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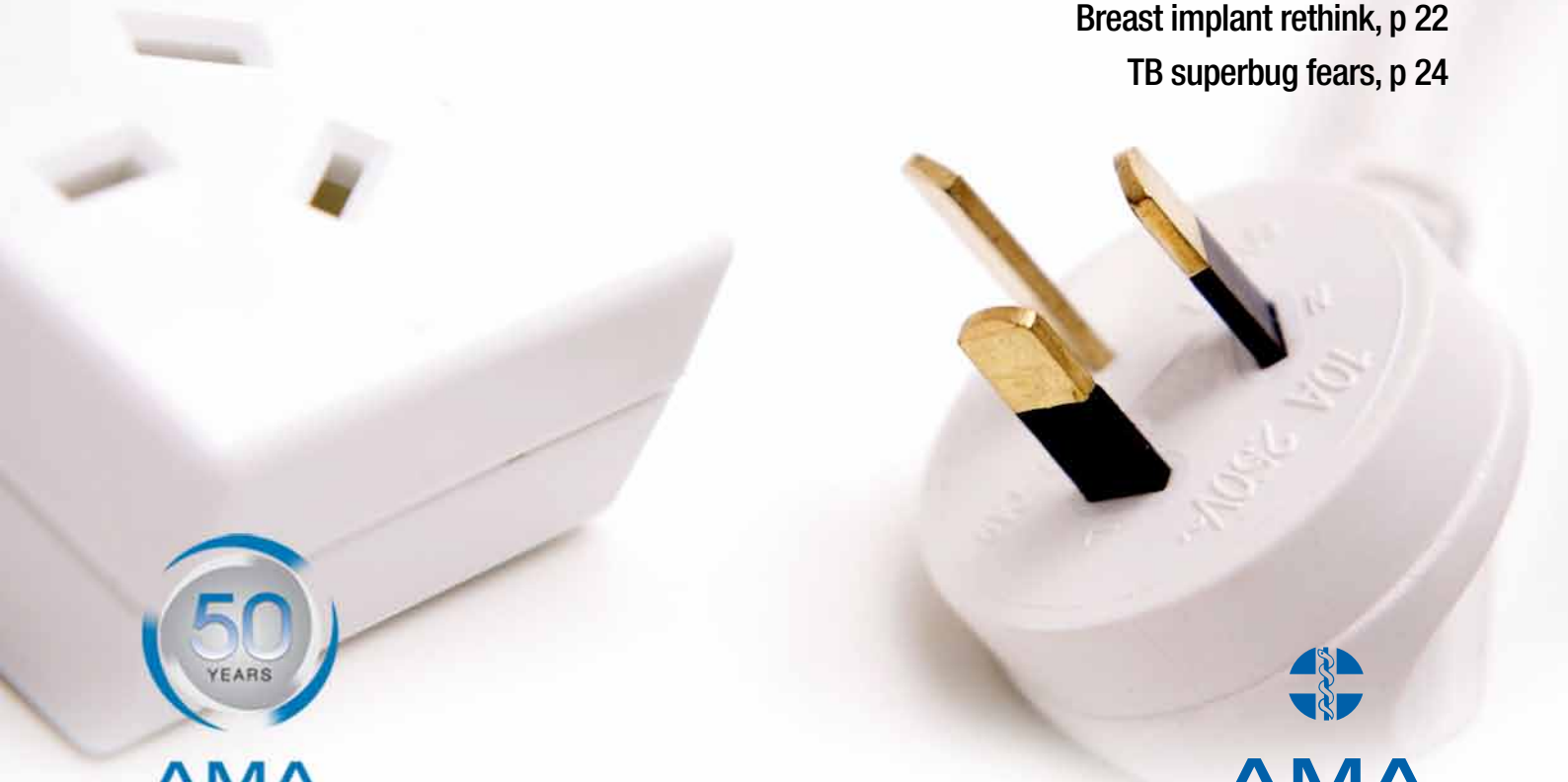

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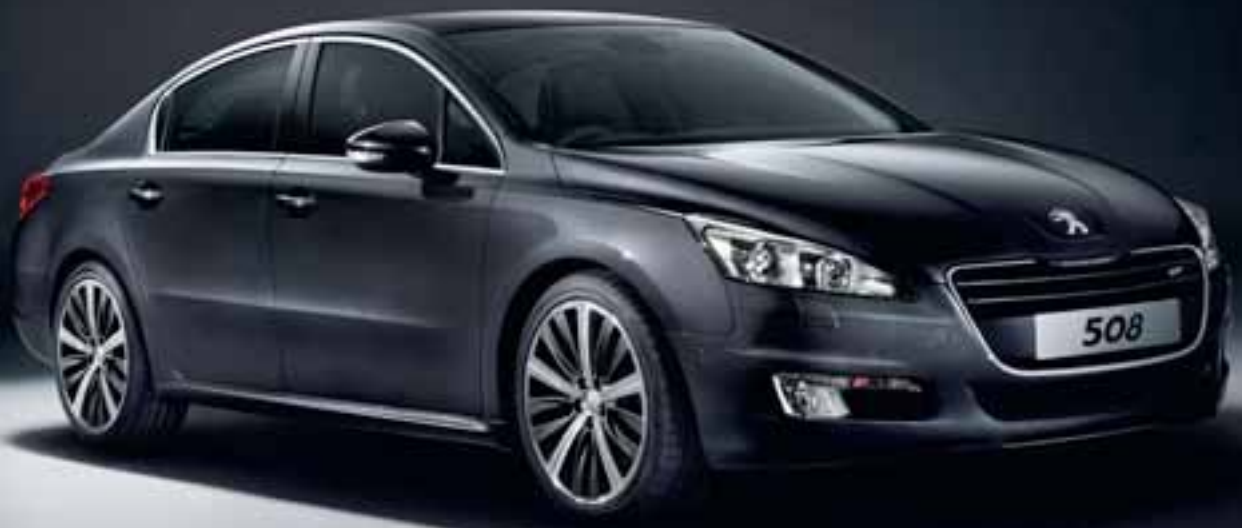

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Production Coordinator: Kirsty Waterford

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

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

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Five years on and health reform remains a moot point

BY AMA SECRETARY GENERAL FRANCIS SULLIVAN

Five years on and health reform remains a moot point. As a matter of fact, what was originally Kevin Rudd's challenge to State governments to smarten up the administration of public hospitals quickly morphed into a wide-ranging canvass of reform proposals that were eventually settled through a protracted and complex set of intergovernmental agreements on health care.

They encompass far more than the funding of public hospitals. General practice, aged care, disability services and governance matters complement the new funding and performance mechanisms for public hospitals. In essence, they reflect the power balance between the Commonwealth, the States and Territories. Taxing powers, above all, skew this balance in the Commonwealth's favour, but the agreements keep the management of hospitals with the States.

For some this seems a neat solution, but for others, including the COAG Reform Council, it is far from satisfactory.

Does this outcome come near to addressing Rudd's challenge? Will this improve the administration of public hospitals? Will those States and Territories with declining revenue bases be able to adequately fund their hospitals and develop a sustainable workforce? Or did the country miss an opportunity to put the health system on better footing?

The COAG Reform Council's first set of reports throws little light on these questions. The National Healthcare Agreement charges the Council to report on the performance of State and Territory governments in return for their Commonwealth funding. Despite the Council's qualification that "the full benefits of health reforms for Australians will be reflected in future years", their report presents a very underwhelming narrative of improvement.

The most glaring finding is that public hospitals are still too short of beds. With an ageing population, the option of hospitalisation is integral to the overall safety net for the elderly. Sub acute beds were earmarked for development, but precious few have emerged. Waiting times have blown out rather than decreased. Emergency department efficiencies still lag well below the targets set in the National Healthcare Agreement. Elective surgery wait times have worsened overall.

In general practice, the reported waiting times to see a GP improved in 2010-11. This is heartening. So too is the Council's finding that GPs are affordable and accessible. Interestingly, these results indicate that major reforms to general practice are not warranted. Rather, they definitely indicate that a prudent primary care reform agenda would build on what works, not seek to substitute what is demonstrably a good, effective and affordable system.

The policy architecture of the health reforms was based on a shift in demand from hospitals to primary care services, the assumption being that public hospitals could cope with the demand for those services that genuinely belong in a hospital. Patients that go to emergency departments rather than GPs, and elderly patients that should be catered for in the community, need to be accommodated beyond the hospital walls. To that end casemix payments for hospitals and patient redirection through programs run by Medicare Locals are meant to achieve these changes.

But while the design may have merit, unfortunately the fundamental building blocks remain bedevilled by dual governmental responsibilities. The blame game remains alive and well. Even the Commonwealth's desire to have Lead Clinician Groups involved in hospital management has been widely rejected or paid lip service to in most States.

So the path to substantial reform is hard. Little confidence can be drawn from the fact that despite a new hospital funding agreement being struck, it took little time for Tasmania to claim that they couldn't meet the demand for services and in fact cut hospital funding to meet broader budgetary pressures. This is exactly the point made by Kevin Rudd when the first set of funding proposals were laid on the table. The Commonwealth needs to contribute more to the hospital funding pool, and the streamlining of funding responsibilities should be brought back on the table.

With the Hospital Pricing Authority and the Health Performance Authority commencing work, the focus of attention may well fall again on the capacity of hospitals and the inadequacy of funding. It will not be enough to dismiss these as either 'teething problems' or issues for another time. Despite the amount of funding that has been introduced in the healthcare agreement, the public hospitals are far from 'fixed' and Australians will continue to press for reforms that make a difference.

TO COMMENT CLICK HERE

Booze and sport don't mix

AMA President Dr Steve Hambleton has criticised the Federal Government for its refusal to contemplate a ban on alcohol advertising, particularly in sport.

Dr Hambleton said big sporting organisations were very influential and should not be involved in associating drinking with a healthy lifestyle.

The AMA President's comments came after Federal Health Minister Tanya Plibersek ruled out suggestions of a ban on alcohol advertising similar to that imposed on tobacco.

The AMA had earlier welcomed a decision by the Federal Government to set up a $25 million fund to provide an alternative source of revenue for sporting groups that reject alcohol sponsorship.

But Ms Plibersek said that although the fund would help convey the message that binge drinking was not part of being a successful athlete, the Government was not interested in "over-the-top" policing of alcohol advertising.

"I think banning alcohol sponsorship is a step too far," she said on Sky television. "We know that a lot of sports depend on alcohol sponsorship."

The Minister said the Government was not contemplating moves to restrict alcohol advertising similar to the ways in which it had cracked down on tobacco advertising.

"There's a big difference between alcohol and tobacco," Ms Plibersek said. "You can have safe consumption of alcohol. You can't have safe consumption of tobacco."

Dr Hambleton said he was disappointed by the Minister's "simplistic" comments.

"It is too simplistic to say that there is a safe level of consumption of alcohol, because if you are under 18 or if you are pregnant, there's no safe level," he said.

Dr Hambleton applauded the establishment of the Community Sponsorship Fund – which draws on proceeds from the alcopop tax – as an important initiative to help tackle binge drinking.

So far 12 major sporting organisations, including Football Federation Australia, Netball Australia and Swimming Australia, have signed up to the program, under which they will share $25 million in Government funds in exchange for foregoing alcohol sponsorship.

But so far neither of the nation's major football bodies, the Australian Football League and the National Rugby League, has signed up to the fund, which Dr Hambleton warned would limit its impact.

"Young people, in particular, are easy targets of alcohol promotion at sporting and cultural events that portray drinking as part of a healthy lifestyle," he said. "The involvement of key national sporting organisations is vital [because] they are high profile role models."

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INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

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PCEHR starts with a whimper, not a bang

The Federal Government's much-heralded electronic health system has officially begun operations, but for a scheme with a $470 million price tag it has so far proved to be almost invisible.

From today patients can register to get a personally controlled electronic health record (PCEHR), but only if they contact a Medicare call centre or go in person to a Medicare office. The ability to register online, Department of Health and Ageing officials admit, is still some time off.

For practitioners, access to the scheme is even further away, and the AMA is warning members to consider carefully the cost in time and money involved – let alone outstanding concerns regarding the integrity and reliability of the electronic health records themselves – before deciding whether or not to participate.

The AMA, through President Dr Steve Hambleton, has been vocal in highlighting significant shortcomings in the Federal Government's scheme, and is concerned that even many Government MPs do not understand the system.

Dr Hambleton said that during a Senate debate last month, several Labor senators talked about the scheme as though it was providing a shared electronic health record, which was far from what it will in fact do.

"What they were talking about is a shared health record," the AMA President told The Australian. "[But] this is not a shared health record. It's a personally controlled e-health record that contains a point-in-time health summary which is curated by a nominated health provider.

"The senators were talking as though this is a real-time, online, live shared health record and suddenly we'll have everyone's records available to everyone who needs them. That is not what's going to happen."

The AMA has long supported the development of reliable and secure electronic health records that give practitioners and patients an accurate and up-to-date summary of ailments, treatments, tests and medications.

But the system being implemented by the Government falls far short of this ideal.

"The AMA's wish for shared electronic heath records all along has been for doctors to have access to all the necessary clinical information," Dr Hambleton said. "Patient safety and the quality of care will be improved if treating doctors can access and contribute to electronic medical information about the patients they are treating.

"Unfortunately, the PCEHR has been designed in a way that can work against this - patients might not sign up, might not give access to their treating practitioner, or might take information off.

"We can only hope that, in the best of circumstances, patients sign up, give widespread access to treating clinicians and respect the information that medical practitioners upload in their best interests."

Under current arrangements there is little incentive for doctors to sign up to the scheme, and plenty of reasons not to.

In an effort to get doctors to participate, the Government has threatened to withdraw e-health Practice Incentive Payments worth up to $50,000 a year from practices which have not signed up to the PCEHR scheme by February next year.

But Dr Hambleton is scathing of the threat, not least because the system is far from ready to accommodate practitioner participation.

The Government has made much of the success of its e-health PIP program, which it claims has led to IT upgrades in 96 per cent of practices sufficient to make them "e-health ready".

But the AMA President said most GPs would not know if their practice software was compatible with the Government's system, and faced significant expenses if it wasn't.

"The fact is, in the practice where I'm working, our software isn't compatible," he said. "If we're going to participate in the PCEHR we'll need to change software, and that's a huge undertaking."

"While a shift in the Government's position on the issue would be welcome, it does not address the underlying concern that the system being introduced has fundamental flaws"

In a message to AMA members sent out last week, Dr Hambleton itemised the steps practices would have to take in order to prepare themselves to use the PCEHR.

The 10 steps include purchasing and installing Individual Healthcare Identifier-enabled software, purchase and install a secure messaging system, purchase and install PCEHR software, put in place administrative protocols that conform with PCEHR legislation, train staff and medical practitioners, check indemnity cover and possibly upgrade practice insurance and implement fees to cover the costs incurred in becoming PCEHR ready and compliant.

Dr Hambleton and other AMA officials have put the case directly to Health Minister Tanya Plibersek that the date at which e-health PIP payments are withdrawn for non-participating practices should be pushed back at least a year to early 2014 in recognition of the significant

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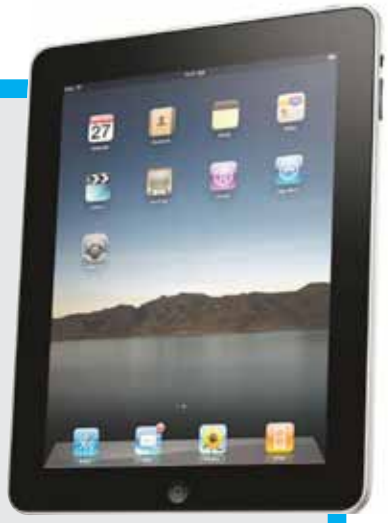

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The AMA Member-only survey can be completed online at

http://www.surveymonkey.com/s/7YN7Z5L.

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PCEHR starts with a whimper, not a bang

CONTINUED FROM PAGE 6...

work involved for practices in getting prepared for the system, and that there be extra Medicare payments to compensate doctors for the additional work they will need to undertake to prepare and maintain quality, useful shared health summaries for the PCEHR.

At a meeting with Dr Hambleton and other United General Practice Australia leaders last week, Ms Plibersek stuck firm to the Government's timetable for the roll-out of the PCEHR, but was more open to concerns about changes to the e-health PIP arrangements.

The Minister told the meeting she was hearing "significantly conflicting views" about the work involved in preparing shared health summaries for the PCEHR.

Ms Plibersek indicated that although the roll-out of the system would continue as planned, she would take further advice about the e-health PIP changes.

While a shift in the Government's position on the issue would be welcome, it does not address the underlying concern that the system being introduced has fundamental flaws.

"The PCEHR has practical clinical limitations for medical practitioners in the treatment of patients in respect of the content, accuracy, and accessibility of the information," Dr Hambleton said. "[And] the AMA would have preferred the PCEHR to be an opt-out system, rather than opt-in, to ensure the success of the system in healthcare delivery."

The Draft AMA Guide to Using the PCEHR is at http://ama.com.au/node/7648

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GP infrastructure grants value for money

"The auditor also criticised a compliance-driven approach to assessing applications, and inconsistencies in the way selection criteria were applied, leading to unfair outcomes"

Government grants to upgrade existing medical practices offer far better value for taxpayers than the expensive and troubled GP Super Clinics program, a report by the official auditor shows.

AMA President Dr Steve Hambleton said an inquiry into the Primary Care Infrastructure Grants Program by the Australian National Audit Office found that under the $117 million scheme, 74 practices had already been upgraded, while work on a further 108 was currently underway, and there was potential for another 190 projects to be funded.

"There is strong demand for the grants, which means that local GPs in private practice are in for the long haul and want to provide their patients and communities with more and better services," Dr Hambleton said. "They should not have to compete with Government-subsidised competition from GP Super Clinics where they are not needed."

The Audit Office found that the Department of Health and Ageing had made "steady progress" in implementing the scheme, which was introduced in 2010 to fund upgrades to about 425 existing general practices as a way of reducing chronic disease, cutting hospital admissions and reducing health inequality by boosting primary health care.

The official auditor found 214 practices shared grants worth $54.4 million in the scheme's first funding round in 2010, with a further 66 so far receiving $19.1 worth of grants for the 2011 round. The ceiling for individual grants was set at $500,000.

By contrast, the Federal Government's $600 million GP Super Clinics program has struggled.

As at May just 24 of the promised 64 clinics were operating, with nine not expected to open until 2015-16.

Among the problems bedevilling the program, a clinic planned for Sorrell in Tasmania was scrapped because of cost blowouts, a planned clinic in Townsville has been delayed by problems in finding premises and a $5 million clinic in Cairns is operating at less than 20 per cent capacity and is not expected to become fully operational until 2014.

Dr Hambleton said the audit report showed that investing in existing local general practices was much smarter than importing expensive, poorly-planned "white elephants" that drain vital funds from the health system.

The Audit Office said the department had successfully developed guidelines for the Infrastructure Grants program "within a very compressed timeframe" and had taken appropriate measures to introduce the scheme in the limited time available to it.

But it identified problems in how grant applications were being assessed.

The auditor said the selection criteria used by the department were heavily weighted toward physical infrastructure works and away from the other objective of the program, improving access to new primary care services.

It found proposed infrastructure works were accorded a weight of 64 per cent of the total assessment score, while the potential to provide new services was given a 26 per cent weighting.

"While there is no requirement to inform applicants of the weightings to be given to criteria, it does help applicants to shape their submissions if they were aware that selective weightings will be applied," the audit report said.

The auditor also criticised a compliance-driven approach to assessing applications, and inconsistencies in the way selection criteria were applied, leading to unfair outcomes.

It found that in a sample of 105 applications, three applications were rejected that would have been shortlisted with a more consistent approach to assessment.

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Grant opens door to practice efficiency

Brian Morton and Nurse Juliet Grant in refurbished treatment area

The old storage room

The old treatment room

For Brian Morton and his colleagues at the small Northbridge Medical Practice in Sydney's northern suburbs, the shortcomings of their premises were beginning to grate.

Limited areas for treatment, a shortage of consulting rooms, outdated computers and tired beds meant that the practice was, as Dr Morton put it, "not very efficient".

So when the Federal Government offered grants to help pay for clinic upgrades, Northbridge was among 280 practices to apply.

Little more than 12 months and $153,000 later, Dr Morton is chuffed with the results.

The renovations involved demolishing three cramped and ill-suited rooms used for treatment, storage and utilities into a large and well-equipped treatment area complete with electric height adjustable beds, an extra consulting room, a dedicated area for minor surgical procedures, and upgraded desktop computers.

After barely being used before the upgrade, the enlarged and improved treatment area is now a hub of activity as Dr Morton and the practice's seven other doctors, together with a complement of nurses, make full use of the new facilities without the delays and waiting times caused by the old set up.

"The efficiency gains and the [ability to make] increased use of the nurses has been invaluable," Dr Morton said.

According to the GP, the process of obtaining the grant and getting the work done was relatively painless, attributing much of the success to his practice manager, Deb Whiley.

"Having a practice manager is terrific, because she had the expertise and the time to do it," he said, praising her for her initiative in hiring an outside adviser to help draw up the grant application.

Ms Whiley said there was an "enormous amount" of documentation required to apply for the grant, and subsequently account for the way it was spent, but expert guidance by Department of Health and Ageing staff and report templates it provided had greatly smoothed the process.

"I didn't find it particularly onerous," Ms Whiley said. "There is a huge amount of documentation involved in the process, but I didn't think it was unreasonable, and it was not difficult to get through."

Work began on the application in May 2011, when Ms Whiley hired a consultant who had previously prepared a successful grant application for a practice on the central coast.

The application was submitted just before the closing date for the second round of Primary Care Infrastructure Grants in June last year, and the practice was informed its request had been shortlisted for approval in late November.

During this time architects and designers were engaged to prepare plans and, once the grant was approved in January this year, the deposit on the building contract was paid.

The grant itself was paid in three instalments, the first soon after approval was granted, the second while works were underway and the final payment upon completion in early June.

Ms Whiley said the practice had to make an initial outlay to cover fees for the consultant, architect and designers, as well as to pay the building contract deposit.

But once the grant funds began to flow, they arrived in a timely manner, she said.

According to Dr Morton, the results of the upgrade show that for a relatively small investment of taxpayer funds, the Government can achieve significant improvements in the delivery of health care.

"What we have got for the money is fantastic," he said. "It is very clear that spending government grants on renovating existing practices gives a far better bang for your buck than a Super Clinic can ever be."

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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 on prominent issues including electronic health records, alcohol sponsorship of sport, obesity, medical training and mental health checks for pre-school children, President Dr Steve Hambleton attended the AMA Council of General Practice's annual two-day conference and met with Health Minister Tanya Plibersek – along with other leaders of United General Practice Australia – to push for changes to the implementation of the personally controlled electronic health records scheme, highlight concerns about changes practice incentive payments and argue for a boost to general practice training.

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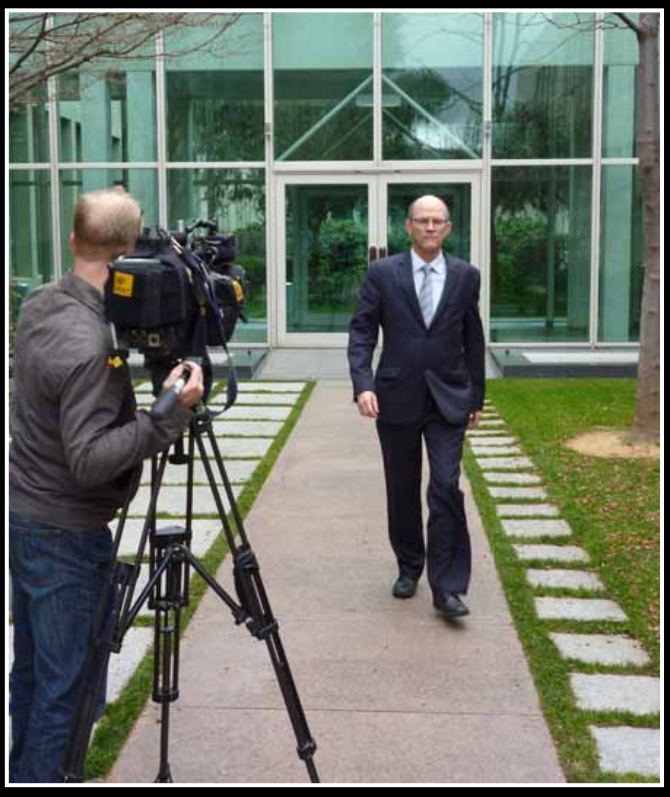
AMA President Dr Hambleton at the recent AMA Council of General Practice meeting

Health Minister Tanya Plibersek met with AMA President Dr Steve Hambleton and United General Practice Australia members

AMA President Dr Steve Hambleton talking to the media at Parliament House



AMA President Dr Steve Hambleton fronts the media at Parliament House

GPs need voice in Medicare Locals

The nation's peak independent national council for GPs has raised "serious concerns" that local doctors will be sidelined from involvement in key healthcare decisions under the Federal Government's Medicare Locals program.

The AMA Council of General Practice, which met in Canberra late last month, has set reforms to the delivery of primary health care – particularly the implementation of Medicare Locals – high on its agenda.

AMA President Dr Steve Hambleton, who is a Brisbane GP, said the Council would push for a more active role at the local level to support GPs in the emerging Medicare Locals environment.

"The AMA has serious concerns about the direction of Medicare Locals and the absence of meaningful GP involvement in their governance structures," Dr Hambleton said. "Medicare Locals are replacing the former Divisions of General Practice and there are genuine fears that medical leadership in primary care decision-making at the local level will be watered down."

The Government is establishing a national network of 62 Medicare Locals to coordinate primary health care delivery and tackle local health care needs and service gaps.

The Government's ambition is that Medicare Locals will drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities.

But the AMA Council of General Practice, chaired by Dr Brian Morton, is driving to make sure local GPs are well represented in the process.

Dr Hambleton said the Council reinforced that "the AMA is the only body equipped to provide independent high quality nationally-coordinated political and policy advocacy for all GPs.

"Local GPs need assurance that their interests are being protected and championed by a strong voice in Federal health politics – and that voice is the AMA."

At its meeting, the Council also identified a number of priority areas in which the views of GPs will be advanced in the lead-up to the next Federal election, including boosting the teaching capacity of general practices, ensure better support for general practices delivery mental health care, securing payments in recognition of the additional work GPs will be required to undertake to implement personally controlled electronic health records and advancing the AMA Complex and Chronic Disease Plan.

At its meeting, the Council elected a new executive.

It confirmed Dr Morton as chair, while Dr Cathy Hutton was elected deputy chair and Professor Bernard Pearn-Rowe was made Convenor. Other members of the executive elected were Dr Richard Kidd, Dr Barri Phatarfod, Dr Shaun Rudd, Dr Peter Beaumont and Dr Chris Clohesy.

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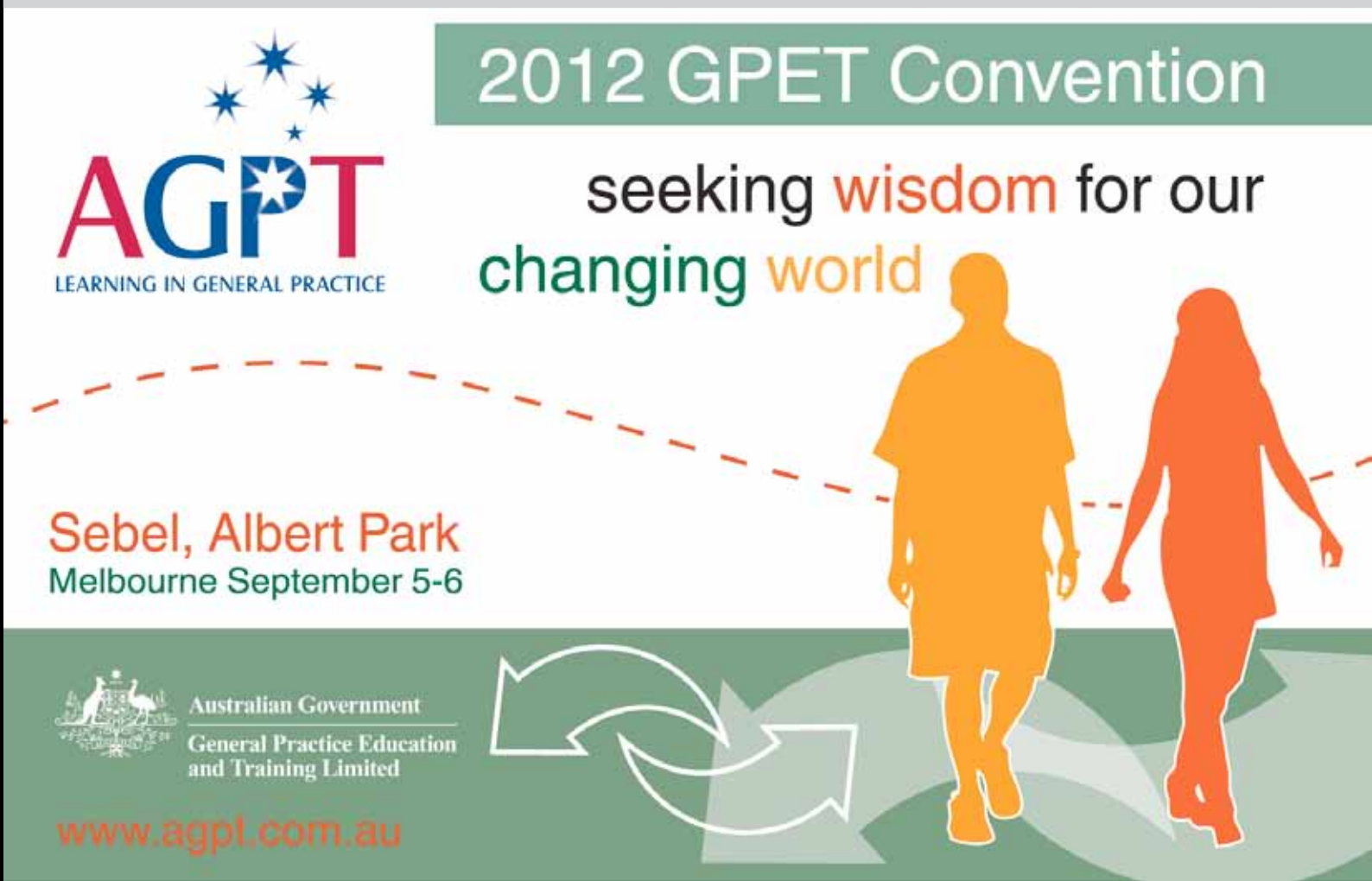

No sign of an end to Fluvax ban for young children

A ban on giving the influenza vaccine Fluvax to young children has been reaffirmed following an investigation into convulsions associated with the medication.

Drug company CSL Biotherapies, which manufactures Fluvax, said it supported a continuation of the decision taken by health authorities in 2010 to withdraw the license for the vaccine to be given to children under five years of age.

The ban was slapped in place following evidence that up to seven in every 1000 children inoculated with the vaccine suffered fever-related convulsions.

CSL admitted that a two-year investigation, monitored by the Therapeutic Goods Administration and the Food and Drug Administration, showed that Fluvax probably triggered febrile fits in some children.

But the company said it was still some way from definitively determining why its vaccine caused such a severe reaction.

Earlier this year it was revealed that a several young children have been inoculated with Fluvax despite the 2010 ban, with one confirmed case of severe adverse reaction and two suspected cases.

AMA President Dr Steve Hambleton, who was AMA representative on the National Immunisation Committee, said that although it was unacceptable that children had been given an unlicensed vaccine, people should be confident in the effectiveness of systems to monitor and detect adverse reactions caused by vaccines.

"It is very important that we have rapid alert systems in place for adverse events," Dr Hambleton said. "This [Fluvax case] was an extreme event. The system is pretty good, but we need to make sure we are as good, if not better, over time."

In a preliminary finding, CSL said its method of manufacturing Fluvax meant its vaccine retained more virus components than did those of competitors, and the characteristics of the 2010 virus components "elicited an excessive immune response in some young children, triggering increased fever and fever-related convulsions".

CSL's Vice President of Medical and Research, Dr Darryl Maher, said that although vaccines must contain components of the virus to stimulate antibody protection against influenza, "it appears that components of the virus retained in Fluvax 2010 over-stimulated the immune systems of some young children".

Dr Maher said further work was being undertaken to understand how the reactive virus components of Fluvax contributed to the "adverse events" suffered by children in 2010, and make changes to reduce the risk of this reoccurring.

"There is more work to do, but we have made substantial progress," Dr Maher said. "[But] until these further studies are complete, and both CSL and the regulators are fully confident that our manufacturing process can consistently produce a safe and effective influenza vaccine for children, we will continue to fully support the age restrictions currently in place."

Fluvax is not licensed for children younger than five years, and is only recommended for children between five and nine years if they are judged to be at risk from the infection and there is no other licensed influenza vaccine available.

There are no similar restrictions in place for its use in older children and adults.

A review by the Australian Technical Advisory Group on Immunisation determined that Fluvax had an "acceptable safety profile" in people aged 10 years or older.

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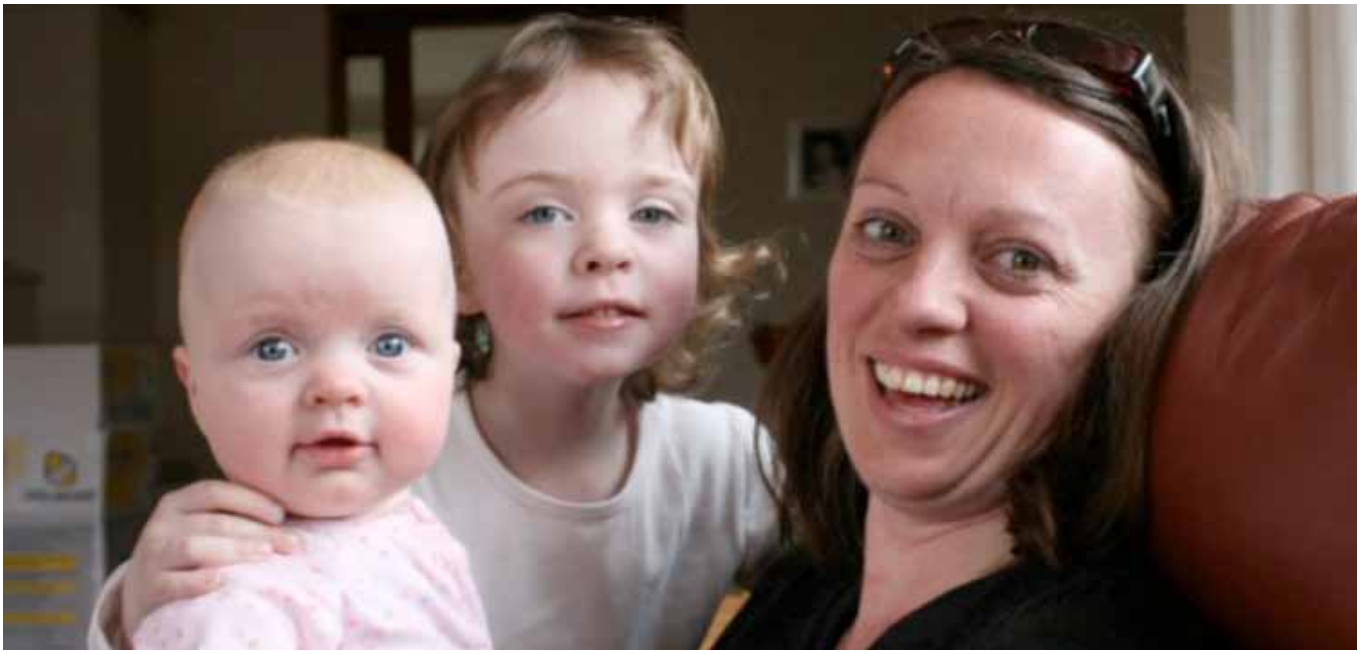
My Life As a GP



Dr Amanda Howard
Bombala, NSW

Life for me is usually more about being a mother, but every Thursday morning I and my two girls – one four years old, the other 15 months - drive two hours south of Canberra to the tiny yet important town of Bombala, where I work as a "rural" GP for two days.

I have been working for almost eight years in this town – it sounds a long time, yet I am a newcomer. Why do I work in Bombala? It is a caring community of about 1500 people who work (and play) hard, and who value me. I have left for maternity leave twice now and each time I return, I feel more cherished than before. My "boss" values me – it is the only way he can leave town.

The essentially solo nature of my work has obvious downsides but it has meant that I can make decisions alone, without another questioning or arguing. I realise that for some, this is frightening, but this is the medicine I love!

Why a GP? I admit I still get great excitement from wondering, "what will come through the door next?" and enjoy thrill of not knowing what the day will bring.

But even more than this, it is the opportunity to be so many things to so many people. Last week I was the *cheerleader* for a 58-year-old woman who is trying to wean herself off sedatives (and doing well); the *advocate* for a 63-year-old woman receiving chemotherapy who needs to receive it closer to home rather than drive to Canberra each week; the *counsellor* for the 31-year-old who had a miscarriage after receiving fertility treatment for more than two years; the person who provided reassurance for the 49-year-old man with haematuria, who burst into tears when I revealed that a scan showed the cause was a large renal stone rather his presumed renal cell carcinoma; I was the *emergency physician* for the 94-year-old man who presented with cyanosis and pleuritic chest pain; I was the *interpreter* for new parents of a thriving four month old who were concerned her facial rash may mean food allergy, when cradle cap is a simple problem to solve. And that was only part of the morning!

When deciding upon general practice training, a mentor motivated me by the different places a GP can work – rural, urban, city, regional, remote, overseas, in an embassy, on an ocean cruise! Yet for me now, the thrill remains not the location but the variety of people I meet and the different roles I perform for each. It continues to be an adventure!

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General practice a gateway to a rewarding and balanced life

Dr Tim Ross
Glen Iris, Victoria

The 15 years that I have enjoyed in general practice have given me untold opportunities and resulted in my settling into a balanced and fulfilling life.

Having experienced the GP training program, I immersed myself further as a registrar liaison officer and continued as a junior medical educator. A fellowship year in the Department of General Practice at the University of Melbourne provided another side to being a GP, as did 12 months working as a GP in the National Health Service in England.

In the 15 years I have been a GP I have experienced general practice in rural, outer urban, urban and overseas environments, through nine different clinics. The longest stint was six and a half years in forested Olinda, in the hills on the eastern outskirts of Melbourne. In the past year I have moved to a clinic closer to home so that I can help in school drop-offs as my children reach school age.

Having taught general practice in various roles, I decided that the most rewarding teaching was as a supervisor in the practice, where I teach medical students and registrars.

The rewards and challenges of general practice are constant. The lack of recognition and respect from some in other specialties, and from the Government, is balanced by the unique relationship GPs have with our patients. Caring for individuals, families and communities over long periods of time is a privilege and a pleasure. Being an intimate witness to people's growth and development over time, combined with the management of complex medical issues, brings both great joy and, at times, great sorrow.

My longest attending patient dates back 13 years through four clinics, with others not far behind. The diversity and unpredictability of presentations was a prime motivation for my choice of general practice.

I now work in an urban practice. This was in part dictated by my partner's work. Being a specialist, she has strong links with major city hospitals and balances her public and private work with family demands. We are fortunate that we both have flexibility that assists one another, and helps ensure we can provide the appropriate care for both our children and our patients.

I work four days a week, plus a share of weekends, giving my patients access to consultations, procedures, counselling and visits to their homes and residential aged care facilities. This balance keeps me fresh and focussed, and I am confident I will continue to enjoy my work well into my 60s.

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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

No doctors in the house

The Age, 27 June 2012

AMA President Dr Steve Hambleton says universities need to shut off new places for medical students entirely, because there is insufficient infrastructure to give the wave of new graduates proper clinical training.

Fact and fiction of e-health changes

The Australian, 26 June 2012

AMA President Dr Steve Hambleton says politicians have voted to introduce a shared e-health record system, but they have got a very different beast in the Gillard government's personally controlled e-health record scheme.

Medical students languish in a critical condition

The West Australian, 26 June 2012

AMA President Dr Steve Hambleton highlights the curious situation where the nation has a shortage of doctors, yet there are too few internships. A report by Health Workforce Australia has forecast a shortfall of 2701 doctors by 2025.

12 sports ditch booze sponsorship

The Sydney Morning Herald, 23 June 2012

AMA President Dr Steve Hambleton urges big sporting codes to realise the days of accepting cash from alcohol companies are quickly coming to an end after Sports Minister Kate Lundy announced the "Be The Influence" strategy to encourage sporting codes to end all existing and future alcohol sponsorship agreements in exchange for Government funding.

Australians are living longer but getting fatter, a new report says

The Daily Telegraph, 23 June 2012

Australian Medical Association President Dr Steve Hambleton says obesity rates in Australia highlighted in an Australian Institute of Health and Welfare report are alarming. Dr Hambleton says Australia is following the US trend and this must be reversed if life expectancy is to continue to increase.

AMA calls for e-Health penalty delay until 2014

The Australian,19 June 2012

The AMA says the withdrawal of incentive payments to doctors who fail to sign up to the e-health scheme must be delayed until 2014 because of the multiple problems dogging the scheme ahead of its 1 July launch date.

No demand for Curtin medical students:AMA

The Australian, 20 June 2012

Curtin University's plan for a new medical school is slammed by the Australian Medical Association. AMA President Dr Steve Hambleton says there is no place for opening up a new school at this time. Australia has as many medical students in the pipeline now as it can train.

Radio

Dr Hambleton, 2GB, 24 June, 2012

Doctors hope cancer will eventually be wiped out with significant increases in survival rates compared with 30 years ago. Australian Medical Association President Dr Steve Hambleton says Australia has some of the best survival rates in the world for breast, prostate, bladder and many other cancers because of our good screening programmes and better-targeted therapy.

Dr Hambleton, 5AA, 23 June, 2012

Health groups have welcomed moves by sporting organisations to ban alcohol promotions at their events, after the Gillard Government offered a share in $25 million of funding for placing a ban on alcohol sponsorships. Swimming Australia and the Football Federation of Australia have signed up. AMA President Dr Steve Hambleton says the move will help prevent binge drinking at sporting events.

The latest from AMSA

AMSA National Convention

Former Prime Minister Kevin Rudd, former AMA President Dr Rosanna Capolingua, former Australians of the Year Professor Fiona Wood and Professor Patrick McGorry, and former Collingwood Football Club coach Mick Malthouse will address the AMSA National Convention being held in Perth from 1 to 8 July.

Lack of leadership on asylum seekers costs lives - AMSA

AMSA calls on federal politicians from all parties to stand by Australia's commitment to treat asylum seekers humanely, including ensuring that when they are detained, the period of detention is minimised.

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Practice Infrastructure Grants are good value for money

BY **DR BRIAN MORTON**

"A recent Australian National Audit Office report shows the PCIG Program is making good progress, with 74 projects complete and 108 currently underway"

Infrastructure funding for general practices is a better way for Government to spend precious taxpayer dollars than the hundreds of millions that have been splurged on building GP Super Clinics, many of which are struggling to employ doctors and have been plagued with problems.

For several years the AMA has been urging Government to help general practices expand their capacity to provide training and multidisciplinary care.

The $117 million Primary Care Infrastructure Grants (PCIG) Program announced in the 2010-11 Budget was recognition of the fact that tired and outdated facilities were getting in the way, preventing practices delivering a broader range of integrated and multidisciplinary services and limiting their capacity to provide training places.

In 2010 the first round of grants saw the Department of Health and Ageing award $54.4 million to 214 facilities. The second round of grants, launched in 2011, has so far seen $19.1 million awarded to 66 practices, and there is potential for a further 190 facilities to receive funding under the round.

A recent Australian National Audit Office report shows the PCIG Program is making good progress, with 74 projects complete and 108 currently underway.

Given the PCIG program was only announced in 2010, its rollout has been progressing at a rapid pace. The AMA believes this is the direct result of focusing funding on existing practices, which enables the program to move quickly to enhance infrastructure in a way that supports improved access to services for patients and training of the next generation of GPs.

Compared with the Government's GP Super Clinics Program, which commenced in 2007-08 and has been plagued with problems ever since - including financial bailouts, shortages of GPs and scrapped clinics - the PCIG is streets ahead on delivery. Only 25 GP Super Clinics are operating to date, well short of Government targets.

In the our submission to the 2012-13 Federal Budget the AMA called for funding for GP Super Clinics not yet finalised or fully supported by their community to be redirected into GP infrastructure grants, in addition to a $175 million funding boost which would provide for an extra 575 infrastructure grants at about $300,000 each.

The Audit Office is currently investigating the GP Super Clinics Program, and the AMA expects the outcomes of its inquiry will provide additional impetus for the Government to rethink the program and redirect unspent monies to where they deliver the best gain - upgrading the infrastructure of existing general practices.

TO COMMENT CLICK HERE

Patient safety has to be priority in widening prescribing pool

BY **PROFESSOR GEOFFREY DOBB**

"AMA members see the inherent risks to patient safety that arise from the inconsistency of these arrangements and, consequently, the uncertainty of who is ultimately responsible for the management and care of the patient"

The AMA Therapeutics Committee has had a busy few months responding to several consultation opportunities regarding prescribing and medicine regulations.

Health Workforce Australia is investigating a nationally consistent approach to expanding the prescribing of medicines by non-medical health practitioners registered under the National Law, and the Committee has made a submission in response to its consultation paper *Health Professionals Prescribing Pathway* (see www.ama.com.au/node/7989).

We welcome the development of a consistent platform from which registered non-medical health professionals can undertake prescribing, consistent with their scope of professional practice.

However, prescribing by non-medical health professionals should only occur within a consistent and sustainable medically delegated environment, where each member of a health professional team is collaborating with the other team members under clear and transparent arrangements.

AMA members have first hand experience of the wide range of arrangements under which non medical health practitioners prescribe medications. AMA members see the inherent risks to patient safety that arise from the inconsistency of these arrangements and, consequently, the uncertainty of who is ultimately responsible for the management and care of the patient. Without collaboration and coordination, which should be through a patient's general practitioner, the risks of duplication and drug interactions will increase exponentially with the number of prescribers.

On the theme of public safety, the Therapeutics Committee also assessed new draft guidelines on the evidence required before medicines can be listed. The guidelines, *Evidence required to support indications for Listed Medicines*, were released for comment in April, and are a considerable improvement. They give sponsors much clearer and more detailed instructions on the type and level of evidence required before medicines can be listed.

In its response, the Committee noted that strengthening regulations governing the listing of complementary medicines would help better protect the public. But it warned that until the TGA has the resources to undertake more audits of sponsor information, the system for listing evidence would still be open to fraud and abuse (see full letter at www.ama.com.au/node/7992).

The AMA was also invited to comment on a review being conducted by the Pharmaceutical Benefits Advisory Committee (PBAC) of the current Emergency Drug Supplies (Doctor's Bag) section of the PBS. The review was prompted by recommendations made in an article published in the *Australian Prescriber* in February this year.

In its response, the Committee supported several recommended changes, including replacing diazepam with midazolam, replacing haloperidol and chlorpromazine with olanzapine, and withdrawing verapamil and terbutaline.

However, the experience of AMA members 'in the field' led us to disagree with some other recommendations, including the suggestion that frusemide 20 mg in 2 mL injections be replaced with glyceryl trinitrate 50 mg in 10 mL injections for intravenous infusion, because of the impracticalities of setting up an infusion in home settings.

PBAC will meet in July to consider the Doctor's Bag review results and we will advise members of any subsequent changes.

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Tales from the edge for next generation of doctors

BY **JAMES CHURCHILL**

"Delegates will once more fiercely contest the Emergency Medicine Challenge and other competitions throughout the week, in the race for the Convention Cup, and no doubt delegates' costumes will again amaze during the social program"

July is a special month on the calendars of Australia's medical students.

For some, it's the month of gruelling end-of-semester exams. For luckier students, it's that time just after exams in which to recharge after a long few months of medical school.

For the luckiest - at least as far as AMSA is concerned - this July it's time to head west to the 53rd annual AMSA National Convention, *On The Edge*, in Perth from 1 July to 8 July.

More than 850 delegates from every medical school in Australia will make the trip across the Nullarbor for an exciting academic and social program.

Convention delegates will hear from thinkers *On the Cutting Edge*, with eminent orthopaedic and trauma surgeon Professor Rene Zellweger, Triple J's popular science guru Dr Karl Kruszelnicki, Professor Michael Kidd AM and eminent pathology author Professor Vinay Kumar.

Delegates will be brought to *The Edge of Disaster* with plastic surgeon and Australian of the Year 2005, Professor Fiona Wood AM and Dr Mal Lishman AM, a surgeon who has practiced in the world's most extreme environments.

The Leading Edge will bring medical students face-to-face with AFL triple-premiership coach Mick Malthouse and former Prime Minister Kevin Rudd.

By the final day of the National Convention academic program, delegates will be *Blurring The Edges* with Professor Pat McGorry, Australian of the Year 2010, and international crime author Dr Kathryn Fox.

The Convention program will also host the AMSA *Big Issues* panel session, where representatives of AMSA, the AMA, Curtin University and University of Western Australia will discuss the question "Is medical education in crisis?"

This certainly seems an apt question, given the number of issues currently affecting medical education in Australia, including the impact of increasing medical student numbers, the pressure on prevocational and vocational training positions, inadequate funding of medical education and the changing needs of medical professionals in the 21st century.

Delegates will once more fiercely contest the Emergency Medicine Challenge and other competitions throughout the week, in the race for the Convention Cup, and no doubt delegates' costumes will again amaze during the social program.

From humble beginnings in Brisbane in 1960, the annual National Convention has become the largest student conference in Australia. No doubt this year's National Convention will amaze delegates, leaving them *On The Edge* until July next year.

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HEALTH ON THE HILL

Hospitals get collective bargaining go-ahead

Up to 50 private hospitals will be allowed to join together to bargain with suppliers and health funds under a draft ruling issued by the competition regulator.

In a decision that could substantially cut costs for smaller operators, the Australian Competition and Consumer Commission has given conditional approval to a proposal for the nascent Private Hospital Collective Bargaining Group to negotiate supply and health fund agreements on behalf of its members.

The dispensation is conditional on limits to the size and geographic spread of the Group, but would allow hospitals to share information for bargaining purposes.

For an organisation that has in the past cracked down hard on cartel behaviour, the decision is significant.

ACCC chairman Rod Sims said the proposed authorisation, which is open to public comment, would initially last for five years.

"The ACCC considers that the collective bargaining is likely to result in cost savings and provide small private hospitals greater input into their contracts," Mr Sims said. "Performance benchmarking has the potential to improve the management or efficiency of participating private hospitals."

The proposed Group does not yet have any members, but that is likely to quickly change following the ACCC's ruling.

The draft determination would give Group members, which will be limited to private hospitals and groups of hospitals with up to 200 beds, statutory protection to negotiate as a collective with health funds and medical and non-medical suppliers.

Members would also be protected from prosecution for sharing information about processes and procedures to enable benchmarks to be set.

The ACCC said that, reflecting health fund and supplier concerns about the potential size of the Group, its membership would be limited to 50 hospitals, with no more than 10 hospitals in any one State or Territory.

"The ACCC's preliminary view is that this will increase the likelihood that the arrangement will result in overall benefit," the regulator said.

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Tasmania bail-out a one off, says Government

The Federal Government has warned other States not to expect handouts similar to its multi-million dollar rescue package for Tasmania's ailing health system.

Federal Health Minister Tanya Plibersek said the $325 million bailout was to address "particular problems" afflicting the nation's southern-most State and did not set a precedent for other jurisdictions.

"Tasmania does have some particular problems," Ms Plibersek said on Sky television. "It's got the equal oldest and fastest-ageing population in Australia. It's also got a much higher burden of chronic diseases than the national average."

The package includes a $31 million drive to cut elective surgery waiting times, almost $50 million for Medicare Local services, $54 million to boost medical specialist and nurse training, $37 million to roll-out electronic health records in Tasmanian hospitals, almost $75 million for post-discharge and palliative care, $22 million for walk-in clinics in Hobart and Launceston and $42 million for clinical services research.

Ms Plibersek said that "these investments respond to the ideas that frontline clinicians have told me will be the best ways to tend to Tasmania's health system".

The Minister admitted the money was required in part to offset funding ripped out of the Tasmanian health system by the State government.

"In the last two budgets, the Tasmanian Government [has] taken money out of their health system," she said. "It was plain that if the Commonwealth did not take steps in Tasmania, that Tasmanian patients would suffer. This package was an effort to ensure that the patients in Tasmania continue to have a decent health system."

Opposition health spokesman Peter Dutton questioned expenditure in the package, including the allocation of almost $37 million for the roll-out of personally controlled electronic health records in public hospitals and $54 million for specialist and nurse training."

"Surely this is a long-term priority, not something that will assist patients immediately to address the health crisis in Tasmania," he said.

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Claims of mass exodus from private health insurance rubbished

A brawl has erupted between the Commonwealth and the Queensland Government over claims that 320,000 Queenslanders would drop their private health insurance cover because of rebate means testing.

Federal Health Minister Tanya Plibersek dismissed the claim as "rubbish" and accused her Queensland counterpart Lawrence Springborg of misleading the public and spreading fear.

Mr Springborg told the *Courier-Mail* that

HEALTH ON THE HILL

although it was not yet clear how many people would relinquish their private health insurance as a result of means testing of rebates, "even at the lower end of current forecasts, the actual number of people affected will be significant".

He warned this would have a knock-on affect for public hospitals already under pressure, adding to demand for their services.

But Ms Plibersek said Mr Springborg was exaggerating the affect of the introduction of means testing, with Treasury modelling suggesting 99.7 per cent of those with private health insurance would retain it after the means test was introduced on 1 July.

Under the changes, which have been vigorously opposed by the Coalition, individuals earning up to $84,000 a year and families with a combined income of up to $168,000 retain access to a 30 per cent rebate on private health insurance premiums.

But the rebate has dropped to 20 per cent for individuals earning between $84,001 and $97,000 and families earning between $168,001 and $194,000, and has shrunk to 10 per cent for individuals earning between $97,001 and $130,000 and families with an income between $194,001 and $260,000.

Individuals with an income greater than $130,000, and families earning more than $260,001 receive no rebate.

Ms Plibersek said the changes brought to an end the subsidies lower and middle income earners paid to higher income earners, and would leave almost eight million private insurance policyholders unaffected.

"A family would need to have an income of more than $260,000 a year before they would lose the rebate entirely," the Federal Minister said. "To suggest thousands of people who might not even be affected by the changes will drop out is ridiculous."

Ms Plibersek said the latest showed that the reverse was happening, with an additional 50,000 people taking out private health insurance cover in the first three months of the year.

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National health profession registration expanded

Occupational therapists, Chinese medicine practitioners and specialists in Aboriginal and Torres Strait Islander health will have to meet uniform national registration and accreditation standards under changes that have just come into effect.

The National Registration and Accreditation Scheme (NRAS), which was established by the State and Territory governments two years ago to ensure nationwide recognition of practitioner qualifications, has been expanded to encompass four additional professions - Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupational therapy.

The increase, which came into effect on 1 July, takes the number of professions with uniform national registration and accreditation standards to 14.

Under the change, all occupational therapists wishing to provide Medicare eligible mental health and occupational therapy health services must be registered under the NRAS.

In addition, those wanting to provide Medicare eligible focussed psychological strategies will have to continue to satisfy mental health credentialing requirements set by Occupational Therapy Australia.

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Report on rural doctors delayed

A parliamentary inquiry into rural doctors and health services has been extended by two months.

The Senate's Community Affairs References Committee, which began an investigation into the factors affecting the supply of health services and medical professionals in rural areas in October last year, was due to report to Parliament on 30 April this year.

But the Committee's deputy chair, Senator Claire Moore, successfully sought an extension until 15 August.

The Committee has so far held five public hearings, and a sixth is scheduled in Canberra on 10 July.

The AMA has made both written and verbal submissions to the inquiry, including a presentation by President Steve Hambleton, chair of the Rural Medical Committee, Dr David Rivett, and senior official Warwick Hough on 11 May.

In its submissions the AMA recommended a range of measures to address the growing shortage of doctors in rural areas, including adoption of the Rural Rescue Package developed in conjunction with the Rural Doctors Association of Australia.

Among the recommendations, the AMA has called for a rural isolation payment for all rural doctors (including GPs, specialists and registrars) to reflect the isolation associated with rural practice; and a rural procedural and emergency/on call loading to better support rural

procedural doctors (including procedural specialists) who provide obstetric, surgical, anaesthetic or primary emergency on-call services in rural communities.

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Australians live longer – at a cost

Australians are living longer and, in many respects, healthier lives, but this has come at a hefty cost to governments and individuals, according to an Australian Institute and Welfare report.

Spending on health virtually doubled last decade to reach more than $121.4 billion in 2009-10 – equivalent to almost a tenth of entire national output.

And while the vast bulk of funding came from government – the Commonwealth accounted for almost $53 billion of total spending and the States and Territories $31.5 billion - the report, *Australia's Health 2012*, shows the health system's reliance on individuals to directly contribute to the cost of their care is increasing, with out-of-pocket payments well above the average among advanced economies.

Institute figures show that between 1999 and 2009 average annual out-of-pocket health expenses, in addition to taxes and health insurance premiums, rose from less than $500 to $900 per person – a jump of more than 80 per cent.

By the end of last decade total such payments reached $21.2 billion and accounted for more than 18 per cent of total health spending – well above the average of 15.8 per cent among Organisation of Economic Co-operation and Development countries.

Unsurprisingly, hospitals consumed the largest share of overall health funding, accounting for more than $48.5 billion of total spending from all sources in 2009-10, while spending on GPs and specialist medical services was less than $22 billion and $17 billion was expended on medication.

While there are complaints that up to a third of health spending is used poorly or inefficiently, the Institute report indicates that Australians are living longer and – by many measures – becoming healthier.

According to the snapshot of the nation's health, in 2009 the country had the sixth highest life expectancy among developed countries – more than 79 years for men and almost 84 years for women.

And while heart attacks, lung cancer and strokes remain the nation's biggest killers, the Institute said there had been a "spectacular" 78 per cent plunge in deaths from cardiovascular disease since 1968 – saving the equivalent of 156,000 lives in 2009 alone.

At the same time rates of smoking have been falling, with the proportion of those aged 14 years or older smoking daily halving from 30 to 15 per cent in the 25 years to 2010, and cancer survival rates have been improving.

Between 2006 and 2010 the five-year relative survival rate for all cancers reached 66 per cent.

The nation is also benefiting from high rates of immunisation. More than 92 per cent of children are immunised by the age of two years, and almost 90 per cent of five-year-olds are fully immunised.

But while the threat from some illnesses is easing, among others – frequently linked to lifestyle factors like diet and exercise – it is growing.

The Institute reported that obesity rates among Australian males are the second highest in the world, and among women they are the fifth highest.

According to the report, almost three million Australians spread across all age groups were considered overweight or obese in 2007-08.

AMA President Dr Steve Hambleton said the incidence of obesity in Australia was alarming.

"It's very disturbing," Dr Hambleton said. "Australia is following the US trend, and we've really got to turn it around to continue to increase life expectancy."

"These statistics don't bode well for the future. They're great predictors of lifestyle diseases like diabetes, heart attack and stroke."

The prevalence of such conditions is already increasing, according to the Institute's report, which showed that the diabetes rate virtually doubled between 1989-90 and 2007-08, with almost 900,000 living with the condition.

Linked to this, the incidence of end-stage kidney disease – where survival relies on dialysis or a transplant – has increased more than sevenfold in the past three decades to reach 18,300 people, and is expected to surge a further 80 per cent by 2020.

Australians also suffer from relatively high rates of mental illness – 45 per cent of adults have experienced a mental disorder at some point – and rates of dementia are expected to climb from 1 per cent of the total population last year to 1.6 per cent in 2031.

Commensurate with this spread of maladies, the most commonly used and prescribed medicines are for reducing blood cholesterol, lowering stomach acid, controlling blood pressure and tackling infections (antibiotics).

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Damning UK report prompts implant rethink

The Therapeutic Goods Administration is reviewing its advice to women with Poly Implant Prothèse breast implants following a damning report by British health authorities.

An expert group appointed by the UK Department of Health has found that although there is no evidence PIP implants pose a significant risk to health, they are "significantly" more likely to rupture or leak than other implants.

In a report released on 18 June the expert group, led by National Health Service Medical Director Sir Bruce Keogh, recommended that taxpayers cover the cost of having implants removed – even if intact – if a woman wants to have them taken out and her original provider is unwilling or unable to pay for the procedure.

The group made the recommendation despite finding no evidence that PIP implants posed a threat to health as long as they were intact.

But it warned the risk of rupture in PIP implants was higher than other devices.

"PIP implants are clearly substandard," the report said. "[They] are significantly more likely to rupture or leak silicone than other implants, by a factor of around two to six, and this difference is detectable within five years of implantation."

It found the failure rate for PIP implants was between 6 and 12 per cent at five years, and between 15 and 30 per cent at 10 years, compared with 10 per cent at 10 years for Allergan implants and 14 per cent at eight years for Mentor implants.

The group's findings have forced the TGA to reconsider earlier advice to 4500 Australian women with the implants that there was no evidence that they were more likely to rupture than other similar devices.

In an update issued four days following the release of the British report, the TGA said it was "reviewing the report in light of its own investigations to see how the new data might impact on the current advice being provided to women with these implants".

Australian authorities have so far declined to recommend that women with PIP implants have them removed unless there is evidence they have ruptured.

Instead, women in Australia who have, or suspect they have, PIP implants, have been offered a Medicare rebate for MRI scans to assess the condition of the devices.

While the Keogh report suggests the National Health Service pick up the tab for taking even intact implants out, Australia's Chief Medical Officer, Professor Chris Baggoley, has advised against routine removal of implants.

"There is not enough evidence to conclude that women with PIP silicone breast implants have a greater health risk than women with other brands," Professor Baggoley said. "Australian tests to date have all been conducted in accordance with international standards and the results show the implants have met the standards required.

"Therefore, in light of the risks of surgery, there is insufficient evidence to recommend routine removal of PIP implants without a medical indication such as rupture or significant symptoms."

The UK expert group has recommended that all women with PIP implants should be consulted by specialists and, if there is any sign of rupture, offered to have the device removed.

If the implant appears intact, "she should be offered the opportunity to discuss with her specialist the best way forward".

The group recommended that, if a woman with intact PIP implants wants to have them removed "her healthcare provider should support her in carrying out this surgery. Where her original provider is unable or unwilling to help, the NHS will remove but not normally replace the implant".

Two year ago an international recall was issued for PIP devices that had not been implanted after French health authorities found they had been manufactured using substandard materials, causing widespread alarm among patients.

But studies by both Australian, British and French health authorities have found no evidence that the implants put women at increased risk of breast cancer or connective tissue diseases.

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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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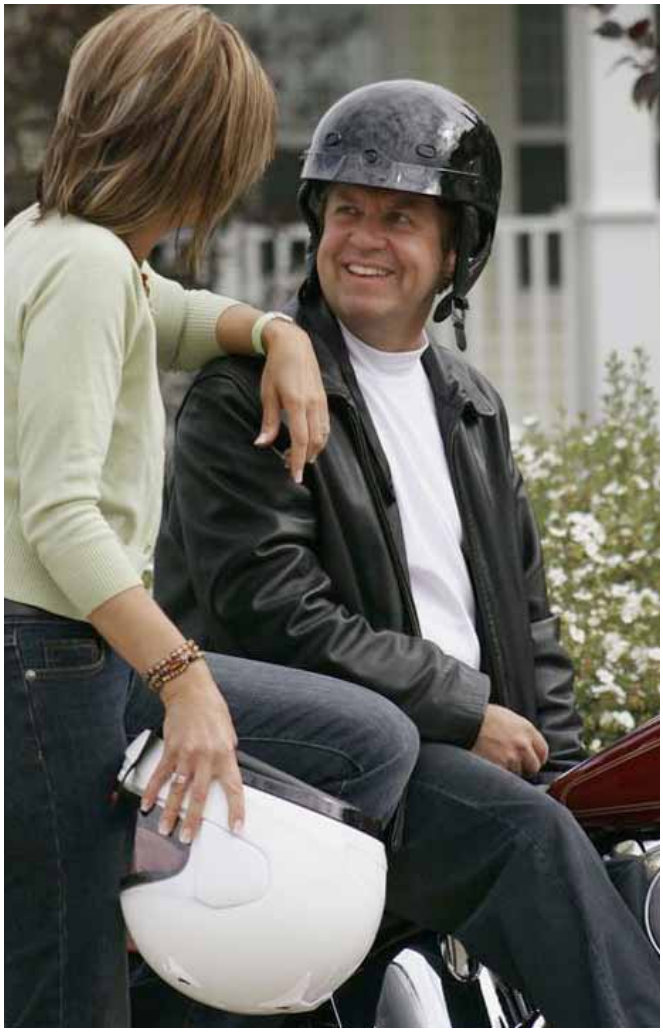
Middle aged bikers crash out



The rush of middle-aged men to embrace a life on two wheels is coming at a cost.

Figures compiled by the Australian Institute of Health and Welfare show there has been a steep rise life-threatening motorcycle and bicycle accidents in the past decade, particularly involving older men.

The proportion of motorcyclists and bicyclists sustaining life-threatening injuries grew by almost 7 per cent a year in the nine years to 2008-09, compared with an annual rise of less than 2 per cent among all road users.

The Institute's figures show the rise in risk was particularly marked among middle-aged men, with life-threatening injury rates growing above 14 per cent a year among male bicyclists and motorcyclists aged between 45 and 64 years.

The rise came despite little change in the overall in the safety of the nation's roads in the past decade.

While the death rate from traffic accidents came down over the period from 9.2 per 100,000 to 7.3, the incidence of life-threatening injuries climbed at an annual rate of 1.7 per cent between 2000-01 and 2008-09, and the proportion seriously injured rose from 138.3 per 100,000 people in at the start of last decade to 156.7 per 100,000 nine years later – though these would have been influenced by the proliferation of vehicles since the early 2000s.

Unsurprisingly, given the dominance of cars, trucks and vans on the roads, rates of life-threatening injury were highest among people involved in motor vehicle accidents, averaging around 22 per 100,000 people over the period covered by the report.

By comparison, the rate among motorcyclists rose from 5.5 per 100,00 to 9 over the same time frame, and among bicyclists it jumped from 2.6 to 4.2.

But the risk of serious injury was much higher among those on a motorbike than people in cars.

Among car users, rates of life-threatening injury held steady at a little over 3 per 10,000 registered vehicles each year between 2000-01 and 2008-09, compared with more than 30 per 10,000 registered motorbikes.

While the risk of injury per registered motorcycle was largely unchanged over the period, rates of injury increased because the rise in motorbike use outstripped the population growth rate.

Similarly, the mounting popularity of cycling, both as a sport and a means of transport, helped drive the rise in injury rates among cyclists.

The ACT led the nation in the growth of life-threatening injury rates among both motorbike riders and cyclists which, in the case of the latter rose almost 20 per cent over the period covered by the report.

In the ACT, there were 8 life-threatening injuries from cycling accidents per 100,000 people, compared with 4.8 in Victoria, 4.6 in Queensland, and 3.4 in New South Wales, though this may be influenced by differences in the prevalence of cycling rather than the inherent dangers of traffic in different jurisdictions.

While ACT had higher rates of injury among those on two wheels, it also boasted the nation's best survival rate from life-threatening crashes.

According to the Institute's figures, 91.3 per cent of people suffering life-threatening injuries from a traffic accident in the ACT survived in 2008-09, compared with the nationwide average of 85.1 per cent.

Among the larger states, only Victoria (88.5 per cent) exceeded the national average, while NSW (84.9 per cent) was just below, and followed by South Australia (84.3), Queensland (83.6), Tasmania (82.6), Western Australia (80.1) and the Northern Territory (76.3).

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Safety standards for drivers upgraded

Taxi drivers and other commercial vehicle operators face being banned from driving for five years if they suffer blackouts under tough new medical standards for driver safety.

Motorists face an even lengthier 10-year exclusion from driving if they suffer seizures, but the time that they will have to spend off the road following a heart attack has been slashed, according to revised rules issued by the National Transport Commission and Austroads.

The new standards have been developed drawing on expert opinion and following a comprehensive review of medical evidence, and are guided more by how symptoms may impair the ability to drive safely rather than applying blanket rules tied to specific conditions.

As a result, the length of the updated guidelines have been cut from 23 to 10 chapters, and focus on conditions likely to affect fitness to drive, including blackouts, diabetes, seizures, psychiatric conditions, sleep disorders and musculoskeletal conditions.

For the first time, the standards include a chapter on blackouts, which is cross-referenced with chapters on disorders that can involve such symptoms, including epilepsy, diabetes and sleep disorders.

Under the new standards, motorists will have their license withdrawn immediately upon their first blackout episode, and commercial vehicle drivers must be blackout-free for five years before being considered for a conditional license, up from six months under the previous guidelines. For private drivers, the required blackout-free period has been increased from two to six months.

The new rules include a default standard for those suffering seizures or epilepsy.

Commercial drivers must be seizure-free for 10 years before being considered for a conditional license, while for private motorists the period is 12 months.

The extent of restrictions on licenses for drivers who have met the seizure-free criteria is to be guided by the particular variant of epilepsy involved.

The revised standards also take account of advances in the treatment of heart attacks, cutting the non-driving period for commercial motorists following acute myocardial infarction from three months to four weeks, with a similar reduction for private drivers following syncope due to cardiovascular causes.

The standards can be viewed in full at: www.austroads.com.au

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TB vaccine shortage looms

Supplies of a crucial TB vaccine may soon run out after production was halted following a potentially harmful breakdown in the manufacturing process.

Sanofi-Aventis Australia Pty Ltd has recalled batches of its Bacillus Calmette-Guerin vaccine amid concerns its sterility cannot be assured because of an "environmental monitoring excursion" during manufacture.

Though the breakdown was not considered life-threatening, there are concerns tainted vaccine could cause illness.

The Therapeutic Goods Administration said production of the vaccine has been halted and will only resume when it is satisfied that its sterility can be assured.

The TGA said that in the interim it was working with Sanofi-Aventis to secure alternate supplies of the vaccine, but admitted this may not happen quickly enough to prevent a severe depletion of stocks.

"There may be a potential shortage of BCG vaccine in Australia in the interim," the regulator said.

The batches of BCG 1.5 milligram powder for injection being recalled are:

- C3787AA (expiry date August 2012);
- C3787AC (expiry date December 2012);
- C3787AE (expiry date February 2013); and
- C3787AG (expiry date February 2013).

In a separate development, two painkiller manufacturers have succeeded in forcing the TGA to reconsider a ban on their products.

Late last month the Administrative Appeals Tribunal directed the TGA to revisit its decision to ban Di-Gesic and Doloxene, along with two other types of painkillers containing dextropropoxyphene, from the Australian Register of Therapeutic Goods.

Late last year the TGA announced its decision to cancel all four drugs from the Register, effective from 1 March this year, a ruling subsequently affirmed by a delegate of the Health Minister in January.

But the manufacturers of Di-Gesic and Doloxene mounted a challenge to the decision in the AAT, which in February granted a stay on the ban pending a full hearing, which was conducted in late May.

The Tribunal decided last month the TGA should reconsider the ban, and it is expected to make a final determination by 15 August.

The regulator has flagged it still remains concerned about the potential for harm from the painkillers.

While it formulates its final decision, the TGA is urging doctors and patients to "carefully consider" product and consumer warnings and contraindications for Di-Gesic and Doloxene before prescribing or taking these medicines.

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INFORMATION FOR MEMBERS

Doctors to be given lessons in pain

International experts in chronic pain research and treatment are being brought together for a one-off workshop for medical practitioners as part of efforts to improve understanding and management of the debilitating condition.

University of Virginia Emeritus Professor David Morris and head of the University of NSW's Pain Management Research Institute Professor Michael Cousins will be headline speakers at the one-day forum 'Painful Truths' being held at Parliament House, Canberra, on Wednesday, July 25, as part of National Pain Week.

The RACGP-accredited workshop, which will be chaired by ABC presenter Dr Norman Swan, is open to all practitioners, including GPs, physiotherapists, dieticians, pharmacists, nurses, exercise physiologists and other health workers caring for patients suffering chronic pain.

The program is intended to provide practitioners with the results of the latest research into the causes of pain, as well as reviewing evidence about the most effective treatment options.

It is intended the one-day workshop will develop a communiqué to the Federal Government highlighting the need for support for GPs and other practitioners in treating patients with chronic pain.

For details about the workshop and registration, go to:

https://www.dcconferences.com.au/eventReg.asp?eventid=2

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Grants for medical equipment running costs

The Federal Government is offering a lump-sum payment to patients using ventilators, dialysis machines, respirators, heart pumps and other essential medical equipment at home to help offset the effects of the carbon tax.

The payment, worth $140 in 2012-13, is intended to compensate the ill and infirm for the higher energy costs they will incur for using equipment, heating or cooling essential to managing their disability or medical condition.

The assistance is open to concession card holders, and claims for the 2012-13 financial year can be lodged now.

Details of the scheme, including a comprehensive list of the medical equipment whose operation is covered by the payment, are available by calling 132 468, or visiting http://www.humanservices.gov.au/spw/customer/forms/resources/ci016-1206en.pdf

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Fears rise of untreatable TB

Concerns are mounting that a deadly strain of tuberculosis resistant to all known treatments is spreading through India.

In a nightmare scenario for patients, doctors and health authorities, there is a small but growing number of TB cases involving a variant that has so far proved impervious to all known treatments, according to a *Wall Street Journal* report.

While authorities have so far baulked at suggestions that a totally drug-resistant strain of the disease has emerged, doctors in Mumbai, Bangalore and New Delhi have reported cases where even very aggressive treatments have failed to curb the infection and patients have died.

There have long been fears that India, which has the most number of TB cases in the world, could be an incubator of a mutant strain of the disease immune to treatment because of inadequate supervision of the use of drugs.

According to the *WSJ*, Indian authorities estimate that about 100,000 patients have drug-resistant variants of TB.

The South Asian country has had an ambitious TB treatment program, involving 640,000 practitioners dispensing medicine through 13,000 clinics.

But strained medical staff are not able to closely monitor patients, who must take medicines for many months.

Drug-resistant strains emerge when patients do not complete the full course of treatment, or are not on strong enough drugs to kill off the infection.

The World Health Organisation is working with Indian authorities to combat the mutation of the disease amid fears that TB could re-emerge as a deadly worldwide plague.

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Supreme Court gives Obamacare clean bill of health

The US Supreme Court has delivered President Barack Obama a significant election year victory, backing the legality of his controversial health care reforms.

In a narrow five votes to four judgement, the Supreme Court rejected arguments that so-called individual mandate provisions in the Patient Protection and Affordable Care Act, which require people to take out a minimum level of health insurance, were unconstitutional.

Chief Justice, John Roberts, said the Act's requirement that certain individuals pay a financial penalty if they do not obtain health insurance could reasonably be characterised as a tax.

He said that because such a tax was permitted by the Constitution, it was not the Court's role to forbid it or consider its wisdom or fairness.

The judgement is an important victory for Mr Obama, who was facing the prospect of campaigning for re-election robbed of the single most important achievement of his first term if the Supreme Court had knocked the Act back.

The US President said that, with their vote, the Supreme Court justices had "reaffirmed a fundamental principle - that here in America, in the wealthiest nation on Earth, no illness or accident should lead to any family's financial ruin whatever the politics".

"Today's decision was a victory for people all over this country whose lives will be more secure because of this law and the Supreme Court's decision to uphold it."

But approval of Obamacare brings with it a sting in the tail for the Government's finances.

US Government figures show the rate of health spending growth slowed in 2010, reaching $US2.6 trillion, a 3.9 per cent rise from the previous year.

But Government officials expect that, while growth will remain modest through to the end of next year, it will surge in 2014 when Obamacare reforms come into effect, predicting annual growth to spike up to 7.4 per cent.

Under their projections, health spending will increase sharply during the decade, reaching a massive $US4.8 trillion in 2021 – equivalent to almost 20 per cent of gross domestic product – with the Government stumping up almost half of the bill.

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Bahrain doctors imprisoned for condemning violence, treating injured

Eleven Bahraini doctors and medics face prison terms of up to 15 years after the country's High Court of Criminal Appeal upheld convictions stemming from anti-government protests last year.

In a case that has sparked international outcry about the treatment of health workers by the Bahrain government, nine practitioners from the Salmaniya Medical Complex in the capital Manama are to be jailed for between one month and five years, while another two earlier sentenced to 15 years imprisonment have had their appeals rejected.

The medical staff were charged by Bahrain authorities with illegal gathering, calling for the overthrow of the government by force and instigating hatred against another sect after they treated an influx of patients injured during anti-government protests in February and March last year.

Accusations against a further nine health workers have been dropped.

Human rights organisation Amnesty International has condemned the charges and convictions as politically motivated, and the organisation's Deputy Director for the Middle East and North Africa, Hasiba Hadj Sahraoui, has called for them all to be quashed.

"These are politically motivated charges against meical professionals who were working to save lives amid very trying circumstances," Ms Sahraoui said. "The real reason for targeting these health professionals is the fact that they were very vocal in denouncing the excessive force used by the security forces against peaceful protesters to the international media, and exercised their rights to freedom of expression and association during marches and protests."

One of the accused, Ghassan Dhaif, credited international pressure with forcing the regime to cut his prison sentence from 15 years to 12 months, but called for efforts to be sustained until all charges were withdrawn.

"I brought in six witnesses who deny these allegations," Mr Dhaif told Amnesty International. "All the charges, and the trial itself, has been politicised, and I am being punished for speaking to the press."

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Ban considered for potentially deadly sports supplement

Food safety authorities have urged athletes to stop taking a sport supplement linked to at least two deaths overseas.

Food Standards Australia New Zealand (FSANZ) has issued a nationwide alert calling on athletes and other consumers to immediately stop taking performance enhancing dietary supplements containing the product dimethylamylamine (DMAA).

The authority warned that taking DMAA – which is typically used by bodybuilders and other athletes as a pre-workout supplement – could lead to high blood pressure, vomiting and other adverse health effects.

The United States Defence Department banned the substance last year amid concerns it contributed to the deaths of two soldiers, and Australian authorities are giving urgent consideration to a similar ban here. Its use is already prohibited by several sporting codes.

FSANZ is currently working with State and Territory Governments to investigate a range of products.

FSANZ Deputy CEO Melanie Fisher said DMAA has been linked overseas with various adverse health effects including high blood pressure and vomiting, and there had been similar reports about the product in Australia.

FSANZ spokeswoman Lorraine Belanger told ABC radio's *The World Today* program that although DMAA was not currently a banned substance, a Therapeutic Goods Administration committee was given urgent consideration to including it in a schedule of prohibited medicines and poisons.

In the meantime, the authority has urged consumers who have bought products containing DMAA to immediately stop taking the supplements and discard them.

Brands testing positive for DMAA include: Noxpump; 3-D explosion; Beta-Cret; PreSurge; 1 MR; Cyroshock; Jack3D; Mesomorph; Neurocore; Oxyelite powder; and Hemo Rage Black.

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Sleeping habits affect mental health of children and parents

Within the first six months of starting primary school 40 per cent of children will develop a sleep problem affecting their mental health and that of their parents.

A study involving more than 1500 parents with children beginning their first year of school study found 27.9 per cent of students had a mild sleeping problem and 10.8 per cent had a moderate or severe sleeping problem - including difficulties going to sleep, unwillingness to sleep alone, night walking and nightmares.

Parents taking part in the study reported on the severity of any sleep difficulties, pre bedtime activities including television and electronic game playing, whether their child had a television in their bedroom, their child's caffeine intake, their child's mental health and their own mental health during the fist six months of their child's school experience.

The researchers discovered that sleep problems are not only common in children starting school, but were associated with poor mental health for the child, poor health-related quality of life and poor parent mental health.

Lead researcher Dr Jon Quach said the findings strongly suggest that the impact of child sleep problems is not limited to sleep.

"We found that sleep problems were associated with markedly worse child mental health and parent depression, anxiety and stress," Dr Quach said.

"This association with poorer child and parent mental health may hinder the child's ability to make a successful transition to school."

Interestingly, the study found that media usage and caffeine consumption in children was only marginally associated with sleep problems.

Dr Quach said the findings pointed to the need to help parents improve the quality of sleep their children were getting before they start school, as a way to help improve their mental health.

The researchers are planning further inquiry in the area.

"Our next trial aims to address sleep problems in children starting school. In the study we will be providing parents with standardised yet flexible strategies to help improve their child's sleep," Dr Quach said.

"Addressing these sleep problems may improve many children's transition to schools, and successfully treating the child's sleep problems could in turn improve both the child and parent's mental health."

The study was published in the *Journal of Paediatrics and Child Health*.

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Earlier birth is best for twins

Twins born at 37 weeks are much less likely to suffer serious problems and complications than those delivered later in pregnancy, a study has found.

Researchers from the University of Adelaide found that twins born at 37 weeks were significantly less likely to be small for their gestational age compared with babies born at 38 weeks or later.

Lead researcher Professor Jodie Dodd said the study, involving 235 women in Australia, New Zealand and Italy, showed that at 37 weeks "elective birth is

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associated with a significant reduction in the risk of serious morbidity for the infants, without increasing complications related to immaturity or induction of labour".

Professor Dodd said the research was undertaken because infants from twin pregnancies carry a higher risk of problems, particularly arising from slow growth rates in either one or both twins.

"This slowing of the growth rate can result in low birth weight, which is associated with an increased need for care in the neonatal nursery in the short term and increased risk of health problems in later life, including heart disease and diabetes. There is also the risk of one or both twins being stillborn," Professor Dodd said. "This is why we've taken such a great interest in the optimal time for twins' birth."

There has been a lot of uncertainty about the optimal time for twins' birth in clinical practice. According to the ABC, almost half of all twin births are at 38 weeks or later.

Professor Dodd said she hoped her study would help clinicians make recommendations to women with healthy twin pregnancies that lead to less complications at birth and to happier, healthier lives for the babies.

The study was published in the *British Journal of Obstetrics and Gynaecology*.

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Tea drinkers on the way to a healthy heart

The humble cuppa could be an important weapon in fighting heart disease – as long as it is taken black with no sugar, according to research.

A study undertaken by the Heart Foundation found that drinking three cups of tea per day for 12 weeks with no milk or sugar reduced blood sugar levels and triglyceride levels –blood fat, which can clog the arteries and increase the risk of heart disease.

Triglyceride levels fell by up to 39 per cent in males and 29 per cent in females drinking unsweetened black tea. In addition, drinking tea led to reduced blood glucose levels and increased levels of HDL or good cholesterol, as well as boosting levels of antioxidants in the blood.

Clinical Issues Director at the Heart Foundation, Dr Robert Grenfell, said there were many positive links between tea consumption and heart health because of the high antioxidant content of green and black tea.

"When consumed without milk and sugar, tea has virtually no kilojoules, making it a good choice over sweetened drinks," Dr Grenfell said.

Dr Grenfell said that although triglyceride levels did fall significantly in the study, further investigation was needed.

He said a more effective way to reduce triglyceride levels was to consume oily fish two to three times a week or take fish oil supplements.

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INFORMATION FOR MEMBERS

Diabetes patients offered huge savings on life-saving tests and equipment

Diabetes patients are potentially missing out on massive savings because they are not signed up to the National Diabetes Services Scheme (NDSS).

Figures provided by the NDSS show that diabetes patients using the scheme can purchase diagnostic tests at less then 10 per cent of the cost of buying them over the counter or through prescription.

A box of 100 blood glucose-testing strips costs $35.40 through PBS on prescription but patients registered with the NDSS pay only $15.20, or as little as $2.40 if they have a health care card. Patients signed up to the scheme also receive free insulin syringes and pen needles, which typically cost between $28 and $44 for a box of 100 syringes, and only have to pay $30 a month for insulin pump consumables, far less than the $200 to $250 a month that patients not in the scheme pay.

The Australian Diabetes Council estimates that over 90,000 Australians living with diabetes could be missing out on such discounts and additional support services, and is urging health professionals to make sure their patients are registered with the NDSS so they qualify for substantial price cuts on the items they need to monitor and treat their disease.

The NDSS is a free Government-funded service for all Australians with diabetes, including gestational diabetes. In addition to free syringes and heavily subsidised blood glucose testing strips and insulin pump consumables, people who are registered with NDSS can also obtain urine testing strips and tablets, as well as information on managing life with diabetes.

People with diabetes and their carers can register for the NBSS by picking up a form from their pharmacy, Diabetes Centre or health clinic, getting it signed by their doctor or Credentialled Diabetes Educator, and returning the form. The registration form is also available at www.ndss.com.au

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Doctor registration fees rise

The Medical Board of Australia has increased its annual registration fee by $10 to $680.

But, in keeping with the commitment it made to the medical profession two years ago, the Board kept the 1.49 per cent rise below the consumer price index inflation rate of 1.6 per cent.

Board chair Dr Joanna Flynn defended the increase as necessary to enable the MBA to meet its obligations to regulate the medical profession under the terms of the National Law.

Dr Flynn said the National Registration and Accreditation Scheme was funded entirely from registration fees, and assured practitioners that there was no cross-subsidisation between specialties.

"The Board is pleased to have contained the registration increase to below CPI, consistent with its commitment to the profession in 2010," she said.

The revised fee, which came into effect yesterday, will provide for registration between 1 October this year and 30 September 2013.

Renewal reminders will be sent out later this month, and doctors have been warned they will be liable to a late fee of $170, in addition to the annual fee, for late payment.

Australian Medicine reported in its 18 June edition (see http://ausmed.ama.com.au/complaints-against-doctors-chew-half-regulator-investigation-costs) that figures obtained under FOI laws showed doctors contributed more than $44.6 million in fees last financial year to help pay for the Australian Health Practitioner Regulation Agency's running costs – almost 39 per cent of the organisation's total fee income.

Dr Flynn said the Medical Board was committed to transparent and accountable financial reporting, and next month will publish the terms of the Health Profession Agreement between the Board and the Regulation Agency that sets out the services AHPRA will provide to help the Board regulate the medical profession.

"As our reporting capability strengthens, the Board and AHPRA will publish more detailed information about the Board's financial operations to complement the audited data published in each year's annual report," she said.

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Organ donation must be altruistic and free of conflicts of interest

The AMA has called for a strict separation between medical teams involved in treating organ donors and recipients under formal policy guidelines for organ and tissue donation developed issued by the Association.

While the AMA said it "strongly encourages" people to consider becoming organ donors, in a Position Statement issued last month it argues donation must only be made as a result of free, informed choice, and within a system that enjoys strong public confidence.

AMA Vice President Professor Geoffrey Dobb said that around 1600 people are on waiting lists for organ and tissue transplants at any one time, and a single donor can save or improve the lives of 10 or more people.

But Professor Dobb said potential donors needed to think carefully about their choice, and discuss it with relatives and the family doctor.

"It is important that family members discuss the issues and are aware of each other's organ donation wishes – and are prepared to honour those wishes," he said. "People can register their consent to become an organ donor on the Australian Organ Donor Register, but their families will still be asked to provide the final consent.

"Organ donation is a discussion that families need to have."

In addition to free and informed consent, the Position Statement highlights the need for measures to prevent a conflict of interest for medical teams involved in transplanting organs.

"The primary obligation of doctors is to their patients, whether they are potential donors or recipients," the Statement said. "It can be seen as a conflict of interest for the same medical team to look after both the donor and the recipient.

"There should be a separation of roles between the medical team involved in caring for the donor and their family, the medical team involved in retrieving the organs and tissues, and the medical team involved in caring for the recipient."

The Position Statement also canvasses the "unique ethical considerations" involved when organs or tissues come from a living donor.

The AMA believes that in such a situation, not only must donation be made for altruistic reasons rather than being coerced, it must only take place where the risks of harm to the donor are clinically acceptable and chances of success are high, and the welfare of the donor must take precedence over the needs of the recipient.

The AMA said living donation involving a potential donor who lacks decision-making capacity, such as a child, was particularly challenging, and should only be considered in exceptional circumstances.

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Environment, development and health closely linked

BY **PROFESSOR STEPHEN LEEDER**

"Truly grand scale preventive interventions are needed to control the global epidemic of chronic disease, which is everywhere and kills many, including young people"

In Rio in the last week of June, a large international conference on sustainable development took place convened by the UN.

Known as Rio+20, it looked back to the Rio Earth Summit of 1992 - the UN Conference on Environment and Development, as well as looking forward. Its theme was *The Future we Want.*

More than 5000 delegates were expected, including heads of state and concerned citizens. Topics for a multitude of side meetings ranged from 'Green Jobs: a chance for Youth!' to '9 Months to Save the World: Mother Key to Sustainable Development' run by the World Organisation of Prenatal Education Associations.

The brochure for the conference dealt at length with security arrangements. "Only handguns will be admitted," it said, and radio jammers were definitely out. Several delegations planned to bring their own armed details. The organisers must have been anticipating robust debate!

The concern of ordinary citizens was strong. The brochure told of "an indigenous village built at Colônia Juliano Moreira, Jacarepaguá, comprised of 400 Brazilian indigenous people and 1,200 indigenous people from other countries. The village, called Kari-Oca, is a duplicate of the one built also in Jacarepaguá for the Rio 92 Conference". Indigenous leaders from all over South America "made their way by foot, canoe and eventually on buses to be part of the Kari-Oca Caravan to Rio de Janeiro, to talk to world leaders".

As a result, with the endorsement of Secretary-General Ban Ki-moon, the UN is now discussing ways whereby the Millennium Development Goals - that sought to halve world poverty by 2015 - could be succeeded by a set of Sustainable Development Goals – SDGs instead of MDGs. A high-level advisory committee, including President Susilo Bambang Yudhoyono of Indonesia, President Ellen Johnson Sirleaf of Liberia, and British Prime Minister David Cameron, has been appointed for that purpose. Sceptics suggest that this may sideline the debate, set up another self-serving structure and not advance the cause. Much therefore depends upon what we make of, and contribute to, a new structure.

At first blush high-level discussion and debate in the UN about sustainable development may seem remote from the clinic and the operating theatre and not worth worrying about. But sustainable development, among the many things it depends upon, depends on a healthy and productive workforce, and this implies citizens who are basically well, fit and able. No health, no development.

In addition, there is considerable overlap between the environmental changes that sustainable development necessitates and those that lead to a lessening of the burden of chronic disease. Healthy, well-designed cities, with secure food supplies, space for physical activity, high-quality public transport systems and solid levels of education, make the grade not only on the test of sustainable development, but also as being places where the risk of chronic disease can be curbed.

It is interesting how the tension between rapid industrial growth and urbanisation and environmental health is playing out in China, particularly regarding water and air pollution, food safety and energy and food security. Sustainability and health are tightly bound.

Iran – not the world's most popular destination – was almost barred from Rio20+ because of its unsustainable, gas-guzzling development policies causing air pollution levels in Tehran that have raised health concerns, especially because of effects on those with chronic respiratory problems.

Truly grand scale preventive interventions are needed to control the global epidemic of chronic disease, which is everywhere and kills many, including young people. Such interventions are generally in accord with those designed to achieve sustainable development.

Let's hope that the agendas for sustainable development and chronic disease prevention converge in a new era of effective action.

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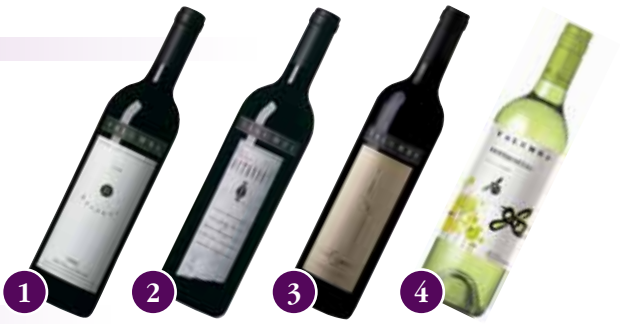
Yalumba - Firing on all cylinders



BY **DR MICHAEL RYAN**

Yalumba is Australia's oldest family-owned winery, and for five generations has spearheaded the Australian wine industry's foray into the overseas market.

It was founded by Samuel Smith, a former brewer from Dorset, on a 30-acre plot in 1847. A further 80 acres were added by Smith using 300 pounds he earnt from a stint in the Victorian gold fields, and it has since never looked back.

Yalumba is Aboriginal for "all the land around", and the sense of connection the winery has with the land is reflected in attachment of the Smith family to the area across generations, and in the loyalty if their staff - personified in their winemaking emissary, Jane Ferrari.

Jane can often be found in boardrooms from London to New York, passionately informing her wide-eyed devotees of the history of Yalumba and the intricacies of how each wine has originated, evolved and then flourished. Family stories abound with romantic flare and create that palpable sense of belonging. I could imagine Baz Lurhman directing the next big Australian movie, simply entitled "YALUMBA".

For a while it appeared Yalumba had become an anachronism: too big to be small and too small to be big. Successful generational businesses survive because every so often they use the non-self effacing "retro-spectascope", and build on the quality they are known for and trim the deadwood. Jane is the vociferous peripatetic ambassador with more than a hint of candour that I am sure has helped Yalumba steer that steady course into the future.

In a private tasting event organised by the Purple Palate, based in Queensland, I was privileged to taste wines of amazing calibre that highlight the use of improved oenology and vinous practices. NASA software developed to analyse terrain is used to identify canopy and cropping health. Even entry-level wines such as The Scribbler Barossa Cabernet Shiraz 2009, The Patchwork Barossa Shiraz 2010 and Eden Valley Viognier 2011 show the exemplary fruit selection, handling and quality balanced oak exposure that make these $20 or there-abouts wines great value. Yalumba is one of the few wineries in the World with its own cooperage, explaining how all wines get the oak they deserve while still meeting the accountant's budget. The future of Yalumba looks promising, with wine maker Louisa Rose tipping in with experimental whites like Vermintino, Fiano and Verdejo, and the Colossus-like Kevin Glastonbury in charge of the flagship reds.

Wines Tasted

1. 2004 Yalumba The Reserve Barossa Cabernet Shiraz

You may as well start with best! Made in exceptional vintages and aged in French and American oak, the nose is a hypnotic blend of soft stewed plums, tobacco and chocolate. The palate is the lingering kiss of an insatiable lover that covets the tongue with silky fruit and lithe tannins. Probably the best mature premium red I have had in the last 12 months. A joy to be had with seasoned, seared aged rib eye. It needs nothing else.

2. 2006 Yalumba The Octavius Barossa Shiraz

First made in 1990 and aged in unique 100 litre American and French oak barrels, this is another premium red. The nose boasts red and dark fruits with classic mocha and some warm spice characteristics. Another full palate effect, with rich savoury plum and gripping tannins. A long life wine of up to 20 years, it should be decanted two hours prior to serving with braised lamb and saffron rice.

3. 2010 Yalumba The Cigar Coonawarra Cabernet Sauvignon

First made in 2006, it is intimately related to the multi-award winning The Menzies, from the cigar-shaped strip of Terra Rossa known as the Coonawarra. A precocious wine full of cassis and olive notes with a hint of "Cabernet Dust". The moderately generous palate finishes with a classic tannic Cabernet structure and is lively enough to match a well-seasoned plate of carpaccio beef and extra virgin olive oil.

4. 2011 Yalumba South Australian Vermintino

The label has a couple of bees on it, hinting at this wine, which buzzes with fruit and lively acid. Pale green and low in alcohol at 11.5 per cent, it jettisons it floral grassy bouquet with a zingy citrus sherbet-like palate. It is a summer wine to rival Sav Blanc and needs Peter Doyle's famous flathead and chips whilst looking at the Coat Hanger.

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Aussie invasion of Le Tour

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

Take an ostensibly British team, Sky, make an impossibly gangly and skeletal half Aussie called Bradley Wiggins - born in Belgium of an Australian father – its leader, surround him with eight riders including the world's fastest road sprinter Mark Cavendish and two of Australia's best cyclists – Michael Rogers and Richie Porte.

Then see if you can knock off the reigning Tour de France champion, Cadel Evans, also Australian.

While Evans will rely on support from a collection of cyclists drawn from the US, Belgium, Switzerland, Italy, Norway and France racing under the US-registered BMC Racing Team banner to help defend his title, it is testament to the increasingly Australian flavour of the world's most famous bike race that its two main contenders have such strong ties Down Under.

This year 12 Australians from seven teams were at the start line for the 99th Tour de France, which began on Saturday with a 6.4 kilometre time trial in the streets of the famous Belgian town, Liege.

And they are not there just to make up the numbers.

In addition to Evans, who many pick as favourite to repeat his heroics from last year and win the yellow jersey as overall race leader, at least two Austrlaian's – Orica-GreenEDGE's Matt Goss and Rabobank's Mark Renshaw – are contenders for the sprinter's green jersey, while Simon Gerrans (Orica-GreenEDGE) could steal an opportunist stage win, and Matthew Lloyd (Lampre-ISD) is a chance to win a mountain stage and vie for the polka dot King of the Mountains jersey.

In the absence of Alberto Contador, who has been suspended from racing after testing positive for a banned substance, and last year's second place winner, Andy Schleck, this year's Tour is, on paper at least, one of the most open in years.

But in the minds of many it is likely to come down to a battle between Evans and Wiggins, turning the Tour into a virtual Ashes on wheels.

It is certainly something that both Australian and British cycling fans can be expected to play up over the next three weeks as Evans and Wiggins slog it out through almost 3500 kilometres of racing, including 25 mountain passes and more than 100 kilometres of individual time trialling.

The Tour draws massive crowds.

In recent years it has been estimated that up to 15 million people have lined the roads of France to cheer the racers on.

In recent years Australian and British fans have become an increasingly common sight on roadside as the race passes – something that veteran cyclist Robbie McEwen – who works as a coach at Orica-GreenEDGE after retiring from racing at the Tour of California in May – says is appreciated by the riders.

McEwen told Bicycling Australia magazine that although the riders might not have the chance to acknowledge support while the race is on, they are certainly aware of it and he himself likes to go back after the finish and spend some time with the fans – as I can attest.

I was among the throng of spectators – estimated to number close to 1.5 million people – lining the Champs-Elysees when McEwen won the sprint finish at the end of the 1999 Tour.

For the race leader, the final stage is usually a procession, but the sprint on one of the world's most famous boulevards is hotly contested, and McEwen's victory – and the subsequent celebrations – made a very long day worth it.

One of the best vantage points on the Champs-Elysees to view the Tour's final minutes (aside, that is, from the temporary grandstand erected at the finish line) is at the bottom of the avenue as it makes a right hand turn onto the Place de la Concorde, forcing the racing peleton to slow, giving fans a close-up view of the cyclists.

But to secure a spot, spectators begin arriving before 8am, and by mid-morning the crowds along the entire two-kilometre long avenue are several people deep.

By the time the race arrives, usually around 4pm, excitement is high, and the final few laps of the Champs made by the racers pass by in a blur.

Perhaps the best part of the day is when the race ends and the riders begin their celebrations.

The Champs – like a suburban footy oval following a match – teems with people as fans mingle with riders, the beginning of revelries that go on well into the next day in bars across town.

It's a great way to see Paris and meet with people from all around the world who share your passion for cycling – including more than a few Aussies.

Details

Getting there: Return flights to Paris from Sydney in July start from around $2500.

Accommodation: Hotels close to the city centre can cost upwards of $400 a night in July, but if you are prepared to stay further out or do without a bit of luxury you can budget on around $150 a night. But be warned, you need to book ahead.

TO COMMENT CLICK HERE

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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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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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:

Sandra Riley
Administrative Officer
AMA
PO Box 6090
KINGSTON ACT 2604

PLEASE PRINT CLEARLY

Name:

Address:

❑ I wish to order the AMA List of Medical Services and Fees on CD for $51.

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

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

AMP

Let AMP Bank take the stress out of buying property

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

Borrowing for an investment property

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

Some things to consider

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

Making the most of your home loan

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

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

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

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