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50 YEARS

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Not the Best of British

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

The Australian Labor Party and many health commentators have looked to Britain and its National Health Service (NHS) to inform policy development.

Looking elsewhere to see what has improved health service delivery has merit, especially where the initiatives adopted have been properly evaluated and been shown to improve patient outcomes and be relevant to the Australian setting.

In this context, it was fascinating to hear the presentation by Lord Darzi at our National Conference. In particular, his reflections on his period as Health Minister in the British government – with the perspective of a surgeon in active clinical practice – had some clear take home messages. The one that most caught my attention was the impact of meaningful clinician engagement on both health system performance and the morale of its workforce.

My holiday after National Conference included a short time in England with an opportunity to catch up with former colleagues and trainees. Conversation turned to today's NHS and the wind back of genuine clinician engagement in operational or strategic decision-making. Instead, clinicians have been sidelined into "clinical governance", which in NHS terms can mean accountability without authority.

Meanwhile, the rise of managerialism as an end in itself, and a focus on explicit performance indicators rather than the overall performance of health services, seemed widespread.

With the wind back of health reform around Lead Clinician Groups in Australia, it will be interesting to see if Australia follows the NHS down this road.

Other impressions of today's NHS came from the newspapers. A report on a survey by the King's Fund drew attention to the biggest drop in public satisfaction with the NHS in 30 years. The proportion of people who said they were satisfied with how the iconic NHS was run had dropped from 70 per cent in 2010 to 58 per cent in 2011.

Another survey, this time of a million patients by the Department of Health, found high levels of dissatisfaction with out-of-hours services. The answer is to be a new telephone help line NHS 111 – does that sound familiar?

As Medicare Locals take over responsibility for out-of-hours GP services in Australia, the words of the spokesman from the British Medical Association are worth noting: "When it comes to out-of-hours services, the BMA is concerned about the patchy nature of the service provided. Unfortunately, many primary care organisations have been keen to cut costs at the expense of investing in a quality out-of-hours service."

The other high profile issue brought to my attention was a discussion document *Shape of the Medical Workforce:* starting the debate on the future consultant workforce [www.cfwi.org.uk/publications/leaders-report-shape-of-the-medical-workforce] from the Centre for Workforce Intelligence – a body analogous to Health Workforce Australia.

Modeling assumptions based on current training numbers, the document foresees a considerable over-supply of fully trained hospital doctors in 2020, implying a possible 50 per cent increase in the salary costs for hospital consultants compared with 2010.

The document's authors go on to consider potential options for hospital medical consultant and specialist career pathways. These include shifting trainees to general practice; fixing the number of consultant posts that are available, based on demand criteria; introducing a "consolidation period" during training (this paradoxically seems to be a period of service without training); and changes to the work of fully trained consultants and specialists, with contemplation of a graded career structure.

Models for the role of consultants and fully trained hospital specialists include the current consultant lead service, in which the consultant provides leadership but is not always present; a service that has consultants present or able to be present to lead, advise and supervise other staff, but does not see all patients; and a consultant-delivered service in which the consultant personally delivers most clinical services with support from a team of healthcare professionals.

The last clearly has implications for the experience and training of trainees, and sounds similar to arrangements in most Australian private practice settings. With the large increase in medical student numbers in recent years in Australia, the potential implications if workforce planning has gone wrong are obvious.

As Lord Darzi pointed out, it's important to learn from the mistakes of others.

TO COMMENT CLICK HERE

Punishing hospital rosters put doctors and patients at risk

More than 50 per cent of hospital doctors are working dangerously long or irrgeular hours that have the potential to impair their judgement and put the health of patients at risk, a survey of almost 1500 practitioners has found.

The AMA's third nationwide study of doctors' working hours has found that although there has been a fall in the proportion of practitioners working risky hours in the past decade, the majority of those in hospitals still work shifts that pose a heightened risk of impaired performance because of fatigue.

Of the 1400 hospital-based doctors who took part in the *AMA Safe Hours Audit 2011*, 53 per cent reported working hours that put them at significant or higher risk of fatigue-related performance impairment.

The result was an improvement from 2001, when 78 per cent of those surveyed reported working high risk hours, and 2006, when the proportion was 62 per cent.

But AMA Vice President Professor Geoffrey Dobb said that although the trend decline in unsafe work hours in the past decade was pleasing, the demands being placed on many doctors were still too great and State and Territory governments and public hospital administrators needed to intensify efforts to ensure better rostering and safer work practices for hospital doctors.

The study confirms that, while there has been an overall decline in risky work hours in the past decade, demands on some doctors continue to be extreme.

One doctor reported working a 43 hour shift in 2011 – four hours more than the longest shift recorded in 2006 – and the maximum total of hours worked during the survey week reached 120 hours last year, seven more than five years earlier.

Professor Dobb, who works and teaches in a public hospital, said the AMA audit exposed work practices that contribute to doctor fatigue and stress and, ultimately, affect patient safety and quality of care.

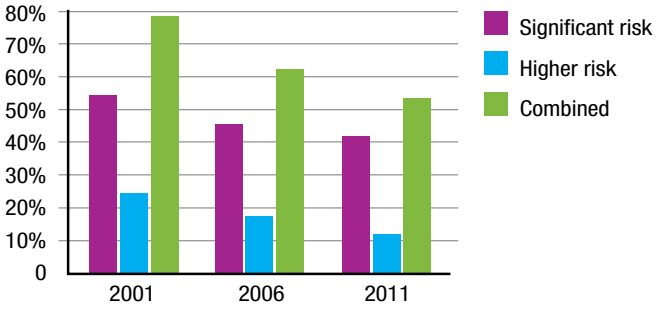
The most stressed discipline was surgery, with 77 per cent of surgeons assessed as being at significant or higher risk of performance-impairing fatigue, followed by GPs, 65 per cent of whom were at risk of similar impairment.

Even doctors in the lower risk category were working shifts of up to 19 hours, according to the audit, which was conducted in August last year and drew on responses from 1486 practitioners.

Professor Dobb said that long, unbroken shifts can have a significant physical effect on performance.

"The performance impairment of a person after 17 hours of sustained wakefulness has been shown to be equivalent to that at a blood alcohol concentration greater than 0.05 per cent," he said. "If this performance impairment was actually the result of alcohol consumption, prevailing hospital policies would prevent these doctors from working. It is not right to have doctors exposed to working conditions that could impair their performance."

Safe hours audit chart



Source: *AMA Safe Hours Audit 2011*

Professor Dobb said reducing fatigued-related risks did not necessarily mean doctors had to work fewer hours, just better-structured ones.

"Often it is simply a case of smarter rostering practices and improved staffing levels, so that doctors get a chance to recover from extended periods of work," he said.

Chair of the AMA Council of Doctors in Training, Dr Will Milford, said fatigue had a big affect on junior doctors as they tried to juggle the competing demands of work, study and exams.

"Public hospitals are not just about service delivery," Dr Milford said. "They play an essential role in teaching and training. Yet many doctors can get to the point where they are simply too tired to learn."

He said a much better balance needed to be struck so that recognition was made of the contribution good teaching and training can make to delivering quality patient care.

The AMA's *National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors*, which can be found at http://ama.com.au/node/3756, provides guidance on how to reduce the risks of fatigue, and the Association believes it should be adopted by all States and Territories as an absolute minimum.

The *AMA Safe Hours Audit 2011* can be viewed at http://ama.com.au/node/8025

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Many standards undermine consistency of care

The development of a set of provisional clinical indicators for general practice has underlined concerns that conflicting, out-of-date and overlapping standards and guidelines are contributing to gaps and inconsistencies in the quality of care.

The AMA is closely scrutinising 22 clinical indicators proposed by the Royal Australian College of General Practitioners (RACGP) as a way to monitor and improve the quality of care.

The indicators cover a range of conditions and procedures from the prescription of medicine and the use of antibiotics through to cancer screening, heart failure management, patient triage and palliative care.

The College said the indicators are intended to deal exclusively with the safety and quality of clinical care, with GPs using them on a voluntary basis to monitor and improve the services they provide.

"No single group of indicators will encompass safety and quality in general practice," the College said. "However, this provisional set of clinical indicators has been chosen because they cover common presentations, are supported by evidence, are important for safety and quality, and should pose minimal administrative burden on general practices."

In a cautious response, the AMA has said that while clinical indicators have the potential to support improvements in the quality of care, there were "inherent dangers that they can be used in the wrong way".

The AMA is concerned that, used improperly, indicators could be linked to pay-for-performance outcomes or to dictate quality levels, and may unduly increase the administrative demands on practices.

"The AMA is concerned that, used improperly, indicators could be linked to pay-for-performance outcomes or to dictate quality levels, and may unduly increase the administrative demands on practices"

The AMA Council of General Practice has developed a position on clinical indicators which calls for their use only if they are devised by the profession and are independent of Government, are based on evidence and voluntary, are subject to on-going review and evaluation, do not entail penalties, are not used for pay-for-performance purposes and are not used to dictate quality levels.

The College has invited comment on its proposed indicators, and the AMA is preparing to make a submission before the 30 July deadline.

The College's proposal coincides with the publication of a paper in the latest edition of *The Medical Journal of Australia* calling for an end to diverse and fragmented clinical guidelines and the establishment of integrated, nationally-agreed standards, indicators and tools for use in routine care.

Drawing on the findings of a study, also published in the latest edition of the *MJA*, that found gaps and inconsistencies in the appropriateness of health care, the paper's authors argue the need for consistent and agreed standards to monitor care.

In the paper, University of South Australia Professor William Runciman and his co-authors document a proliferation of repositories and guidelines for practitioners, including 558 issued by the National Health and Medical Research Council, 338 by the Australian Council on Healthcare Standards and 41 from the RACGP.

They argue that there is much duplication and overlap among these indicators, while recommendations for treatment frequently vary, are often out-of-date and can be hard to use, underlining the case for consistent, nationally-agreed standards – an outcome they acknowledge will be "a huge challenge" to achieve.

"Following this path will necessitate changing some work practices, which will require negotiation and inevitably be inconvenient for busy clinicians," Professor Runciman and his co-authors admit. "But the looming alternative to self-regulation – heavy-handed external regulation – should provide an incentive."

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Patient care being lost in drive to meet targets

Evidence of extensive manipulation of Canberra Hospital emergency department data has underlined long-standing AMA concerns that governments are downplaying quality of care in the push for public hospitals to meet time-based performance targets.

An investigation by the ACT Auditor-General's Office found that treatment records for up to 11,700 emergency department patients were doctored between 2009 and 2012 to show waiting times and lengths of stay shorter than they actually were.

In her report, ACT Auditor-General Dr Maxine Cooper found that at least one Health Directorate official had engaged in "seriously inappropriate and improper conduct" in manipulating the data.

In a finding with significant implications for the way in which hospital performance is assessed in future, the auditor reported that although there was no evidence the official had acted under ministerial direction, there had been substantial pressure on her to "improve the publicly reported performance information of the Emergency Department".

"The managerial pressure reflects the significant and ongoing focus on the timeliness performance of the Canberra Hospital and the requirements of the National Partnership Agreement," the auditor's report said.

The 2011 National Partnership Agreement between the Commonwealth, States and Territory governments set a time limit of four hours within which 90 per cent of all emergency department patients have to be admitted, discharged or referred on for treatment elsewhere.

Under the Agreement, State and Territory governments have to ensure their hospitals meet this target in order to be eligible for reward funding, which the Auditor estimated would be worth around $800,000 a year for the ACT through the next four years.

The performance of hospital emergency departments is also assessed according to the Australasian Triage Scale, which sets patient treatment times according to the severity of their condition.

Category 1 patients are those classified as those who life is under immediate threat, and all in the category must be treated immediately. At the other end of the scale are patients in the "less urgent" category 5, 70 per cent of whom should be treated within two hours of presenting at emergency.

The Audit estimated that in the 12 months to April this year, Canberra Hospital's records were manipulated such that the timeliness of treatment for category 3 patients (classified as suffering "potentially life-threatening" conditions) was overstated by 19 per cent, and for category 4 patients ("potentially life-serious") they were overstated by at least 10 per cent.

"This involved changes to at least 5800 patients records out of a total of 43,000 records in one year for these two triage categories," the audit report said, though it admitted that "the level of over-estimation cannot be established with certainty".

It found that "very poor systems and practices in the Canberra Hospital" had created ample opportunity for people to manipulate hospital records virtually undetected.

Inquiries in other jurisdictions suggest this is unlikely to be an issue solely in the ACT.

In 2009, the Victorian Auditor-General's Office warned of "a significant risk of incorrect reporting associated with Emergency Department timeliness performance", and a 2008 report by Deloitte Touche Tohmatsu found that the majority of public hospitals used the same information system as that so easily manipulated at Canberra Hospital.

The ACT audit report noted that the introduction of the four-hour rule in the United Kingdom was "accompanied by widespread gaming and fraudulent manipulation of hospital data".

The issue has brought into sharp focus the significant shortcomings of time-based measures in assessing the care provided by hospitals.

The ACT Auditor-General lamented a lack of benchmarks relating to the quality of treatment, rather than its speed – a shortcoming acknowledged by the Director-General of the ACT's Health Directorate, Dr Peggy Brown.

"The attention placed on Emergency Department [ED] timeliness as a performance measure is significantly higher than the attention placed on almost all other parts of the health system," Dr Brown wrote in response to the audit findings. "The focus on

...CONTINUED ON PAGE 7

Perverse incentives in hospital funding, experts warn

Reforms to the nation's hospital funding arrangements will not improve patient care or end the blame game between Commonwealth, State and Territory governments, leading health economists have warned.

While the Independent Hospital Pricing Authority has dismissed concerns that all states and territories except NSW and Victoria will lose millions of dollars of Commonwealth support in the shift to activity-based funding, Melbourne Institute economists Professor Anthony Scott and Associate Professor Jongsay Yong predict the system will fail to deliver better care.

IHPA acting Chief Executive Tony Sherborne told the *Weekend Australian* that Authority modelling obtained by the *Tasmanian Times* showing Queensland would lose almost $654 million under the new funding scheme, while WA would lose $124 million and SA almost $30 million was outdated, and the Commonwealth had guaranteed all funding for the next two years.

But Professor Scott and Associate Professor Yong argue there are deep flaws in the design of the national activity-based funding system.

Writing in *The Conversation*, the economists warn that the scheme does not reward measures to keep people out of hospital, and instead provides incentives for institutions to "cherry-pick" patients and avoid those whose treatment involves the greatest complexity or least opportunity for efficiency.

Under the system, there is the potential for hospitals to make a profit on services if they can deliver them at a cost below the national efficient price.

This means, according to Professor Scott and Associate Professor Yong, that the strongest incentive will be for services that deliver the greatest potential profits – not necessarily those that deliver the greatest health gains for the population.

They warn the system will also encourage hospitals to dump unprofitable services and send patients with complex problems elsewhere, while doing nothing to end the blame game between different levels of government over health funding.

The system came into effect at the start of the month, with current levels of funding guaranteed until mid-2014, when the Commonwealth cuts its share of funding to 45 per cent.

The AMA has raised a number of concerns about the new system, particularly regarding its capacity to take account of the future funding needs of hospitals.

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

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

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Patient care being lost in drive to meet targets

...CONTINUED FROM PAGE 6

ED timeliness does not take into account broader measures of patient outcome."

The Auditor-General recommended that hospital performance indicators be reviewed to "include, and give a greater emphasis to, qualitative indicators relating to clinical care and patient outcomes", a suggestion that Dr Brown said would be adopted by the Health Directorate.

The audit report's findings and recommendations echo concerns and reservations expressed by the AMA two years ago regarding the setting of time-based targets for public hospital emergency departments.

In a 2010 position paper, the AMA said it "cautiously supports…an aspirational time-based target", but only as part of a suite of measures, noting that emergency department delays were largely due to capacity constraints elsewhere in a hospital.

"Improving ED waiting times can only occur with investment in whole-of-hospital, and community, capacity," the position paper said. "This means funding more beds to reduce average bed occupancy rates in hospitals to 85 per cent, and to provide an appropriate quality of care for all hospital patients."

In a prescient warning, the paper cautioned that "targets should be used to drive improvements and to identify hospitals needing further investment ands resources. Penalties will only lead to data manipulation and gaming…not lead to improvements in patient care".

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Cancer patients waiting three months for surgery: report

Many cancer patients are waiting more than three months for elective surgery, highlighting AMA concerns about the nation's chronic shortage of hospital beds.

Prostate cancer patients face an average wait of more than 30 days for elective surgery, with 10 per cent still to receive treatment after almost 100 days, a study by the Australian Institute of Health and Welfare has found.

According to the study, bladder cancer patients are only marginally better off, facing an average wait of more than 20 days, with 90 per cent of patients treated within 80 days.

Lung cancer and breast cancer patients fared the best, with patients waiting an average 11 and 15 days respectively for treatment, and 90 per cent admitted to hospital within 30 days.

AMA President Dr Steve Hambleton said lengthy waits for elective surgery were symptomatic of a hospital system that was struggling to cope with demand for care.

Dr Hambleton said a recent Council of Australian Governments report showed that increases in the number of public hospital beds were only just keeping pace with population growth, meaning that no inroads were being made into waiting lists for elective surgery.

"There were 872 more public hospital beds [in 2010-11] than in the previous year, but the number of beds per 1,000 population did not change," the AMA President said. "This means the new beds merely kept pace with the population and did nothing to increase the capacity of the hospitals.

"This has a direct impact on elective surgery performance, which is not improving. This is not acceptable to the patients waiting long periods for treatment."

Dr Hambleton said the situation was even worse when hidden waiting lists were taken into account.

"There are people who have been referred by their GP and are waiting to see a public hospital specialist to be assessed for surgery who are not counted in the waiting list data. They only get counted after they see the specialist and get booked in for surgery," Dr Hambleton said.

The Institute report found that more than a quarter of all patients hospitalised in 2010-11 required surgery. Of these, 12 per cent were emergency admissions while 82 per cent were for elective surgery. The majority of emergency surgeries were performed in public hospitals, while two-thirds of elective treatments were carried out in private hospitals.

Of those who received emergency surgery, the most common reasons were appendicitis, hip fractures and heart attacks. For elective surgeries, the most common reasons were cataracts followed by skin cancer, knee disorders and procreative management (including IVF).

More than 50 per cent of hospitalisations involving surgery were same-day admissions and the average stay of patients admitted to hospital requiring surgery was 8.3 days for emergency admissions and 3.9 days for elective admissions.

Compared with national rates, Indigenous Australians and people living in remote areas had higher rates of emergency surgery admissions but lower elective surgery rates.

For more information visit www.aihw.gov.au

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The AMA – the independent voice of GPs

The AMA is a powerful voice for general practice, working to ensure that Government policies and funding serve the needs of patients, the community and GPs.

Real advocacy requires independence, and the AMA is the leading body equipped to provide independent, high quality and nationally-coordinated political advocacy for GPs and their patients.

GPs can be assured that their interests are being championed by the strong voice of the AMA, both in the corridors of power and through the media.

In addition to highly-public and effective advocacy through the nation's newspapers, radio stations and television shows, a lot of work goes on behind the scenes.

AMA officeholders meet regularly with ministers, MPs from all sides as well as senior government officials. Even less visible, but just as significant, is the work AMA representatives do advancing the interests of GPs on government committees and advisory groups - all contributing to the mission of ensuring that the voice of GPs is heard loud and clear in setting Australia's health policy.

GPs have a direct say in the work of the AMA through the AMA Council of General Practice (AMACGP), which guides AMA policy and direction. The AMACGP – the peak independent national council for GPs – represents a diverse range of GPs from across Australia.

AMACGP members come from practices of all sizes and settings, including those in rural and remote areas - ensuring that the Council is truly reflective of general practice across the country.

In addition to its advocacy work on behalf of GPs, the AMA has also developed a one-stop shop specifically for GPs, bringing together essential information and resources at one easily accessed site website: http://ama.com.au/generalpractice

The AMA website has a host of information about the work the Association is doing to advance the interests of GPs as well as improve health care. Currently the AMA is working hard to:

- ensure personally controlled electronic health records work to the benefit of GPs and other medical specialists and their patients;
- support the needs of International Medical Graduate doctors to ensure they are able to practice competently and confidently and meet Australia's high standards for medical practice;
- develop a better model for managing complex and chronic care;
- boost the teaching capacity in general practices, including better infrastructure and support for teaching; and
- greater support for the role played by GPs in providing mental health care.

Some recent achievements by the AMA in getting a better deal for GPs include:

- increasing the number of medicines covered by the streamlined PBS authority prescription process;
- lobbying successfully for a significant expansion of prevocational and vocational GP training places;
- securing funding for GP-referred MRI - from 1 November 2012, GPs will be able to order MRIs for under 16 year olds for some conditions, with a further expansion in November 2013;
- convincing the Government to dump its plan to introduce new capped funding arrangements for the care of patients with diabetes;
- securing extra funding to support the employment of practice nurses, complete with transitional measures to ensure GPs are not disadvantaged by new funding arrangements;
- funding for GP infrastructure grants to around 425 GP facilities;
- delaying Government changes to the after-hours funding arrangements; and
- the launch of the DVA Coordinated Veterans' Care Program, with additional funding for GPs in caring for the veterans' community

AMA Family Doctor Week 2012

The AMA Website is a good place to find all the resources developed to support the work of GPs. AMA GP members will find the following recently developed resources particularly useful:

GP Desktop Practice Support Toolkit

This toolkit contains links to more than 300 commonly used practice tools for general practitioners. It is available free for AMA members and can be easily accessed via a link that can be placed on your desktop.

AMA CPD Tracking Service

The AMA CPD Tracking service is available to all medical professionals to help manage Continuing Professional Development (CPD) recording requirements. This service is available free to AMA members and at a small cost to non-members.

GP Network News

The AMA produces a weekly electronic bulletin summarising the key political and policy issues affecting general practice for the week. If you are not on the current email list for GP Network News, send an email to ama@ama.com.au so you don't miss out. You will also find copies of recent editions on the AMA GP landing page.

The AMA is proud to represent Australia's GPs and on behalf of all of us at the AMA, we congratulate GPs on all the work you do in providing a *lifetime of trusted care* to your patients and their families.

TO COMMENT CLICK HERE

When being a general practitioner is like being a great friend

Dr Chris Clohesy
Leabrook, South Australia

A great friend is someone you can sit on a veranda with, never saying a word, and leave thinking that was the best conversation you've had.

Luke, one of my long term patients, noticed a small white lump on his lower lip. Via the usual referral pathways, Luke had the lump excised. Histology revealed melanoma but incompletely excised. Subsequent excision was complete and Luke was all fine until two years later when he noticed a lump in his neck.

Biopsy demonstrated melanoma and Luke was devastated. Cervical clearance was performed, followed by radiotherapy to the lip and neck. After three long, painful months of mouth ulcers and pain, Luke finally recovered well. Six months later a small lump again developed in the lower lip near the original excision site. Luke underwent another excision of the lip, which again demonstrated melanoma with a suggestion of neural invasion. A conservative approach was decided upon.

Luke was a keen cyclist and found riding was a great way to make him forget about his illness. I can still remember when he came to my clinic saying he had fallen off his bike that morning and couldn't understand why. That night his wife called me to say Luke had fallen at home and he had grazed his face. She asked if I could do a home visit. Luke had some minor abrasions and I reassured him and his wife and said I would catch up with him again in the morning.

Early the next morning Luke was found unconscious by his wife in bed. He was taken to hospital and MRI demonstrated trigeminal nerve invasion by melanoma extending all the way to the brainstem. Luke never regained consciousness and died several days later.

As Luke's general practitioner, I travelled the long illness journey with Luke. Sometimes he would sit in my office and we would have long conversations about life. Other times he would just cry and not say much at all.

General practice is much like a great friend. Someone you feel comfortable and secure with. Someone you can rely on. Someone you can sit with, without saying a word, but on leaving, thinking that was the best conversation you've had. I tried to provide that for Luke, and I think that is what being a general practitioner is all about.

TO COMMENT CLICK HERE

Looking after the unworried unwell

Dr Bowman with three women from Wurrumiyanga

Dr Jan Bowman
Wurrumiyanga, Tiwi Islands, NT.

I sat on the side of her bed and cried. Around me, in the open air outside her house, 50 or more relatives yelled at each other. I held her hand. "Monday," she said, "I'll go to hospital on Monday".

"Monday is four days away, by then it will be too late," I replied.

Meanwhile, the arguments raged around her, with some of the family saying "make her go", and the other half saying, "we must respect her wish to die in her own country".

I reached over and turned off her IV, propped up on a forked stick at the end of the bed. The antibiotics were finished, but they were not going to save her now. Her four-year-old held onto her closely, wondering what was happening.

It had been a long road for Possum. From recurrent attacks of rheumatic fever as a child to severe mitral valve disease, a very large heart, atrial fibrillation, warfarin, and the unavoidable need for surgery.

Twice she had got as far as the plane and twice declined to go at the last minute. Getting the money to pay for travel again had been a major problem. It was not just to Darwin – she had to go all the way to Adelaide for her surgery.

She died next morning. At least 100 people had spent the night around her fire, singing, praying and giving her support as she lay on her bed under the stars. Because of all the fighting, a smoking ceremony was held to heal the family. I was the first person led through the smoke and brushed all over with leaves. The family had seen my tears.

There have been many tears over the years. People ask "Do you enjoy your job?" and I say, "Enjoy is not the right word. It is very challenging. Satisfaction, contentment, but not enjoyment."

Yet there is nothing I would rather be doing. I have come to love these people, with a realistic and accepting love. No, they are not saints – although some of them would probably qualify.

Yes, they do drink too much and smoke too much and not take their pills. They don't complain and they never come in because "I'm tired doctor" - although they often should.

Dr Bowman contemplates a mangrove worm for lunch

Dealing with the Aboriginal community is not about looking after the worried well; it is about looking after the unworried unwell. I could never work in suburban general practice after this.

TO COMMENT CLICK HERE

Patient trust and variety the spice of GP life

Dr Liz Marles
Hornsby, NSW

My passion for general practice began to take root as I was teaching biology and maths in high school.

At the age of 28 I left my established teaching career to study medicine, and found that there were very few areas that were not intrinsically interesting. After working in the hospital system for a few years, I completed the Royal Australian College of General Practice training program to qualify as a general practitioner.

There has never been a day that I have regretted embarking on this journey. I love general practice and I love being a family doctor.

I love the generalist nature of my profession, where I can utilise all my clinical skills, as well as being able to pursue my special interests in Aboriginal health, diabetes and mental health. Not only is the diversity of medical conditions appealing, it is also the diversity of people that I encounter in my job that makes general practice a career of choice.

To do this job you need to enjoy talking to people. This is what makes it really interesting. I find it a privilege that people are willing to share their most intimate stories with me and that I am the person they come to when they are having problems.

As a family doctor, I am able to know my patients really well. I know what is going on in their lives, in their workplace and in their homes. I know their family members and what has happened to them in the past. All of this helps build a context so that when they come in with a particular problem, I can much more easily understand where they are coming from. This doctor-patient relationship is the very essence of general practice and underlies its appeal.

Due to my continuing relationship with my patients, I am able to prioritise their problems with them and we proceed to work through them over weeks, months and sometimes years. It is this ongoing continuity of care that really brings home the results. Being able to spend time talking to my patients, understanding what's going on, formulating a management plan and relieving their anxiety gives me great satisfaction.

As family doctors, we are diagnosticians, counsellors and managers of care. General practice is the best discipline in medicine. General practitioners are committed to their patients and deliver high quality patient care through a very personal doctor patient relationship.

TO COMMENT CLICK HERE

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, Stilnox sleeping pills, doctor flu vaccinations and the disclosure of drug company payments to doctors, Dr Hambleton was briefed on aspects of New Zealand's primary health care system during a visit to the country earlier this month. Dr Hambleton met with senior New Zealand Medical Association officials including chief executive officer Lesley Clarke, and held discussions with a number of primary healthcare providers including Ron Hooton, chief executive officer of ProCare Health, the staff of Rotorua Health Services, and Tim Mallory of Coast to Coast Health Care.

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First aid station at Coronet Peak, New Zealand

Dr Hambleton with New Zealand Medical Association CEO Lesley Clarke and guest

Dr Hambleton with Rotorua Area Primary Health Services staff

Dr Steve Hambleton meets Ron Hooton (second from left), CEO of Auckland based ProCare Health and guests

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

Minister, we have a problem: AMA boss Steve Hambleton, *The Australian*, 3 July 2012

The launch of the personally controlled electronic health record system was akin to "throwing a paper plane out the window at Cape Canaveral", AMA President Dr Steve Hambleton says.

Sleeping menace, *The Adelaide Advertiser*, 3 July 2012

AMA President Dr Steve Hambleton comments on the sleeping medication Stilnox. He says the drug had a place when used as recommended but should never be used long-term

Doctors shy from jab, *Sunday Mail*, 8 July 2012

AMA President Dr Steve Hambleton says patients deserve to know if their doctor has been immunised for the flu.

Medical apps have a healthy take up, *Canberra Times*, 7 July 2012

AMA President Dr Steve Hambleton assesses 15 smart phone apps from a US website and says some might help patients.

Patients less likely to catch their child's cold, *The Daily Telegraph*, 11 July 2012

Dr Brian Morton, Chair of the AMA's Council of General Practice, says the results of a study showing parents of young children are less likely to get ill than adults without children seems counter-intuitive to popular thinking.

Radio

Dr Hambleton, 2SER FM, Sydney, 30 June 2012

AMA President Dr Steve Hambleton responds to controversial claims made by US ageing expert David Specter that Alzheimer's is not a tragedy but a normal part of ageing.

Dr Hambleton, 6PR Perth, 5 July 2012

The Australian Medical Association has welcomed moves by drug companies to disclose payments they make to doctors who endorse their products. AMA President Dr Steve Hambleton says some disclosure is better than none.

Dr Brian Morton, 2GB, 9 July 2012

Dr Brian Morton, Chair of the AMA's Council of General Practice, says a vaccine for human obesity is likely to be a long way off despite successful trials on mice.

Television

Dr Steve Hambleton, ABC1, 30 June 2012

AMA President Dr Steve Hambleton discusses the launch of personally controlled electronic health records, which he says will help improve the health system.

Dr Brian Morton, ABC News 24, 3 July 2012

The Australian Medical Association is supporting a move to ban athletes from using sedatives like Stilnox. The AMA says there are better, healthier ways of getting to sleep.

AMSA

Lack of leadership on asylum seekers costs lives – AMSA, 28 June 2012

The Australian Medical Students' Association calls on all politicians to put partisan politics aside and treat asylum seekers humanely.

Organ donation a key priority – AMSA, 2 July 2012

The Australian Medical Students' Association urges greater effort to promote organ and tissue donation.

Training needed for smooth transition to new era of e-health – AMSA, 2 July 2012

Hundreds of medical students at the Australian Medical Students' Association National Convention hear from the National E-Health Transition Authority regarding the personally controlled electronic health record scheme following its launch on 1 July.

Medical students call for marriage equality, 3 July 2012

The Australian Medical Students' Association calls for changes to legislation to give same-sex couples the right to marry.

AMSA calls for leadership on climate change, 3 July 2012

Celebrity scientist Dr Karl Kruszelnicki highlights the absurd reality that some politicians are still denying the potentially catastrophic effects of climate change to an audience of almost 1000 medical students at the Australian Medical Students' Association National Convention.

1000 medical students gather to address looming threats for medical education, 5 July 2012

The Australian Medical Students' Association urges the Federal Government to put an immediate hold on the number of medical school places.

AMSA launches National Blood Drive Campaign, 6 July 2012

The Australian Medical Students' Association launches its National Blood Drive, with medical students from universities across Australia competing to achieve the greatest number of donations.

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Where will Medicare Locals be in three years time?

BY **DR BRIAN MORTON**

"Any remodelling of Medicare Locals must be done in a way that is supportive of general practice, the rest of the primary health care sector, and the community"

At this year's National Conference the Shadow Minister for Health and Ageing, Peter Dutton, said: "We won't continue with the Medicare Local structure." Mr Dutton cited a range of concerns with the Government's Medicare Local model, including the potential for additional bureaucracy, and much of what he said reflected what the AMA has been saying.

What does this mean for Medicare Locals, should the Coalition win the next Federal Election? Will they be gone? Will the Divisions be restored? Or will they be redefined, reconstructed and rebadged? Clearly there is a need for some sort of structure, but the Coalition is yet to fully reveal its plans.

The AMA has said that if the Government got its Medicare Local model right, they could play an important role in supporting GP care by enhancing patient access to coordinated, necessary and integrated health services.

Mr Dutton is already on the record as saying there is a role for primary health care organisations to support general practice. This was enunciated in a speech in March this year to the General Practice Registrars Australia Conference, where he gave a positive assessment of the role of divisions of general practice.

The divisions of general practice had their good points, but many GPs would question how relevant many were to their day-to-day practice. Clearly, the AMA will need to guide the Coalition in the development of its policy platform so that it learns from the lessons of the past.

The AMA has the framework for that model in its position statement on Medicare Locals. Key aspects of a better model include skills-based boards with a strong GP presence; meaningful local GP involvement in the governance structure and decision-making processes; efficient administrative structures; and accountability and transparency in governance, decision-making, and the allocation of resources.

What must be guarded against is their evolution into powerful fund-holding bodies purchasing GP services directly for a population group, interfering in the clinical care and fee-for-service aspects of general practice and rationing much-needed health services, while adding to the misuse of resources and the proliferation of bureaucracy within bureaucracy – with all the disconnection from the community and health care providers that entails.

Any remodelling of Medicare Locals must be done in a way that is supportive of general practice, the rest of the primary health care sector, and the community.

The AMA stands ready to provide strong advice to the Coalition, and I look forward to meeting with Mr Dutton in the coming months to discuss his plans for Medicare Locals and how to deliver outcomes for patients.

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Plans to force doctors to the country are duds

BY **DR DAVID RIVETT**

"Persisting with more of the same programs and incentives driving workforce provision is not going to work, and we are going to remain heavily dependent on overseas-trained doctors"

Currently we are seeing radical solutions touted to solve the rural doctor shortage. Geographic provider numbers and a compulsory period of rural service for all medical graduates seem to be top of the list. These are not sound or long-term solutions. Rather, they are bandaids and temporary fixes to paper over the glaring cracks in the current system.

Geographic provider numbers, assuming they are brought in with all current providers retaining their existing Medicare approved practice locations, would force newly-graduating doctors wishing to purchase an inner urban provider number to do so either on the open market with dollars, or to accrue rural service credit points from some years of rural service.

Those who couldn't afford to buy an inner urban provider number up front would be forced to go to rural or outer urban areas and save for a number of years to accumulate the funds or workplace credits needed to make such a move. This is a happy solution for those looking to sell their "desirable" inner urban practice locations. They would either get a handsome financial reward if locations are traded on the marketplace, or benefit from a restriction on potential competition if a workplace credit system was introduced.

Would such a scheme give rural Australia doctors keen to be in rural practice and likely to stay there? No way.

Would it make politicians and bureaucrats feel an inner glow that they had solved a difficult dilemma? Quite possibly it would, hence its danger.

Compulsory terms of rural service for all newly-graduating doctors, applied one would hope after their college training was complete, would mean the least experienced conscripted to gain workplace experience in rural regions. Not the best solution for rural Australians, and again a proposal unlikely to produce a happy workforce inclined to put down permanent roots - which is what rural Australia needs.

But much as we may damn these solutions, we need to weigh them against the current situation. Persisting with more of the same programs and incentives driving workforce provision is not going to work, and we are going to remain heavily dependent on overseas-trained doctors.

Thankfully, the AMA has a balanced multi-faceted solution containing carrots, not handcuffs. It involves providing enhanced training for doctors taking up rural practice, both when they are beginning as well as on an ongoing basis. In addition, it calls for better, more secure workplaces and an insistence on attracting sufficient numbers to allow doctors to have an occupationally healthy work-life balance.

It may be harder for bureaucrats to get their heads around this solution, but if it is embraced it could provide a high quality and lasting solution.

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Doctors and nurses must be heard in aged care reforms

BY **DR PETER FORD**

"... Dr Hambleton highlighted that with a greater focus on home care in the Government's aged care package, it will be very important that funding for medical and nursing services ensures older Australians have access to affordable, quality care"

The Minister for Ageing, Mark Butler, has established a high-level Aged Care Reform Implementation Council, to be chaired by Professor Peter Shergold, with the other members yet to be announced.

The Council will provide half-year updates on progress in the implementation of the $3.7 billion aged care reform package, *Living Longer. Living Better.*, announced in April.

The Minister will also set up a number of groups to "engage" the sector in the implementation of the aged care package, including a stakeholder reference group, a workforce advisory group and an Advisory Panel on Positive Ageing.

AMA President Dr Steve Hambleton has written to Mr Butler asking him to establish a specific forum for clinical providers in the aged care sector to advise both he and Health Minister Tanya Plibersek on the best options to better incorporate medical and nursing care in the aged care sector.

In his letter, Dr Hambleton highlighted that with a greater focus on home care in the Government's aged care package, it will be very important that funding for medical and nursing services ensures older Australians have access to affordable, quality care.

Over the years, the AMA has found it difficult to get traction on higher Medicare rebates for medical care for the elderly in home-based environments because of the siloed approach to Medicare and aged care policy and funding.

We have also worked hard to introduce efficiencies in providing medical care through improvements to infrastructure and workforce – chart-based prescribing, electronic records, clinical treatment rooms, GP video consultations to residents, more nurses to work with to better coordinate and manage patient care and improved access to allied health services.

A clinical advisory group that brings together medical and nursing groups with the relevant areas of the Department of Health and Ageing would stand a chance of being able to consider these issues in a connected way. We hope the Minister understands his responsibility in this area and we look forward to a positive response from him.

In the meantime, the AMA is consulting with its members on their experiences in providing medical care to older Australians. The results of a confidential online survey will inform AMA policy and lobbying for medical services for older Australians. This survey repeats a survey undertaken in 2008 and will provide a unique snapshot of whether anything much has changed for our members in the past four years.

The survey only takes about five minutes to complete. Click here to complete the online survey. http://ama.com.au/node/7959 The survey closes on 27 July 2012.

Your participation will help your AMA to ensure medical practitioners are appropriately supported in providing medical care to the growing proportion of older Australians.

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Supporting the best start in life for Aboriginal Peoples and Torres Strait Islanders

BY **DR STEVE HAMBLETON**

"The AMA believes that Australia needs to make a substantial investment in the life of Aboriginal and Torres Strait Islanders. There is now some strong evidence as to where those investments might best be made to support the best start in life"

It is generally accepted that the quality of a person's early years in life will have a significant effect on the quality of their later life, in terms of health and other outcomes. This is true for Aboriginal and Torres Strait Islander peoples, as much as for other Australians.

The health and early life circumstances experienced by many Aboriginal and Torres Strait Islander children are disturbing, and more on a par with those experienced in Third World countries rather than a wealthy nation such as ours. The AMA's 2008 Report Card *Ending the Cycle of Vulnerability: The Health of Indigenous Children* gives an indication of what these circumstances are, and what some of the potential directions forward might be.

Until recently, there has been a limited understanding of just what early life factors and conditions have on an individual's development and progression through life, and how significant. However, there is now an emerging body of research and longitudinal studies tracing various early life influences to outcomes later in life. This research can provide a more solid basis for identifying the types of interventions that will have the greatest effect in supporting families in the early years to ensure healthy development as a child and maximize positive health outcomes later in life.

As a continuation of its earlier focus on the health of Aboriginal and Torres Strait Islander children, the AMA's Taskforce on Indigenous Health will now explore best practice in early intervention to support the healthy development of Aboriginal people and Torres Strait Islanders through their early years. The Taskforce will interrogate the latest high quality research and expertise in the area, and also look at programs and measures that are already in operation, supporting resilience in Aboriginal and Torres Strait Islander children and youth.

The Taskforce on Indigenous Health Committee will visit the APY (Anangu Pitjantjatjara Yankuntjatjara) lands in South Australia to get first hand experience of the problems that affect healthy child development, as well as see the work groups in local communities are doing to develop solutions to these problems.

The AMA believes that Australia needs to make a substantial investment in the life of Aboriginal and Torres Strait Islanders. There is now some strong evidence as to where those investments might best be made to support the best start in life.

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Measuring quality in teaching, training and research: a puzzle with no pieces

BY **DR WILL MILFORD**

"The scramble for hospitals to adapt continues and it remains to be seen what impact this will have on hospital services"

With funding in the headlines and healthcare in a tight fiscal environment, July has seen the start of the roll-out of activity-based funding nationally – although the Commonwealth has guaranteed funding for the states and territories through to the end of the 2013-14 financial year.

The scramble for hospitals to adapt continues and it remains to be seen what impact this will have on hospital services. At this stage, funding for teaching, training and research remains unchanged, with continuation of pre-existing block funding.

Plans are afoot, however, for a scheduled change to activity-based funding for teaching, training and research in 2017-2018. The Independent Hospital Pricing Authority has flagged that it will be beginning work in this area within the next 12 to 18 months. It is vital that any changes to funding models for teaching, training and research are linked to performance measures that serve to enhance quality and accountability. Questions remain about how these will be developed, defined and measured.

In the Australian setting, a small number of initiatives provide information on the quality of the medical training experience. Projects such as the Medical Schools Outcomes Database and Longitudinal Tracking Project, which tracks medical students through undergraduate education, prevocational and vocational training, and the 2010 AMA Specialist Trainee Survey, which examined the views of vocational trainees about their specialist medical education and training experience, have provided some insight in this area.

It is also worth revisiting AMA's first Training, Education and Supervision (TES) survey. This voluntary survey of the quality of junior doctors' training, education and supervision was first conducted in 2009 and attracted 900 respondents.

It delivered a mixed report card. Public hospitals provided more than 80 per cent of junior doctors with easy access to educational and information resources, and around 75 per cent of respondents reported that they received useful team- and unit-based teaching on a regular basis.

On the other hand, nearly one-third of respondents believed that they were not provided with adequate and appropriate supervision. Similarly, 48 per cent of the junior doctors surveyed felt that their training hospital did not quarantine sufficient time from service delivery for education and training. Other significant conclusions included decreased opportunities for education and training due to inadequate investment in staffing, a culture lacking in encouragement for high-quality medical education and poor investment in the next generation of clinical teachers and researchers.

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RESEARCH

Adverse effects of obesity kick in at age six

Children only begin to suffer detrimental effects from being overweight or obese beyond six years of age, after which the damage caused to their health gets progressively worse as they get older, according to a study by Murdoch Childrens Research Institute.

The study, based on an examination of morbidity patterns in more than 16,300 normal, underweight, overweight and obese children between the ages of two and 18 years, found that the relationship between poor health and weight varied greatly depending on age.

Toddlers and pre-schoolers were most likely to have poor health if they were underweight, according to the research, but this was reversed for older children. Between the ages of six to 18 years, children and adolescents who were obese suffered poorer health than those carrying less weight. Surprisingly, children in the age group who were underweight were among the healthiest, at least physically.

Children between the ages of six and 18 years whose weight was in the normal range were the most likely to have the best psychological and mental health outcomes.

The study found that obesity rates were consistent across all age ranges, with more than 20 per cent of children identified as overweight or obese compared with 5 per cent who were underweight.

Lead researcher Professor Melissa Wake said the study confirmed previous findings that obese children overall experience a lower health-related quality of life, though not when they are very young. The association between being overweight and suffering poorer health only becomes apparent when children reach school age, and strengthens as they get older.

"Our findings are consistent with research that shows overweight and obese older children and adolescents report poorer global health, more primary health care needs and higher prevalence of wheeze and asthma than children of normal weight," Professor Wake said.

"Importantly, what it also highlights is this period of time between early onset of obesity, when young children don't really feel its full health related effects, and adolescence, when obesity really starts to bite.

"The positive flip-side of this is that doctors and researchers have a really long window to intervene."

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Second hand smoke linked to obesity

Adults who are exposed to second hand smoke are at similar risk of developing Type 2 diabetes and obesity as smokers, according to a new study.

Based on an examination of the health of more than 6300 people, the study found that in addition to an increased risk of diabetes and obesity, people exposed to second hand smoke also had elevated insulin resistance, higher levels of fasting blood sugar, and a higher haemoglobin A1c reading.

The study, presented to US Endocrine Society's annual meeting, found that the risk of developing Type 2 diabetes for people exposed to second hand smoke was the similar to that of smokers. Interestingly, the study also found that smokers were more likely to have a lower Body Mass Index than non-smokers.

Lead researcher Dr Theodore Friedman said the study showed that the association between second hand smoke and Type 2 diabetes was not due to obesity, though he added more research was needed to show whether second hand smoke is a cause of diabetes.

Dr Friedman said that more effort needed to be made to reduce the exposure of individuals to second hand smoke.

The findings highlight the AMA's longstanding concerns regarding the risk to health from tobacco smoke and its push for smoke-free workplaces and public areas.

SmokeFree Australia – a coalition of organisations for the promotion for tobacco free workplaces, which includes the AMA – has called for governments to end smoke free law exemptions and loopholes in order to protect people from exposure to tobacco smoke in workplaces.

Co-ordinator of the coalition, Stafford Sanders, said that in some states workers still face preventable exposure to second hand smoke and risk significant and permanent damage to their health.

Workplaces where employees are still exposed to second hand smoke include;

- fully enclosed high roller gaming rooms (NSW, VIC, QLD, WA, NT);
- outdoor or partly enclosed public drinking and dining areas (NSW, VIC, SA); and
- prisons, custodial and mental health settings

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Mothers turn to GPs for help overcoming baby blues

More than 110,000 mothers suffer perinatal depression and the majority turn to their family doctor for help, an Australian Institute of Health and Welfare study has found.

The report showed that one in five mothers with children younger than two years reported being diagnosed with depression 2010, with half indicating that it had arisen in the period between the onset of pregnancy and their child's first birthday.

In a sign of the important position family doctors occupy in the care of mothers and infants, almost 70 per cent of women diagnosed with perinatal depression said their first port of call in seeking assistance was their GP.

AMA President Dr Steve Hambleton said family doctors were well placed to help patients who became mothers.

"Our long-standing relationships with our patients, and our knowledge of their family background and its support structures (or lack thereof), are vital to early diagnosis of, and intervention in, this common problem," Dr Hambleton said.

The report found those most at risk of suffering perinatal depression were women aged less than 25 years, smokers, those from low-income households and hose whose first language was English.

Women were also more likely to develop perinatal depression if they were overweight, their child regularly used a dummy, their baby was delivered by an emergency caesarean section, they did not take leave for the birth or care of the child or, alternatively, if they were not working.

Mental Health Minister Mark Butler welcomed the report and said Labor was committed to addressing prenatal depression though its National Perinatal Depression Initiative.

"The National Perinatal Depression Initiative aims to improve prevention and early detection of antenatal and postnatal depression, and to provide better care, support and treatment for expectant and new mothers experiencing depression," Mr Butler said.

Mr Butler said the Government has provided $55 million towards the Initiative, with a large portion going to universal screening, support services, and training.

Beyondblue, with Government assistance, have developed clinical guidelines for the screening and treatment of perinatal depression and related disorders for medical professionals. For more details, go to http://www.beyondblue.org.au/index.aspx?link_id=7.102

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Primary health care research gets a funding boost

The economics of primary health care, and how it can be better used to tackle obesity and improve oral health, will be the focus of a multi-million dollar research effort at the Australian National University.

The ANU's Australian Primary Health Care Research Institute has announced $7.5 million in funding to establish three new Centres of Research Excellence in primary care, including the Finance and Economics of Primary Care, Primary Oral Health Care and the Centre for Obesity Management and Prevention Research.

The Finance and Economics centre will examine ways to reform primary health care to improve its availability, governance, performance and sustainability, while the other centres aim to provide insights into ways to better prevent or manage chronic conditions.

Research Institute director, Robert Wells, said the three new centres would add significantly to the depth of health care research in Australia.

"The Centre of Research Excellence in the Finance and Economics of Primary Care will focus on the finance and economics of health care, aiming to build an evidence base to support primary care reform," Mr Wells said.

"The Centre of Research Excellence in Primary Oral Health Care will research the growing concern of oral health care. Oral health is fundamental to overall health and quality of life and this Centre will focus on improving oral care through addressing knowledge gaps and forging links between dental care and primary health care.

"Finally, the Centre of Research Excellence for Obesity Management and Prevention will focus on another key issue facing Australia – obesity. The team will provide evidence of the effectiveness of interventions and strategies in primary health care to assist people to improve their lifestyle and achieve and maintain weight goals."

The Centre of Research Excellence in the Finance and Economics of Primary Care will be based at Sydney's University of Technology in Sydney, in collaboration with the University of Queensland and the University of New South Wales. The Primary Oral Health Care centre will be based at the University of Adelaide in collaboration with the University of Tasmania, while the Centre for Obesity Management and Prevention will be based at the University of New South Wales, in collaboration with the University of Sydney, Deakin University, the University of Adelaide and the Inala Indigenous Health Service.

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HEALTH ON THE HILL

Treaty threat to generic medicines put on hold

An influential parliamentary committee has warned against ratification of a controversial trade treaty amid concerns it could restrict access to generic medicines.

The Joint Standing Committee of Treaties has urged the Federal Government to delay signing up to the Anti-Counterfeiting Trade Agreement (ACTA) because of doubts that it is in the national interest.

The Agreement, which has encountered stiff opposition in Europe, the United States and Asia, is intended to strengthen international intellectual property right standards and crack down on counterfeiting and piracy.

But Committee chairman Kelvin Thomson, a Labor MP, said it had a number of flaws and should not be considered for ratification until an independent analysis of economic costs and benefits is conducted and there is greater certainty about the scope and operation of the proposed treaty.

"The Committee is concerned about the lack of clarity in the text, the exclusion of provisions protecting the rights of individuals, and ACTA's potential to shift the balance in the interpretation of copyright law, intellectual property law and patent law," Mr Thomson said, adding that the Committee was yet to be convinced the Agreement was in the nation's interests.

Under prodding by large companies with major investments in copyrighted and patented products, he United States and Japanese governments began working on the Agreement in 2006, and Australia and several other countries and regions including the European Union, South Korea, Switzerland, Mexico, New Zealand, Morocco and Singapore subsequently joined negotiations, and the text was finalised in May last year.

According to the Department of Foreign Affairs and Trade the treaty would ensure Australian intellectual property protections were observed internationally.

But critics, including generic medicine producers, trade experts and civil society groups argue that its provisions would skew rights and protections heavily in favour of copyright and patent holders at the expense of the public, and infringe on the powers of the Therapeutic Goods Administration.

Generic medicines manufacturer Alphapharm described the Committee's recommendation to delay ratification of ACTA as a "win for the nation's health system".

"While we support strong anti-counterfeiting measures, ACTA…had the potential to delay access by Australians to quality, safe, efficacious and affordable generic medicines," Alphapharm managing director Martin Cross said.

Dr Cross said that under ACTA, generic medicines that had been approved by the TGA and entered on the Australian Register of Therapeutic Goods could be declared counterfeit, potentially overriding the regulator's authority.

"It is essential that the Government does not become party to an international treaty which, in its current form, could have the unintended consequence of denying access to quality, safe, efficacious and affordable medicines," he said. "[Otherwise] taxpayers, government and consumers could [be] forced to pay unnecessarily high prices for medicines, causing cost blow-outs for the health system."

Australian National University trade policy expert, Hazel Moir, said the Agreement was "very poorly drafted, with a wide range of expansionary, ambit and unclear terms", especially regarding the protection of intellectual property and patents.

In a submission to the Committee, Dr Moir said broad-ranging references to intellectual property in the treaty opened up the possibility it could interfere with the functioning of the nation's patent system, particularly in the area of medicines.

"It would be a major policy change for Australia to introduce the measures proposed in this treaty with respect to patents," she said, particularly potential infringement on the authority of the TGA to approve manufacturing standards.

"It would be dangerous to prejudice this potentially life and death issue by removing clear and full control from the TGA," Dr Moir said.

The future of the Agreement is unclear, with even the US yet to ratify it.

The European Parliament's Committee for International Trade has recommended that the treaty be rejected, and countries including Germany, Switzerland and Poland have deferred decisions on its ratification.

Mr Thompson said it was significant that so many countries with interests similar to those of Australia were yet to approve ACTA, adding to the case for ratification to be deferred until an independent assessment of its economic and social costs and benefits had been made.

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Leak gives shape to Coalition health policy

An Abbott-led Coalition Government would devolve authority over hospitals to local boards, scrap means-testing for the private health insurance rebate, "rationalise" the health bureaucracy and defer to expert opinion on subsidising medicines, according to confidential briefing notes obtained by online publisher *Crikey*.

The 138-page document, marked "Confidential – Not-For-Distribution in this Format", was distributed to Coalition MPs earlier this month and outlines the Coalition's stance across a broad range of policy issues as well as suggesting lines of attack on both the Government and the Australian Greens.

While lacking fine policy detail, the briefing notes set out the general position the Coalition is likely to adopt on a number of health issues in the lead-up to the next federal election, including hospital finding, private health insurance, e-health records, dental services, GP Super Clinics and the Pharmaceutical Benefits Scheme.

In the document, the Coalition excoriates the Government over its efforts to reform hospital funding, accusing it of failing in its goal to end the "blame game" between Federal, State and Territory governments that has marred health policy.

According to the briefing, the Coalition supports increased public hospital finding, but wants to ensure it is more closely directed to the delivery of services to patients.

To this end "the Coalition will devolve power and decision making to hospitals", the document said, hinting at a reprise of the policy it took to the 2010 election calling for the creation of local hospital boards.

The document also attacks the Government over its $325 million bailout for Tasmanian's health system, promising the Coalition will "strengthen conditions on Commonwealth funding so the Tasmanian Labor-Greens' cuts to frontline hospital services are not rewarded".

On the Government's broader health reform agenda, the Coalition says it supports the functions that a host of new authorities and bodies have been created to perform, including the National Health Performance Authority, the Aged Care Financing Authority and the Medicare Locals Network.

But, in a sign that at least some will disappear under an Abbott-led Government, the Coalition promises to "rationalise the number of entities to reduce duplication, waste and over-regulation".

Shadow Health Minister Peter Dutton told the recent AMA National Conference that a Coalition government would not continue with the present Medicare Local structure, though he is yet to reveal what might replace it.

Minister for Mental Health and Ageing, Mark Butler, has seized on the leaked document to accuse the Coalition of muddle-headed policy thinking.

Mr Butler said that while Mr Dutton intends to abolish key agencies such as the National Mental Health Commission if he gets into government, other Coalition MPs are pushing for the creation of a mental health commission.

"On the one hand Peter Dutton plans to abolish key independent agencies like the National Mental Health Commission, and on the other hand Senator [Concetta] Fierravanti-Wells wants to establish another mental health commission. So what's the plan?" the Minister said. "Do they want to rationalise these national organisations or re-create them?"

In the document, the authors accuse the Government of interfering in the listing of medicines on the Pharmaceutical Benefits Scheme in order to save money, and pledges that a Coalition government would abide by the recommendations of the Pharmaceutical Benefits Advisory Committee.

The briefing note shows that the Coalition is unwavering in its hostility to the introduction of means testing for the private health insurance rebate, which it claims will cause many to dump their private health cover.

But the document gives only a qualified commitment to scrapping the means test, saying only that it will be done "as soon as it is financially possible".

The Coalition condemns the Government's GP Super Clinics program as a "missed opportunity beset by waste and mismanagement", arguing the money would have been better spent enhancing existing services and boosting teaching and training, but falls short of promising to axe the program and provides no detail about alternative support for GP services.

Regarding e-health, the Coalition says that although it supports the principle of the Government's controversial personally controlled electronic health records scheme, its implementation has been botched.

In the briefing notes the Coalition says it would have been better to have taken a more incremental approach to the introduction of the scheme, and there should have been "more productive leveraging of the non-government sector".

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HEALTH ON THE HILL

Polio sufferers going undiagnosed

A parliamentary committee has been told that more than 150,000 people may be at risk of suffering the late effects of polio even though the country has been declared free of the devastating illness for more than 12 years.

In a discussion paper intended to raise awareness of the condition, which can cause debilitating physical and neurological symptoms, the House of Representatives Health and Ageing Committee said that although there are no reliable estimates of the prevalence of the condition, it was likely that thousands of Australians were unknowingly suffering from late effects polio or post-polio syndrome.

In the paper the Committee said evidence suggested between 20,000 and 40,000 people were infected by polio between the 1930s and 1960s and could be at risk of developing late effects polio or post-polio syndrome (LEOP/PPS), while immigrants coming from areas where the disease has only more recently been eradicated or continues to be endemic may also suffer from the condition.

At a public roundtable to discuss the issue, Dr Stephen de Graaf, Director of Pain Services and Senior Rehabilitation Physician at Epworth Healthcare, estimated that between 0.6 and 0.8 per cent of the population were polio survivors, suggesting that between 132,000 and 176,000 people may be at risk of the condition.

The Committee said one of the factors making it hard to accurately gauge the prevalence of late effects polio and post-polio syndrome was that they were difficult to diagnose – a problem exacerbated by the lack of clear diagnostic tests and limited awareness among health professionals of the conditions.

The discussion paper said that early diagnosis was essential if patients were derive the greatest benefit from treatment, but this was hampered by lack of a definitive diagnostic test.

It heard evidence from sufferers that many had been misdiagnosed with chronic fatigue syndrome, and reported that "many people living with LEOP/PPS continue to experience frustration, often waiting years to receive the correct diagnosis".

The Committee heard that the effects of the affliction were substantial, including physical impairment as well as social, emotional and financial effects.

Committee chair, Labor MP Steve Georganas, said that "LEOP/PPS and its [sic] impact on the lives of sufferers, their families and careers have gone largely unrecognised in Australia".

"The Committee was particularly concerned about the lack of information on the prevalence of LEOP/PPS and the size of the population at risk," Mr Georganas said. "While the Committee understands that basic research is needed to improve diagnostic capability which will enable accurate determination of prevalence, in the meantime there is still a crucial need to establish a mechanism to gauge the possible extent of LEOP/PPS in Australia and the population at risk."

The Committee recommended that the Australian Bureau of Statistics and the Austrlaian Institute of Health and Welfare collect data on the size of the population of polio survivors, while medical schools include LEOP/PPS in their curricula and Medicare Locals work with groups such as Polio Australia to raise awareness of the condition both among health professionals but also the broader community.

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Promising signs disability not what it used to be

More than one million Australians report suffering disabling back problems or arthritic disease severe enough to limit their movement and ability to care for themselves.

But, in an encouraging sign of the increasing effectiveness of treatments and preventative action, official figures show the prevalence of disability is declining, with the proportion of the population describing themselves as disabled falling by 1.5 percentage points between 2003 and 2009 to 18.5 per cent.

Allowing for changes in the age composition of the population, there was an even great 2.1 percentage point fall over the period.

The Australian Bureau of Statistics' *Disability, Australia 2009* report found that in the six years to 2009, the proportion of those aged between 15 and 24 years with a reported disability shrunk from 9 to 6.6 per cent, while among those aged 25 to 34 years it fell from 11 to 8.6 per cent and among 45 to 54 year-olds it also dropped back, from 22 to 18 per cent.

By contrast, rates of disability among older age groups and the very young remained virtually unchanged, and the ABS attributed much of the improvement seen in the middle age groups to a decline in the proportion of people suffering disabling physical ailments such as arthritis and heart disease.

The ABS found that diseases of the musculoskeletal system and connective tissue were the most prevalent causes of disability, though their rate of incidence declined last decade, dropping from 6.8 per cent in 2003 to 6.5 per cent in 2009.

The most marked improvement was among those in the 45 to 64 years age group, where the rate of prevalence dropped 1.6 per cent, and there was a decline of almost 1 per cent among 18 to 44 year-olds.

Overall, the ABS found that of the four million who reported suffering a disability in 2009, almost 625,000 complained of debilitating back problems (15.6 per cent) and more than 590,000 (14.8 per cent) said they were suffering arthritis severe enough to impair their mobility or their ability to look after themselves or communicate with others.

But although chronic back pain remains the most common cause of disability, there is encouraging evidence that its prevalence among younger adults is shrinking even as it continues to grow among older Australians.

The proportion of the population reporting disabling back pain eased from 3.1 to 2.9 per cent in the six years to 2009, driven by a sharp 0.7 percentage drop in the 18 to 44 years age group to 1.9 per cent and an even greater 0.8 percentage point fall among 45 to 64 year-olds.

By contrast, rates of occurrence among those 65 years and older jumped from 4.9 to 6.3 per cent.

The ABS found a similar improvement among 45 to 64 years olds regarding rates of arthritis, with the percentage reporting disabling afflictions of the disease dropping from 4.7 to 4 per cent between 2003 and 2009 – an improvement it attributed to factors including the development of new and more effective treatments and the withdrawal of medication with significant side effects.

In a promising sign of the effectiveness of efforts to improve diet and exercise and discourage smoking and other activities that increase the risk of heart disease, the official figures showed there was a statistically significant fall in the proportion of 45 to 64 year-olds reporting to have been disabled by heart disease, from 1.1 per cent in 2003 to 0.6 per cent in 2009. Among those aged 65 years or more the proportion fell from 3.8 to 3.4 per cent over the same period.

Of the other sources of disability, 240,000 people (6 per cent of all disabled) reported that their mobility, or their ability to care for themselves and communicate with others, was impaired by hearing loss, while 120,000 each claimed disability stemming from leg injuries from accidents, from depression or from asthma.

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Drug companies to fess up to doctor payments

AMA President Dr Steve Hambleton has welcomed moves by the drug industry to disclose aggregate payments made to doctors.

Under a code of conduct developed by industry peak body Medicines Australia, pharmaceutical companies will be required to disclose all payments made to healthcare professionals, including for advisory and consultancy work, sponsorships to attend conferences and educational events, as well as for speaking engagements.

Dr Hambleton said the move to increased transparency of payments would help protect public confidence in the integrity of the medical profession.

But consumers groups have criticised the code for not going far enough.

Consumers Health Forum of Australia chief executive, Carol Bennett, told the *Sydney Morning Herald* the new rules were of little use because they stopped short of identifying individual doctors and the payments they received from drug companies.

"Consumers want to know that a practitioner is making a decision in their best healthcare interests, and that there is not some other purpose behind it," Ms Bennett told the *SMH*. "'It is important the practitioner, amount and source is identified. Until we get to that level of detail it is not that valuable to consumers, because it doesn't allow them to make an informed decision."

Medicines Australia chief executive, Dr Brendan Shaw, said his organisation was overseeing the establishment of a working group, including representatives of practitioners and consumers, to consider if and how to identify individual doctors and the payments made to them.

In its present form, the code requires only that aggregate payments be disclosed, including the number of doctors receiving funds.

Dr Shaw said that, even without the identification of individual practitioners and how much they received, the code represented a major shift toward greater transparency by the industry.

"Transparency is critical because it builds public confidence in the valuable and necessary engagements industry has with consumers and health professionals," he said. "Engagement with doctors is important and legitimate because patients want to be sure that their doctors know how to use the medicines they're being prescribed. Now the nature of that engagement will be much more transparent."

In addition to the disclosure of payments, the code bans competition prizes, personal gifts, and brand name reminders for health professionals, and well as an explicit requirement that clinical trial results be published in the scientific literature.

The code has been submitted by Medicines Australia to the Australian Competition and Consumer Commission for approval.

The AMA is considering making a submission to the ACCC regarding the code.

Dr Shaw said the new rules would ensure that relationships between the medicines industry, doctors and patients continued to meet expected ethical standards.

"Sponsorship of doctors to attend conferences and educational events, and payments for speaking, consulting or serving on advisory boards are important activities, and serve the interests of patients," he said. "Records of those payments will be publicly available. This kind of transparency will help ensure we continue to earn the trust and confidence of the community."

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Australia's first paperless hospital under construction

Work has begun on the nation's first 'paperless' hospital, which will use digital technology to give clinicians access to electronic records, x-ray results and pathology readings from virtually anywhere and anytime.

Under the plans St Stephen's Hospital, a 96-bed private facility, will open its doors in Hervey Bay in two years' time as the first centre of its kind in Australia to take advantage of the latest e-health technology.

The project, which is supported by a $47 million contribution from the Health and Hospitals Fund, will enable clinicians to get the latest information on their patients, including the results of any diagnostic and pathology tests, just by using their tablets, mobile phones, laptops or mobile computers on wheels.

The hospital's nurse call and telephone systems, as well as equipment such as blood pressure machines and infusions pumps, will be fully integrated into the system, increasing efficiency and giving practitioners scope to spend more time with their patients.

Mark Bulter, who was acting Health Minister at the time of the project's announcement, said the facility would deliver the residents of Hervey Bay and surrounding areas access to world class patient care with assistance from the latest in e-health technology.

"St Stephen's is an important local project that will deliver the benefits of the Federal Government's Health Reform agenda and commitment to e-health initiatives," Mr Butler said.

General Manager of St Stephen's Hospital, Leanne Tones, said the project was a unique opportunity to provide a flagship hospital not only for Hervey Bay, but for Australia.

"To be the first to build a fully integrated digital hospital in the nation is a privilege and an enormous responsibility," Ms Tones said.

"We are putting together a prestigious e-health project team, sourced from the best available in Australia and complemented by leaders in the field from the US."

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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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Implant rules tightened as regulator comes under fire

The Federal Government is tightening the regulation of joint implants following a spate of health scares and product recalls that have fuelled accusations of regulatory failure by the nation's medical watchdog.

Almost three years after an inquiry into the assessment of medical devices, the Therapeutic Goods Administration has re-classified all hip, knee and shoulder joint implants as high-risk, Class III medical devices, effective from 1 July, meaning they will subject to significantly greater scrutiny before being approved for use in Australia, and to much closer monitoring.

The move comes more than 18 months after the Administration finalised a report recommending reforms to the regulatory framework for medical devices, and comes amid accusations that it has failed to adequately protect patients from dangerous implants.

A Senate inquiry found that it took the TGA 21 months to directly contact surgeons to alert them and their patients about problems with French-made Poly Implant Prothèse breast implants after they were subject to an international recall.

As reported in *Australian Medicine* (2 July edition), the TGA is reviewing its advice to women PIP implants following a damning report by British health authorities which found that they were "significantly" more likely to rupture or leak than other implants.

Independent Senator Nick Xenophon has condemned the Administration for having an "incredibly lax attitude" toward the safety of PIP implants by approving them for use without requiring evidence that they were medically safe.

Senator Xenophon said two parliamentary inquiries had found there were serious systemic failures within the TGA, and "people are paying for these failures with their own health".

The decision to upgrade the classification of hip, knee and shoulder joints follows a string of incidents regarding the safety of such devices in recent years.

In 2001 the TGA recalled zirconia ceramic femoral head hip replacement components manufactured by Saint Gobain CÉramiques AvancÉes Desmarquest in France following reports of serious failures with the product, while in May last year it ordered the withdrawal of DePuy ASR hip replacements from the market, and earlier this year it cancelled the MITCH TRH System metal-on-metal hip replacement system from the Australian Register of Therapeutic Goods.

Senator Xenophon said the National Joint Replacement Registry had very early on flagged serious concerns about the DePuy implants, but it took the TGA a long time to act on the advice.

Parliamentary Secretary for Health and Ageing, Catherine King, said the decision to re-classify joint implants would increase protection for patients.

"It will better assure the safety, quality and performance of joint replacement devices," Ms King said.

Under the toughened regime, products will now need to be registered individually on the Australian Register of Therapeutic Goods, rather than being registered as a group, as they have done in the past.

Ms King said manufacturers and suppliers of existing joint implants would have two years to meet the more stringent regulatory standards, while those entering the market would need to comply immediately.

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E-health records off to a shaky start

The launch of the Federal Government's controversial electronic health records system has been marred by technical glitches amid concerns that efforts to consult with doctors on the introduction of the scheme have stalled.

Patients attempting to register for a personally controlled electronic health record on line have encountered problems including lengthy delays between registering and receiving access to their health record and the rejection of names that have an apostrophe in them.

AMA President Dr Steve Hambleton likened the system's launch to "throwing a paper plane out the window at Cape Canaveral".

"It's been a bit like, 'Houston, we have a problem' at 10 seconds to go, and now there's a three-month hold on the rollout," Dr Hambleton told The Australian. "At the moment, we haven't got anything other than an ability for consumers to register an expression of interest in having a personally controlled e-health record one day.

"But it will be October or later, probably, before the system can actually be used.

"GPs aren't ready, hospitals aren't ready – we haven't even seen what we'll need to do to get the software in place."

The Government has in recent months attempted to lower expectations about what would be available when the system was launched on 1 July, with Health Minister Tanya Plibersek outlining a staged introduction beginning with patient registration before moving to include doctors and hospitals in the system.

The AMA has raised a number of problems with the system directly with Ms Plibersek, including a lack of compensation for practitioners for the work involved in creating and maintaining accurate and useful electronic health records, inadequate time and resources available for doctors in preparing to take part in the scheme and the threatened withdrawal of information technology support for practices that do not take part in the scheme by early next year.

In a disappointing sign that Government efforts at consulting with doctors about the system's introduction have dropped away, Health Department officials are yet to agree to discussions to follow-up a meeting between Ms Plibersek and peak medical groups including the AMA on the issue last month.

Despite this, the Government is pushing ahead with aspects of the scheme, including the announcement that the role of the Australian Privacy Commissioner, Timothy Pilgrim, had been expanded to cover the electronic health system.

Mr Pilgrim urged patients to read the terms and conditions for using the system carefully.

"You are in control, so make sure you understand how your personal and health information will be collected, used and disclosed," the Commissioner said, adding that doctors and other healthcare providers also needed to fully understand their obligations under the scheme.

"Healthcare providers' obligations include not collecting more information from a patient's e-health record than is necessary, and making sure their staff are trained in how to handle e-health records correctly."

Mr Pilgrim said that in his expanded role he had the power to seek civil penalties and require enforceable undertaking form providers who fail to adequately protect information.

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World-first move to vaccinate boys against cancer

The AMA has welcomed a world-leading move by the Federal Government to fund vaccination for schoolboys to protect against a range of cancers.

Health Minister Tanya Plibersek has announced the Government will fund a program to administer the successful Gardasil vaccine to 870,000 12 and 13-year-old boys from February next year, following a recommendation from the Pharmaceutical Benefits Advisory Committee.

Ms Plibersek said the Commonwealth would provide $21.1 million over four years to fund the program, which will also include catch-up vaccinations for boys in Year 9 in the next two years.

AMA President Dr Steve Hambleton said the decision meant that Australia was leading the global charge against the human papillomavirus (HPV), which has been linked to cancers of the anus, penis, vagina and vulva.

Dr Hambleton said HPV was incredibly prevalent in the community, and targeting the vaccine at young people before they become sexually active will help significantly lower its incidence.

The Minister said that providing the human papillomavirus vaccine to boys would not only protect them against a range of cancers, but would increase the effectiveness of the existing vaccination program for girls.

"Already the HPV vaccine has had an impact – significantly reducing the number of lesions that lead to cervical cancer amongst women in the vaccinated age group," Ms Plibersek said. "It is estimated that a quarter of new infections will be avoided by extending the vaccine to boys."

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Treatment of wounded Diggers under scrutiny

A parliamentary inquiry has been launched into the treatment of Australian soldiers wounded in battle or injured while on operations as casualties continue to mount in Afghanistan.

The investigation, to be conducted by the Joint Standing Committee on Foreign Affairs, Defence and Trade, will examine the care provided to wounded and injured Australian Defence Force personnel, from initial treatment through to repatriation and long-term support for those discharged as medically unfit.

Queensland Labor Senator Mark Furner, who chairs the Defence Sub-Committee that will conduct the inquiry, said that while a lot of attention had rightly been focused on the circumstances surrounding the death of soldiers, less had been paid to the management of, and support for, those injured and wounded while on operations.

Defence Force figures show that 227 personnel have been wounded in action in Afghanistan since 2002, including 65 in 2010, 50 in 2011 and 14 so far this year.

Of those hurt in 2012, 10 have been wounded by roadside bombs and other improvised explosive devices and four have suffered wounds during direct contact with the Taliban.

The nature of injuries sustained included three personnel with broken bones, two with fragmentation wounds, one with lacerations and contusions, four with gunshot wounds and four cases of mild traumatic brain injury.

Senator Furner told *Australian Medicine* the members of the multi-party committee decided to examine the treatment of wounded and injured soldiers following a visit to a military hospital in Afghanistan's Kandahar province last year.

The Senator said the committee was concerned to ensure that soldiers, sailors and other personnel hurt in the line of duty receive the care and support they need, either to return to work or to move successfully into life outside the defence forces.

"The premise [of the inquiry] is that we always hear about fatalities, and we never get to hear about what happens to injured soldiers," Senator Furner said.

Senator Furner said the ADF, like any employer, had an obligation to have a rehabilitation plan for staff, and had provided the committee with some "very impressive" statistics on the return of wounded and injured soldiers to work.

As part of the inquiry, the committee will examine the care provide dto wounded and injured personnel in the theatre of operations; repatriation arrangements; on-going care on return to Australia; return to work arrangements; and the management of personnel unable to return to service - including those deemed medically unfit.

The inquiry, submissions to which close on 10 August, follows the announcement that Medibank Health Solutions has been awarded a $1.3 billion contract to provide health services including on-base health support, pathology, imaging and radiology and a 24-hour ADF national health hotline, to defence personnel for the next four years.

Minister for Defence Science and Personnel, Warren Snowdon, said Defence Force medical staff would continue to provide services for personnel while on deployment overseas, while Medicare would attend to the health of staff while in Australia.

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Controversial sleep drug stays on the market

The nation's medicines watchdog has refused to withdraw the controversial sleep pill Stillnox from the market despite a ban on Australian Olympic athletes using the drug amid revelations of dangerous side effects and dependency.

The Therapeutic Goods Administration said that although there was evidence Stillnox caused "extreme side effects" in some people, it was an effective treatment for severe insomnia if used properly, and should remain available.

The watchdog's decision came despite the Australian Olympic Committee's decision to ban athletes from taking prescription sleeping medication and revelations from Olympic swimming champion Grant Hackett that he had become heavily dependent on the medication after being prescribed it in the lead-up to the 2004 Olympic Games.

The TGA said that in 2008 it acted to reduce the sized of Stillnox packets and insist on "the most extreme warning available" to be placed on packaging to alert consumers to the possible side effects of the medicine.

The alert warns users that the drug zolpidem [Stillnox] may be associated with "complex sleep-related behaviours [including] sleep walking, sleep driving and other bizarre behaviours" and is not to be taken with alcohol.

Figures compiled by the TGA show that between 2009 and April this year zolpidem was associated with more than half of all drug-related documented cases of sleepwalking, an eighth of all drug-related documented cases of amnesia, almost 15 per cent of drug-related traffic accidents and almost 10 per cent of cases of legal drug dependence.

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Flu season could be worst in years

Experts have warned the country is headed for its worst influenza season in years amid signs infection rates and hospital admissions are soaring.

The Influenza Specialist Group, chaired by former World Health Organisation senior official Dr Alan Hampson, has reported that more than 5000 people have so far been diagnosed with the H3N2 and Type B strains of influenza – almost double the number who contracted the illness at the same time a year ago.

The Group said Queensland, with 2536 diagnosed cases as at 10 July, was the worst affected State, followed by NSW with 2391 confirmed infections.

While children younger than nine years have so far been hit hardest, the expert group said rates of infection among the elderly and those aged between 35 and 44 years were also rising quickly.

Dr Hampson warned the fact that the two strains had been relatively rare in recent years heightened this risk that this year's flu season could be particularly severe, with the likelihood of more fatalities.

"When we see high levels of H3N2, which is the predominant strain this season, there is significant impact, especially in high risk groups," he said. "Typically, we can expect to see more deaths and hospital admissions."

Dr Hampson urged those who have contracted the flu, particularly the elderly and those with underlying medical conditions, to see a doctor when they first notice symptoms.

"Antivirals can be beneficial if taken within 48 hours of noticing symptoms," he said, reducing the time spent ill and potentially reducing the severity of the infection.

Dr Hampson said people with the infection should stay home from work and avoid social situations, both to speed their own recovery and to reduce the risk of spreading the disease.

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Embattled governments take knife to health

Growth in health spending among developed countries has virtually stalled as severe government cutbacks and soft global conditions cut deep into health budgets.

Organisation for Economic Co-operation and Development figures show that after growing by almost 5 per cent a year between 2000 and 2009, health spending was flat in 2010 and preliminary data indicates it was similarly weak last year.

The deepest cutbacks in expenditure have been among European countries, particularly those at the epicentre of the eurozone crisis, where governments have been forced to slash spending in order to qualify for bailouts.

In Ireland health spending shrunk by a massive 7.6 per cent in 2010 after growing at an annual average of 8.4 per cent in the previous 10 years, and Iceland executed an even sharper turnaround, from an average gain of 9.3 per cent between 2000 and 2009 to 7.5 per cent cut in 2010.

The embattled Greek government slashed its health budget by 6.5 per cent in 2010 after it grew at an average annual rate of 6 per cent in the preceding decade.

As a result of the cutbacks, average health expenditure among OECD countries as a proportion of gross domestic product (GDP) fell back 0.1 of a percentage point in 2010 to 9.5 per cent – the first such decline in figures going back to 1990.

Australia bucked the trend, registering a 0.3 percentage point lift in health spending as a proportion of GDP in 2010 – the largest increase of any country included in the OECD and one of just nations out of its 34 members to record an increase.

The other nations in which expenditure as a proportion of GDP grew were New Zealand, Korea, Hungary and the Netherlands.

While health spending growth in the United States virtually halved in 2010, it continues to massively outspend every other country, with health consuming the equivalent of 17.6 per cent of GDP in 2010, compared with 9.4 per cent in Australia, 9.6 per cent in the UK, 10.1 per cent in New Zealand and 11.6 per cent in Germany. Mexico (6.2 per cent) and Turkey (6.1 per cent) had the lowest shares of national income devoted to health.

The OECD said that although health spending had withstood the initial phase of the global financial crisis in 2008 and 2009, it had been unable to escape the effects of the subsequent severe shocks that had hit the eurozone, particularly in countries on the zone's economic periphery.

"While government health spending tended to be maintained at the start of the economic crisis, cuts in spending really began to take effect in 2010," the OECD said. "This was particularly the case in the European countries hardest hit by the recession."

The organisation said medical workers had borne the brunt of the cutbacks in European countries, while investment plans have been scrapped, increasing the risk of facilities and systems become overloaded in future.

"Reductions in public spending were achieved through a range of policy measures," it said. "In Ireland, most of the reductions have been achieved through cuts in wages or the fees paid to professionals and pharmaceutical companies, and through actual reductions in the number of health workers.

"Investment plans have also been put on hold in a number of countires, including Estonia, Ireland, Iceland and [the] Czech Republic, while gains in efficiency have been pursued through mergers of hospitals and ministries, or accelerating the move from in-patient hospitalisation towards out-patient care and day surgery.

"The use of generic drugs has also been expanded in a number of countries."

The OECD said several governments had also acted to increase the contribution individuals make to the cost of their own care.

"For example, Ireland increased the share of direct payments by households for prescribed medicines and appliances, while the Czech Republic increased users' charges for hospital stays," it said.

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Carbon tax and fees

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

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

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Helmet push for dangerous sports

The American Medical Association is considering a push for the compulsory use of helmets in potentially hazardous sports and activities amid mounting concerns about the prevalence of traumatic brain injuries.

AMA delegates are urging the Association, which already backs legislation requiring people to wear helmets when skiing or snowboarding, to expand the range of activities encompassed by the proposed laws.

At least 1.7 million people suffer traumatic brain injuries each year, including almost 1.3 million cases of concussion, according to the United States Centers for Disease Control. Of those injured, 52,000 die and 275,000 are hospitalised.

The proposed policy calls on the Association to promote awareness that even mild cases of traumatic brain injury can have serious and prolonged consequences, including affecting the ability to think, feel sensations and communicate, as well as increasing susceptibility for developing Alzheimer's disease later in life.

The move comes amid increasing concern in Australia about sports-related head injuries.

While helmets have been compulsory for cyclists on the nation's roads since 1990 and are regularly worn by cricketers, there is increasing discussion about the need for head protection in other sports including Australian Football League, rugby and professional boxing.

Earlier this year US brain injury expert Chris Nowinski, co-director of Boston University's Centre for the Study of Traumatic Encephalopathy, warned that AFL players could be prone to the debilitating condition, chronic traumatic encephalopathy, which has been diagnosed in many US sports stars – particularly gridiron players – who have suffered multiple blows to the head.

The issue came to prominence last year when former Melbourne Football Club player Daniel Bell launched action seeking compensation after revealing he had been diagnosed with brain injury linked to multiple concussions.

But the head of the AFL Medical Officers Association, Dr Hugh Seward, last month cast doubt on assertions that AFL players were exposed to the same level of brain injury risk as US gridiron athletes.

Dr Seward told The Age last month that although AFL physicians were "not naïve" about the threat of brain injury for AFL players, "we've got no evidence to suggest that the condition we're seeing in America from multiple head knocks - up to 1500 in a season - is akin to what we see in Australian football."

But the AFL Players Association has demanded that the issue be "taken seriously", and both it and the sport's governing body has commissioned a number of studies to examine the issue.

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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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Millions of poor could be left in the lurch despite Obamacare

Millions of the America's poorest citizens could be denied publicly-funded healthcare despite the Supreme Court's landmark decision approving key elements of President Barack Obama's Affordable Care Act.

While the US Supreme Court upheld the right of Washington to require that almost all citizens have health insurance by 2014 or pay a financial penalty, it knocked back provisions in the Act allowing the Federal Government to penalise States that do not extend coverage of the jointly-funded Medicaid program to cover all people earning less than 133 per cent of the national poverty level – the equivalent of $14,856 a year for singles and $30,657 a year for a family of four.

The Obama health reform plan had called for Medicaid – a means-tested program jointly funded by the Federal and State governments and administered by the States to cover the health needs of recipients – to be extended to include an additional 17 million low-income earners, around half of whom were uninsured.

Under the plan, States that refused to extend Medicaid coverage

Would have their Federal funding withheld.

But, while the Supreme Court allowed the expansion of Medicaid to stand, it ruled that the Federal Government could not threaten to withhold all funding – only that part that would pay for the extended coverage.

The American Medical Association said the decision meant States could refuse to extend Medicaid without opting out of the scheme altogether.

But Chief Justice John Roberts acknowledged that, even with the Federal funding threat withdrawn, States that decided not expand Medicaid could still pay a political price.

Under the terms of the statute following the Supreme Court's ruling, people earning up to 133 per cent of the national poverty level will not be eligible for Federal private health insurance subsidies, which are only for those earning between 133 per cent and 400 per cent of the poverty level (between $14,856 and $55,880 a year for singles, and between $30,657 and $115,280 a year for a family of four).

This means that the poorest people in the States who opt out of extended Medicaid might be penalised under the Affordable Care Act's individual mandate provisions requiring people to have health insurance, unless they are able to secure a waiver on hardship grounds, according to *American Medical News*.

Doctors have also raised concerns about other aspects of Obamacare, including the ability of the health system to meet the increased demand for care from additional 25 to 30 million people with health insurance.

The American Medical Association, which has long supported universal health insurance coverage and supports the Affordable Care Act, has nonetheless strongly objected to a provision allowing the Medicare Independent Advisory Board to recommend spending cuts when the program exceeds growth targets – a measure it believes will leave doctors exposed to arbitrary pay cuts.

And the new law is being challenged on provisions to block the expansion of existing physician-owned hospitals and bar new facilities from opening.

Despite these reservations, American Medical Association President Jeremy Lazarus welcomed the outcome of the Supreme Court challenge.

"This decision means millions of Americans can look forward to the coverage they need to get healthy and stay healthy," Dr Lazarus said. "The AMA remains committed to working on behalf of America's physicians and patients to ensure the law continues to be implemented in ways that support and incentivize [sic] better health outcomes and improve the nation's health care system."

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INFORMATION FOR MEMBERS

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

TO COMMENT CLICK HERE

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.

TO COMMENT CLICK HERE

AMA Fee List Update – 1 July 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 July 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 July 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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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

TO COMMENT CLICK HERE

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.

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

TO COMMENT CLICK HERE

Call for ideas to tackle global health issues

Health professionals concerned about global health issues will have an opportunity to hear from leaders in the field at a conference to be held in Melbourne next month.

Vaccine pioneer Sir Gustav Nossal, population health expert Professor Rob Moodie, maternal and child health expert Dr Alison Morgan and executive director of the HIV/AIDS Project Bill Bowtell are among the speakers who will address the Global Ideas Forum, to be held at the University of Melbourne from 24 August.

The forum is intended to help health professionals just embarking on their careers and who have a deep interest in global health issues to develop their ideas and advocacy skills.

All-inclusive tickets, which cover the cost of a conference dinner, are $250.

Details can be found at: http://www.globalideasforum.com/GlobalIdeasForum/Home.html

TO COMMENT CLICK HERE

Health a career option for Indigenous students

The Federal Government has launched a campaign to encourage Aboriginal and Torres Strait Islander secondary school students to consider becoming doctors and health workers.

Boosting the number and range of health services delivered by Indigenous Australians is considered an essential part of closing the gap in health and life expectancy between Aboriginal and Torres Strait Islander people and other Australians, and the initiative is aimed at getting young Indigenous people interested in working in the area.

The *Health Heroes* campaign features a website (www.australia.gov.au/healthheroes) that provides information about a range of health jobs, training options, career pathways and support.

The campaign includes 20 case study videos of young Aboriginal and Torres Strait Islander people who have taken up careers in health and talk about their experiences, and resource kits with DVDs, brochures, posters and lesson plan ideas for teachers and career advisors are available.

TO COMMENT CLICK HERE

Bangkok taxis - "Thai take-away!"

BY **DR CLIVE FRASER**

Anyone who has driven in Bangkok will agree that the traffic there is a nightmare and even crossing the road as a pedestrian is not for the faint-hearted.

Most visitors to Bangkok are far safer in a taxi, though even they can provide some hair-raising excitement, and drivers are notorious for ripping off customers by refusing to use the meter.

On my last flight to Bangkok I sat next to a very elderly man who struggled down the aisle with a particularly awkward limp.

As we would be sitting next to each other for 10 more hours I started chatting to him and asked him about his leg.

Now, we all know that conversations with the person sitting next to you on a long-haul plane flight can be either a grunt as they amble past to get to the toilet or their whole life history.

On this flight it would be the latter, and the lovely old gent explained that he'd been involved in a car crash in Bangkok.

He told me that his Toyota Corolla collided with a much larger truck and, as a result, he'd badly fractured his femur.

His Australian doctor said the Thai orthopaedic surgeon had done a pretty good job on the internal fixation, but he'd still been left with two inches of leg shortening, hence the limp.

He was fairly confident in the Thai health system, but only in as far as he was able to meet the surgeon's and hospital's request for payment by credit card on a daily basis, with the total bill being about $A30,000.

He believed that failure to pay up on time each day would have resulted in his sudden discharge from the hospital to the nearest pavement.

When I enquired a little more about exactly how "the accident" had occurred, he then explained to me that he'd been driving home after a night on the turps and that he was so p***ed he wasn't really sure what happened, but he thought "the accident" was clearly all his fault.

Eager to find out how the local constabulary might have dealt with such an event, he then explained to me that for the princely sum of 10,000 Thai Baht (approx $A308), the investigating police officer turned a blind eye to his drunkenness and wrote a report stating that the cause of the crash was unclear.

For someone from Queensland who'd lived through the Fitzgerald Inquiry this was all starting to sound very familiar, and it reminded me of just how much we take for granted the rule of law in Australia.

On returning to Queensland I was then surprised to read that the Australian Health Practitioner Regulation Agency doesn't conduct any criminal history checks on overseas-trained doctors (OTDs), other than to ask for self-disclosure of previous criminal activity.

Whilst OTDs are overwhelmingly an asset for medicine in Australia, one might wonder just how forthcoming anyone with something to hide might be.

Locally, all registrants are assessed by CrimTrac for matters that have occurred in Australia that might affect registration.

And whilst I was surprised that AHPRA itself doesn't request proof that a registrant has no criminal background, it is worth saying that those checks occur as part of the normal immigration process.

Even if AHPRA did start checking criminal histories, the proof from many countries does leave a lot to be desired.

For example, a US criminal history check is undertaken by the FBI and they require two sets of your finger-prints.

But some countries will simply provide a certificate from the local police, who hopefully aren't partial to bribes to afford an escape from justice.

In Australia we enjoy the option of telling our children that if they ever need help, they should find a police officer.

That isn't always the case in every other country.

As for my neighbour on the plane flight, he still has a blameless driving record, compliments of an obliging Thai police officer.

Bangkok taxis	
For	They should know where they are going.
Against	It may be faster to walk if the traffic is congested.
This car would suit	Ozzie travellers
Specifications	Thai taxis are mainly Toyota Corolla sedans There are 150,000 taxis in Bangkok Run on LPG 35 Baht flag-fall and 5 Baht per kilometre It costs 280 Baht to go 28 kilometres from Suvanabhumi Airport to downtown Bangkok (about $A8.60)

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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