as a commercial partner of a major Australian law firm.

Ms Trimmer has held several leadership positions in professional and educational bodies, including a period as President of the Law Council of Australia, Deputy Chancellor of the University of Canberra, and Chair of the Australian Government's Advisory Council on Intellectual Property.

Anne chairs the Centre of Excellence in Vision Sciences at the Australian National University and is a director of Research Australia and Plan International Australia.

In 2003, she was awarded a Centenary Medal for services to law and society.

Ms Trimmer is expected to assume her duties in August.

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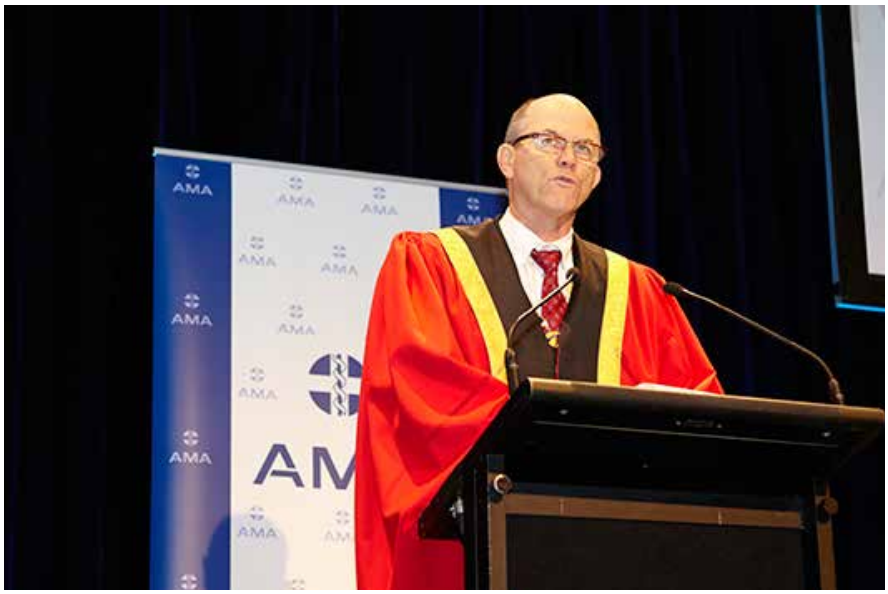
POLITICAL NEWS:
Hambo goes Rambo



AMA President Dr Steve Hambleton addresses the National Conference

AMA President Dr Steve Hambleton used his Presidential Statement at National Conference to set the tone for how the AMA will perform during the 'real' Federal Election campaign, which is due to kick off in early August ahead of polling day on 14 September.

It looks like it will be more Rambo than Columbo, as Dr Hambleton cited the Four Horseman of the Apocalypse in his assault on the Government's recent Budget raids on Medicare and medical training.

"Like the Four Horseman of the Apocalypse, four key Budget decisions will combine to wreak havoc on Australian families," he said.

"The Budget contained a quadruple hit on patients that will have long-term impacts on their ability to pay for their health care needs.

"Budget decision number one is to defer indexation of the Medicare Benefits Schedule (MBS) from 1 November 2013 to 1 July 2014 – a freeze of eight months. That's $664.3 million from rebates.

"Budget decision number two is to cap work-related self-education expense tax deductions to $2000 a year.

"This measure, estimated to provide savings to the Budget of $514.3 million, will have a devastating effect on medical education for doctors.

"Budget decision number three is to increase the upper Medicare Safety Net threshold to $2000.

"This means that families that incur high or numerous health care costs in one calendar year will pay more and more without relief.

"This is another $105.6 million of costs transferred to patients!

"Budget decision number four - which just compounds the above - is the phasing out of the medical expenses tax offset, which adds another $963.5 million - taking the extra total cost to patients to over $1 billion.

"The Government is targeting sick Australians to help fix their Budget black hole.

"GPs and specialists cannot absorb these new imposts and will have to pass on costs to their patients.

"This Budget means that people will pay more for their health care every time they visit their doctor, year after year.

"The sicker that people are, the more they will pay.

"For some families, the changes to the Medicare Safety Net mean that they will need to accrue significantly more health care bills before they get financial support.

"At the end of the year, when the same family expects to claim something back on the medical expenses tax offset, they will be told that that has been scrapped too.

"The chronically ill, the elderly, young families, accident and trauma victims, and our war veterans will be among the hardest hit by these life-changing Budget decisions.

"It will almost certainly drive patients towards an already stressed public hospital sector."

The President's speech energised the opening day of the Conference, striking a chord with the delegates whose branches and craft groups know all too well the feeling among their members about the Budget changes.

The core messages from the speech – plus feedback from other sessions at National Conference – will form the basis of the Federal AMA's upcoming '*Key Health Issues for the Federal Election 2013*' document.

Dr Hambleton – aka 'Rambo' Hambo – will set out the Federal AMA's election strategy at the National Press Club in Canberra on 17 July.

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EDUCATION AND TRAINING:

Govt acts quickly on rural training and classification flaws

The Federal Government has moved to develop an end-to-end training pathway for rural medical students and overhaul the heavily criticised geographical classification system.

Health Minister Tanya Plibersek said she had directed her department to immediately begin work on implementing two key recommendations of the *Mason Review of Australian Government Health Workforce Programs*, which she publicly released at the AMA National Conference on 24 May.

"The AMA was actively engaged in the Review, making a lengthy submission and meeting on several occasions with the Review panel"

Ms Plibersek told the Conference that although the Government was still digesting the detail of the 450-page report, she had ordered quick action on recommendations for rural training improvements and changes to the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system, which she admitted was badly flawed.

The Minister said the Government had made significant investments in rural medical training in recent years, but despite this "the end-to-end process from medical students to specialist training has been lacking, so I have commissioned work to begin straight away on an end-to-end rural pathway for medical students".

The Mason Review also backed concerns expressed by the AMA and others about significant anomalies in the operation of the ASGC-RA, and Ms Plibersek said work on overhaul had already begun.

"There has been a lot of disquiet about the system [and] I have asked for immediate work to begin on a review of the system," the Minister said. "We have seen some anomalies where some towns that are quite different are in the same zone, and towns that are very similar in different classifications.

"For the sake of having a clear and consistent approach to the overseas medical trained workforce and incentives for placement, we need to have a more finely-tuned system," the Minister said.

Ms Plibersek said any classification system would be contentious because of where lines were drawn on the map, but "we need a more consistent, finely-tuned and sophisticated way of making these decisions".

AMA President Dr Steve Hambleton commended the Minister for moving quickly to adopt two key recommendations of the Mason Review, and said the Association would work closely with the Government on improvements in both areas.

"The decision to overhaul the discredited ASGC-RA classification system, which is currently used to underpin a range of Commonwealth health workforce programs, is long overdue," Dr Hambleton said. "It is not meeting the needs of rural and regional areas and suffers from a range of anomalies."

The AMA President added that the new rural training pathway for medical graduates was an exciting development.

"This has the potential to improve recruitment and retention in rural areas, as well as expand critical medical training opportunities as graduate numbers grow and our traditional settings, such as public hospitals, struggle to meet the demand for training places."

Ms Plibersek said she commissioned the Review, undertaken by former NSW Department of Human Services and Community Services Director General Jennifer Mason, "because I wanted to be certain that all the programs that we have interact well and give us the most value for money".

The AMA was actively engaged in the Review, making a lengthy submission and meeting on several occasions with the Review panel.

The Review's report can be viewed at: http://www.health.gov.au/internet/main/publishing.nsf/Content/review-australian-government-health-workforce-programs

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EDUCATION AND TRAINING:

Mason review and rural workforce: evolution or revolution?

BY **DOCTORS IN TRAINING CHAIR DR WILL MILFORD**

Review of the myriad, disparate health workforce programs offered by the Federal Government's Department of Health and Ageing (DoHA) has been long overdue. Serious concerns exist around the efficacy and efficiency of many of the programs, especially the value they represent in terms of attracting and maintaining medical workers in rural and remote areas.

In October last year the Federal government undertook a comprehensive review of all programs offered by DoHA, the *Review of Australian Government Health Workforce Programs* or Mason review (http://www.health.gov.au/internet/main/publishing.nsf/Content/review-australian-government-health-workforce-programs).

Given the title, assumptions could be made that this forms a root and branch review of all medical workforce programs. But this is not the case. Instead, it supplements the impending review of Health Workforce Australia as part of the National Partnership Agreement on Hospital and Health Workforce Reform, and the ongoing Productivity Commission review of health workforce, although it seems that neither of these reports will be delivered before the impending federal election.

Given that the report is only a small piece of the health workforce puzzle, the title is a misnomer - the majority of the report is concerned with medical workforce maldistribution. The review provides an insightful snapshot of existing government programs in this area, and delivers interesting recommendations - some expected and others surprising.

It is a staggering 450 pages long, and was informed by analysis, research and consultation. Somewhat alarmingly, the consultation was brief, and the curious result is that stakeholder input is inversely proportional to the length of the document!

Health Minister Tanya Plibersek launched the Mason review at the AMA national conference on 24 May, with a commitment to immediate implementation of two findings and consideration of the remainder of the report.

Of the two commitments, conceptually the most important was the development of rural training pathways. While details remain scarce, it seems that this will deliver integrated training pathways in regional Australia, allowing junior doctors keen to practice in rural and remote areas to complete their prevocational and vocational training in these regions without the traditional migration to capital cities for training.

The other commitment was to overhaul the ASGC-RA classification system, recognising its inherent problems, particularly the RA2 and RA3 categories. The review has suggested the adoption of a modified 'Monash model', a scheme proposed by the Monash University School of Rural Health and informed by the *Medicine in Australia: Balancing Employment and Life (MABEL) Study*, as it would add other layers of discrimination to the traditionally problematic categories.

Other recommendations include reform to the existing District of Workforce Shortage (DWS) classification system, phasing out of the Medical Rural Bonded Scholarship (MRBS) scheme, and redirection of funds to schemes similar to the Rural Australia Medical Undergraduate Scholarship (RAMUS) scheme.

Importantly, there is an implicit acknowledgement that decisions concerning medical workforce distribution must be informed by the evidence currently gathered by important studies such as Medical Student Outcomes Database (MSOD) and MABEL.

More controversial were the conclusions drawn on the Bonded Medical Places scheme (BMP). While there is limited evidence regarding this scheme, some changes were suggested, many informed by previous feedback from the AMA. These include broadening the return of service obligation to rural and remote areas beyond DWS classification, and combining deferral of return of service obligations until after attainment of fellowship with a shorted return of service obligation.

Not all of the recommendations were positive. The specter of universal bonding of all medical graduates was a pointed inclusion, although the constitutional barrier to civil conscription was also acknowledged. Further expansion of prescription rights to non-medical health professions was also discussed.

Health Workforce Australia (HWA) was singled out for specific comment. Recommendations were made attempting

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EDUCATION AND TRAINING:

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to resolve the clear overlap in activity between HWA and DoHA. Devolution of HWA's role to that of data collection and synthesis was proposed.

The risks to the ongoing existence of HWA are clear, particularly in an election year with an Opposition wedded to weeding out 'unnecessary' bureaucracies. Given that HWA seems to be the actor most likely to produce to a coordinated response to the medical training pipeline crisis, further advocacy will be needed for HWA to retain this role.

In other areas, the Mason review added little. Ironically, the review called for the further review of some workforce programs such as the Specialist Training Program (STP), despite this being well within the terms of reference of the report.

Digesting this lengthy report will take time. The AMA, with significant contributions from AMACDT, will provide a considered response.

Acceptable solutions must be found to the ongoing rural and remote medical workforce issues without sacrificing the aspirations of junior doctors and medical students.

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PUBLIC HEALTH:
Health picture promising, but incomplete

Australians are cutting down on smoking and are less likely to die of a heart attack, but obesity is increasing and the wait to see a GP or have surgery has increased.

A snapshot of the nation's health presented to the AMA National Conference by the Chair of the Council of Australian Governments Reform Council John Brumby showed that, overall, Australians enjoy among the greatest life expectancy and lowest infant mortality rates in the world.

But Mr Brumby warned that, behind the figures showing aggregate national progress lurked great disparities in health, the extent of which were not yet captured in the data collected by the nation's governments.

And he said little progress had yet been made in assessing the sustainability of the nation's health system, which has coming under increasing doubt because of rapid growth in expenditure.

The National Healthcare Agreement report launched by Mr Brumby at the AMA Conference showed that the nation is continuing to make progress in eliminating smoking, with 16.5 per cent of adults lighting up in 2011-12, down from 19.1 per cent in 2007-08.

Leading public health campaigner Professor Mike Daube recently suggested Australia could be smoke free within 15 years. Mr Brumby said this was probably ambitious, but COAG's goal to cut the smoking rate to 10 per cent by 2018 was "a good starting point".

The report also found substantial progress in reducing the rate of heart attacks, which plunged by 16 per cent in the three years to 2010.

But there was disturbing evidence that, in other respects, the nation's health is deteriorating, particularly when it comes to putting on weight.

More than 63 per cent of adults were either overweight or obese in 2011-12 – 35 per cent overweight, 28 per cent obese – up from 61.1 per cent in 2007-08.

"These are disturbing numbers," Mr Brumby said. "We know that obesity is contributing to the burden of chronic disease."

He said there would be greater insight into the burden it is placing on the health system next year when data on the prevalence of diabetes – for the first time derived from biosamples collected nationally - will begin to be collected.

"Diabetes, which has been described as a silent pandemic, is already a major test of our health system, and having the Council monitor and report on it will bring it into much sharper focus for all governments," he said.

The report included evidence that aspects of the health system are already struggling under the burden of demand.

Mr Brumby said although a decline in the occurrence of preventable hospitalisations suggested the effectiveness of primary and preventive health care was improving, there were other signs of stress.

> "The report included evidence that aspects of the health system are already struggling under the burden of demand"

While most people reported they could see a GP within four hours if the matter was urgent, the proportion who said they were forced to wait more than a day for a GP appointment has jumped, from barely one in 10 in 2010-11 to almost one in four in 2011-12.

Similarly, waiting times for elective surgery have increased.

Disturbingly, there is little data to indicate how sustainable the health system, as currently configured, is.

A recent Grattan Institute report suggested much of the 74 per cent surge in government spending on health in the last 10 years had been driven by increases in the number and complexity of treatments rather than the demands of an ageing population.

But what that growth means for the long-term prospects of the system remains unclear.

Mr Brumby said that although governments acknowledge the need to begin assessing the sustainability of the health system, they are yet to agree on exactly what this means, let alone begin devising measures to gauge it.

"Work is needed to develop more meaningful measures of whether our health system can be sustained, given the type of cost, funding and utilisation pressures it faces," Mr Brumby said.

He added that another significant gap in knowledge concerned incomplete data measuring health in rural and remote areas, compared with outcomes in metropolitan Australia.

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POLICY SESSIONS:
Revalidation: do doctors need it?

Dr Joanna Flynn, Chair, Medical Board of Australia

Professor Ron Paterson, Professor of Health and Law Policy, University of Auckland

Doctors in future will have to undertake regular evaluations of their competence and fitness to practice that go beyond current accreditation, registration and continuing professional development (CPD) standards.

That was the underlying message from Medical Board of Australia Chair Dr Joanna Flynn and former New Zealand Health and Disability Commissioner Professor Ron Paterson at a forum on the controversial topic of doctor revalidation, held at the AMA National Conference.

The Medical Board has initiated discussion about the establishment of a system of revalidation amid the introduction of similar schemes overseas, most recently in the United Kingdom.

Dr Flynn and Professor Paterson made it clear they thought it would become increasingly untenable for the medical profession to rely on current accreditation, registration and CPD systems as a way to reassure the public of the competence of individual practitioners.

One of the issues proponents of some form of revalidation requirement for doctors have grappled with is to clearly identify the problem that such a process would be set up to address.

The forum was told that only a small proportion of doctors are the subject of formal complaints from patients or colleagues.

Dr Flynn said that of 95,000 registered practitioners in Australia, less than 5000 are the subject of complaints each year and, of these, only a small number are upheld and result in regulatory action.

Professor Paterson cited research showing that just 3 per cent of doctors are the source of 49 per cent of complaints.

But both said that the complaints system itself was not an effective way to ascertain the competence of a particular practitioner, with Professor Paterson pointing to evidence that several doctors who were the subject of multiple complaints continued to practice.

"There is an underbelly of problem doctors beyond those that come to the attention of the Medical Board and State and Territory Health Complaints Commissioners," he said.

Professor Paterson said the public wanted reassurance that when they saw a doctor, they were not taking "pot luck" that the practitioner was fit to practice.

"We like to think that we are in the hands of capable doctors, but I don't believe that the current self-declaration of having completed CPD gives me the same sense of assurance that I get with an airline pilot," he said.

Dr Flynn admitted that the problem that a revalidation-style system would help solve was not yet defined.

But she was nonetheless confident that to maintain the trust of the public, the medical profession had to accept the need for a system that verified the competence of practitioners.

"We will need to do something beyond what we are currently doing," Dr Flynn said, adding that claims that CPD programs provided sufficient assurance were unconvincing.

"Can you assure me that everyone who has done your CPD program is actually competent and practising at a reasonable standard?" she asked. "My sense is that, for most CPD programs, they don't do that, or at least, not to a high enough level of certainty."

As to what a revalidation program would look like, Dr Flynn was keen to emphasise the Medical Board had no preconceptions, and thought it unlikely to approximate the systems operating in the United States or the UK.

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POLICY SESSIONS:

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British Medical Association President Professor Sheila the Baroness Hollins gave an account of her own experience with the UK's recently-introduced revalidation system, which requires doctors to provide six categories of supporting information.

These included CPD, reports on quality improvement activities and significant events, feedback from at least 13 patients and colleagues (with responses), and a review of complaints and compliments.

Professor Hollins said the process, while not particularly lengthy, might nonetheless "engage you in different types of activities, which might take some time".

The AMA and the broader medical profession has expressed disquiet about the potential of revalidation to add to the administrative burden and costs of doctors with little demonstrable gain.

Dr Flynn said the Medical Board was cognisant of these concerns, and wanted to develop a system, in close consultation with the AMA and other representatives of the profession, that was of benefit to practitioners as well as patients.

She said that any test should be seen to have intrinsic worth for those undertaking it, that it be relevant to each doctor's practice, that it be readily available and accessible, and that it not be burdensome.

Dr Flynn said it would most likely involve feedback from multiple sources, practice visits from peers, the use of practice data and, probably, some form of test.

"I think we need to do something. All of us as medical practitioners are weakened by poor standards of practise and the failure of our colleagues," she said.

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Let's talk about death: GPs should do it more

Dr Kate Robins-Browne, GP

Professor Michael Ashby, Director of Palliative Care, Royal Hobart Hospital

Dr Peter Saul, Director Intesive Care, Newcastle Private Hospital

The medical profession and broader society have to become better and more comfortable talking about death if patients are to receive improved care at the end of their lives.

Speakers at the AMA National Conference forum on end-of-life care drew on personal experiences and research to highlight concerns about the way the approach of death is often handled in clinical settings.

Newcastle Private Hospital Director of Intensive Care Dr Peter Saul said the nature of death and dying was changing as the demographics and health of the broader population evolved, but many practitioners tended to brush over or ignore this.

Dr Saul said reduced rates of cardiac disease and other improvements meant that sudden death was no longer the norm, and people were now more likely to experience a slow decline involving progressive organ failure and multiple admissions to hospital – raising complex questions about when treatment should stop.

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He said advance care plans (ACP), in which patients specify how they would like to be treated, particularly toward the end of their lives, helped provide clinicians with some guidance.

Dr Saul together with the other speakers at the forum, Royal Hobart Hospital Director of Palliative Care Professor Michael Ashby and GP Dr Kate Robins-Browne, bemoaned the reluctance of many GPs to talk about death with their patients and help them prepare ACPs.

Professor Ashby said there was a reticence on behalf of many practitioners and family members to engage in "death talk", but that is what was needed if the experience of many approaching the end of their life was to improve.

"Dying is a natural part of life. Medical progress will not change that," he said.

Professor Ashby said clinicians should provide clear and honest information to patients and their families, paraphrasing the famous quote that the despair they could take, it was the hope they could not stand.

"We may talk about a patient's wishes, but there is also clinical reality," he said. "The work we often do is around grief trauma and the reality that there is no further treatment."

Professor Ashby said doctors should pay close heed to what patients and their families said, noting that the most powerful diagnostic tool in determining the approach of death was when the patient or their family started talking about it.

Professor Ashby bemoaned that too often junior doctors in hospitals were left by their senior colleagues with the responsibility of conducting end-of-life conversations with patients and families.

He said GPs reluctant to take on this task were locking themselves out of a major aspect of their key brokerage role between their patients and hospitals.

"This is a very important area for GPs," he said. "This is one area where I am concerned that GPs are losing a lock on their brokerage role."

Dr Robins-Browne said GPs were in an ideal position to discuss the end-of-life with their patients and families, but many seemed reluctant to be involved with developing ACPs for a range of reasons including the time involved, concerns about reimbursement and difficulty in understanding what is involved.

But Dr Robins-Browne said more ACPs by themselves were not a panacea to improving end-of-life care.

She said ACPs embodied an individualistic approach to end-of-life decisions that reflected a false dichotomy between a person and the significant relationships they have developed.

Dr Robins-Browne said her research had shown that people displayed an implicit trust in the judgement of their significant others – including spouses, children and family doctors – that they would make decisions about their care that would accord with what they would want in the circumstances.

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Market part of the cure for ailing health system

Australians will face increased rationing of medical services without a major overhaul of the health system's operation and funding, speakers at the *Market economy for health* policy session at the AMA National Conference warned.

Projections that spending on health and aged care will consume 46 per cent of the Commonwealth Budget by 2050 have fuelled calls for a re-think in who pays for medical services, and how.

At the core of each of the presentations, by Chair of the AMA Council of General Practice Dr Brian Morton, Health Services Management Chair Professor Just Stoelwinder and Australian Unity Group Managing Director Rohan Mead, was the need for a shift away from current government-centred funding arrangements toward much greater involvement of the private sector and individuals.

Dr Morton argued the case for a vast expansion in the role of private health insurers to make them an effective partner with general practitioners in the prevention and management of disease.

"Policy failures [in the present system] abound, and are mainly concerned with the high level of demand for health services (the irresistible force) coming up against the budget limitations of government (the immovable object)," he said.

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POLICY SESSIONS:

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Dr Brian Morton, Chair AMA Council of General Practice

Professor Just Stoelwinder, Chair Health Services Management

Rohan Mead, Group Managing Director Australian Unity

Under current arrangements, private health funds are effectively hamstrung from participating in most aspects of health care except financing private hospital activity, Dr Morton said, robbing the system of a potentially major contributor to improved preventive and primary care.

According to Dr Morton, there is a genuine intersection of interests between the medical profession and health funds in the provision of pre- and post-operative care, and the treatment of patients with chronic and complex conditions which – if not managed well – can lead to increased hospital admissions.

He said that so far health insurers and other funders were more concerned about finding ways to shift costs than open up new areas of business, and many funds had resisted overtures from the medical profession.

But the potential benefits – both for insurers and for public health – were enormous.

"If done correctly, this [partnership] would provide a tangible benefit for privately insured patients over public patients, which would provide a service-and-quality-driven incentive to take up private health insurance," Dr Morton said, adding that it had the potential to encourage much more effective preventive health action to tackle obesity, smoking, alcohol abuse and other health risks.

"The implication is that private health insurers would be able to become an effective partner in health prevention, which is now forbidden, and that GPs would be able to work with [them] to achieve population health outcomes," he said.

There are tentative signs of interest from some in the industry. Medibank Private has developed an integrated care package that Dr Morton said showed promise, though it currently lacked appropriate remuneration for GPs.

But his biggest concern was that progress in this direction would continue to be disappointingly slow unless or until there was a major shift in thinking among federal politicians and health bureaucrats – something he thought unlikely within the next decade.

"Broader health financing reform which better integrates the public and private care sectors and liberates medical practice from the current strictures in the Health Insurance Act would go a long way to breaking down the barriers and improving patient care," Dr Morton said. "But it would require a greater crisis than we have now, or a political leader of much greater vision and calibre than we see on the horizon."

Mr Mead and Professor Stoelwinder proposed funding models of patient-centred care involving market mechanisms to help ensure health funds – whether they came from the central government, health funds or individuals – were spent to greatest effect.

Professor Stoelwinder said under his Medicare Select model, the Commonwealth would be the single source of funding, but consumers would have a choice between competing hospitals and health services.

Mr Mead said he did not think a shift to a full market-based health system was desirable ("I don't believe the health system would work in some adolescent view of the free market"), but he said it needed to be reoriented around consumer interests.

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POLICY SESSIONS:

Improved early years best investment in nation's health

Dr Harald Klein, Director Community Building and Economic Participation, Victorian Department of Human Services

Dr Mark Kennedy, GP

Professor Victor Nossar, Program Leader, Child and Youth Health, Department of Health (NT)

Poor experiences in early life have major ramifications for future health, underlining the need to boost levels of education, employment and nutrition in disadvantaged areas.

AMA National Conference delegates attending the *Health has a Postcode* plenary session were told that research into epigenetics and social disadvantage had shown that where someone lived, and the experiences they were exposed to in early childhood, had profound effects on health later in life.

Senior paediatrician Professor Victor Nossar of the Northern Territory Department of Health said it was difficult to overestimate the importance of what happens in the first three years of a person's life.

Professor Nossar said that by the age of three, the human brain is about 80 per cent developed, and experiences in the early years such as abuse, neglect and poor nutrition have ramifications that last through the rest of life.

He told the Conference there was "a strong dose-dependent relationship" between experiencing neglect, abuse or dysfunctional family relationships early in life and the likelihood that someone would take up smoking, engage in early sexual activity or attempt suicide as a teenager.

Professor Nossar cited an Australian study that found children neglected in their first three years of life had a 57 per cent risk of becoming involved in juvenile crime, and US research found that 66 per cent of children who grew up in chronic poverty developed serious learning and behavioural problems by the time they were 10 years of age.

But Professor Nossar said that, significantly, the US study found that a third of children who grew up in chronic poverty developed into competent, caring adults.

He said the difference was the environment they grew up in and the care they received.

"The care-giving environment was the predictor of whether or not they broke out of that cycle," Professor Nossar said. "Eighty per cent of development risk is about the care given – it is what parents do, not who they are."

This was not just about lifestyle choices: the environment in which people grow up affects the physiology of the brain, he said.

"Your self-control is derived from the way your parents cared for you in your early life," Professor Nossar said. "Environment shapes your neurological interpretation of the environment, it actually changes the endocrine environment and the methylation of specific genes.

"By that, I am actually saying you have a lifetime inherited risk that stays with you."

He acknowledged the danger that this could be seen as deterministic, potentially undercutting efforts to improve the prospects of older children and adults.

But instead, Professor Nossar said, it was an argument for the importance of efforts to address the underlying causes before they took effect.

"The focus must be on prevention," he said, noting the success rate of interventions aimed at changing behaviour later in life was poor.

As an example, he cited a study of two Indigenous communities in Northern Territory where children saw a doctor, on average, 28 times in their first years of life ("more clinical contact in their first year than any other children in Australia"), yet

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in that time 40 per cent were admitted to hospital with a serious illness.

"Services alone are not going to redress that imbalance," Professor Nossar said. "Getting the mother through 12 years of high school is more important to children's growth and development than any intervention you or I can muster."

His emphasis on the importance of tackling the underlying causes of disadvantage were echoed by the session's other panellists, Dr Harald Klein of Victoria's Department of Human Services and Dr Mark Kennedy, a GP involved in the Neighbourhood Renewal program in Victoria's Corio/Norlane area.

Dr Klein said the link between social disadvantage and poor health was well established.

But he said in recent years disadvantage and associated poor health had become increasingly "super concentrated" in a small number of neighbourhoods.

To tackle this he has overseen a program that cuts across several ministerial portfolios to improve the physical and social environment of disadvantaged communities, one example of which was the Neighbourhood Renewal program in Corio/Norlane area involving Dr Kennedy.

"Health policy cannot change the upstream forces that cause health inequality in the first place," Dr Klein said. "Fragmented approaches are not working, and nor are paternalistic approaches.

"We need to deliver interventions that change the structural drivers of inequality."

He said this included improving education and reducing insecurity and unemployment.

The Neighbourhood Renewal program involves improving the physical surroundings and encouraging participatory community governance.

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Video of this and other sessions of the AMA National Conference 2013 can be viewed at https://ama.com.au/live

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Election will change govt, not health

Hon John Della Bosca, Former NSW Health Minister

Peter Lewis, Director, Essential Media

Sue Dunlevy, National Health Correspondent, News Ltd

Voters are deeply concerned about health care, but the tight fiscal environment and political focus on saving rather than spending means the forthcoming federal election will be a tough one for advocates of health reform.

The National Conference forum, *The Politics of Health*, was told that although health rated highly in the voter list of concerns – second only to the economy – the political appetite for reform that involved extra funding was almost non-existent.

Political analyst, consultant and pollster Peter Lewis, Director of Essential Media, was blunt in his assessment of the Gillard Government's prospects.

Mr Lewis said polls had consistently shown the Coalition had a 10 percentage point lead over Labor on a two-party preferred basis, indicating that "this is a change of government election".

There has been concern that health will be largely neglected as an issue in the lead-up to the 14 September election, and Mr Lewis said such fears were well-founded.

He said recent polls by his organisation had shown more than half of voters

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Sue Dunlevy, Hon John Della Bosca and Dr Jeremy Sammut, Centre for Independent Studies Fellow

ranked health as one of their top three issues of concern.

But despite this, there was little appetite among the major parties for potentially expensive health reform.

"The political narrative will be around saving rather than spending. It is a very difficult climate for spending," he said, warning that this was likely to persist well after the election.

"This is a climate that is ripe for a conservative government to wind back the state. It is going to be very tough for the AMA."

One possible cause for optimism if there is a change of government is Tony Abbott's record as Health Minister in the Howard Government.

Panellist Sue Dunlevy, who is National Health Correspondent for New Limited, said that when in Government, Mr Abbott was "a spender, not a saver", and several of the schemes he had introduced have since resulted in multi-billion dollar blowouts.

Former NSW Health Minister and Campaign Director for the National Disability and Carers Alliance John Della Bosca told the forum Mr Abbott was not the hardline fiscal conservative that some sort to portray him as.

"In his Budget Reply speech, Tony Abbott fundamentally endorsed the fiscal program of the current Government, except the carbon tax and the Gonski education reform," Mr Della Bosca said. "The ALP is campaigning against the wrong Tony Abbott. He is a Grouper [socially conservative Catholic], he is not a dry Liberal.

"He is going to do exactly the same things, in fiscal terms, as the ALP."

The panellists did not expect to see fundamental changes to the way health was funded, meaning the "blame game" between the Commonwealth, State and Territory levels of government was likely to remain a feature of the health landscape.

Centre for Independent Studies Research Fellow Dr Jeremy Sammut said there was "a strong chance" the country would continue to muddle through, with only marginal changes made to arrangements, which meant that rationing of health services would increase.

Dr Sammut said the blame game was, at its core, about politics not money, noting that there had been a huge increase in Commonwealth outlays in recent years from $17 billion to $38 billion.

Mr Della Bosca said recent attempts to end the blame game had foundered because they were not underpinned by a coherent policy on the nature of the Federation – and he warned this was likely to remain the case even if there was a change of government.

"Neither Tony Abbott nor Julia Gillard have articulated anything around the relationship between the Commonwealth and the states," he said. "[And] I don't think the blame game will end until there is a proper re-examination of the Federation itself."

The trick, according to Mr Della Bosca, is that reform does not come cheap.

"The only way to achieve what you want to achieve in the public hospital system is that you have to buy reform," he said.

He said his experience as NSW Health Minister was that you could never shut down a health service, even if it was superseded by a new service in the same area, meaning the system was burdened by a growing legacy of costly and inefficient operations.

Mr Della Bosca said, to much applause from AMA delegates, that the solution was to give medical professionals far greater control in the management and delivery of health services.

Asked about the effect of the Government's freeze on Medicare rebates, Ms Dunlevy said history showed that would eventually lead to a decline in the rate of bulk billing – which earlier this year reached a record high above 82 per cent.

The journalist observed that significant inequalities in health outcomes were often ignored in health policy debates, noting that health was related to income and geography.

Video of this and other sessions of the AMA National Conference 2013 can be viewed online at https://ama.com.au/live

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Award winners

AMA-ACOSH-ASH National Tobacco Scoreboard High Commendation

- Australian Government
- Tasmania

AMA-ACOSH-ASH National Tobacco Scoreboard Dirty Ashtray Award

- Victoria
- Queensland

State Awards

- Best Public Health Campaign – AMA NSW for 'Kids Don't Fly'
- Best State Publication – AMA SA for MedicSA
- Best Use of New Media or Website – AMA Vic for Creative use of Twitter
- Best Lobby Campaign – AMA Vic for Violence and Security in Hospitals

President's Award

- Dr Brian Morton
- Dr Peter Ford

Roll of Fellows

- Dr Richard Kidd
- Associate Professor David Mountain
- Professor Simon Willcock

MJA, MDA National Prize for Excellence in Medical Research

- Sandra Eades, head of the Indigenous Maternal and Child Health Research Program at the Baker IDI Heart and Diabetes Institute in Melbourne;
- Rob Sanson-Fisher, Laureate Professor of Health Behaviour at the University of Newcastle;
- Mark Wenitong, Senior Medical Officer at the Apunipima Cape York Health Council in Cairns;
- Katie Panaretto, Population Health Medical Officer at the Queensland Aboriginal and Islander Health Council in Brisbane;
- Catherine D'Este, Professor of Biostatistics at the University of Newcastle;
- Conor Gilligan, lecturer at the University of Newcastle; and
- Jessica Stewart, a PhD student at the University of Newcastle.

MJA Dr Eric Dark Creative Writing Prize

- Dr Rebecca Rowe, author of *Enough?*, a touching account of three women's experiences in a labour ward.
- Second-year University of Notre Dame student John Farey is the winner of this year's Medical Students section, with his piece, entitled *Esther*.

NDIS Advocacy Award

- AMA – presented by Immediate Past President Dr Andrew Pesce

AMA NSW President Dr Brian Owler accepts the State Award for Best Public Health Campaign

AMA South Australian president Dr Patricia Montanaro accepts the State Award for Best Publication

AMA Victoria President Dr Stephen Parnis accepts the Best Lobby Campaign State Award

Award winners

Dr Richard Kidd addresses delegates on behalf of the Fellows

AMA Queensland President Dr Alex Markwell and AMA Victoria President Dr Stephen Parnis - joint winners of the Dirty Ashtray Award

AMA President Dr Hambleton with the winners of the MJA Dr Eric Dark Creative Writing Prize

AMA President Dr Steve Hambleton awarding Health Minister Tanya Plibersek with the AMA-ACOSH-ASH High Commendation for Tobacco Control

AMA President Dr Steve Hambleton with President's Award recipients Dr Peter Ford and Dr Brian Morton

Former AMA President, Dr Rosanna Capolingua (R) and MJA Senior Deputy Editor Dr Ruth Armstrong (L), with recipients of the MJA-MDA National Prize for Excellence in Medical Research

Award winners

Dr Peter Ford accepting his President's Award

Dr Hambleton presents Tasmanian President Dr John Davis with the AMA-ACOSH-ASH National Tobacco Scoreboard High Commendation

Chair of the AMA Council of General Practice Dr Brian Morton accepting the President's Award

Roll of Fellows Dr Richard Kidd, Associate Professor David Mountain, Professor Simon Willcock with Dr Hambleton

AMA Victoria President Dr Stephen Parnis also accepts the State Award for Best Use of Website or New Media

President's Cocktail reception

Following the first day of the National Conference, which included major addresses from AMA President Dr Steve Hambleton, Health Minister Tanya Plibersek, Shadow Health Minister Peter Dutton, NSW Governor Professor Marie Bashir and COAG Reform Council Chair John Brumby, as well as a policy session on the Medical Board of Australia's controversial revalidation proposal, delegates were invited to a cocktail reception hosted by Dr Hambleton. The winners of several AMA awards including the National Tobacco Scorecard/Dirty Ashtray Awards, the keenly contested AMA State Awards, the MJA Dr Eric Dark Creative Writing Prize and the NDIS Advocacy Award were announced at the function, which provided a chance for AMA members from across the country to meet and mingle.

Her Excellency NSW Governor Professor Marie Bashir, who formally opened the AMA National Conference

Leadership Development Dinner

Always a popular event with the Doctors in Training, the Leadership Development Dinner has a record of attracting high-calibre speakers who have achieved national or international prominence for their achievements. This year the Dinner's guest speaker was practitioner, entrepreneur and philanthropist Dr Sam Prince, who told the packed audience of junior doctors about his experiences in medicine, aid work, and business, encouraging them to develop the skills needed to advocate effectively for the needs of their patients and profession.

Leadership Development Dinner

Chair of Doctors in Training representative Dr Will Milford with Dr Sam Prince and AMA Vice President Professor Geoffrey Dobb

The Gala Dinner

The social highlight of the National Conference was the annual Gala Dinner, which came at the end of the second day of proceedings. In keeping with the Dinner's "Flirty Fifties" theme, the band the Aston Martinis played a stylish mix of Motown-inspired swing, jazz and soul favourites. The dance floor was crowded and the festivities continued late into the night.

The Gala Dinner

The Gala Dinner

Parents should prove child immunisation: AMA

The AMA has called for parents nationwide to be obliged to fully document their child's immunisation status before they can enrol them in schools and child care centres.

The AMA Federal Council has confirmed its support for tough, uniform national immunisation requirements for parents enrolling children after New South Wales last week passed laws demanding that parents vaccinate their children or register for an exemption before they can attend childcare.

The NSW legislation, the first of its kind in the country, has been introduced following evidence that child immunisation rates in pockets of the State have fallen to levels that leave the population vulnerable to sustained outbreaks of potentially deadly diseases such as measles.

Under the new laws, parents or guardians trying to enrol children in childcare will be required to provide evidence that their child has been fully vaccinated, is on a recognised vaccination catch-up schedule, or has a doctor-approved exemption on religious or medical grounds. To obtain an exemption, parents will have to undergo counselling and make formal statements.

Childcare centres that fail to enforce the new standards face a $4000 fine.

AMA President Dr Steve Hambleton said vaccination rates for infants and very young children were "pretty good", but were trailing off among four and five-year-old children, in some areas dipping below 90 per cent, undermining herd immunity and leaving populations vulnerable to sustained disease outbreaks.

Dr Hambleton said the measure should be effective in giving parents of these older children the incentive they needed to take action and get their children vaccinated, and was not particularly directed at the small minority who had a conscientious objection to vaccination.

"We're not worried about those conscientious objector numbers because they actually aren't growing and they're still below 2 per cent," Dr Hambleton told ABC radio. "We need to get those parents who, for whatever reason, haven't got around to it or just need that extra information to get our immunity up to where we need it.

"There's international evidence that it actually works. It gives those parents a bit of a nudge at a time when they're trying to get their children into childcare to get those rates up."

The AMA has been at the forefront of national action to lift and sustain high immunisation rates, and wants to see similar demands placed on enrolling parents in other states and territories.

Federal Health Minister Tanya Plibersek has put tougher vaccination requirements for parents enrolling children at schools and childcare centre on the agenda of the forthcoming meeting of the nation's Health Ministers, which Dr Hambleton said was a welcome move.

"The Commonwealth's proposal to introduce nationally consistent policy for schools to assess and document immunisation status is welcome," Dr Hambleton said. "The process should also include a pathway so that children who have fallen behind with their immunisations can participate in a 'catch up' program relatively easily."

He said schools would need to be actively engaged in the process to ensure it was workable, and urged cooperation among the Federal, State and Territory governments "to develop a nationally consistent approach to school entry and immunisation to raise childhood immunisation rates".

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If in doubt, turn CSG off: AMA

Coal seam gas developments should be blocked where there is any doubt about their potential to cause serious and irreversible harm to health, according to the AMA.

In an important intervention in the gathering national debate about the safety of coal seam gas (CSG) mining, the AMA Federal Council has called for nationally-consistent standards requiring that all CSG developments be subject to rigorous and independent health risk assessments.

In its resolution, the Council urges that all existing CSG projects be regularly monitored for potential health effects, including air and ground water pollution, while any proposed developments be subject to health risk assessments that take into account environmental pollution.

Significantly, given the paucity of evidence so far gathered regarding the safety of CSG mining, the Council demands that, "in circumstances where there is insufficient evidence to ensure safety, the precautionary principle should apply".

AMA President Dr Steve Hambleton said this principle was essential, given the uncertainty over CSG safety and the potential for "serious and irreversible harms" to health.

"Despite the rapid expansion of CSG developments, the health impacts have not been adequately researched, and effective regulations that protect public health are not in place," Dr Hambleton said.

"There is a lack of information on the chemicals used and wastes produced, insufficient data on cumulative health impacts, and a lack of comprehensive environmental monitoring and health impact assessments."

The AMA President said regulation of CSG projects varied widely between the states, with some imposing health regulations while others virtually ignore the issue.

Dr Hambleton said the move by the Commonwealth to strengthen environmental protection laws regarding the affect of CSG projects on water resources was welcome, but greater safeguards were needed.

"The assessment of the health impacts of CSG developments needs to strengthened and made consistent across all jurisdictions," he said.

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Scam alert - Australasian Health Professionals Directory

AMA President Dr Steve Hambleton has alerted AMA members to a scam in which medical practices are being charged up to $5200 for listing in the Australasian Health Professionals Directory.

The Association has been informed that a number of practices have been approached with an offer of free listing in the Directory.

Dr Hambleton said several practices had been sent a notice advertising the Directory and asking them to update their details.

But the fine print of the contract shows that the listing in fact costs $1300 a year for a minimum of three years, and will continue on for a further year if not cancelled.

There are a range of other concerns about the material that doctors have received, including the fact that the directory website does not currently appear to exist, and the listing form asks for a great deal of information that puts participants at risk of identity fraud.

Dr Hambleton said the scam used a well-established strategy to mislead recipients and con them into signing the enclosed contract, before then making demands for payment.

The AMA President advised doctors and practices who have received material spruiking the Directory to ignore it.

He said those who have already signed up to Australasian Health Professionals Directory should immediately send a follow up communication rescinding their participation.

"On no account should doctors or practices make any payment or provide credit card details," the AMA President said.

Doctors and practices that receive demands for payment or financial information from Australasian Health Professionals Directory should immediately contact their local Office of Fair Trading or the Australian Competition and Consumer Commission. State and Territory AMA offices are also available to assist members.

The AMA has alerted Fair Trading offices in each State and Territory, as well as the Australian Competition and Consumer Commission, of this latest scam.

More detailed advice for doctors can be viewed at: https://ama.com.au/urgent-advice-members-australasian-health-professionals-directory

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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

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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

Sights set on fat tax, *The Herald Sun*, 20 May 2013

The AMA and other health organisations want the option of a fat tax explored even though the Henry Tax Review was cool on the idea.

Plan aims to boost organ donations, *West Australian*, 20 May 2013

AMA Vice President Professor Geoffrey Dobb welcomed the move by WA to source organ donors from regional hospitals.

AMA call to vet healthcare apps, *The Australian*, 21 May 2013

AMA President Dr Steve Hambleton said medical bodies should be involved in the approval process for apps so they do not give biased or misleading information.

Walking to school a lesson in health, *West Australian*, 24 May 2013

The AMA urged parents to break their normal routine and walk their children to school to help them form healthier habits.

Growing abuse of Xanax leads to restrictions, *The Sydney Morning Herald*, 24 May 2013

President of the Australian Medical Association Dr Steve Hambleton said there had been a significant increase in benzodiazepine prescription, despite the drugs not being recommended as a first-line treatment for anxiety.

Fears GP Training course could put patients at risk, *The Saturday Age*, 25 May 2013

GPs are receiving government-mandated training by doctors who claim vaccines are linked to autism, and that temper tantrums can be treated by delaying immunisation. Australian Medical Association President Dr Steve Hambleton said doctor training courses should be reviewed.

Radio

Dr Hambleton, 2HD Newcastle, 21 May 2013

AMA President Dr Steve Hambleton discussed the possibility of a fat tax.

Dr Hambleton, 666 ABC Canberra, 22 May 2013

AMA President Dr Steve Hambleton welcomed prospective tougher rules designed to halt over-prescription of the anti-anxiety drug Xanax.

Dr Hambleton, ABC New England North West Tamworth, 24 May 2013

AMA President Dr Steve Hambleton discussed the AMA's call for coal seam gas projects to be the subject of health risk assessments before they can proceed.

Dr Hambleton, 3AW Melbourne, 29 May 2013

AMA President Dr Steve Hambleton talked about e-cigarettes. Dr Hambleton said they were not regulated or registered in Australia and were not listed with the TGA. He said it was illegal to sell them under most state regulations.

Television

Dr Hambleton, Today, Channel 9, 21 May 2013

AMA President Dr Steve Hambleton discussed the facts and figures surrounding the vaccination of children.

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Australian Medical Association Limited ACN 008 426 793 ABN 37 008 426 793

Invitation for nominations for election to Federal Council as Craft Group Nominee

Following the outcome of the 2013 election for the positions of Chair of Council and Treasurer, pursuant to the Articles of Association, nominations are now invited for election to the Federal Council of one Ordinary Member as a Nominee of each of the following Craft Groups:

- Anaesthetists
- Ophthalmologists

1. Nominees elected to these positions shall hold office until the conclusion of the May 2014 AMA National Conference.
2. A nominee must be an Ordinary Member of the AMA and a member of the relevant Craft Group for which the nomination is made.
3. The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations.
4. Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Craft Group for which the nomination is made.
5. Nominations should be addressed to the Returning Officer (marked "Private and Confidential") and to be valid must be received at AMA House, 42 Macquarie Street, Barton, ACT 2600 no later than 5.00pm Wednesday 17 July 2013.
6. A nomination may be accompanied by a statement by the nominee of not more than 250 words. Such statement will be circulated with the ballot paper if it is approved by the Federal Council.

For a copy of a nomination form or any general enquiries please contact Ms Nadene Sharpe, Office of the Secretary General and Executive (email: nsharpe@ama.com.au).

Mr Warwick Hough
Company Secretary
1July 2013

CT scans boost cancer risk

The Federal Government is developing protocols governing the use of CT scans following research showing exposure to the procedure in childhood significantly increases the risk of developing cancer later in life.

Chief Medical Officer Professor Chris Baggoley has formed an expert group to develop guidelines in the use of computed tomography (CT) scans, particularly for children, amid increasing knowledge of the cancer risks associated with the technology.

The latest evidence has come from a large Australian study, published in the *British Medical Journal* late last month, which found a 24 per cent jump in the incidence of a large range of cancers caused by exposure to CT scans.

The study, led by University of Melbourne epidemiologist John Mathews, used Medicare data to identify more than 680,000 people who had undergone a CT scan between 1985 and 2005.

Of those who had a CT scan during this period, 60,674 developed cancer no less than year after the procedure, with the mean duration to diagnosis nine and a half years.

"Overall cancer incidence was 24 per cent greater for exposed than for unexposed people, after accounting for age, sex and year of birth," the authors said, adding that the incidence rate ratio increased the younger a person was when they had the CT scan.

They concluded that there was an excess of 608 cancers in people exposed to CT scans, including 147 cancers of the brain, 356 cases of cancer in other organs such as female genitals, skin and the thyroid gland, and 48 cases of leukaemia.

"The increased incidence of cancer after CT scan exposure in this cohort was mostly due to irradiation," Professor Mathews and his colleagues concluded.

Disturbingly, they warned that the cancer risk among those exposed to CT radiation is likely to be higher than reported in their study.

"Because the cancer excess was still continuing at the end of follow-up, the eventual lifetime risk from CT scans cannot yet be determined," the study authors said.

In an editorial accompanying the study, Harvard Medical School's Medical Director of Computed Tomography Associate Professor Aaron Sodickson said the risks identified by the "well designed" research were significant, but should not be overstated.

"The finding that will probably dominate media headlines is that exposure to CT in childhood increased the incidence of cancer by 24 per cent," Associate Professor Sodickson said. "However, it is important to recognise that the baseline incidence of cancer in a general paediatric population is extremely small, so that a 24 per cent increase makes this risk just slightly less small."

Associate Professor Sodickson said the findings equated to about one excess cancer for every 4000 CT scans of the head at typical radiation doses using current technology.

He said there were many steps practitioners could take to control radiation exposure before, during and after the CT scan, including carefully evaluating the need for multiple scans, using dose reduction tools and employing methods that enable the large scale capture of data from a single scan.

While CT scanning is seen by Australian health authorities as a valuable diagnostic imaging tool, accumulating evidence about the increased cancer risk of exposure has underlined the need to ensure the technology is used only when clinically necessary, and at a dose rate that is as low as can reasonably be achieved.

The Government has extended the ability of GPs to request MRI tests for children younger than 16 years of age, as a substitute for CT scans where clinically appropriate.

Professor Baggoley's expert group has also agreed on the need for better education for the medical profession about using the lowest dose possible for CT scans on children, and increased public awareness of radiation exposure from CT and its possible consequences.

But Professor Baggoley sought to reassure parents of children who have had - or may have - a CT scan, that the study's findings should not be cause for alarm.

Associate Professor Sodickson said the clinical benefits of a medically-indicate scan "usually far outweigh the small associated risk of developing cancer", though he added that "this is the time for critical assessment of what impact the imaging result might have on the patient's care".

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Implants to come under increased scrutiny

"Given the potential impacts, it is critical to examine how to increase the level of rigour applied to pre-market assessment, rather than solely relying on post-market mechanisms"

Medical implants would be subject to a tougher inspection regime before being approved for use under plans unveiled by the medicines watchdog.

The Therapeutic Goods Administration has proposed an overhaul of regulations governing the approval of implantable medical devices following widespread perceptions that the PIP breast implant scandal and the ASR artificial hip disaster showed the system was failing to protect patients.

The TGA has issued a regulation impact statement setting out two alternatives for reform, acknowledging that maintaining the status quo was no longer a viable option.

"No medical device is completely safe, or immune from failure, irrespective of the level of pre-market scrutiny it has undergone," the TGA said. "[But], over time, consistent concerns have arisen about certain elements of the regulatory framework. They were brought to prominence by recent issues with the ASR hip joint replacement implants and PIP breast implants."

The watchdog said manufacturers had lobbied hard that there be no change in the regulatory environment.

"However, this fails to address the fundamental concerns of other stakeholder groups on the need for increased transparency and rigour of pre-market assessment, particularly around implantable medical devices," it said.

The regulator recognised the legitimacy of these concerns, given the far-reaching ramifications for patients implanted with faulty devices, not least the complications and risks incurred in removing and replacing an implant.

"Given the potential impacts, it is critical to examine how to increase the level of rigour applied to pre-market assessment, rather than solely relying on post-market mechanisms."

The TGA has come under heavy criticism over its handling of the PIP breast implant scandal.

A Senate report highly critical of the regulator was released earlier this year.

The Senate Community Affairs References Committee inquiry found that the PIP devices were approved for listing in Australia despite a lack of evidence to show they were medically safe.

Furthermore, the TGA ignored the recommendation of its own expert advisory group and did not impose reporting conditions on the supplier, Medical Vision Australia.

Independent Senator Nick Xenophon, who instigated the inquiry, said the TGA had shown an "incredibly lax attitude towards the PIP implants, even though breast implants are classed as a high risk device. Approving something just because it's similar to other approved items isn't good enough."

The revised regime proposed by TGA would increase scrutiny of devices before they are allowed onto the market, and reduce the reliance on assessments made by regulators overseas, particularly in Europe.

Under its preferred option the type of products subject to mandatory audits would be expanded and additional evidence of their conformity with set standards would be required.

In addition, all regulatory decisions would be publicised – a significant change to existing practice.

"This provides a balanced approach to addressing concerns about the transparency and rigour of pre-market assessment of medical devices whilst minimising the additional regulatory costs to industry and, eventually, to consumers," the TGA said.

According to the regulator, the changes would result in an extra 139 mandatory product audits a year, at an extra annual cost to it of $6.4 million, plus an extra $5.4 million impost on industry.

A more stringent regulatory regime was projected to cost the TGA an extra $18.2 million a year and industry an additional $17 million.

The watchdog proposes that the new regulatory arrangements come into effect from 1 July 2015.

The regulation impact statement can be viewed at: http://www.tga.gov.au/newsroom/consult-ris-medical-devices-premarket-assessment-130510.htm

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Bookie backdown in face of tough odds

High-profile bookmaker Tom Waterhouse has moved to pare back advertising spruiking live odds betting during rugby league broadcasts following a public backlash against the gambling industry.

Mr Waterhouse is expected cut his advertising on the Nine Network by a fifth after becoming the focus of mounting community concern over the heavy promotion of gambling, especially the exposure of children to betting promotions during sports broadcasts.

The bookmarker made his decision days after Prime Minister Julia Gillard announced a crackdown on the promotion of live betting odds during broadcasts of sporting events.

Under the plan – agreed to by the television industry – all television and radio networks must ban the promotion of live odds during sporting matches, and restrict gambling advertisements.

"Families have become increasingly frustrated about the penetration of live odds into sporting coverage, and worried that their son or daughter is now talking about the game, not through the prism of what's happening on the field but through the prism of the associated betting," Ms Gillard said. "From the moment the players step onto the field [until] the moment they leave the field there will be no live odds."

But the rules are not as comprehensive as the Prime Minister has suggested.

While gambling advertisements would be prohibited during commercial breaks while matches are being played, they would be allowed during breaks in play such as quarter-time or half-time, and before or after a game.

The Prime Minister made her announcement days after South Australian Premier Jay Weatherill revealed similar plans, to widespread public support.

The AMA has been a vocal public advocate for gambling controls, and earlier this year released a Position Statement highlighting the health effects of problem gambling.

The Association has raised particular concerns about the proliferation of online betting.

"Online sports betting is Australia's fastest growing form of gambling, and has been associated with a rapid escalation in young males seeking treatment for problem gambling," AMA President Dr Steve Hambleton said, adding that for every problem gambler, up to 10 other people – family, friends, workmates and employers – felt the effects, in strained relationships, financial problems, reduced productivity, depression and substance abuse.

"This means that up to 5 million Australians feel the health, social and financial impacts of problem gambling, including family, friends, work colleagues and employers," Dr Hambleton said.

"Medical practitioners see first-hand the devastating consequences of gambling.

"Problem gamblers see their GP more often than the average, and suffer a range of stress-related conditions from hypertension and insomnia to stomach upsets, headaches and depression."

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Hard bargaining helps sustain PBS

The financial sustainability of the Pharmaceutical Benefits Scheme has been assured by reforms that will save the Commonwealth almost $18 billion by mid-2018, according to a report.

An analysis of the PBS by Victoria University's Centre for Strategic Economic Studies has found that the introduction of market-based pricing mechanisms and other changes will deliver the Government huge savings, even taking into account continued growth in the number of medicines subsidised by the scheme.

The study's author, Dr Kim Sweeny, estimated that reforms made to the PBS since 2007, including the introduction of the market-based price disclosure mechanism, will save the Government $17.9 billion through to 2017-18.

Dr Sweeny said the changes assured the affordability for the Government of publicly subsidising medicines despite an upward spiral in overall health costs.

"As intended by the introduction of substantial reforms to the PBS, projected overall PBS expenditure will remain constrained," he said. "It is evident that the impact of any new listings on projected PBS expenditure is not likely to threaten the sustainability of the PBS."

But the report found the number of new medicines being listed by the PBS had slowed dramatically, with just 15 added in 2011-12 and 16 added last financial year – well below the five-year average of an extra 30 medicines a year.

Dr Sweeny's study was commissioned by Medicines Australia, which seized on the findings to accuse the Government of shortchanging patients by failing to use PBS savings to subsidise more medicines.

"These savings were intended to fund new medicines on the PBS, but this report shows that the number of new PBS medicines listed last year was the lowest in 20 years," Medicines Australia Chief Executive Dr Brendan Shaw said. "That's very alarming, because it means many patients who need new treatments aren't getting access to them."

But Health Minister Tanya Plibersek said a separate Government report co-authored by Medicines Australia directed contradicted these claims.

Ms Plibersek said the *Trends and Drivers of Pharmaceutical Benefits Scheme Expenditure* report showed that 780 new listings and indications for existing medications had been added to the PBS since 2007 at a cost of more than $5 billion.

The Minister said the figures cited in the Victoria University report only included drugs being listed for the first time, "completely ignoring 85 new indications for treatment listed by the Government since 2011-12".

Ms Plibersek said the Government report showed the ageing population and increasing incidence of chronic disease were the main drivers of growth in PBS expenditure.

"More than half of PBS spending goes to people aged over 65 years, with 86 per cent going to concessional patients who pay just $5.90 a prescription," she said.

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INFORMATION FOR MEMBERS

Veteran mental health – online resource

Armed conflict and military service can have a complex and long-lasting affect on those who experience it.

Service personnel can be exposed to multiple traumas, and changes in culture, outlook and technology mean that younger veterans are likely to present with symptoms substantially different from those experienced by older generations.

To help mental health practitioners care for their patients and keep abreast of advances in knowledge and treatment, the Department of Veterans Affiars has developed the At Ease Professional website (www.at-ease.dva.gov.au).

The At Ease Professional website, developed in consultation with the Australian Centre for Posttraumatic Mental Health, provides one-stop access to the latest research on veteran mental health, along with assessment tools, evidence-based treatment, outcome tools and patient resources.

The website will be updated regularly to ensure it remains up to date with developments, and practitioners can subscribe to receive quarterly updates on the latest research and innovations.

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Complacency and misinformation are deadly

BY **DR BRIAN MORTON**

The AMA has in recent months been actively countering misinformation and fear mongering regarding immunisation. It seems that we must also counter immunisation complacency.

Recent news reports have put the national average of those who refuse vaccination at 1.5 per cent of the population. Given the vaccination rates of children at five years of age in a number of areas is less than 90 per cent, with the lowest being 84 per cent in eastern Sydney, that means there are a lot of parents out there who have let protecting their kids from preventable disease slip down their list of priorities.

It has taken only about a generation for us to forget the deadly and debilitating impact of diseases such as measles, tetanus, polio and diphtheria.

The growing "out of sight, out of mind" mentality within some sectors of the community is putting lives at risk. Increasingly, we are now seeing outbreaks of disease such as measles and whooping cough, with deadly consequences.

The AMA is currently looking at what might be appropriate strategies for lifting immunisation rates to safe levels.

The AMA recently sent 7500 copies of the Australian Academy of Science publication, The Science of Immunisation: Questions and Answers, to general practitioners in every State and Territory.

We did this to ensure that every GP can easily share with parents the most authoritative evidenced-based information on immunisation available. Each of us must be active in ensuring parents are well informed when deciding about immunisation.

Debunking the myths and misrepresentations perpetuated by anti-vaccination groups is essential in the interests of public health.

With the five-year-old vaccination rate so low, herd immunity in some areas is seriously compromised.

The Australian Academy of Science publication, drawing on strong scientific evidence, provides clear explanations about the safety and efficacy of immunisation.

Increasing immunity to preventable disease is a no brainer.

But, it is not all about the kids. What about the adults?

At this time of year, in particular, it is important to encourage our elderly and pregnant patients to get their flu shot.

This may also be a good opportunity to check when they last had a tetanus shot, or to check if they are caring for young children and would benefit from a pertussis booster to protect the grand kids and themselves from whooping cough.

This is where the benefits of a Whole of Life Immunisation Register would have been realised. Hopefully, in time, the electronic health record will assist in this regard.

The AMA welcomes the surge in media interest about immunisation, and will continue at every opportunity to promote its importance to the community and to policy makers.

TO COMMENT CLICK HERE

Salaried Doctors – an important voice in the AMA

BY **DR STEPHEN PARNIS**

"The AMA has a high profile on many of the matters important to salaried doctors like public hospital funding and teaching and training, and we need to ensure that this remains the case"

The AMA Council of Salaried Doctors (CSD) is an important part of the AMA. It includes among its numbers nominees from all State AMAs, and a representative from the Australian Salaried Medical Officers' Federation (ASMOF).

It is recognised by Federal Council as a Special Interest Group, and the Federal Councillor representing salaried doctors is also the Chair of the CSD.

The CSD represents the interests of those doctors employed on a salaried basis, mostly in public hospitals, but sometimes in other institutions.

They are hard working men and women whose livelihoods and wellbeing are dependent on a strong voice and robust advocacy. Their industrial position is susceptible to the whims of government, and they are frequently the target of aggressive budget cuts. They are constantly being asked to do more with fewer resources at their disposal.

The main areas of focus for the CSD are industrial and workplace issues, funding and organisation of public hospitals, medical education and training (including the supervision of junior doctors), working conditions, and doctors' health and welfare. It also works with other AMA Committees in the formulation of policy.

All of these issues have the potential to affect the profession more broadly, as well as the health care of all Australians.

Currently, CSD has been considering a number of issues that are of concern to salaried medical staff across the country, including:

- evidence that clinical support time is being eroded, with scant regard for the essential delivery of teaching, and the quality improvement it can deliver;
- the imposition in the Federal Budget of a pathetic $2000 cap on professional self-education expenses, which will seriously undermine ongoing training opportunities for many doctors;
- the details of funding arrangements for Doctors' Health Programs across Australia, to ensure no services are lost or devalued; and
- the difficult budgetary positions of State and Territory governments, which encourage them to impose harsh (and sometimes draconian) industrial measures on hospital doctors, both senior and junior.

There are several thousand AMA members who are salaried doctors, yet many are recorded on our database as identifying with their own craft group.

Although this is understandable, strength in numbers is critical to the CSD's success in lobbying for your issues to be heard.

The AMA has a high profile on many of the matters important to salaried doctors like public hospital funding and teaching and training, and we need to ensure that this remains the case.

So next time you call your state AMA or renew your membership, please check how your details are recorded on our database.

If you want the AMA to continue to be a strong advocate for salaried doctors and the issues you face in your day-to-day practice, then simply ask for your membership categorisation to be updated so that you are classified as a member of the salaried doctors' special interest group.

This will make a big difference, and will continue to deliver the right balance of advocacy from the AMA on issues affecting both the private and public sectors.

TO COMMENT CLICK HERE

What hospitals can learn from Apple

BY **MARTIN SENEVIRATNE**

Martin Seneviratne is a 3rd year medical student at the University of Sydney with a background in physics and computing. He is the Community and Wellbeing Officer of the Australian Medical Students Association.

I recently had a technical problem with my Mac computer. It had been gradually slowing down and then one day it simply refused to turn on. The little spinning wheel just kept spinning ad infinitum. I consider myself to be reasonably tech savvy, so it was with a hint of defeat that I paid a visit to the Apple store.

After booking the appointment online, I arrived to be greeted by the iPad-wielding store managers, who directed me to a back desk where I would be seen by one of the "Apple Geniuses". Meanwhile, they logged the serial number from underneath my computer to get a full record of exactly where that computer was sold, when it had been repaired, what Apple user IDs were associated with it. All of which appeared on my Genius' iPad when he arrived to help us.

The Genius turned out to be quite an eminent diagnostician. He took a history of the problem, asked about any previous issues I had experienced with the computer, and then began a very methodical series of investigations. He ran a script to check the integrity of the hardware, used an algorithm to detect logic errors in the software, checked the most recent internal error logs. The conclusion – a fatal software problem requiring a full reboot of the operating system.

At each step, he documented his findings in an electronic pro-forma built into an iPad app, which in the end generated a full report of the encounter for upload to Apple's international database. Before he rebooted the system, I had to sign (with my finger on the iPad) an automatically-generated consent form. And when I left, with a software-refurbished Mac convalescing under my arm, I was emailed a complete summary.

It struck me afterwards how medical this whole experience had been. My computer had basically come in GCS-3 on a background of chronic dementia with an acute deterioration. There was triage, investigations, diagnosis, intervention. And finally the computer was discharged. Yet it was all done with a level of slick technological efficiency that I had never seen in a hospital before. So the question naturally occurred - what if a hospital was run like an Apple store?

There are three aspects in particular of the 'Apple model' that would be interesting to imagine in a healthcare context:

1. **Bedside technology:** In most hospitals, the average morning ward round could benefit significantly from some technological support. Currently so much time is wasted juggling different charts, deciphering illegible handwriting, running to check information on the computer. What we need is an iPad app with centralised patient information and a pro-forma interface for formulaic tasks like recording vitals, reporting examination findings and charting medications. This is precisely what Apple has already developed for computer maintenance.
2. **Electronic records:** Apple gives us aglimpse of what centralized e-health records might one day be. It has a global database where both devices and consumers are tracked with unique IDs, and information is synchronised across every Apple store internationally. That being said,concerns have been raised about the quantity of personal information held by Apple and the privacy regulations protecting it.
3. **Staff training:** Applecan monitor the time and outcome of each Genius consult and thus track the performance of each employee. This may seem overly intrusive, but imagine the potential efficiency gain if medical consults were electronically tracked and collectively analysed.

Of course, we cannot model our entire healthcare system on an Apple store. There would not be very good patient follow-up, no personalised healthcare, and we would only treat people if they were still under warranty. And the hospital gift shop would have to expand considerably.

However, by leveraging technology to streamline routine tasks, Apple have designed an amazingly efficient 'computer healthcare' system from which the medical world can learn some valuable lessons.The old mantra "an apple a day keeps the doctor away"almost implies a rivalry between doctors and apples. In fact, there should probably be more crosstalk.

TO COMMENT CLICK HERE

A window on truth

BY **PROFESSOR STEPHEN LEEDER**

"Money for research projects and assistance writing up drug trials for publication are all 'iffy', and provoke a tendency not to disclose the relationship"

Transparency is the rage of the age.

As doctors we are urged to behave with complete transparency, which sometimes equates with providing patients with all the information we gather about their disorders.

Transparency means full disclosure of how decisions are made (surgery or chemotherapy), including the data on which those decisions are based and making available all test results, scientific articles and advice used in making those decisions, and disclosing any financial interest that may be involved.

While much good sense lies in the expectation of complete transparency, there are limits and risks that deserve consideration as well.

Moving away from medicine, the exquisitely painful Watergate inquiry into President Richard Nixon's behaviour was chalked up as a triumph for complete transparency. And so it was. If he had chosen a path of greater honesty, the Watergate break-in may not have occurred and the disaster of his cover-up not enacted. I recall seeing his brief letter of resignation hanging suspended in a Perspex case in a Washington museum: a tragedy in every respect.

And then President Bill Clinton and the pursuit of him by Kenneth Starr, and the inquiry costing millions and yielding the tawdry tale of Monica Lewinsky. Where is she now? And Clinton? And America? If this is the result of the pursuit of complete transparency, we surely have to wonder.

Back to medicine, I remain unconvinced that complete transparency in inquiries into medical misadventure is an unalloyed good thing.

Whether it is the publication of every scrap of evidence collected in a root cause analysis of a clinical error, or the forensic demolition of a professional career under the Klieg lights of a litigation trial, I have seen clinicians – doctors and nurses – who may have made small errors, savaged for life. If this is complete transparency, then it deserves to be gone over with a scanner for fundamentalism and sadism.

I am also unconvinced that the full disclosure of everything associated with a clinical mishap, or even a death due not to misadventure, is good for patients and their carers in every case. Others who hold divergent views from mine I am sure will tell me!

Segue to business, especially the pharmaceutical industry, and we have another aspect of transparency to review. Complete transparency in the commercial world is nonsense and 'commercial in confidence' draws a cover over transactions and information whose disclosure may cause serious loss of competitive advantage.

But, like Harry Potter's invisibility cloak, 'commercial –in-confidence' can be used to hide evil weapons of magical power. Public-private partnerships for new hospitals are especially susceptible if 'commercial-in-confidence' impedes a relationship of trust among the partners.

Pharmaceutical companies and doctors - especially research workers - have a history of fraught relationships. Pens, cakes for morning tea, samples, conference attendances, airfares and more, easily distort the independence of the practitioner.

Money for research projects and assistance writing up drug trials for publication are all 'iffy', and provoke a tendency not to disclose the relationship. In this setting, complete transparency - especially to patients treated in drug trials - makes excellent sense.

There is a more general observation to make, and it concerns patient privacy.

Our age of IT means that traditional notions of privacy are changing. Health, genetic, family and psychiatric histories are often held on electronic records, and these can provide useful data bases for research. At present we insist that these data are carefully guarded. The only identified data transferred are those for which the patient has given written permission. But how long will this dyke hold? Not long, would be my prediction.

'Big data', comprising information gathered widely and assembled in the electronic cloud, will come to be a fact of life. In the meantime, 'the right to know' should be shot down as a fake. There is no such right. But transparency, judiciously applied, can be our friend.

TO COMMENT CLICK HERE

Under DSM-5, we might all be labelled mad

BY **ALLEN FRANCES, PROFESSOR EMERITUS OF PSYCHIATRY AT DUKE UNIVERSITY***

This article first appeared in The Conversation on 20 May 2013, and can be viewed at: http://theconversation.com/under-new-psychiatric-guidebook-we-might-all-be-labelled-mad-14132?utm_medium=email&utm_campaign=Latest+from+The+Conversation+for+21+May+2013&utm_content=Latest+from+The+Conversation+for+21+May+2013+CID_34dcb342f5e8e9067d03f4776a27eb64&utm_source=campaign_monitor&utm_term=Under%20new%20psychiatric%20guidebook%20we%20might%20all%20be%20labelled%20mad

"We are all mad here" explains the Cat to Alice when she wonders about the strangeness of Wonderland. Well, life is starting to follow art. If people make the mistake of following DSM-5, the new diagnostic manual in psychiatry that was published on Saturday, pretty soon all of us may be labelled mad.

When I worked on the taskforce for DSM-4, we were very concerned about taming diagnostic inflation – but we only partly succeeded. Then, four years ago, I became aware of excessive enthusiasm around all the new diagnoses being proposed for DSM-5, including many that were untested. I hate to rain on anyone's parade, but I knew this would be disastrous for the millions of people who were likely to be mislabelled, stigmatised and given excessive treatment.

In the US, the "sick" are distinguished from the "well" by the diagnostic and statistical manuals developed by the American Psychiatric Association.

The problem is that definitions of mental disorders are already written too loosely, and are applied much too carelessly by clinicians, especially by the GPs who do most of the prescribing of psychiatric drugs.

And things are about to get much worse. Under DSM-5, diagnostic inflation looks set to become hyperinflation, and will lead to an even greater glut of unnecessary medication. I would qualify for a bunch of the new labels myself – and you might too.

The grief I felt when my wife died would now be called "major depressive disorder"; forgetfulness in older age "mild neurocognitive disorder"; my gluttony now "binge eating disorder"; and my hyperactivity "attention deficit disorder". As for my twin grandsons' temper tantrums, this could be misunderstood as "disruptive mood dysregulation disorder". And if you have cancer and your doctor thinks you are too worried about it, there's "somatic symptom disorder." It goes on, but you get the idea.

About half of Americans already qualify for a mental disorder at some point in their lives, and the rates keep skyrocketing - especially among kids. In the past 20 years, the prevalence of autism has increased, childhood bipolar has multiplied 40-fold and attention deficit disorder has tripled.

One consolation: the kids are not suddenly getting much sicker – human nature is pretty stable. But the way we label symptoms follows fickle fashions, changing quickly and arbitrarily. And freely giving out inaccurate diagnoses can lead to grave harms – medication that isn't needed, stigma, lower self-confidence and reduced self-expectation.

There are also downstream effects. Many parents were panicked about the alarming rise in rates of autism and fell for the disproven belief that it was caused by vaccination. Trying to avoid a false epidemic of autism caused by nothing more than changed labelling meant they stopped vaccinating their kids and exposed them to the very real measles outbreak that recently occurred.

And medication use in the US is out of control – 20 per cent of Americans regularly use a psychotropic drug; 10 per cent of teenage boys are taking a stimulant for ADHD; 25 per cent of our active duty troops report abuse of a prescribed med; and the US has more deaths from prescription drug overdoses than from street drugs.

The United Kingdom is protected against the worst effects of diagnostic and drug exuberance because doctors use ICD-10, the classifications compiled by the World Health Organisation, not DSM-5; the British-based Cochrane group emphasises evidence-based medicine; GPs do less prescribing; and drug companies exert much less power, and cannot advertise directly to consumers as they do in the US.

But bad ideas from America sometimes have much more influence than they deserve.

My advice is to be an informed consumer. Never accept a diagnosis or a medication after a cursory evaluation. A psychiatric diagnosis can be a turning point in your life – as important as choosing a spouse or a house. Done well, it can lead to life-improving treatment; done poorly it can lead to an inaccurate label and a harmful treatment.

People who have mild and transient symptoms don't need a diagnosis or treatment. The likelihood is they are visiting the doctor on one of their worst days and will get better on their own. Medication is essential for severe psychiatric problems, but does more harm than good for the worries and disappointments of everyday life. Better to trust time, resilience, support and stress reduction.

** Professor Francis was Chair of the task force that developed DSM-4, the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.*

TO COMMENT CLICK HERE

Psychiatrists need guidelines like the DSM

BY **DARRYL P. WATSON, CLINICAL SENIOR LECTURER IN PSYCHIATRY AT UNIVERSITY OF ADELAIDE**

This article first appeared in The Conversation on 20 May 2013, and can be viewed at:http://theconversation.com/despite-the-critics-psychiatrists-need-guidelines-like-the-dsm-5-14221

Last month saw the release of the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5). The manual has been attracting controversy throughout its revision process, but critical voices reached fever pitch in the weeks leading up to its release.

Indeed, in the fortnight before its release, DSM-5 was panned by the director of the US National Institute of Mental Health (NIMH) as well as the British Psychological Society's (BPS) division of clinical psychology. Interestingly, the criticisms were at odds with each other.

The NIMH wants psychiatry to focus on the biological bases of mental illness, while the BPS opts for psychosocial therapy. It seems that the DSM would have been damned whichever way it opted to go.

NIHM director Dr Thomas R Insel accused the manual of lacking scientific rigour, announcing that he intended to:

reshape the direction of psychiatric research to focus on biology, genetics and neuroscience so that scientists can define disorders by their causes, rather than their symptoms.

Criticism from the BPS was not directed straight at DSM-5 but was "provocatively timed", according to the Guardian, and questioned the benefits of the manual. Here the BPS' spokesperson said:

it was unhelpful to see mental health issues as illnesses with biological causes.

But what are clinicians like me to think when confronted by criticism from such respectable sources? We need a set of labels, updated routinely, as a shorthand for talking with colleagues. Patients and families expect a diagnosis. We need to justify funding for medication and hospital care. Even funders of talking therapies and social supports expect a label.

The truth is that making a diagnosis in health care is complex, and it is even more complex in psychiatry. Imagine the difficulty of diagnosis where the bulk of the information is from a patient's own report of symptoms that are not necessarily observable by the clinician. There's no definitive x-ray or blood test to point you in the right direction.

Welcome to the world of clinical psychiatry, where psychiatrists regularly treat people who experience marked distress and loss of function caused by diseases or syndromes that have continued to evade definitive biological definition.

The early DSM editions were American modifications of the World Health Organization's International Classification of Diseases. DSM-1 and DSM-2 were clumsy by today's standards, and labelled the world as it was without much help from research.

But the American Psychiatric Association (APA) followed ground-breaking work into the categorisation of psychiatric conditions of the 1970s with the third edition of the DSM in 1980. DSM-3 made a "best guess" at an archipelago of diagnoses, where each island or illness was confirmed as discrete, with borders separated by clear water. A revision to iron out inconsistencies followed in the form of DSM-3-R, and DSM-4 was published in 1994.

By 2002, the APA was convinced that two decades of "modern" DSM categories had not generated valid, clearly separated diagnoses. Research, it seemed, had "not confirmed the wisdom of the current structure." The islands tended to stick together and overlapped repeatedly. The map was a mess for researchers and clinicians alike.

In the latest edition of the manual, conditions will be clustered in chapters with dimensional measures encouraged over discrete diagnostic categories. If you can't separate each island, drag them together and describe different bits as mountains or lagoons. This represents the triumph for supporters of a "spectrum of illness".

The leaders of the process that changed the diagnostic concepts (driven by more than two decades of peer-reviewed scientific research) might have expected some public applause. Instead, even before the launch of the DSM-5, negative public comments criticised their work.

But the narrow debate that has ensued presumes mental illness has either a biological or psychosocial basis, which does no justice to our current scientific knowledge. Surely, in 2013, we can accept that all human memory, behaviour and emotion is connected to the chemistry of our brain.

All of us are clearly a complex mixture of nature and nurture. Clinicians of all types, including psychologists, need to stay focused on the person in their office and use their judgment when making a diagnosis.

The previous edition of the DSM included a reminder to use diagnostic criteria as guidelines rather than a cookbook. Regardless of other changes, we can hope that this reminder is retained in the latest version, lest any of us stray into using multiple unnecessary labels that distract from the distress of the person sitting in front of us.

TO COMMENT CLICK HERE

Extreme Medicine:

Just another day for naval medical teams at sea

BY LIEUTENANT GRANT MCDULING*

Being self-sufficient for months on end in a remote environment is the name of the game for doctors and medics serving in warships of the Royal Australian Navy. When it comes to facing and overcoming challenges of just about any kind, this has got to be one of the most demanding, and satisfying, fields to operate in.

This is what 29-year-old Dr Luke Edwards found when he joined the guided missile frigate HMAS Sydney for a five-month deployment, which will see the ship operate, for a time, as part of the US Navy's 7th Fleet George Washington Carrier Strike Group in Japan.

According to Dr Edwards, who holds the rank of Lieutenant, preparations for the deployment involved delivering around 300 vaccinations tailored to the health threats prevalent in the ship's area of operations.

"We have to ensure we are prepared to counter the threat posed by diseases such as typhoid, influenza and meningococcal disease," Dr Edwards said.

"We need to ensure the crew is fit for sea and has appropriate medication and medical support in place for the duration of the deployment. We also have to have the right type of equipment on board to deal with a large variety of incidents such as the amputation of fingers, concussion, sea sickness or other occupational injuries that are not as prevalent, or common, ashore."

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Extreme Medicine

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"The biggest problem faced regarding both "in-hospital" and "out of hospital" IT systems is a lack of inter-operability, where multiple different systems are not able to talk to each other, they require multiple log-ins, and there is no common place to view and collate information"

When Australian warships leave the Australian station and venture overseas, they may carry a medical officer as well as the usual compliment of two fully trained medics. Sydney is in the enviable position of carrying an additional medic under training.

"The task of our sickbay on board HMAS *Sydney* (and any Australian warship for that matter) contrasts sharply with that of a garrison support ashore or other civilian GP centres," Dr Edwards said.

As well as a doctor and three trained medics, the ship also operates a Ship's Medical Emergency Team (SMET), which consists of twelve personnel who are trained in basic medical responses.

"My three medics are skilled in emergency management, triage and the training of the ship's medical emergency team. Not many work places ashore have a dozen people ready at a moments notice to apply advanced first aid if a medical emergency occurs," Dr Edwards said.

Another significant difference between seaborne medical staff and their shore-based civilian counterparts is that naval medics participate in a range of whole ship activities such as man overboard response, flight deck operations, resupply and damage control.

"All of the permanent medical staff aboard HMAS *Sydney* are new to our posts, which means we have to learn our way around the ship just as other sailors do when they join," Dr Edwards said.

"Another attraction for a life at sea is that our medics do have some limited prescribing and treatment roles that extend beyond their usual shore duties.

"Having said that, we mostly attend to upper respiratory track infections, sports injuries, and occupational injuries to fingers, hands or heads caused by machinery or tools. And, of course, we need to attend to the crew's regular medical examinations," he said.

Naval medical staff get little respite while at sea. And they are just as prone to sea sickness as anyone else. They provide 24-hour coverage for the ship's crew for the entirety of the deployment.

"We have capabilities on par with any emergency department ashore, although admittedly only for a short time. We have two beds and an operating/resuscitation table at our disposal," Dr Edwards said.

"We are equipped with a significant range, and quantity, of medications and tools to be as independent as possible for months between resupply."

Another interesting aspect of running a well-equipped medical facility at sea is that every day is different.

During this voyage, HMAS *Sydney's* Commanding Officer Commander Karl Brinckmann has enlisted the help of the ship's medical team to run a quit smoking challenge to reduce the number of smokers onboard. Nicotine patches and gums were ordered and issued to personnel in the interests of better health for their wallets and their bodies.

Of course, the ship's sickbay can't cope with every situation.

"We are limited in the procedures we can perform at sea," Dr Edwards explained. "Sometimes we are reliant on external support for seriously unwell sailors. In instances like that we transfer the patients ashore by boat or carry out an aeromedical evacuation by helicopter."

Dr Edwards said he is able to perform minor dentistry if needed, but would always seek guidance from ashore in the first instance.

HMAS Sydney's time with the US Navy's 7th Fleet will allow the Royal Australian Navy to increase its knowledge and skills regarding air defence procedures, strike group integration and other high-end defence capabilities. It will also expose the ship's medical team to a wide range of differing perspectives and ways of operating through opportunities to cross decks onto US Navy warships.

** Lieutenant McDuling is a public relations officer with the Royal Australian Navy Reserve. This article was supplied by the Department of Defence.*

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Research

Sun exposure key to good eye health

Exposure to sunshine as a small child is crucial to the development of a healthy eye, according to new research.

University of Sydney researchers found that small children younger than six years of age needed to spend at least 10 hours a week outdoors in the sunshine to prevent the development of short-sightedness or myopia.

Lead researcher Associate Professor Kathryn Rose said exposure to sunlight at a young age assisted in the growth of a normal healthy eyeball, preventing it from growing too fast or over-expanding and becoming oval or egg-shaped instead of round.

A five-year follow-up study that examined more than 2000 children for a number of risk factors linked with myopia found similar results.

All participants had a comprehensive eye examination and completed a detailed questionnaire, which gathered information about a child's ethnicity, general physical activities and near-sighted activities, such as computer use.

Lead author and PhD candidate Amanda French said the results showed that the protective effect of time spent outdoors as a very small child persisted, even if the child in later years did a lot of near-sighted work, such as reading.

The study found that while watching television or using the computer appeared to have little effect on the development of refractive errors on the eye, children with one or more parents who were myopic had a greater likelihood of developing the condition. But even for these children, time spent outdoors had a mitigating effect.

Ms French said prevention of myopia is important for future eye heath, as even low levels of the condition place you at higher risk of cataracts and glaucoma in adulthood.

"Promoting outdoor activity to parents and families, and including more outdoor pursuits in school curricula, could be an important public health measure to avoid the development of myopia," Ms French said.

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Sleeping with babies increases death risk

Babies who share a bed with their parents are five times more likely to die from Sudden Infant Death Syndrome (SIDS), even when parents follow other recommendations that lower the risk of death.

Researchers from the London School of Hygiene and Tropical Medicine analysed results of five previous studies involving 1472 cases of cot death and 4979 normal babies. They found that nearly nine out of 10 SIDS deaths that occurred when the baby was in the parents' bed would not have happened if the baby was sleeping in its own sleeping place.

There was also an increased risk of SIDS if the mother or her partner smoked, or if the mother had more than two alcoholic drinks in the previous 24 hours.

Lead researcher Professor Bob Carpenter said bringing a baby into bed temporarily is acceptable only if it is returned to its cot immediately afterwards.

"The current messages saying that bed sharing is dangerous only if you or your partner are smokers, have been drinking alcohol

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Research

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or taking drugs that make you drowsy, are very tired or the baby is premature or of low birth weight, are not effective because many of the bed sharing deaths involve these factors," Professor Carpenter said.

Professor Carpenter said medical professionals should take a more definite stand against bed sharing, especially for babies less than three months of age.

The research was published in the *British Medical Journal.*

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Fat stem cells boost immunity more than those from bone marrow

Danish researchers have discovered that stem cells harvested from fat are more potent than those collected from bone marrow in helping modulate the body's immune system.

Because of the low number of stem cells available in bone marrow, and the invasive procedure required to retrieve them, the researchers from Leiden University in The Netherlands were searching for alternatives when they stumbled across stem cells in fat (adipose) tissue.

Stem cells were collected from the bone marrow and fat tissue of age-matched donors.

The researchers compared the ability of the two cell types to regulate the immune system in vitro and found that the two performed similarly, although it took a smaller dose of stem cells derived form adipose tissue to achieve the same effect on immune cells as bone marrow stem cells.

The researchers also found adipose tissue derived stem cells were far more plentiful in the body than those found in bone marrow, and could be collected from waste material from liposuction procedures.

The adipose tissue derived stem cells also outperformed the bone marrow derived stem cells when secreting cytokines – the cell signalling molecules that regulate the immune system.

Stem cells are considered potential therapies for a range of conditions, from enhancing skin graft survival to treating inflammatory bowel cancer.

Lead researcher Dr Helene Roelofs said adipose tissue was an interesting alternative, as it contains approximately 500 times the frequency of stem cells that bone marrow does, and tissue collection is far simpler.

"This all adds up to make adipose tissue derived stem cells a good alternative to bone marrow stem cells for developing new therapies," Dr Roelofs said.

Editor of *STEM CELLS Translational Medicine* Dr Anthony Atala said cells from bone marrow and from fat were equivalent in terms of their potential to differentiate into multiple cell types.

"The fact that cells from fat tissue seems to be more potent at suppressing the immune system suggest their promise in clinical therapies," Dr Atala said.

The research was published in *STEM CELLS Translational Medicine.*

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Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
Dr Peter Ford	Treasurer (until 26 May)	NACA - Aged Care Gateway Advisory Group	8/5/2013
Dr Gino Pecoraro	Obstetricians and Gynaecologists craft group nominee	MSAC Review Consultation Committee for Vulvoplasty	8/5/2013
Dr Brian Morton	General Practitioners craft group nominee	Medical Home Small Consultative Group	9/5/2013
		National Residential Medication Chart Advisory Committee	28/5/2013
Dr Ian Pryor	AMA member	MSAC Review Consultation Committee for Inguinal Hernia	13/5/2013
A/ProfJohn Gullotta	NSW/ACT area nominee	Health Professionals Prescribing Pathway Advisory Group	14/5/2013
Dr Steve Hambleton	President	National Palliative Care Week Parliamentary Breakfast panel member	16/5/2013
		Meeting with Senator Fierravanti-Wells on medical care in aged care	27/5/2013
		NeHTA eMedication Management Governance Group	31/5/2013
Prof Geoffrey Dobb	Vice President	Meeting with Korean Medical Association DRG and fee for service research team	23/5/2013
Dr Elizabeth Feeney	Treasurer (from 26 May)	Medicines Australia Transparency Working Group	27/5/2013

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FDA puts energy drink makers on notice

The US Food and Drug Administration is considering imposing limits on the amount of caffeine that can be added to beverages as alarm about the health effects of highly-caffeinated energy drinks on young people mounts.

American food and drink manufacturers have been put on notice by the nation's top food and medicine regulator, which has launched an investigation into the safety of adding caffeine to products.

FDA Deputy Commissioner for Food and Veterinary Medicine Michael Taylor said the inquiry had been set up to find out how caffeine is consumed and used, and by whom, and to determine what the safe level of total caffeine consumption might be.

"Importantly, we need to address the types of products that are appropriate for the addition of caffeine, especially considering the potential for consumption by young children and adolescents," Mr Taylor said.

The FDA's move follows repeated calls by the AMA for Australian authorities to crackdown on the marketing of energy drinks amid mounting concerns they are harming children and adolescents.

AMA President Dr Steve Hambleton has demanded that the caffeine content of energy drinks be reduced, or their sale restricted to adults, following evidence linking them to serious effects in young people, including tachycardia and agitation.

In 2009, the death of a young woman was linked to caffeine from energy drinks, and a study published in the *Medical Journal of Australia* found 297 calls relating to caffeinated energy drinks were made to the NSW Poisons Information Centre between 2004 and 2010, 128 of which resulted in hospitalisation.

According to the *Journal of Caffeine Research*, more than two-thirds of 6309 poisoning cases where caffeine was present that were reported to the American National Poison Data System in 2011 involved people younger than 20 years of age.

Of these cases, more than 2300 involved the ingestion of energy drinks.

Under Food Standards Australia New Zealand regulations, the caffeine content of soft drinks cannot exceed 145 milligrams per kilogram, while for energy drinks the maximum caffeine or caffeine equivalent that they can contain is 320 milligrams per litre.

"If they are being sold like soft drinks, then regulate them like soft drinks and bring the caffeine content down," Dr Hambleton told the *Sunday Age*. "Or, if they are, as manufacturers say, only suitable for adults, then sell them in outlets that are only accessible to adults."

In the US, there are no rules governing the addition of caffeine to food and drink, apart from alcoholic beverages.

According to the FDA, adults can safely ingest around 400 milligrams of caffeine a day – equivalent to around four or five cups of coffee – without suffering negative effects.

There is no similar benchmark for children and adolescents, though Mr Taylor noted that the American Academy of Paediatrics discouraged the consumption of caffeine and other stimulants by young people.

He said the only time the FDA explicitly approved the addition of caffeine was in the 1950s, when its use in cola drinks was given the go ahead.

"Manufacturers can add it to products if they decide it meets the relevant safety standards, and if they include it on the ingredient list," the FDA official said.

But drinks companies have not had it completely their own way. In 2010 the regulator ordered that caffeinated alcoholic drinks be withdrawn from the market because of concerns they "may lead to hazardous and life-threatening situations".

Mr Taylor said the inquiry reflected the FDA's concern about the exposure of children and adolescents to caffeine in food and drink.

"We believe that some in the food industry are on a dubious, potentially dangerous path," he said. "If necessary, and if the science indicates that it is warranted, we are prepared to go through the regulatory process to establish clear boundaries and conditions on caffeine use. We are also prepared to consider enforcement action against individual products, as appropriate."

"American food and drink manufacturers have been put on notice by the nation's top food and medicine regulator,"

But the regulator was cool on suggestions that age limits be imposed on the purchase and consumption of caffeinated drinks and food.

"Enforcing age restrictions would be challenging," Mr Taylor said. "For me, the more fundamental questions are whether it is appropriate to use foods that may be inherently attractive and accessible to children as the vehicles to deliver the stimulant caffeine, and whether we should place limits on the amount of caffeine in certain products."

In Australia, the Legislative and Governance Forum on Food Regulation (formerly the Australia New Zealand Food Regulation Ministerial Council) has ordered a full review of policy guidelines on caffeine, and is awaiting advice from the Intergovernmental Committee on Drugs regarding the mixing of energy drinks with alcohol.

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Swine flu pandemic reaches Venezuela

An outbreak of swine flu in Venezuela has killed 17 people and left around 250 suffering with symptoms of the disease, according to local health agencies.

The Venezuelan Government has not confirmed the spate of infections, but news agency Reuters cited health authorities in areas of the South American country bordering Columbia, where most of the reported cases have been identified.

According to the Reuters report, former Health Minister Rafael Orihuela told a Venezuelan television station the outbreak was the legacy of the H1N1 infection that swept the globe in 2009-10 and left 18,500 people dead, according to World Health Organisation estimates.

"We're suffering a tail-end of the pandemic," Mr Orihuela said.

Venezuelan health officials said most high-risk groups in the nation of 29 million had been immunised against the disease, with three million vaccinations carried out so far this year.

While the Venezuelan outbreak is yet to be officially confirmed by national health authorities, it has come amid mounting suggestions that the scale of the pandemic late last decade was much greater than has previously been acknowledged by health agencies such as the WHO.

A study published in *The Lancet* last year claimed the actual death toll from the H1N1 pandemic may have reached more than 280,000 people, around 15 times the WHO estimate.

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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

It's a Corolla!

BY **DR CLIVE FRASER**

Toyota Corolla Ascent Sport Multi-drive Hatch

Since 1966 Toyota has produced more than 39 million Corollas, more than 1.1 million of which have been sold in Australia.

That's a lot of cars in anyone's language, and I think I must be the last person on Earth who has never actually owned one.

Approaching 50 years of age, the Corolla has been successful because, although it's always been small and cheap, it's never been nasty, and it has always had a reputation for reliability.

In 1985, after five model cycles, Corolla switched to front-wheel drive.

For 2013, and in its 11th generation, the changes in the new model are evolutionary rather than revolutionary.

That is for everything other than the automatic transmission, which is now a continuously variable type (CVT).

I've never really been a fan of this set-up.

There is an un-nerving constant droning from the engine as the vehicle accelerates.

This is because the input shaft (and therefore the engine) runs at a constant RPM.

Many vehicles have electronics which make it seem more like a normal automatic which changes gears.

Toyota calls their transmission "multi-drive" and say it has seven speeds, but they are simply pre-set ratios.

It just takes a little getting used to, and one up-side is that fuel economy is optimised as the engine spins at its most efficient revolution.

As the car is always in the right gear, automatic Corollas actually use less fuel than manuals.

All of this engineering does make the 1970 Corolla seem pre-historic, as it only had a two-speed auto box.

Acceleration from the 1.8 litre motor is leisurely rather than exhilarating, but the speedometer does optimistically read up to 240 kilometres per hour.

The Corolla is produced in 16 counties and there are many other variants elsewhere, with some markets having 1.3 and 1.5 litre engines and all-wheel drive as an option.

Australian Corolla's are all the same with the lights out.

Inside there is an acre of plastic in all the models and the seats are very flat, to accommodate a multitude of rear ends.

Moving one notch up from the base model Corolla Ascent, the Sport comes with a fancy steering wheel, touch screen audio, alloy wheels, fog lamps and a reversing camera, all for only an extra $1000.

So, as I enter my twilight years having never owned a Corolla, would I buy one now?

Well no, because I'm such a big fan of diesel powered cars, and Toyota doesn't make one.

But this year about 45,000 people in Australia will buy a Toyota Corolla, many of them simply because, "it's a Corolla".

Toyota Corolla Ascent Sport Multi-drive Hatch	
For	More economical than Mazda 3.
Against	Like all Corollas, they're a bit boring.
This car would suit	Retired doctors.
Specifications	1.8 litre 16 valve 4 cylinder petrol 103 kW power @ 6,400 rpm 173 Nm torque @ 4,000 rpm Continuously variable transmission 6.6 l/100 km (combined) $22,990 + ORC

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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Web: http://www.ama.com.au/node/5292

GREAT MEMBER DEALS

Discounts off new Volkswagen and Skoda vehicles for AMA Members*

AMA members can access substantial discounts off the list price of new Volkswagen and Skoda vehicles. **A deal that could save you thousands!**

The discount is model dependant and does not include options and accessories. Please see your local VW dealership for further details on the discount structure.

To access this exclusive offer simply contact AMA Member Services on 1300 133 655 or email memberservices@ama.com.au.

*Please Note: Must be an AMA Member for minimum 3 months prior to vehicle delivery. Cannot be used in conjunction with any other offer.

Great Qantas Club Rates for AMA Members

Joining Fee: $230.00
One Year Membership: $300.00
Two Year Membership: $530.00

As a Qantas Club member you also receive complementary Qantas Frequent Flyer membership and access to dedicated Qantas Club check-in counters.

Call AMA Member Services on 1300 133 655, email memberservices@ama.com.au or login to the AMA website http://ama.com.au/memberservices-qantas to obtain an application form.

powerbuy

PowerBuy and the AMA have partnered to give Members savings on popular IT products and services. PowerBuy offers discounted deals on brands including Dell, Lenovo, HP, Fuji Xerox and NETGEAR.

For further details and to access PowerBuy's special offers for AMA Members, simply visit **www.ama.com.au/powerbuy** or phone AMA Member Services on **1300 133 655.**