

A U S T R A L I A N

# Medicine

The national news publication of the Australian Medical Association

## Midwife changes put mothers, babies at risk

Policy u-turn cuts doctors out of care loop, p4

### Inside

Training: Govts scramble to find more places, p5

Doctors ask for up to \$240,000 to go bush, p8

Aged care reforms fall short, p10

Anti-vaccination movement losing momentum, p13

Global breakthrough on heroin, morphine addiction, p30

US to set global standard for medical training, p31



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## IN THIS ISSUE

### NEWS

4-17, 20-22, 31-32

### SPECIAL FEATURE

33 AMA: A HISTORY

### REGULAR FEATURES

3 VICE PRESIDENT'S MESSAGE

18 HEALTH ON THE HILL

23 GENERAL PRACTICE

24 RURAL

25 DOCTORS IN TRAINING

26 ECONOMICS AND WORKFORCE

27 PUBLIC HEALTH & CHILD AND YOUTH  
HEALTH

28 RESEARCH

35 BOOK REVIEW

36 MOTORING

37 INFORMATION FOR MEMBERS

39 MEMBER SERVICES



# May the workforce be with you

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

How the pendulum swings. It doesn't seem so long ago that fears of an over-supply of doctors led to a cutback in medical student numbers.

Then it was realised that our medical workforce was only being sustained through immigration of doctors who had trained overseas, especially in regional and rural Australia and our public hospitals. This led to a huge expansion in medical student places and new medical schools. The stated focus of some new courses was to 'fix' the under-supply of doctors in general, regional and rural practice.

Now the students attracted into the expanded medical courses are graduating in increasing numbers. Even though it is still early days for an expanded Australian medical workforce, cracks are starting to show in the planning and policy settings needed to ensure that Australia's best and brightest students become the fully trained medical workforce Australia needs in the future.

Late last year there were concerns that there would not be enough intern places for all our medical graduates, but finally the pieces fell into place with jobs for all. Now the story is repeated. There are estimates that, nationally, the number of intern places could be as many as 500 short of the number of medical graduates.

I have faith that a way will be found to balance the numbers, but this shouldn't be an article of faith. The number of medical graduates is predictable, within narrow limits, years ahead. Coordinated planning by the nation's health ministers needed to start at least three years ago, and should not have been left to the last minute.

One of the risks of last minute planning is that it will result in taking easy options. The easiest, especially in an era of constrained financial resources for health services, is to cannibalise medical posts currently filled by postgraduate year two

and postgraduate year three doctors. Apart from the adverse effect that would have on the skill mix available within medical teams, it will just move the problem on a year and potentially create a jobs shortage further down the career pathway. The other easy option is the creation of 'jobs' with little educational or experiential value.

Those on committees responsible for the accreditation of intern posts have a heavy responsibility to ensure all intern posts meet their standards and not bow to external pressure in the interests of expediency. Fortunately, these committees include colleagues with high standing within the profession, and I have faith that they will continue to apply the high standards that have always applied.

The number of doctors passing through the postgraduate training pipeline is monitored by the Medical Training Review Panel (MTRP). The Panel was established by statute and includes representatives from the Commonwealth, jurisdictions, postgraduate medical committees and medical colleges, as well as the Australian Medical Students' Association, the Australian Salaried Medical Officers' Federation and the AMA. Each year it produces a report detailing postgraduate training numbers – a vital resource for workforce planning and to assist doctors in making informed career choices. The composition of the MTRP also positions it well to advise on policy directions that will address Australia's medical training and workforce needs.

Most estimates from Health Workforce Australia indicate an impending shortfall in available vocational training positions. Policies and commitments by all Australian governments are needed to ensure we provide the opportunities for Australian graduates to complete their training. This will require a significant expansion of quality training places in general practice and other specialties

in both our public hospitals and private healthcare system. It will not be cheap. However, it is an essential component of following through on previous policy directions set to provide the medical workforce Australia needs while increasing our self-sufficiency.

How ironic that even now, while health ministers are still bemoaning the shortage of general practitioners, only 1138 places are available within the Commonwealth-supported Australian General Practice Training program for a reported 1510 applicants. Yes, there has been an increase in GP training positions, but much more is needed.

With over 3200 medical graduates, maintaining a balance between general practice and other specialties suggests over 1600 GP training positions will be needed, especially to follow through on medical school education that has emphasised the primacy of general practice. That means not just increased support for training places and their supervision, but investing in general practice infrastructure.

As the medical workforce pendulum swings away from shortage, there will be new challenges. A risk as Australia moves towards increased self-sufficiency is that the doctors trained overseas who have filled the deficiencies in our health system will be abandoned. Many of these are on 457 visas. If they lose their job, they lose their visa. The AMA will be alert to their needs. They have helped Australia when we needed them, and to abandon them now could only tarnish Australia's international reputation.

We now have more medical graduates than ever before. Health Workforce Australia is giving us more information on our medical workforce than ever before. Now these need to be combined to plan and create policies for the medical workforce of the future.

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# Midwife changes put mothers and babies at risk

“The AMA President said the change meant doctors could effectively be cut out of the care loop, and would instead allow independent practice by a midwife”

The AMA has accused the nation’s health ministers of putting the safety of mothers and babies at risk by approving changes that undermine collaboration between doctors and midwives.

In an unheralded move, the Standing Council on Health – which includes Federal, State and Territory ministers – announced at its 10 August meeting agreement to “vary the determination on collaborative arrangements to enable agreements between midwives and hospital and health services”.

AMA President Dr Steve Hambleton said the change was as dangerous as it was unexpected.

“There has been no consultation on this serious about-turn on an important policy that took years to implement,” Dr Hambleton said. “The collaborative care arrangements were carefully devised and agreed to by the relevant health professional groups in the best interests of patient safety and team-based coordinated care.”

The AMA President said the change meant doctors could effectively be cut out of the care loop, and would instead allow independent practice by a midwife.

“Does this now mean that, should a delivery become complicated, would the midwife have to transfer the care of the mother and baby to a hospital administrator instead of a highly skilled medical practitioner?” Dr Hambleton asked.

“This change not only risks safe patient care, it is unnecessary. When the collaborative care arrangements were being developed, it was agreed that the

midwife could have an agreement with a doctor in a hospital, who would ensure appropriate care arrangements were in place.

“This decision is transferring sensitive patient care and management from a doctor to a bureaucrat. It must not proceed.”

Midwives Australia President Liz Wilkes played down what she described as a “largely administrative” change, and said midwives would continue to work closely with doctors.

But the Australian College of Midwives said the change was long overdue, accusing obstetricians of refusing to enter into formal collaborative agreements with midwives.

College President Sue Kruske disputed Dr Hambleton’s warning that the change would put questions of medical treatment into the hands of hospital administrators.

“It will not be a hospital administrator midwives will be collaborating with,” Ms Kruske said, “but an entire health service team, of which obstetricians are an important part.”

“These changes will... hopefully open the doors of hospitals to private midwives through clinical privileging arrangements which to date have been slow.”

But Dr Hambleton said the change was unnecessary.

“Under the current process, the private arrangements mirror those in the public hospital sector, where the entire medical, nursing and midwifery team works together and understands the roles and responsibilities for maternity

care,” he said. “They already allow for midwives to have collaborative arrangements with a medical practitioner employed or engaged by a hospital authority and authorised by the hospital authority to participate in a collaborative arrangement.”

The Western Australian health minister, Dr Kim Hames, has been directed to present a paper on long term collaborative arrangements to the Standing Council on Health in November.

At their meeting, the health ministers also agreed to extend the exemption for midwives from professional indemnity insurance until mid-2015.

There has been no professional indemnity insurance cover for home births since the collapse of HIH in 2001, and midwives providing home births have been operating under an exemption originally due to expire mid next year.

The exemption issue came to public prominence in tragic circumstances in June during an inquest into the death of three babies during home birth.

The midwife at the centre of the case, Lisa Barrett, attended all three fatal homebirths in her capacity as a “birth advocate” after letting her registration lapse.

The South Australian Deputy State Coroner Anthony Schapel found that Ms Barrett had let her registration lapse because she did not want to comply with the safety and quality requirements imposed on registered midwives, which in turn helped make them eligible for the insurance exemption.

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# Governments promise to act as pressure on training places mounts

The nation's health ministers are scrambling to boost medical intern places as evidence of a looming crisis in training opportunities for aspiring doctors mounts.

In a joint statement following a meeting of the Standing Council on Health, Federal, State and Territory health ministers acknowledged the importance of internships and said they were "working to develop additional intern placements in private and other settings".

The commitment came as the Commonwealth, in answer to a question on notice from Liberal Senator Concetta Fierravanti-Wells, admitted more than 1300 additional GP training supervisors would be needed in the next five years to meet rising demand for training places from medical graduates.

The Government said the Australian General Practice Training program would have to expand through to 2016-17, when the number of registrars are expected to peak.

It said the increased demand would be partially met by requiring existing GP supervisors to take on more trainees. But the Government admitted that the number of supervisors would also have to increase, from 3438 this year to 4762 by 2017 – an increase of 1324.

The Commonwealth appears confident it will be able to recruit the extra trainers needed from among the 17,000 GPs currently practising nationwide, but the AMA has warned that to do so it will have to double the support it provides for doctors who take on the responsibility to teach and train future general practitioners.

AMA President Dr Steve Hambleton called last month for the Practice Incentives Program payment for teaching



and instruction to be immediately increased from \$100 to \$200 per session to encourage more doctors to pass on their skills and experience to medical students.

Dr Hambleton cautioned that pressure on GP supervisor places was only part of a more general shortage of training places that was quickly developing in the medical system.

Speaking following the health ministers' meeting on 10 August, the AMA President said the need to develop more intern places was urgent.

Dr Hambleton said the AMA had been loudly warning of the problem for some time, and warned that 250 medical graduates faced missing out on an intern place next year unless a solution was found urgently.

"There are 3236 Australian-trained medical graduates who have applied for internship positions in 2013, with just 3082 available positions across the country," he said. "The recent *Health Workforce 2025* report concluded that Australia needs to find places for these graduates if we are to ensure that the medical workforce can keep up with future community need."

Dr Hambleton said the problem was not confined to intern places.

"There is an upcoming shortage of training places for medical graduates throughout the training pipeline," he said. "In 2016, there will be 3867 doctors who require a first year advanced specialist training places, whereas the most recent data show that there are currently only 2817 positions available.

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

Dr Hambleton said "any solution will require high level COAG commitments to ensure that the funding and resources required to address these bottlenecks in the medical training pipeline are delivered, so that patients can get access to the medical services they need".

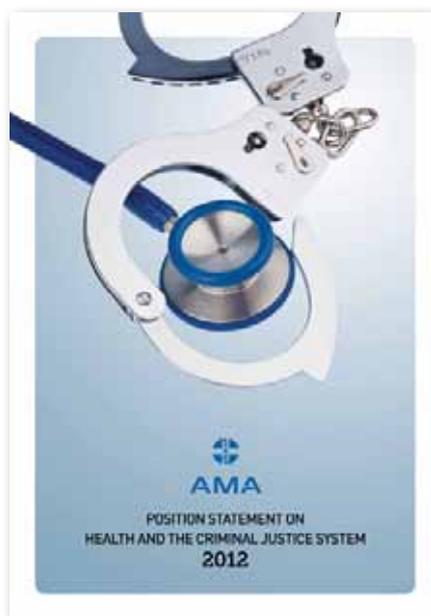
Dr Will Milford, chair of the AMA's Doctors in Training committee, has called for a big expansion of training opportunities in the private sector (see p 25).

See also *US seeks global standard for medical education*, p31

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# AMA backs prison needle exchange as part of broader plan to improve health



The AMA has called for a nationally coordinated approach to health in the criminal justice system as a prison in the ACT is set to become the first in Australia to trial a needle exchange program.

Highlighting the strong link between imprisonment and poor health, the AMA said there was a need to ensure offenders received continuous, coordinated and integrated treatment throughout their contact with the criminal justice system, from their first point of contact with correctional services to their successful reintegration into the community.

Releasing the *AMA's Position Statement on Health and the Criminal Justice System 2012* – which backs needle exchange programs in prisons - Vice President Professor Geoffrey Dobb said imprisonment could accentuate and further entrench the social and health disadvantages that contribute to

incarceration in the first place, and added that improving the health of prisoners would enhance the wellbeing of the broader community.

“Access to quality health care for prisoners and detainees has important implications for the health of the wider community,” Professor Dobb said. “With the constant interchange between prisons and the community, health problems and medical conditions experienced in custody become issues of public health for the community when people are released from prison or detention.”

The release of the AMA Position Statement coincided with an announcement by the ACT Government of plans to trial a national-first needle exchange program in Canberra’s Alexander Maconochie Centre.

ACT Chief Minister Katy Gallagher said the system – which has yet to receive the backing of prison guards – was being tested as a way to help tackle the spread of blood-borne viruses such as hepatitis C in prison, and would be conducted on a one-for-one basis.

“It is essentially a medical model,” Ms Gallagher said. “It would be a matter between the detainee and the doctor about whether or not access to sterile injecting equipment is in their clinical interests as part of treatment.

“There is only clean injecting equipment provided if dirty equipment is handed in.”

Ms Gallagher said about 50 per cent of prisoners in the Centre had hepatitis C, an “extraordinarily high” number, and there was evidence of drug use in the jail.

In its Position Statement the AMA backs needle and syringe exchange programs

in prisons, and Professor Dobb said that, as a group, prisoners had health needs far greater than the general population, with “high levels of mental illness, chronic and communicable diseases, injury, poor dental health, and disability”.

“Many prisoners come from disadvantaged backgrounds characterised by high levels of unemployment, low educational attainment, drug and alcohol addiction, insecure housing, and illiteracy and innumeracy,” Professor Dobb said, adding that rates of imprisonment were disproportionately high among Aboriginal and Torres Strait Islander peoples.

In its Position Statement the AMA said the criminal justice system was one of the ways to deliver health care to people who largely existed on the fringe of society and were otherwise difficult to establish regular contact with.

Professor Dobb said prisoners should retain their entitlement to Medicare and the PBS, including their Medicare card, while in prison.

Among the AMA’s recommendations are that state health authorities, rather than corrective services, should be responsible for providing health care in prisons, that the principle of continuous health care be embedded in correction practices and procedures, that upon admission prisoners be screened for health problems, that specialist treatment be available for prisoners with drug and alcohol disorders, and that mental health specialists be involved in the day-to-day management of prisoners with psychiatric disorders.

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# Public health the winner as High Court butts out tobacco challenge

The AMA has hailed a landmark ruling by the High Court upholding Australia's world-first tobacco plain packaging laws as an important victory for public health.

In a widely-anticipated decision, the High Court has rejected a legal challenge to the plain packaging laws mounted by the world's major tobacco companies.

The outcome of the case, which has been closely monitored by countries around the world, is a significant setback for tobacco companies, ensuring that cigarettes can only be sold in plain olive green packets carrying graphic health warnings.

AMA President Dr Steve Hambleton expressed hope that the Federal Government's victory in the High Court would encourage other countries to introduce similar laws.

In their legal challenge to the plain packaging laws, the tobacco companies claimed the new measures amounted to the acquisition of their brands and logos by the Government, and should be thrown out.

But the High Court found in favour of the counter argument from the Government that although the laws required the removal of trade marks from all cigarette packets, they did not weaken the companies' exclusive ownership of their trademarks.

Dr Hambleton said that the tobacco industry should accept the Court's decision and get to work on adhering to the plain packaging legislation.

"The tobacco industry's complaints have been found to have no reasonable basis. They have tried to delay the introduction of plain packs so they could continue to put profits ahead of the health of millions of people," the AMA President said.



"The AMA has been a strong supporter of plain packaging and congratulates the Government, particularly Nicola Roxon, on promoting this world leading public health initiative and getting a big win in the High Court.

"We look forward to seeing the plain olive green packs with graphic health warnings appear on shelves as soon as possible to act as a further deterrent to people taking up the killer habit of smoking.

Attorney-General Nicola Roxon, who introduced the plain packaging legislation as Health Minister, and her successor Tanya Plibersek, said the High Court decision was "a victory for all those families who have lost someone to a tobacco-related illness [and] a relief for every parent who worries about their child picking up this deadly and addictive habit".

"Plain packaging is a vital preventative public health measure, which removes the last way for big tobacco to promote its deadly products," the Ministers said

in a joint statement. "Over the past two decades, more than 24 different studies have backed plain packaging, and now it will finally become a reality."

The laws, which will come into effect from 1 December, will restrict tobacco industry logos, brand imagery, colours and promotional text appearing on cigarette packs. Brand and product names will be in a standard colour, position and standard font size and style.

"This is a watershed moment for tobacco control around the world," Ms Roxon and Ms Plibersek said. "Australia's actions are being closely watched by governments around the world, including by Norway, Uruguay, UK, EU, NZ, France, South Africa and China. Other countries might now consider their next steps."

"The message to the rest of the world is big tobacco can be taken on and beaten. Without brave governments willing to take the fight up to big tobacco, they'd still have us believing that tobacco is neither harmful nor addictive."

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# More than just money needed for doctors to embrace country life

The AMA has welcomed a report suggesting that doctors would need to be offered substantial incentives and compensation in order to lure them to work in rural areas.

While not specifically endorsing findings in the Melbourne Institute research that doctors would have to be offered up to an extra \$237,000 a year to consider rural practice, AMA President Dr Steve Hambleton said it was clear there was a need for a comprehensive plan to attract doctors and medical students to live and work in rural and regional Australia.

“The research confirms what we all know, and that is that there is no silver bullet solution,” Dr Hambleton said. “A whole range of issues including on-call commitments, locum support, remuneration and professional and family support must be addressed.”

An overwhelming majority of the 3700 GPs involved in the Melbourne Institute study indicated they would be reluctant to work in rural areas and would need to be offered large financial rewards to consider doing so.

The research showed that the extra compensation required to consider working in rural areas varied considerably according a number of characteristics including population size and location, the amount of on-call work involved, variability of hours, the difficulty of arranging locums, the size of the practice and opportunities for social interaction.

The study found that a majority of doctors (65 per cent) were not interested in changing their jobs, and just 8 per cent would choose to work in a rural area.

Investigating what financial incentives might be required to lure doctors into country practice, the Melbourne Institute researchers found that the amount of

“The study found that in order to consider moving to a practice with the least attractive characteristics (small inland town, longer hours, high on-call demands, great difficulty in arranging locums) doctors would require an extra \$237,000 a year”

money that had to be offered shrunk as town size increased, work hours stabilised and on-call requirements fell – so much so that in one scenario GPs indicated they preferred the rural practice to metropolitan work and would be willing to forgo almost \$16,000 a year to work there.

But in the remaining eight scenarios presented to doctors taking part in the study, the scale of the financial incentive needed swelled as work demands increased and town size fell.

The doctors indicated they would need to be offered around \$70,000 a year on top of their existing salary to consider moving to a town with between 5000 and 20,000 inhabitants, and the offer would have to go up to about \$116,000 to encourage them to move to an inland town with fewer than 5000 people.

The study found that in order to consider moving to a practice with the least attractive characteristics (small inland town, longer hours, high on-call demands, great difficulty in arranging locums) doctors would require an extra \$237,000 a year.

The study’s authors said the research was not to suggest that financial incentives alone could address the shortage of doctors in rural areas, adding that their findings highlighted the “strong preference” for GPs to minimise their on-call workload.

“The issue of recruitment and retention

of GPs in rural areas is complex,” they said. “There is no suggestion here that financial incentives alone will resolve the problem of a rural undersupply. On the contrary, recent research has shown that appropriately supported practices not only provide high levels of professional satisfaction in rural areas, but also lessen the importance of the workforce ‘problem’.”

Dr Hambleton said that rural and regional communities remained overly reliant on international medical graduates to fill workforce gaps despite additional efforts by the Government to address the problem, and it was time to adopt the AMA’s plan to get locally trained doctors to the bush.

The *AMA Position Statement on Regional/Rural Workforce Initiatives 2012* (which can be viewed at <http://ama.com.au/node/7681>) recommends a dedicated and quality training pathway for GPs to work in rural areas; ensuring there is a realistic work environment with flexibility, locum relief and family support; financial incentives to ensure competition remuneration; and opportunities for quality training and supervision.

Dr Hambleton said there also needed to be a “proper” review of the current Australian Standard Geographical Classification – Remoteness Areas system, which he said was leading to perverse outcomes in some areas.

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# Tackling climate change could cut national health bill by \$6 billion

The AMA has thrown its support behind a report highlighting the health benefits of tackling climate change and reducing carbon emissions.

According to the *Our Uncashed Dividend: The Health Benefits of Climate* study, prepared by the Climate and Health Alliance and The Climate Institute, shifting to cleaner energy sources could save up to \$6 billion a year in reduced health spending, as well as leading to a sharp improvement in respiratory and cardiovascular health.

“By reducing greenhouse gas emissions we can deliver immediate, and potentially large, improvements in population health,” the report said. “Many of the biggest health care challenges today, and the greatest drains on the public purse, are preventable chronic diseases associated with carbon-intensive lifestyles.”

Climate and Health Alliance Convenor Fiona Armstrong said heart, lung and nervous system diseases associated with burning coal to generate electricity cost the community \$2.6 billion a year, while the annual health bill generated by pollution from cars, trucks and other fossil-fuelled transport was \$3.3 billion.

“These conservative estimates suggest the shift to clean energy and transport could save the Australian community up to \$6 billion annually in avoided health costs,” the report said.

AMA President Dr Steve Hambleton welcomed the study, which he said would contribute to the base of evidence about the health effects of climate change.

“The AMA believes that climate change is a significant worldwide threat to human health that requires immediate action, and we recognise that human activity has contributed to climate change,” Dr Hambleton said.

The Association has been lobbying vigorously for the development of a national strategy on health and climate change, and has had a comprehensive Position Statement on Climate Change and Health since 2004.

Dr Hambleton said a strategic approach was required to ensure the country could respond effectively to the health effects of climate change, including those arising from higher temperatures, an increase in extreme weather and natural disasters, and changes in the prevalence of dangerous and exotic diseases.

“The AMA wants to see a national strategic approach to climate change and health, and we want health professionals to play an active and leading role in educating the public about the impacts and health issues associated with climate change,” he said.

According to the report, many of the changes required to cut carbon pollution also improved health.

It said that if less fossil fuel was burnt the incidence of heart and lung disease and neurological disorders would be reduced, while improving the energy efficiency of homes, factories and offices would help lower emissions, and encouraging transport alternatives like cycling and walking “has the potential to substantially reduce obesity, lung disease, heart disease, breast cancer, and depression”.

According to the report, a shift away from more energy and carbon-intensive foods like meat and dairy could also help improve cardiovascular health and reduce the incidence of diet-related cancers.

The AMA believes a national strategy on climate change and health should include comprehensive local disaster management plans, the fostering of strong links between hospitals, medical centres, emergency services and weather



services, the development of effective steps to address mental health problems arising from natural disasters and climate-caused social dislocation, improved education for health professionals about the effects of climate change, and measures to prevent the introduction and spread of exotic diseases and surveillance of dangerous arboviruses.

Dr Hambleton said doctors and other health professionals had a role to play in educating their patients and the broader community about the effects of climate change on health, supporting research in the area and encouraging the sustainable reduction of carbon emissions.

The *Our Uncashed Dividend: The Health Benefits of Climate* report is at <http://caha.org.au/resources/reports/>

The AMA Position Statement on Climate Change and Health is at <http://ama.com.au/node/4442>

The World Medical Association Declaration of Delhi on Health and Climate Change is at <http://www.wma.net/en/30publications/10policies/c5/>

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# Medical care essential for real aged care reform

The Federal Government's ambitious aged care reforms will fall short of expectations because they neglect the medical needs of older Australians, the AMA has warned.

AMA President Dr Steve Hambleton said too much of the Government's policy focus for aged care had been on "bricks and mortar, and not enough about flesh and blood".

"The health needs of older Australians are not being given top priority," Dr Hambleton said. "The human dimension of aged care is an afterthought for policymakers".

The warning came as an AMA survey found that the aged care medical workforce is ageing rapidly, and more than 15 per cent of practitioners plan to cut back on visits.

The survey of 845 GPs, consultant physicians and palliative medicine specialists found that just 8 per cent of those providing care to residents in aged care facilities were aged less than 40 years.

It found that although the average number of visits made by practitioners to aged care facilities each month had fallen by a quarter since 2008, the number of patients seen per visit had gone up, as had the time spent on each consultation.

Dr Hambleton said the survey showed that "the medical workforce in aged care is ageing and individuals are starting to cut back their visits, and that younger health professionals are not moving in to fill the gap".

He said policies were urgently needed that supported and built medical services in aged care.

Addressing the National Aged Care Conference in Adelaide earlier this month, the Minister for Mental Health and Ageing, Mark Butler, said the \$3.7 billion *Living Longer. Living Better* package of reforms developed by the Government would set the course for aged care policy for the next 20 years.

Mr Butler said the policy was developed to tackle key problems in the provision of aged care, including unmet demand for care and support in the home, increasing difficulty in attracting and retaining aged care workers, industry over-regulation and insufficient resources to handle challenges such as the growing prevalence of dementia and the increasing diversity of the elderly.

"*Living Longer. Living Better* does deal with all of those challenges, and it responds to the community's expectations of what aged care should look like, not just in the next few years, but the next couple of decades," the Minister said.

At their meeting on 10 August, the nation's health ministers noted "the importance of links between aged care and the health system", and agreed that aged care and ageing would be a standing item on the agenda of the Standing Council on Health meetings.

But Dr Hambleton said the Commonwealth aged care package and the National Aged Care Conference both missed the "one big

idea" crucial to aged care.

"There will be no discussion about securing medical and nursing services for older Australians who are living independently or in residential aged care facilities," he said. "*The Living Longer. Living Better* package gives medical care little attention."

Dr Hambleton said all it contained was unspecified funding to enable medical practitioners to make a more timely diagnosis of dementia, and more money for palliative care.

The AMA has released a position statement, Access to Medical Care for Older Australians, which can be viewed at <http://ama.com.au/node/8119>

*Dementia set as national health priority*, see p19

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## Electronic health records fizz

Little more than 5000 people have so far registered for a Personally Controlled Electronic Health Record (PCEHR), in an underwhelming response to the Federal Government's flagship scheme.

Department of Health and Ageing figures published by the *Sun Herald* show that, since the system was launched on 1 July, just 5029 people have registered an interest in having an e-health record.

The Government has for months been playing down expectations of the initial take-up rate of the scheme, but AMA President Dr Steve Hambleton said the weak public response underlined long-standing concerns about the design and introduction of the system.

In a nationally televised speech last month, Dr Hambleton warned that without the support of GPs – which was far from a given – the PCEHR scheme would stall.

He said that while the AMA supported the creation of e-health records, doctors had significant concerns about the Government's scheme.

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.

Dr Hambleton told the *Sun Herald* a critical mass of participants was needed to make the system function properly, and it was still a long way short of reaching that.

"There is no health information on the system yet anyway, and GPs still haven't got software in their computers that lets them talk to the system," the AMA President said.

Earlier this month Department of Health and Ageing secretary Jane Halton told the Health Informatics Conference in Sydney that it was more important for the system to be rolled out in a "careful and methodical" way than strive for a notional registration target, and admitted the Government might not achieve its goal of signing up 500,000 people to the PCEHR scheme in its first year.

"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."

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## Busy doctor-mum wins *Australian Medicine* reader survey



Brisbane general practitioner and mother of two, Dr Tracey Purnell, struggles to think of any downsides to her work as a GP.

"This is a great job," she says. "It is very rewarding looking after patients and families over a number of years."

Dr Purnell, who began working in general practice 10 years ago, has won one of the latest generation 16 gigabyte iPads, complete with full WiFi capability, for taking part in the *Australian Medicine* reader survey.

There was a great response to the survey, with more than 1720 readers taking part.

It has provided much valuable feedback about the publication's strengths and weaknesses, as well as good ideas for how it could be improved.

Readers will see changes in the presentation and content of *Australian Medicine* in coming months as many of your suggestions are put into practice.

Dr Purnell is a regular reader of *Australian Medicine* but, like many of our readers, admits that it can sometimes be a struggle to read as much as she would like because of competing demands on her time.

As with many of her colleagues, Dr Purnell – whose children are aged six and nine – has to juggle work with family commitments.

She is one of eight women doctors – all of whom work part-time and most of whom have children – working at the Women's Wellbeing Clinic in Greenslopes.

But Dr Purnell said she tries to find time to read *Australian Medicine* because it is a good way to keep abreast of what is happening in the profession and health policy more broadly.

"I like it [*Australian Medicine*] for its coverage of practice management and local issues," she said. "At the moment I don't own my own practice, but that might change in the next couple of years," she said.

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# Headache for TGA over paracetamol claims



A group of doctors has accused the Therapeutic Goods Administration of making exaggerated and misleading statements about the risk of paracetamol poisoning that could cause harm to patients.

In a bulletin released earlier this month (to view, [click here](#)), the medicines regulator warned paracetamol could cause liver damage, even when taken at normal doses.

“The hepatotoxic effects of paracetamol when taken as an intentional overdose are well known,” the TGA bulletin said. “However, paracetamol hepatotoxicity can also occur in other situations, including accidental overdose and use at normal doses.”

The regulator cited as evidence a study published in the *Medical Journal of Australia* in 2007 by J.S. Lubel *et al* of 662 patients with severe paracetamol-induced hepatotoxicity.

According to the TGA, the research showed that “48 per cent had not exceeded the recommended maximum daily dose of 4 g[rams]”.

But toxicologists at the Victorian Poisons Information Centre and the Austin Toxicology Service have accused the authority of misrepresenting the findings of the study.

In a joint letter to the TGA, Dr Zeff Koutsogiannis, Dr Shaun Greene and Dr Bronwyn Bebee, said the actual finding made in the Lubel paper was that, of the 662 patients with severe paracetamol-induced hepatotoxicity who were studied, “48 per cent had not intended to poison themselves, and took the drug for therapeutic purposes only”.

Dr Koutsogiannis and his colleagues said this finding was significantly different from the way it was characterised by the TGA in its bulletin.

“[The study was] essentially saying that supratherapeutic accidental ingestions make up a significant proportion of the severe paracetamol-induced hepatotoxicity, and not at therapeutic doses,” the letter from Dr Koutsogiannis and his colleagues said.

“It is well characterised that supratherapeutic ingestions of paracetamol certainly increases your risk of hepatotoxicity, particularly in an already diseased liver, but to claim that use at therapeutic doses can cause hepatotoxicity is a gross overstatement and misleading.”

The doctors agreed with advice from the regulator that, when administering paracetamol, it was advisable to check whether the medication was also being taken from other sources.

But they said that, if taken as directed, paracetamol was a proven safe and effective analgesic.

“Discouraging its use by physicians and patients could potentially lead to more harm through [use] of other analgesic alternatives, including non-steroidal anti-inflammatory agents, salicylates and opiates,” the doctors said.

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## INFORMATION FOR MEMBERS

### Expert witness training

Doctors and other health professionals are invited to attend a two-day training session on providing expert testimony in court.

The course, to be run by the Australasian College of Legal Medicine, provides instruction on how to be an expert witness, and what will be expected when attending court.

As part of the training, attendees will be required to submit a report (from which identifying details have been deleted) a month prior to the course. During the training they will be led and cross-examined on the contents of the report.

**When:** 24-25 November, 2012

**Where:** Royal College of Surgeons, 250-290 Spring Street, East Melbourne

**Registration:** Forms available at [www.legalmedicine.com.au](http://www.legalmedicine.com.au)

**More information:** Australasian College of Medicine, 02 4573 0775

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# Push against immunisation losing steam

There are signs that the movement against vaccination for children is losing momentum, with growth in the proportion of parents formally objecting to the inoculation of their offspring slowing markedly in the last four years.

Figures released by the Department of Health and Ageing and published by *Australian Doctor* and *Six Minutes* show that, after surging by almost 80 per cent in 2000, annual growth in the percentage of parents lodging conscientious objections to the vaccination of their children has steadily slowed in the past decade and rose by just 3.7 per cent in 2011.

The data indicate that the number of children with a conscientious objection to vaccination recorded against their name has soared from 4271 at the end of 1999 to 30,882 at 31 May this year – a jump of more than 620 per cent.

But the rate of gain has slowed, and overall vaccination rates – as well as the proportion of children with no vaccination history – have remained relatively steady for the last decade.

Figures compiled by the Australian Childhood Immunisation Register show that since 2001 the proportion of one-year-olds who are fully immunised has held at close to 92 per cent, while among two-year-olds it has remained consistently above 92 per cent since 2003, and among five-year-olds it improved from around 80 per cent to close to 90 per cent by 2011, and inched higher to 90.5 per cent by March this year.

Department of Health and Ageing figures show that the proportion of children with no vaccination history has remained similarly steady between 2002 and this year. Among one-year-olds it dropped by 0.1 of a percentage point to 3.1 per cent over that period, while for two-year-olds it increased by 0.1 of a percentage point

to 3 per cent and for five-year-olds it has slipped down 0.5 of a percentage point to 2.9 per cent.

Taken together, the results suggest the movement against child vaccination had been steadily losing momentum even before the introduction on 1 July of a Federal Government measure to withhold more than \$2100 in tax benefits from families that refuse to have their children fully immunised.

But AMA President Dr Steve Hambleton has warned that achievements made in sustaining historically high child immunisation rates have been put at risk by the Federal Government's decision in the May Budget to scrap the GP Immunisation Incentives Scheme – a move he condemned as posing a “public health risk of the highest order”.

“Australia is a world leader in childhood immunisation rates, but this decision could undermine that reputation and undo a lot of hard work by parents, GPs and other health professionals who promote the importance of immunisation in the community and in schools,” Dr Hambleton said.

The activities of those campaigning against childhood vaccination have come under increasing scrutiny.

Earlier this year the chief lobby group against immunisation, the so-called Australian Vaccination Network (AVN), won a complaint against the New South Wales Health Complaints Commission over a statement it had issued warning that the organisation presented only anti-vaccination views and conveyed incorrect and misleading information.

But American Airlines has withdrawn ads by the AVN on its in-flight television channel, and the Australian College of Midwives apologised last month

after promoting an event run by the organisation.

Anti-vaccination campaigners suffered another setback earlier this month when a Texas court threw out defamation action launched by a man over research he claimed showed a link between immunisation and autism-like symptoms (see *Defamation suit over discredited study thrown out*, p32).

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## INFORMATION FOR MEMBERS

### Suicide Prevention Conference

A key adviser to the United States military on suicide will be among the keynote speakers to address the annual Suicide Prevention Conference in October.

Dr Thomas Joiner, who is Director of the US Military Suicide Research Consortium and Professor in Psychology at Florida State University, headlines a group of speakers that includes Dr Jerry Read, Director of the National Suicide Prevention Centre in the United States, Edinburgh University Professor of Health Policy Stephen Platt and Jonathan Nicholas, chief executive of the Inspire Foundation.

The conference, organised by Suicide Prevention Australia, is being held at the Crowne Plaza Hotel, Coojee Beach, New South Wales, on 10-11 October.

For registration and further details, visit:

[www.suicidepreventionaust.org/conferences](http://www.suicidepreventionaust.org/conferences)

[TO COMMENT CLICK HERE](#)

# Moves to increase drug company disclosure

The AMA is working with Medicines Australia and other key health and consumer groups on ways to enhance the transparency of relationships between health professionals and drug companies.

The AMA will be represented on the Transparency Working Group set up by Medicines Australia to develop measures and policies to increase the disclosure of payments and other “transfers of value” between health care professionals and the pharmaceutical industry.

The Association has already backed the public disclosure of aggregate payments made by drug companies to health practitioners, and has welcomed the formation of the Working Group.

Medicines Australia chief executive Dr Brendan Shaw said the group would be asked to recommend what further transparency measures should be introduced that would best serve the community.

“The working group will evaluate the different models for further transparency and identify an effective mechanism for ensuring additional transparency of what

is a vital relationship for the effective operation of the health system,” Dr Shaw said.

Dr Shaw said transparency was critical in building public confidence, and the industry moves to increase disclosure had the backing of consumers and peak medical groups.

“There are a number of possible models for further transparency, and the key task for the working group will be to recommend a model that is practical and provides consumers with the information they need,” he said.

While backing transparency, the AMA has warned that any move to report payments to individual practitioners had to be sensitively handled.

AMA President Dr Steve Hambleton warned in *The Australian* of the risk that “public reporting may misinform the public and, if it is attributed to the wrong practitioner, it could be damaging”.

Dr Hambleton said that, just as doctors were required to disclose to their patients any interest they had in a hospital to

which they were referring them, so too they should tell them of any relevant links with pharmaceutical companies.

The Association pointed out that sponsorship or payments by pharmaceutical companies to individual practitioners was appropriate when conducted within an ethical framework and, in fact, had a public benefit, such as when providing clinical advice, assessing the efficacy of medicines in real-life practice settings and disseminating important health information to colleagues.

The AMA warned that any move to disclose individual payments needed to be supported by sound governance arrangements that ensured correct, complete and current information was presented in ways that allowed the public to make correct and informed judgements about individual practitioners.

The Working Group will hold its first meeting next month, and its first interim report is due in March 2013.

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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](mailto:ausmed@ama.com.au), including the book subjects you would be interested in reviewing and a current postal address.**

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# NSW gives it up to join national donor scheme



The nation is set to have a single national tissue and organ donor registry following a decision by the New South Wales Government to scrap the state's stand-alone system.

In a move hailed by the AMA and donor groups, NSW – which has been the last hold-out state – has agreed to decommission its organ donor register and drop the link between donor status and its driver licence system.

AMA Vice President Professor Geoff Dobb said the Association had been working hard behind the scenes to get NSW to shut down its registry and join in with the national scheme.

“The New South Wales Government’s

decision is very positive,” Professor Dobb said, predicting it would help boost organ donation rates.

While the number of organ donors rate has improved sharply in recent years, up from 205 in 2008 to 337 last year, demand for healthy organs and tissues remains well above supply, condemning many to debilitating and frequently fatal waiting times.

Professor Dobb said breaking the link between getting or renewing a driver’s licence and deciding whether or not to become an organ donor was an important development.

“New South Wales has had a lower organ donation rate than the other states, and

one of the contributing factors to that seems to have been the licence-linked organ donor registry,” the AMA Vice President said. “People are renewing their licence and getting an incidental question about becoming an organ donor without having much information on which to make the decision.

“It’s something that needs consideration in terms of what a person’s wishes are, and it is something best done as part of a family discussion.”

NSW Health Minister Jillian Skinner said the move to scrap donor registration status as part of the driver’s licence process would be complete by November and would help lift donor rates.

Federal Parliamentary Secretary for Health and Ageing Catherine King said the NSW Government’s decision could “ultimately save lives”.

Ms King urged NSW residents to register their organ and tissue donation decision on the Australian Organ Donor Register at [donatelifelife.gov.au](http://donatelifelife.gov.au)

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## INFORMATION FOR MEMBERS

### Bulk-bill forms and cheques on the way out

**No more printed bulk-bill forms from 1 September.**

**No more cheques to practices from 1 November.**

Medical practices have been warned that the Department of Health and Ageing is about to cease printing and distributing bulk-bill forms and issuing cheques for bulk-billing and Department of Veterans’ Affairs claims.

In a shake-up to long-standing arrangements, the Department has given notice that from 1 September bulk-bill forms will only be available online, and orders for such documents will not be accepted from that date.

“From 1 September we will no longer be printing or accepting orders for bulk-bill forms,” the Department said in a statement, and urged practices to either sign up for electronic claiming or obtain forms online.

The Department has also warned practices that, from the start of November, it will no longer issue cheque payments to practices for bulk-bill and DVA claims.

“All providers currently receiving cheques for bulk-bill or DVA services will need to provide bank account details for each service location,” the Department said.

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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/Online

### Doctors concerned by midwife hospital deal, *ABC*, 11 August, 2012

AMA President Dr Steve Hambleton warns that changes approved by the nation's health ministers to allow midwives to bypass doctors and strike agreements directly with hospitals could endanger patients and undermine collaboration between doctors and midwives.

### New medical school hopes hit hurdle, *The West Australian*, 10 August, 2012

In a letter to AMA President Dr Steve Hambleton, Federal Health Minister Tanya Plibersek admits that pressure on training places for existing medical graduates makes plans for more medical schools "difficult to support at this time".

### Cabinet keeps its grip on PBS drug approvals, *The Australian Financial Review*, 14 August, 2012

AMA President Dr Steve Hambleton accuses the Federal Government of undermining the work of the Pharmaceutical Benefits Advisory Committee by reasserting the need for all medicines approved by PBAC to be added to the Pharmaceutical Benefits Scheme to first be scrutinised by Cabinet.

### Patients reject eHealth system, *Sun Herald*, 12 August, 2012

Department of Health and Ageing figures showing that just 5029 people have registered for a Personally Controlled Electronic Health Record since 1 July shows the Government erred in not making it an automatic opt-in system, says AMA President Dr Steve Hambleton.

### Children's cold products on outer, *The Age*, 16 August, 2012

AMA President Dr Steve Hambleton backs advice to parents from the Therapeutic Goods Administration that cough and cold medication should not be given to children younger than six years, and should only be given to those between six and 11 years on medical advice.

## Radio

### Dr Hambleton, 4BC, 4 August, 2012

Dr Hambleton warns tourists travelling to South East Asian countries to avoid free or cheap drinks because they might contain methanol. The warning follows an incident in which a 19-year-old Australian was left blind after drinking up to 10 complimentary cocktails at a bar in Bali.

### AMA, ABC 720 Perth, 10 August, 2012

The Australian Medical Association says it is not unreasonable for doctors to seek big pay increases to work in rural areas, following the findings of a Melbourne Institute study showing additional payments above \$200,000 a year might be needed to lure doctors to some regions.

### Dr Hambleton, 3AW, 11 August, 2012

Dr Hambleton warns that changes to allow midwives to establish collaborative arrangements directly with hospital administrators without needing to include doctors poses a risk to patient safety.

### Dr Hambleton, 2UE, 12 August, 2012

Dr Hambleton says the slow take up of electronic health records, with just 5000 signing up in the first month, reflects the fact that only a small piece of the system

has so far been launched, and software that would enable GPs and hospitals to connect with the system is not yet available.

### Professor Dobb, ABC Radio National, 16 August, 2012

In a long segment on the *Life Matters* program, AMA Vice President Professor Geoffrey Dobb details the AMA's concerns about the health of the nation's prison population and outlined proposals to improve the care of prisoners, which he argues will help improve the health of the broader community.

## AMSA

### Higher student fees not the answer: AMSA, 7 August, 2012

AMSA is deeply concerned by calls for steep hikes in student fees as a way to increase funding for the higher education system, warning it would restrict access to education and create undue financial burdens for families.

### Medical internship places still lacking as second round offers released, 8 August, 2012

AMSA President James Churchill warns that 244 medical graduates appear likely to miss out on a medical internship despite the efforts of governments, and urges them to act quickly to increase the number of internships on offer next year.

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# AMA in action

AMA President Dr Steve Hambleton and other AMA officials have been busy pushing forward the AMA agenda across a range of areas in the past two weeks. In addition to numerous media interviews on prominent issues including changes to collaborative care arrangements with midwives, e-health records, incentives for rural doctors, the health implications of climate change and health in criminal justice system, Dr Hambleton and AMA Vice President Professor Geoffrey Dobb attended a number important events. Dr Hambleton supported the launch in Canberra of the *Our Uncashed Dividend: The Health Benefits of Climate Action* report showing potential savings of up to \$6 billion for the health system from steps taken to curb carbon pollution. Professor Dobb launched the *AMA's Position Statement on Health and the Criminal Justice System 2012* at the Justice Health in Australia forum in Canberra. Dr Hambleton, along with former AMA President Dr Mukesh Haikerwal, was a guest at a dinner for AMA Victoria President Dr Stephen Parnis in Melbourne.

[TO COMMENT CLICK HERE](#)



Dr Hambleton with (l to r) Michael Moore, Fiona Armstrong, John Connor, Tony McMichael and Tony Capon



Justice Health in Australia panel (l to r) Professor Tony Butler, Professor Geoffrey Dobb, Dr Andrew Miller, Professor Michael Levy and Dr Helen Watchirs



Professor Geoffrey Dobb (l) and Dr Andrew Miller



Dr Hambleton with Dr Parnis and Dr Haiherwal

# HEALTH ON THE HILL

## Government acts to close Medicare loophole

Parliament is expected to approve changes to Medicare to close a loophole that could potentially save the health budget close to \$100 million in the next four years.

The Federal Government is pushing for reforms to the Extended Medicare Safety Net to impose a cap on payments where multiple procedures are billed as one professional service.

The Health Insurance Amendment (Extended Medicare Safety Net) Bill 2012, outlined in the May Budget and introduced in late June, aims to close a loophole under which the cap on payments for individual services was not enforced where they were carried out as part of multiple procedures.

The move is the latest change to the Extended Medicare Safety Net scheme, payments under which were capped following a review that found there was a sharp drain on the health budget.

The scheme, which has been in place since 2004, provides an additional reimbursement to patients on top of the Medicare rebate and safety net, once their out-of-pocket expenditure exceeds and annual threshold.

But in 2010 the Government capped payments made under the scheme for certain services deemed to have excessive fees, including obstetrics, IVF, cataract and varicose vein procedures, hair transplantations and midwifery services.

Before the caps, spending under the scheme was growing by more than 20 per cent a year, and a review found that much of the extra money was going to higher doctor fees rather than reduced patient costs, and that 55 per cent of

the benefits paid out went to patients in wealthier areas.

Following the imposition of the cap, Extended Medicare Safety Net spending has dropped, falling from \$538 million in 2009 to \$312 million in 2010.

In a speech in support of the Bill made to Parliament in late June, Health Minister Tanya Plibersek said the Government did not have a problem with practitioners performing multiple procedures simultaneously, but was concerned where this was being done to avoid the spending cap.

“There are, of course, many instances where claiming for multiple operations on the same occasion is appropriate,” Ms Plibersek said. “For instance, patients can benefit from having more than one operation at the same time because they do not need to have a second anaesthetic. An example is where a patient is having several skin cancers removed by surgical excision.”

The Minister said the Bill would apply the Extended Medicare Safety net benefit caps to a further 39 Medicare Benefits Schedule items and all consultation services from 1 November 2012.

“These items have been selected to reduce the government’s exposure to subsidising excessive fee inflation by some doctors, or where there is a risk that practitioners may shift fees on to uncapped items,” Ms Plibersek said, adding that 35 of the items to be added fell under the definition of operations for the purposes of the multiple operations rule, and would therefore be deemed to constitute one professional service.

Under the proposed amendments, the cap for the deemed service would be calculated as the sum of the caps that would otherwise apply if each service were billed individually.

The Health Minister defended the changes as a way of “making the most of every precious health dollar”.

“We are being guided by the evidence and investing wisely,” she said. “Where the evidence said things were not working, the Government has done things differently. And the Bill before the House is part of this. We have looked at the evidence on how the Extended Medicare Safety Net works, and it says we need to close a loophole to protect the integrity of the system.

“Currently a doctor can avoid EMSN benefit caps by performing other operations at the same time. If the government cannot be certain that EMSN benefit caps will apply to selected items, it may not be in a position to introduce funding for important new high cost technologies.

“This Bill will ensure that where items are deemed to constitute one professional service, and all of the original MBS items that are part of that service are capped, the Extended Medicare Safety Net benefit caps will apply. This will ensure that the full [\$96.5 million of] savings announced in the budget are realised.”

A Parliamentary Library report said the changes should slow growth in Extended Medicare Safety Net spending, but warned there could be an associated rise in out-of-pocket costs for patients.

“It would therefore be prudent, if the Bill is passed, to continue to monitor and report on the impact of the expanded caps on doctor’s fees as well as patient costs,” the report recommended.

The proposed legislation also includes changes to make it less onerous for families to register for both the original and extended Medicare safety nets.

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# HEALTH ON THE HILL

## Dementia not forgotten

The nation's health ministers have nominated dementia as one of the nation's top health priorities amid expectations that the number of Australians suffering the debilitating condition is likely to reach more than one million by mid-century.

The Standing Council on Health approved a proposal from Federal Health Minister Tanya Plibersek that dementia be added to the existing list of eight national health priorities, which includes cancer, asthma, diabetes, obesity, cardiovascular disease and mental health, to help drive efforts to tackle the syndrome.

In a joint statement, the ministers said the recognition would add impetus to the development of a national plan of action regarding dementia.

The ministers said about 280,000 people currently have dementia, and the lives of a further 1.5 million carers, relatives and friends were affected by it.

Federal Mental Health Minister Mark Butler warned that by 2050 more than one million people were likely to have the condition, and it was on track to be the nation's most expensive health condition: "We expect dementia spending to top \$80 billion by 2062-63".

Mr Butler said early diagnosis had been shown to have significant potential benefits for both those with dementia and their carers and family, and designating the condition as a national health priority would help intensify efforts in the area.

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## St Vincent's Private gets competition nod

The competition watchdog has flagged approval for the St Vincent's Group of hospitals to bargain as a collective to save money and improve efficiency.

The Australian Competition and Consumer Commission has announced it proposes to allow St Vincent's Private

Hospital, Sydney, to join with the other hospitals in the group and operate as "a single economic entity".

Because of the terms of a bequest which requires it to be operated by the Sisters of Charity, St Vincent's Private Sydney is a separate legal entity to the rest of the St Vincent's Group.

Currently, St Vincent's Private cannot participate in negotiations with the other St Vincent's Group hospitals without authorisation.

ACCC chairman Rod Sims said the remaining hospitals in the Group are already able to legally engage in collective and joint activity, and the watchdog proposed to give St Vincent's Private a 10-year dispensation to join them.

"The ACCC considers that the detriments from this agreement, if any, will be small due to the fact that the applicants, other than St Vincent's Private Hospital Sydney, are currently able to legally engage in collective and joint activity," Mr Sims said. "Allowing St Vincent's Private Hospital Sydney to join with the other members of the St Vincent's Group of hospitals will result in cost savings and operational efficiencies".

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## Cabinet keeps PBS under its thumb

The Federal Government has knocked back attempts to reduce political interference in the listing of medicines, reaffirming its power to have final say in the approval of subsidies for low-cost medicines.

The Commonwealth has rejected the recommendation of a Senate inquiry that medicines costing less than \$10 million a year that have been approved by the Pharmaceutical Benefits Advisory Committee (PBAC) be listed on the Pharmaceutical Benefits Schedule without requiring Cabinet approval – the

so-called \$10 million rule.

In a contentious decision, the Government told the Senate's Finance and Public Administration References Committee that it was appropriate for it to "apply responsible fiscal scrutiny to proposed new PBS listings, as it does for all new expenditure".

"The Government will continue to consider all new PBS drug listings in a timely manner, and how these listings compare with other health spending priorities such as training new doctors and nurses, opening new hospital beds and investing in new preventative health programs," it said.

AMA President Dr Steve Hambleton told *The Australian Financial Review* the Government's position undermined the work of the PBAC, which recommended only drugs that were found to be cost effective.

The Senate inquiry was triggered by the Government's decision last year to defer the listing of several new drugs recommended by the PBAC, and to make all new listings subject to Cabinet consideration.

The AMA led a chorus of outrage at the decision, which led to a 12-month moratorium on the move to scrap the \$10 million rule, which is due to expire at the end of next month.

The Government also refused a committee recommendation to drop its requirement that new PBS listings be offset by savings.

"The Government is committed to supporting a strong economy and continues to apply responsible fiscal scrutiny to all new expenditure, including those relating to PBS listings," it said. "It has always been the Government's role to consider where finite resources would best be directed, and to weigh expenditure decisions against competing pressures in the Budget."

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[TO COMMENT CLICK HERE](#)

# Road toll stays stubbornly high, but signs safety is improving

The nation's road toll is holding stubbornly high despite the efforts of road safety campaigners and police crackdowns on speeding, drink-driving and other dangerous practices, official figures show.

Bureau of Infrastructure, Transport and Regional Economics data show that in the 12 months to the end of July 1286 people had died on the nation's roads, virtually unchanged from the preceding 12 months period, in which 1289 people died.

But the result confirms that the long-term trend decline in road deaths in recent years continued through late 2011 and the first half of this year, a creditable result given the nation's population grew 1.4 per cent in 2011 and has been expanding at an annual rate of between 1.5 and 1.9 per cent for much of the past five years, pushing the number of Australians above 22.7 million.

The BITRE figures show annual road deaths per 100,000 people was 5.7 in the 12 months to the end July - a fall of almost 1 per cent from the preceding 12-month period - helped by a sharp

8 per cent drop in traffic fatalities last month compared with July 2011. Ninety-two people died on the nation's roads last month, a 20 per cent fall compared with July 2011.

The result suggests the nation's roads are about as safe as those in Britain and Japan (around 5.4 deaths per 100,000 people), slightly better than those of Germany (6 deaths per 100,000) and much safer than in the US (13.5-14 deaths per 100,000).

The bureau's figures show that among the most populous states, Queensland has made the greatest sustained progress in cutting its road toll since 2008, achieving an average annual reduction of 7.2 per cent in the last four years.

Victoria and South Australia have made substantial inroads, recording average annual reductions of 4.3 and 4.9 per cent respectively over the same period.

Western Australia has recorded a more modest improvement of 2.4 per cent a year, while in New South Wales it has barely shifted, down by an annual average of just 0.3 per cent.

The biggest fall in death rates has been among drivers, down by 5.6 per cent a year, and passengers, 5.4 per cent, while among cyclists it has been climbing, up by 3.1 per cent a year.

The sharpest improvement has been among those in the 17 to 25 years age group, where there has been an average annual decline in road deaths of 9 per cent, while fatalities among 60 to 69-year-olds climbed by 8.6 per cent a year over the same period.

The most common deadly crashes are single car and low speed (below 60 kilometres per hour) accidents.

But, in a sign that authorities are making same inroads on speeding, the number of fatal crashes involving speeds of between 70 and 110 kph has dropped by an average annual rate of between 5 and 6 per cent since 2008.

The results are likely to lend weight to the push by governments such as that in Victoria to expand 40 kph speed limit zones in cities.

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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](mailto:generalpractice@ama.com.au)

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# Doubts raised about Sonic's grab for Healthscope

Analysts have slashed forecasts for one of the nation's largest pathology businesses, Sonic Healthcare, after the competition regulator raised concerns over its planned \$100 million purchase of pathology services in several states.

The Australian Competition and Consumer Commission has flagged that Sonic's bid to buy pathology services operated by Healthscope Limited in Queensland, New South Wales, the ACT and Western Australia "may raise competition concerns".

The watchdog issued the preliminary assessment in a Statement of Issues regarding the proposed deal released on 2 August, sparking concerns that the deal might struggle to get approval and sending Sonic's share price plunging 1.7 per cent lower to \$12.48. It was trading at \$12.68 at the time of going to press.

Sonic Healthcare chief executive Colin Goldschmidt appeared confident of receiving regulatory approvals when he announced the planned acquisition on 16 May, triggering a 2.3 per cent surge in the company's share price to \$12.83.

But in its Statement, the ACCC noted that Sonic operated 29 per cent of the nation's approved collection centres, close behind its major rival Primary (35 per cent) and well ahead of third-placed Healthscope (16 per cent) – which was strongest in Victoria and South Australia.

"Therefore, the ACCC's preliminary view is that the proposed acquisition would remove an effective competitor in the provision of community pathology services in Queensland, NSW/ACT and Western Australia," the Statement said.

Announcing a deferral of its final decision until 30 August, the regulator said it was seeking "further information on certain competition issues which have arisen

from the ACCC's review to date".

The watchdog was seeking further information and input regarding the potential for a merged Sonic-Healthscope entity to exert pricing power, determine service levels and erect barriers to entry from other competitors, particularly in smaller markets.

Investor concerns over the proposed deal may be heightened by fears the Federal Government could clamp down on its spending on pathology services.

Medicare payments account for 85 per cent of total revenue in the pathology market, and figures show spending grew 6.7 per cent last year – well above the 4.88 per cent cap on growth agreed to by Government and the industry, according to a report in *The Australian Financial Review*.

The blowout will be considered by a committee established to oversee the agreement, and the *AFR* cited concerns by industry watchers that it will recommend a cut in spending.

But a spokesman for the nation's largest pathology services provider, Primary Health Care, told the *AFR* it would contest any such cutback, claiming the increase in pathology services was as a result of Government policies such as the GP Super Clinics and the decision to give nurse practitioners Medicare provider numbers.

The spokesman said the policies amounted to a change in market conditions, and meant the terms of the agreement should be re-negotiated.

Primary Health Care managing director Edmund Bateman warned that further cuts to Government spending would increase pressure on struggling operators and fuel consolidation in the industry.

Dr Bateman last week revealed a 49 per cent jump in Primary Health Care's profit to \$116.6 million in 2011-12, and expressed confidence that earnings per share would rise a further 25 per cent this financial year.

But he warned that smaller operators, turning over less than \$200 million a year, were "not particularly viable" in the long term.

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## INFORMATION FOR MEMBERS

### Grants for medical equipment running costs

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

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

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

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

[TO COMMENT CLICK HERE](#)

# Cough and cold medicines no good for young kids

The medicine watchdog has warned that cough and cold preparations should not be given to children younger than six years and should only be administered to older children on medical advice.

In a significant update on advice to parents, the Therapeutic Goods Administration has directed that all cough and cold medicines – including those claiming to be specifically formulated for children such as Bisolvon Chesty Kids Strawberry Flavour, Chemists' Own Children's Cold and Allergy Mixture and Otrivin Junior Nasal Spray and Drops - carry warnings that they not be given to those younger than six years and only be administered to those aged between six and 11 years of age on the advice of a doctor, pharmacist or nurse practitioner.

The regulator said a review found that although there were no immediate safety risks regarding these products, "there is evidence that they may cause harm to children. Furthermore, the benefits of using them in children have not been proven".

The TGA said such preparations only provided temporary relief from symptoms, and could delay diagnosis of more serious underlying conditions such as asthma, influenza, pneumonia, bronchitis and middle ear infection.

"Cough and cold medicines offer only temporary relief of



common symptoms such as runny nose, cough, nasal congestion, fever and aches," it said. "They do not affect the severity of the viral infection or shorten the time the infection lasts."

AMA President Dr Steve Hambleton endorsed the regulator's decision.

Dr Hambleton said children with colds could still be given paracetamol and ibuprofen for pain and fevers, but if the illness persisted or other symptoms such as a rash or neck pain developed, parents should seek medical attention.

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## Govt seizes on rise in private health insurance

The Federal Government has claimed vindication for controversial health insurance changes following a solid increase in the number of people taking out private health cover.

Figures released by the Private Health Insurance Administration Council show more than 81,600 new private health insurance policies covering almost 150,000 people were purchased in the three months to June, a 0.5 per cent increase from the previous quarter, taking total coverage to more than 12.3 million – more than 54 per cent of the population.

The proportion with private hospital cover increased by 0.4 per cent over the same period to reach almost 10.6

million people, close to 47 per cent of all Australians.

Health Minister Tanya Plibersek seized on the figures to rubbish Coalition claims that the Government's controversial move to means-test the private health insurance rebate would lead to a mass exodus from private health insurance.

"Despite the Opposition Leader's doomsday prediction that thousands would drop their cover after the Government passed [the means-test legislation], the exact opposite has happened," Ms Plibersek said.

Under the changes, individuals earning more than \$84,000 a year and couples with a joint annual salary above \$168,000

stand to lose some or all of their private health insurance rebate.

Treasury predicted the change would have minimal effect on private health insurance coverage, particularly because the Lifetime Health Cover and Medicare Levy Surcharge systems would continue.

But attempts to assess the full effect of the rebate changes, particularly at this early stage, have been complicated by the fact that a significant number of policyholders have in effect delayed the crunch decision on whether or not to retain their health insurance by paying premiums for the next 12 to 18 months up-front before the means-test came into operation.

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# Better Access now poorer access

BY DR BRIAN MORTON

“Unfortunately, a recent AMA survey has found that with the Budget cuts to the patient rebates for GP mental health services, Better Access has become poorer access”

A recently published report in *The Medical Journal of Australia*, using data from the Better Evaluation and Care of Health (BEACH) project, has shown that under the Better Access to Psychiatrists, Psychologists and General Practitioners (Better Access) initiative, patients do indeed have better access to mental health care.

The analysis, which looked at the GP management of depression (as the most frequently managed psychological problem in general practice), also showed that under the Better Access initiative GPs remain heavily involved in the management of this condition. What this demonstrates, which the AMA has been saying all along, is that GPs play a very important role in mental health care. GPs are at the front line every day in helping individuals and their families through traumatic events, family crises and ongoing mental and other health conditions.

The mental health services provided by GPs are easily accessed, non-threatening, non-discriminatory, and inexpensive compared with mental health hospitalisation.

According to BEACH data, there are around one million GP consultations involving a mental health issue each year. Prior to the Government's cuts to patient rebates for GP mental health services, announced in the 2010-11 Budget, there was significant trend growth in the use of Better Access mental health services accessed through GPs.

Unfortunately, a recent AMA survey has found that

with the Budget cuts to the patient rebates for GP mental health services, Better Access has become poorer access.

According to the survey, the proportion of GPs bulk-billing patients for preparing mental health plans dropped from 78.1 per cent before the cuts to 38.6 per cent once they were implemented. While I am encouraged that a significant percentage of GPs are not prepared to devalue their services, the cuts to patient rebates for GP mental health services has resulted in increased costs to patients, which affects the ability of some patients to seek care.

These cuts will do nothing to improve outcomes for patients with common mental health conditions. Evaluations of Better Access published in 2011 showed the initiative was providing good value for money and fulfilling its promise of improved access to care. The evidence was there, the initiative was working well, but this Government chose to ignore it in favour of improving the Budget bottom line.

The funding for GP mental health services through the Better Access program must be restored to ensure continued patient access to cost-effective mental health care. The *MJA* article has reinforced the need for this to happen, and completely contradicts the ill-informed views of those who have portrayed GPs as glorified referrers.

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# Unadulterated city-centric madness

BY DR DAVID RIVETT

“They are a recipe for disaster, and will serve to force State and Territory governments to either largely bear the cost of rural hospitals or shut them down”

The Independent Hospital Pricing Authority (IHPA) has struck, and must win gold for stupidity.

Even very small rural hospitals are to be denied block funding and forced to waste limited resources chasing Activity Based Funding. As a result, clerical workers who could be doing something useful will devote their weeks to combing through all admissions to maximise returns to their hospital, at considerable cost and for no net clinical gain.

An adjustment of 8.7 per cent to the “National Efficient Price” has been made for “outer regional” locations, 15.3 per cent for “remote” locations and 19.4 per cent for “very remote” locations. This is all well and good, but totally ignores the fact that most rural hospitals are classified as “inner regional” under the daft Rural, Remote and Metropolitan Areas classification system which currently exists. As we all know, if you feed rubbish into your calculations you get rubbish out.

These adjustments were formulated, as far as I can ascertain, by agreement among State and Territory bureaucrats, with no input from rural clinical representatives. Please correct me if I am wrong.

They apply according to the postcode of the patient, not the hospital. A truly bizarre decision.

They are a recipe for disaster, and will serve to force State and Territory governments to either largely bear the cost of rural hospitals or shut them down.

Small country hospitals cannot have a constant level of activity, and should receive either block funding or realistic loadings that reflect the need to

recruit and maintain core staff numbers, and which allow for the inevitable delays to patient episodes of care flowing from lack of timely or immediate access to diagnostic radiology, pathology and specialist opinion.

An adjustment of 5 per cent has been made to the National Efficient Price for Indigenous patients. This is unrealistically low and should be lifted closer to 50 per cent until the gap between Indigenous and non-Indigenous health outcomes is closed.

Intensive and paediatric care both get loadings, but only if such services are provided in designated intensive care and specialist paediatric units. Again, small rural hospitals are forgotten.

The Board of the IHPA has a lot to explain. Firstly, where did they derive these city-centric, and plainly crazy, loadings from? (I trust not from Victoria, which is geographically very different from New South Wales, Queensland and Western Australia.)

Secondly, have they got the sense to call a halt now and seek rural input? Or do they plan to wait and see which rural hospitals fall over before they review their madness?

Another gold must go to the Rural Doctors Association of Australia - NSW for apparently accidentally allowing NSW Health to cut rebates for specialists on the Rural Doctors' Association award from 155 per cent of the Medicare Benefits Schedule to 140 per cent. Such behaviour serves only to emphasise the importance of the AMA Rural Health Committee, which works to serve all doctors in rural and regional practice, not just GPs.

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## Expanded settings: an answer to a training system at the brink?

BY DR WILL MILFORD

“Providing teaching, supervision and mentorship in new settings requires significant investment, not only in funding, but also in time and resources”

Medical training, at all levels, is under pressure. Unprecedented numbers of medical students, chronic underfunding and public hospitals preoccupied with efficiency at the cost of training, have created an unsustainable medical education system.

The evidence is already obvious. Despite significant efforts by both Government and health services, 244 medical graduates could be left without an internship by the end of 2012. If the status quo continues, Health Workforce Australia is predicting a shortfall of 404 first year vocational training places by 2015 and 1265 by 2025. These figures are a clear indication of a traditional medical training system at capacity. Innovation must occur if the full benefit of increased medical school enrolments is to be realised by the Australian community.

The greatest untapped resource for medical training is expanded or non-traditional settings. To take examples from a procedural perspective, almost 50 per cent of laparoscopic cholecystectomies - and the majority of gynaecological procedures - are performed in private hospitals. Data concerning consultations is harder to obtain, but it is clear that at least an equivalent number of specialty consultations are conducted within private rooms, even without considering general practice. It is obvious that substantial scope exists for training within these settings.

Beyond the sheer volume of possible training experiences, the content of these experiences is also significantly different. Aspects of many specialties have poor exposure in traditional teaching settings, and access to expanded settings offers a more rounded learning experience for medical students and trainees. Some specialties are (almost) entirely privately based, such as dermatology and sports medicine, and training in these disciplines must occur within expanded settings.

Consent, indemnity and funding remain difficult problems to resolve, making the transition into expanded settings challenging. Trainees continue

to be anxious about maintaining their employment entitlements and ensuring that their training is of a similar standard to that to which they are accustomed.

Providing teaching, supervision and mentorship in new settings requires significant investment, not only in funding, but also in time and resources.

The Specialist Training Program (STP), initially set-up and funded by the Commonwealth Government, has now been running for almost five years. This successful program has established 105 funded positions in expanded settings for vocational trainees this year, in addition to 518 pre-existing positions. The Commonwealth has also committed to significant increases to this program in the future.

With the recent dissolution of the Enhanced Medical Education Advisory Committee, the body previously tasked with overseeing the STP, there is a risk that this valuable program could lose direction and fall by the wayside. This seems a backward step, especially given the current situation.

A similar program, Prevocational General Practice Placement Program, offers valuable positions in general practice to pre-vocational trainees, providing experiences beyond the scope of those available in traditional teaching hospital settings.

While acknowledging the expansion in private settings achieved so far, significantly more is required. The challenge is now the timeframe. The clichéd ‘wave’ is already upon the health system. Examination and adoption of successful models, streamlining of accreditation processes and adequate funding are vital, but safeguards to maintain training quality must not be forgotten in the rush to increase capacity.

Medical training in expanded settings is already a major part of the solution, but further expansion has to be supported. It is no longer appropriate for one half of the health system to shoulder the burden of the entirety of medical training.

[TO COMMENT CLICK HERE](#)



# Changing health funding does not add up to health reform

BY DR STEVE HAMBLETON

“The voice of the AMA members who are working on the ground is critical to this work. I need your views and input about how health financing arrangements could be improved”

The Government has established a number of new organisations in the health system.

There is the National Health Performance Authority (NHPA) to monitor and report on health performance, the Independent Hospital Pricing Authority (IHPA) to manage and report on the activity-based pricing framework for hospitals, and the National Health Funding Body (NHFB) to administer the funding pool.

Individually, these new bodies and processes being rolled out under the National Health Reform Agreement have the potential to make improvements in their specific areas. But, while it is still early days, there are some significant risks.

The AMA has argued that the reforms are overly focused on backroom issues, such as how governments split funding responsibilities, how they measure performance in the abstract, and how they create new organisations, but don't invest in the system's overall capacity for service delivery.

There is no clear picture of the overall performance of the system, and the impacts of the new bodies and processes are not fully predictable. The AMA has highlighted key issues to the Government through comments and submissions on proposals such as the National Efficient Price, the IHPA Work Program 2012-13, and the NHPA Strategic Plan 2012-2015.

I have also written to Health Minister Tanya Plibersek to raise specific concerns on the new hospital pricing arrangements, including the impact on training places and quality of care, and to question whether reforming health financing will actually lead to reform in the delivery of services, particularly in a system that is not well positioned to respond to increasing demand.

In the broader context, it is becoming increasingly clear that while the National Health Reform

Agreement has delivered reform of Government funding arrangements, it has not delivered health reform.

This is shown by the Government's recent decision to provide a \$325 million emergency rescue package for Tasmania's health system. This additional funding is targeted to direct health care delivery and is evidence that the reforms and new funding arrangements themselves fall short of being able to improve service delivery.

While some good and significant changes have occurred, the dream of health reform that began in 2007 has not been realised. 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.

Health reform as defined and constructed by the Government has not delivered direct improvements in health capacity, services and a sustainable funding base for medical care. At the same time, the Government has been relying increasingly on the goodwill of medical practitioners to keep the system going.

It's time to begin considering whether there might be a better way to fund the delivery of health services. What should be the criteria for a better system? And what might be the basic design and key elements of a sustainable health financing system that meets these criteria?

The Economics and Workforce Committee will begin considering these issues and developing its thinking on health financing options, informed by some external expertise, at its meeting in October.

The voice of the AMA members who are working on the ground is critical to this work. I need your views and input about how health financing arrangements could be improved.

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# Healthier Food Labelling

BY PROFESSOR GEOFFREY DOBB

“The introduction of Front of Pack Labelling will need to be supported by a significant and well-targeted public education campaign”

Earlier this year I wrote an *Australian Medicine* column advising members that obesity was a key priority area for the AMA's Public Health & Child and Youth Health Committee. I noted that a number of AMA submissions had been developed in the areas of nutrition and obesity.

The AMA's Position Statement *Obesity – 2009* highlights the need for a multifaceted approach to obesity in Australia, and calls on Government to employ measures that make it easier for consumers to make healthy choices.

In order to make healthier food choices, people need effective food labelling that provides the right health information in the right way. Studies show that many consumers find the current approach (the Nutrition Information Panel) to be too technical, difficult to understand, and confusing (if not misleading) – and that's if you can read it. By contrast, Front of Pack Food Labelling aims to provide consumers with 'at a glance', easy to understand and comparable information about packaged food items.

Views have differed about the best approach to Front of Pack Food Labelling in Australia, with many health-related organisations, including the AMA, voicing support for the Traffic Light approach, while many food producers and retailers have supported the Percentage Daily Intake approach. Not surprisingly, this was a key issue identified in *Labelling Logic: Review of Food Labelling Law and Policy* (the Blewett Review), which was handed down in December 2011.

As a way forward, the Government has undertaken to bring key stakeholders together (in the Front of Pack Labelling Stakeholder Working Group) in

order to develop a new Front of Pack Labelling system. The AMA was recognised as a key stakeholder in this area and I now represent the AMA on the Working Group, which is chaired by Federal Department of Health and Ageing Secretary Jane Halton. The Working Group aims to develop a Front of Pack Food Labelling approach that health groups and the food industry can support.

Meetings of the Working Group have been productive and have included the development of agreed objectives and principles that will guide the group in the development of the preferred labelling model. Terms of reference for two sub-groups have also been agreed. They focus on technical design and implementation aspects. At this stage it is hoped that the Working Group will have an agreed proposal for Front of Pack Labelling finalised early in 2013.

The introduction of Front of Pack Labelling will need to be supported by a significant and well-targeted public education campaign.

It is pleasing to see the Government, health groups and the food industry working towards the development of a Front of Pack Food Labelling system, which ultimately aims to assist consumers in making healthier food choices.

While no one believes that Front of Pack Food Labelling is a panacea to address obesity in Australia, it is an important component, and will help to raise public awareness of the importance of energy consumption and nutritional value to their diet. I look forward to being able to keep members updated about progress on this matter of considerable interest for public health.

[TO COMMENT CLICK HERE](#)

# RESEARCH

## Brain stem cells eavesdrop

American researchers have made a significant advance in understanding how the brain works, discovering that stem cells in parts of the brain responsible for learning, memory and mood regulation use chemicals to tap neural networks to find out what is happening in the external environment.

In an important development that could shed new light on how the brain reacts to the world around it, researchers at Johns Hopkins School of Medicine have found that brain stem cells use chemicals to tap into communications between neurons.

Lead researcher Professor Hongjun Song, Director of the Stem Cell Program at the School's Institute for Cell Engineering, said that brain stem cells essentially "eavesdrop" on chemical communications among nearby neurons to determine when the system is stressed and when they need to act.

"What we learned is that brain stem cells don't communicate in the official way that neurons do, through synapses or by direct signalling each other," Professor Hongjun Song said.

"Synapses, like [mobile] phones, allow nerve cells to talk with each other.

Stem cells don't have synapses, but our experiments show that they indirectly hear the neurons talking to each other. It's like listening to someone near you talking on the phone."

The researchers said the 'indirect talk' that stem cells detect is comprised of chemical messaging, fuelled by the output of neurotransmitters that leak from neuronal synapses. Neurotransmitters released by one neuron trigger those receiving it to change their electrical charges, causing them to either fire off an electrical pulse or to remain dormant.

The researchers attached electrodes to stem cells in mouse brain tissue. They measured whether there was any change in electrical charge after different neurotransmitters were added, and discovered that when brain stem cells were treated with the neurotransmitter GABA – a known signal-inhibitor – the stem cells' electrical charges changed, suggesting that the stem cells can detect GABA messages.

"Traditionally, GABA tells neurons to shut down and not continue to propagate a message to other neurons," Professor Song said. "In this case, the neurotransmitter also shuts off the stem cells and keeps them dormant."

Professor Song said the brain stem cell population in mice and other mammals is surrounded by as many as 10 different kinds of intermingled neurons, and any number of these may be keeping stem cells dormant.

In an effort to find which neurons control the stem cells, the researchers inserted special light activating proteins into neurons to get them to send an electrical pulse and release neurotransmitters when exposed to light. They found that parvalbumin-expressing interneurons message the stem cells.

The researchers then created stress for normal mice by socially isolating them, and did the same in mice lacking GABA receptors in their brain cells. After a week, socially isolated normal mice had an increase in the number of stem cells but the socially isolated mice without GABA receptors did not show any increase.

"GABA communication clearly conveys information about what brain cells experience of the outside world and, in this case, keeps the brain stem cells in reserve, so if we don't need them, we don't use them up," Professor Song said.

KW

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## INFORMATION FOR MEMBERS

### Puggy Hunter Memorial Scholarships for 2013 now open

Scholarships worth up to \$15,000 a year are being offered for Aboriginal and Torres Strait Islander people studying for professional health qualifications.

Applications are being invited for Puggy Hunter Memorial Scholarships for 2013, offering up to \$7500 a year for those engaged in part-time study and \$15,000 a year for full-time students.

The scholarships will be available from the start of the 2013 academic year, and are offered to Aboriginal and Torres Strait Islander people who are, or will be, studying at a TAFE (certificate IV and above) or entry-level university course in one

of the following health professions:

- Aboriginal and Torres Strait Islander health worker;
- Allied health (excluding pharmacy);
- Dentistry/oral health (excluding dental assistants);
- Medicine;
- Midwifery; or
- Nursing.

Scholarship applications close on 16 September, and more details can be found at the Royal College of Nursing Australia website: <http://www.rcna.org.au/>

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# RESEARCH

## Brains fight back against schizophrenia



There is mounting evidence that the brains of people suffering schizophrenia fight back against the debilitating condition, launching an immune response and attempting to repair damage caused.

A study of the brain immune activity found that those who had schizophrenia were more likely to have increased inflammation around the dorsolateral prefrontal cortex - an area of the brain affected by schizophrenia.

The researchers found increased levels of pro-inflammatory cytokines in 40 per cent of people with schizophrenia. Cytokines are proteins involved in cell-to-cell communication, and pro-inflammatory cytokines drive immune responses, including the activation of microglia.

Lead researcher Professor Cyndi Weickert, from Neuroscience Research Australia and the University of New South Wales, said the fact that this pattern of immune response was found in almost half of people with schizophrenia examined, raised the possibility that it was a root cause of the disease.

“The part of the brain we looked at is indeed ‘in crisis’ in people with schizophrenia. From the types of immune markers we measured, it’s like the brain is on red alert,” Professor Weickert said.

“As there are multiple biological root causes of schizophrenia, the fact that inflammation occurs in 40 per cent of individuals is huge, and opens up a whole new range of treatment possibilities.”

The paper was published in *Molecular Psychiatry*.

A separate study led by Professor Weickert found that the brains of people with schizophrenia may attempt to repair damage caused by the disease.

Researchers focused on the orbitofrontal cortex, the part of the brain responsible for regulating emotional and social behaviour.

Most neurons are in tissue near the surface of the brain but researchers found a higher density of interstitial white matter neurons in deeper areas of the brain in people with schizophrenia, and a decreased density of neurons emitting GABA in their grey matter.

The researchers said the pattern suggested that interstitial white matter neurons migrated towards areas where they are lacking because of schizophrenia – suggesting the brain was attempting to repair damage caused by the disease.

“For over a decade we’ve known about the high density of neurons in deeper brain tissue in people with schizophrenia. Researchers thought these neurons were simply forgotten by the brain, and somehow didn’t die off like they do during development in healthy people.” Professor Weickert said.

“What we now have is evidence that suggests these neurons are derived from the part of the brain that produces new neurons, and that they may be in the process of moving. We can’t be sure where they are moving to, but given their location it is likely they are on their way to the surface of the brain, the area most affected by schizophrenia.”

**KW**

[TO COMMENT CLICK HERE](#)

## Hepatitis C vaccine in view



Australian researchers have claimed a major advance in the development of a vaccine for hepatitis C.

In a significant development, researchers at the Burnet Institute, led by Associate Professor Heidi Drummer, have produced a vaccine candidate that protects against a number of different strains of the hepatitis C virus (HCV).

Associate Professor Drummer said the finding meant that a major hurdle in tackling the virus had been overcome, and could lead to the first ever HCV vaccine.

“Hepatitis C has a great ability to change its structure and evade the immune response,” Associate Professor Drummer said. “This makes vaccine development challenging.”

“Our vaccine is unique as it contains only the most essential, conserved parts of the major viral surface protein, eliciting antibodies that prevent both closely and distantly-related hepatitis C viruses from entering cells, thereby preventing infection.”

Associate Professor Drummer presented details of the research to the Immunotherapeutics and Vaccine Summit in Cambridge, Massachusetts, on 13 August.

**AR**

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# RESEARCH

## Pains in the back bring people down

People with back problems are more likely to experience psychological distress and mental disorders, according to new data from the Australian Institute of Health and Welfare.

Figures released by the Institute show that one in 11 Australians – around 1.8 million people – reported having back problems in 2007-08, and were more than twice as likely as the general population to have mental health issues such as depression.

Institute spokeswoman Louise York said that the chronic and pervasive nature of back problems often leads to poorer quality of life, psychological distress, mental disorders and disability.

“Affective mental disorders such as depression are particularly common among people with back problems,” Ms York said.

“People with back problems are two-and-a-half times as likely to report having affective disorders, 1.8 times as likely to report an anxiety disorder and 1.3 times as likely to report a substance disorder, as people without back problems.

“They are also 1.2 times as likely to report high or very high levels of psychological distress, and more likely to rate their health status as fair or poor.”

According to the Institute, more than 40 per cent of those with back problems said their mobility was limited, with a third reporting severe or profound activity limitations.

People with back injuries aged between 15 and 65 were also less likely to be employed full time and 1.3 times more likely not to have a job.

The snapshot also found that Indigenous Australians were 25 per cent more likely to report having back problems than the general population.

**KW**

[TO COMMENT CLICK HERE](#)

## Breakthrough in addiction-free pain relief

Australian researchers have found a way to block cravings for opioid drugs like heroin and morphine in a discovery AMA President Dr Steve Hambleton has hailed as an “absolute breakthrough”.

A joint study by scientists at the University of Adelaide and the University of Colorado have found a receptor in the immune system that amplifies addiction to opioids, and which can be blocked using the drug plus-naloxone.

The discovery, published in the *Journal of Neuroscience*, could lead to the creation of drugs that provide pain relief while at the same time blocking off any chance of an addiction developing, as well as offering potential new treatments for heroin addiction.

Lead author Dr Mark Hutchinson, ARC Research Fellow in the University of Adelaide’s School of Medical Sciences, said the while it was well known that both the central nervous and immune systems play important roles in creating drug addiction, the research has shown that only the immune response needs to be blocked to prevent cravings developing.

Dr Hutchinson said opioid addiction was created when the chemical dopamine was produced in the brain, creating a sense of pleasure in the user, and the drug plus-naloxone prevented such a reaction from occurring.

“It really changes what we understand is actually happening in the brain and based on what we understand is happening in the brain,” he told ABC television. “We’d previously thought that the addiction was created by the wiring of the brain and solely the wiring of the brain. But what our study shows is that the immune-receptor Toll-Like receptor 4 (TLR4) is crucial for drug-reward to opioids, and our drug specifically blocks this and nullifies the rewarding properties of opioids.”

Dr Hutchinson said that “drugs such as morphine and heroin bind to TLR4 in a similar way to the normal immune response to bacteria. The problem is that TLR4 then acts as an amplifier for addiction.

“The drug plus-naloxone automatically shuts down the addiction [and] the need to take opioids, it cuts out behaviours associated with addiction, and the neurochemistry in the brain changes – dopamine is no longer produced.”

Dr Hambleton said the discovery was “an absolute breakthrough in this area and I was really excited to read this material, and particularly interested because here it is, again Australia, University of Adelaide, coming up with a really world-breaking opportunity.”

Dr Hambleton told the ABC the study had the potential to lead to major advances in patient and palliative care.

“Who could benefit? Nearly everyone in the population is going to need pain management at some time in their life, so this could be very widely applicable,” he said.

“That if we could block that addiction potential for multiple different molecules by having a look at this particular immune system molecule, that’s going to have very broad implications.”

Dr Hambleton said the discovery could lead to drugs that help with chronic pain without the risk of creating addiction.

“We do have trouble managing chronic pain, we do have trouble with diversion of pain medicine into illicit markets, and it looks like there’s now been clarification of exactly how this addiction process works and it doesn’t stop the ability for us to stop pain,” he said. “[It will be] very, very good for clinical use, if we can get it to market.”

The researchers said clinical trials could begin within the next 18 months.

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# US seeks global standard for medical education

The United States is conducting an international audit of medical education in a massive undertaking that could set a de facto global standard for doctor training.

The US's Educational Commission for Foreign Medical Graduates (ECFMG), which certifies international medical graduates seeking to work in America, aims to examine the accreditation of more than 2500 medical schools worldwide in the next 11 years to ensure that they comply with World Federation for Medical Education standards before considering applications by graduates for certification to practice in the US.

The US, like Australia, relies heavily on international medical graduates to bolster the nation's supply of doctors, and they comprise about 25 per cent of the physician workforce.

Last year the ECFMG certified 9791 offshore graduates, according to *American Medical News*, with large numbers coming from India, Dominica, Grenada, Pakistan and China.

The Commission evaluates their

credentials and proficiency with English, and ensures they have passed the first two steps of the United States Medical Licensing Examination, and is relied upon heavily by local medical licensing boards and residency programs.

Without ECFMG certification, international medical graduates are not eligible for residency programs, and are barred from embarking upon the third and final step involved in qualifying for an unrestricted medical licence.

New rules will require that by 2023 all international medical graduates seeking to work in the US must come from medical schools accredited by the World Federation for Medical Education (WFME).

ECFMG President Dr Emmanuel Cassimatis admitted to *American Medical News* that it was "a really complex undertaking" to achieve a global consensus on the fundamentals of medical education and what it means to be a physician, as well as evaluating and – where necessary – establishing accreditation agencies, all by 2023.

WFME President Dr Stefan Lindgren, from Lund University in Sweden, said international guidelines for medical education had already been developed, and Dr Cassimatis said the intention of his organisation was to evaluate national accreditation agencies rather than try to evaluate each individual medical school itself.

But he said that, because many countries producing medical graduates did not have such agencies, it would be a big task to set up national accreditation systems in time.

The ECFMG and the WFME are working together on a pilot accreditation project in the Caribbean, and five out of 27 medical schools in English-speaking countries in the region have been accredited so far.

Medical education experts said that although the move toward a common global standard was an important undertaking, allowance had to be made for variations in teaching methods and curricula.

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## Be an *Australian Medicine* travel writer

**Sick of glitzy infomercials posing as travel stories?**

**Want to tell your colleagues what places, near and far, are really like?**

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

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

**Please send stories, with your contact details, to: [ausmed@ama.com.au](mailto:ausmed@ama.com.au)**

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## Ebola outbreak leaves more than a dozen dead, scores fighting for their life



The deadly Ebola virus has killed at least 16 Ugandans in the first major outbreak of the disease in three years.

A Medecins Sans Frontiers (MSF) team has rushed to join local health workers in Kigadi in Uganda's western Kibaale district to help treat more than 53 people struck down by the illness and try to stem the rate of infection, with unconfirmed reports of a further 312 cases.

Authorities believe the outbreak – which was formally notified on 28 July – had its origins two weeks earlier at the funeral for a three-month-old girl thought to have been the first victim of the disease,

according to a report in the *New York Daily News*.

It is claimed that of the 65 people who attended the funeral, 15 contracted Ebola and 11 have since died.

As part of its response to the outbreak, MSF has set up a treatment centre to isolate people infected with the disease, and has begun an education program for health workers and the broader community about the virus and how to prevent it spreading.

“It's very important to react quickly to find where the disease is focused and

to isolate it as fast as possible,” MSF's emergency co-ordinator for the Uganda Ebola intervention, Olimpia de la Rosa, said. “It is also essential to take care of the caregivers – which means supporting and working closely with the Uganda health teams who are already struggling to stop the virus spreading.”

Just days after a World Health Organisation official declared the outbreak under control, one of five prisoners suspected of being infected with the deadly disease escaped a treatment centre, provoking alarm that he could spread the infection.

Ebola was first identified in 1976, and is a haemorrhagic fever that can spread rapidly through direct contact with the blood, body fluids and even clothes of an infected person, according to MSF.

The last major outbreak was in early 2009 when 14 people in Congo were killed by the disease.

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## Defamation suit over discredited study thrown out

A Texas court has dismissed defamation action taken against the *BMJ* and two of its staff over claims that a leading medical researcher had faked data in a high-profile study.

The action was launched by Andrew Wakefield, who has become a cause celebre of the anti-vaccination movement, after the *BMJ* published a series of articles and editorials accusing him of using fake data in a 1998 study published in *The Lancet* connecting measles-mumps-rubella vaccinations with gastrointestinal and autism-like symptoms in about a dozen British children.

The revelations in the *BMJ* prompted *The Lancet* to retract Mr

Wakefield's 1998 paper, which has also been repudiated by several of his co-authors.

Mr Wakefield, who now lives in Austin, Texas, decided to launch his defamation in the American state, arguing that it had jurisdiction in the matter because the *BMJ* was distributed there.

But Judge Amy Clark Meachum disagreed, ruling that her court had no jurisdiction over the British-based *MJA*, or the individuals named in the suit, *BMJ* editor-in-chief Fiona Godlee and journalist Brian Deer.

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# More Than Just A Union – a history of the AMA

This is the second in a series of excerpts from a history of the *AMA*, *More Than Just A Union: A history of the AMA*, launched by AMA President Dr Steve Hambleton during a nationally televised speech to the National Press Club on 18 July.

In this edition, former presidents Bruce Shepherd and Brendan Nelson recount their experiences and achievements at the helm of the organisation during the dying days of Bob Hawke's prime ministership and his succession by Paul Keating.

The publication, which can be viewed at <http://ama.com.au/a-history-of-the-ama>, is considered by the AMA to be very much a work in progress, and invites contributions from members past and present.

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## Setting the agenda

BY DR BRENDAN NELSON, AMA PRESIDENT, 1993-95



Four months after Bruce Shepherd placed the chains of office on my shoulders at the 1993 AMA national conference, I gave my first address as president to the National Press Club.

I had thought long and hard about what to say, the direction in which the Association needed to go and my own beliefs about what had to be done.

And so I laid out the agenda - the critical importance of an independent medical profession, the consequences to health care and its financing of universal bulk billing and the crucial role played by private health care and insurance to an effectively functioning hospital sector.

But in addition to these core issues, I laid out an AMA agenda in Aboriginal health, environmental health, the human and health effects of unemployment,

discrimination against women in the profession, illicit drug use, immunisation, youth suicide, euthanasia and gay law reform, among others. The AMA would be a voice for those with neither power nor influence, reflecting in what it said and did the profession's commitment to an ethic of service to others.

That day I also held to the cameras a packet of Winfield cigarettes in one hand and Ratsak in the other. I asked why the warning on one killer of Australians was a barely legible note about its impact on fitness, while the other, in 'black on gold' told its consumers exactly what it did - "kills rats and mice". Hours later, health minister Graham Richardson rang to concede that the Commonwealth would finally move on explicit health warnings on tobacco products.

This was a period of immense change and transformation for the Association.

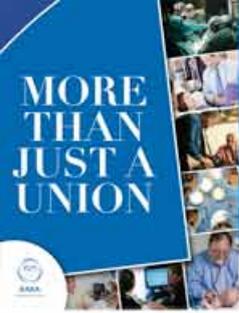
Among the many changes was the AMA-led development of the Professional Services Review, bedding down the nascent Divisions of General Practice, establishing the AMA Council of General Practice, the move to commence the Relative Value Study, and agreement on the concept of 'informed financial consent' prior to surgery. We also convinced the

new Health Minister, Graham Richardson, of the need for government to encourage private health insurance.

The AMA employed its first Indigenous health advisor, successfully campaigned for responsibility for Aboriginal health to be removed from the Aboriginal and Torres Strait Islander Commission and placed into the Health Department, seeded establishment of the Indigenous Doctors' Association, facilitated changes to medical education to increase and support increased numbers of Indigenous students, campaigned for increased resourcing of Aboriginal Community Controlled Health Organisations, and encouraged support for specialist services in Indigenous Australia. The first indigenous artwork for the AMA was commissioned but, most importantly, Aboriginal health was made a mainstream health issue by the AMA.

A great deal of effort was invested in tobacco control. In addition to explicit health warnings on cigarette packets, the prohibition of tobacco sponsorship of sport and early bans on smoking in public places, in 1994 we did something that has literally changed the world.

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In 1994 I successfully moved on behalf of the AMA that the World Conference on Tobacco and Health in Paris adopt a resolution calling for a United Nations strategy on tobacco control. This was subsequently embraced by the UN as the Framework Convention on Tobacco Control, the global template for action on tobacco control.

My young family sacrificed much to allow me to serve the AMA. We lived in Hobart and I literally spent half the year on the mainland. I juggled GP locums and many nights doing house calls in the satellite suburbs of the city with the leadership of the AMA, on many occasions having little or no sleep. I did not appreciate just how hard – or rewarding - those two years

were, until it all finished in May 1995.

The only medical organisation in Canberra that counts – really counts - is the AMA. Its influence and respect relies entirely on the strength of membership, quality of leadership and, above all, a commitment to the nation's best interests and health, transcending all else.

## Let the battle commence

[TO COMMENT CLICK HERE](#)

BY DR BRUCE SHEPHERD, AMA PRESIDENT, 1990-93



These were tough years to be AMA President. The previous decade had seen the Labor governments in New South Wales and Canberra aggressively pursue, with intent to destroy, the independence of the medical profession.

The-then premier, Neville Wran, had told me at our first meeting, "Doctor Shepherd, you represent the last independent group in society. As such I will move to control you".

In a pincer movement, Neil Blewett in Canberra used Federal legislation to restrict our right to treat private patients in public hospitals as he simultaneously sought to bring general practice to its knees with bulk billing. Governments started funding rampant medical consumerism. This emergent group of predators considered patients as 'clients' and professional standards the domain of their relentless activism. Our profession had given our nation the highest standard of care in the world, yet we were besieged as the enemy in some kind of class war.

We had to fight. The AMA has been captured by a group for whom negotiation was little more than

appeasement. They regarded the AMA office as a reward for years of serving on committees and councils rather than fighting on behalf of the profession.

Through three hard years, I had to firstly reshape the AMA itself – the secretariat, branches (Victoria especially), build a team of people prepared to energetically bleed for the cause, and professionalise the AMA to be a fearless and respected voice for the medical profession. None of this was easy.

The Australian Doctors Fund established in 1988 was an essential complement to the AMA, focusing as it did on issues as diverse as the decriminalisation of healthcare, the looming crisis of medical immigration, AIDS and road trauma. It would later support the courage of plastic surgeon Cholm Williams, in his legal battle to have patient records remain the property of the doctor.

My critics forget that we were dealing with a government that had withdrawn all support for private health care, telling Australians that Medicare was all they needed.

The-then Health minister Brian Howe finally offered a Medicare co-payment in 1991. At first we thought we had finally broken through. However, on closer examination, what he was actually planning was to cut the Medicare benefit for patients who paid their fees, and shift half a billion dollars a year out of health to play with cities. We said no. Paul Keating used it to knock off Bob Hawke.

In October 1992, Brian Howe told us not to bother telling him what the government

should do. He said that if we wanted to change what the government was doing, we'd have to change the government.

Although I was not often inclined to take Howe's advice, I did on this occasion.

We worked tirelessly in support of John Hewson's Fightback! His health policy was to restrict bulk billing to pensioners and the unemployed while allowing private health insurance for outpatient services up to 85 per cent of the AMA fee. Families would get means tested assistance to buy private health insurance. I took the view that if you were not prepared to fight for that then the AMA should pack up its tent and go home.

I battled corporatisation of health care and the profit motive of those who wanted to bring our younger colleagues to servitude in medical emporia.

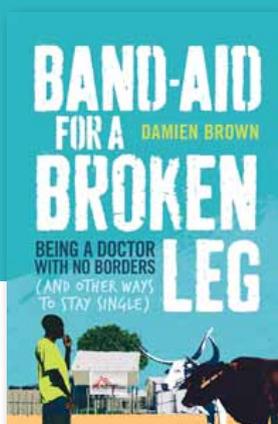
Amid all of this, we fought tobacco companies to get them out of sport and off television. Although Jeff Fenech was a mate and patient, we argued the case to better regulate boxing.

Fred Hollows was another mate who put his heart and soul into Aboriginal blindness. Inspired by this and the neglect the government, I asked Gordon Briscoe to address the federal council in 1992. That started us on the journey of Aboriginal health.

I felt that by the time my three years ended in 1993 that I had played a role in building the AMA into a modern effective organisation. It would – and should - be one to be feared and respected.

[TO COMMENT CLICK HERE](#)

## BOOK REVIEW



## Adventures in medicine from the edge of the world

Band-aid for a broken leg: Being a doctor with no borders (and other ways to stay single)

By Dr Damien Brown

Allen & Unwin, 360 pages, \$29.99. ISBN 978-1-74331-021-2

Reviewed by Dr Sam Merriel

Australians are blessed with a first-class health care system, and Australian doctors have ready access to the latest diagnostic testing equipment and a variety of pharmaceuticals with which to care for their patients. As a consequence, most Australians have one of the highest life expectancies in the world and very low maternal and child mortality rates. Not everyone in the world enjoys such privileges. Damien Brown's raw, amusing, and at times tragic account of volunteering with *Medecins Sans Frontieres* (MSF) in Africa reminds us of the stark reality of practising medicine in countries that aren't so lucky.

South African born and Australian trained, Dr Brown's first published work is drawn from an online blog he maintained during his volunteer overseas placements. After completing his undergraduate medical training and a couple of postgraduate years as a junior doctor, Dr Brown's interest in medical volunteering was stirred by a stint in a HIV clinic in Thailand. Soon enough he was bouncing down a sandy runway in a tiny Cessna to begin his first MSF placement in Mavinga, Angola (dubbed 'the edge of the world' by the Portuguese during colonial times).

Dr Brown's first stint as a medical volunteer involved a massive adjustment on all fronts. Not only was he the sole doctor for hundreds of kilometres in an under-resourced hospital, but he also had to compete with the language barrier (Dr Brown didn't speak a word of Portuguese), stubborn - and almost hostile - local health workers resistant to change, and more than a few local hazards (unexploded land mines and a leopard attack to name a couple). Then there is the dizzying array of

presentations to his hospital to deal with. Anything from severely malnourished children to fungating end-stage cancers to acute appendicitis must be managed as best they can.

Dr Brown's next African volunteer placement landed him in southern Sudan, after a brief MSF relief effort in Mozambique during a flood crisis. This strife-torn African nation presented many of the same challenges as in Angola, but also some very new ones. Heavily armed militia roamed the streets, and constant clashes between armed factions kept this particular hospital busy with a stream of trauma victims. HIV and TB were far more prevalent here, and Dr Brown was pushed to the brink in a seemingly hopeless situation.

In the book the despair and desolation of these third-world regions is held in stark contrast to the simple joys and determination of the local people. They carve out a living in any way they can, and the children use imagination and creativity to create toys out of whatever is available (including clay, hair and empty soft drink bottles). The tireless efforts of the MSF volunteers from around the world are honoured by Dr Brown and the thousands of underprivileged they have tried to help.

Dr Brown's adventures (and misadventures) as an MSF volunteer in Africa are entertaining, uplifting, despairing and sobering, all at the same time. Disparities in health across the world remain as wide as ever, and any doctor wanting to get a genuine account of how much of a difference can be made in less fortunate countries than Australia should read this book.

[TO COMMENT CLICK HERE](#)



# Range Rover Evoque: “Evocative!”

BY DR CLIVE FRASER



According to my dictionary, the word evoke means “to re-create imaginatively”.

There is little doubt that Range Rover’s latest addition, the Evoque, fulfils that definition.

Love or hate it, it is undeniably a Mini-Me version of a full-size Range Rover, with quite a lot of modern technology thrown in to match its futuristic looks.

For starters, while the floor pan is loosely based on a Freelander, making the bonnet and roof out of aluminium help to make total weight savings of 100 kilograms.

Inside there is a very luxurious feel to the cabin, but you will need to be well-heeled if you start ticking the Evoque’s option boxes.

In the most basic “Pure” model there are no rain-sensing wipers, xenon or auto headlights, features I would expect for my 60 something thousand dollars and which can be had in the optional Clearview Pack for an additional \$1700.

But you can option up the Evoque to your heart’s desire, and this does create a healthy revenue stream for its makers from a model that is in short supply.

For \$1300, I thought I could go without the heated washer jets and steering wheel found in the Cold Climate Pack, and \$3400 did seem a bit steep for the Sat Nav.

Under the bonnet you can start with a 2.0 litre eco-boost petrol engine that is the same as the one that slots into Ford’s Falcon and Mondeo and Volvo’s S60.

My test vehicle was powered by the 2.2 litre turbo-diesel, which has two variants.

Power starts in the diesel at 110 kilowatts (kW), but for about \$4000 more there is a higher performance engine with 140 kW.

Acceleration is faster in the six speed automatic than the six speed manual, and even Kath and Kim should be able to get to 100 km/h in about 8.5 seconds.

If you’re not planning to go off the beaten track, there are two-wheel drive variants that are priced \$3400 below the equivalent all-wheel drive.

But in true Land Rover fashion, there is some real off-road potential. Range Rover quotes a wading depth of 500 mm for the Evoque.

I did suggest to my colleague who owned the test vehicle that we would need to check the validity of that claim on our test drive, but we weren’t able to find any flooded streams to ford in suburban Buderim.

Like most owners our journey would simply be to the local golf club and, disappointingly, the boot wouldn’t hold our clubs without folding down the rear seat.

So what sort of doctor is likely to buy a Range Rover Evoque?

Well, I’m thinking 50-ish, mid-life crisis, kids have left home, etcetera.

That sounds a lot like me!

## Bangkok taxis

For	Looks stylish and sexy
Against	Options soon add up
This car would suit	50 something doctors in the midst of a mid-life crisis
Specifications	2.2 litre 4 cylinder turbo-diesel 140 kW power @ 3500 rpm 420 Nm torque @ 1750 rpm 6 speed automatic 8.5 seconds 0-100 km/h 6.5 l/100 km (combined) \$59,875 + ORC + options

Safe motoring,

**Doctor Clive Fraser**

doctorclivefraser@hotmail.com

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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 performance 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/feelist>.

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](http://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://feelist.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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## 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](http://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](http://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](http://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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## Income replacement – getting it right.

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

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

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

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



## Let AMP Bank take the stress out of buying property

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

### Borrowing for an investment property

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

Some things to consider

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

### Making the most of your home loan

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

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

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

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1300 553 399  
**Web:** [www.ama.com.au/fitnessfirst](http://www.ama.com.au/fitnessfirst)



**General Enquiries:**  
1300 133 655  
**Web:** <http://www.ama.com.au/node/5292>



**General Enquiries:**  
1300 788 215  
**Web:**  
[www.ama.com.au/memberservices](http://www.ama.com.au/memberservices)

## GREAT MEMBER DEALS

### Discounts off new Volkswagen and Skoda vehicles for AMA Members\*

AMA members can access substantial discounts off the list price of new Volkswagen and Skoda vehicles. **A deal that could save you thousands!**

The discount is model dependant and does not include options and accessories. Please see your local VW dealership for further details on the discount structure.

**To access this exclusive offer simply contact AMA Member Services on 1300 133 655 or email [memberservices@ama.com.au](mailto:memberservices@ama.com.au).**



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

### Great Qantas Club Rates for AMA Members

**Joining Fee:** \$230.00  
**One Year Membership:** \$300.00  
**Two Year Membership:** \$530.00

As a Qantas Club member you also receive complementary Qantas Frequent Flyer membership and access to dedicated Qantas Club check-in counters.

**Call AMA Member Services on 1300 133 655, email [memberservices@ama.com.au](mailto:memberservices@ama.com.au) or login to the AMA website <http://ama.com.au/memberservices-qantas> to obtain an application form.**



**PowerBuy and the AMA have partnered to give Members savings on popular IT products and services. PowerBuy offers discounted deals on brands including Dell, Lenovo, HP, Fuji Xerox and NETGEAR.**

For further details and to access PowerBuy's special offers for AMA Members, simply visit [www.ama.com.au/powerbuy](http://www.ama.com.au/powerbuy) or phone AMA Member Services on **1300 133 655**.