AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Urgent changes needed to pay for health

AMA President tells Government: 'Work with us to improve health spending', p10

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Doctors in Training column

A large section of the Doctors in Training column by Dr Will Milford in the 16 July edition of *Australian Medicine* was inadvertently cut in the Flipbook and PDF versions of the publication. *Australian Medicine* apologises to readers for any inconvenience caused. The error occurred during production. The column can be viewed in full at: http://ausmed.ama.com.au/doctors-in-training/3504

Better, cheaper way to manage chronic disease

BY AMA PRESIDENT DR STEVE HAMBLETON

"GPs are skilled and ready to do more to ensure patients have access to multidisciplinary care and support services but, in its current configuration, the Medicare system stands in the way"

The AMA has proposed an overhaul of the way care is provided for patients with chronic ailments to improve coordination of health services, simplify access for patients and cut hospital stays.

The current arrangements to manage chronic disease – which accounts for around 70 per cent of total spending on disease – are limited, cumbersome, difficult to use and lead to unnecessarily high rates of hospitalisation.

We believe that the quality of care provided for people with multiple chronic conditions, and their associated complex care needs, could be improved by drawing more effectively on the skills and knowledge of GPs.

The recently-released *AMA Chronic Disease Plan: Improving Care for Patients with Chronic and Complex Care Needs* calls for better support for GPs to enable them to provide patients with chronic disease access to multidisciplinary care and essential support services.

GPs manage a vast array of conditions, with over one-third of the problems they manage chronic in nature.

The most common conditions treated are hypertension, depressive disorder, diabetes, cholesterol-related disorders, chronic arthritis, oesophageal disease and asthma.

GPs are skilled and ready to do more to ensure patients have access to multidisciplinary care and support services but, in its current configuration, the Medicare system stands in the way.

Current Medicare-funded chronic disease management arrangements are too limited, are difficult for patients to access, and involve considerable red tape and bureaucracy.

GP Management Plan (GPMP) arrangements in the Medicare Benefits Schedule do not provide for patient access to allied health and other support services, and GPs trying to arrange a team approach to care, including allied health professionals, become embroiled in red tape.

The *Chronic Disease Plan* calls for Management Plan arrangements to be simplified and streamlined to provide "automatic" access to a predetermined range of GP-referred services, similar to those provided for Department of Veterans' Affairs patients.

On referral from a patient's usual GP, GPMP arrangements could provide patients with access to five funded visits to allied health services a year; parenting programs for children at risk; and selected home aids.

This would relieve the burden on GPs from the current requirement that they consult with other care providers before referring patients.

Such a change would aid early intervention and treatment and help prevent or reduce episodes of hospitalisation.

This would not only improve the quality of care, it would lower health costs.

The AMA plan enhances existing arrangements and supports patients to spend more time with their GP when they need to.

It provides patients with streamlined access to a broad rang eof allied health and other support services, and it supports a more proactive approach to the delivery of care.

Our plan would ultimately provide savings for the overall health budget.

TO COMMENT CLICK HERE

Mentally ill lose out for sake of Budget bottom line

Health care for the mentally ill has become more expensive and harder to get as a result of Federal Government cutbacks to its Better Access Program, an AMA survey has found.

The proportion of doctors who bulk-bill for the preparation of mental health plans has plunged from more than 78 per cent to less than 39 per cent since the Government slashed $580 million from the program in the 2011-12 Budget, according to the survey of 404 GPs, while charges have increased.

Although 51 per cent of doctors who bulk-billed before the cutbacks continued to do so despite a drop in the Medicare rebate, 40.1 per cent have begun charging a co-payment, which for half of these averages between $21 and $40 per consultation.

Overall, the co-payment for completing a GP mental health treatment plan has jumped, with the proportion of doctors charging $31 or more surging from less than 29 per cent to 40 per cent following the cuts and almost 20 per cent charging more than $50.

Not only has treatment become more expensive, but the survey shows it has also become harder to obtain.

Almost 76 per cent of doctors reported access to mental health care for their patients had deteriorated as a result of the Better Access Program cuts, including 40 per cent who thought it had become "a lot" worse.

More than 63 per cent said that the number of mental health treatment plans they were preparing had fallen since the funding cuts.

AMA President Dr Steve Hambleton said the survey results showed that mental health care had suffered as a result of the Budget cuts, and urged the Government to restore the funding.

"The 2011-12 Budget cuts were clearly all about the Budget bottom line and nothing to do with improved outcomes for mental health patients," Dr Hambleton said. "Under the new arrangements, patients with mental illness receive less Medicare support than patients with physical ailments."

The AMA President criticised the Government for not consulting with practitioners about the cuts, or taking adequate account of their effect on care.

"There was evidence that the program was working well, but it was ignored," Dr Hambleton said. "There was no consultation with the medical profession about the possible impact of the decision."

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Family doctors provide a lifetime of quality care

The role of GPs in providing and coordinating quality health care through all stages of life was the centrepiece of Family Doctor Week 2012, which had as its theme *Your Family Doctor: For A Lifetime of Trusted Care.*

To deliver the message, AMA President Dr Steve Hambleton presented seven short videos – posted on YouTube - highlighting the care the family doctor provides from pregnancy and infancy, through childhood and adolescence to middle age, old age, palliative care and dying.

The videos, which can be viewed at http://ama.com.au/familydoctorweek2012, illustrate how family doctors are uniquely placed to provide the breadth and quality of care people need as they develop and age.

Throughout the week, which ran from 16 to 22 July, Dr Hambleton also drew attention to issues affecting primary care and what the AMA was doing to promote and protect the interests of general practitioners.

The AMA President used a televised address to the National Press Club on 18 July to urge measures to support and improve access to GP and other primary care services, including streamlining Medicare Chronic Disease Management items, expanding the GP infrastructure grants program, improving incentives for GP teaching and training, restoring funding for GP mental health services, and support for general practices and other specialties to implement the Personally Controlled Electronic Health Record.

Dr Hambleton warned the Federal Government that its Medicare Locals program would only succeed if it was led by GPs and reflected their front line experience in the health system.

"The key to getting primary care right is to work with and for GPs, not around or against us," the AMA President said. "General practices – our family doctors – are key to ensuring that any changes deliver the best possible health care to patients and communities."

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Hospital regulators warned not to neglect quality of care, training

The AMA has flagged concerns that regulators may overlook the potential for new hospital funding arrangements to cut services and undermine the quality of care and training.

In a submission to the Independent Hospital Pricing Authority on its planned work program for the next 11 months, the AMA has warned that insufficient attention is being paid to the early detection of adverse developments in the delivery of hospital care and training as a result of the introduction of activity-based funding.

In its submission, the AMA said it was concerned about the potential for the new funding arrangements to cause a real reduction in the number of services hospitals provide, as well as a shift toward more "lucrative" treatments and procedures at the expense of more complex and costly care.

The AMA is also worried the new system could undermine the quality of care and downgrade the importance attached to training.

"It is unclear from the work program what specific mechanisms are in place, or will be put in place, to identify and monitor the incidence and effects of these and other changes, so that action can be taken to ensure patients continue to receive clinically appropriate and timely treatment in public hospitals," the submission said.

It warned that although mechanisms to monitor and evaluate activity-based funding may provide some guide, "there is also a need to identify and evaluate the broader impacts of the new arrangements, including any changes to clinical care, hospital capacity and sustainability issues".

The AMA expressed concern that the Authority was not giving sufficient priority to bringing hospital teaching, training and research into the new arrangements.

"These are critical areas for the overall performance and sustainability of the hospital system," the submission said. "Any further delay affecting their incorporation into the new funding arrangements creates a significant risk that teaching, training and research will not be sufficiently recognised and built in to ongoing arrangements.

"This work is urgent and must be undertaken with the clear objective of guaranteeing the provision of education, training and research opportunities.

"This capacity is absolutely critical to the ongoing performance of our hospital system and training the future generation of medical practitioners."

The Association is also worried that the work the Authority proposes to undertake on hospital care standards in the new arrangements will come too late to prevent a drop in quality.

"The AMA is concerned that the low price for services under the new arrangements, together with the overriding focus on efficiency, will impact on the quality of hospital care," the submission said. "This impact is likely to increase the longer it takes to properly address quality as part of the pricing framework."

It urged the Authority to shift the context in which its work program was framed away from a focus on efficient price.

"The AMA…strongly believes, and has consistently argued, that the focus for funding arrangements should actually be the effective price of hospital services, in which quality of care is an important element," the submission said.

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Governments wobble on food health claims

AMA President Dr Steve Hambleton has called for an "urgent clarification" from Australian and New Zealand food ministers about the regulation of health claims made by food manufacturers.

Dr Hambleton said assertions made about the health benefits of food products should be subject to the same rigorous testing and analysis as applies to any other good or service, and suggestions food manufacturers may be able to make unsubstantiated claims was concerning.

The AMA President's concerns were prompted by signs that Australian and New Zealand food ministers have bowed to pressure from food manufacturers to allow them to make health benefit claims for their products without first having them cleared by regulators.

Australian and New Zealand ministers responsible for food regulation say they have reached agreement on a "preferred approach" to the regulation of food health claims.

In a communiqué issued following a Food Standards Australia New Zealand teleconference on the issue held late last month, the ministers confirmed their support for the use of "nutrient profiling scoring criteria to ensure that health claims only appear on healthy foods.

"This means that foods that contain high levels of sugar, fat and salt will not be able to claim health benefits".

But the ministers appeared to offer food manufacturers a potential escape clause, giving them the option of "self-substantiation" of new claims which complied with the criteria.

Dr Hambleton said the ministers needed to urgently clarify the intention of the proposed regime, which appeared to allow food manufacturers to make health claims about their products without prior approval from regulators.

"Dr Hambleton said the ministers needed to urgently clarify the intention of the proposed regime, which appeared to allow food manufacturers to make health claims about their products without prior approval from regulators"

"We need urgent clarification to ensure that they [the ministers] are not letting the food manufacturers off the hook," Dr Hambleton said.

"It's a health claim, and when people make health claims they need to aspire to a higher set of standards. Unusually high standards for health claims should be expected in any field, and a similar set of high standards must apply here."

The ministers have extended consultation on the draft Standard for Nutrition, Health and Related Claims to 31 October.

Concerns about the ability of food companies to self-regulate have been underlined by the Advertising Standards Board, which ruled last month that McDonald's fast food chain had breached the industry code in an online promotion.

The Board found that McDonald's had breached numerous clauses of the voluntary code regarding advertising to children by promoting unhealthy food choices using characters and online games aimed at children.

Concerns about food health claims have arisen amid mounting evidence that poor diets are helping make many Australians fatter and unhealthier.

An Australian Institute of Health and Welfare report has found that while Australian households spent an average of $237 a week on food and drinks in 2009-10, the overwhelming majority (91 per cent) did not eat enough vegetables and only half consumed sufficient fruit.

The biggest slice of the weekly food budget (30 per cent) was spent on take-away food or eating out, and spending on alcohol was the next biggest outlay, accounting for 15 per cent of total expenditure, followed by meat and seafood (just below 15 per cent), vegetables and fruit (around 12 per cent) and confectionery (10 per cent).

Unbalanced and dangerous diets are contributing to weight and health problems.

According to the Institute's *Australia's food & nutrition 2012* report, one in five adults drink so much alcohol they are posing a risk to their health, while almost 70 per cent of men and 55 per cent of women are overweight or obese, as are 8 per cent of children aged between five and 17 years of age.

The focus on food policy has been heightened by the release of a Federal Government discussion paper on the development of a National Food Plan.

The National Food Plan Green Paper, released on 17 July, seeks to encourage debate on several areas of food policy including production, trade, supply chains, food safety and healthy eating.

Agriculture Minister Joe Ludwig said the Plan would not only set the long-term direction for the nation's food industry, but also help "ensure that all Australians enjoy access to high quality, affordable food".

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Health Minister delivers body blow to new medical school plans

Health Minister Tanya Plibersek has cast doubt on the push by several universities to create new medical schools as evidence of a looming crunch in training opportunities for existing medical students mounts.

In a letter sent to AMA President Dr Steve Hambleton on 14 July, Ms Plibersek said it was "difficult to support" any proposed increase in medical places in the current environment, delivering a blow to plans by universities, including Curtin and Charles Sturt, to develop new medical schools.

"In relation to proposals for new medical schools in Australia, I would like to assure you that the current position of the Commonwealth is that any proposed increase in medical places, whether via establishment of new medical schools or through allocation of new places at established schools, is difficult to support at this time," the Minister said.

"It is essential that all governments continue to address their commitment to existing medical trainees, clinical supervisors and patients to increase capacity and maintain high quality training for the existing group of future medical practitioners prior to making any decisions to increase the intake of medical students."

Ms Plibersek gave her assurance just days before the release of a report showing growth in the number of medical graduates was far outstripping increases in postgraduate training places, highlighting the AMA's call for urgent Commonwealth, State and Territory Government action to improve workforce planning and provide more intern positions.

In a review article published by the *Medical Journal of Australia* on 23 July, Monash University Associate Professor Catherine Joyce warned new graduates faced "significant bottlenecks" in postgraduate training, predicting that 1000 intern places will have to be added in the next five years to meet likely demand.

"Difficulties are already being experienced in attaining sufficient settings and supervisors, and these seem likely to continue, or worsen, in the next few years," Associate Professor Joyce said.

Dr Hambleton seized on the findings to highlight concerns that around 370 medical graduates will miss out on an intern position next year, with the shortfall increasing to more than 450 places in 2016.

Dr Hambleton said Associate Professor Joyce's study echoed the conclusions of a recent Health Workforce Australia (HWA) report that "there is a looming shortage of training places for medical graduates throughout the training pipeline".

The AMA President has raised the issue directly with Health Minister Tanya Plibersek, and has received assurances that the Federal Government intends to work closely with its State and Territory counterparts to tackle the problem.

In her letter to Dr Hambleton, Ms Plibersek wrote that "as you have noted, the creation of additional junior doctor positions must be carried out as part of a planned approach to current and future health workforce needs. It is important that quality is not compromised for quantity".

"An important element of planning will include better alignment of full-fee paying medical student numbers with workforce pipeline planning through close working relationships between universities, State and Territory governments and HWA," the Minister wrote.

Dr Hambleton said it was understood that HWA was developing plans, to be presented to the nation's health ministers later this year, on ways to address the critical shortage of training positions.

"The Government recognises the benefits of Australian-trained medical graduates remaining in Australia to work as medical practitioners, and the importance of keeping these doctors here as part of the future medical workforce," the AMA President said.

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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

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Nation faces tough questions on health funding and reform

AMA President Dr Steve Hambleton has flagged the possibility of scrapping the "misleading" Medicare levy as part of a much-needed overhaul of health funding.

In a provocative, nationally televised speech to the National Press Club, Dr Hambleton lamented a loss of momentum in health reform and called for a serious national debate on health spending priorities.

"We have to have the conversation about the fact that the funding is limited and is not unlimited, and that priorities do need to be made," the AMA President said. "We need to spend appropriately, and we need to have that debate so people understand if we spend it here, we can't spend it there."

Dr Hambleton said the Medicare levy was deceptive, and the Government should stop using it as a way to raise money.

Asked whether the Medicare levy should be increased to help meet health costs, he said the impost "does mislead people to think that they're actually paying the total cost of health care, because it doesn't cover it".

"It would probably be better to scrap it rather than increase it, because it should just form part of the revenue base of the Government," Dr Hambleton said.

The AMA President warned the country was rapidly approaching the point at which it would no longer be able to cover the costs of providing health care unless changes were made to current funding and administrative arrangements.

"If we don't do something soon, we're not going to be able to afford health," he said. "We've actually seen State governments tell us [that] if health costs keep growing [they're] going to overwhelm the entire State budget. It's a bit like what Tasmania said recently."

Dr Hambleton said Labor under Kevin Rudd had made a promising start to the task of health reform when it came to office in 2007, but in the intervening years the effort had become "diluted".

"There was a very strong vision from the Government at that stage. We were talking about majority funding from the Federal Government," he said. "That original vision was something that the AMA supported, and we certainly still support that, and we'd like to see some of that original vision be delivered."

Dr Hambleton said there was significant scope to improve the effectiveness of health spending and make sure taxpayers get maximum value for their dollar.

But he said this could only be achieved if Government worked much more closely with doctors and others at the front line of health care.

"Real health reform for doctors, patients, nurses and allied health professionals means more resources at the hospital bedsides, in the surgeries, and in community health services," the AMA President said. "The AMA is determined to ensure that the grassroots experience of medical practice is not drowned out in the health reform debate. We need to think about the investment in primary care to look at prevention, early management and good management of chronic disease, [which] will save expensive health costs down the track."

Dr Hambleton said the Government was making a mistake by not working more closely with GPs.

"I am concerned that the Government is getting some poor advice on what really happens on the front line of primary care," he said. "It seems that a lot of the reform is being brought in around GPs – through Medicare Locals and other health professionals for instance – rather than being led and coordinated by GPs, as it should be."

In his speech, Dr Hambleton urged the Government to dramatically increase its support for the upgrade of medical practices, increase training incentives for GPs, reinstate funds for after-hours services, unwind cuts to Better Access mental health services and promote a team-based model of health care.

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Bullies put on notice

AMA President Dr Steve Hambleton has welcomed renewed efforts to tackle bullying in schools.

Dr Hambleton said the Anti-Bullying Forum convened by Minister for School Education Peter Garrett in Canberra last week had produced a "commendable" list of ideas for action in schools and within families to address bullying, and provided a useful addition to broader strategies to tackle the issue.

"Schools have an important role to play in the prevention of bullying, and many schools are making concerted efforts to prevent and address the problem," Dr Hambleton said. "Unfortunately, bullying is not limited to school. Cyber bullying can occur at any place and at any time. "Young people may be reluctant to disclose that they are being affected by cyber bullying, and may look beyond their parents and teachers for confidants with whom to share and discuss their problems."

Dr Hambleton said doctors were a trusted and confidential source of information for young people and their families, and the AMA has produced two brochures on the issue.

One, for adolescents and older children, can be viewed at http://ama.com.au/youthhealth/bullying and a guide for doctors on childhood bullying is available at http://ama.com.au/youthhealth/bullying-guidance-for-doctors

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NOTICE TO MEMBERS

Reminder to renew AHPRA registration by 30 September 2012

The AMA reminds all members to renew their medical registration by 30 September 2012.

AHPRA is encouraging registrants to renew online at www.ahpra.gov.au. To do this you will need to know your User ID and your password. If you have misplaced your User ID and password, contact AHPRA on 1300 419 495. Please note that your User ID is different to your registration number that appears on the National Register.

If you have not yet renewed your registration, you would have received electronic or hardcopy reminders from AHPRA. If you have not received any reminders to renew
or are unsure, please check the National Register to make sure your details are up to date or contact AHPRA on
1300 419 495.

There are four things you can do to prepare for your renewal:

- **CHECK YOUR REGISTRATION EXPIRY DATE:** You can check the online National Register at www.medicalboard.gov.au to confirm when your registration is due to expire and check your details.
- **UPDATE AHPRA WITH YOUR EMAIL ADDRESS YOUR CONTACT DETAILS:** Make sure your contact details, including your email address, are correct and current. This will allow AHPRA to send you email renewal reminders and to contact you if necessary. If you have your User ID, go online at www.ahpra.gov.au, click online services and follow the prompts to update your contact details. If you do not have your User ID, complete an online enquiry form, selecting 'User ID' as the category of enquiry or by calling 1300 419 495.
- **WATCH FOR THE REMINDER TO RENEW:** A reminder to renew registration will be sent to each practitioner up to eight weeks before registration expires. Set your email account to receive communications from AHPRA and the Medical Board to avoid misdirection to an account junk box.
- **RENEW ONLINE, ON TIME:** The quickest and easiest way to renew your registration is online. Make sure you renew on time because under the National Law there is no option for AHPRA or the Medical Board to renew your registration after it has lapsed without a new application.

Leaving renewal to the last minute may have serious consequences for your practice.

- Should you fail to lodge your application to renew by 30 September, there is a late payment period during the month of October.
- If you lodge your application to renew during the late payment period ending 31 October, you will pay a late fee of $170 in addition to the renewal fee of $680.
- If you fail to lodge your application to renew your registration during the late payment period, your registration will automatically lapse from 1 November.
- Once your registration has lapsed, you will have until 30 November to apply to AHPRA for a fast-track application for re-registration at the cost of $340, in addition to the registration fee of $680. If you apply through the fast-track process AHPRA processes most applications within 48 hours of receiving a completed application. Applications that include adverse declarations can take longer.
- If you fail to re-register through the fast-track process by 30 November you will have to apply for new registration and only pay the registration fee of $680. AHPRA will process your application as a new registrant within the usual timeframe of up to 90 days.
- Should your registration lapse, you will not be able to practice until your registration application has been granted.

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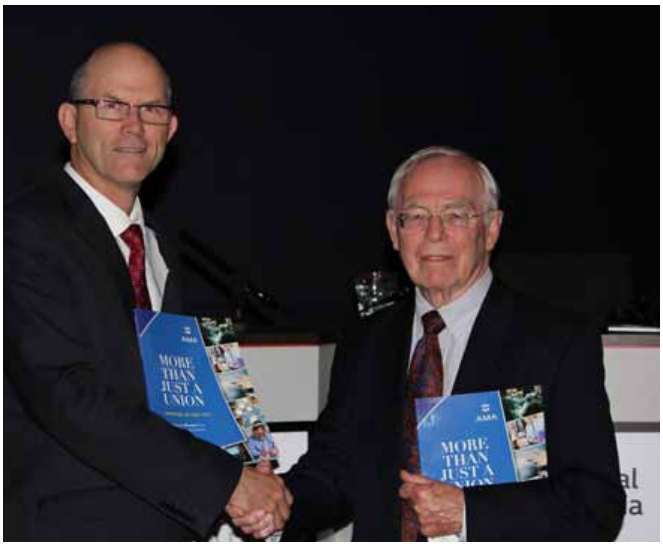
More Than Just A Union – a history of the AMA

Dr Steve Hambleton addresses the National Press Club



Dr Steve Hambleton and AMA history author Dominic Nagle

The AMA has marked its 50th anniversary by launching a history of its origins dating back to the early years of settlement and its eventual distillation from the British Medical Association in Australia.

AMA President Dr Steve Hambleton unveiled the 160-page history *More Than Just A Union: A history of the AMA* during a nationally televised speech to the National Press Club on 18 July, lauding it as "a fascinating account" of the Association and the pivotal role it has played on the medico-political stage.

The history charts the origins of the AMA through the fractious early days of medical organisation in the Australian colonies, where professional rivalries and jealousies undermined efforts to establish a common voice and purpose.

It shows how the medical fraternity, initially under the auspices of the British Medical Association before establishing it own local identity as the AMA in 1962, has been a constant and constructive partner in the development of the country's health system - advising (and often challenging) governments on major issues such as national health insurance, hospital funding, medical insurance, public health, medical indemnity and Indigenous and Torres Strait Islander health.

The history includes accounts by past presidents as well as major contributions on topics including public health, medical ethics, e-health, aged care, medical research and the medical workforce from leading thinkers.

Dr Hambleton called on members past and present to help "fill in the gaps" in the history.

The AMA President praised the history's author, AMA staffer Dominic Nagle, for his Herculean efforts in pulling together fragments of information from many disparate sources to create a seamless narrative, but said the account was but one version of the Association's history, and urged people to provide their own recollections of events.

"The source material has been patchy in places – poor or incomplete record keeping, lost files, missing files and fading memories," Dr Hambleton said. "So this particular AMA history does not end here. It is the beginning. It is a living history."

The history is published online and can be viewed at http://ama.com.au/a-history-of-the-ama

"We invite people to provide comment, offer their version of events or add episodes of AMA history that we may have missed," Dr Hambleton said. "We want to build on this history, round it out, and fill in the gaps."

Beginning with this edition, *Australian Medicine* will publish contributions made by past AMA Presidents to *More Than Just A Union.*

On the following pages are accounts by Lindsay Thompson and Trevor Pickering.

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Change in the Air

BY **DR LINDSAY THOMPSON, AMA PRESIDENT, 1982-85**

On assumption of the Presidency in May 1982, I was deeply conscious of the new Labor Government's health plans, to be called Medicare, and the ongoing continuum of problems dating back to the introduction of Medibank which had, in 1973, been fiercely opposed by the AMA.

Then it had been difficult for the AMA to engage in meaningful discussions with the Labor Government because of the stated non-negotiatability of many of its plans. On this occasion, the AMA resolved to minimise, and indeed remove, government interference in the practice of medicine. Much was achieved but the greater control of medicine remained the Government's frequently stated objective.

At a broader level, the Government unsuccessfully sought to control the incomes of all the professions by persuading professional bodies to submit their fees for determination by the Australian Conciliation and Arbitration Commission. The AMA was heavily involved in this issue through the Australian Council of Professions – unity is strength, a lesson that individual doctors and groups of doctors tend to forget.

The major activity in 1984 was the fight against the onerous provisions of Section 17 of the Health Insurance Act introduced with Medicare. Section 17 gave the Minister the power to impose any controls he chose on the private practice of medicine in public hospitals, including control of fees.

Following many negotiations, we received the report of the Penington Inquiry, which showed that the Government had acted in haste on wrong information when it provoked Australia's first doctors' strike.

While the report was being considered at many meetings, the New South Wales hospitals dispute erupted. I was asked by the NSW Branch and the Senior Royal Clinical Colleges to intervene. This led onto a period of frenetic activity, which was to last almost to the end of my Presidency in 1985.

The peace package announced in early April 1985 addressed many of the problems arising from the dispute.

Most commentators saw it as a major victory for the AMA and for the profession. The major concession was undoubtedly the complete retraction by the Federal Government of the amendments to Section 17 of the Health Insurance Act.

Other concessions included choice of modified fee-forservice for visiting doctors at metropolitan district and country hospitals, withdrawal of the Commonwealth from regulation of private hospitals, and an improved private hospital insurance

package.

Some dissident members of the Association, whose real agenda seemed to be the fall of the Hawke Labor Government, called for an extraordinary general meeting to consider a motion of no confidence in me. It was held in Canberra on 11 May. The motion was defeated on proxy votes by 7232 votes to 1196 – 86 per cent of the votes were cast in my favour. After the meeting, I issued the following statement:

Today's vote not only vindicates me personally but also preserves the honour, stability and credibility of the Association. This is of great importance to all doctors.

The AMA is and will continue to be the only effective representative body of the medical profession.

My ongoing thanks remain for the support of the members of Federal Council and our excellent staff, led by the Secretary General, Dr George Repin.

As Chairman of the Constitution Committee of Federal Council, I had long recognised the need for the AMA to adapt its structure and function to meet demands placed upon it.

Fortunately, constitutional change occurred under my successor as President, Dr Trevor Pickering, but not without vigorous opposition. This has allowed the Association to continue to represent the profession as a whole in an effective manner. The profession needs an effective unified national body.

Looking at the profession today, I see increasing bureaucracy and unnecessary red tape. As a true profession, we seem in danger of losing our sustaining ideals and of becoming a series of fragmented disciplines that are prisoners of the technology that increasingly separates us.

We need to re-commit to ethics and quality of service.

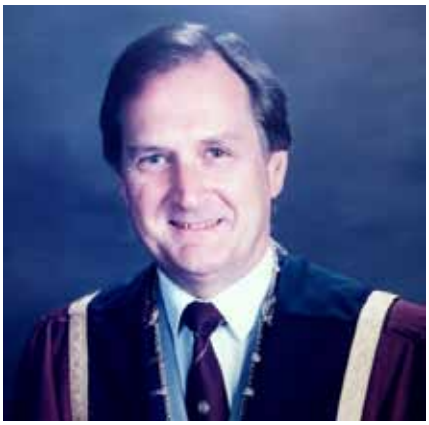
Remember the words of a former editor of *The Lancet*, Sir Theodore Fox: "the human race does not need a doctor, whereas human beings do".

I greatly enjoyed my term as President despite the stresses and strains, especially on my family and patients.

TO COMMENT CLICK HERE

Search for Unity

BY **DR TREVOR PICKERING, AMA PRESIDENT, 1985-88**



Presidency of the AMA led me to valued friendships and down paths that proved challenging.

The major challenge was to review the Articles of Association of the AMA (adopted in 1962) and render them relevant to the changing needs of the profession and the community. My Presidency began in the wake of the New South Wales hospitals' dispute and the disunity within the profession that followed.

The Hawke Labor Government ntroduced Medicare in February 1984 with the inherent threat of nationalisation of medicine included in the legislation that granted the Minister unfettered power over doctors' fees in hospitals. The dispute was eventually resolved to the AMA's satisfaction in early 1985 but it clearly demonstrated the increasing importance of the rapidly expanding specialty groups and the need for them to have a voice in decision-making at a political level.

This had to be acknowledged within the AMA structure. Although deficiencies in its constitution had been recognised for some years, the branches remained implacably resistant to any dilution of their powers. The state branches then exerted almost total control over the Federal AMA where there was no craft group representation.

My three-year term was largely consumed by a search for unity within the profession, a search that led eventually to a successful major review of its outdated constitution. Sir Robert Cotton, a distinguished businessman, politician and diplomat, agreed to undertake a review and present a report on the structure, function and constitution of the AMA. The 200-page Cotton Report as delivered in March 1987. Recommendation 2 was critical. It stated "that the AMA becomes a national organisation and the autonomy of the Branches be removed".

An intensive, exhaustive exercise followed to explain and discuss the report's recommendations to all members of the profession. This process strongly reinforced the need for closer involvement of the expanding specialist groups, especially the Royal Clinical Colleges, which proved vital in the subsequent successful creation of a far-reaching blueprint for the future. Regrettably, but understandably, it was not achieved without bitterness, anger and frustration within some sections of the profession.

Bulk billing and its inherent temptations, fraudulent billing and alleged verservicing of patients appeared with the introduction of Medicare. The setting up of fair monitoring systems and the collection of meaningful data remains a problem for the Association 25 years later.

From the outset, the AMA has advocated early professional involvement in the review process. Public challenges by government over alleged excessive medical fees and incomes occurred on a regular basis. It was the time of 'national wage restraint'. Although the attacks were largely based on the misuse and distortion of data, responding to them required a lot of attention.

It was a volatile time. Confrontation with government over fees and Medicare benefits led to the AMA withdrawing from future participation in annual enquiries into fees for Medicare benefit purposes. Subsequently, because of undue obstruction by departmental representatives on the Medicare Benefits Schedule Revision Committee, the AMA also withdrew its participation from that body.

Fees were again in the news in late 1987 when the Chairman of the Government's Price Watch Committee launched an outrageous attack on alleged overcharging by doctors, an attack which lasted several months. In the end, the AMA succeeded in protecting the interests of doctors and patients.

Quality assurance was in its relative infancy in Australia, although the AMA was in the forefront of international activity. The AMA/ACHS Peer Review Resource Centre was established in 1979 with seeding funding from the government. When that funding ceased in 1986, so did the Resource Centre. The AMA took over responsibility for the further expansion and consolidation of clinical review activity, while the Australian Council on Healthcare (or Hospital as it was then) Standards was responsible for continuing education in peer review.

Looking back, one recalls the difficulties and intense resistance generated by the introduction of the concept. Yet, against strong initial opposition, it is now a principle embraced by all professions and disciplines. Diagnosis-related groups were introduced in 1986 as the basis for hospital funding.

I wish to pay tribute to the members of my Executive, Federal Council and members of the Secretariat. Their support, loyalty and advice were essential in carrying out my duties. I thank them sincerely.

TO COMMENT CLICK HERE

Drug company disclosures could backfire

The AMA has backed moves to force drug companies to disclose aggregate payments made to doctors and other health professionals but has warned revealing amounts paid to individual practitioners could undermine public health unless handled with care.

In a submission to the Australian Competition and Consumer Commission, the AMA said it supported proposed changes to the Medicines Australia Code of Conduct that would require pharmaceutical firms to report aggregate amounts paid to health professionals in sponsorships, travel and per diem expenses and consultant fees.

But the Association warned that any move to disclose payments made to individual practitioners had the potential to undermine public confidence and inhibit the professional development of doctors unless it was managed carefully and sensitively.

The AMA said sponsorships and payments made "within an ethical framework" were not inappropriate, though it acknowledged there was public benefit in reporting the total amount spent by drug companies on sponsorships and other payments, just as there was public benefit in ongoing ethical relationships between doctors and the pharmaceutical industry that help in the development of more effective medicines.

"Medical practitioners' involvement and provision of advice in the development of medicines contribute to a product that is not only efficacious in a laboratory setting but also in a real-life practice setting," the AMA submission said. "These medical practitioners are often best placed to pass on knowledge to their colleagues to ensure new medicines are used appropriately.

"Educational events sponsored by pharmaceutical companies fill a vacuum in the provision of education that would otherwise have to be funded and delivered by other entities."

The AMA added that it was only reasonable that practitioners were compensated for time, travel and other costs and expenses incurred in providing services and advice to drug companies.

But it warned any move to identify payments to individual practitioners needed to be carefully considered and managed.

"If not done correctly, public reporting has the potential to misinform the public and…unduly affect a medical practitioner's reputation," the submission said.

Consumers groups have criticised the proposed Medicines Australia code for not going far enough.

Consumers Health Forum of Australia chief executive, Carol Bennett, has said the new rules were of little use, and patients needed to know whether their doctor was being paid by drug companies, and what that money was for.

"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 said. "'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."

But the AMA warned of the risk that naming individual doctors could lead patients and other members of the public to make "incorrect judgements" about the independence of the practitioner involved.

"Public reporting does not allow medical practitioners to explain the nature of the relationship as they can on a one-to-one basis with a patient," the AMA submission said. "Any public reporting mechanism would have to ensure patients are fully informed about the nature of the payment…otherwise, it could discourage medical practitioners from participating in legitimate activities with pharmaceutical companies that in fact have a public benefit."

The AMA added that the right to privacy of practitioners also needed to be taken into account.

"The sensitivity and impact of publicly reporting elements of individual health professionals' personal incomes needs careful consideration," the submission said. "Significant work would need to be done to develop the right reporting framework and mechanisms for correcting errors."

The AMA said that in light of this, it commended the decision of Medicines Australia to work further with doctors and other stakeholders on the issue.

The Code of Conduct in its current form is under consideration by the ACCC.

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Doctors need more support to train future GPs

"There has been a surge in the number of medical students in recent years, with more than 3700 expected to be graduating by 2014"

The AMA has called on the Federal Government to double its support for doctors who take on the responsibility to teach and train future general practitioners.

In a statement marking the start of Family Doctor Week, AMA President Dr Steve Hambleton said the Practice Incentives Program payment for teaching and instruction should immediately be increased from $100 to $200 per session to encourage more doctors to pass on their skills and experience to medical students.

Currently only 13.6 per cent of general practices are involved in teaching medical students, and Dr Hambleton said that if the Government wants more students to consider a career in general practice then it must make sure instructing doctors get the support they need.

He said the current payment had not been increased since 2005 and did not cover the costs doctors incurred in taking on a teaching role.

"Supervising medical students takes time and commitment," Dr Hambleton said. "It inevitably means that GPs must see fewer patients because they are devoting extra time and resources to training."

He said doctors and practices who might consider becoming actively involved in teaching and training were discouraged by the current, inadequate pay rates.

"Properly resourced, general practices could play a vital role in steering young doctors into a career as a GP," the AMA President said. "The Government says it wants more students to consider a career in general practice, but it must increase essential support for practices if it is serious about meeting that objective."

A study published in the *Medical Journal of Australia* two years ago found that, taking into account all expenses and benefits, teaching a fourth-year medical student cost practices $1385 a week, while they incurred a weekly loss of $1285 for instructing a fifth-year student and $630 for a sixth-year student.

Dr Hambleton's call for increased support for practices came as Health Minister Tanya Plibersek announced there would be a record 1138 GP training places offered next year.

Ms Plibersek said there were 1510 applicants for General Practice Training places in 2013, and they were vying for 401 places in NSW and the ACT, 255 in Victoria, 236 in Queensland, 101 in Western Australia, 86 in South Australia, 32 in Tasmania and 27 in the Northern Territory.

The number of places on offer in 2013 is up more than 10 per cent from this year, and Ms Plibersek said there had been a massive increase since 2007 as the Government strived to increase the availability of general practitioners.

"We want to make it easier for families to be able to see a GP when and where they need one, and this record number of GP training places will help that happen," the Minister said.

"By 2014 we will have doubled the number of GPs in training. This is part of the Government's plan to massively increase the medical workforce, and by 2020 there will be an extra 5500 GPs and 680 specialist doctors nationwide."

But the AMA has warned that many aspiring doctors face being blocked from entering practice because an explosion in university places has not been matched by an expansion in hospital and GP practice training places.

In a report released earlier this year, Health Workforce Australia warned that pre-vocational and specialist training places for medical graduates were not keeping pace with the intake of medical students, raising the prospect of a shortage of 2700 doctors by 2025.

There has been a surge in the number of medical students in recent years, with more than 3700 expected to be graduating by 2014.

But Dr Hambleton said the *Health Workforce 2025* report showed the number of graduates would soon exceed the number of training places available, highlighting the need for governments to act quickly to ensure the nation's medical workforce would be adequate to meet future needs.

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Book Reviewers

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

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

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

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

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Smarter incentives needed for rural practice

AMA President Dr Steve Hambleton has said conditions for medical graduates looking to build a career in rural practice have improved despite "seriously flawed" Government incentives intended to attract more doctors to country areas.

Dr Hambleton said more medical students were being trained locally, and were graduating with practical experience of working in rural areas, but urged Government to overhaul its policies to encourage more to work outside the major cities.

"Country practice is now a more attractive option for young doctors, but could be more attractive with the right Government incentives," the AMA President said.

Dr Hambleton said the Government needed to overhaul its Australian Standard Geographical Classification – Remoteness Areas scheme, which is used as the basis for providing incentives for doctors to move to country areas.

"The scheme is seriously flawed," he said. "There is no incentive for doctors to move to the smaller centres under this system."

"A doctor working in the rural NSW town of Cowra is classified the same as a doctor working in the Hobart suburb of Sandy Bay," Dr Hambleton said. "A doctor working in the central Queensland town of Moranbah is classified the same as a doctor working in bustling Townsville."

The AMA is urging the Federal Government to adopt the Rural Rescue Package drawn up by the AMA and Rural Doctors Association.

The package includes a payment to all rural doctors to reflect the isolation associated with rural practice, as well as a procedural and on-call loading to help practitioners meet the particular demands of providing specialist and extended care services in rural communities.

Dr Hambleton added that more needed to be done to provide an advanced rural training pathway for GPs, as well as greater recognition of the needs of the spouses and children of doctors considering moving to a country practice.

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Big states swing behind deal for the disabled

The New South Wales and Victorian governments have buckled to pressure over the National Disability Insurance Scheme and kicked in extra money for trials of the landmark initiative.

AMA President Dr Steve Hambleton was among a widespread chorus of condemnation of the two State Governments late last month after they initially refused to meet Commonwealth demands to help fund trials of the scheme in their jurisdictions.

After a Council of Australian Governments meeting ended on July 25 without agreement from NSW and Victoria on hosting NDIS trials, Dr Hambleton accused the governments of the major states of nobbling the scheme for the sake of "self-interest, petty bickering and political point scoring".

"Some of our political leaders should be hanging their heads in shame," Dr Hambleton said. "[The COAG meeting] was a rare opportunity for all our governments to work together to deliver something very important for all Australians – but they blew it.

"The Federal Government presented COAG with a workable proposal to establish the first stage of an NDIS from next year, but the bigger states, for their own reasons, have decided not to participate at this stage."

The Commonwealth has made an initial commitment of $1 billion to help set up and trial the disability insurance scheme.

After initially refusing to increase their contribution to the cost of hosting trials in the states, the NSW and Victorian governments eventually agreed to join South Australia, Tasmania and the ACT in participating in the scheme.

Victorian Premier Ted Baillieu lifted his state's contribution to the trial to $42 million to allow a trial in the Barwon region to commence from July 2013, and the NSW Disabilities Minister Andrew Constance offered an extra $35 million over three years to help fund a trial in the Hunter Valley.

The additional funding from the NSW Government is half of what the Commonwealth sought, but Prime Minister Julia Gillard said the crucial benchmark was an annual state contribution of $20,779 per person involved in the trials.

Ms Gillard said that with the concessions from the two major states, she was confident that the details of the trials for the scheme could be quickly concluded.

"This is a huge reform – easily as big as Medicare," the Prime Minister said. "This is a big win for people with disabilities.

"Because we are seeing politics swept aside, we will now be able to get on and get to work to get this done."

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AMA IN THE NEWS

Your AMA has been active on policy and in the media on a range of issues crucial to making our health system better. Below is a snapshot of recent media coverage.

Print

Medicare levy misleads on costs:AMA *The Age*, 19 July 2012

Scrapping the Medicare levy would prompt Australians to get a more realistic idea of the soaring costs of healthcare, says Australian Medical Association federal president Steve Hambleton.

Health reform 'almost lost' *The Australian*, 19 July 2012

In a speech to the National Press Club in Canberra, Australian Medical Association president Steve Hambleton said the "dream of health reform that began in 2007 has not been realised".

AMA chief Steve Hambleton urges rethink on federal health reform *The Australian*, 18 July 2012

The head of Australia's peak doctors' lobby group has called on the federal government to urgently rethink a number of its signature health reforms, warning the "dream of health reform ... has not been realised" and ministers are "getting some poor advice".

Get tough on alcohol ads and labels: AMA *The Sydney Morning Herald*, 18 July 2012

The federal government should finally crack down on alcohol advertising and require warning labels on booze after the bashing death of Thomas Kelly, the head of the Australian Medical Association Dr Steve Hambleton says.

Tour takes toll on concentration levels *Herald Sun*, 18 July 2012

Millions of Australians staying up late to watch the Tour de France are probably finding it hard to concentrate at work during the day, according to the Australian Medical Association.

Medical meltdown *The Mercury*, 22 July 2012

Tasmania's medical practitioners are feeling the greatest funding pressures in the country, says the Australian Medical Association. AMA President Dr Steve Hambleton said Tasmania was the first state to see the impacts of a health budget threatening to consume a state's entire Budget.

Doctors, Labor at odds over mental health *Herald Sun*, 22 July 2012

Australian Medical Association President Dr Steve Hambleton says the 2011-12 budget cuts were clearly all about saving money rather than improving care. "Under the new arrangements patients with mental illness receive less Medicare support than patients with physical ailments," Dr Hambleton said in a statement.

One doctor's two-year overtime bill: $681,759 *The Sydney Morning Herald*, 22 July 2012

Australian Medical Association President Dr Steve Hambleton says the amount of overtime worked by a doctor who earned almost $700,000 in two years was unacceptable. "It would be much safer to pay a locum," Dr Hambleton says.

Mixed up with trouble, *MX Melbourne*, 30 July, 2012

The AMA is calling for tighter controls on drinks that mix caffeine and alcohol. Australian Medical Association President Dr Steve Hambleton says such drinks impair a person's judgement of how intoxicated they are because they mix stimulants with depressants.

Radio

Dr Hambleton,ABC 666, 18 July, 2012

Speaking on the morning of his National Press Club address, Dr Hambleton says one of the main functions of the AMA is to assist governments on health policy. He notes there is a shortage of GPs but hopes it will be alleviated as more medical students come through the system.

Dr Will Milford,ABC NewsRadio, 13 July, 2012

Dr Milford, chairman of the AMA Council of Doctors in Training, says an audit of doctors' working hours show more than half of the practitioners surveyed worked hours that were unsafe.

Television

Dr Hambleton,ABC, 18 July, 2012

Australian Medical Association President, Dr Steve Hambleton, laments a loss of momentum in health reform since 2007 during a nationally-televised address to the National Press Club. Dr Hambleton says there needs to be a frank national debate on health care costs, which are becoming increasingly unsustainable for the states.

AMSA

Medical students face uncertainty as first round of internship offers released, 23 July, 2012

AMSA has presented a petition with more than 6500 signatories to the nation's health ministers calling for more training places for medical graduates amid warnings that 374 medical students will miss out on an internship place in 2013.

AMSA calls for an end to predatory UMAT preparation courses, 25 July, 2012

AMSA President James Churchill has raised the alarm about commercial Undergraduate Medical Admissions Test preparation courses which make unsubstantiated claims about helping students gain entry to medical courses and charge up to $2000 per course.

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AMA in action

AMA President Dr Steve Hambleton and other AMA officials have been busy pushing forward the AMA agenda across a range of areas in the past three weeks. In addition to numerous media interviews on prominent issues including the National Disability Insurance Scheme, health funding, food labelling, alcohol and the importance of family doctors, Dr Hambleton delivered a major televised address to the National Press Club at the National Gallery of Australia in which he lamented a loss of momentum in health reform and called for a frank national debate on the cost of health care and spending priorities. Dr Hambleton also spoke at a roundtable, convened by the AMA and chaired by Employment Minister Bill Shorten, on the definition of medical treatment injury under the proposed National Injury Insurance Scheme. The roundtable was attended by leading doctors, lawyers and public servants, including Queensland orthopaedic surgeon Michael Holt, Victorian spinal surgeon Gary Speck, West Australian paediatrician Kate Langdon, South Australian paediatrician and rehabilitation physician James Rice, South Australian GP Patricia Montanaro, Queensland obstetrician Gino Pecoraro, ACT ophthalmologist Iain Dunlop and NSW neurosurgeon Brian Owler.

The AMA President used his National Press Club Address to officially launch a history of the AMA, *More Than Just a Union*, praising the efforts of author, AMA staff member Dominic Nagle.

Dr Hambleton also met with senior Health Workforce Australia officials Ian Crettenden, Ruth Kearon and Maureen McCarty.

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National Injury Insurance Scheme roundtable (l to r) Michael Holt, Gary Speck, Kate Langdon, James Rice, Patricia Montanaro, Gino Pecoraro, Iain Dunlop, Brian Owler and Steve Hambleton

Dr Steve Hambleton (2nd from l) with (l to r) Dr Ruth Kearon, Ian Crettenden and Maureen McCarty

Dr Steve Hambleton addresses the National Press Club

Family Doctor Week 2012

BY **DR BRIAN MORTON**

"The primary purpose of Family Doctor Week is to send a public health message to the community reminding them about the importance and benefits of having a family doctor"

Last month the spotlight fell on GPs, with the AMA celebrating Family Doctor Week from 16 to 22 July. It was a great week to focus our attention on what it means to be a GP and the contribution we make to the community and to the medical profession.

The theme for this AMA event was **Your Family Doctor: For A Lifetime of Trusted Care**. The AMA Council of General Practice chose the theme to promote to the community the high level of training GPs receive and the quality and holistic nature of the care they provide, as well as the fact that GPs provide care at every stage of life.

Throughout the week AMA President, Dr Steve Hambleton, presented a series of short videos about what it means to be a GP treating patients at all the stages of life. I encourage you to have a look at the seven short YouTube videos on the Family Doctor Week website (http://ama.com.au/familydoctorweek2012).

The primary purpose of Family Doctor Week is to send a public health message to the community reminding them about the importance and benefits of having a family doctor. One of the short YouTube messages was about the role of GPs in caring for adolescents. I am pleased to note that the radio station *Triple J* used the AMA message to remind their young audience to go see their GP. It is great to see Family Doctor Week having this kind of reach.

The AMA also uses Family Doctor Week to draw attention to the issues affecting general practice and the solutions that the AMA has for problems we know exist in the primary care system.

During Family Doctor Week, the President addressed the National Press Club, taking the opportunity to highlight the need for changes to the Government's Medicare Local model to ensure that they are GP-led.

He also outlined several initiatives that the AMA is calling for to improve access to GP and other primary care services, including streamlining Medicare Chronic Disease Management items, expanding the GP infrastructure grants program, improving incentives for teaching and training, restoring funding for GP mental health services, a commitment that existing practices will not lose after hours funding under Government reforms, and support for general practices and other specialties to implement the Personally Controlled Electronic Health Record.

All the material related to Family Doctor Week is available at the above website. For general information about how the AMA is working for family doctors, visit the new landing page on the AMA website dedicated to general practice: http://ama.com.au/generalpractice.

TO COMMENT CLICK HERE

Privacy law reforms must not undermine doctor-patient relationship

BY **DR LIZ FEENEY**

"As the reforms develop, the AMA will lobby to ensure legislative changes do not inadvertently undermine the doctor-patient relationship, compromise patient care or add an unnecessary burden to doctors' administrative duties"

Where is the Government up to with privacy law reform?

In 2008, the Australian Law Reform Commission (ALRC) released its report on Australian privacy law, *For Your Information: Australian Privacy Law and Practice*. The report recommended 295 amendments to improve and update Australia's privacy framework. In response to the report, the Government is addressing the recommendations in two stages.

As part of their first stage response, the Government recently released the *Privacy Amendment (Enhancing Privacy Protection) Bill 2012* that incorporates the development of the Australian Privacy Principles (APPs), addresses credit reporting and strengthens and clarifies the Information Commissioner's powers and functions. According to Attorney-General Nicola Roxon, the rest of the Government's first stage response, which relates to health services and research provisions along with the remaining ALRC recommendations, will be considered by the Government after the Bill has progressed.

The AMA recently provided a submission to an inquiry into the Bill, highlighting the essential role that privacy and confidentiality plays in supporting the doctor-patient relationship and optimising patient care. The submission emphasised that when patients trust doctors and the wider health care system to protect their personal information, they are more confident in disclosing personal, and often sensitive, details required by doctors to make an accurate assessment of patients' health care needs. Without full disclosure, the doctor's ability to make an accurate diagnosis or treatment plan is seriously undermined and patient care compromised.

Should patients feel their personal information will not be appropriately protected, they may either not attend a doctor or may limit or falsify the personal information they provide to their doctor, potentially resulting in serious consequences for their health care.

The AMA's submission also highlighted the following:

- patients' right to privacy and confidentiality is not absolute. There may be exceptions, such as in a medical emergency or where permitted or required by law. Where a doctor is permitted or compelled to disclose a patient's personal information without consent, this must overwhelmingly serve the public interest;
- there should not be an undue administrative burden placed on medical practices when complying with any changes to privacy legislation;
- any changes to the legislation should be accompanied by draft explanatory guidelines for doctors and other health care providers; and
- a community awareness campaign should also accompany any changes to privacy legislation in relation to health information so that patients, carers and others understand their rights and obligations under the new law.

Reforming and updating privacy legislation is a huge task. In particular, ensuring any changes to the legislation stay relevant with the rapidly changing world of information technology is no small feat.

As the reforms develop, the AMA will lobby to ensure legislative changes do not inadvertently undermine the doctor-patient relationship, compromise patient care or add an unnecessary burden to doctors' administrative duties.

We will continue to keep members informed about privacy legislation reforms and the impact they will have on your practice.

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Regulation needed for courses with exorbitant fees and inflated claims

BY **JAMES CHURCHILL**

"With some courses costing up to $2000, there is a significant risk that predatory providers are taking advantage of high school students and their families – particularly those from disadvantaged backgrounds – at a time of significant pressure and vulnerability"

Each July, many thousands of eager Year 12 students sit the Undergraduate Medical Admissions Test (UMAT), the aptitude test required for entry to most undergraduate medical courses in Australia.

For most candidates, the three-hour test is gruelling. Given the competition for medical places, the stakes are high and, with a registration price of $210, the test is already a significant financial burden for students and families.

The big problem with the UMAT, however, is not the test itself but the preparation for the test. Over 50 different providers now offer UMAT preparation courses, in many shapes and sizes, with no mandatory system of commercial regulation.

These courses exist despite the test's developer, the Australian Council for Educational Research (ACER), asserting that the aptitude test does not draw on a particular body of knowledge or curriculum. ACER does not recommend any of the commercial courses and advises that candidates "should be wary of advice to spend many hours practicing on 'UMAT-style' questions."

Course providers disagree with ACER, with some advertising such claims as "we'll get you into medicine" through participation in their "critically important" preparatory courses.

With such intense pressure on students, many turn to these preparatory courses for what they are told will give them a competitive edge for entry to medicine.

But what does the evidence say?

A study by Griffin et al, published in the *Medical Journal of Australia* in 2008, indicated that coaching delivered no significant benefit for UMAT marks after correcting for a candidate's Australian Tertiary Admission Rank score, age and sex. Furthermore, the study actually found coaching had an adverse effect on student scores in the multiple mini-interview, another of the selection tools used by medical schools.

It's clear that the extraordinary claims of some courses must be examined, and misleading advertising withdrawn. With some courses costing up to $2000, there is a significant risk that predatory providers are taking advantage of high school students and their families -- particularly those from disadvantaged backgrounds -- at a time of significant pressure and vulnerability.

AMSA is calling for a system of mandatory regulation of the UMAT training course sector, so that courses with unrealistic claims and exorbitant fees are subject to examination according to best evidence.

AMSA's policy on UMAT training courses can be viewed at www.amsa.org.au

TO COMMENT CLICK HERE

Palliative and End of Life Care

BY **DR STEPHEN PARNIS**

"Demand for palliative care is increasing as our population ages. Patients and their families are seeking access to services to provide care to people who are dying from such diseases as cancer and other chronic and complex conditions"

Palliative care can be a sensitive issue.

Palliative Care Australia defines it as: "Specialist care provided for all people living with, and dying from, a terminal condition and for whom the primary goal is quality of life."

I can't think of a better way to define it but, as simple as it is to define, it is - as we all know - a very complex area, often fraught with strong emotions.

It is usually associated with the last chapter of a person's life – months, weeks or days - and for the practitioner it represents the transition in treatment to symptom management and the provision of comfort.

Demand for palliative care is increasing as our population ages. Patients and their families are seeking access to services to provide care to people who are dying from such diseases as cancer and other chronic and complex conditions.

The AMA has previously commented on the Government's *Living Longer. Living Better.* plan. Its measures to assist older Australians to live in their homes for longer has been a welcome response, along with additional funding for palliative care.

Gaps remain, however, in this sensitive and critically important area. Palliative care is usually provided in an admitted patient context or in a community or home-based setting. Many patients prefer the latter, but our health system is not always able to offer the home-based care that patients seek.

In March this year the AMA made a submission to a Senate Community Affairs References Committee inquiry into palliative care in Australia.

The submission focused on a range of key areas, including equity of access to services, an equitable range of Medicare rebates available to practitioners to improve the delivery of medical palliative care in private settings and education of community and health professionals about the reality of death and dying.

Further, the AMA supports the introduction of advance care directives (ACDs) as a means of informing health care decisions. These, combined with consistency in law and policy at a national level, would provide guidance to medical practitioners and allow them to confidently give effect to an ACD without fear of contravening the law.

A patient's right to specify future health care treatment preferences while they still have the capacity to do so should be protected and encouraged. Legislation should also provide protection for medical practitioners who follow ACDs, or who make a decision not to do so for clinically valid reasons.

These protections should be combined with access to legal clarity, such as rulings from a tribunal to ratify an ACD if necessary, and protection from criminal and civil liability for doctors acting in good faith who are caught up in this complex area. Patients should, where practicable, be able to end their days in a supportive, comfortable setting with support from their doctor.

In an ideal world, State, Territory and Commonwealth governments would work together to provide the necessary funding and provide a strong legal framework in which palliative care can be conducted with dignity and certainty.

This will require considerable political will and the funding to back the necessary initiatives. The support this would give to practitioners, patients and their families as they undergo end of life care would be much appreciated, and would ease the acute burden that all stakeholders often face at this difficult time.

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Europe crisis unlikely to prompt interest rate cut

BY *AUSTRALIAN MEDICINE* EDITOR ADRIAN ROLLINS

Renewed pessimism about Europe's sovereign debt crisis and America's faltering economy are unlikely to convince the Reserve Bank of Australia to cut official interest rates this month.

Global stockmarkets reeled late last week as investors, disappointed with the outcome of a critical European Central Bank meeting, dumped Italian and Spanish government bonds, forcing up yields and increasing the vulnerability of some of the eurozone's largest economies.

The developments in Europe have come amid signs that the US economic recovery is struggling to gain momentum, with unemployment stubbornly above 8 per cent.

The US Federal Reserve admitted last week that the world's largest economy had "decelerated somewhat" in recent months but, in an outcome that disappointed markets hoping for another round of stimulus measures, the central bank has decided to await developments before committing to more quantitative easing.

But the minutes of the Reserve Bank of Australia board's 3 July meeting show that the central bank had largely anticipated such developments in it deciding to keep official interest rates on hold at 3.5 per cent last month and there have been few developments since then that are likely to have substantially changed its outlook.

While the RBA is keeping a close watch on concerning developments in Europe and the US, it is drawing confidence from more promising signs closer to home.

In a major speech on 24 July, RBA Governor Glenn Stevens struck an optimistic note on the Chinese economy.

There has been mounting concern about evidence economic activity in the giant Asian economy is slowing, particularly because it is now Australia's largest trade partner, leaving the local economy vulnerable to swings in China's business cycle.

But Mr Stevens tried to soothe rattled nerves, arguing that although Chinese economic activity had slowed, the China growth story remained "roughly on course".

"The Chinese economy has indeed slowed over the past year or so," the RBA Governor said. "It was intended that a slowing occur. But the recent data suggest that, so far, this is a normal cyclical slowing, not a sudden slump of the kind that occurred in late 2008."

The RBA appears to be similarly relaxed about the domestic economic outlook.

While not denying the marked divergence in strength between those parts of the economy tied into the mining boom and the rest, the central bank has drawn comfort from evidence that activity has been considerably stronger than had earlier been thought.

The central bank, along with most commentators, was surprised by recent data showing gross domestic product expanded by 1.3 per cent in the March quarter, pushing the annual growth rate to 4.3 per cent.

The unexpectedly strong result was underpinned by very strong business investment and a rebound in consumer spending on both goods and services.

While the housing sector remains weak, household incomes are being supported by the relatively low unemployment rate of 5.2 per cent.

Consumer buying power is also being supported by low inflation. Official figures show the RBA's preferred measure of underlying inflation reached 1.95 per cent in the June quarter – below the central bank's 2 to 3 per cent target band.

Having cut the official cash rate from 4.25 to 3.5 per cent in the first half of the year, the central bank appears content to sit tight for the time being.

In the minutes of its 3 July meeting the RBA board said that the rate cuts it had made this year had prompted a 0.2 percentage point cut in home loan rates, pushing the average standard variable mortgage rate down to 6.85 per cent - about 0.6 of a percentage point below the post-1996 average.

Businesses were also benefiting from lower rates – business loan interest rates were between 0.5 and 0.75 of a percentage point below their 16-year average – supporting a pick up in business borrowing.

When the RBA board meets in Sydney tomorrow it is likely to conclude, as it did last month, that "with as material easing in monetary policy having occurred, and with recent signs that the domestic economy had a little more momentum than had earlier been indicated, [there was] no need for any further adjustment to the cash rate".

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Experts question fall in suicide rate

Mental health experts have accused the official statistician of producing "misleading" data showing a fall in the national suicide rate.

The Australian Bureau of Statistics has reported a 17 per cent fall in the rate of suicides in the past decade – down from 12.7 per 100,000 people in 2001 to 10.5 deaths per 100,000 last year.

But outspoken mental health expert Professor Ian Hickie, Executive Director of the Brain and Mind Research Institute, said the figures created a misleading impression that there has been a marked and steady improvement in suicide prevention.

Professor Hickie said the base year for the data comparison, 2001, was marked by an unusually high number of suicides and expressed concern that differences in the way different states determined and recorded causes of death led to an under-reporting of suicides.

"Coroner practices are different in each State, the timing of reporting is different, and the final conclusion of cases is different. So we haven't had a well co-ordinated national approach," Professor Hickie said.

Professor Ian Hickie said a proper registry with real-time information on suicide is needed to record accurate suicide-related death numbers.

"You don't need spin. You don't need a Pollyanna approach. You need accurate reporting in order that there can be the appropriate public policy responses, politicians can make investments, health services can respond, communities can put together supportive action that's required to reduce suicide," Professor Hickie said.

The ABS reported that NSW had the lowest suicide rate in Australia with 8.6 deaths per 100,000 people between 2006-2010. However, former Chairman of the National Advisory Council on Mental Health and Director of ConNetica consulting Professor John Mendoza said it was "a dishonest representation" for the ABS not to mention "well-documented evidence" that NSW was less reliable at reporting suicides.

"The media release also ignores the fact that NSW has the worst record for reporting suicide deaths in a timely way and that [in] the reporting of open case findings in the period from 2002 to at least 2007, NSW increasingly left 'open findings'," Professor Mendoza said.

The National Coroners Information System has only been nationwide since 2001 and, according to the Australian Institute of Health and Welfare, the actual numbers of suicides could be up to 16 per cent higher than indicated in the data collected by the ABS up to 2007 because of different collection methods.

After 2007, the ABS altered its processes to allow later classification or reclassification of suicides. Currently cases are examined initially, then again at 12 and 24 months, in order to capture any changes to suicide codes.

Director of Social and Demographic Statistics at the ABS, James Hinkins, defended the Bureau's data collection methodology.

"We have a very robust cause of death collection. And while there may be challenges in terms of determining causes of death, especially suicide deaths, we have a very consistent process to ensure that we can capture the coroner's findings when they're made," Mr Hinkins said.

"And we also have the ability, where someone dies and it's a potential suicide, to look at the coroner's database and be able to look for additional evidence that might support a finding of suicide or a code of suicide to be applied."

The ABS figures show suicide rates of men aged between 15 and 35 years of age have fallen, with a decrease of 34 per cent among males aged 15 to 24 years, and a 46 per cent decline for those between 24 and 34 years of age. By contrast, the Bureau found there had been little change in suicide rates among women, with men accounting for three-quarters of all suicides.

Suicide rates for Indigenous Australians were found to be roughly double those of non-Indigenous Australians, and the rates were particularly high among 15 to 34 year olds.

For help or information on information on depression, anxiety and related disorders, visit beyondblue.com.au or call Lifeline on 131 114.

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HIV cure moves closer to reality

Researchers believe they are closing in on developing a cure for HIV following the identification of a rare genetic mutation that blocks the virus from entering uninfected cells.

Human trials are beginning on two promising techniques that have the potential to armour the body's immune system against the AIDS virus without the need for lifelong antiviral drugs.

Professor Alan Trounson, who left Monash University in 2008 to become director of the California Institute for Regenerative Medicine, said there was now realistic hope for treatments which could "fireproof" the body's immune cells against HIV.

Professor Trounson said his organisation was following a promising line of research using blood stem cells to mimic a genetic mutation found in a small proportion of the population who are immune to the virus.

The approach is based on the experience of an American patient infected with

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HIV who received a stem cell bone transplant to treat his leukaemia. The bone marrow was from a donor with a rare genetic mutation that eliminates the CCR5 protein, which HIV needs to enter cells. As a result of the transfusion, the patient was cured of HIV and remains off antiretroviral drugs.

To date, the American patient is the only person to be cured of HIV, but scientists have since been able to successfully replicate the CCR5-eliminating mutation.

Professor Trounson said if trials of the technique were successful, further research would be needed to modify the technology so it could be affordably used in Africa, where it is most needed.

"I want the HIV work to go globally because it shouldn't be restricted to patients in Western [countries]," Professor Trounson told AAP.

A second technique, being trialled in Australia, essentially 'wakes up' the HIV virus in cells where it lies dormant.

Anti-HIV drugs are unable to completely eradicate the virus because the virus burrows deep into the DNA of immune cells, essentially becoming invisible to antiviral medication.

Director of Alfred Hospital's Infectious Disease Unit, Professor Sharon Lewin, said that the reawakened virus would self-destruct by killing the cell it inhabits.

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Lax travellers exposed to risk of typhoid

Travellers to developing countries are being urged to consider getting vaccinated against typhoid amid concerns that outbreaks of the deadly disease are multiplying.

Immunisation specialists are urging doctors to discuss typhoid vaccination with patients planning to travel to countries where the infection is endemic, amid warning signs that many travellers are not taking enough precautions against contracting the disease.

A Coalition Against Typhoid congress held in Bangkok heard of the high burden of endemic typhoid in developing countries and a growing number of outbreaks in the Pacific and South East Asia region.

The World Health Organization estimates that 21 million people are affected by typhoid each year with 200,000 dying annually from the infection, which is becoming increasingly resistant to antibiotics.

National Medical Advisor for Travel Doctor, Dr Tony Gherardin, a delegate at the congress, said that many Australians preparing for overseas travel often don't think about being vaccinated, even if they are travelling to a country where typhoid fever is common.

"Typhoid is an extremely serious, life-threatening disease, which is increasing in a number of places Australians are travelling to; in particular the Indian subcontinent, including India, Pakistan, Bangladesh and Sri Lanka," Dr Gherardin said.

"Most Australian cases of typhoid infections are acquired overseas by individuals eating contaminated food or water while visiting a developing country.

The Coalition Against Typhoid congress resolved that typhoid vaccination efforts needed to be implemented in conjunction with public health programs such as access to safe drinking water and the promotion of good hygiene practices, including hand washing.

Dr Gherardin said there was increasing concern about Australians who were travelling to typhoid endemic countries to visit family or friends, because they were less likely to seek advice or vaccinations before their journey.

"With the growing number of outbreaks of typhoid fever and the significant threat of emerging antibiotic resistance, the role of preventative vaccines is critical," he said. "It is increasingly important that healthcare professionals are consulting with their patients who are going to the developing world about taking the necessary precautions before travelling."

For more information about typhoid go to http://www.health.nsw.gov.au/factsheets/infectious/typhoid.html

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Bounty mutiny may provide window on poor eyesight

The infamous Bounty mutiny could lead to a breakthrough in understanding the causes of short-sightedness, which has been estimated to afflict more than 800 million worldwide, and is particularly prevalent in Asia.

Researchers from the Lions Eye Institute have found that descendants of Bounty mutineers living on Norfolk Island have among the lowest rates of myopia – short-sightedness – in the world.

The research, conducted as part of the Norfolk Island Eye Study, found that the incidence of myopia among those descended from the Bounty mutineers was half that of the broader Australian population, and scientists hope that identifying underlying genetic differences could lead to a breakthrough in understanding the causes of the condition.

Mutineers from the British naval ship, the Bounty, who famously set their captain William Bligh adrift in the South Pacific in 1789, first settled at Pitcairn, and in 1856 moved to Norfolk Island.

Professor David Mackey, Managing Director of the Lions Eye Institute, said Norfolk Island was unique because almost half the islanders could trace their ancestry back to the original Pitcairn population of just nine British mutineers, 12 Tahitian women and six Tahitian men.

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The study examined eye problems among the descendants of the sailors and their Polynesian wives.

"One component of the study has found the prevalence of myopia on Norfolk Island is lower than on mainland Australia," Professor Mackey said. "But there was a two-fold higher prevalence of myopia in people without Pitcairn ancestry.

"We found that the rate of Pitcairn group myopia is approximately one-half that of the Australian population and, as a result, would be ranked among one of the lowest rates in the world."

The researchers were unable to conclude why the levels of myopia were different but said further research may identify genetic differences in the Norfolk Island population that could lead to a breakthrough in the causes of myopia.

The prevalence of myopia is increasing, with estimates that 16 per cent of Australians aged over 40 years have the condition.

Other research under the Norfolk Island Eye Study examined the effect of exposure to sunlight on eye health.

The study investigated the association between conjunctival ultraviolet autofluorescence and pterygium – benign growth on the cornea.

It found pterygium affects 10 per cent of Norfolk Islanders and was more prevalent among men.

An additional study found that the prevalence of blindness was low – especially among those with Pitcairn Island ancestry.

The study was published in the *Investigative Ophthalmology and Visual Science* journal.

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Call to stop drinks companies going after the young

The AMA has called for government regulation of alcohol advertising amid evidence that the industry is targeting young people in its advertising and its voluntary warning labelling scheme is a flop.

The Foundation for Alcohol Research and Education has released the results of a study showing that just 16 per cent of alcohol products in the past year carried voluntary DrinkWise labels cautioning about the effects of alcohol on health, particularly for children and pregnant women.

The audit, conducted by the IPSOS Social Research Institute, found that just 39 of 250 products examined carried one of the four DrinkWise consumer information messages, and in 98 per cent of cases where they were used, they took up less than 5 per cent of the label, rendering them virtually invisible.

Foundation chief executive Michael Thorn said the results showed that alcohol industry self-regulation had been an "abject failure".

"The IPSOS audit brings into sharp relief the fundamental weaknesses of the industry's voluntary [labelling] scheme," Mr Thorn said. "What we need are evidence-based warning labels that are applied consistently across all alcohol products. That's something the industry's half-baked voluntary scheme can clearly never deliver."

The alcohol industry's advertising practices are also coming under heavy criticism.

AMA Vice President Professor Geoffrey Dobb said alcohol companies were deliberately targeting young people in their advertising and the practice must stop.

Professor Dobb is a member of the non-government Alcohol Advertising Review Board, which in three months upheld 42 complaints about alcohol ads, particularly campaigns and promotions explicitly directed at young people.

"The fact that alcohol companies continue to advertise in ways that are targeted to young people clearly shows that the current system of self-regulation does not work," Professor Dobb said. "The AMA believes that the alcohol industry has had its chance, it has failed to do the right thing, and now it is time for governments to act by regulating and prohibiting the marketing and promotion of alcohol to young people and teenagers."

AMA President Dr Steve Hambleton has underlined the dangers of mixing energy drinks with alcohol .

Dr Hambleton warned that caffeine-rich energy drinks masked the effect of alcohol, making it difficult for drinkers to judge how intoxicated they were.

"You've got a stimulant being mixed with a depressant, [so] the person drinking alcohol's interpretation of how intoxicated they are is impaired," the AMA President told *MX Brisbane*.

"There's absolute evidence that people who mix energy drinks with alcohol are sexually assaulted more often, they sexually assault others more often, they're more likely to get in a car with someone who is intoxicated."

The US Food and Drug Administration has declared that caffeine be considered an "unsafe food additive" because it can mask the effects of alcohol on drinkers.

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HEALTH ON THE HILL

Doctors challenged to define medical injury

Employment Minister Bill Shorten has urged doctors and lawyers to short-circuit decades of uncertainty and come up with a definition of medical treatment injuries that should be covered by the National Injury Insurance Scheme (NIIS).

Mr Shorten told a roundtable convened by the AMA bringing together representatives from state and federal AMA branches, the Law Society and Government departments, including Treasury and Health, that there was a unique opportunity to set out the ground rules for how cases of permanent and catastrophic injury arising from medical misadventure should be classified and treated under the proposed no-fault NIIS.

"This is an important opportunity to work out what we all have in common," said Mr Shorten, who chaired the 25 July meeting. "This is part of a bigger debate about the status and treatment of people with preventable and profound disabilities. There are too many people in Australia who have second-class lives because of a lack of power."

The Minister, who was the driving force behind the creation of the National Disability Insurance Scheme (NDIS), said that although the NIIS "is not going to fix everything", it would make a profound difference to the lives of many currently condemned to the fringes of society.

Mr Shorten said many people suffering permanent and catastrophic injury as a result of medical treatment currently fell through a gap in the legal system, and he favoured the creation of a no-fault scheme, though "I do still see a role for aspects of tort law".

"We do need to see what we can do to resolve the medical indemnity issue," he said. "This is an issue that has been around for decades and it would be a shame if we were not able to find a long-term solution. You have an opportunity where a lot of people are interested in resolving this issue in a speedy fashion."

Dr Steve Hambleton talks with Employment Minister Bill Shorten at the National Injury Insurance Scheme forum

Former AMA President Dr Andrew Pesce, who is on an expert group advising the Government on the creation of the NIIS, told the roundtable the scheme was intended to cover, among other things, permanent and catastrophic injury arising from medical treatment – though in practical terms this would be limited to severe brain and spinal cord injury and blindness.

But, because the scheme would operate as a companion to the disability insurance scheme, important definitional issues had to be resolved.

He said people who suffered such injuries as an unavoidable consequence of appropriate medical treatment would be covered by the NDIS and the support it provides for lifetime care.

But those hurt as a result of medical error or substandard treatment might fall under the NIIS which, in addition to support for lifetime care, would also cover ongoing hospital and medical costs.

The Productivity Commission recommended that an expert panel be appointed to examine and classify individual cases of injury, though Dr Pesce said the AMA believed such an arrangement posed several critical problems – not least the influence the panel's decision might exert on subsequent legal proceedings.

He said another possible way to define injury that could be compensated through the NIIS would be to use the definition of a "rare and serious outcome" in which the concept of error or avoidable injury is not considered.

AMA President Dr Steve Hambleton and others attending the roundtable questioned the Government's approach in establishing both the NDIS and the NIIS, but Mr Shorten said this was the path that had been set by the Council of Australian Governments, and it was more fruitful to focus efforts on defining what injuries should be covered by the injury insurance scheme.

He said one of the Government's major goals with the NIIS was to minimise litigation and ensure doctors were not distracted by concerns about liability in going about their work.

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HEALTH ON THE HILL

Sick travellers to be stopped from boarding planes, boats

Quarantine officers will have the power to prevent ill travellers from boarding ships or aircraft or undergo treatment or vaccination under draft biosecurity laws to be considered by Federal Parliament later this year.

In a far-reaching overhaul of the Quarantine Act 1908, the Government plans to strengthen powers to prevent the transmission of communicable diseases, including by preventing infected people from travelling internationally.

The Department of Health and Ageing has proposed that the new laws give the Governor-General and the Health Minister the power to act locally, or as part of a co-ordinated international effort, to limit the spread of disease.

A regulatory impact statement on the proposed changes prepared by PricewaterhouseCoopers acknowledged that "currently Human Quarantine Officers have limited powers to respond to the threat of communicable diseases".

It said the new rules would allow authorities to order ill passengers into isolation, require them to undergo treatment or vaccination, or ban them from travel for a period of time.

The proposed legislation, which is open for public comment until 10 August, also seeks to augment the Commonwealth's powers to implement the International Health Regulations (2005) to prevent, protect against and control the national and international spread of disease.

"The power to enforce travel movement restrictions would be included to ensure Australia meets international obligations to ensure that people with particular diseases do not travel internationally," the regulatory impact statement said. "DoHA (Department of Health and Ageing) is proposing that the biosecurity legislation provide them with sufficient power to restrict a person suspected of having a listed human disease from travelling on an overseas passenger aircraft or vessel.

"The proposed legislation would allow the Director of Human Biosecurity to issue an alert to all border agencies and relevant operators, advising them of travel restrictions in place…to ensure suspected individuals subject to a traveller movement restriction are not allowed to board an aircraft or vessel."

A Department of Health spokeswoman told *The Australian Financial Review* that the upgraded powers would be used to control diseases that posed the most serious risk to public health, such as smallpox, rabies and yellow fever.

In extreme cases, the Biosecurity Bill would allow emergency powers to be invoked by the Health Minister if she or he is satisfied that a listed human disease is posing a severe and immediate threat, or is causing harm on a nationally significant scale to human health.

These powers would include authority to set up exit screening and controls and "public health measures that would not normally be available if emergency management actions were restricted to the quarantine power", the legislation says.

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Breast implant failure rate rising

Almost 400 of the controversial Poly Implant Prothèse (PIP) breast implants have ruptured, according to updated figures released by the medical watchdog.

The Therapeutic Goods Administration, which has been accused of failing to adequately protect Australian women over its handling of the international recall of PIP implants by French authorities in 2010, has released figures showing there have been 370 confirmed cases of PIP implants rupturing – including almost 250 reported by surgeons and 100 by patients – while there are a further 29 suspected ruptures.

With estimates that around 13,000 of the implants were supplied in Australia between 1998 and 2010, the data suggest a failure rate of a little more than 3 per cent – below the 10-year failure rate of between 15 and 30 per cent identified in a recent UK report.

In its report, an expert group appointed by the UK Department of Health said that although there was no evidence PIP implants posed a significant risk to health, they were "significantly" more likely to rupture or leak than other implants – a finding at odds with previous assurances from the TGA.

The authors of the UK report recommended that taxpayers foot the bill for having the implants removed – even if intact – if a woman wants to have them taken out and her original provider is unwilling or unable to pay for the procedure.

But, although the TGA is reviewing its advice to women with PIP implants following the UK findings, it has so far stuck by its view that the prostheses are no more likely to rupture than any other silicon implants.

The pressure on the TGA over its regulation of breast implants and other medical devices such as hip replacements has come as the Federal Government has announced the formation of a council to provide "broad strategic advice" to the watchdog, particularly regarding communications.

Parliamentary Secretary for Health and Ageing Catherine King has announced the appointment of Chief Medical Officer Chris Baggoley to chair the Australian Therapeutic Goods Advisory Council, which will "provide expert advice from the perspective of the TGA's three main stakeholder groups – consumers, health professionals and industry".

Ms King said membership of the Council, which will have up to 12 members, would be finalised by early September, with the first meeting to be held in the last three months of 2012.

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Health insurance industry shakeout yet to deliver for consumers

Competition between private health insurers is set to come under close scrutiny from the industry regulator amid concerns that consumers are yet to benefit from a slow-burn shakeout among providers in the sector.

The process of consolidation in the industry, which has seen more than one in five funds disappear since the turn of the century, continued last month with the successful completion of a merger between Medibank Private and the Australian Health Management Group (AHM).

But, alarmed that that the increasing dominance of larger, for-profit funds is yet to translate into slower premium growth or tighter profit margins, the industry regulator, the Private Health Insurance Administration Council (PHIAC), is setting up a unit dedicated to findings ways to bolster competition in the sector and put downward pressure on costs and charges.

PHIAC has cancelled AHM's registration following the full transfer of its assets, liabilities and policyholders to Medibank, which was completed on 1 July, confirming the increasing dominance of for-profit insurers in the private health insurance industry.

The move means the number of registered private health insurers has fallen to 34 organisations, down from 44 in 2000 and 40 in 2005.

Management and industry theory holds that as market growth slows, competition among firms intensifies, driving up the pace of mergers and takeovers as companies scramble to realise efficiencies of scale to give them an advantage over rivals – in the process holding costs for consumers down.

But the regulator's figures show that although there are big changes underway in the private health insurance industry, there is yet to be much pay-off for consumers – at least not in the way they might want it.

There are two changes happening concurrently.

While the overall number of funds has shrunk, those operating on a for-profit basis have almost doubled in number over the same period, from four to seven funds, and their market share has ballooned.

Council figures show the market share of for-profit insurers has grown more than five-fold in the past 12 years, from 12.5 per cent in 2000 to almost 69 per cent last year.

Over the same period, premium revenue has virtually trebled from less than $5.5 billion to $15.4 billion, while the amount paid out in benefits has grown from $4.5 billion to $13.1 billion.

PHIAC said the industry's transformation had been driven by a combination of economic uncertainty, government policy and regulatory changes, and had further to run.

"In the increase in for-profit insurers, [there has also been] significant industry consolidation since 2000," the regulator said in its *Annual Report 2010-11*. "PHIAC expects that further consolidation of the industry will occur in the future."

But the authority admitted it was yet to detect signs that the major changes underway in the structure of the industry were increasing competition and bearing down on premiums.

"Many commentators expected that the rapid conversion of much of the industry to for-profit and consolidation to fewer insurers would sharpen competition in the sector, though the sustained margin outcome and the profitability of the industry suggests that this has yet to occur, at least insofar as premiums are concerned," PHIAC said.

Competitive forces in the sector have been muted to a considerable extent by government policy and regulation.

The industry receives massive subsidisation through the Commonwealth's Private Health Insurance Rebate, and is also supported by the provisions of the Lifetime Health Cover scheme, under which a 2 per cent loading is added to a person's health insurance premium for every year beyond 31 years they delay taking out private health cover.

But, as a price for subsidisation and support, insurers have to have proposed premium increases approved by Government.

The regulator is commissioning research into competition in the industry, "including the markets and sub-markets for private health insurance products and the main participants in those markets".

The findings will be used to inform the work of a four-person Premiums and Competition Unit being established by the Council using an allocation of $2.3 million over four years in the 2012-13 Federal Budget.

The move has come amid claims by South Australian Senator Nick Xenophon that private health funds are short-changing private hospitals in his state.

Senator Xenophon said that PHIAC figures show health fund gross hospital insurance margins in South Australia were almost 50 per cent higher than the average across all other states and territories, while Private Hospital Data Bureau figures showed that the funds paid between 10 and 20 per cent less to SA hospitals for the same treatment provided interstate.

"This is a scandalous situation," the Senator said. It discriminates against people in SA with private health insurance as well as all SA private hospitals.

"Patients in South Australia shouldn't be short-changed because the health fund they've chosen is using our state to save a few bucks," Senator Xenophon said, calling on Health Minister Tanya Plibersek to intervene.

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Clinical standards not the way to improve care quality

AMA President Dr Steve Hambleton has warned that attempts to boost quality of care by prescribing and benchmarking treatment according to an imposed set of clinical standards as misconceived.

Dr Hambleton said efforts to push strict and deterministic protocols and clinical standards onto the profession were doomed to fail.

"Professionals do not respond well to increased red tape, tick box medicine and protocol-driven decisions," the AMA President said, particularly because neat checklists often bore little relationship to the complexity of cases that GPs frequently had to treat.

"We are treating patients, not conditions," Dr Hambleton said. "You might have three major conditions to treat simultaneously, and what might help with one may aggravate another."

The AMA President's comments followed the release of a study that found just 57 per cent of consultations with doctors conformed with clinical standards and guidelines, prompting claims that many patients – particularly those seeking treatment for alcohol dependence, obesity and the management of asthma – were receiving sub-standard care.

The CareTrack study, published in the *Medical Journal of Australia*, used clinical guidelines set by organisations including the National Health and Medical Research Council and the Australian Council on Healthcare Standards to assess the care provided by doctors to 1154 adults with at least one of the 22 most common maladies.

The study's authors admitted that clinical standards were frequently inconsistent, overlapping or out-of-date, and the AMA warned that many were based on limited evidence.

Only 15 per cent satisfy the benchmarks set by the NHMRC as having a body of evidence sufficient that they can be trusted to guide practice.

Dr Hambleton said the CareTrack study concentrated on processes rather than outcomes, and neglected the fact that Australia ranked highly among developed countries for the quality of its health care.

He said that, rather than imposing a set of standards from the top down, quality of care would be improved by ensuring GPs were given the means to be able to measure their own performance and analyse it.

Dr Hambleton said that one of the strongest drivers of change in professional pratice was self-reflection, based on the information needed to improve the quality of care.

"Our core role in general practice is high quality individually tailored care to our patients which forms the building blocks of population health," the AMA President said. "Part of general practice's opportunity in health reform is to demonstrate the quality of the care it is already delivering, and the best way we can demonstrate that is to measure it."

Dr Hambleton said significant progress had been made in giving GPs the opportunity to demostrate their performance was the development by the National E-Health Transition Authority (NEHTA) of a classification system.

"I honestly think that NEHTA has does some very good things," the AMA President told the National Press Club last month. "It's easy to poke fun at NEHTA for what it hasn't done. But what it has done is actually given us a classification system that we've finally settled on, that we can all use.

"And that means I can actually analyse my practice and I can compare it with another practice."

Dr Hambleton said a lack of appropriate software currently limited the ability of GPs to measure and analyse their performance, but expected the shortcoming would eventually be addressed, giving doctors the tools they needed to track, assess and demonstrate their performance.

He said this was important for two reasons: both as a means for practitioners to gauge the quality of care they provide and identify where and how it could be improved, and as a way to prove to government and the broader community that their care is world-class.

"We GPs should be measuring what we do," he said. "It is not enough for us to know that we are providing high quality care. In the new fiscal environmemt GPs have to be able to prove that the services they are delivering are of the high quality that we know they are."

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Dangerous sports supplement banned

The medicines watchdog has banned a sport supplement used by body builders and other athletes that has been linked to at least two deaths overseas.

The Therapeutic Goods Administration has added dimethylamylamine (DMAA) to its list of prohibited substances following an urgent review of the health risks posed by the supplement.

"The TGA has made a final decision to include DMAA in Appendix C of the Poisons Standard," an Administration spokesperson said. "This means that it is a substance of such danger to public health as to warrant prohibition of sale, supply and use."

The ban, which comes into effect on Wednesday, 8 August, follows a nationwide alert issued by Food Standards Australia New Zealand in mid-June urging athletes and other consumers to immediately stop taking performance enhancing dietary supplements containing the product.

DMAA, which is typically used by bodybuilders and other athletes as a pre-workout supplement, has been associated with high blood pressure, vomiting and other adverse health effects, and the United States Defence Department banned the substance last year amid concerns it contributed to the deaths of two soldiers.

Its use is already prohibited by several sporting codes, and the TGA recommends that people who have products containing DMAA should immediately stop using them.

Products found to have DMAA include: Noxpump; 3-D explosion; Beta-Cret; PreSurge; 1 MR; Cyroshock; Jack3D; Mesomorph; Neurocore; Oxyelite powder; and Hemo Rage Black.

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Health chief admits e-health target may be missed

The nation's most senior health bureaucrat has admitted that the number of people who sign up for a Personally Controlled Electronic Health Record (PCEHR) in the first year may fall short of the Federal Government's target.

But Department of Health and Ageing secretary Jane Halton told the Health Informatics Conference in Sydney last week that it was more important that the system be rolled out in a "careful and methodical" way than strive for a notional registration target.

Dr Halton said she was unsure if the goal of signing up 500,000 people to the PCEHR scheme in its first year would be met.

"The 500,000 was an estimate based on some international evidence, but every country is different," she said. "I think the important thing is that what we do roll out we roll out successfully, and that we deliver the kind of functionality that people want."

The Government and the Department have come under fire over the introduction of the scheme, which was officially launched on 1 July despite major outstanding policy and technical concerns.

In a televised speech to the National Press Club on 18 July, AMA President Dr Steve Hambleton warned that without the support of GPs – which was far from a given - the PCEHR scheme would stall.

The AMA has spoken directly with Health Minister Tanya Plibersek about its concerns, including a lack of funding for the extra work required of doctors to create and maintain electronic health records, a lack of software to enable practices to link in with the system, unresolved concerns about record security and privacy and insufficient public information about the scheme.

"We all want it to succeed, but it has to be done the right way, and it must be supportive of GPs," Dr Hambleton said. "We need to know how doctors will be funded to do the Government's work. Patients need to know what they can realistically expect to receive when they try to sign up at the doctor's surgery."

Dr Halton said the Government had deliberately adopted a low-key approach to the introduction of the PCEHR and, given this, the 4000 registrations received so far was nothing short of "miraculous".

"The fact that we've said this to almost nobody, it's a huge number," she said. "The fact we've had that many registrations I think is quite miraculous, to be honest."

Dr Halton said functions were being progressively added to the system, and promised that by the end of the month there would be access to Medicare data, and GP software capabilities would come on line in September.

But she said functions would only be added when they had been tested and refined at the scheme's 12 test sites.

"Until we've got the GP desktop software up and running and we've had some of those early experiences in the Wave sites, we don't want to get everyone running around the country recreating the same experiences," Dr Holton secretary said. "We want those experiences to inform how they have been helping others roll out. This is about a careful and tagged roll out."

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WHO lashed over killer Cambodian bug

A Cambodian-based Swiss paediatrician has accused the World Health Organisation of causing unnecessary panic by making unprofessional and misleading claims about an illness that has killed dozens of young children in the Asian country.

Dr Beat Richner, founder of the Kantha Bopha Children's Hospitals group in Cambodia, first raised the alarm about the infection – which has killed 64 of the 66 children diagnosed with the condition – in May.

So far no cases have been reported outside of Cambodia, but the WHO has put neighbouring countries on alert for the disease.

Symptoms include a high fever, followed by respiratory and neurological symptoms, with "rapid deterioration of respiratory functions".

Dr Richner said his hospitals treat "85 per cent of all Cambodian sick children", and children with the infection suffered encephalitis and – in the final stages before death – "a total destruction of the alveolas in the lungs".

Cambodian authorities report that infections have been confined to children between the age of three months and 11 years, with the majority of cases occurring among children three years or younger.

But, while admitting that the exact cause of the fatalities is yet to be identified, Dr Richner was nonetheless scathing of the WHO's statement early last month that Cambodia had been struck by a mystery killer disease.

Dr Richner said that days before the WHO made its announcement, Kantha Bopha had alerted Cambodia's Ministry of Health that the illness was most likely caused by an enterovirus or an "intoxication by a medication", or both.

Tests by the Institut Pasteur du Cambodge have ruled out influenza, SARS and the Nipah virus, while confirming that in a significant number of cases enterovirus 71 - which causes hand, foot and mouth disease – has been present.

Dr Richner welcomed the results, but said more work needed to be done to identify the exact cause of the fatalities.

"We have now to see what really is causing the deadly pulmonary complication, and see if a toxic factor is playing a role too," he said, pointing out that all 64 children who had died from the condition had come to Kantha Bopha after being treated at private clinics.

"Unfortunately, [the] WHO has given a declaration on 3 July without being clear on the facts," Dr Richner said. "WHO was telling the whole world: new mystery killer disease in Cambodia. This was causing unnecessary panic."

"This declaration was neither professional nor necessary, but causing panic for nothing."

Dr Richner said that the disease, while devastating for those infected and their families was "not an alarming issue" in public health terms.

He said the 34 children hospitalised with the disease in June had to be compared with the almost 75,800 children suffering dengue fever who were treated by his hospitals as outpatients in June, while a further 16,500 severely ill children had to be admitted, of whom 5500 had haemorrhagic dengue fever.

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Breakthrough in quest for malaria vaccine

There has been a major advance in efforts to develop a vaccine for malaria following a significant discovery by researchers at Australia's Burnet Institute.

Led by Professor James Beeson, scientists at the Institute have identified a key target of the immune system's attack on malaria, opening the way for the development of a vaccine that stimulates the body to increase its defences against the parasite.

The researchers found that people who are immune to malaria develop antibodies to a protein, PfEMP1, produced by malaria.

Professor Beeson said this was a major advance toward the development of an effective vaccine by unlocking the mystery of which proteins should be targeted in order to develop immunity.

"A vaccine could be developed that stimulates the immune system so that it specifically mounts a strong attack against the PfEMP1 protein that malaria produces," he said.

The discovery came soon after it was announced that Sydney will host a high-level conference bringing together governments and global malaria experts later this year.

The Government will host the conference, to be held in late October, to deepen international and regional co-operation in tackling the disease, including ways to head off the threat from emerging drug-resistant strains of the parasite.

Announcing plans for the *Malaria 2012: Saving lives* in the Asia Pacific conference, Foreign Minister Bob Carr said that although progress had been made in curbing malaria, more than 200 million people worldwide – and about 30 million in the region – were infected, causing debilitating illness and, in some cases, death.

Senator Carr said 42,000 people in the Asia Pacific were killed by the disease in 2010, and many more were unable to work and care for their families because of the infection, undermining economic activity as well as health.

International efforts to combat malaria have been given renewed impetus in recent years, with the efforts of national governments and multilateral organisations augmented by the actions of major non-government organisations, most notably the Bill and Melinda Gates Foundation, which has funded the Malaria Eradication Research Agenda and supports the Malaria Vaccination Initiative, which aims to develop a vaccine against the disease by 2025.

Senator Carr said Australia had been working with countries in the region to combat malaria, including through funding for the Asia Pacific Malaria Elimination Network and the distribution of mosquito-proof nets for beds.

He said that since 2003 such efforts had helped slash the incidence of malaria in the Solomon Islands by 70 per cent, and in Vanuatu by 85 per cent.

But there is mounting evidence that the effectiveness of existing control methods is waning as mosquitoes become increasingly resistant to the insecticides used in bed nets and sprays, and the drugs used against the malaria parasite lose their potency.

Senator Carr said stepping up efforts in the face of growing resistance would be a major focus of the conference, to be held from 31 October to 2 November.

"Gains in controlling and eliminating malaria are threatened by emerging drug resistance in the region," the Minister warned. "The conference will provide an opportunity for Asia Pacific leaders to build on our successes, protect the gains and further develop regional responses to malaria.

"It will also provide a forum to discuss how we can work together to combat emerging drug resistant strains and explore ways of contributing to the global effort to eliminate deaths from malaria by the end of 2015."

The announcement of the conference, to be co-chaired by the UN Special Envoy for Malaria Ray Chambers was welcomed by the Medicines for Malaria Venture, which manages more than 65 anti-malarial research projects worldwide.

The Venture's chief executive officer David Reddy said the Australian Government's decision to host the conference was significant.

"Today, some of the world's leading scientists in malaria drug research are based in Australia, and their continued research into new anti-malarials will be critical to the achievement of global malaria eradication strategies," Mr Reddy said.

He said the Venture and its partners were managing a pipeline of more than 50 projects developing anti-malarial medicines in anticipation of increasing resistance to the current most effective treatment, artemisinin.

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Health for sale, US-style....

The gulf in access to doctors between the rich and the poor is wider in the United States than any other developed country, a study by the Organisation for Economic Co-operation and Development has found.

In a result that lends support to the Obama administration's reform of health care financing in the US, a survey of 19 OECD member countries – not including Australia - found the gap between the well-off and the poor in terms of the likelihood of seeing a doctor for treatment was far greater in America than any other country surveyed.

On an index measuring the effect of income inequality on the probability of visiting a doctor, the US scored close to 0.06 points, far above the country with the next highest score, Estonia, which had an index of around 0.025 points.

For most countries measured, the index was between 0.0 and 0.01 points – with New Zealand close to 0.01 points, Germany around 0.005 points, and the United Kingdom at zero.

"Pro-rich inequities in the probability of a doctor visit are observed in most countries, but not at a high level," the OECD reported. "Only in the United States was a higher level of inequity apparent; for the same level of need for health care, people with higher incomes are more likely to visit a doctor than those with lower incomes."

In a finding with significant implications for models of health funding, the study reported that the degree of public financing, the size of out-of-pocket expenses and the extent reliance on private health insurance were all factors influencing the extent to which access to health care was determined by need rather than wealth.

The OECD study showed that among countries where public spending accounted for between 70 and 85 per cent of total health expenditure, inequity in doctor visits was relatively low.

By comparison, in the United States, which has historically relied more on private insurance to fund health care and government spending is 50 per cent of the overall health bill, the rate of inequity in doctor visits was at least three times higher than most of the other countries surveyed.

"Private funding is often regressive and negatively impacts on the uptake of needed services, in particular for vulnerable people at risk of social exclusion," the report said. "The United States, with its reliance on primary health insurance, stands out as having a substantially lower share of public health expenditure. Countries with a higher degree of private provision of care display higher level of inequity in… consultations."

The OECD said another important factor in widening the divide in access to health care between the well-off and the rest was the size of out-of-pocket payments.

"Out-of-pocket payments increase inequalities in access to care," the report said. "Direct payments for health care penalise the worst-off, creating barriers to access and potentially further damaging health."

The OECD said private health insurance also played a significant role in improving access to care, whether as a complement to help cover out-of-pocket expenses, a supplement providing coverage for additional health services, or as a means to speed up treatment by circumventing waiting times in the public health system.

Unsurprisingly, it found that higher-income households in all 19 countries surveyed were more likely to have private health insurance than those less well off.

The OECD said that, although inequalities in access to health care persist, in most countries the worse-off are just as likely as the well-to-do to see a GP when they need care.

But it said more could be done to ensure health care is provided to those who need it, regardless of wealth.

"Broader health insurance coverage improves access," the Organisation said. "The higher the share of public health expenditure, the lower the inequity in doctor visits.

"Similarly, greater inequity in specialist visits accompanies a higher degree of private provision. A greater share of out-of-pocket payments is associated with inequity in specialist and dental care.

"Secondary private health insurance facilitates the use of care, with the privately insured more likely to visit doctors and dentists."

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...but comrades also pay through the nose in China

The Chinese Government is trying to wean hospitals and doctors off medicine sales and kick-backs as part of far-reaching health reforms, amid mounting anger over the cost and quality of health care.

In a sign that spiralling health costs and unequal access to care are not just problems for developed countries like the United States, increasingly vocal and violent complaints about hospital and doctor fees and the cost of medicine have prompted China's Communist Party to launch an ambitious overhaul of the nation's health funding arrangements, according to *The Economist*.

The Chinese Government's share of total health spending has risen to almost 30 per cent in the last three years after slumping close to 15 per cent in 2000, though it is still short of the 40 per cent share common before the country's economic transformation got underway in the mid-1980s.

The flow of Government funds has meant the direct cost burden for patients, which reached 60 per cent of total health spending in 2000, has steadily shrunk to around 40 per cent.

But although the Chinese Government has been successful in encouraging people to join subsidised insurance schemes, *The Economist* reports that it is still a long way from breaking the reliance of doctors and hospitals on medicine sales.

According to the report, hospitals typically gain about 40 per cent of their revenues by selling medicine to their patients, usually for a mark-up of around 15 per cent, while another 40 to 50 per cent of funds comes from charges for diagnostic tests, treatments and other services, while less than 10 per cent comes from Government.

China's lowly-paid hospital doctors, with some earning as little as about $755 a month, top up their wages by getting a share of the profits from medicine sales and treatment fees, as well as kick-backs from drug companies when they stock and prescribe their medicines.

Unsurprisingly, the system has encouraged exponential growth in medicine sales, diagnostic testing and treatment, with attendant concerns about over-prescribing and unwarranted treatments and procedures.

But, *The Economist* reports, attempts to end the reliance of hospitals and doctors on medicine sales and service charges could be confounded by concerns that local governments will not make up any shortfall in revenue foregone.

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Trade fight over plain packaging laws spreads

The Dominican Republic has joined international action against the Australian Government's world-leading plain cigarette packaging laws as tobacco companies fight a rearguard action against increasing restrictions internationally on the sale of their products.

While the Caribbean nation is a tiny trade partner, exporting just $20 million worth of goods to Australia last year, it is a major producer of cigars, and has lodged a formal complaint about the plain packaging laws with the global trade umpire, the World Trade Organisation.

Late last month the Dominican Republic government formally notified of a trade dispute by requesting consultations with Australia "on certain measures concerning trademarks, geographical indications and other plain packaging requirements applicable to tobacco products and packaging" through the auspices of the WTO.

It has joined Ukraine and Honduras in complaining that the laws, which have also been challenged by the major tobacco companies in the High Court, unfairly restrict trade and should be scrapped.

Under the laws, from 1 October all cigarettes must be sold in generic olive green packets, with similar restrictions coming into force for cigars from 1 December.

British American Tobacco, Imperial Tobacco Australia, Philip Morris and Japan Tobacco International launched their High Court action late last year, and a judgement is expected soon following hearings held in April.

Regardless of the outcome of the High Court case, the laws are coming under significant international challenge.

Both Honduras and Ukraine, both tobacco-exporting nations, are already well advanced in the preliminary steps that need to be taken before the matter proceeds to WTO adjudication, having requested consultations with Australia over the measure.

Under WTO rules, if the matter cannot be resolved by negotiation within 60 days, the complainant can ask the WTO to set up a panel to adjudicate the case.

Diplomats give little chance of the dispute being resolved by negotiation, and expect the Dominican Republic's complaint to be joined with that of the other two nations when the case proceeds to adjudication.

The issue has drawn significant international interest, with a large number of countries acting as third-party observers in the case.

New York mayor Michael Bloomberg, who has donated millions of dollars to global anti-smoking campaigns, last month met with Health Minister Tanya Plibersek – who was visiting the giant US city - to discuss Australia's plain-packaging laws.

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What is needed for real prevention is full Government participation

BY **PROFESSOR STEPHEN LEEDER**

Most of the things that affect our health, and most of the care given to people with serious and continuing illnesses, lie outside the health system.

In the studies I and my colleagues at the Menzies Centre for Health Policy have done over the past five years with people suffering from chronic illness, these two truths have borne in on us at every turn.

Where people live, their income, transport, housing and social connectedness, all determine how well they will do with complex diabetes, chronic pulmonary disease or heart failure (the three index conditions we studied). Caring by relatives and friends outweighs that provided by the health and social welfare system by about 50 to one.

We can advocate on behalf of our patients for improvements in these determinants, but they are not in our grasp to influence directly as doctors. And when we look at what sets the health (in distinction to the sickness care) of our populations, we find the same thing and our frustration grows. But we need to face the truth.

As Michael Marmot and his colleagues in the WHO Commission on Social Determinants of Health wrote in 2008:

> *"Lack of health care is not the cause of the huge global burden of illness; water-borne diseases are not caused by lack of antibiotics but by dirty water, and by the political, social and economic forces that fail to make clean water available to all; heart disease is not caused by a lack of coronary care units but by the lives people lead, which are shaped by the environments in which they live; obesity is not caused by moral failure on the part of individuals but by the excess availability of high-fat and high-sugar foods. The main action on social determinants of health must therefore come from outside the health sector. [The World Health Organization Commission on Social Determinants of Health, Closing the Gap in a Generation – Health Equity through Action on the Social Determinants of Health, 2008, p. 35.]*

It is this awareness that has led public health advocates in South Australia to pursue the idea of having health considered as an element - rather like we do with the environment these days - of all policies, whether they be in education, transport, trade or social welfare.

Dozens of interest groups clamour around every public policy table – as they should – and to be heard above the cacophony a clear, loud message is necessary. Will thinking about health consequences be politically feasible? If our interest is in assuring that a new urban development has sufficient fresh food outlets, is friendly to walking, is well served by public transport and is safe, how do we win a contest with interests that are strongly committed to the highest profit possible? The latter may easily conflict with investment in the 'commons' - amenities shared by all but paid for by none. To move health in all policies from tick-box status to something that stops us in our tracks and asks us to reflect on what influence on health will follow from our proposed policy, is no easy task.

"The concern with chronic illness is not misplaced, as some argue: of course, everyone must die of something. The question is: of what and when?"

These concerns have never been theoretical in the developing world, where the environment is readily seen to be so frequently health-destructive. Not so in Australia. But with the rise of chronic illness, concentrated among older people and dominating our health care agenda in Australia, in hospital as well as in the community, demand for efforts to ameliorate and prevent are rising.

The concern with chronic illness is not misplaced, as some argue: of course, everyone must die of something. The question is: of what and when? There is a world of difference between a person dying, after a long and healthy life, of a stroke or heart attack in their nineties, with no significant prodrome, and a person lingering into their eighties with a 10-year history of progressive inability to breathe.

The prevention agenda in relation to chronic disease concerns morbidity, and only to a smaller extent, mortality. To achieve the changes in the environment that widen the band of life in which people can make choices about behaviours that influence their health is no longer a soft option but necessary to achieve a sustainable health care system. Only a whole-of-government approach will suffice. Health cannot go it alone.

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BOOK REVIEW

Neurology for general practitioners

Roy Beran

Churchill Livingstone Australia, 2012, ISBN 978-0-7295-4080-3

Reviewer: Associate Professor Jeffrey Looi

This book is framed by Professor Roy Beran, a neurologist who was previously a GP, as a quick reference for the GP who encounters neurological conditions in the rough and tumble of a busy general practice.

Beran distills clinical insights gleaned from his experience in general practice, leavened by his specialist training in neurology and sleep medicine, and is upfront about what this means for the guidance he provides. As he himself states, "*Throughout my writings I reiterated that this book reflects the idiosyncratic approach of a single doctor.…*" (p. ix), predicated on his experience. This is both the book's greatest strength and limitation.

This handbook breezily covers a large range of general practice neurology, including headache, stroke, dementia, epilepsy, vertigo, multiple sclerosis, Parkinson's disease, muscular disorders and peripheral neuropathy.

The inclusion of non-organic neurological disorders, sleep medicine and pain is useful, typical of the somewhat broader purview he sees for general practice neurology. These sections are well illustrated, with useful diagrams, and contain recommended references.

The author indicates he is keen to improve the book for future editions, and it would benefit from the alignment of advice with recent evidence-based guidelines, as opposed to distilled personal experience. For example, Beran has developed his own cognitive assessment battery, which may prove useful in his skilled hands, but GPs may be better to use a validated instrument with scoring norms due to the infrequency with which they may perform such testing. Similarly, in discussing the intelligent patient concerned about cognition but whom "*may still be above the norm.…*"(p.161), he states "*Personal experience has taught that such a patient deserves a trial of therapy if reporting impaired cognition, in the absence of confounding factors.…*" (p.162). However, such patients may suffer from depression or anxiety affecting their cognition, which may in turn warrant specific treatment before treating for a presumptive dementia.

The broad coverage of this book could be improved by informing GPs of the considerable psychiatric co-morbidity associated with the common neurological disorders covered. For example, anxiety and depression are very common in Parkinson's disease and, while the book recommends two of the older tricyclic antidepressants for treatment of depression, there is more that can be done – such as using newer medications and psychological therapies. Similarly, there is little guidance for the GP on how to care for patients with non-organic neurological disorders, which can indeed be challenging for the GP.

This pithy book will be useful in assisting a busy GP in navigating neurological disorders in day-to-day practice. If there are to be other editions, some broadening of the evidence base for recommendations, and inclusion of guidance on neuropsychiatric aspects, may improve the appeal and reach of this handbook.

It is said that a medical specialist is one who knows a great deal about a little, and that a GP knows more than a little about a great deal: the former, teaching the latter, must impart more than a little of the great deal they know.

Associate Professor Jeffrey Looi
Academic Unit of Psychological and Addiction Medicine, Australian National University Medical School

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Burgundy Rules

BY **DR MICHAEL RYAN**

When one speaks of Burgundy, the images should be of hedonistic wine enthusiasts, held in an aromatic trance while their visual cortex transfers them back to a rustic region in the mid-east of France.

This is where Romans first made wine 2000 years ago, where Benedictine monks tasted the soil to analyse the premier terroir, where the French revolution divided up the wealth of the land and Napoleon's rules of inheritance made for multifaceted ownership.

Beyond such complexities, the people are tied to a geographical heritage that in the end makes for some of the most sought after and hauntingly great wines of the world.

It certainly is one of the most complicated appellations in the world, and therein lies its attraction - and controversy. To get an understanding of such an important and complex region, you need to spend some time with dedicated Burgo-philes, such as those to be found at The Wine Emporium in Brisbane.

Recently I attended a master class run by Brent Williamson, who is soon to qualify as a wine maker, and supported by orthopaedic surgeon Dr Bill Ryan, who is a stalwart supporter of all that is Burgundy and is a frequent visitor to the area.

The classes were run over two nights with whites, then reds. It was informative, efficiently run and, more importantly, there was no shortage of good quality Burgundy to be had. The night was akin to watching two great scrum halves running off each other, although Bill is no longer the speedy back he once was and has probably moved more to the forwards.

Terroir is paramount in this region just south of Dijon. Burgundy's north-south orientation, combined with slopes at 250 to 350 metres above sea level, 70 million year old sea deposits and a mild continental climate, create the Cote d'Or. Literally these are the "Golden Slopes", and form the heart of Burgundy.

While Chablis, some 160 kilometres to the north-west, and Beaujolais, to the south, are included in the Burgundy region, the Golden Slopes produce magnificent Pinot Noir and Chardonnay.

Within this region, the more northerly area known as the Cote-de-Nuits produces complex and more robust red Burgundies while, to the south, the Cote de Beaune is lauded for its White Burgundy. The Grand Cru wines make up 2 per cent of production in the area, and the Premier Crus 15 per cent, with less prestigious Village and Commune wines described by the term, Vin de Bourgogne.

Generic offering can result in disappointment, so I would respect the offerings of reputable outlets like The Wine Emporium.

The Wines

2009 Domaine Ramonet Chassagne Montrachet "Morgeot" 1er ($120-Chardonnay

The colour is a medium yellow, with a nose of minor lemon notes that morph into grapefruit and apricots. Toasty oak and creamy notes complement the background. The palate is well-rounded and long-lived, with minor acidity. It is well matched with Foie Gras.

2008 Louis Jadot Corton Charlemagne Grand Cru ($280-Chardonnay)

A deeper but lively yellow colour. The bouquet is bursting with lemon grass and some funky tropical fruit ester characteristics. This is a full expression of Grand Cru wine, with a generous but step-like palate that just keeps giving more. Lobster in a creamy tarragon sauce with grilled polenta would suit.

2009 Domaine Bruno Clair Gevrey Chambertin ($135-Pinot Noir)

The bouquet is distinctly of the dark cherry family, with liquorice and rose petal secondary characteristics. The palate initially abounds in sweet fruit but the secondary step in structure kicks in and makes the flavour linger and the mind sated. Pigeon and porcini red wine risotto would go well.

2009 Leflaive and Associes Charmes Chambertin Grand Cru ($330-Pinot Noir)

A very serious wine oozing notes of red currants and sweet spicy fruits with violets. The satisfying and alluring initial burst of flavour pales into the back palate with a structural peak that exemplifies what a Grand Cru wine should be. Rare Venison with saffron potatoes is my pick.

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INFORMATION FOR MEMBERS

Free tool to track registration requirements

The AMA has developed a free online tool to help doctors to keep track of the information they need to meet the Medical Board of Australia's annual continuing professional development CPD requirements.

Each September, practitioners, when renewing their Medical Board registration, may be required to provide evidence they have complied with the Board's CPD requirements.

The AMA CPD Tracker has been developed to enable doctors to progressively gather and organise the information needed to substantiate declarations made to the Board about CPD, so that evidence can be quickly and easily produced on demand.

The AMA CPD Tracker can be used to:

- List courses completed, including the organisation that accredited the CPD activity;
- Store all certificates of completion;
- Keep a log of practice-based reflective activities, including clinical audits, peer reviews and perfomance appraisals; and
- Log hours spent on online learning, reading journals, teaching and other activities.

The system keeps a tally of hours, enabling practitioners to keep track of what needs to be completed before the end of the registration year.

The Tracker has been developed taking full account of the requirements set out in the Medical Board's Continuing Professional Development Registration Standard.

The service is free to AMA members. Non-members can subscribe for an annual fee of $250.

To register for the product, please sign up here.

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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

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

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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 later this 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 and posters. Lesson plan ideas for teachers and career advisors are also available.

TO COMMENT CLICK HERE

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