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AMA meets with Minister on PCEHR

Doctor concerns recognised – p6

Inside

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Managing Editor: John Flannery
Contributing Editor: Dominic Nagle
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford

Graphic Design:
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Advertising enquiries
Streamline Creative
Tel: (02) 6260 5100 Fax: (02) 6260 5200

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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

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IN THIS ISSUE

NEWS

NATIONAL CONFERENCE

REGULAR FEATURES

Cover photo: Current and former AMA Presidents at National Conference (left to right) Dr Lindsay Thompson AO, Dr Bryce Phillips AO, Dr Keith Woollard, Dr David Brand, Professor Kerryn Phelps AM, Dr Bill Glasson, Dr Mukesh Haikerwal AM, Dr Rosanna Capolingua, Dr Andrew Pesce, Dr Steve Hambleton

The Trials of Clinical Trials

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

It's not often that I have had the opportunity to attend a meeting that was both inspirational and motivating. But this was the quality of the Clinical Trials Research Summit hosted by the AMA's *Medical Journal of Australia* on 18 May at the University of Sydney.

The quality came from the precision of the presentations, the outstanding expertise of the presenters and the obvious commitment and passion from all who attended to help provide the robust evidence that forms the foundation for medical practice. Speakers covered the full spectrum of medical practice, government and the NHMRC.

Funding for medical research in Australia is severely constrained - we account for about 1.1 per cent of global spending on health research, but from that produce 3 per cent of all research publications. By way of comparison, the United States spends about 0.3 per cent of gross domestic product health research and Australia 0.09 per cent - leaving us in the middle of OECD countries despite our relatively buoyant economy.

The AMA has made submissions to the Federal Budget as well as to the review being conducted by 2011 Australian of the Year Simon McKeon, calling for increases in medical research funding of 10 per cent a year in real terms for the next four years, increased support for research infrastructure, tax incentives for philanthropic support for health research, and other measures to support investment in health research - an investment that repays many times over.

The National Health and Medical Research Council (NHMRC) has done what it can to streamline the processes needed to conduct large clinical trials with patient-centred outcomes, and to open pathways to funding that are not tied to the annual cycle of project grants.

The Clinical Trials Action Group, which was set up in October 2009 and reported findings in March last year, made 11 recommendations to support the conduct of clinical trials in Australia, including publication of a list of clinical trials networks and other resources.

The Group's recommendations have been supported by Government, but the message from the Summit was clearly that despite their excellence, clinical trials groups in Australia are struggling.

The reasons relate to the ever-increasing cost of conducting clinical trials, a tough environment for funding, and a lack of support for the essential infrastructure needed to conduct high quality multi-centre clinical trials. Many clinical trials networks are run on less than the smell of an oily rag, and whether the extreme dedication and voluntary commitment of those involved can be sustained is questionable, posing a significant risk that hard won expertise will be lost.

Much of the money to run clinical trials comes from the NHMRC but last year, for example, it received 3369 applications for grants to be met from a budget of less than $788 million. Of this, $253 million went to clinical research, including 107 new clinical trials that received $95.6 million. This funding was very welcome, but in the aftermath of the global financial crisis the pharmaceutical industry seems to be investing less in clinical trials, certainly in Australia, where the high dollar has hit our international competitiveness despite the high quality of data contributed by Australian sites.

This has reduced the industry-funded infrastructure that was available to support or subsidise investigator or clinical trial network-initiated trials. Add to this the difficult environment for medical charities and foundations, and the trend points towards a watershed for the sustainability of Australia's clinical trials networks, if not a perfect storm.

Presenters at the Summit highlighted the economic impact of their work. Collectively, the return on investment in terms of improved health and reduced demand for services is many times the entire annual funding for NHMRC. Of course, this doesn't show up as a reduction in health care costs year on year, just less of an increase than would otherwise have occurred, and that is much harder to sell.

So are there any answers? The United Kingdom's National Health Service has established the National Institute for Health Research. This provides clinical trial infrastructure for a portfolio of studies, many of which are randomised clinical trials, and funding for the investigations and staff needed for clinical data collection at the front line of clinical research. A national resource such as this could be funded by all Australian governments and deserves careful consideration by the Council of Australian Governments.

An additional or alternative proposal would be to set aside funding from the teaching, training and research block grants from the Independent Hospital Pricing Authority funding pool to support Australian clinical trials networks.

Other funding models are possible but, whichever is chosen, it is in everyone's interests to ensure that the outstanding resource represented by Australia's clinical trials networks is not allowed to wither for lack of investment.

Australia's health expenditure is approximately $60 billion a year. A small fraction of this to support clinical trials will pay dividends for patients and the system by reducing future health costs. There are few other investments that have the potential to simultaneously improve the quality of care and reduce its cost. It's a message the AMA will be delivering loud and often.

TO COMMENT CLICK HERE

Mental health needs more than beggar thy neighbour budgets

BY AMA SECRETARY GENERAL FRANCIS SULLIVAN

It's hard not to get cynical when it comes to mental health reform.

Although 'reform' often becomes a 'reshaping' or even 'redesigning' from existing programs and funding, what the sector really needs is extra investment and capacity - not simply doing more without more resources or, worse yet, doing the same with less.

But that mantra has become the standard response when demands put increasing pressure on existing services.

This begs the big question: what is the effective value of Medicare cover for people with mental illness? Tragically, the lack of real transparency in Federal Budget announcements only misleads the community into assuming that mental health services are now on the 'way up', when in actual fact elements of the safety net have been frayed.

Last year's Budget cut $600 million from the successful and popular Better Access Program. This effectively withdrew resources from GPs, squeezed patient consultation times and undermined the quality of care. Bulk billing rates have risen, which gladdens the Commonwealth, but strains the viability of the program, which in turn threatens the safety net. It is all very counter-productive.

Now, in a smaller scale, the Mental Health Nurse Incentive Program has had a ceiling placed on its projected expansion. Again, a budget decision that further strains the general practice capacity to provide care.

Make no mistake, people with mental illness need secure support systems. Their first point of call is usually a GP and their surgery staff. These are the people who provide the non-discriminatory care and support that too often is lacking in other settings. The service they provide is easily accessed and designed to be non-threatening and practical. It is a vital link in what is already a stretched chain of support. And it is extremely cheap when compared with hospitalisation.

Yet it is here that the razor gangs have looked for the sharpest cuts. Some may say that it is typical that the Commonwealth will concentrate on 'soft targets' such as this rather than push for major resource distribution across the health sector. The mental health service always seems to fail to receive any distributional benefits from hospital funding efficiencies, or savings from health insurance rebates. When was the last time a government was prepared to direct revenue form increased tobacco taxes or alcohol duties to investment in the mental health sector?

Is it because the mental health lobby has traditionally been too weak and too easily satisfied with little more than token gestures?

If some wonder if this criticism is too extreme, even cynical in itself, it is worth taking another look at the Federal Government's mental health package. While the Government presented it as a big $2.2 billion investment in mental health, in reality actual new spending comprised just $650 million spread over five years – with the bulk not spent until 2014-15 and 2015-16.

Even more tellingly, the money to pay for the package has simply been taken from another area of mental health, the successful Better Access Program.

Bulk billing in the Better Access program appears to be holding, so many patients are not out of pocket. But are they out of time? In other words, are doctors now pressed to spend less time with patients in order to offset the loss in practice income? If so, who is losing out?

This is the conundrum for policy makers. Medicare insurance continually drops well short of covering the costs of care. When the headline effects of changes are only analysed in monetary terms, what looks like good indicators on access - bulk billing rates - often hide the reality of less quality time for patients. In chronic disease care this is a negative. So, one person's budget cut becomes another's lost opportunity for care.

Seasoned Canberra observers will tell you that the frenzy in the months leading up to budget night has a life all of its own. When budget savings are accorded a higher priority than spending, the human aspect to cuts falls prey to the euphoria of reaching the bottom line target. Even when savings are relatively small, their effects on individual care are considered less important than the interests of a concocted 'greater good' in cutting spending.

Some may be prepared to accept this type of budgetary strategy if the restructuring of the budget actually delivered durable savings and didn't blow out in years to come in other areas. But inevitably it does, and the hunt for more 'saves' begins anew. Tragically, that hunt zeros in on the same 'soft' areas, and the plight of the mentally ill doesn't improve in real terms.

Unless an authentic investment strategy is adopted where successful programs like Better Access are sustained and enhanced by measures like the expanded Mental Health Nurse Initiative, then necessary growth in mental health safety nets will only amount to a reallocation of resources rather than an increase in capacity.

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AMA holds talks with Health Minister on PCEHR

BREAKING NEWS

"Dr Hambleton said that although doctors embraced the idea of electronic health records, the way the Government had so far gone about it was flawed"

AMA President Dr Steve Hambleton presents Health Minister Tanya Plibersek with Global Leadership in Tobacco Control Award during meeting in Minister's office last week - Alan Porritt/AAP

AMA President Dr Steve Hambleton and Health Minister Tanya Plibersek have held the first of what is likely to be several detailed discussions about the medical profession's concerns with the Government's electronic health records scheme as the deadline for its introduction looms.

While there was no early breakthrough on the issue at the meeting, held in Canberra last Thursday, the Minister indicated that she has taken on board the issues raised by the AMA about the personally controlled electronic health records (PCEHR) scheme, particularly the lack of any acknowledgement of the costs that will be incurred by doctors in helping set up and maintain individual health summaries, and the haste with which the program is being introduced.

The meeting followed a major speech Dr Hambleton made to the AMA National Conference a week earlier in which he highlighted the increasing pressure and demands faced by general practitioners.

Dr Hambleton said GPs had been hit by a succession of payment cuts and penalties in recent years that were undermining their capacity to operate.

"GPs have taken a big hit under this Government," the President said. "We hear the words 'general practice is the foundation' of the health system, but we see no action to support this. In fact, we are seeing the opposite."

Dr Hambleton said that not only had payments and incentives in immunisation, mental health, diabetes and other services been scrapped or cut, the Government was also giving subsidies to competitors.

"Add [to these cuts] the Government-subsidised competition from GP Super Clinics and the struggle to get proper GP leadership in Medicare Locals and we have a problem – a big problem," the AMA President said.

He told the Conference that the AMA had stood virtually alone in the medical community in demanding greater clarity from the Government about the introduction of the PCEHR scheme.

Dr Hambleton said that although doctors embraced the idea of electronic health records, the way the Government had so far gone about it was flawed.

"We want the PCEHR to work. The promise of reducing adverse events and reducing duplication of treatment is compelling," he said.

"[But] rather than front-loading the PCEHR with support, the Government instead announced a big stick in the Budget.

"The e-PIP [Practice Incentive Payment] paid to practices would be withdrawn unless practices participate in the PCEHR. [There is] no recognition of the extra work that will fall to GPs."

The concerns come amid revelations that the Government expects to save billions of dollars through the introduction of electronic health programs.

In a post-Budget speech to the Committee for Economic Development of Australia, Ms Plibersek said the efficiencies to be gained from electronic health services had the potential to provide huge savings.

"The national eHealth records system will mean better, more efficient, more convenient healthcare," the Minister said. "We estimate eHealth will save the Federal Government around $11 billion over 15 years. However you look at it, that's pretty good bang for your buck."

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AMA – time for a 50th Anniversary check-up

BY DR STEVE HAMBLETON

AMA President Dr Steve Hambleton

The activities and discussions and formalities of our very successful 50th Anniversary National Conference are covered in detail elsewhere in this edition of *Australian Medicine*.

I want to take this opportunity to explain to members another important activity that we are undertaking this year.

Throughout its history, the AMA has changed and evolved and adapted to be able to lead effectively and to respond to issues, both external and internal.

So, as the AMA celebrates 50 years since separation from the British Medical Association, it is timely to reflect on the environment in which we operate.

The Federal Council has discussed the AMA's governance structure over the course of the last two years, its impact on the efficient development of public policy, and its responsiveness to the membership.

Put simply, there is a widespread view that we can better utilise the expertise of Councillors by allowing the function of Federal Council to be exclusively about policy development and analysis.

The Federal Council recognises the need to be inclusive, represent the entire profession, and to use its time more effectively in what is becoming an increasingly complex and challenging health care environment.

This is consistent with current best practice, whereby every organisation should regularly review its own internal governance performance and structure to analyse whether it best aligns with the role, function and activities of the organisation.

To that end, the Council resolved to adopt a smaller board of governance for the Federal AMA.

The Council has not taken this step lightly. It acknowledges the AMA's history and the significant participation of the various stakeholders and other AMAs to the work of the Council.

However, the Council recognises that the AMA's core purpose of representing the medical profession requires a more streamlined governance framework to diligently lead the operations of the AMA group of companies, while its representative framework enables it to comprehensively assimilate the voice of the profession into public policy advocacy.

The Council has resolved to embark on a consultation with the membership - who, after all, have the final determination in the matter – to become engaged in the options to achieve the particular model of a smaller board of governance.

We will be releasing a discussion paper and will conduct a State-by-State consultation process between July and October.

Council will be presented with the results of that consultation in November.

The next phase of governance reform will then be determined.

A report to all members will be provided immediately after that Council meeting.

I encourage you all to be a part of this process to help guide the AMA through the next 50 years of advocacy and achievement for members and for the Australian health system.

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Budget cuts guided by clinical advice: Plibersek

Health Minister Tanya Plibersek addresses the AMA National Conference

Health Minister Tanya Plibersek has stood by controversial cuts to practice incentive payments in the Budget, batting away concerns that they undermine public health.

In a robust defence of the Government's Budget strategy, Ms Plibersek told the AMA National Conference that abolishing payments like the immunisation incentive had been guided by clinical advice and evidence.

In her speech, the Health Minister did not directly address concerns that scrapping the immunisation incentive threatens to undermine the nation's vaccination rate, potentially delivering a major setback to a key public health initiative.

Instead, Ms Plibersek emphasised the care that had been taken in reprioritising spending within the health portfolio.

The Minister said the Budget had been "difficult", and the cuts and reprioritisation of spending it contained had been "strongly informed by clinical advice and the evidence of what works".

Ms Plibersek said the Budget should not be viewed in isolation, but as part of the Government's ongoing investment in health reform – particularly regarding public hospital services.

She said the Commonwealth would invest around $20 billion by mid-2020 in public hospitals through new arrangements intended to make spending more effective and transparent while safeguarding the quality of care.

"Significant funding will be paid to states where they have met targets for elective surgery and emergency department performance," Ms Plibersek said. "These targets were developed with close consultation with medical experts, chaired by the Chief Medical Officer. We are also introducing Activity Based Funding from 1 July this year, to ensure all hospitals are paid in the same way, based on the services they actually deliver."

The Minister said there would also be "unprecedented transparency" regarding the flow of Commonwealth, State and Territory funds into the health system, while the creation of Local Hospital Networks and Medicare Locals would "put greater control about health care into the hands of the experts – the clinicians who practise in those communities – rather than the bureaucrats".

The Health Minister tackled head on complaints that the introduction of electronic health records was hasty and inadequately resourced.

Ms Plibersek told the AMA Conference the Government had already spent $160 million helping 96 per cent of practices upgrade their IT systems to be ready for e-health services, and a further $233.7 million would be spent in the next two years to support the roll-out of a national e-health system.

"Now many practices have most of the IT in place, we want to make sure government focuses its investment on the roll-out and take up of the e-health record," Ms Plibersek said. "Once the digital infrastructure is in place, patients will be able to register for their own e-health record through Medicare shopfronts and over the phone. And mums and dads will be able to register for their kids."

The Minister acknowledged the health profession's acceptance of other Budget cuts and savings, including a crack down on rorts of the Extended Medicare Safety Net and dumping private health insurance rebates for natural therapies that are not shown to be clinically effective.

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GPs lose out under bloated bureaucracies and flawed policies: Dutton

Shadow Health Minister Peter Dutton at the AMA National Conference

Flagship Federal Government health initiatives face the axe if Labor loses office, after Shadow Health Minister Peter Dutton pledged to scrap Medicare Locals and savaged the troubled GP Super Clinics program.

Mr Dutton told the AMA National Conference in Melbourne that a Coalition Government "would not proceed with the Medicare Locals structure", which has been the subject of concern because of inadequate representation of GPs under current arrangements.

The Shadow Minister made the comments following a speech in which he attacked the GP Super Clinics scheme, but stopped short of promising to shut it down.

Mr Dutton condemned the $600 million Super Clinics program – which is being investigated by the Australian National Audit Office – as an "absurd [and] unconscionable" policy, and declared that if elected, the Coalition would explore ways to redirect the funds to better support primary care.

"Like many of you, I have been a fierce critic of the so-called Super Clinics," the Liberal frontbencher told the AMA conference on 25 May. "$650 million [sic] of taxpayers' money went to fund practices to operate in competition with existing practices. That model is absurd. Using taxpayer funds to cannibalise existing practices in unconscionable."

In his speech, delivered soon after Health Minister Tanya Plibersek addressed the National Conference, Mr Dutton also took aim at the Government over its cuts to immunisation and treatment incentives for medical practices and its handling of the introduction of personally controlled electronic health records (PCEHR).

In a carefully-worded statement, the Shadow Health Minister stopped short of pledging to abolish GP Super Clinics outright, but said the Coalition would try to curb the program – funding for which was sliced by $44 million in the recent Budget - where possible.

"Given the Government has signed contracts with each of these providers, we will look at these on a case-by-case basis and decide their future, and possible better uses [of funds]," Mr Dutton said.

The Liberal MP said that a future Coalition government would look at measures to strengthen general practice, including changes to scope of practice and remuneration models.

"Under the Coalition we doubled the number of medical schools, and we should be refreshing general practice to attract as many of these young doctors as possible into a very, very worthy specialty," Mr Dutton said. "For many in general practice, it has been far too long the poor man's medicine and it deserves to be addressed. If we can sharpen our response in the delivery of primary care we can turn good intentions into positive and tangible outcomes."

The Opposition frontbencher also criticised the Federal Government's handling of the introduction of its PCEHR scheme.

Mr Dutton said the Coalition "strongly supports" e-health, but accused the Government of botching the introduction of electronic health records by rushing to establish the scheme without adequate consultation and before resolving outstanding technical issues.

"The hurried introduction of PCEHR to meet some arbitrary timeline risks alienating not only the GPs who will be key to the implementation, but the patients, who will simply receive a flawed and inadequate record," he said.

The Shadow Minister's comments came amid warnings from AMA President Dr Steve Hambleton that incompatible software systems and a lack of compensation for doctors for the time and resources required to established and maintain electronic health records threatened take-up of the PCEHR scheme when it goes live on 1 July.

See also 'AMA holds talks with Health Minister on PCEHR', see p 7.

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Policy Sessions

The AMA National Conference included a number of sessions addressing key issues for the future of medicine in Australia, with presentations from leading experts and vibrant discussions from the floor.

Christine Bennett - former Chair of the National Health and Hospitals Reform Commission

The Hon Jim McGinty - Chair of Workforce Australia

Dr Nick Coatsworth - President Medecins Sans Frontieres

Leading for Difference

Dr Christine Bennet, former chair of the National Health and Hospitals Reform Commission, began the Leading for Difference session by giving a brief history of women in medicine, arguing that the development of their position in the profession had mirrored the evolution of their position in society. She pointed out that 50 years ago the ratio of women to men in medicine was roughly one to six, whereas today it is almost one to one.

Dr Bennet reflected on how medicine has developed, likening its evolution to the transformation from a solo cowboy to a race car pit crew. She highlighted the differences between the current medical environment and that of 50 years ago, particularly the growth in knowledge and treatments, to the extent where there are now more than 10,000 illnesses which have diagnoses and treatments, and practitioners and patients have access to 6,000 drugs and 4,000 medical procedures. These advances have brought with them an expectation from the community to cure illness.

She concluded by saying that a health system is dependant on the training of health professionals and, by shaping it for the needs of the future, Australia can maintain its high quality health care system.

Mr Jim McGinty, Chair of Workforce Australia, told the session there were four essential elements that were needed for a sustainable health workforce – supply and demand projections for national workforce planning, clinical training capacity, workforce innovation, and the attraction, retention and support of international health professionals.

He said Australia's health system is facing significant challenges in providing the workforce to meet the demand of health care. "We simply don't have enough doctors and nurses to look after those who need medical care and attention, and if we don't put measures in place now we risk compromising the health outcomes of our citizens – it's that critical," Mr McGinty said.

Mr McGinty said the medical training pipeline needed to be organised and controlled by one organisation. He said currently there is a mismatch between graduating doctors and the amount of doctors we need, with the number of interns out of kilter with available training places.

Global health on our doorstep

Dr Nick Coatsworth, President of Médecins Sans Frontières in Australia, talked about the dark sides of humanitarian aid and global health, where comprises have to be made, money can be wasted and where people can be killed, all in the name of getting to the patient to treat them.

Dr Coatsworth said the sphere of global health is changing - mental health and chronic disease have become more prominent as countries develop, and humanitarian organisations have adapted to this by incorporating treatment for these diseases in their work, in addition to their on-going work treating more traditional diseases such as HIV and tuberculous.

Associate Professor Christine Phillips from the Australian National University addressed the delegates about resettling refugees in Australia and the challenges involved.

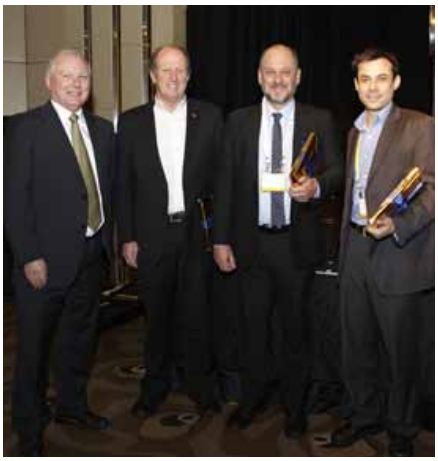
Professor Phillips went through a brief history of the nation's refugee program, pointing out that since 1947 700,000 refugees have been settled in Australia. She said refugee health care needs had evolved over time. "Today's refugees have missed out on basic primary health care, we are seeing the consequences of the use of children in the military, and torture is now conducted without a trace, via electroshock or psychological means," Professor Phillips said.

Mr Benedict David, Principal Health Specialist for AusAid, discussed the role the Australian Government plays

Policy Sessions

Dr Bill Pring - AMA representative on the Private Mental Health Alliance

Dr Brian Morton - Chair of the AMA Council of General Practice



AMA Vice President Professor Geoffrey Dobb (L) with Health and the Environment presenters (L-R) Professor Rob Adams, Professor Tim Flannery, and Mr Rob Cawthorne

Associate Professor Christine Phillips - Australian National University

Benedict David - principal Health Specialist at AusAID

in aid assistance, especially in health, and provided a sense of how a bilateral aid agency works, and the relationship AusAid has with the region globally and in Australia.

Health and the Environment

Professor Tim Flannery, Chief Climate Commissioner, addressed delegates of the need to engage the Australian public in the climate change debate by informing them about the science of climate change, the economic options, and international action taken against climate change.

He said the health effects of climate change are already evident. The World Medical Association has estimated that between 1970 and 2004 global warming caused more than 140,000 deaths a year.

Professor Flannery said medical systems had to prepare for the challenges that will eventually arise from climate change, such as developments in infectious diseases and increases in heat stroke.

Professor Rob Adams, Director of City Design for the City of Melbourne, discussed the issues around urban design strategy.

Mr Rob Cawthorne, managing director of the Carbon Reduction Institute, urged delegates to examine their current energy inefficiencies.

Mental Health: Where to from here?

Dr Brian Morton, Chair of the AMA Council of General Practice, discussed the role of the GP in delivering mental health care, the types of patients and how GPs work with other mental health professionals. Dr Morton highlighted barriers to patient access to mental health facilities and the Government's obliviousness regarding the role of the GP in delivering mental health care.

Dr Morton said the AMA's mental health position statement got it right. "It is crucial patients have access to services ongoing when GPs cannot manage the patient," Dr Morton said. He said that communication between mental health professionals and GPs was frustratingly poor.

Dr Bill Pring, AMA representative on the Private Mental Health Alliance, discussed the 10-year roadmap for mental health, saying the AMA's plan is a very good one and more comprehensive than that prepared by the Government because it emphasises the role of the GP and listens to the needs of the specialists and physiatrists in this area.

He said that, in general, primary care is working remarkably well, while specialist mental health care is not working.

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National Conference Awards

During the Conference, President Dr Steve Hambleton handed out several special awards, including the Dirty Ashtray Award and State and Territory AMA Trophies. And the winners were….

The Global Leadership Award

AMA President Dr Steve Hambleton presents Health Minister Tanya Plibersek with the Global Leadership Award for Tobacco Control

A new award was created this year to recognise the Australian Government's outstanding national and international action and leadership in tobacco control.

Dr Hambleton said Australia was setting an example for the rest of the world to follow in the ongoing battle to stop people smoking and destroying their health, and is not afraid to take on Big Tobacco in the process.

Minister for Health Tanya Plibersek was at the Conference to accept the award.

The Global Coffin Nail Award

Big Tobacco was again presented with an award this year – this time for its desperate, devious and dishonest tactics in opposing the introduction of plain packaging for tobacco products.

Unsurprisingly, there were no representatives from Big Tobacco present to accept the award.

The Dirty Ashtray Award

In a disappointing turn, the Victorian Government was announced as the winner of the 2012 Dirty Ashtray Award.

Victoria has historically been one of the nation's tobacco control leaders, but the state is the only one in the country without either a ban on smoking in outdoor dining areas, or a commitment to

its introduction, and Victoria still does not have a tobacco-licensing program.

AMA Victoria President Dr Stephen Parnis said the State Government has dropped the ball with tobacco reform.

The AMA/ACOSH/ASH National Tobacco Scoreboard

Two years after being awarded the Dirty Ashtray Award, South Australia has since made big advances and this year took out top honours for doing the most to combat smoking.

Dr Hambleton said South Australia has made outstanding progress in recent years and merits high commendation for its improvements in tobacco control legislation and investment.

State Awards

Dr Hambleton presented the Presidents and CEOs of the State and Territory AMA organisations with awards for their exceptional work in advocacy and communications.

Best Lobby Campaign: AMA Western Australia – *Four hour rule campaign*

Best Public Health Campaign: AMA New South Wales – *Preventable Child Deaths and Injuries campaign*

Most Innovative Use of Website or New Media: AMA New South Wales – Informz survey technology

Best State Publication: AMA South Australia – *MedicaSA*

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Prospects for closing the Indigenous health gap improve

Dr Hambleton launching the Indigenous Health Audit report

Momentum is building to close the gap in health equality between Aboriginal peoples and Torres Strait Islanders and the rest of the community, an AMA audit of government initiatives has found.

The audit, presented to the AMA National Conference, showed that although Indigenous disadvantage remains significant and progress in the past decade has often been patchy and disappointing, recent coordinated action by Federal, State and Territory governments has delivered fresh impetus to efforts to raise the standard of Indigenous health.

The audit, which can be viewed by clicking here, summarised the recommendations made by the AMA in its annual Indigenous Health Report Cards in the past 10 years, and analysed the measures taken by governments related to these recommendations.

AMA President Dr Steve Hambleton told the conference the $1.6 billion commitment to improve Indigenous health made at the Council of Australian Governments meeting in 2008 had "added a significant and proportionate impetus to the prospects for closing the health equality gap within a generation".

Dr Hambleton said that although the renewed focus by governments on the issue was still in its early stages, developments in the number of areas were promising.

In particular, the AMA President noted there had been:

- a spending boost for comprehensive child and maternal health services for Aboriginal peoples and Torres Strait Islanders;
- a concentrated focus on chronic diseases and greater attention paid to mental health and social and emotional wellbeing;
- targeted campaigns to lift the number of Aboriginal peoples and Torres Strait Islanders entering the health profession;
- increased focus on collaboration and integration between health services; and
- recognition of the need to include Aboriginal and Torres Strait Islander communities in framing health policy and strategies.

Dr Hambleton said it was encouraging that many of these government initiatives resonate well with recommendations made by the AMA in its Report Cards during the past decade.

But he warned prospects for improvement could falter without a commitment by governments to at the least sustain the current level of funding beyond the expiry of the current COAG agreement next year.

Dr Hambleton said the AMA audit also highlighted significant gaps and weaknesses in government programs that need to be addressed.

He said the high rate of incarceration of Aboriginal peoples and Torres Strait Islanders was "a national shame" and had to be brought down, efforts to build the workforce for Aboriginal and Torres Strait Islander health services needed to intensify, Aboriginal community-controlled health services must be accorded greater priority, and communities themselves must be given greater support to help address health problems.

"There is every reason to expect that a healthy future for Aboriginal and Torres Strait Islander peoples can be secured with the right support, the right partnerships, and the right opportunities for these Australians to empower themselves for better health," Dr Hambleton said.

But the AMA President warned that the progress made so far was fragile, and issued a plea for an across-the-board commitment from all the major political parties to sustain and increase the level of effort already reached.

"This expectation [to close the health gap in a generation] will only be met if the momentum of policy and program activity now taking place continues," Dr Hambleton said. "This means that government of all political persuasions will need to commit, across their electoral cycles, to finish the job."

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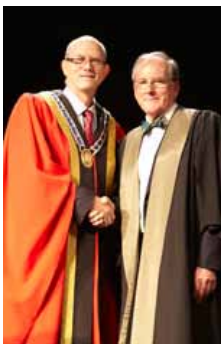
Roll of Fellows

Dr Peter Francis Burke



During a long and distinguished career, Dr Burke has held senior medical posts in the Victorian health system as well as in the AMA, which he joined in January 1970.

Dr Burke was Director of Casualty at Melbourne's St Vincent's Hospital in the 1980s before moving to Gippsland, where he has been a senior medical practitioner for many years.

Dr Burke was heavily involved in negotiations underpinning the establishment of the La Trobe Regional Hospital in 1991 and has been a vigorous advocate for Gippsland health services, doctors and the AMA.

Dr Christopher Davis

Dr Davis has been a prominent and influential figure in Queensland medicine, both within the AMA and the state's health system.

Not only has he made a notable contribution in his chosen area of geriatrics, Dr Davis has been a dedicated leader of the medical profession in the state, challenging the bureaucracy over staff appointments and capital spending, and advising on the review established in the wake of the Jayant Patel scandal.

As AMA Queensland President he drove and overhaul of the constitution and forged links with medical colleges.

Dr Henry Hicks

Dr Hicks has used his expertise as a surgeon and his commitment to rural health to raise the quality of care and medical leadership in the Wagga Wagga region, along the way becoming the quintessential rural surgeon dedicated to his local community.

Dr Hicks moved to the area in 1994 and joined the AMA at the same time. Ever since he has demonstrated a great commitment to his patients as well as working hard to draw attention to the challenges of rural care, particularly cancer treatment.

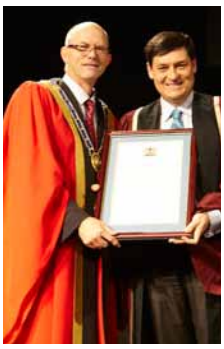
Dr Catherine Hutton

A GP for almost 30 years, Dr Hutton has brought to her work a particular commitment to women's health and paediatric care, combined with a strong ambition to foster and improve general practice.

In addition to her GP work in Melbourne's inner west, Dr Hutton has been a very active member of the AMA, serving in many senior capacities.

She is currently Deputy Chair of the AMA Council of General Practice, is the AMA nominee to the National Immunisation Committee and was last year recognised by the University of Melbourne for her commitment to research.

Dr Gino Francis Pecoraro



When Queensland was lashed by a succession of natural disasters in early 2011, Dr Percoraro – as the-then AMA Queensland President – was prominent in helping lead an early response, warning of the immediate physical risks and longer-term emotional and financial stresses.

In addition to a succession of senior roles in AMA Queensland, Dr Pecoraro is also the Obstetrician and Gynaecologist representative on AMA Federal Council, and is a board member of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Dr Gary Raymond Speck

From his earliest days of involvement with the AMA as a Resident Medical Officer campaigning for better conditions, Dr Speck has been an active and successful contributor in his specialty of orthopaedics as well as to the broader medical profession.

Dr Speck is a leading authority on the treatment of spinal disorders, particularly minimally-invasive surgery. He has been heavily engaged in AMA activities throughout his career, including serving as Federal Vice President between 2007 and 2009.

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AMA in action

Around three hundred doctors and their partners, international medical experts, politicians and medical students flocked to Melbourne for the AMA's 50th annual National Conference, which was held over three days beginning Friday, 25 May. Health Minister Tanya Plibersek and her Opposition counterpart Peter Dutton both addressed the Conference, as did former UK Health Minister Lord Darzi. Thought-provoking sessions on medical workforce planning, global health issues, Indigenous health and mental health were leavened with less formal events to give conference goers the opportunity to mingle socially. AMA President Dr Steve Hambleton hosted a cocktail party at the Grand Hyatt Hotel on Friday night, followed by a Doctors in Training dinner at Chapter House, and Saturday night the Gala Dinner was held at the National Gallery of Victoria's Great Hall.

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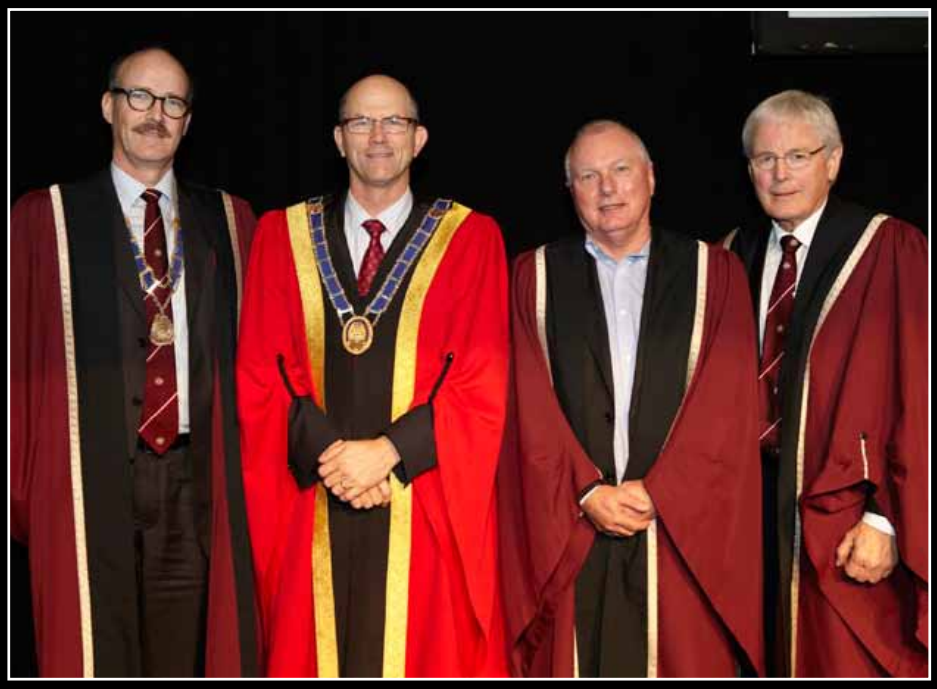

Dr Hambleton with Dr Rod McRae, Professor Geoffrey Dobb and Dr Peter Ford

Dr Hambleton presents Glenda Kay with the Indigenous Peoples' Medical Scholarship

Professor the Lord Darzi of Denham - Former Health Minister of the United Kingdom

Simon McKeon 2011 Australian of the Year addressing the Doctors in Training Leadership dinner

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Gala dinner

Gala Dinner in the National Gallery of Victoria's Great Hall

AMA Federal Councillors and guests with Secretary General Francis Sullivan

Former President Dr Bill Glasson (second from right) with Dr David Mountain (third from left), Professor Clare Jackson (r) and guests

AMA Victoria President Dr Stephen Parnis (second from right) and guests

Doctors in Training enjoying the Gala Dinner

Dr Hambleton with British Medical Association President Professor David Hasslam and their wives

Previous AMSA Presidents with current President Mr James Churchill (right)

Cocktail party

AMA ACT President Dr Iain Dunlop (L) speaking to former NSW President Dr Michael Stiner (R) and Allan Rosenberg (C)

AMA Executive Officer Dr Liz Feeney (second from left) talking with fellow Victorians

AMA NSW celebrating their State Award wins

AMA President Dr Steve Hambleton (C) with Brad Horsburgh (L) and Roger Sexton (R)

AMA South Australia celebrating their State Award win

Former President Dr David Brand (C) talking to delegates

Victorian AMA Doctors in Training

AMA Queenslanders enjoying the festivities

GP Super Clinics get the scrutiny they deserve

BY **DR BRIAN MORTON**

"The general public, and certainly GPs, deserve answers about what is happening with a significant investment of taxpayer money"

When it comes to advocacy, it pays to be persistent and consistent.

The AMA recently welcomed the announcement that the Australian National Audit Office (ANAO) is conducting an official audit of the Government's troubled GP Super Clinics Program. The AMA has been calling for the audit since October last year.

The AMA's message about the GP Super Clinics has been consistent since the time they were first announced. While not opposing GP Super Clinics where it can be demonstrated there is a clear community need, the AMA has been vehement in its opposition to such clinics being established solely for political advantage or worse, such as when Super Clinics have been set up in direct competition with established local general practices.

The AMA has consistently argued that the GP Super Clinics Program is an expensive enterprise that is failing to reach the vast majority of the community, including those patients who are in areas with poor access to health services. Rather than focussing excessive subsidies on a very small number of practices, the AMA believes the Government could achieve more for patients by providing reasonable grant funding to a larger number of existing practices, to improve their facilities, increase services and expand opportunities for teaching and training.

The $650.4 million allocated by the Commonwealth for GP Super Clinics - cut by $44 million to $606.4 million in the 8 May Budget - could have provided every GP practice with $91,000 in infrastructure grants.

The AMA wrote to the Auditor General late last year following a number of concerns raised about the GP Super Clinics Program, including decisions not to proceed with Super Clinics in Darwin and Sorrell, Tasmania, and to commit emergency funding to support the completion of the Redcliffe, Queensland, clinic.

The AMA has certainly had a win with the announcement of the Audit Office investigation. The general public, and certainly GPs, deserve answers about what is happening with a significant investment of taxpayer money. The AMA looks forward to the ANAO's investigation and its findings and recommendations.

If the ANAO's audit reveals that the GP Super Clinic Program is failing, the funding should be directed to support new infrastructure and services for existing practices. In the meantime, the AMA will continue to argue such funds are much better spent supporting existing general practices and putting in place the infrastructure and mechanisms needed to train the GPs of tomorrow, rather than building white elephants.

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Advanced care planning in the interests of all

BY **DR LIZ FEENEY**

"An advanced care plan can be used to formally appoint a surrogate decision-maker and/or develop an advance care directive or other form of verbal or written instruction that clearly outlines the patient's values, preferences, and goals of care"

This year's National Palliative Care Week ran from the 20 to 26 of May on the theme 'Some things are too important to be left unsaid……Let's chat about dying.'

Palliative Care Australia (PCA) decided on this theme as a way to help ensure that "Australians who are approaching the final stages of their lives are aware of what care and support is available to them, can make choices and have control over their care, and are confident their choices are known and supported by their loved ones and health professionals."

PCA conducted a survey of 1000 Australians that showed more than 80 per cent had not recorded their end-of-life wishes or prepared a plan, more than 60 per cent had not discussed their preferences with loved ones, and 75 per cent did not know what their loved one's preferences were.

This serves as a timely reminder for AMA members to discuss advance care planning with patients. Advance care planning plays an important role in patient self-determination by giving competent patients the opportunity to think about, and articulate, their goals and values for their health care should they lose decision-making capacity in the future.

An advanced care plan can be used to formally appoint a surrogate decision-maker and/or develop an advance care directive or other form of verbal or written instruction that clearly outlines the patient's values, preferences, and goals of care.

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

Some patients may prepare a plan while they are healthy, while others may not do so until they develop a life-limiting condition. Doctors can play a key role in assisting patients to develop, or revise, an advanced care plan by providing guidance, advice and discussing treatment issues related to incapacitating conditions and/or future health care options. Advance care plans should be reviewed as the patient's condition, and possibly preferences, change.

Patients should be encouraged to discuss their advanced care plan with family members (or nominated surrogate decision-makers, where relevant) and ensure that its existence and location is known to others so it can be found when required.

The AMA's *Position Statement on the Role of the Medical Practitioner in Advance Care Planning 2006* serves as a useful resource for AMA members and the wider public. This statement can be found on the AMA's website at http://ama.com.au/.

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Pressing need for more graduate training places

BY **DR STEPHEN PARNIS**

"The need for training places for medical graduates is not going to go away, nor is it an issue that can be solved overnight"

It is a myth widely held by governments and members of the community that once a medical student has graduated from university they are a fully qualified doctor. Little or no account is taken of the years junior doctors must commit to postgraduate training in order to become the independent practitioners that they need to be, and the community expects them to be. Adequate training can take many years, in some cases upwards of 10 years.

All junior doctors require specialist training, though the number of senior specialists available to train them is inadequate at best. Senior doctors are under a great deal of pressure to provide training and mentoring to trainees. They do this willingly, in the knowledge that they are helping to create the next generation of competent doctors who will continue to provide leadership in the health care system, but they need support and adequate resources in order to prevent them from becoming inundated.

How do we achieve a balance between trainee and supervisor numbers to ensure standards are maintained, without leaving despondent junior doctors stuck in limbo for years, waiting for appropriate training places to come up?

Currently there are simply not enough positions for the increasing number of junior doctors emerging from medical schools. In recent years, the number of junior staff has more than doubled, without an associated increase in the number of training places or senior staff to supervise them. The number of junior doctors is set to increase further in the next few years. Greater numbers of graduates and inadequate training places means a frustrating bottleneck at a critical stage in the career of junior doctors, and there is no solution in sight.

This is completely at odds with Health Workforce Australia's *Health Workforce 2025* report, which calls for long-term reforms to various areas of the training and workforce systems to better provide for Australia's future health workforce.

Public teaching hospitals are still the mainstay of clinical placements for junior doctors, but other settings may also provide potential for quality training, including aged care and community settings, private hospitals and general practices. All of these have potential, but also come with challenges, and will require significant commitment and resourcing to develop. For example, the format and quality of assessment in settings other than public hospitals is an issue that is far from settled, and needs to remain on the public health agenda.

The responsibility for resourcing training places is shared among the Commonwealth, the states, territories, colleges and General Practice Education and Training Limited. The system is complex and inadequately funded. The recent Commonwealth Budget has not made health care a priority, and there is no direct provision for training places for medical graduates. State budgets offer little in the way of funding in this area either. For example, the Victorian State Budget 2012-13, released on Tuesday 1 May, had no allocation for education and training of junior doctors.

The need for training places for medical graduates is not going to go away, nor is it an issue that can be solved overnight. Australian governments and healthcare providers need to look to the future and plan for long-term, sustainable delivery of quality training places for medical graduates and on-going support for the senior doctors who supervise them. This needs to be clearly reflected in budget allocations.

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Challenges in medical education: an update from AMA National Conference

BY **JAMES CHURCHILL**

"It is only with robust, nationally-coordinated training pipelines that we can hope that training crises will be avoided in the future"

The recent 50th AMA National Conference has provided an opportunity to take stock of the many significant challenges facing medical education in Australia.

Perhaps the biggest of these is the doubling of the number of medical school graduates since 2006, and associated pressures to find sufficient numbers of quality internships for them all.

Alarmingly, for a number of years, these increases have been met with seriously insufficient workforce planning, and it seems that 2012 is the year in which a much-feared workforce disaster will strike.

Recent official figures indicate that this year a number of Australia's medical graduates are likely to miss out on an internship. Data published by the Postgraduate Medical Council of Victoria and the New South Wales Health Education & Training Institute show that, between these states alone, there will be a shortfall of 315 internship positions for the projected number of medical graduates in 2013.

Without jobs in Australia, many of these new graduates may be forced to look for training places overseas, without Australian general registration, stuck with a medical degree they cannot use and with a debt of up to $300,000.

We now have the ridiculous situation where, on the one hand, we rely on overseas-trained doctors to meet Australia's health needs yet, on the other hand, we are shipping out Australian-trained graduates who are familiar with the Australian healthcare system.

Put simply, to produce medical graduates without internships is a waste of taxpayer dollars and valuable teaching resources, and robs communities of new graduates they need to serve them.

Although the number of internship places has increased in recent years, the current situation does little to demonstrate that governments have planned adequately to resource their health systems to keep pace with the number of graduates being produced by new and existing medical schools.

A lack of regulation of full-fee places, and chronic underfunding of the medical education system, has combined to cause medical schools to enrol increasing numbers of students. Unregulated student numbers are clearly a danger in a system severely lacking coordination between training providers and State and Federal governments.

AMA National Conference delegates heard from Jim McGinty, Chair of Health Workforce Australia, regarding this and other challenges presented in the long-awaited *Health Workforce 2025* report. The report, released in late April, predicts a modest undersupply of doctors by 2025 under a range of likely scenarios.

AMSA certainly welcomes Health Workforce Australia's recommendation for national coordination of the medical training system. It is only with robust, nationally-coordinated training pipelines that we can hope that training crises will be avoided in the future.

Further information on the Internship Crisis is available at www.amsa.org.au. Mr Churchill's speech to AMA National Conference will be published in the upcoming edition of AMSA Panacea.

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RESEARCH

Study could reignite statins stoush

Controversial restrictions on subsidised access to cholesterol-lowering medication are set to come under renewed scrutiny following findings that the benefits of such drugs are widespread.

A joint British-Australian review of research into the use of cholesterol-lowering drugs such as statins found that even patients at low risk of heart attacks and strokes derived significant benefit from the medication.

The study, led by a collaborative group including researchers from the National Health and Medical Research Council, the University of Sydney and British counterparts, showed that statin therapy safely and effectively reduced the likelihood of heart attacks and strokes in low risk patients by about 20 per cent.

The study's authors said the findings showed the benefits of statin therapy greatly outweighed the known hazards, calling into question current restrictions on subsidised access to the medication.

But the Government is expected to keep use of the drug under a tight rein in order to hold health costs down.

Statins are the most commonly prescribed drug in Australia and are a major expense for the Pharmaceutical Benefits Scheme.

Updated guidelines on their use due out soon are expected to reaffirm that their prescription should be limited to only those considered to be at high risk of heart attacks and strokes.

The latest findings come less than three months after debate on the use of statins was ignited by a decision of United States regulators to require that the medication carry warnings that it increased the risk of diabetes and cognitive impairment.

The move sparked international consternation about the safety of the drug, but the National Heart Foundation urged those already using statins to continue taking the medication, and discuss any concerns with their doctor.

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Hopes high for giant advance in melanoma treatment

Researchers are on the brink of a big leap forward in the treatment of melanoma following success with a drug that shrinks secondary brain tumours.

A study published in the British medical journal *The Lancet* last month found that the drug Dabrafenib was extremely effective in shrinking and, in some cases, eliminating secondary brain tumours in melanoma patients.

The joint American-Australian study, which was funded by the manufacturer of Dabrafenib, pharmaceutical company GlaxoSmithKline, involved 184 melanoma patients, of whom just 10 had brain tumours.

One of the lead authors of the study, Melanoma Institute Australia oncologist Georgina Long, told *The Australian* the initial trial results pointed to a major advance on existing treatments.

"It's a huge leap forward," Dr Long said. "Until now there has not been a single drug that has shrunk brain metastases in more than 10 out of 100 patients with metastatic melanoma."

Secondary brain tumours are common in melanoma patients, and are fatal within four months for about half of those diagnosed with the condition.

Dabrafenib works by inhibiting two mutant variations of the protein BRAF, which is found in 50 per cent of advanced melanoma cases that involve secondary tumours.

In the study, all patients with secondary brain tumours treated with the drug were alive after five months, including two still alive after a year.

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Be an *Australian Medicine* travel writer

Sick of glitzy infomercials posing as travel stories? Want to tell your colleagues what places, near and far, are *really* like?

Here's the chance to reveal your favourite holiday spot, or to share travelers' tales from the exhilarating and glorious to the tedious and disastrous.

Australian Medicine invites readers to write and submit travel stories of up to 650 words, with two bottles of fine wine sent to the author of each article published. Pictures welcome.

Please send stories, with your contact details, to: ausmed@ama.com.au

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HEALTH ON THE HILL

Stoush erupts over alcohol labelling

A public health group has accused the alcohol industry of misleading a parliamentary inquiry into ways to tackle Foetal Alcohol Spectrum Disorder.

The Foundation for Alcohol Research and Education has attacked industry claims about the prevalence of the disorder, and has challenged the effectiveness of current labelling warning of the dangers of drinking while pregnant.

FARE chief executive Michael Thorn accused four alcohol industry groups of making false or misleading claims about the disorder and the effectiveness of measures to prevent it, in their submissions to the parliamentary inquiry.

Mr Thorn said it was crucial that none of the industry's claims go unchallenged.

"This is not simply about claim and counter-claim," he said. "This is about separating the facts from the industry fiction."

FARE has taken particular exception to claims in the Distilled Spirits Industry Council of Australia (DSICA) submission, including that 97.5 per cent of pregnant women already cut their alcohol intake or abstain completely and that evidence on the health effects of low-level drinking among pregnant women is inconclusive.

In its submission, the Council warned that "public health campaigns should avoid alarmist statements about the impact of low levels of alcohol on fetal [sic] development with the goal of scaring women into abstinence. Alarmist and simplistic statements have real potential to cause great harm if they lead to unwarranted anxiety, depression, or terminations."

Mr Thorn condemned the statement as "scare mongering at its worst. There is not one shred of evidence to support that position."

The House of Representatives Standing Committee on Social Policy and Legal Affairs has commenced a series of roundtable hearings examining the effectiveness of alcohol labelling as part of its inquiry into Foetal Alcohol Spectrum Disorder.

The Committee said it decided to hold the hearings, which began on 24 May with a session involving representatives from three alcohol industry groups including DSICA, in response to conflicting evidence about the effectiveness of alcohol labelling – particularly warnings of the dangers of drinking when pregnant.

According to the Brewers Association, by the end of next year at least 80 per cent of beer brands will carry pregnancy advice labels.

FARE has described the DrinkWise labelling voluntarily used by many companies on their alcohol products as "far from adequate", but the Brewers Association said it should be seen as a prompt to remind people to seek advice from health professionals rather than as a stand-alone source of health information.

Committee chair Graham Perrett said the divergence of views on the issue warranted further investigation.

"We've received evidence that alcohol labels need to be introduced as part of a wider health promotion strategy, and also evidence that alcohol labels don't work," Mr Perrett said.

The inquiry began in November last year and the committee was asked to develop recommendations on how to prevent Foetal Alcohol Spectrum Disorder, identify effective diagnostic tools and early intervention therapies and present options on how to manage the disorder and support the individuals, families and communities effected by it.

Details of further roundtable hearings are yet to be announced.

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Final steps in hospital funding reform

Measures to end the Commonwealth and state blame game over hospital funding are moving close to fruition following bipartisan support for key legislation.

Senate's Finance and Public Administration Legislation Committee has approved a Bill that adds the last remaining building blocks to arrangements that will put hospital funding – long a bone of contention between the Commonwealth, State and Territory governments – at arms length and make it far more transparent than under current arrangements.

Already three key statutory bodies, the Australian Commission on Safety and Quality in Healthcare, the National Health Performance Authority and the Independent Hospitals Pricing Authority, have been established under the terms of the Council of Australian Government's National Health Reform Agreement.

The Bill approved by the Senate committee will allow for the appointment of an administrator to oversee the collection and distribution of Commonwealth, State and Territory

HEALTH ON THE HILL

money in the National Health Funding Pool – which is the last remaining piece of the administrative apparatus to give effect to the COAG agreement.

Under proposed legislation, the administrator will be appointed by a council of Commonwealth and State ministers, and will be empowered to tell the Commonwealth how much it needs to contribute to the funding pool, and monitor and publicly report on payments into and from State pool accounts.

Under the agreement, the Commonwealth will no longer provide primarily block payments to each State and Territory, and instead funds will be disbursed largely according to activity.

The pool will receive all Commonwealth and activity-based State public hospital funds, and payments will be made to State-managed funds and Local Hospital Networks in accordance with the terms of service agreements. The Commonwealth will not have ownership or control of money in State pool accounts.

In its report, the Committee said the reforms "will improve transparency in the funding and operation of the health system while ensuring that the unique features of funding Australia's hospital sector will be adequately addressed".

"Tensions between the Commonwealth and States in relation to funding of hospitals have been ongoing," the Committee said. "States have disputed the adequacy of the Commonwealth contribution. The Commonwealth, in turn, has found it difficult to determine if States are maintaining levels of service provision, and have been concerned that States have shifted public hospital-provided services to private practice arrangements that draw subsidies from Commonwealth programs."

"The NHRA addresses these issues through a shift to primarily activity-based funding and the setting of a national efficient price, while maintaining a provision for block funding where required."

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Call for anaphylaxis action

School teachers and childcare workers will have to know how to treat children suffering an anaphylactic reaction under rules being considered by Parliament.

The House of Representatives is debating a motion calling for nationwide laws to ensure all schools and childcare centres educate staff and students about the dangers posed by food allergies and are well-prepared to handle medical emergencies, particularly potentially life-threatening anaphylactic reactions.

The motion, which is still being debated, calls for Federal Government legislation requiring all preschools and primary and secondary schools to educate students on the case, effects and treatments of anaphylaxis, have action plans in place in case of an anaphylactic reaction, ensure staff are trained in life-saving techniques when such reactions occur, and have an anaphylaxis management program in place for each student.

Deputy Speaker Anna Burke, who led debate on the motion late last month, said that rapid growth in food allergies in recent years meant nationally-uniform measures to raise awareness of anaphylaxis and how to treat it were becoming critically important.

"The need for government action in relation to anaphylaxis has become even more apparent, given that the number of children suffering from severe food allergies has doubled in a generation," Ms Burke told Parliament on 21 May.

"The number of hospital admissions for anaphylaxis has doubled in the last 15 years [and] a study has estimated that a quarter of the population will have an adverse reaction to food, especially during infancy and early childhood."

Three other MPs, Laura Smyth from the ALP, and Karen Andrews and Greg Hunt from the Liberal Party, spoke in support of the motion.

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Children to get advocate on national stage

Children will have a dedicated nationwide advocate to protect their rights and advance their interests under legislation presented to Federal Parliament.

Attorney-General Nicola Roxon has presented a Bill calling for the establishment of a National Children's Commissioner to ensure that the rights of children are taken into account in developing laws, as well as putting significant issues affecting them on the national agenda.

Ms Roxon said the Commissioner "will be a strong and forceful voice for Australia's children and young people", and would have a particular focus on the interests of the vulnerable, including children who are Aboriginal or Torres Strait Islander, have a disability, are homeless, or who witness or are subject to, violence.

The Attorney-General said the Commissioner would not act as a guardian, nor handle complaints or have a role in dealing with individual children.

But it may intervene in court proceedings that raise significant children's rights issues, she said.

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Coronial investigation of stillbirths on the table

Coroners will have the power to investigate stillbirths under measures being debated in Federal Parliament.

Deputy Speaker Anna Burke has moved a motion in the House of Representatives urging uniform national laws to broaden the statutory and judicial authority of coroners so that they can investigate stillbirths.

Ms Burke told Parliament that around 1 per cent of babies born each year are stillborn – close to 3000 babies - and current laws prevent an adequate investigation to determine the cause of death.

"Currently, there are discrepancies in State and Territory legislation over the definition of 'a person' and 'death' that prevent coroners from investigating any deaths of stillborn babies," Ms Burke said.

"Allowing for public coronial inquiries into stillbirths would give us the opportunity to identify clinically important lessons from these deaths, and would contribute to research on the topic of stillbirth and early infant death, potentially reducing the numbers of stillbirths occurring each year."

The Labor MP said that not only might such a measure advance medical knowledge, it could potentially provide significant comfort to grieving parents.

"Ensuring that parents are offered the opportunity for a full and timely assessment of the factors relating to their baby's death is an essential part of helping them cope with their loss, and may provide answers that avoid a repeated occurrence," Ms Burke said, though adding that the choice of an autopsy must reside with the parents.

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Carbon tax and fees

With the introduction of the Carbon Tax from 1 July 2012 will come increases to electricity costs for households and businesses. Medical practices are encouraged to set their fees based on their own practice costs, and are entitled to increase these fees as necessary to continue to effectively provide their service.

However, the ACCC warns that any claims that attribute price rises to the Carbon Tax must be truthful and reasonable. If you intend to advise patients that fee increases are a result of the Carbon Tax, you must ensure that you have appropriately researched these costs and have accurately calculated fee increases, and be able to justify this if requested to do so by the ACCC. Detailed guidelines on Carbon Tax Claims for businesses are available on the ACCC website.

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INFORMATION FOR MEMBERS

AMA Fee List Update – 1 June 2012

The AMA List of Medical Services and Fees (AMA List) has been updated to include changes to ophthalmology, pathology and to central vein catheterisation items.

Summary of Changes / CSV File

The Summary of Changes for 1 June 2012 is available from the Members Only area of the AMA website at http://www.ama.com.au/feeslist.

The comma delimited (CSV) ASCII format (complete AMA List) is also available for free download from the Members Only area of the AMA Website (www.ama.com.au).

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

1) Once you have entered your login details, from the home page go to **Members Benefits** at the top of the page.
2) Under AMA Member Services, select **AMA List of Medical Services and Fees** link.
3) Select first option, **AMA List of Medical Services and Fees - 1 June 2012**.
4) Download either or both the **Summary of Changes** (for viewing) detailing new, amended or deleted items in the AMA List and the **CSV** (for importing into practice software).

AMA Fees List Online

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

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

Mr Marcin Zygmunt
Administrative Officer
AMA
PO Box 6090
KINGSTON ACT 2604
Ph: 02 6270 5400

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Public health fears in wake of bin Laden vaccination ploy

Efforts to immunise communities in Pakistan and other developing countries against deadly diseases may be endangered by reports the CIA used the cover of a vaccination program to verify the whereabouts of Osama bin Laden, public health experts have warned.

University of Copenhagen PhD Fellow in Global Health, Alessandro Demaio, and Monash University health law consultant Fiona Lander, have raised concerns that claims the CIA recruited a Pakistani doctor to stage a hepatitis B vaccination campaign in Abbottabad in order to obtain DNA samples from bin Laden's children could damage public trust in health campaigns and immunisation programs.

Details of the alleged plot became public late last month after the doctor, Shakil Afridi, was sentenced to 33 years imprisonment by Pakistani authorities, who had accused him of treason for the role he played in the scheme.

The US Government has yet to confirm details of the plot, but Defence Secretary Leon Panetta told the US ABC network that Dr Afridi had been "very helpful" in gathering intelligence on bin Laden, and strongly condemned his prison sentence.

There is evidence the incident has already disrupted humanitarian work in Pakistan.

Save the Children fund's Pakistan director David Wright told the British newspaper *The Telegraph* that the charity's work in the country had been severely hampered ever since Dr Afridi falsely claimed to have been working on its behalf.

Mr Wright said staff had been denied visas and supplies had been bound up in red tape ever since the incident, despite denials by the organisation that it had any links with the Pakistani doctor or involvement in the CIA plot.

He accused intelligence agencies of breaching international humanitarian law and risking the safety of aid groups around the world.

"The blame lies squarely with the CIA, which use[s] humanitarian work for intelligence gathering or worse," he said. "If it continues then we won't be able to do our jobs at all in 10 years time."

In an article on *The Conversation* website, Mr Demaio and Ms Lander warned that regardless of whether or not reports of the CIA plot were true, the accusation itself was corrosive for the credibility of public health initiatives.

"We know that these types of rumours have potential to hamper vaccination campaigns in developing countries," they wrote. "More importantly, such rumours can harm perceptions of public health and development aid efforts on a global scale."

"Public trust is an essential element of any well-designed public health intervention. But if accusations like these are proven, public health will lose out to political imperatives."

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International polio emergency declared

Eradication of the polio virus has been declared a global emergency amid fears of a resurgence of the crippling illness.

The World Health Assembly, which is the governing body of the World Health Organisation and includes representatives from almost 200 countries, has urged a re-doubling of efforts to eradicate the disease amid concerns that immunisation programs are being wound back prematurely.

"Polio eradication is at a tipping point between success and failure and necessary funding is essential to ensure success," a resolution adopted by the Assembly said. "In this regard, Member States declared the completion of polio eradication a programmatic emergency for global health."

There has been signal progress in efforts to stamp out the illness. For the first time in its recorded history, India had not registered a case of polio in the 12 months to January, and there were outbreaks recorded in only three countries – Afghanistan, Nigeria and Pakistan.

But a $US1 billion shortfall in funding for the Global Polio Eradication Initiative has led to immunisation programs to be scaled back in 24 vulnerable countries, raising the risk of polio outbreaks in communities recently considered free of the disease.

Australia has committed $50 million towards the purchase and delivery of polio vaccines, but humanitarian organisation The Global Poverty Project wants other countries to also devote extra funds to eradicate the disease.

"The world is more than 99 per cent of the way towards eradicating the disease," Global Poverty Project policy manager Michael Sheldrick said. "[But] a funding shortfall has already caused vaccination activities to be cut back, putting vulnerable communities at risk."

Mr Sheldrick said that if the world fails to seize this historic opportunity to eliminate the disease, the number of cases could soon multiply to more than 200,000 a year.

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Bulk billing reaches record high

The number of GP services that are bulk billed has reached a record high, in a result seized upon by the Federal Government as proof that its health policies are working.

Medicare figures show that 81.2 per cent GP services were bulk billed in the first three months of the year, a 1 percentage point increase from the same period a year earlier, with record high rates in New South Wales (85.9 per cent) and Victoria (80.8 per cent).

Health Minister Tanya Plibersek admitted that bulk billing rates can fluctuate, but had been rising in recent years.

"The Government is pleased to see [the rates] have been trending up for some years and are now at record highs," Ms Plibersek said.

The Medicare figures showed that bulk billing rates for radiation therapy services have surged, and have also risen in pathology, diagnostic imaging, allied health and obstetrics, though in the latter it still remains relatively low.

Bulk billing for radiation therapy jumped more than 13 percentage points in the 12 months to the end of March, rising to almost 55 per cent of services, while in pathology it rose almost 1 percentage point to 88 per cent and for diagnostic imaging it was also up 1 percentage point to 74.1 per cent.

Ms Plibersek the increases followed the introduction of incentive payments for bulk billing for diagnostic imaging and pathology services.

But bulk billing rates remained very low for anaesthetic services, steady at 8.5 per cent, and barely increased for specialist attendee services, where they accounted for 27.4 per cent of all charges.

In obstetrics, instances of bulk billing increased by 2.4 percentage points in the year to the end of March, reaching 41.1 per cent.

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AMA Executive Council

AMA President Dr Steve Hambleton, Vice President Professor Geoffrey Dobb and Chairman of Council Dr Roderick McRae will continue to serve in their roles for the next 12 months after their positions were not contested at the AMA National Conference.

Federal Treasure Peter Ford saw off a challenge from Dr Douglas Travis for his position, and will continue to serve on the Executive Council. Dr Travis remains on Federal Council as Area Nominee for Victoria.

Dr Elizabeth Feeney and Dr Iain Dunlop are the two elected Executive Council officers.

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Accused doctors not yet in the clear

Four doctors who prompted an overhaul of Professional Services Review (PSR) Scheme legislation after successfully challenging the findings of an adverse review could be the subjects of fresh investigations.

As reported in the last edition of *Australian Medicine* (click here for story), the Federal Government has made legislative changes that close a loophole exploited by the doctors to challenge the validity of the PSR findings.

The Federal Court last year upheld a complaint by the doctors that the PSR committees which investigated them were not constituted in accordance with the law, invalidating their findings and calling into question the outcome of around 70 other PSR investigations, according to a report in *The Australian*.

The government was preparing to challenge the Federal Court ruling in the High Court, but that action has been withdrawn following the passage of the legislation.

Health Minister Tanya Plibersek said the revised legislation would not apply to the four doctors, but amendments it contains could potentially allow for them to be investigated by the PSR again, according to *The Australian*.

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Be an *Australian Medicine* travel writer

Sick of glitzy infomercials posing as travel stories? Want to tell your colleagues what places, near and far, are *really* like?

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Please send stories, with your contact details, to: ausmed@ama.com.au

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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 requirements.

Each September practitioners, when renewing their Medical Board registration, may be required to provide evidence they have complied with the Board's continuing professional development (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 practise-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 practioners 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.

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Medical indemnity claims surge

The number of medical indemnity claims has jumped almost 30 per cent in three years, though almost half are dropped before settlement and the majority of payouts are less than $10,000.

Figures compiled by the Australian Institute of Health and Welfare show that there were almost 2900 claims lodged between July 2009 and June 2010, a 28.6 per cent increase from 2007-08, with general practitioners the most common target of complaint, accounting for 18 per cent of all new claims.

According to the Institute report, 58 per cent of all claims closed in 2009-10 were settled for less than $10,000 – including 17 per cent where no payment was made – while the payout exceeded $500,000 in just 6 per cent of cases.

The figures show that only a fraction of claims are decided by court.

A majority (51 per cent) were resolved in 2009-10 through negotiated settlements, the action was dropped in a further 46 per cent of cases, and just 3 per cent ended up being ruled upon by a court.

The AIHW report showed that, reflecting their preponderance in the medical profession, GPs accounted for the largest share of medical indemnity cases, being the subject of 522 new claims in 2009-10, followed by obstetricians and gynaecologists (268 cases, equivalent to 9.3 per cent of all new claims), general surgery (220 cases, 7.6 per cent), orthopaedic surgery (178 cases, 6.2 per cent) and emergency medicine (144 cases, 5 per cent).

The most common source of complaints arose from procedures, including the failure of treatments or post-operative complications, and were particularly associated with obstetrics and gynaecology and general and orthopaedic surgery.

GPs, by contrast, were the most likely to be hit with claims regarding diagnosis or medication, accounting for a third of all such actions served on the medical profession as a whole, though around 10 per cent of diagnosis-related complaints involved physicians in emergency medicine or diagnostic radiology.

Not only do GPs account for the largest proportion of diagnosis-related claims but, the Institute reported, their share of such actions is growing.

In 2007-08, 22 per cent of new diagnosis-related claims involved GPs, but by 2009-10 that had risen to 28 per cent. Over the same period, the share of such actions involving emergency medicine practitioners had virtually halved from 25 to 13 per cent.

The findings come against the backdrop of a cut in Federal Government subsidies for medical indemnity insurance payments by doctors through the Premium Support Scheme.

Under the scheme, if a doctor's gross medical indemnity costs exceed 7.5% of his or her gross private medical income the Commonwealth will pay 80 per cent of the premium above that threshold.

But cuts announced in the 8 May Budget will wind back the Commonwealth's contribution to 70 cents in the dollar from 1 July 2012 and 60 cents in the dollar from 1 July 2013.

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INFORMATION FOR MEMBERS

Junior doctors – does your hospital support your training?

Public hospitals are fundamental to educating and training doctors and the AMA wants to know if they are striking the right balance between caring for patients and training the next generation of doctors.

Adequate medical training requires proper facilities, adequate clinical supervision, appropriate channels for feedback and protected time for education and training.

Each is crucial to high quality clinical training, and the pressure on the hospital system to provide them is only going to intensify as the number of medical students and graduates grows.

The AMA is conducting a confidential, online survey of junior doctors in each State and Territory on the quality of the training, education and supervision that they are receiving in their training hospital.

This is the second survey of its type. The first, conducted in 2009, attracted more than 900 responses and delivered a mixed report card on the quality of the public hospital training environment.

It was vital in highlighting the need for more resources to ensure that the quality of medical training in our public hospitals was maintained and improved.

AMA Council of Doctors in Training Chair, Dr Will Milford, says it was critical that junior doctors are appropriately supported and supervised during their formative training years, and that the breadth of their experiences properly prepares them for independent medical practice.

"Access to a high-quality training environment and educational resources is an issue of great importance to junior doctors. It is vital that they receive a proper learning experience in their training hospital," he said.

Dr Milford said the 2012 survey would assess what changes have taken place since 2009, and provide a measure of the commitment of hospitals to maintaining the high quality of care that Australians expect from their doctors.

Dr Milford said that with the number of medical graduates rising even further in the coming years, there will be growing demand for training posts in hospitals.

"Health Workforce Australia recently released its National Training Plan Report, Health Workforce 2025 (HW2025), highlighting that the health system as it currently stands will not cope with the demand for training places from 2016 onwards," he said.

"Governments need to address this, otherwise thousands of junior doctors will not be able to achieve specialist qualification, and the community will not realise the full benefit of its investment in increased medical school places."

The AMA will use the results of the survey to lobby hospitals and governments to commit the resources necessary to ensure that junior doctors are working in an environment that supports a high-quality training experience.

The anonymous, five minute survey – which runs from 18 June to 20 July – is open to AMA members and non-members, and all junior doctors are encouraged to participate.

If you would like to participate, please go to http://ama.com.au/dit-training-survey-2012

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Book Reviewers

If you devour books and want to share your knowledge, passion, likes and dislikes with your colleagues, *Australian Medicine* invites you to become a book reviewer.

You can review books on any medical or health topic you like, and can be as complimentary or scathing as you think is warranted (as long as it is not libellous). Just keep it under 650 words.

Australian Medicine will supply the book, which you get to keep after the review.

Interested? Just email the editor at ausmed@ama.com.au, including the book subjects you would be interested in reviewing and a current postal address.

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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

System not ready for e-Health: GPs

The Australian Financial Review, 29 May, 2012

Australian Medical Association President Dr Steve Hambleton has urged the Federal Government to delay the roll-out of electronic health records, warning that the technology is not ready and there is no business case for GPs to participate in the scheme. Dr Hambleton says the AMA shares the vision for electronic health records but condemns the "headlong rush" to introduce the system on 1 July.

Open wide: health fund's GP home visits

The Australian, 21 May, 2012

Australian Medical Association President Dr Steve Hambleton raises concerns about a deal struck by health fund HCF for members to receive GOP home visits, warning of the risk health funds could interfere in doctor-patient relationship. "If the is the provider, they are fairly and squarely looking at the bottom line, which presents a conflict of interest," Dr Hambleton said.

Call to rip out toxic teeth

Sunday Herald Sun, 27 May, 2012

Climate Commissioner Professor Tim Flannery tells the AMA National Conference in Melbourne that undertakers should be required to removed mercury-based tooth fillings from corpses before cremation to prevent the element entering the atmosphere and oceans and becoming part of the food chain.

Ending violence is student's aim

The Sydney Morning Herald, 27 May, 2012

The AMA awards Indigenous medical student Glenda Brown, who wants to specialise in Indigenous child protection issues, a medical scholarship. The award coincides with release of the AMA's annual audit of Indigenous health, which President Dr Steve Hambleton says shows momentum to improve health has been building in recent years.

With ash on its face

Sunday Herald Sun, 27 May, 2012

The AMA awards its Dirty Ashtray Award, which signifies a lack of progress on tobacco control, to Victoria. President Dr Steve Hambleton says this is an especially disappointing result, because historically Victoria has been a national leader in tackling smoking.

No butts, we're tops

Sunday Mail, 27 May, 2012

Australian Medical Association President Dr Steve Hambleton announces that the South Australian Government has topped the AMA/ACOSH/ASH National Tobacco Scorecard for having made the biggest advances in the past 12 months in controlling tobacco.

Is Chinese herbal medicine safe?

Sunday Herald Sun, 27 May, 2012

Australian Medical Association President Dr Steve Hambleton says that although herbs are used in many modern medicines, there needs to be more scientific evidence about the efficacy of Chinese herbal medicine. He says practitioners of Chinese medicine should be subject to registration standards as stringent as those for other health professions.

Medical internships fall short

The Australian, 29 May, 2012

The Australian Medical Students' Association has questioned the commitment of State governments to doctor training following warnings that a shortage of internship places in Victoria and NSW means more than 300 medical graduates will be unable to begin work as doctors next year.

Radio

Dr Hambleton, 2GB Radio, 23 May 2012

Australian Medical Association President Dr Steve Hambleton tells Alan Jones that the AMA welcomes the Australian National Audit Office's decision to investigate the Federal Government's GP Super Clinics program, amid concerns that the siting of some clinics has been driven by political rather than clinical considerations.

Dr Hambleton, ABC Radio, 28 May 2012

AMA President Dr Steve Hambleton warns that technical problems have yet to be sorted out with the Federal Government's personally controlled electronic health record scheme, which is due to go live on 1 July. Dr Hambleton says the software used by many medical practices is so far incompatible with the Government's program.

The latest from AMSA

Key players recognise critical issues in medical training, AMSA

AMSA President Mr James Churchill says it is promising that Health Minister Tanya Plibersek and her political opponent, Shadow Health Minister Peter Dutton, both acknowledged challenges in medical education and training in addressing the AMA National Conference. "It is critical that the quality of training for Australia's doctors remains a priority. Challenges like under-funding, increasing student numbers and a lack of adequate workforce planning must not be allowed to impact on the quality of the training medical students receive," Mr Churchill says.

Needy communities robbed of health services – no intern places for more than 300 medical graduates

The Australian Medical Students' Association has condemned the appalling lack of government planning for medical student internship places following NSW and Victoria reports that a shortfall of training places will deny 315 medical graduates the opportunity to begin working as doctors next year.

TO COMMENT CLICK HERE

World takes small but important steps to tackle lifestyle diseases

BY **PROFESSOR STEPHEN LEEDER**

Consider China for a minute: by 2050 there will be 100 million Chinese people aged 80 years or more. They will challenge the health system with frailty, non-communicable diseases, dementia and fractures and the need for care in a society where the one child policy stretches each child a long way when it comes to looking after mum and dad. It is no wonder that health policy wonks, including those at the World Health Organisation (WHO), wake in fright when faced with figures such as these.

What does WHO have to offer? Fundamentally, when it comes to global health problems - and non-communicable diseases (NCDs) are global - it is the only show in town, so we had best learn how to use it well.

At a special high-level meeting last September, representatives from more than 100 countries resolved to find ways to prevent and manage chronic disorders such as diabetes, heart disease, stroke, cancer, chronic respiratory disease, mental illness, sensory loss and musculoskeletal problems.

Of course, there is a huge difference between what may seem a wise idea to endorse in a splendid meeting in New York and what then happens when you wake several days later back home. Harsh reality penetrates the jet lag and the thought of actually doing something – speaking with food producers about the salt and fat content of their goods, developing school-based programs to empower children with health literacy skills necessary for making healthy choices – feels like a hangover.

Indeed, when the WHO followed up on the summit late last year to find out how countries were feeling about what they had signed up to do, most did not reply.

Those that did respond felt that nothing could be done about obesity or alcohol - two important areas for action – and many were indifferent about other health-promoting efforts, although most considered tobacco was an area where there was potential for improvement.

But NCDs are a problem we cannot simply wish away.

The WHO's governing body is the World Health Assembly (WHA), comprising 194 member states, and at a meeting last month one of its key committees deliberated on the prevention and control of NCDs.

All states present agreed on the need for "united global and cross-sectoral action to prevent and control NCDs".

In an account of its deliberations, the Committee noted that "many [countries] recognised the important work done in the past year, but there was still a common feeling that more consultation is needed to decide on measurable indicators as well as to set realistic, achievable targets for measuring progress".

The second day of the WHA meeting, 21 May, was when debate about NCDs was at its most extensive. The Assembly recognised the value of "placing emphasis on disease prevention throughout the life-course, starting at the earliest stage possible, in particular from NCDs such as cardiovascular diseases, cancers, diabetes and chronic respiratory diseases".

This was an important shift of emphasis within the NCD control agenda, as it recognised the importance of maternal and perinatal health in adjusting to the genetic profile of children in ways that probably affect later susceptibility to cardiovascular disease. It also provides a bridge between concern for NCD prevention and concern for maternal and child well-being.

In addition, it approved the development of a global monitoring framework for theprevention and control of NCDs, backed programs to improve the health of older people, discussed the need for a multi-disciplinary approach to tackle tobacco and alcohol consumption, poor diets and inactivity, and was given an update on global action to prevent avoidable blindness.

The Non-Communicable Disease Alliance, comprising most of the important non-government organisations interested in NCDs, was pushing for the adoption of a resolution that would commit signatory countries to the goal of slashing mortality from NCDs by 25 per cent by 2025. The United States, Barbados, Brazil, Canada and the Russian Federation tabled a draft decision expressing strong support for this target and for others relating to blood pressure, tobacco, salt, and physical activity.

The discussions within Committee A considered "action involving other sectors than health, in particular education, energy, agriculture, sports, transport, communication, urban planning, environment, labour, employment, industry and trade, finance, and social and economic development…to reduce exposure to risk factors for NCDs, mainly: tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity".

It has taken us decades to get ourselves into the mess we now have with NCDs, and it will decades to get out. By no means has every disease that has come and gone done so because of human intervention (for example, leprosy's arrival and departure from Europe), but the social determinants of NCDs are so strong and obvious, and are things we can do something about.

Australia's record for action – a combination of judicious treatment for high-risk individuals combined with population-based efforts to control tobacco and promote healthier lifestyles – is among the best. We have ideas and experience to share.

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To hell and back, Scandinavian style

BY **ADRIAN ROLLINS, *AUSTRALIAN MEDICINE* EDITOR**

More than most other countries, Iceland can legitimately claim to have been to hell and back – both geologically and financially.

Physically, it is a wild and craggy place, moulded by violent and powerful eruptions of gas, rock and steam unleashed by the restless movement of massive continental plates grinding against each other just beneath the surface.

The island nation sits astride the faultline separating the European and North American tectonic plates, making it one of the most active volcanic and geothermal regions on earth - a fact immediately apparent to travellers when they arrive.

The country's main international airport, which lies about 80 kilometres from the capital Reykjavik, has been carved out of a vast lava field in which dark rock has been frozen in an endless variety of jagged and chaotic shapes.

The main road into the city cuts through it for much of the way into town.

In many ways Iceland's landscape feels primeval – the ground either encased in lava and vast ice sheets or littered with rocks, sand and ash. Its tallest trees stand little more than chest high, and most of the vegetation is scrub.

Large volcanic peaks and ridges surround Reykjavik, and endless plumes of steam billow from their midst.

But the city itself seems like nothing so much as the smart, well-ordered and sophisticated capital of a Scandinavian country.

While it might lack soaring skyscrapers and large office blocks (the tallest building in the city is the cathedral), Reykjavik is nonetheless a bustling commercial centre with internationally renowned restaurants and hotels, not least the famed 101, which is the epitome of sophisticated Scandinavian design.

The truth is that Icelanders have worked hard to impose a remarkable degree of order on a landscape that is ultimately wild and untameable, and harness the power beneath to their own purposes.

Turn on the hot water tap in any hotel in Iceland's capital, Reykjavik, and visitors are given an instant and pungent reminder of the island's volcanic origins.

Just about every building in Reykjavik, as in much of the rest of the country, has its hot water piped directly from underground springs brought to the boil by geothermal energy, and has an unmistakable sulphurous tang to prove it.

It is truly the land of the long hot shower, which is just as well considering its climate.

While the name Iceland may be a bit of an exaggeration – during summer ice cover retreats to three large glaciers – there is no getting away from the fact it is a cool place. The average summer maximum is a little above 10 Celsius, and anything above the mid-20s is getting into heatwave territory.

Icelanders have been tapping into geothermal energy long before the rest of the world has cottoned on to its potential.

The nation's first geothermal power station was built in 1970 and Iceland produces its own tomato crops thanks to greenhouses heated using geothermal energy.

Living in such a potentially explosive environment could put the nervous constantly on edge, but Icelanders are

nothing if not laconic, and treat eruptions and earthquakes with equanimity.

It is an attitude that probably helped them cope with a violent detonation of an altogether different kind when, in late 2008, Icelanders found themselves at the forefront of the global financial crisis.

They were among the first to feel the full fury of the collapse of international credit markets, which threw their whole banking system into meltdown.

But ask locals and they will say, with a shrug, that their savings have gone to "money heaven".

While Iceland has none of the ostentatious wealth of the oil-rich sultanates of the Middle East, it is nonetheless exudes the prosperity of a well-educated and creative people.

For the adventurous looking to explore one of the most volatile landscapes on earth, Iceland offers the traveller that virtuous combination of wild and rugged landscape with excellent food and facilities.

Getting there:

Iceland Air operates daily direct flights to Reykjavik from Heathrow Airport, London, from $A268 one-way, and $443 one-way from New York.

Accommodation:

The centrally-located 101 Hotel, Reykjavik offers standard rooms with Queen beds from $A459 a night.

TO COMMENT CLICK HERE

Biodynamic wines of Beechworth, Part two

BY **DR MICHAEL RYAN**

The north-eastern Victorian town of Beechworth is a gem of a place. It has restaurants with wholesome and cutting edge cuisine, great local produce, magnificent buildings funded by the 1800s gold rush and, of course, 17 local vineyards.

There is a biodynamic or organic influence found in some of the region's most notable wine producers. As featured in the last column, Biodynamic wines of Beechworth, Part One, producers Savaterre and Giaconda both use organic and some biodynamic principles. But hard core biodynamic growers include ex-film producer Julian Castagna from Castagna Wines and former pear farmer Barry Morey from Sorrenberg.

Julian Castagna is a fascinating man. During his many years in the London film industry, Julian found wine to be a social lubricant that forged relationships. During those exchanges Julian started to appreciate the complexities of wine. Embracing the French concept of terroir and the synergies of biodynamics, the wines he has produced have become ambassadors in this cause. There are nine biodynamic preparations – numbered 500 to 508 – and Julian uses them all to improve the growing environment. He also employs charts to help with harvesting and fertilising cycles.

The end results of his endeavours are complex wines with structure, subdued power and elegance that highlight the region from which they come. Julian is aghast at the homogenous direction some growers are heading in. He warns that "catering to markets overseas that push the dollar first and quality second will ultimately be our undoing". He has been named by the Financial Times as one of the top 12 wine makers in Australia, and he is internationally sought-after as a source of advice in the field of biodynamics. The Castagna Genesis Syrah has been added to Langton's wine classification, a decision that is testament to its quality.

Barry Morey's love of farming reflects the deep stirrings of tradition that have steered him towards wine making. His wine making heritage stretches back some 500 years to Mosel. Sorrenberg was the name of the family winery owned by his ancestors of the Barzen lineage, and now graces his own label. Sorrenberg is certified biodynamic and, for a vineyard of only 2.5 hectares, it excels in quality and diversity. First planted in 1985, Barry and his wife Jan have since forged a following with Chardonnay, Sauvignon Blanc and Gamay varieties. Cabernet Sauvignon production is also significant, while lesser amounts of Pinot Noir, Cabernet Franc, Merlot and Semillon are produced and are used in blends.

Barry is the emblematic image of the laconic Aussie wine maker: full beard, khaki work gear and boots with a hat that is a permanent fixture, akin to Molly Meldrum. Both Jan and Barry exude an air of sincerity matched only by their wines.

The Wines

2009 Castagna Beechworth and 2001 Genesis Syrah

Julian was keen to show the potential development of similar vintage characteristics in wines.

The 2009 was a dark purple, and its bouquet was dominant in dark red fruits and of plums, with secondary aromas of leather, pepper and spice. The French oak use is about one third new, and is in tune with acid and tannin levels.

The 2001 was the maturing brother to 2009's petulant juvenile. It displayed the complex nose of an older wine that is hauntingly alluring: dark brooding fruits that have amalgamated with spicy tobacco notes. The palate is seamless in its fruit and structural components. This wine is the reward for effort: res ipsa loquitur (translation: the thing speaks for itself). Both wines will cellar for 10 to 15 years. Try with spiced lamb shanks.

2010 Sorrenberg Beechworth Gamay

By far the best Australian example of this French variety known as Beaujolais. Medium red colour, spicy strawberry and cherry nose, the palate is of medium weight and silky. I believe there to be a hint of Pinot Noir present, aiding its mild but noticeable tannin structure. Sashimi tuna would match.

2009 Sorrenberg Beechworth Chardonnay

Rich yellow colour with a bouquet of white stone fruits morphing with sensual aromas of limes, spice and creamy notes. Plenty of new oak and a full anterior palate, with balanced acidity. Will cellar for five to eight years and be a blockbuster. Try with rabbit fricassee.

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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.**

OnePath
a company of ANZ

Income replacement – getting it right.

When you are looking to insure one of your most important assets - your income, it helps to find a policy that could help pay the bills if you can't work due to illness or injury.

OnePath Life, Smart Investor's Life Company of the year for the past four years, has developed ProSecure Income Replacement Plan exclusively for professionals. This protection is available to AMA members and can provide up to 75% of your monthly earnings (to a maximum of $20,000 per month) 1. To find out more click here or call 1800 658 679.

ProSecure Income Replacement Plan is issued by OnePath Life Limited (ABN 33 009 657 176, AFSL 238341). You should consider the Product Disclosure Statement, available online at www.onepathprofessionalinsurance.com.au/AMA or by calling 1800 658 679 in deciding whether to acquire or continue holding this product.

1 The monthly amount payable for the Total Disability Benefit is the lesser of (1) the monthly benefit that you choose to insure (to a maximum of $20,000) and (2) 75% of the first $20,000 per month of your pre-claim earnings plus 50% of the next $10,000 per month of your 'pre-claim earnings' less 'other payments'. Please refer to the Glossary in the PDS for further information on 'pre-claim earnings' and 'other payments'. It is in your interest to not insure more than the maximum you can be paid. The monthly amount payable excludes business expenses.

AMP

Let AMP Bank take the stress out of buying property

Buying a property can be a fraught experience full of decisions that can be costly if you don't get it right. Whether you're new to the market or you already own a property, the information below can help take some of the stress out of buying.

Borrowing for an investment property

Investing in property is a business decision. It can be a great way to build your wealth, if you do it right. Make sure you have considered every angle before you buy an investment property. We recommend that you speak to a financial planner before going ahead.

Some things to consider

- Check the rental vacancy rates in the local area. Fewer vacancies mean it's usually easier to find tenants.
- Negative gearing can have taxation benefits. Contact your financial planner, accountant or the ATO for more information.

Making the most of your home loan

Most importantly, find the right loan for your investment property. By understanding all the ins and outs of your loan, you may be able to pay off your loan sooner and take better advantage of the benefits on offer. For example:

- Fully explored the additional repayment options available to you?
- Investigated whether or not you're able to split your loan between a Fixed and Variable rate?

For more information call AMP Bank today on 1300 360 525, Monday to Friday 9am – 5pm (Sydney time) or visit www.amp.com.au/amahomeloan

AMP Bank Limited ABN 15 081 596 009, AFSL No/ACL. 234517.