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Patients languish as health reforms fall flat

Year-long surgery wait for some - 5

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Cover photo: AMA President Dr Steve Hambleton (R) meets with COAG Reform Council chair Paul McClintock at Parliament House, Canberra

Hospital statistics – who do we blame now?

BY AMA PRESIDENT DR STEVE HAMBLETON

"We all need to be clear which level of government is accountable so we can hold them to their promises. We also need to measure things that are important to patients – like those hidden waiting lists"

As reported in this edition of *Australian Medicine*, the COAG Reform Council last week released its latest report on the state of the National Healthcare Agreement.

Rather than being a report on the performance of State and Territory Governments in return for Commonwealth funding (its stated purpose), the report reads more like a report on the performance of hospitals and primary care providers.

A big problem with the report, however, is that it presents many of the important numbers but it does not reveal the stories behind those numbers – the real life reasons why some States or some hospitals may not be doing as well as others.

The National Healthcare Agreement was supposed to be the end of the blame game, with the States expected to take on full responsibility and accountability for hospital performance.

But there is yet to be strong evidence that this is happening. The new health landscape under the Agreement is still being bedded down. There is still a significant danger that the new arrangements could lead to less accountability if the States dodge their responsibility.

That is why we need more data, and more relevant data. We need to be able to more effectively monitor activity if we are to get a meaningful national snapshot of performance that will allow policy makers to better prepare the health system for future need.

For the AMA, key performance indicators are hospital bed numbers and fully transparent waiting lists for elective surgery.

This means exposing and reporting the 'hidden waiting lists'. These are the patients who have been referred to a hospital specialist by their GP but have not yet been to see the specialist to be booked for surgery. This is a lot of patients. They need to be counted if we are to get a true picture of need.

We won't see a return to efficiency until we get real action on hospital beds.

The AMA has put the estimate at more than 3700 beds nationally, a number that former PM Kevin Rudd agreed with when he was at the tiller of health reform.

The COAG Reform Council tells us there were only 872 more public hospital beds in 2010-11. This did not keep pace with population growth.

We need more beds and we need better reporting of beds.

The AMA recommends that, as well as measuring the hidden waiting lists, the COAG Reform Council should adopt the AMA's Bedwatch proposal to conduct a national stocktake of the actual numbers of beds needed in each hospital to provide safe care.

Bedwatch would track existing beds, new beds and bed occupancy rates to ensure that bed occupancy rates in public hospitals meet the AMA's preferred level of 85 per cent bed occupancy.

I mentioned *Bedwatch* to Chairman of the COAG Reform Council Paul McClintock AO when we met informally last week. He seemed genuinely interested.

I will be watching the next COAG Reform Council report with great interest.

If we are to end the blame game we need to see the greater transparency that we were promised.

We all need to be clear which level of government is accountable so we can hold them to their promises. We also need to measure things that are important to patients – like those hidden waiting lists.

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Surgery queues grow as hospitals feel the pinch

Some patients are waiting close to a year for treatment amid a nationwide rise in elective surgery waiting times and persistent emergency department delays that highlight shortfalls in public hospital funding, according to the AMA.

Figures released by the Council of Australian Governments (COAG) show the national average waiting time for public hospital elective surgery grew from 34 to 36 days in the three years to 2010-11, with some patients in New South Wales waiting as long as 333 days for treatment.

"You are entitled to ask whether the money being spent through the national partnerships [is] really delivering long-term improvements"

AMA President Dr Steve Hambleton said the increases, which came despite a big injection of Commonwealth funds, demonstrated the acute shortage of public hospital beds.

"Doctors on the ground, working in public hospitals every hour of every day, know that there has been little change to relieve the stress on hospitals and health professionals despite an almost 10 per cent increase in recurrent expenditure," Dr Hambleton said.

The AMA President made the comments following a meeting with COAG Reform Council chairman Paul McClintock last week to discuss the outcome of the Council's annual report on the National Healthcare Agreement.

Not only did the report identify an increase in national elective surgery waiting times – driven by a massive blowout in the average waiting time for treatment in NSW from 39 to 47 days between 2007-08 and 2010-11 – but found there had been no improvement in how long it took for emergency department patients to receive treatment.

The report showed that 68 per cent of patients were seen by emergency department medical staff within the time stipulated in national benchmarks in 2010-11, virtually unchanged since 2007-08, when the proportion was 67 per cent.

Mr McClintock said the results called into question the effectiveness of national partnership agreements in achieving improvements in the delivery of health services.

"Nationally, we have not seen a consistent improvement in either elective surgery or emergency waiting times," Mr McClintock told *The Australian Financial Review*. "You are entitled to ask whether the money being spent through the national partnerships [is] really delivering long-term improvements."

A spokesman for Health Minister Tanya Plibersek told *The Australian* the increase in elective surgery waiting times reflected the effects of the Federal Government's blitz on elective surgery waiting lists, which had deliberately targeted patients who had waited the longest for surgery, thereby pushing up the median waiting time.

But Dr Hambleton said the figures showed hospitals were struggling to cope with growing demand for health services.

He said that although there were an extra 872 beds opened in public hospitals in 2010-11, the number of beds per 1000 people had not changed.

"This means the new beds merely kept pace with the population and did nothing to increase the capacity of hospitals," the AMA President said.

Dr Hambleton said the pressure on waiting lists was even worse than that indicated by the COAG figures, because they did not take into account patients who were yet to be assessed for surgery by a public hospital specialist following referral from their GP.

He said patients were only counted towards waiting lists once they had seen a specialist and were booked in for surgery.

Dr Hambleton said official figures should take account of this hidden waiting list, and called on the COAG Reform Council to also adopt the AMA's *Bedwatch* proposal for a nationwide stocktake of the actual numbers of beds needed in each hospital to provide safe care.

"*Bedwatch* would track existing beds, new beds and bed occupancy rates to ensure that public hospitals meet the AMA's preferred level of 85 per cent bed occupancy."

The Reform Council's report showed that the proportion of patients complaining they had to wait an unacceptable time to see a GP fell from almost 18 per cent in 2009 to 15.5 per cent in 2010-11, while the proportion who deferred seeing a GP because of cost climbed from 6.4 per cent to 8.7 per cent over the same period.

But the AMA said the results, based on an Australian Bureau of Statistics survey asking patients about their experience, needed to be treated with caution.

Dr Hambleton said the rise in the proportion who claimed they had not seen a GP because of perceived cost was not consistent with Medicare data showing a record 81.2 per cent of GP services were bulk billed in the first three months of the year.

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Doctors warned on sexual and professional boundaries

Doctors have been warned to ensure they have informed patient consent for examinations and at all times maintain appropriate sexual boundaries with their patients.

The advice is included in updated guidelines and position statements developed by the AMA to help doctors maintain professional relationships with their patients.

The position statements, which cover the conduct of physical examinations and appropriate professional boundaries between doctors and patients, canvass issues around the awarding and withdrawal of consent, the use of chaperones, the maintenance of sexual boundaries and mandatory reporting requirements for misconduct.

The *AMA Position Statement on Sexual Boundaries Between Doctors and Their Patients 2012* provides guidance to doctors on maintaining appropriate sexual boundaries with patients, former patients, and patients' carers and close family members.

In particular, the Position Statement makes it clear that "a doctor should not engage in sexual activity with a current patient (regardless of whether or not the patient has consented), make sexual remarks, touch patients in a sexual way, or engage in sexual behaviour in front of a patient".

In addition, it warns that "it may be inappropriate for a doctor to engage in a sexual relationship with a former patient if this breaches the trust the patient had in the doctor at the time of the therapeutic relationship".

The statement instructs that doctors should not solicit or engage in a sexual relationship with a patient's career or close family member and, where a patient displays inappropriate sexual behaviour, should either attempt to re-establish professional boundaries or end the therapeutic relationship and refer the patient to another doctor.

The AMA has also issued *Patient Examination Guidelines 2012*, which detail the steps that should be taken to obtain and observe patients consent for physical examinations, including the use of chaperones and how to respond when consent is withdrawn.

According to the guidelines, "it is essential that the patient consent prior to the examination".

This includes explaining to the patient why the examination is necessary, what parts of the body are to be examined, what the examination entails and if anyone else will be present during the examination, the guidelines said.

The statement said that if the patient withdraws consent at any time the examination must be stopped immediately, and may be deferred or referred to another doctor.

The guidelines also canvassed the use of chaperones, particularly where they are requested by the patient or the patients appears particularly reluctant or distressed about being examined, or where the doctor is uncomfortable examining the patient without an impartial observer present.

The statement sets out who might be appropriate to act as a chaperone, what will be required of them, and how the examination should be conducted in their presence.

The *AMA Position Statement on Sexual Boundaries Between Doctors and Their Patients 2012* is at http://ama.com.au/node/521

The *AMA Patient Examination Guidelines 2012* statement is at http://ama.com.au/node/514

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E-health records face more delays

Senior Health Department officials have admitted patients may not be able to register for an electronic health record on 1 July and doctors will not be able to upload clinical information before at least September, in the latest setback for the Government's troubled personally controlled electronic health records (PCEHR) scheme.

The admission to a Senate estimates committee has come amid Government efforts to talk down expectations that electronic health records will be available from 1 July, which was the original start-up date for the program.

"Parliament is yet to pass legislation to set up the scheme and, with just two sitting weeks left before 1 July, the Government is rapidly running out of time to have the laws passed"

Department secretary Jane Halton told Senate's Community Affairs Legislation Committee on 30 May that "1 July is the beginning, not the end point. We do not expect everyone to be registered on that date, and we did not expect all the capability to be available on that date".

Earlier, Health Minister Tanya Plibersek told the AMA National Conference that "we've always said the rollout of the national e-health system would be in gradual, carefully managed phases".

But department officials have admitted that patients may not even be able to register to have an electronic record on 1 July.

Health Department Deputy Secretary Rosemary Huxtable said that in its initial stages the focus of the scheme would be on consumer registration.

Ms Huxtable told the Senate committee that from 1 July consumers would be able to register for an electronic health record by contacting a Medicare call centre or going in person to a Medicare office, though it might be some time before they can register online.

"There will be an online registration function, which we are pushing very hard to have available from 1 July, but it may come some weeks after that," she said.

One of the problems appears to be establishing systems to ensure the security of electronic health records, including verifying the identity of users.

The National E-Health Transition Authority (NEHTA) is pushing IBM, which won the contract to provide the National Authentication Service for Health, to complete its work in time for the promised 1 July roll-out of the scheme, according to a report in *The Australian.*

IBM won a $23.6 million tender to build the authentication service in March last year, and there has been speculation the project is up to five months behind schedule.

But NEHTA official Andrew Howard said he had been assured by IBM that development was on track and the system, which will verify authorised users and support secure communications among medical providers, was moving into the "final assurances" stage, according to *The Australian.*

In addition to technical problems, the introduction of the personally controlled health records scheme – which is expected to have two million users signed up in its first two years - is also being dogged by administrative and legal issues.

Parliament is yet to pass legislation to set up the scheme and, with just two sitting weeks left before 1 July, the Government is rapidly running out of time to have the laws passed.

Ms Halton admitted to the Senate committee that the legislation was "the cornerstone of the rollout".

But the departmental head said it was not "terminal" for the scheme if the legislation was not passed in time.

The Government is also trying to address concerns raised by the AMA regarding liability for incomplete or incorrect information in electronic records.

NEHTA official Chris Mitchell told the Senate committee said his organisation had been working closely with the AMA on guidelines for the appropriate use of electronic health records.

"Those guidelines are currently in draft form, and they are still being widely consulted on through the profession," Dr Mitchell said.

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Baby deaths prompt call for crackdown on unregistered midwives

A South Australian coroner has called for a crackdown on unregistered midwives following findings that the deaths of three babies during homebirths could have been prevented.

In what could be a landmark case for the regulation of midwifery and homebirthing, Deputy State Coroner Anthony Schapel rejected the evidence of the unregistered midwife who attended all three births and recommended laws making it illegal to practice as a midwife without registration, and requiring formal notification of planned homebirths involving a heightened risk of complications.

The AMA has backed the recommendations, and South Australian President Dr Peter Sharley said more should be done to break down misconceptions about hospital births and improve the attractiveness of midwife-led birthing units.

The case has highlighted a loophole in national health regulations that enables and - according to the coroner, encourages – midwives to operate outside formal jurisdiction, with little or no protection for mothers or their infants in the case of complications.

The case centres of the activities of Lisa Barrett, an experienced midwife who let her registration lapse early last year to work instead as a 'birth advocate', and who attended all three fatal homebirths.

The coroner found that in each instance the babies – Tate Spencer-Koch, born in July 2007, Jahli Jean Hobbs, born in April 2009 and Tully Oliver Kavanagh, born in October last year – were "robust and viable" immediately before delivery, but died as a result of complications that would not have been fatal if they had been born in hospital.

He found that Tate was a large baby

– a fact known by Ms Barrett before delivery – whose birth was obstructed by shoulder dystocia and died as a result of intrapartum hypoxia.

Jahli's was a breech birth – also known by Ms Barrett before delivery – and delays in her delivery meant she too died of intrapartum hypoxia.

The third infant, Tully, was the second of twins and was delivered more than an hour after his sister. During the course of his delivery placental separation occurred, leading to fatal hypoxic ischaemic encephalopathy.

In each instance, the coroner found "as a matter of certainty" that each child would have survived had they been born by caesarean section.

The coroner heard evidence of a fourth death, of the second of twins during a home birth attended by Ms Barrett in July last year in Western Australia.

In her testimony, Ms Barrett argued that since she relinquished her midwifery registration she no longer attended births in a clinical capacity, and merely provided support as a birth advocate.

But Mr Schapel rejected Ms Barrett's testimony, describing it as "disingenuous".

"It is obvious to the court that Ms Barrett was performing the clinical duties and responsibilities of a midwife, and was not merely present as a birth advocate," the Deputy Coroner said. "To my mind, Ms Barrett's evidence that she was a mere birth advocate, not performing the duties and responsibilities of a midwife, has to be rejected."

Ms Barrett told the court she had decided to relinquish her midwifery registration and practice because of new requirements that came into effect at the time of the introduction of the Health Practitioner Regulation National Law.

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Baby deaths prompt call for crackdown on unregistered midwives

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But, in a damning judgement, Mr Schapel rejected her testimony, and instead found that Ms Barrett had let her registration lapse in order to exploit the fact that there were no sanctions or restrictions on people practising as unregistered midwives.

Under the National Law, registered midwives can obtain an exemption from the requirement to have liability insurance while attending a homebirth, but the exemption is set to cease in mid-2013.

Ms Barrett denied suggestions she discontinued her registration because she would not qualify for the exemption, as she did not want to comply with the safety and quality requirements imposed on registered midwives.

"I find that Ms Barrett handed in her registration as a midwife because she well knew that in order to practise as a registered midwife with the benefit of an insurance exemption in respect of intrapartum care in homebirths, she would have to conduct her practice within the Nursing and Midwifery Board of Australia's Safety and Quality Framework and the Australian College of Midwives Guidelines," Mr Schapel said. "I further find that she was not prepared to do this as it would act as a hindrance to her homebirthing practice in respect of high risk homebirths."

The Deputy Coroner recommended measures to crackdown on unregistered midwives, require notification of intended homebirths, improve information to parents and investigate the establishment of alternative birthing centres, as suggested by AMA South Australia.

In particular, Mr Schapel recommended laws that would "render it an offence for a person to engage in the practice of midwifery…without being a midwife or a medical practitioner registered pursuant to the National Law".

The Australian College of Midwives warned such a measure could drive women wanting homebirths out of the health system entirely.

The Deputy Coroner said he had carefully considered this issue, and decided that the very availability of unregistered midwives made it possible for women to undergo homebirths that were of enhanced risk, and that the tendency to do so might be altered if patients were given full knowledge and understanding of the potential consequences.

Immediate past president of AMA South Australia, Dr Andrew Lavender, testified at the inquest, and said that although the AMA did not in principle object to home births, they most be conducted "within the parameters of the lowest potential risk to the baby and mother".

"It must also be within the context of fully-informed consent [that] must include the increased risks associated with delivery in a home environment away from acute medical intervention facilities," Dr Lavender said.

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Midwives not using Medicare, PBS

Less than 70 of the nation's registered midwives have become Medicare providers despite being awarded access to the Medicare Benefits Schedule more than 18 months ago.

Department of Health and Ageing officials have told a Senate estimates hearing that just 69 midwives, out of total pool of 42,000 registered practitioners, have joined the scheme since the MBS was opened up to them in November 2010 – well short of the expected take up rate of 360 by 2011-12.

Head of the department's Medical Benefits Division, Dr Richard Bartlett, said midwives with access to Medicare had performed 14,664 services, worth $940,000 in benefits, while 112 nurse practitioners had performed 70, 163 services worth $1.76 million.

The Australian College of Midwives has blamed the poor take-up rate on the requirement that midwives have to enter into collaborative agreements with doctors in order the use the scheme.

Dr Bartlett admitted the take-up rate of midwives had been unexpectedly slow, but thought this was due to the substantial shift in operating that was involved, rather than any blockage by practitioners.

"It involves a significant change in the way in which they (midwives) practice [and] that has taken quite a long time to occur," he said. "[But] the numbers are continuing to grow, so although uptake has been a little slower than expected, we are certainly seeing it picking up over time."

Dr Bartlett said there had been no claims requiring Commonwealth contribution under the midwives professional indemnity insurance scheme.

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Complaints against doctors chew up half of regulator investigation costs

More than half the money spent by the health regulator investigating complaints against practitioners is used on cases involving doctors, figures obtained by the AMA under Freedom of Information laws show.

Details of the Australian Health Practitioner Regulation Agency (AHPRA) budget obtained by the AMA indicate that more than $11.3 million was expended on 'notification costs' in 2010-2011, of which $5.7 million was spent investigating 4122 complaints against medical practitioners – even though they represented just 16 per cent of all registered health professionals.

But the Agency described the over-representation of doctors in the complaints process as "unsurprising".

"Medical practitioners are the major focus of notifications in the National Scheme, which is unsurprising given the complexity of modern medicine," the Agency said in its 2011 annual report.

Overall, the figures obtained by the AMA show doctors contributed more than $44.6 million in fees last financial year to help pay for AHPRA's running costs – almost 39 per cent of the organisation's total fee income.

In addition to the 13 per cent that went to help fund investigation of complaints, doctors contributed almost $6 million in regulatory fees to New South Wales' Health Professional Councils Authority, $2.6 million for administrative expenses and $4 million in one-off transition and decommissioning costs.

The Agency indicted that it spent $21.7 million on staff employed to undertake activities related to the medical profession – 41 per cent of its overall budget for staffing costs.

AHPRA attributed 39 per cent of its 2010-11 running costs to the medicine profession, 37 per cent to nursing and midwifery, 7.6 per cent to psychology, 6 per cent to dental, 5 per cent to pharmacy, 1.1 per cent to chiropractic, and less than 1 per cent to each of optometry, podiatry and osteopathy.

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Family Doctor Week 2012

AMA Family Doctor Week 2012
For a lifetime of trusted care

Each year the AMA sets aside a week to celebrate the role played by general practitioners (GPs), in delivering high quality health care in local communities all around Australia.

This year, *Family Doctor Week* will be held from Monday 16 July to Sunday 22 July. This year's theme is 'For A Lifetime of Trusted Care'. The theme encapsulates family doctors' ability to provide skilled care for patients at every phase of life. *Family Doctor Week* is also an important reminder to the community of the importance of having a family doctor.

The AMA will be using this week to strongly highlight some of the top issues facing GPs and a series of *YouTube* videos will be produced to showcase the everyday workings of a GP. For more information visit http://ama.com.au/familydoctorweek2012

Commonwealth sets its price for activity-based funding

The Commonwealth has set the price it will use to pay for its share of public hospital services under the new national activity-based funding scheme.

The Independent Hospital Pricing Authority has announced that the national efficient price for hospital services next financial year will be $4808 per unit of activity.

Pricing Authority chair Shane Solomon said that setting the price was key to the introduction of activity-based funding from 1 July.

Under the new system, the cost of hospital services will be expressed in terms of National Weighted Activity Unit.

For example, a same day inpatient admission for a cataract procedure will have a weight of 0.5726 of an activity unit, meaning the efficient price the Commonwealth will be paying for the service in 2012-13 will be $2753.

The amount set out under the formula only applies to Commonwealth funding, and State and Territory governments can decide to contribute more or less than the efficient price set by the Pricing Authority, Mr Solomon said.

He said it was part of a system that would increase the transparency of health costs, and encourage greater hospital efficiency in use of taxpayer money.

"The benefits to public hospital patients of activity-based funding include better value for public money spent on hospital services, and a more transparent system," Mr Solomon said. "Public hospital governing bodies and managers will be in a much better position to measure their efficiency against a range of other hospitals in Australia."

But the AMA has raised a number of concerns about the new system, particularly what it means for public hospital capacity.

The AMA said it is unclear what effect the efficient pricing mechanism will have on the capacity of public hospitals to meet future demand, such as opening more beds to cater for extra elective surgery procedures.

It is particularly worried that there is no guarantee that State and Territory governments will provide the capital funding needed to increase the capacity of public hospitals to meet the demands of local communities.

There are also concerns about how it might affect funding for hospital-based teaching, training and research.

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Protecting the young is Indigenous scholar's mission

Glenda Brown receives AMA Indigenous Scholarship from AMA President Dr Steve Hambleton

AMA Indigenous Scholarship winner Glenda Brown is in no doubt what she needs to do.

The third-year University of Newcastle medical student, who received the award from AMA President Dr Steve Hambleton at the AMA National Conference, is committed to protecting children from the violence that wracks many Indigenous communities.

A descendant of the Wiradjuri people of northwest New South Wales, Ms Brown has personal experience of the deep and long-lasting effects of violence, alcohol and substance abuse on the young, describing her own childhood as "very unstable".

Currently working as an Aboriginal community nurse, she is determined to do what she can to end what often is a destructive cycle of violence and substance abuse that blights many lives.

"One of the most important issues facing Aboriginal people is family and community violence," Ms Brown says. "Through my work as an Aboriginal child protection officer and registered nurse, I have often see the effects of violence and abuse on women and children.

"I believe violence in our communities undermines every health care strategy."

Ms Brown believes that by becoming Australia's first Aboriginal doctor specialising in Aboriginal child protection issues, she can not only make a difference for individuals, but can help curb violence and explode the myths and ignorance that surround Indigenous health.

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Govt talks begin on extra graduate training places

The AMA has called for urgent Commonwealth, State and Territory action to boost medical graduate training places as high level intergovernmental meetings on the issue get underway.

AMA President Dr Steve Hambleton has written to Health Minister Tanya Plibersek urging the Federal Government to show strong leadership as a series of meetings involving senior Commonwealth and State health department officials are held to discuss way to address the looming shortage of intern positions.

Dr Hambleton said that although there had been a commendable increase in medical school places in recent years, this had not been matched by a commensurate lift in the training places needed by graduates to complete their education and prepare them for practice.

He said reports showed that there would be a shortage of about 300 intern positions in New South Wales and Victoria alone next year, and a recent Health Workforce Australia study indicated that without an increase in training positions the country would face a shortage of around 2700 doctors.

"It is a key issue for all governments to ensure that there are sufficient internships for all medical graduates," Dr Hambleton said. "Australia needs to find training places for the growing number of students graduating from medical school, including specialist training posts."

The AMA President said that without additional training positions, thousands of junior doctors would not be able to achieve specialist qualification, and the community would not realise the full benefit of its investment in increased medical school places.

"Finding a solution will require strong leadership from the Federal Government and strong cooperation between the States and Territories to do their bit to ensure that community access to quality medical care is maintained and improved to meet growing demand," Dr Hambleton said.

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HEALTH ON THE HILL

Master plan to stamp out smokes

Cigarettes would become increasingly expensive and difficult to spruik while opportunities to smoke would shrink under a strategy devised by an intergovernmental expert advisory panel.

The draft plan, which has been released for public consultation, calls for further increases in tobacco excise, the elimination of all remaining areas of tobacco advertising and sponsorship, more stringent conditions on the contents and supply of tobacco products, tighter smoke-free restrictions and intensified quit and anti-smoking campaigns.

The strategy has been drawn up by the Intergovernmental Committee on Drugs - which advises the Ministerial Council on Drug Strategy comprising Commonwealth, State and Territory health and law enforcement ministers – with the goal of cutting adult rates of smoking from the present 15 per cent to 10 per cent by 2018, down from almost 25 per cent in 1991 and 16.6 per cent in 2007.

"This is an ambitious target, but substantial progress will be made towards achieving this if the actions in this draft Strategy are fully implemented," the Committee wrote.

According to the Committee, increasing the cost of cigarettes and other tobacco products is an effective measure to cut smoking, particularly among lower income earners and the less well off.

"Over the period January 1999 to December 2006, a one Australian dollar increase in price was associated with a decline in prevalence of 2.6 per cent among low income groups compared with a 0.2 per cent decline among high-income groups," the Committee said. "The study concluded that increasing the price of cigarettes is an effective tobacco control strategy to lower smoking prevalence in the general population [though] it is important to ensure that increases in the price of tobacco are accompanied by efforts to prevent and minimise the illicit trade in tobacco."

While the High Court is yet to deliver its verdict on a challenge mounted by big tobacco firms against the Federal Government's world-first cigarette plain packaging laws, the strategy calls for the measure to be fully implemented by the end of the year.

The Committee wants government to go further by implementing laws to ban tobacco advertising online, examine ways to remove tobacco products from shopper rewards programs and consider upgrading the film classification system to include the portrayal of smoking.

The draft National Tobacco Strategy 2012-2018 can be viewed by clicking here. The closing date for submissions is 25 June.

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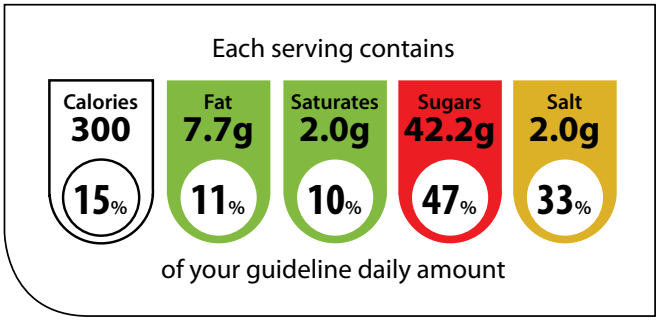
Clearer food labels a step closer



Australia and New Zealand government ministers have commissioned a report on clearer and simpler food labelling, to be finalised by the end of the year.

Australia and New Zealand ministers responsible for food regulation have called for industry and consumer stakeholders to advise on a system of front-of-the-pack food nutrition labelling by December as part of a push to make it easier for consumers identify and choose healthy foods.

The call came at a meeting of ministers early this month that approved the development of a joint Australia-New Zealand standard governing claims for the nutritional content and health benefits of food products.

The meeting also discussed a review of policy guidelines regarding caffeine that is underway.

Parliamentary Secretary for Health and Ageing, Catherine King, said "good progress" had been made on the introduction of front-of-the-pack food nutrition labelling.

Under the plan, all packaged food would carry a standardised, clearly visible and easily interpreted label indicating nutritional content.

"This is an important project that aims to help consumers to make more informed food choices, while fostering a strong and innovative food industry through the development of one front-of-the-pack system that will be widespread, simple and interpretive, for packaged, manufactured or processed foods," Ms King said.

The issue of food nutrition and labelling has been given renewed prominence following the decision by the Walt Disney Company to phase out junk food advertising on its television channels and websites by 2015.

Australian Medical Association President Dr Steve Hambleton welcomed the move, arguing that commercials often undermine the efforts of parents to encourage healthy eating by their children.

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HEALTH ON THE HILL

Grants on offer to improve clinical supervision

Hopes for action to tackle the shortage of training places for medical graduates have been bolstered by Health Workforce Australia's decision to offer almost $400,000 for research into improving the capacity and quality of clinical supervision programs.

The Australian Medical Association has welcomed Health Workforce Australia's move to offer 15 National Clinical Supervision Fellowships, worth up to $25,000 each, as a small but encouraging step towards addressing the mounting shortage of pre-vocational and specialist training places for medical graduates.

A report by Health Workforce Australia (HWA) released in late April warned there could be national shortage of almost 3000 doctors by the middle of the next decade unless there is a major boost to training places for medical graduates.

According to the *Health Workforce 2025* report, in 2016 there will be 3867 doctors who require a first year advanced specialist-training place, whereas the most recent data shows that there are currently only 2817 positions available.

Even factoring some growth in these places, *Health Workforce 2025* is still projecting a shortage of 451 training positions.

Under the initiative, fellowships worth up to $25,000 each will be awarded to those involved in providing or researching clinical supervision.

The funding will be provided for projects that help increase opportunities for clinical supervision, improve its quality or develop new models for oversight and training.

Health Workforce Australia is particularly interested in research proposals with an "inter-professional" focus, though those specific to particular disciplines will also be considered

Chair of the AMA's Doctors in Training Group, Will Milford, said any research that could lead to more efficient use of limited clinical supervision resources, or may expand the range of settings in which it is provided, was welcome.

"We would certainly encourage giving greater recognition and support to the supervision and training roles undertaken by clinicians" Dr Milford said.

But he warned much more needed to be done.

"There needs to be a concerted and coordinated effort by all those involved," he said, including governments, medical colleges, and hospitals. "[The Fellowship initiative] is small, but any activity in this area is welcome."

Dr Milford said it would be particularly significant if the fellowships signalled an intention by HWA to become more heavily involved in addressing the shortfall in doctor training.

"[In the past] this is not something that has fallen to any one body, and as a result there has not been a lot of focus on it," he said. "If a body like HWA or the MTRP (Medical Training Review Panel) became involved at a co-ordination level, then that would be welcomed."

More information is available at the HWA website (click here).

Fellowship applications close on 31 July this year.

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Alarm on looming nurse shortage

The Federal Government's chief health adviser has admitted it is "not possible" for the nation to train the extra 110,000 nurses needed by 2025.

Department of Health and Ageing head Jane Halton told a Senate estimates hearing a Health Workforce Australia report projecting a shortage of 109,000 nurses and 2700 doctors was a "clarion call" to overhaul systems to recruit and train medical and health workers.

"The notion that we are actually going to train and deliver that many nurses I genuinely think is not possible," Ms Halton said. "One of the things we have to do is look at models of care to find ways to provide care that are sustainable and deliverable. It is very, very, very much on our radar".

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Medicare trawling data to find shonky doctors

Medicare is using sophisticated techniques to identify doctors with suspicious consultation, radiology and prescribing practices, a Senate committee has been told.

Professional Services Review director Dr Bill Coote told an estimates hearing late last month that doctors were coming under scrutiny for more than just generating a high volume of Medicare claims.

"Not all practitioners referred [for Professional Services Review] are simply high volume," Dr Coote said.

He told the committee Medicare used techniques to identify unusual patterns for consultations, radiology services or prescriptions.

"There are patterns which are different in respect of the amount of expensive radiology that is ordered by a practitioner who may actually have a low volume of patients," Dr Coote said. "There are some quite unusual patterns of prescribing. Some practitioners will have a rate of utilisation of the more expensive so-called level C and level D GP consultations – very long consultations."

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Tackling disadvantage could slash chronic illness, save billions

A parliamentary inquiry is set to be launched into effect of education, employment and housing on health following estimates that 60,000 people a year are hospitalised because of causes related to low income and disadvantage.

Minister for Social Inclusion Mark Butler said the Senate Standing Committee on Community Affairs could begin examining the issue later this year following the release of a report commissioned by Catholic Health Australia showing $2.3 billion a year could be saved by tackling the social determinants of ill health.

The study, which examined the economic benefit if the Government implemented World Health Organisation recommendations aimed at reducing health inequities, 500,000 people would be able to avoid the effects of chronic illness, saving the budget $4 billion a year in welfare payments, adding 170,000 workers to the labour force, slashing Medicare services by 5.5 million consultations (saving $273 million) and cutting the number of prescriptions issued by 5.3 million, reducing PBS expenditure by $184.5 million.

Catholic Health Australia chief executive officer Martin Laverty said the report, prepared by the University of Canberra's National Centre for Social and Economic Modelling, highlighted the huge cost of avoidable poor health to the economy.

"The social determinants of health – such as income level, housing status and educational attainment – are factors responsible for health inequities that result in 500,000 Australian having a chronic illness that could be avoided," Mr Laverty said. "Helping people to finish school, to gain secure employment and to better participate in society could see 500,000 Australians remain healthy and save taxpayers billions of dollars."

Mr Butler said that although Australians generally had a good standard of living, about 5 per cent suffered "multiple disadvantages" that affected health.

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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

Just another day in the e-health evolution

The Australian Financial Review, 5 June, 2012

Australian Medical Association President Dr Steve Hambleton criticises the Federal Government's decision to pay Medicare Locals $50 million to help them adopt and use personally controlled electronic health records while threatening to withhold similar assistance from GPs unless they sign up to the e-health system. "The Medicare Locals won't be in the room during a patient-doctor consultation," Dr Hambleton says.

Litigation warning on eve of e-Health

The Australian, 5 June, 2012

Australian Medical Association President Dr Steve Hambleton says it is not safe for doctors to sign up to the Federal Government's personally controlled electronic health record scheme "until we are happy with the regulations", with Chair of the AMA's GP Council Dr Brian Morton warning that the contract doctors would have to sign to use the system would expose them to legal liability if patients are harmed because records are incomplete, outdated or have been hacked.

Parents still searching for answers a year on

The Age, 5 June, 2012

Australian Medical Association President Dr Steve Hambleton renews calls for alcoholic energy drinks to be banned following the death of a 16-year-old girl in Melbourne after she consumed such drinks a year ago. Dr Hambleton says the case is tragic and it "makes no sense" that drinks that combine alcohol and stimulants are allowed to be sold.

Publicity truck hits the road, but AMA warns ehealth will drive into bugs

Sydney Morning Herald, 6 June, 2012

The Australian Medical Association is warning doctors there are outstanding technical and legal problems with the Government's personally controlled electronic health records system, with President Dr Steve Hambleton saying he does not expect arrangements – including software – to be ready until September.

Chubby club a hazard

Sunday Canberra Times, 3 June, 2012

Websites encouraging overweight people to gain even more weight are causing concern in the United States, but AMA President Dr Steve Hambleton says they are not widely used in Australia. Dr Hambleton says most overweight or obese people do not have eating disorders, but consume energy-dense, nutrition-poor foods.

Alert over dangers of sleep drug

Adelaide Advertiser, 14 June, 2012

Australian Medical Association President Dr Steve Hambleton has warned doctors and patients to be aware of the importance of using the sleep medication Stilnox appropriately, after the Therapeutic Goods Administration issued an alert about the potential side effects of the drug. TGA figures show that in the past three years the medication has been associated with 116 incidents of unusual or dangerous behaviour, often when Stilnox is mixed with alcohol.

Radio

Dr Hambleton, Gold FM Melbourne, 5 June, 2012

Australian Medical Association President Dr Steve Hambleton says questions need to be answered over alcholic energy drinks following the death of a teenage girl who drank three Pulse drinks.

Dr Hambleton, Triple M Melbourne, 5 June, 2012

AMA President Dr Steve Hambleton says people should not be so quick to dismiss links between head injuries and mental illness, as a former AFL player raises concerns that his severe depression may stem from blows to the head during his playing career.

Dr Hambleton, 2UE Sydney, 6 June, 2012

AMA President Dr Steve Hambleton welcomes a decision by the Walt Disney Company to ban junk food advertising on its shows, arguing that commercials often undermine the efforts of parents to encourage healthy eating. Dr Hambleton says efforts should also be made to encourage healthy diet messages in schools.

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AMA in action

AMA President Dr Steve Hambleton and other AMA officials have been busy pushing forward the AMA agenda across a range of areas in the past two weeks. In addition to numerous media interviews, including on ABC TV's 7.30 Report, Dr Hambleton has held discussions with Council of Australian Governments Reform Council chairman Paul McClintock about the performance of the nation's public hospitals and hospital funding, met with Mental Health Commission chief executive officer Robyn Kruk, attended the launch of Drug Action Week and discussed child vaccination with senior researchers at CSL Biotherapies in Sydney.

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Dr Hambleton talking to the media about preschool mental health checks

AMA President Dr Steve Hambleton at the launch of Drug Action Week with Robyn Walker and Peter Leavy

AMA President Dr Steve Hambleton with Robyn Kruk CEO of the Mental Health Commission

Dr Hambleton getting ready for his interview at ABC 24 in brisbane

AMA President Dr Steve Hambleton with Dr Alan Paul Medical Director at CSL Biotherapies, Dr Darryl Maher Vice President of Medical & Research at CSL Biotherapies and Dr Robert Menzies Deputy Director of NCIRS discussing childhood vaccinations

GP MRI on its way

BY **DR BRIAN MORTON**

"Just as the AMA has been persistent in its pursuit of MBS funding for GP referred MRIs, the AMA will continue prosecuting our positions on those issues that affect GPs and general practice"

With the impact of the Federal Budget still sinking in for GPs, progress has been achieved on one of the only positives for them out of last year's Budget.

After many years of effort by the AMA, the 2011-12 Budget finally delivered funding for Medicare Benefits Schedule rebates for GP-referred magnetic resonance imaging (MRI). It means that from 1 November this year, GPs will be able to request MRIs for all patients under 16 years of age for clinically appropriate indications. This step is part of a rollout that will see GPs able to request MRIs for all patients over 16 years for clinically appropriate conditions the following year (that is, from 1 November 2013).

In August 2011 the MRI Working Group, of which I am the AMA representative, met to begin nutting out the descriptors for the new items. Consensus on the list of clinical indicators for GP referral for MRI was first required before moving on to the descriptors. When developing descriptors for the MBS it is my belief that they should not be so prescriptive as to restrict appropriate clinical application. Descriptors can all too easily be rendered useless in the name of cost containment. Ensuring common sense prevails is often a challenge, but one that must be won.

With the AMA having successfully advocated for guidelines to support GPs, work has also been underway by another committee to develop clinical guidelines and educational materials for GPs to help ensure that patients receive the most appropriate imaging.

Just as the AMA has been persistent in its pursuit of MBS funding for GP referred MRIs, the AMA will continue prosecuting our positions on those issues that affect GPs and general practice.

Already the AMA Council of General Practice is considering what the key issues will be for general practice in the lead up to the next election. Matters such as appropriate measures to support the implementation of the patient controlled electronic health record, reversing the cuts to GP mental health items, and the sustainability of GP after hours care, will be high on the list.

The AMA's position on health issues is highly regarded by policy makers. A look over the documents that were produced for the last two election issues is testament to this, particularly in relation to preventative health, primary health care, telehealth, and workforce.

I invite you to share your views on which issues you believe should receive particular attention in the lead up to the next election. Email me at generalpractice@ama.com.au.

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Let us not have a plan and just let chaos rule

BY **DR DAVID RIVETT**

"Both State and Federal AMAs are lobbying for a solution and have been doing so for years, so the respective Health Ministers have been well aware of the problem"

Stupidity unsurpassed prevails in workforce planning, with large numbers of students about to graduate from Australian universities with no likelihood of an intern placement for them.

Set against a critical workforce shortage in rural Australia, plus the fact that both State and Federal governments have been well aware of the rise in graduate numbers for more than five years, this is both criminally unintelligent and a huge waste of education dollars. Heads should roll in both Federal and State health departments. Any solution is not rocket science, but basic number crunching and planning. Rural and regional hospitals could be utilised to increase intern numbers and give great educational opportunities of robust quality to those about to be cut adrift and forced to look overseas.

Are our State and Federal Governments so dysfunctional and focused on cost shifting that they cannot provide a solution? It would seem so.

Both State and Federal AMAs are lobbying for a solution and have been doing so for years, so the respective Health Ministers have been well aware of the problem. Brinkmanship by States to pursue Federal dollars to fund extra training places can only make tomorrow's graduates feel unwanted and unappreciated, and should end now.

Having extra graduates is a huge opportunity to gradually redress the rural workforce shortage if it is handled properly with excellence of training in rural and regional Australia. But so far we are off to a miserable start in the exercise.

Block funding, it has been decided, will apply to only very small rural hospitals - those with under 3500 separations a year.

The rest will get activity based funding, which will be capped until 2014-15 before being uncapped thereafter. The Commonwealth will pay a set percentage of the growth in funding: 45 per cent next financial year and then 50 per cent the following year. Overall, the states are set to receive $16.4 billion more up to 2020.

However, we are yet to see any estimates of how much extra funding will be required to employ the bean counters set to infest our hospitals to ensure each episode of care attracts the maximal payola.

Down time for clinicians to complete the necessary paperwork will not be insignificant. A sound IT software program could diminish the load, whereas a substandard IT software program could greatly increase it, as we have found with FirstNet in New South Wales. There must be real clinician involvement in this and many other aspects of the brave new world if the outcomes from activity-based funding are to be positive for our patients, though as yet there are no such assurances.

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Doctors to provide reality check on hospital performance

BY **DR STEVE HAMBLETON**

"We will monitor and report on how the new pricing arrangements affect the Federal Government's share of public hospital funding compared with that from State and Territory governments"

The AMA has published an annual report card on the performance of public hospitals since 2007. The aim of the report is to provide a medical perspective on public hospital performance, by contrast with the many system performance reports released by Federal, State and Territory governments.

The dedicated medical practitioners who work in public hospitals know that the picture on the ground is very different to that painted by sanitised government reports.

The 2012 AMA Public Hospital Report Card will be challenging to compile now that the National Health Reform Agreement has set up myriad reporting measures, through various frameworks and reporting agencies.

The Economics and Workforce Committee is overseeing the selection of new items to report against in the AMA Public Hospital Report Card. The usual capacity measures will continue to be reported as a time series – total beds per 1,000 population; emergency department and elective surgery waiting times; throughput; and administrative staff as a percentage of total public hospital staff.

We know that the many ways in which State and Territory governments are planning to respond to, and implement, the new public hospital pricing framework will have an affect on public hospital services. State governments may well reduce the public hospital service offering in activity-based funding arrangements from July 2012 in order to maximise growth funding after 2014. The AMA will maintain a watch of 'lost' services and list them in future AMA Public Hospital Report cards.

We will monitor and report on how the new pricing arrangements affect the Federal Government's share of public hospital funding compared with that from State and Territory governments.

And we will keep a very close eye on the funding for teaching, training and research. There is a very real risk that this activity will be underfunded at a time when more money is urgently needed to provide quality training places for the increased numbers of medical graduates coming through the universities.

The AMA maintains that there must be no diminution in the quality of care provided to patients as a result of activity-based funding. Quality of care is difficult to measure and monitor through formal performance indicators.

The voice of the AMA members who are working on the ground is critical to the AMA Public Hospital Report Card. I need your views and stories about how the hospital pricing framework is implemented in your hospital and the impact it has on public hospital capacity, patient access to services and the quality of care.

TO COMMENT CLICK HERE

Doctor training bottleneck symptom of bigger problem

BY **DR WILL MILFORD**

It is with great enthusiasm and a touch of trepidation that I introduce myself as the new Chair of AMA's Council of Doctors in Training. It is with honour that I look forward to representing the interests and aspirations of both prevocational and vocational Doctors in Training (DiTs) nationally, carrying on the hard work of the previous Chairs. Coming from a leadership role within a College trainee committee, I hope to bring a fresh perspective to this position.

The next twelve to eighteen months promises to be a turbulent time for both current and future DiTs. I look to build upon the strong legacy left by previous chairs and consolidate the Council's position as the peak advocacy body for DiTs. The Council's priorities have recently been articulated in its strategic plan for 2012-13, which I urge you to read. It is available on the AMA website at ama.com.au/dit.

Three key goals for the Council for the next twelve months are:

- to optimise the AMA's working relationship with Health Workforce Australia to ensure that DiTs have a place at the table when it comes to determining policy solutions to the inevitable bottleneck in the training pipeline, as predicted by the Health Workforce 2025 report;
- to continue the Council's role as one of the policy powerhouses of the AMA and encourage ideas, innovation and thought among doctors in training, both within and outside the organisation; and
- to renew our contact with grassroots doctors in training members, reaffirming the benefits of DiT membership and developing a number of exciting membership tools.

Core to the business of the Council is training. The timely evolution of interns into independent medical practitioners is crucial for the ongoing delivery of healthcare to all Australians. While the Health Workforce 2025 report examined the training pipeline, this remains but one piece of the larger puzzle, and this bigger picture should not be forgotten.

The cornerstone of the 'training house' is funding. That no one can quantify how big this house is, how many occupy it, the dollars it consumes or can measure how well it works speaks volumes about the difficulty of this problem.

Many of the issues on the Council's agenda emanate from the central issue of funding. The origins of the shift to Doctor of Medicine programs can be found here (ably demonstrated by the Higher Education Base Funding Review), as can the looming shortages of clinical supervisors and clinical academics.

Significant research needs to be undertaken to produce meaningful funding models to encompass the spectrum of medical training, from student through to Fellow. Steps are being taken but they remain small and tentative. Promising moves toward the early development of key performance indicators for teaching and training are occurring, but the gestation looks to be lengthy. We fear that until substantial progress is made the funding of medical training will remain in its current vacuum.

It will be a time of significant change. There will be enormous opportunity to improve upon the strengths inherent in the current system. The Council hopes to ensure that the changes that will occur build positively upon the already high quality of training within the Australian setting, at both a prevocational and vocational level.

With those thoughts, I will leave you with this:

> "Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try."
>
> **Atul Gawande**, *Better: A surgeon's notes on performance*

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RESEARCH

Hope for spinal cord recovery

Scientists in Switzerland have restored full movement to rats paralysed by spinal cord injuries, opening the prospect of repairing the human spinal cord.

The scientists used a cocktail of drugs and a program of electrical impulses to stimulate neurons in the spines of the paralysed rats, who were able to begin walking and running after just a couple of weeks of treatment.

The treatment is the culmination of five years of investigation into how the brain and spine can adapt to injury. The combination of drugs and electrical stimulation strengthened the signals sent by the brain down the spinal cord.

"After a couple of weeks neurorehabilitation with a combination of a robotic harness and electrical-chemical stimulation, our rats are not only voluntarily initiating a walking gait, but they are soon sprinting, climbing up stairs and avoiding obstacles," Dr Gregoire Courtine from the Ecole Polytechnique Federal de Lausann said.

"This is the world cup of neurorehabilitation – our rats have become athletes when just weeks before they were completely paralysed. I am talking about 100 per cent recuperation of voluntary movement."

The treatment resulted in a fourfold increase in nerve fibres in the brain and spine.

Dr Courtine is optimistic that human trials will begin within the next two years.

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Doctors and scientists to share expertise for research, teaching and care

More than 10 universities, hospitals, research institutes and health centres are pooling resources and expertise to form a unique research alliance in inner Sydney.

In the first such organisation of its kind in Australia, the University of New South Wales and the University of Technology, Sydney, have joined with hospitals including the Prince of Wales, Sydney Children's Hospital, the Royal Hospital for Women and Prince of Wales Private, as well as the Black Dog Research Institute, Neuroscience Research Australia, Children's Cancer Institute Australia, the Eastern Heart Clinic and Southern Radiology, to form the Randwick-based Health-Science Alliance.

One of the Alliance founders, Professor Terry Campbell, said it was loosely modelled on similar organisations in the United States and Britain that brought together academics, researchers, clinicians and practitioners to advance research, as well as increase teaching and post-graduate training opportunities and enhance patient care.

Professor Campbell said the Alliance – whose logo invokes the memory of Howard Florey, the Australia Nobel Laureate who drove the development of penicillin – was founded upon recognition of the importance of collaboration in driving advances in research, treatment and teaching.

He said the organisation had its genesis in the decision by the New South Wales Government to fund the creation of eight research infrastructure hubs.

Professor Campbell said those in the Randwick hub, centred on the UNSW and nearby teaching hospitals, decided in late 2009 to form a research alliance bringing together not just hospitals and universities but also research institutes and medical practices, and a memorandum of understanding was signed late the following year.

He said the Alliance hoped to secure a substantial share of the $100,000 recently allocated by the NSW Government to each of the eight research hubs, as well as becoming the central conduit for research funding in the area.

"We hope that research funding will flow through the hub rather than go directly to individual organisations," Professor Campbell said.

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Life saving blood test for breast cancer patients

Researchers have found that a simple blood test can quickly diagnose whether a patient with early breast cancer faces high risk of death or relapse after treatment.

The University of Texas researchers discovered that the presence of tumour cells in blood samples taken during the early stages of the disease provided an accurate guide to a patient's chances of survival, and can assist in identifying which patients might benefit from additional treatment, such as chemotherapy.

The researchers said that the presence of one or more circulating tumour cells (CTCs) in the blood indicated the likelihood of an early recurrence of the disease and lower overall survival chances. The more CTCs that were found, the higher risk.

The researchers conducted tests in 302 breast cancer patients and found a quarter had CTCs. Of those, one in seven relapsed after treatment and one in 10 died during the test period. Patients whose blood test results showed no CTCs had a relapse rate of just 2 per cent.

CTC blood tests are not currently used to assess a patient's prognosis or prescribe treatment, as cancer tumours are generally thought to spread through the lymphatic system rather than the bloodstream.

The research was published in *The Lancet Oncology*.

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Bone breakthrough

Scientists have grown human bone from purified stem cells originating from fat, potentially leading to a more efficient way to regenerate bone.

The researchers took mesenchymal stem cells – which have the ability to develop into many other types of body cells - from a patient by liposuction and grew them inside a bioreactor to create living bone.

They then purified the cells and took bone grafts, which were then implanted in mice to assess their bone forming capacity. The purified stem cells formed significantly more bone in terms of potency, identity and purity compared with unpurified stem cells. They were also more predictable.

Scientists are looking to combine the technique with work being done by a collaboration of researchers to develop a three-dimensional scan to assist the fabrication of the bone in the right shape and geometry.

Professor Avinoam Kadouri, head of the scientific board for Israeli biotechnology company Bonus BioGroup, said that the three-dimensional scan technology would allow for bones to be grown outside the body and be transplanted into patients.

"By scanning damaged bone area, the implant should fit perfectly and merge with the surrounding tissue. There are no rejection problems as the cells come from the patient," Professor Kadouri said.

This technique could eventually allow doctors to replace shattered bones, fill in defects where bone is missing and carry out other reconstructive surgery.

The first trial in patients is scheduled for later this year.

Professor Kadouri said researchers were developing techniques to grow the soft cartilage at the ends of bones, which is needed if bones are developed in a laboratory.

Currently bone grafts involve transplanting bits of bone from elsewhere in a patient's body, and complications can arise from the extended operating time needed to collect the bone. The new technique of collecting stem cells from fat tissue is painless and poses minimal risk to the patient.

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CT scans (slightly) increase the risk of cancer in children

Children who get several CT scans have a slightly higher chance of developing brain cancer or leukaemia later in life, a study has found.

Drawing on a massive sample of almost 180,000 British children scanned between 1985 and 2002, the researchers found there were 74 cases of leukaemia and 135 cases of brain cancer in the group. The researchers estimated the radiation doses to individual organs and found that the more scans the children had, and the more radiation they received, the higher the risk of developing the potentially deadly diseases.

Children under 15 who had two or three scans of the head had triple the risk of brain cancer, and five to 10 scans tripled the risk of leukaemia. The researchers emphasised that the diseases were rare and the higher risk was still small. The risk of leukaemia in children is about one in 2000, and following CT scans it rises to about one in 600.

Lead researcher Dr Mark Pearce, from the University of Newcastle, said CT scans were warranted in most situations but more needs to be done to reduce the amount of radiation.

"CT scans are very useful but they also have relatively high doses of radiation when compared to X-rays," Dr Pearce said.

The researchers noted that modern CT scans give off about 80 per cent less radiation than the older machinery used in the study.

The findings underline the importance of Australian Radiation Protection and Nuclear Safety Agency guidelines that prohibit unjustified radiation procedures and require those that are performed to be conducted with the lowest possible exposure to radiation..

The findings were published in *The Lancet*.

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RESEARCH

Funds to tackle deadly Hendra virus

Griffith University researchers believe they are on the brink of developing a cure for the deadly Hendra virus amid fresh outbreaks of the disease in regional Queensland.

Scientists led by Associate Professor Nigel McMillan of the university's School of Medical Science are close to developing a therapy that prevents the virus from duplicating and spreading by "turning off" a vital gene.

"We have already been able to reduce Hendra virus in cells by 99.99 per cent within a laboratory, and we have found the treatment is highly effective in very low doses," Associate Professor McMillan said.

"If someone comes in who has been infected we will be able to give them a therapy which will turn off the virus, and the patient will recover naturally because the virus won't have the opportunity to spread," he said, adding it would give patients lifelong immunity to the disease.

The research is one of eight projects that will share in $3 million of Commonwealth grants in what is a timely injection of funds into Hendra virus research, which has been given renewed urgency following confirmation that properties near Rockhampton and Ingham have been infected.

Biosecurity Queensland has quarantined two farms where the outbreaks occurred.

No humans have so far been infected in the latest outbreak, but authorities are on edge given the infection's high fatality rate.

Since the virus was first identified in Australia in 1994, seven people have been infected with the disease and four of those have died.

Health Minister Tanya Plibersek said the eight projects to receive Commonwealth funding were aimed at increasing understanding of the virulent infection, improving its management and helping develop treatments.

The projects were developed in response to an urgent call for research into the Hendra virus issued recently by the National Health and Medical Research Council.

Five of the projects, worth $1.4 million, will examine possible diagnostic markers for the disease, as well as working on vaccines and potential anti-viral drug targets, while $1.6 million is being used to fund three studies examining immunological responses to the virus, as well as deepening understanding of how host organisms react to the infection.

Ms Plibersek said the research funding formed part of efforts to strengthen biosecurity defences "to protect the nation against Hendra virus".

Associate Professor McMillan said his research, conducted in collaboration with the CSIRO, also had the potential to treat the closely related Nipah virus, which has killed almost 250 people in south east Asia.

Like the Hendra virus, it has a mortality rate above 50 per cent.

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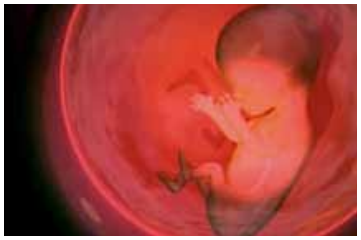
Genetic code of unborn baby mapped



Scientists have mapped the entire genetic code of an unborn baby using a blood sample from the mother and a saliva sample from the father, potentially allowing doctors to scan for genetic disorders before birth without physically disturbing the foetus or mother.

Scientists from the University of Washington were able to sequence the baby's genome as early as eight weeks after fertilisation, though they found the non-invasive technique worked best 18 weeks into the pregnancy.

Foetal DNA appears in the mother's plasma a few weeks after conception and makes up about 10 per cent of her plasma during pregnancy. The scientists isolated the cells from the foetus found in the maternal plasma and extracted its DNA. They used this material as well as DNA extracted from the father's saliva to sequence the entire genetic make-up of the unborn child.

The test is considered a safer alternative to current pre-natal genetic screening that involves tapping fluid from the foetal sac, or taking placental samples. These invasive methods can only identify a small number of birth defects, including Down's syndrome, spina bifida, cystic fibrosis and muscular dystrophy, and pose risks for both mother and child.

In the study, the scientists examined the DNA of babies following birth to test the accuracy of the new technique. The assessment showed that the new test accurately identified 39 of 44 de novo genetic mutations before the baby was born.

De novo mutations are not inherited and are responsible for a large number of genetic disorders. They are also thought to play a role in autism and schizophrenia.

The research was published in *Science Translational Medicine.*

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AMA members honoured on Queen's birthday

The AMA congratulates 22 members who received Queens Birthday honours in recognition of their outstanding contribution to medicine and the community.

The recipients are:

Dr Judith Teng Wah GOH – AO

Dr Keith George Hartman – AM

Dr Thomas Rex Henderson – AM

Professor Robert Siebrand Jansen – AM

Dr James Sunter Muecke – AM

Dr Ludomyr John Mykyta – AM

Clinical Associate professor Jonathan Rampono – AM

Dr Stephen Edward Andersen – OAM

Dr Don Maxwell Bowley – OAM

Professor Philip Rodney Clingan – OAM

Dr Joseph Latimer Davis – OAM

Dr Harry Alfred Derham – OAM

Dr Robyn Mary Horsley – OAM

Dr Catherine Adele Howell CSM – OAM

Dr Christopher St John James – OAM

Dr Johanna Maria Kovats - OAM

Dr David Henry McConnel – OAM

Dr James Herbert Martin – OAM

Dr Neville John Rothfield RFD – OAM

Dr Keith Milroy Whish – OAM

Dr Philippa Nancy Whish – OAM

Dr Raymond Frederick White – OAM

AO – Officer of the Order of Australia

AM – Member of the Order of Australia

OAM – Medal of the Order of Australia

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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:

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

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Hospital performance czar appointed

The Federal Government has appointed a Canadian health performance expert as watchdog of the country's hospital system, filling one of the key posts under its national health reform plan.

Dr Diane Watson has been selected to be founding chief executive officer of the National Health Performance Authority, charged with reporting on the performance of all local hospital networks, public and private hospitals and primary healthcare organisations across the country.

Dr Watson brings to the position extensive local and international experience in assessing and disclosing the performance of health services, including in her most recent role as inaugural chief executive officer of New South Wales' Bureau of Health Information, which provides publicly available reports on healthcare in the state.

Prior to moving to Australia in 2009, Dr Watson was director of research and analysis at the Health Council of Canada, which was established to monitor and report on the performance of the Canadian health system.

In her work, Dr Watson has created health system performance reports with the Canadian Institute for Health Information and Statistics and in 2005 she was a Harkness Fellow in the International Health Policy Program with the Commonwealth Fund.

In her most recent update as Bureau of Health Information chief executive, Dr Watson said the quality of healthcare provided in NSW compared favourably with that of other countries, including the United Kingdom, Switzerland and New Zealand.

But she highlighted shortfalls in the care provided to patients with chronic conditions, particularly the fact that only about half had a regular GP who knew them, was familiar with their health history and was readily accessible, warning that this gap in the system led to much higher rates of hospitalisation and emergency treatment than in comparable countries such as France.

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INFORMATION FOR MEMBERS

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

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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Obamacare funding blow

US lawmakers have voted to repeal a tax intended to help pay for the Obama Administration's controversial health care plan just days before a crucial Supreme Court ruling on the reform's legality.

The US House of Representatives has voted almost two to one in favour of repealing a 2.3 per cent excise tax on medical devices, which was expected to raise $US29 billion ($A29.16 billion) in the next 10 years to help fund the boost to healthcare coverage called for in the Patient Protection and Affordable Care Act.

Medical device manufacturers have lobbied hard to have the tax, which was part of the original Obamacare package, repealed, claiming it would put 43,000 jobs in the industry at risk.

When the repeal motion was put to the vote early this month it received support from both Republicans and Democrats, and in states like Massachusetts that have significant medical technology industries, political candidates of both major parties have pledged to oppose the excise.

The tax was proposed on the grounds that, under Obamacare, an extra 30 million people would gain health coverage, substantially increasing the market for medical devices, and this advantage would be only partially offset by the modest excise.

But although the House of Representatives has voted to repeal the tax, it is far from dead, according to business analyst firm GlobalData.

In a report to clients, it said there was a "good chance" the US Senate will not even have the opportunity to repeal the excise, not least because Senate Majority Leader Harry Reid, a Democrat, has said he will not present it for a vote.

Even if Senate endorses the repeal Bill, senior White House aides have urged President Barack Obama to veto the repeal, according to GlobalData analyst Derek Archila.

The controversy comes as both sides of the healthcare debate prepare for the outcome of a constitutional challenge to the Patient Protection and Affordable Care Act before the US Supreme Court, which is due to make its ruling by the end of June.

Opponents of the scheme have questioned the power of the federal government to require people to take out a minimum level of health insurance, the so-called individual mandate provision in the Act.

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Diesel fumes cause cancer: WHO

Diesel fuel exhaust causes cancer and emission standards must be tightened, according to a landmark ruling by the World Health Organisation.

A panel of experts appointed by the WHO has declared that diesel exhaust causes lung cancer and is associated with an increased risk of bladder cancer, and has called on governments to act to curb the exposure of workers and the broader population to diesel pollution.

The experts, part of an International Agency for Research on Cancer Working Group, found the accumulation of evidence demonstrated that "diesel exhaust is a cause of lung cancer, and also noted a positive association with an increased risk of bladder cancer".

The ruling came 24 years after the Agency first warned that diesel exhaust was "probably carcinogenic to humans", and 14 years after an advisory group recommended that re-classification of the pollutant be made a high-priority.

Working Group chairman Dr Christopher Portier, who is a director at the US Centers for Disease Control and Prevention, said the evidence was "compelling", and action should be taken to reduce the health threat posed by diesel exhaust.

"The scientific evidence was compelling, and the Working Group's conclusion was unanimous: diesel engine exhaust causes lung cancer in humans," Dr Portier said. "Given the additional health impacts from diesel particulates, exposure to this mixture of chemicals should be reduced worldwide."

The WHO said that although advances had been made in recent years to cut the sulphur content of diesel fuel, improve the efficiency of diesel engines and reduce emissions through exhaust control technology, there was as yet little evidence about how beneficial these changes might be to human health.

And it warned that many of these improvements were limited to advanced countries, and diesel fuel technology and emissions were largely unregulated in much of the developing world.

"Existing fuels and vehicles without these modifications will take many years to be replaced, particularly in less developed countries, where regulatory measures are currently also less stringent," the WHO said.

The WHO said the ruling would give governments a "valuable evidence-base" for developing environmental standards for diesel exhaust emissions, and to encourage further innovation by engine and fuel manufacturers.

Agency director Dr Christopher Wild said the Working Group's evaluation was a call for governments to act.

"[The] conclusion sends a strong signal that public health action is warranted," he said. "This emphasis is needed globally."

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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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DeLorean DMC-12 - Back To The Future

BY **DR CLIVE FRASER**

DeLorean DMC-12

In the 1980s Northern Ireland was still deeply embroiled in what came to be known as "the Troubles".

With so much political turmoil, Ulster was always going to be an unlikely place to set up a factory to manufacture a brand new supercar.

But it was in Dunmurry that an adventurous engineer named John DeLorean set up a factory to build his namesake vehicle.

DeLorean had made a sparkling entry into automotive engineering with a 1964 project to build what was probably the world's first muscle car, the Pontiac GTO.

The success of that model propelled him into automotive stardom and ultimately led to his push in the 1970s to create an all-new car carrying his own name.

With 304 grade stainless steel skins over fibreglass body panels and gull-wing doors the DeLorean DMC-12 was unique, and the styling was still fresh in 1985, 1989 and 1990 when the car featured in the *Back To The Future* film trilogy.

While the styling of the car was futuristic, its Achilles heel was its powerplant.

In the movies the DMC-12's flux capacitor was capable of producing "1.21 gigawatts" of power.

In real life, the DeLorean struggled with a Renault-made 2.8 litre, V6 engine producing only 110 kilowatts.

This was exactly the same engine that powered the Volvo 760.

Once emission controls were applied for the US market, the engine's power dropped to only 95 kilowatts, and the lacklustre performance meant the DeLorean couldn't reach the speedometer's top speed of 85 miles per hour.

Hollywood upped the ante by claiming that Doc's DeLorean would need to reach 88 mph to travel back in time.

In the 1980s a new DeLorean would set you back $US25,000 ($63,900 in today's dollars).

It has been 30 years since the last of 9200 DeLoreans left the production line, but miraculously you can still buy a new DeLorean from an enterprising Texan firm.

Pricing starts at $57,500 for a car based on a new stainless steel chassis.

The "new" cars are made up from what is called new/old stock, original equipment and reproduction parts.

It is possible to specify a high performance engine, satellite navigation and Bluetooth in your 2012 DeLorean, or you can go back to the future and keep your newly constructed DeLorean just as it was back in 1982.

DeLorean DMC-12	
For	The best looking car of all-time
Against	Slow, and it is hard to keep fingerprint marks off the stainless steel
This car would suit	Time travellers
Specifications	2.8 litre 12 valve V6 petrol 110 kW power 0-60 mph 8.8 seconds (Europe) 95 kW power 0-60 mph 10.5 seconds (US) 5 speed manual or 3 speed automatic $25,000 US in 1982 $57,500 US in 2012

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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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

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