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The national news publication of the Australian Medical Association

PCEHR breakthrough

Doctors win right to bill for e-health record work, p5

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Cover: AMA President Dr Steve Hambleton (2nd from r) with Prime Minister Julia Gillard, Health Minister Tanya Plibersek and AMA Vice President Professor Geoffrey Dobb at the AMA Parliamentary Dinner, Great Hall, Parliament House

Where's the evidence?

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

Modern medicine is evidence based, so new therapies or procedures need clear evidence of benefit to be accepted into medical practice. Any new drug seeking a listing on the Pharmaceutical Benefits Schedule (PBS) needs a robust body of evidence for efficacy and safety supported by pharmaco-economic evidence of cost effectiveness. A similar framework underlies applications for new listings on the Medicare Benefits Schedule (MBS).

Such an approach is consistent with prudent use of the taxpayers' healthcare dollar, but where is the evidence to come from? In its absence, Australians stand to be deprived of life enhancing or life prolonging drugs and procedures, but calls for evidence can easily become a dead weight on progress and innovation.

The advent of the Independent Hospital Pricing Authority (IHPA) has further potential to stifle innovation. If hospital admission for a disease process or procedure is founded on its historic cost there is less incentive to innovate, especially if innovation carries higher initial costs even though there is increased patient benefit, and perhaps future savings to the cost of health care.

The history of innovation in health care is positive. Costs associated with research, development, passing regulatory hurdles and initial marketing are amortised over time. Benefits associated with reduced hospital length of stay or reduced hospitalisation persist. But innovation needs investment today for the dividends to accrue in the future. With funding for research and development in short supply, and likely to come under even more pressure, a new approach and new funding sources are needed.

This may be a good time to re-think our approach to these difficult issues and provide a robust evidence base for new treatments. When there is some sound evidence of benefit, but perhaps not sufficiently robust to justify PBS or MBS listing or funding through the IHPA, the treatment could be provided to half of those with agreed indications and the funds saved by not treating the other half used to support the clinical trial infrastructure needed to assess the efficacy, safety and cost effectiveness of the treatment in an Australian setting. These trials should have patient-centred outcomes, such as survival or quality of life. The same approach could also be used if drugs or MBS items are being considered for de-listing.

A seasonally suitable example might be the use of vaccines for preventing influenza in the elderly. This intervention is recommended worldwide for individuals aged 65 years or older as a means of reducing the risk of complications in a vulnerable population. However, in 2010 a Cochrane review of 75 studies into influenza vaccination in the elderly found only one randomised clinical trial, and this did not detect any significant effect on influenza complications. The other studies were all of poor quality, so the authors were unable to reach any conclusion about the efficacy of influenza vaccines in the elderly. This doesn't mean that influenza vaccines don't work, just that there isn't good evidence that they do. It's not surprising, therefore, that the authors recommend that, to resolve the uncertainty, an adequately powered randomised clinical trial is needed. But who is to fund it?

A lot of work would need to be done, in consultation with those running clinical trials and with health consumers, to develop the necessary ethical framework and research infrastructure. Public education would be another challenge. This is not an easy option. Nevertheless, public debate about the funding of health innovation is a debate that perhaps we have to have.

Australia has many groups with expertise in running pragmatic clinical trials with patient-centred outcomes, so we should be confident there is the capacity to do it well. Providing new treatments only within the context of a clinical trial is not a new concept, but doing it on this scale may be seen as controversial. However, if the alternatives are to either prevent or restrict the access to new treatments in Australia, or fund them on the basis of imperfect evidence, the clinical trial should be preferred.

Worldwide, countries are struggling to meet the escalating costs of health care. As a profession, we advocate for as much funding as possible to be devoted to health care, but we also have a responsibility to ensure the dollars are well spent. The aging of the baby boomer generation is about to put greater pressure on all health budgets and, in this context, striving for effectiveness - and not just the 'efficiency' that is the focus of bureaucratic attention - will do much to ensure our health system is sustainable.

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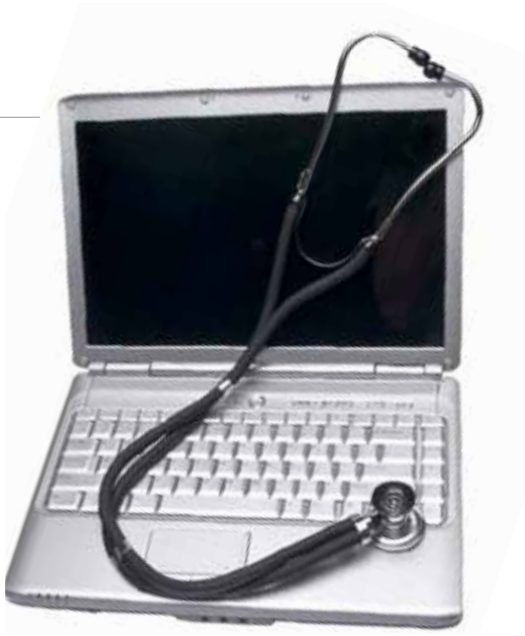
Doctors win recognition for PCEHR work



The Federal Government has bowed to pressure from the AMA and will allow doctors to bill for time spent preparing and maintaining shared electronic health records as part of Medicare Benefits Scheme consultations.

In an important change that should help deliver some much-needed momentum to its Personally Controlled Electronic Health Records (PCEHR) scheme, the Commonwealth has acceded to AMA demands that doctors be compensated for the extra work involved in supporting the system.

In a further breakthrough, Health Minister Tanya Plibersek has delayed the introduction of requirements that practices have PCEHR capability to remain eligible for the Practice Incentive Program (PIP) e-health payment.

The new rules were originally to come into effect in February next year but doctors will now have until May 2013 to meet the PCEHR requirement.

This new cut-off date, while an improvement, remains a tight deadline for doctors to ensure their practices are PCEHR-ready.

Ms Plibersek announced the changes, which she said had been made as the result of "strong representations by the AMA and feedback from GPs", during a speech to the AMA Parliamentary Dinner on 22 August.

"As a result of that consultation, I can confirm that GPs will be able to bill the Medicare Benefits Scheme (MBS) for preparing both shared health summaries and even summaries as part of a consultation," Ms Plibersek said. "In deciding which item to bill, GPs will only have to consider the reasonable time it would take, not the complexity of the consultation, which I know has been something that has been concerning some of you."

The Minister said "strong representations" from the AMA had also convinced her to delay the PCEHR capability requirement for the e-PIP to May 2013.

"We believe that these decisions acknowledge the central role that GPs will be playing in an effective e-health records system," Ms Plibersek said.

AMA President Dr Steve Hambleton said the changes were a welcome and much-needed improvement in arrangements for the PCEHR, and would encourage doctors to become actively involved in the implementation of the scheme.

"The Government has clarified that additional time spent by a GP on a shared health summary or an event summary during a consultation will count towards the total consultation time, and that the relevant time-based GP item can be billed accordingly," Dr Hambleton said.

"The Minister has fully explained how doctors can safely and confidently provide new PCEHR clinical services, such as a shared health summary, under current MBS items."

Dr Hambleton said the move, together with a three-month delay in the full introduction of new e-PIP requirements, was important in helping GPs prepare for the PCEHR system.

"They will allow doctors more time to make the transition to the new e-health environment in their practices, and are a more positive outcome from the ongoing discussions the AMA has had with the Minister's office and the Department [of Health and Ageing]," the AMA President said.

While supporting the principle of shared electronic health records, the AMA has been at the forefront of criticisms of the way the Government has devised the PCEHR scheme, and the haste with which it has been introduced.

The system has been dogged by technical glitches and delays, and in its first six weeks little more than 5000 people registered an interest in having a shared electronic record.

In a nationally televised speech soon after its 1 July launch, Dr Hambleton warned that the scheme would stall without the support of GPs.

The AMA has had a number of meetings with the Minister and senior Government officials about concerns including a lack of compensation for doctors for the extra work involved in creating and maintaining electronic health records and an absence of software for practices to link in with the system, as well as unresolved concerns about record security and privacy and insufficient public information about the scheme.

But Dr Hambleton said the concessions made by the Government would help encourage doctors to take part.

...CONTINUED ON PAGE 6

AMA Guide to using the PCEHR

The AMA has prepared a guide for doctors on how to use the personally controlled electronic health record (PCEHR) system.

The *AMA Guide to Using the PCEHR*, which has been developed in close consultation with practitioners, is available on the AMA website at http://ama.com.au/pcehr.

It provides information and guidance to help medical practitioners decide whether or not to participate in the PCEHR system, and explains how they might use the PCEHR in their day-to-day practice.

AMA President Dr Steve Hambleton said the AMA supports patients taking responsibility for their own health, and giving them control of their health information could help encourage them to do so.

But Dr Hambleton warned that, by putting patients in the driver's seat in terms of managing their health information, the PCEHR also limited its own clinical usefulness for medical practitioners, because of concerns about the content, accuracy, and accessibility of information in the system.

He added that medical practices would also have to make significant investments of time and money to meet all of the PCEHR's legal obligations. This would include changes to clinical and administrative workflows, and practices would have to draw up new operational policies and protocols to comply with the PCEHR legislation.

While these limitations and start-up costs are real, the PCEHR holds the promise of reducing adverse events and duplication of treatments. With the right system and the right support, the PCEHR can help doctors to improve the patient health care experience.

Some elements of the PCEHR system have yet to be put in place for doctors and practices, but key concerns are being addressed (see *Doctors win recognition for PCEHR work*, p5).

As important aspects of the PCEHR are finalised, including the ability to integrate with practice software, the PCEHR should become a valuable addition to quality health care.

The AMA will continue to work to ensure that the best possible PCEHR is available for patients and health professionals.

The *AMA Guide to Using the PCEHR*, which has been prepared with the cooperation of the National Electronic Health Transition Authority, will help doctors get a better understanding of what is involved when they are considering using the PCEHR system, and assist them in making a more informed decision about participating.

TO COMMENT CLICK HERE

Doctors win recognition for PCEHR work

...CONTINUED FROM PAGE 5

"The activity that is required to create and maintain a shared health summary is a new clinical service for doctors that will need to be factored into current clinical practice. The work involved in creating an event summary will also have to be factored into clinical practice," the AMA President said. "These activities are clinically relevant services that will require extra work for the doctors who choose to provide them."

"The announcements are significant incentives for doctors to take part. The Government has delivered a catalyst to accelerate the implementation of the PCEHR."

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The value of GP AMA Membership

Being a member of the AMA helps ensure GPs can get on with their work looking after patients knowing that their own interests are being cared for, according to AMA President Dr Steve Hambleton.

In two videos highlighting the value of AMA membership for GPs, Dr Hambleton says the organisation can look after his interests while he is busy tending to patients.

"AMA is the leading voice for general practice," Dr Hambleton says.

"The AMA in the only independent voice, independently funded organisation that looks out for the interests of GPs."

As part of its advocacy on behalf of GPs, the AMA is currently working with governments on key policy issues including:

- improving care for patients with complex and chronic disease. The AMA plan would see red tape slashed and reward for pro-active quality care;
- encouraging support and training for the next generation of GPs. The AMA is pushing for infrastructure grants to improve training facilities and more funding to support supervisors;
- working to restore funding for GP rebates for mental health;
- getting the Government to go back to the drawing board on Medicare Locals and ensure that GPs at the centre of coordinated primary health care;
- assisting GPs to move away from bulk-billing and to charge a fee that reflects their true practice costs and professional worth.

The videos can be viewed at http://youtu.be/0pdC4myw6sE and http://youtu.be/TxUkcIhPO7c

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Doctors 'critical' to successful PCEHR: Govt report

A confidential Federal Government report has suggested making the use of electronic health records mandatory for "some activities" in order to overcome resistance among some doctors to the adoption of its troubled Personally Controlled Electronic Health Records (PCEHR) scheme.

A confidential Department of Health and Ageing report, completed late last year and released under Freedom of Information laws on 14 August, warned the Government it faced "significant barriers" in convincing doctors to participate in its shared electronic health record scheme because of concerns over compensation, information integrity and system reliability.

Months before the Government relented and decided to allow doctors to bill for time spent preparing and maintaining PCEHR records (see Doctors win billing rights in PCEHR breakthrough, px), the report warned that reimbursement for GPs was one of several actions that would need to be taken to enlist the support of practitioners for the scheme.

In an echo of warnings from the AMA, the report, *The readiness of Australian General Practitioners for the eHealth record*, said the participation of GPs was "critical" to the policy's success.

It said GPs will provide much of the essential information for the system, particularly as many patients were likely to nominate their family doctor as the creator and curator of their shared health summary.

"GPs are also likely to be an important influence on the adoption of eHealth records by patients, and a source of information," the report said. "GPs play an important role in building consumer support for adoption, with 76 per cent of consumers surveyed stating they would be more likely to sign up for an eHealth record if asked to by their GP.

"The successful engagement of GPs is therefore likely to advance the use of eHealth records to improve care delivery and achieve improvements in health outcomes."

But the report acknowledged the extra burden the scheme would impose on the already stretched time and resources of practices and doctors: "All these roles place additional time, resource and financial burdens on GPs, [who] are already known to be time poor, and the negative consequences of any additional time, resource or financial burden associated with this new national system on GPs cannot be understated [sic]".

According to the report, the major concern for GPs about the PCEHR – particularly those most familiar with the scheme – was the lack of reimbursement for time spent implementing and using the system.

It found scepticism was greatest among practice owners and managers, and suggested that to overcome resistance it might be necessary to make the use of e-health records compulsory for some activities.

"Specific training or tools for managers on computerising their systems, or even mandating the use of e-Health records for some activities, may therefore be required," the report said.

In addition to concerns around compensation, doctors expressed doubts about the confidence they could have regarding the accuracy and comprehensiveness of information in shared health summaries, and were worried system breakdowns could undermine their productivity.

Almost 60 per cent of doctors surveyed for the report said system compatibility and the risk of malfunctions were major potential barriers to the successful adoption of e-health solutions.

Underlining concerns about how time-consuming PCEHR-related work might be, 73 per cent of GPs estimated it would take more than 15 minutes to explain the system to patients, and more than half thought it would take more than a quarter of an hour to create a shared health summary.

Reflecting this, inadequate financial incentives was seen as one of the most significant barriers to participation in the scheme, though the potential for improved patient care was listed as the most important inducement to sign up.

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Ensure quality care for asylum seekers, for humanity's sake: AMA President

AMA President Steve Hambleton

AMA President Dr Steve Hambleton has made an impassioned call for the appointment of an independent medical panel to oversee the quality of health care provided to asylum seekers.

In a hard-hitting speech to the AMA Parliamentary Dinner, attended by Prime Minister Julia Gillard, Health Minister Tanya Plibersek, Mental Health Minister Mark Butler and dozens of parliamentarians and senior public servants and health professionals, Dr Hambleton lamented the re-establishment of offshore processing of asylum seekers and urged speedy action to ensure independent supervision of their health care.

"The Australian Parliament has voted for offshore processing of asylum seekers in Nauru and on Manus Island," the AMA President said. "It is now up to the Parliament to ensure that these desperate people seeking a better and safer life have access to quality health services."

The reinstatement of offshore processing brings with it the prospect of indefinite detention, which Dr Hambleton warned was likely to have "a serious mental health impact" on those involved, particularly children.

The Federal Government is facing a large and growing catalogue of compensation action from asylum seekers claiming to have been traumatised by their time in Australian detention centres, and many former detainees held under the previous Government's so-called Pacific Solution have suffered serious mental health problems, with numerous incidences of self-harm and depression.

"Indeterminate detention has a serious mental health impact," Dr Hambleton said. "There is plenty of research evidence of the harm that detention causes to a child's development. We must do the right thing."

He said the most recent figures from the Department of Immigration and Citizenship showed that, as at 30 June, 591 children were in closed detention - more than half of all asylum seekers in detention – while a further 489 were in community detention living under strict conditions, while a further 81 had bridging visas, that allowed them only very limited access to health care and other support.

"The long term detention of desperate people seeking a better life is not good for the health and wellbeing of detainees of any age," he said. "It is a defeat for social justice and fairness. But the contemporary political debate around asylum seekers is far removed from social justice and fairness."

Dr Hambleton called for the appointment of "a truly independent expert medical Panel" to oversee the quality of health services for all detainees, both onshore and offshore.

He said the Panel should be empowered to visit detention centres and inspect their health services – and the access of detainees to them – and provide quarterly reports to Parliament, the Prime Minister and relevant Ministers.

The AMA President said the Immigration Health Advisory Group currently overseeing detainee health services was inadequate to the task and had to be replaced.

"It is limited. Its members are constrained. It does not have the teeth [required]," he said.

Dr Hambleton said that as part of its work, the proposed expert medical Panel would monitor the health services available to the local communities on Nauru and Manus Island who will host the detention centres.

He offered the AMA's assistance in drafting the necessary legislation and providing suitably qualified doctors to serve on the Panel.

"It will add humanity to an otherwise inhumane policy," Dr Hambleton told the parliamentarians.

The AMA's call came amid a brewing stoush between the Commonwealth and the states over access to public hospital services for foreign students and 457 visa holders.

Foreigners are barred from getting Medicare-funded primary healthcare services without insurance, but a report in *The Australian* shows a proportion are using public hospital services while serving out insurance waiting periods, while others have let their insurance lapse altogether.

One Queensland hospital has moved to prevent visa holders receiving anything but emergency obstetric and gynaecological services, and NSW hospitals are being directed to provide only "minimum and necessary" care for visa holders who do not have proof of insurance or the ability to pay.

The Commonwealth has warned such treatment could damage Australia's ability to attract foreign workers and students.

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Senate committee backs AMA call to scrap flawed rating system

A parliamentary committee has called for the much-maligned classification scheme for country doctor incentives to be scrapped as part of an overhaul of arrangements to boost rural health care.

In an outcome hailed by the AMA, the Senate Community Affairs References Committee recommended that the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) system be discarded and replaced with a scheme that takes account of a broad range of factors including location, population, workforce and professional and social factors in determining the allocation of incentives.

The change was part of a range of measures suggested by the committee following its 11-month inquiry into factors affecting the supply of health services and medical professionals in rural areas.

The committee found that there were significant disparities in access to vital health services between metropolitan and rural areas despite efforts over many years to address the imbalance.

"Medical specialist numbers plummet outside the major cities, to levels as low as one-sixth of those in the large capitals," the report said. "Accessibility, particularly in remote areas, is an issue."

It said that while doctors encountered personal and professional barriers to working in rural areas, including income, professional development, housing and opportunities for spouses and children, allied health professionals faced additional hurdles from restrictive Medicare funding arrangements and lower remuneration, which affected the ability to find affordable and secure accommodation.

AMA President Dr Steve Hambleton said the report echoed many of the issues highlighted in the AMA's Regional/Rural Workforce Initiatives Position Statement released earlier this year, and underlined the significant problems that people in rural communities faced in obtaining medical services.

Dr Hambleton said the Committee's findings on the shortcomings of the existing classification system were particularly welcome.

"We are pleased that the Committee has identified the significant weaknesses apparent in the application of the ASGC-RA classification system that underpins Commonwealth programs to support the rural medical workforce, and recommends that it be replaced," he said.

Dr Hambleton said failings in the system, which is currently under review, resulted in many small rural areas being stuck with the same incentive structures as much larger towns, exacerbating inequities in the distribution of health services.

In its report the Committee warned, "there will never be a perfect model that does not result in some anomalies".

"However, evidence provided to the Committee during its inquiry did not support the use of the ASGC-RA scheme in its current form as the sole determinant of classifying areas for workforce incentive purposes," the report said. "Even the evidence in general support of the scheme was heavily conditional on it being augmented with further datasets to provide a more accurate representation of workforce conditions across the country."

The Committee wrote approvingly of a classification model developed by researchers at the Centre of Research Excellence in Rural and Remote Primary Health Care that based the distribution of incentives more on population and professional considerations than geographical location per se.

In their submission to the inquiry the researchers, led by Professor John Humphreys, recommended the use of a classification system in which "sentinel professional and other factors known to be significantly associated with recruitment and retention are used to guide the eligibility for, and distribution of, incentives".

"When these workforce factors are examined in relation to population size and geographical remoteness of communities, population size is a more sensitive measure in directing where recruitment and retention incentives should be provided.

"This new six-level geographical classification provides a better basis for equitable resource allocation of recruitment and retention incentives to doctors based on the attractiveness of non-metropolitan communities, both professionally and nonprofessionally, as places to work and live."

In its report the Committee said it approved the methodology and data utilised by Professor Humphreys and his colleagues, and "would like to see this incorporated into a new scheme".

The Committee also recommended reforms to teaching and training arrangements, including better incentives for rural GPs providing training for pre-vocational and vocational students and the extension of the HECS Reimbursement Scheme for doctors to nurses and other allied health professionals.

Dr Hambleton said the strong focus of the report on supporting teaching and training in rural areas was important, as was increased efforts to encourage more rural students to study medicine.

"The AMA fully supports these approaches, which need to incorporate appropriately funded incentives rather than the current draconian system of unfunded bonding of students to rural areas," he said. "Another welcome recommendation is the need to ensure that Government reforms to after hours GP services do not result in funds being withdrawn from general practices that are currently providing after hours services."

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AMA vows to fight changes to midwife collaboration rules

The AMA has declared war on a move by the nation's health ministers to change collaboration arrangements between doctors and midwives, warning the measure will put the safety of mothers and babies at risk.

The AMA's peak body, the Federal Council, has condemned the proposed changes, which would allow midwives to enter directly into collaboration agreements with hospitals and health services without including medical practitioners, and has resolved to campaign to have the decision reversed.

In a strongly worded speech to the AMA Parliamentary Dinner on 22 August, AMA President Dr Steve Hambleton warned Prime Minister Julia Gillard and Health Minister Tanya Plibersek that the policy about-face was viewed very dimly by his organisation and would be resisted.

"It is a change that brings big risks to patients and quality health care," Dr Hambleton declared. "The AMA takes this change very seriously [and] resolves to campaign against the proposed changes."

As reported in the 20 August edition of *Australian Medicine* (to view click here), the Commonwealth agreed at a meeting of the nation's health ministers on 10 August to "vary the determination on collaborative arrangements to enable agreements between midwives and hospital and health services".

Dr Hambleton immediately condemned the decision, which he said was as dangerous as it was unexpected.

The AMA Federal Council considered the issue as a matter of urgency at its 22 August meeting and passed the following motions:

1. That Federal Council, in recognising that collaborative models of care between midwives and medical practitioners are an essential element of a high quality and safe maternity services system in Australia, calls on the Commonwealth Government to immediately abandon its proposed changes to the National Health (Collaborative arrangements for midwives) Determination 2010 which would permit midwives to enter directly into collaborative arrangements with a hospital or health service.

2. That Federal Council condemns the Government's proposed changes to the National Health (Collaborative arrangements for midwives) Determination 2010 as they:

- *are contrary to original policy intent of the Government to promote collaboration between midwives and medical practitioners;*
- *fail to recognise the significant consultation involved in the development of the existing determination;*
- *will fragment patient care;*
- *will transfer the responsibility for patient care from medical practitioners to non-medical bureaucrats; and*
- *will undermine the safety and quality of Australian maternity services.*

Dr Hambleton urged Ms Plibersek and the Federal Government to re-visit the decision.

"Minister, please don't let the States and Territories railroad good policy," the AMA President said. "We did not expect this change. Let's please talk about it before a final decision is made.

"We want to ensure the best possible care – collaborative care – for mothers and babies."

The West Australian Health Minister, Dr Kim Hames, has been directed to present a paper on long term collaborative arrangements to the peak body of the nation's health ministers, the Standing Council on Health, in November.

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Glasson eyes off challenge to former PM

Former AMA President Dr Bill Glasson is among a field of five candidates contesting Liberal National Party preselection for the Queensland seat of Griffith, held by former Prime Minister Kevin Rudd.

Dr Glasson, who was AMA President between 2003 and 2005, revealed his candidature at the AMA Parliamentary Dinner, which was also attended by Mr Rudd.

Acknowledging the presence of the potential political rivals at the dinner, current AMA President, Dr Steve Hambleton, cheekily suggested to Dr Glasson that "you might like to have a chat with Kevin after the speeches. I can arrange an introduction".

Dr Glasson and Mr Rudd live close by each other in the electorate and know each other well.

The Coalition expects to poll strongly in Queensland in next year's federal election, given the unpopularity of the Gillard Labor Government and the recent landslide result in the state election earlier this year, which saw the Liberal National Party (LNP) swept into power with a massive 71 seat majority in the 89 seat State parliament.

The LNP currently holds 21 federal seats in Queensland, compared with eight held by Labor members.

But the Coalition is sceptical it will be able to unseat Mr Rudd, who is a strong campaigner and popular local member.

At the 2010 election he comfortably held onto his seat despite a 3.8 per cent swing against him, receiving more than 58 per cent of the vote on a two-party preferred basis, compared with his LNP rival Rebecca Docherty, who won 41.5 per cent of the vote.

The result of the LNP preselection for the seat should be resolved by the middle of the month.

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AMA Parliamentary Dinner

Prime Minister Julia Gillard headlined a list of senior politicians including Health Minister Tanya Plibersek, Shadow Health Minister Peter Dutton and Australian Greens health spokesman Richard Di Natale who paid tribute to the AMA at its annual Parliamentary Dinner on 22 August. The following are excerpts of their speeches.

Prime Minister Julia Gillard

Fifty years since the several Australian branches of the British Medical Association merged and created our own national medical association, it's a night to celebrate.

For fifty years you've been advocates – not just on behalf of your members but in the broader cause of health in Australia.

It's quite an achievement that your association, representing your profession, who does from time to time relieve pain for others but give pain to governments, is held in such a respected light.

You've given us the occasional headache, and it's not just this government but governments before. But that's a testament to the power of your advocacy.

I have been working with the AMA for a long time, for around ten years since I became Labor's Shadow Health Minister.

It's good to be able to be with you and think about some of that past, but also to look to the future together.

And in looking to the future I want to speak to you about two important areas where we are doing and continue to do so much good work: Indigenous health and smoking.

Together, we are making progress towards Closing the Gap.

The AMA Indigenous Health Report Cards have been influential in guiding health policies for Aboriginal peoples and Torres Strait Islander peoples for more than a decade now.

They have had a significant influence in our efforts to Close the Gap.

The AMA has been a champion for improving Aboriginal and Torres Strait Islander health.

Your recent *AMA Aboriginal and Torres Strait Islander Health Audit Report* is only your latest important contribution to policy and practice.

You've played a key role in the national debate and just as important, you've played a vital role on the ground, in the communities, with our Indigenous people.

And our public investment is designed to work with you.

Our Stronger Futures in the Northern Territory health initiative is a comprehensive health package to deliver better primary health care, dental and allied health services to more than 65,000 Aboriginal people in the Northern Territory.

It's a lot of work in a lot of areas, but one where we know progress is being made.

It's critical that we speak out strongly on this progress to the Australian community, because the greatest threat to the progress of Indigenous Australians is the false notion that we can't make a difference, that nothing ever works.

It's a journey of countless short steps – not a journey where there are single days of brilliant victory.

But in the fight for better health in our country, there are some of those shining days, and last Wednesday [15 August] was one of them.

The High Court rejected the legal challenge by big tobacco to our plain packaging laws.

Big tobacco threw everything at stopping this – and they failed.

The message here and around the world is now clear: you can beat big tobacco.

It's obvious, when we talk about these issues, that we're all on the same page and I thank you for your support along the way.

It's also obvious that we don't always agree. That's a given in a democracy.

But your expertise and advocacy is invaluable, and there are so many areas where our goals and methods are shared.

You are a staunch defender of our public hospitals.

Your support for the National Disability Insurance Scheme is greatly appreciated.

My Government has put a lot of effort and funding into medical training. We have provided a record number of training places, and you've supported us as we've done it.

Your pressure on the States to provide more intern places and ease bottlenecks in the system in the years to come is important.

You are making a great contribution in the public health area.

Your voice is heard across the board – obesity, alcohol and drug abuse, immunisation, the health of asylum seekers, climate change and health, anti-bullying messages, food labelling, the social determinants of health, mental health.

That's a broad body of work. And it touches and helps many of the more disadvantaged and vulnerable in the community.

A lot has changed in the AMA in the last fifty years, and a lot's changed in our nation too.

But what hasn't changed is the importance of your service and your voice.

TO COMMENT CLICK HERE

Health Minister Tanya Plibersek

We do have a vast number of Members of Parliament here tonight.

I would like to congratulate the AMA on being 50 years young.

It is a wonderful opportunity to be here with all of you.

I know how important the AMA is and what a vital role you play in our health sector.

The AMA is an important voice for doctors and a source of advice to the Government.

It is a strong contest of ideas that produces the best policy outcome, and as Minister I have always been grateful to the AMA for their frank and fearless advice. I do not always take it, but I have always been grateful for the advice.

Through all the debate the AMA has remained for me a valuable link to doctors and clinicians right around Australia.

For years we have been working closely with the AMA and other groups on the roll out of the Government's e-health records system.

And, as a result of that consultation, I want to make a couple of announcements tonight.

First, I can confirm that GPs will be able to bill the MBS for preparing both shared health summaries and even summaries as part of a consultation.

In deciding which item to bill, GPs will only have to consider the reasonable time it would take, not the complexity of the consultation, which I know has been something that has been concerning some of you.

We have worked with the AMA on detailed guidance notes to helps GPs with this, and these will be available on the department's website.

Secondly, I want to confirm that in response to strong representations by the AMA and feedback from GPs, the Government has also decided to delay the PCEHR capability requirement for the e-PIP until May 2013.

We believe that these decisions acknowledge the central role that GPs will be playing in an effective e-health records system.

I look forward to working closely with the AMA and other groups as we roll out this magnificent transformation of health in Australia.

Last week was a terrific week for public health policy. Many are still on a high from that historic High Court victory over Big Tobacco.

It is another fine example of how the Government has worked with the AMA and other organisations to deliver for all Australians.

It was a victory for everyone and every family that has lost someone to smoking.

I remember last year, when Big Tobacco announced it would challenge the Government's plans for plain packaging, the Prime Minister said 'We are not going to be intimidated by Big Tobacco's tactics, whether they are political tactics, whether they are legal tactics, we are not going to take a backward step. There is no compromise. We are going to deliver.'

Well, Prime Minister, you were right.

We were not intimidated, we did deliver and I am very pleased to be here tonight with the Prime Minister and the Attorney General and so many others of you who have been involved in this fight for many decades.

TO COMMENT CLICK HERE

Shadow Health and Ageing Minister Peter Dutton

If institutions could talk they would tell funny tales about different periods of time. From a party political perspective it is amusing sometimes to look beyond our four walls to other political organisations, to the way they interact, to people who have separate state-affiliated arrangements, and to see the goings on in organisations such as the AMA, and I am sure that if the institution could talk, it would talk about 50 years of rich history, some of which I am sure have been repeated from many, many decades, some sets of discussions and deliberations no doubt underway today and tomorrow will have been held in decades past, but I hope not into decades in the future.

I wanted to say in relation to my dealings with Steve Hambleton, with Francis Sullivan - who of course has had a long history around this place in public health policy - and also to the previous Presidents, thank you very much for the professional way you have dealt with us.

I have always thought that a career in the AMA would be some sort of training course for a career in federal politics, considering how rough you play your politics. I suspect that perhaps that it may be the other way around.

If Tony Abbott were here tonight, he would talk about his passion for the health sector, for the time he spent as health minister.

He considers that to be almost the most formative years of his time in this federal parliament, and there is a lot of discussion, of course, around certain political issues at the moment, but if you consider the burden of debt when John Howard came in 1996 - which Campbell Newman has faced coming into Queensland - it makes it very difficult to invest in the sorts of places, particularly in health, that you would want to.

But the first responsibility of Government is that, having paid down debt, you can invest in a number of areas that you would want, and one of [Tony Abbott's] crowning announcements was the $1.9 billion put into mental health in 2006.

It is amazing, when you consider that in 1995-96 the spend in the health portfolio was just under $20 billion. And by the time Tony Abbott left the portfolio with the change of government in 2007 it was over $50 billion a year.

There has, of course, much been made in this Parliament in recent weeks about the Government's changes to plain packaging of tobacco. The other side of the story is the introduction of graphic health warnings, which I think was one of Tony Abbott's greatest achievements as Health Minister.

Of course, the election cannot be far off, and people will rightly be asking what will the Coalition have in store at the next election.

From the Coalition's perspective, we always say that past performance is the best indicator of future capacity, and I think the contrast of the last four years compared with the actions and what was delivered in the preceding 11 years will provide people with a very significant decision to make at the time of the next election.

The Coalition at the next election is committed to taking money away from the ever-growing health bureaucracy. There will be no Super Clinics, there will be no new health bureaucracies, under a Coalition government.

We want to make sure we can get money to the frontline services, to the doctors, nurses and clinicians that can change lives.

That is what you are all dedicated to, and at the time of the next election that is what we will be dedicating ourselves to as well.

TO COMMENT CLICK HERE

Australian Greens Health spokesman Senator Richard Di Natale

My first direct involvement with the AMA was as a fresh faced medical graduate from Monash University.

Soon afterwards, I became an active member and joined the AMA Doctors in Training group, who were aiming to reduce the unsafe working hours for new graduates. We didn't get very far and I'm afraid we've still got a lot more work to do in that area.

I went on to spend the next few decades working in community general practice, Aboriginal health and global public health, and it soon became clear to me that if we are to achieve real progress in health we need to tackle those factors the lie outside the health system.

Our efforts as health professionals are wasted unless we also improve people's access to housing, education, clean air and water, secure employment and participation in community life.

At its core, health is a social justice issue.

I believe this is where the AMA does its best work.

The AMA is strongest when it takes on a bold public health agenda; when it is, to use the AMA's own words, more than just a union.

The AMA has been an important voice in the tobacco control debate, [and] I was really pleased to work with the AMA and a coalition of health groups around the issue of alcohol-related harm.

The AMA has also been an important voice on indigenous issues.

I'd also commend the AMA and Steve Hambleton for speaking out on the harmful health impacts of indefinite mandatory detention for refugees.

I have followed with interest the implementation of the National Health Reform Agenda. In many ways, they are the biggest changes to health policy since the introduction of Medicare.

Many of the reforms we've seen are hospital financing reforms, rather than genuine health reform. They haven't yet led to major changes in the way Australians access health care.

I'm even more interested to see how Medicare Locals develop.

They have enormous potential to ensure that funding is matched to need at a population level.

I understand that the prospect makes some of you nervous about the role of GPs, but general practitioners will remain front-and-centre of primary care.

A core aim of Medicare Locals is to provide the vehicle to reorient the health system away from hospitals to primary care. They will work closely with Local Hospital Networks to make sure that primary health care services and hospitals work well together.

We also welcome developments in e-health. The efficiencies to be gained are enormous.

There will be questions raised about the speed and manner of the implementation, but I think we all agree the end game of networked, real-time and universally accessible access to information will improve health care on the ground.

There will be some things on which the Greens and the AMA will disagree.

The role of pharmaceutical companies in our profession is probably one area. It's always been my view that it is dangerous to underestimate the influence commercial interests can have.

On the vexed issue of private health insurance, we feel that the best way to involve the private sector is to purchase services directly, rather than by subsidising private health insurance. The current subsidy is as inefficient as it is unfair.

But we don't agree with higher penalties for high income earners who don't take it up. That might surprise you, but it runs counter to the principle of universality.

Everyone should have the right to use the public system, just as they have the obligation to pay into it with their taxes.

We don't want to see Australia develop a two-tier health system like the United States.

Our system of universal health care is efficient and fair. It is the envy of much of the world, and we should be justly proud.

The Greens have focused in particular on the area of dental health. It is clearly the greatest area of inequity in the health system today.

We are committed to continue working with the Government to reform the existing scheme and put something even better in its place.

TO COMMENT CLICK HERE

AMA in action

The AMA played host to Prime Minister Julia Gillard and senior Government and Opposition MPs including Health Minister Tanya Plibersek, Attorney General Nicola Roxon and Shadow Health Minister Peter Dutton, who were among more than 180 guests attending the annual AMA Parliamentary Dinner in Great Hall of Parliament House on 22 August. The dinner, which was hosted by AMA President Dr Steve Hambleton, brought together politicians and AMA leaders from across the country. It was attended by more than 30 federal Members of Parliament from all the main political parties, as well as presidents and senior officials from each of the AMA State and Territory branches, together with senior health bureaucrats and leading health experts. The keynote speech was delivered by Ms Gillard, and the guests also heard from Dr Hambleton, Ms Plibersek, Mr Dutton and Australian Greens health spokesman Senator Richard Di Natale. The Parliamentary Dinner coincided with the quarterly meeting of the AMA Federal Council, which was held in Canberra. The day before the Dinner, Dr Hambleton addressed the Australian Medical Students' Association's Leadership Development Seminar in Parliament House, which was also attended by AMA Doctors in Training Committee chair Dr Will Milford and AMSA President James Churchill.

TO COMMENT CLICK HERE

Pre-dinner drinks in Parliament House Marble Foyer

AMA President Dr Steve Hambleotn with Prime Minister Julia Gillard

AMA President Dr Steve Hambleton chats with Attorney General Nicola Roxon

AMA in action

Dr Richard Kidd (2nd from l) with Associate Professor John Gullotta and Liberal MP Teresa Gambaro

AMA President Dr Steve Hambleton with Health Minister Tanya Plibersek

AMA President Steve Hambleton with Chief Medical Officer Chris Baggoley

AMA Queensland President Dr Alex Markwell talks with Health Minister Tanya Plibersek

AMA in action

AMA President Dr Steve Hambleton with participants at the AMSA Leadership Development Seminar dinner

Former AMA President Dr Bill Glasson (r) with AMA WA CEO Paul Boyatzis and former RACGP President Claire Jackson

Former Prime Minister Kevin Rudd with former AMA President Dr Mukesh Haikerwal

AMA President Dr Steve Hambleton addresses the AMSA Leadership Development Seminar at Parliament House

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 diagnose climate health cost, *MX*, 16 August

The Australian Medical Association showing that $6 billion of health spending could be saved by addressing climate change and its causes. AMA President Dr Steve Hambleton said climate change was a significant worldwide threat to human health that "requires immediate action".

AMA President campaigns on midwives and asylum seekers, *6 Minutes*, 23 August, 2012

http://www.6minutes.com.au/news/latest-news/breaking-news-ama-president-campaigns-on-midwives

AMA President Dr Steve Hambleton used the opportunity of the [AMA] Parliamentary Dinner to start campaigns against midwives' collaborative agreements and the detention of children of asylum seekers.

Family GPs hooked on scripts for painkiller OxyContin, *The Herald Sun* 26 August 2012

http://www.heraldsun.com.au/news/national/family-gps-hooked-on-scripts-for-painkiller-oxycontin/story-fndo317g-1226458054965

Australian Medical Association head Steve Hambleton said OxyContin is important for pain management.

Doctors to be paid for e-health work *The Sydney Morning Herald*, 22 August 2012

http://news.smh.com.au/breaking-news-national/doctors-to-be-paid-for-ehealth-work-20120822-24myg.html

Doctors had wanted a separate fee for setting up patient summaries but the Australian Medical Association welcomed Ms Plibersek's announcement they would receive up to $100 for working on e-health records under existing Medicare items.

Radio

Dr Hambleton, *2MCE Orange*, 24 August 2012

The Australian Medical Association says Parliament needs to take responsibility for the health of asylum seekers while in detention. Politicians have been told at an AMA parliamentary dinner an independent panel is vital to observe the health of asylum seekers, and report to Parliament. Dr Hambleton said the panel needs to be above bureaucracy to ensure asylum seekers have access to quality health services.

Dr Hambleton, *5AA*, 23 August 2012

New research shows men should not delay having children because they risk passing on genetic mutations. Scientists have found each year after the age of 20 doubles the chances of mutations in his offspring. Dr Hambleton said the findings should serve as a warning.

TV

Dr Hambleton, *Channel 9 News,* 16 August 2012

http://www.youtube.com/watch?v=_Fbw_NI9Xao&list=UUx5NFeUd5hs3wnViy_LjWrw&index=1&feature=plcp

AMA President Dr Steve Hambleton comments on the decision by the Therapeutic Goods Administration to restrict use of over the counter cough

and cold medicines to children under the age of six.

Dr Hambleton, *Channel 10*, Melbourne, 27 August 2012

AMA President Dr Steve Hambleton discusses this season's influenza strain. He says influenza can affect anyone at any age, and every now and then it will affect someone who is perfectly well.

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

http://www.abc.net.au/news/2012-08-11/doctors-concerned-by-midwife-hospital-deal/4192118

AMA President Dr Steve Hambleton said the move by the Federal and State governments to allow midwives to strike deals directly with hospitals and health services meant they will be able to operate without help from doctors.

AMSA

Medical internship places still lacking as second round offers released

Today, hundreds of medical students will receive internships for next year in the second round of offers, but many still face uncertainty with latest figures indicating that approximately 244 graduates will miss out.

Health leaders of the future converge on Canberra

One hundred of Australia's brightest medical student leaders will today come together in Canberra to discuss pertinent health issues at the Australian Medical Students' Association (AMSA) National Leadership Development Seminar.

AMSA:All talk and no action on internships

Today, the Australian Medical Students' Association (AMSA) is calling for urgent and decisive action to increase the number of medical internships.

Asylum seeker debate lacks humanity – AMSA

Amid hot political debate on processing asylum seekers, the Australian Medical Students' Association (AMSA) is calling upon politicians to recall their humanitarian values.

Senate report highlights need for improved rural workforce planning

The Australian Medical Students' Association (AMSA) welcomes the recent Senate Community Affairs Reference Committee report on the factors affecting the supply of health services and medical professionals in rural areas.

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Pathology and diagnostic imaging request form changes

New laws affecting information that must be provided to patients on pathology and diagnostic imaging request forms have come into effect.

From 1 August, all branded request forms must include a patient advisory statement, which informs patients that they are free to take their referral to a provider of their choice.

The information required is different depending on whether the request form is for a pathology service or a diagnostic imaging service.

Diagnostic imaging request forms

- All branded diagnostic imaging request forms produced and distributed from 1 August must include a statement advising patients that they are free to take their referral to a diagnostic imaging provider of their choice.
- The wording, formatting and positioning of the statement will be at the discretion of the provider but must be obviously positioned to ensure the patient has a reasonable likelihood of noticing and being able to read the advice.

Pathology request forms

- All branded pathology request forms produced from 1 August must include the following mandatory statement: *Your doctor has recommended that you use [insert name of pathology provider]. You are free to choose your own pathology provider. However if your doctor has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.*
- An alternative statement may be used that is the same as above but where the word 'doctor' is replaced with 'treating practitioner'.

In all cases, it will be an offence for pathology and diagnostic imaging providers to produce or distribute branded request forms that do not contain a patient advisory statement.

However, patients who present branded request forms without the patient advisory statement will still be eligible for a Medicare rebate. This recognises that old forms may remain in the system for sometime and providers can only control the distribution of new forms.

It is important that pathology and diagnostic imaging service providers ensure they have up-to-date business and after hours contact details for medical practitioners in their region, not just those in their usual catchment area, in case critical results need to be communicated urgently.

TO COMMENT CLICK HERE

Access to abortion drug opened up

The medicines watchdog has lifted tight restrictions on access to the controversial abortion pill RU486 in a move hailed as an "important milestone" for Australian women.

The Therapeutic Goods Administration has added Mifepristone (RU486) and GyMiso (misoprostol) to the Australian Register of Therapeutic Goods, greatly enhancing access for doctors and women to the drugs, which have until now been subject to tight controls.

The TGA said it had made the decision following rigorous assessment taking into account the safety, efficacy and quality of the medication.

RU486 has been available in Australia since 2006, when ministerial veto over the drug was lifted, but only a small number of practitioners – 187 as at August this year – have been authorised to prescribe it.

But, following last week's decision, registered medical practitioners who have successfully completed a training course will be able to prescribe the two drugs.

The medicine has been sponsored by a not-for-profit subsidiary of Marie Stopes International, which is planning to roll out an education program for medical practitioners, both online and through personally tailored training sessions.

"It is the sponsor's intention that access and distribution will be controlled via successful completion of the training and medical practitioner registration with the sponsor," the TGA said. "The sponsor is planning a comprehensive education program."

Practitioners who have a fellowship or diploma from the Royal Australia and New Zealand College of Obstetricians and Gynaecologists are exempt from the training requirement.

Distribution is expected to be nationwide.

"Based on the sponsor's proposed distribution plan, where a pharmacy is nominated by a medical practitioner recognised by the sponsor as having completed appropriate training to prescribe the medicines, and the pharmacy agrees to supply the product, it will be available," the TGA said.

Health Minister Tanya Plibersek welcomed the regulator's decision, which she said gave Australian women access to medicines that have long been available to millions elsewhere.

"For more than two decades, tens of millions of women throughout the world have used RU486," Ms Plibersek said. "This listing means Australian women will have the same options as women in over 46 countries including the UK, USA, New Zealand and in Europe.

Marie Stopes is considering whether to apply to have the drugs, which are out of patent, listed on the Pharmaceutical Benefits Schedule.

A spokeswoman for the organisation said its intention was to ensure all women had access to "affordable choices in sexual and reproductive healthcare".

The TGA said RU486 was "generally well-tolerated", and since 2006 there had been 792 documented cases of adverse effects, mostly incomplete abortions that required follow-up surgery.

It said common side effects include nausea, vomiting, diarrhoea, dizziness, abdominal pain, headache, vaginal bleeding, uterine spasm, fatigue and chills.

It said there had been rare instances of significant haemorrhage and cervical tearing, and one recorded death in Australia due to sepsis.

According to the TGA, failure rates are slightly higher for medical abortion (between 2 and 7 per cent of cases) than surgical termination, but both were considered to be "safe and effective".

"Experience has shown that bleeding and pain are more significant with a medical termination, but medical termination does not involve an anaesthetic and its attendant risk," the regulator said. "Women may prefer medical termination to surgical termination of their pregnancy, as it occurs in the privacy of home and is less invasive."

It said doctors should confirm pregnancy before administering the medication, and ectopic pregnancy had to be excluded.

"As for surgical termination, follow up is essential," the TGA said in its advice.

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TO COMMENT CLICK HERE

Prostate cancer a grey area for GPs

The majority of GPs are uncertain about how to treat prostate cancer, with 80 per cent complaining the clinical guidelines are confusing and lack clarity, research has found.

According to a study by the Australian Prostate Cancer Research Centre Epworth, around a third of GPs do not refer to any guidelines when testing for prostate cancer, while more than 80 per cent were not confident in managing the sexual rehabilitation and continence problems of prostate cancer patients following treatment.

The findings have been released to coincide with the launch of the Blue September campaign, which aims to raise funds for prostate cancer research.

Dr Jane Crowe, who led the study, said the results showed that there was great uncertainty among GPs about how to treat prostate cancer.

"Clearly more research is required so we can develop better and more accurate testing," Dr Crowe said.

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Govt moves to fill gap in dental health

More than three million children will receive Government-subsidised dental care as part of a $4 billion overhaul of oral health funding by the Federal Government.

In a move hailed by AMA President Dr Steve Hambleton as a "huge improvement", Health Minister Tanya Plibersek has announced the Government will subsidise dental treatment for 3.4 million children and almost 1.5 million pensioners and other adults on low incomes in the next six years.

The initiative is seen as an important advance in an neglected and under-funded area of health care, and will help shield the Government from attacks from both the Greens and the Coalition over the issue of dental health in the lead up to the next federal election.

Ms Plibersek said the Dental Health Reform package was in addition to the $515 million allocated in the May Budget to reduce public dental waiting lists and fund extra training for dentists and nurses.

The Minister said the policy would help fill a gap in the nation's health services.

"While Medicare and free hospital care have been a basic right for Australians for decades, millions of people in this country still go without adequate dental care," Ms Plibersek said. "We have a responsibility to ensure Australians who are least able to afford to go to the dentist, and particularly children, should be given access to government-subsidised oral health care."

Dr Hambleton said the package was a strong acknowledgement of the importance of dental care in overall health, and was a significant advance on current arrangements.

"This is a huge improvement on the existing dental scheme," the AMA President said. "There is less bureaucracy and red tape, and the program is better targeted at those with the greatest need.

"While it is not a universal system, it will go a long way towards improving the dental health of the Australian community."

Dr Hambleton said that GPs saw a lot of patients who had oral health problems but who avoided dental treatment because of the cost.

"This package will give many families the confidence that cost should not be an impediment to good dental care," he said.

Assistance in the package is carefully directed to those in low income households, which are more than twice as likely as the well-off to have family members with untreated tooth decay.

Under the scheme, children aged between two and 17 years whose families are eligible for Family Tax Benefit Part A will be entitled to subsidised basic dental treatment, capped at $1000 per child over a two-year period. The estimated cost of this element of the package is $2.7 billion over six years.

The Commonwealth will provide a further $1.3 billion to State and Territory governments to expand public dental services for low income adults, on the condition that they maintain their current level of dental care services.

A further $225 million has been allocated to build "dental infrastructure" in outer metropolitan, rural and regional areas.

The program will replace the Medicare Teen Dental Plan and the Chronic Disease Dental Scheme, which the Government said was poorly targeted and wasteful.

Ms Plibersek said the package had been devised as a result of "detailed discussions" with the Australian Greens, and legislation to enshrine the new entitlement for children would be introduced during the current Spring session of Parliament, with passage expected by the end of the year.

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TO COMMENT CLICK HERE

Flu losing its grip as season turns

The influenza scourge that has gripped much of the country this winter appears to be petering out.

Official figures show the number of new influenza infections reported by health authorities has declined since peaking in mid-July, with less than 6100 laboratory-confirmed cases between 21 July and 3 August, down from almost 6500 identified in the preceding fortnight.

"Although some jurisdictions have continued to report widespread activity above baseline levels, influenza activity decreased across most of Australia," the Department of Health and Ageing's latest *Australian Influenza Surveillance Report* said. "Influenza-like illness activity has continued to decrease, with current activity levels similar to the peak levels experienced during the 2010 and 2011 seasons."

The exception was Queensland, where the number of cases has continued to increase. In the two weeks to 3 August, the northern state accounted for almost 45 per cent of new cases, with 2664 people confirmed with the infection, compared with 903 in Western Australia, 779 in South Australia, 727 in Victoria, 548 in New South Wales and 347 in Tasmania.

The figures show Queensland has been hardest-hit by the virus, accounting for 31 per cent of all cases nationwide, compared with 21 per cent for NSW, 16 per cent for SA, 13 per cent for WA, 12.2 per cent for Victoria and 3.4 per cent for Tasmania. The territories combined had 3 per cent of cases.

The report said the predominant flu virus this year has been influenza A (H3N2), with "very few" notifications of the pandemic H1N1 2009 virus, which the Department speculated might be due to changes in immunity among the population.

"In recent years the proportion of influenza A viruses circulating in the community has been low," the report said. "This may have led to some reductions in immunity across the population, and thus might be a contributing factor to both the predominance of this virus among the population, and the apparent intensity of the season."

While health experts have raised the alarm about what appears to have been an unusually severe and pervasive flu season, this perception may have been driven more by a rapid spike in infections rather than the total number of cases.

According to the Department, the influenza season began earlier in 2012 than it has in recent years, and the number of cases accelerated much more sharply.

"The intensity of the rise in cases for 2012 has also meant a higher peak in notifications," the Surveillance Report said. "However, the total number of notifications for the entire season (up to 23,553 as at 3 August) may not result in a substantial variance compared to [sic] previous seasons."

The report said that the predominance of the influenza A virus compared with the H1N1 virus has meant that the age profile of those infected has returned to the more familiar patterns of years preceding the 2009 pandemic, with the number of cases peaking among children less than four years of age and among adults older than 70 years.

So far 23 deaths have been officially attributed to influenza, with the median age 74 years.

According to the FluTracking online data collection system, those vaccinated against the flu were marginally less likely to suffer fevers and coughs or lose time from work because of illness than those not immunised.

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TO COMMENT CLICK HERE

TGA admits error but sticks by paracetamol warning

The medicines watchdog has admitted to errors in a warning it issued about accidental paracetamol poisoning following a complaint by toxicology experts reported in *Australian Medicine*.

In a notice posted late last month, the Therapeutic Goods Administration said it had "become aware of an error" in an article outlining concerns that paracetamol could cause harm even when used at therapeutic doses.

But, despite the admission, the regulator has stuck by its warning that paracetamol can cause liver damage even when used as directed.

The warning, published in the *TGA's Medicines Safety Update* Volume 3, Number 4, was heavily criticised by a group of toxicologists at the Victorian Poisons Information Centre, who claimed the watchdog had misinterpreted and misrepresented the studies it cited in support of its announcement.

In the original bulletin (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, which it said showed that "48 per cent [of patients] had not exceeded the recommended maximum daily dose of 4 g[rams]".

But the TGA has since admitted this statement was wrong, as was the citation.

"The text should read 'In a study 662 patients with acute liver failure, 275 were cases of severe paracetamol-induced hepatotoxicity. 131 (48 per cent) of these cases were the result of an unintentional overdose and 19 (7 per cent) of the 275 patients had not exceeded the recommended maximum daily dose of 4 grams," the authority said, adding that the citation should have been to a paper by AM Larson et.al. 2005. "The author and the editor of MSU regret this error."

The admission followed a complaint from Dr Zeff Koutsogiannis, Dr Shaun Greene and Dr Bronwyn Bebee, toxicologists at the Victorian Poisons Information Centre and the Austin Toxicology Service, that the study cited by the TGA showed that "supratherapeutic accidental ingestions make up a significant proportion of the severe paracetamol-induced hepatotoxicity, and not at therapeutic doses."

The doctors argued that to claim, as the TGA had done, that the study showed the use of paracetamol at therapeutic doses can cause hepatotoxicity was "a gross overstatement and misleading."

But despite admitting error in the way it characterised the study's findings, and in the citation, the watchdog refused to back down from its warning about the potential harm from paracetamol use.

"This error does not change the underlying reason for the orginal article, which was to raise awareness among health professionals that in certain situations, paracetamol-induced hepatotoxicity can occur at normal therapeutic doses and, in fact, was the documented cause of death for a 45-year-old Australian woman," the TGA said, adding that risk factors included fasting, regular excessive alcohol use and "concomitant use of drugs that induce cytochrome P450 (CYP) 2E1".

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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TO COMMENT CLICK HERE

Tough TB bug crosses border after defences cut

Pressure is mounting on the Queensland and Federal governments to reinstate funding for tuberculosis clinics in the Torres Strait and Papua New Guinea amid concerns people with drug resistant strains are entering the country in growing numbers.

Doctors warn the decision to close health clinics in the Torres Strait islands in June has forced people coming from PNG with drug-resistant strains of tuberculosis to seek treatment further south, in Cairns, Townsville and Brisbane.

Cairns-based respiratory specialist Dr Graham Simpson told the *Courier Mail* said the country was facing a "slow epidemic" of drug-resistant TB as people infected with the disease in PNG came south in search of treatment.

"Most drug-resistant TB in this state is imported," Dr Simpson said. "It is a slow epidemic, not like the flu season. It takes decades and has enormous momentum. Once it gets a hold, it is hard to stop."

His warning came as an infectious disease expert cautioned that moves to compulsorily screen immigrants for latent TB may not be straightforward, and involved thorny ethical issues.

In a paper in the *Australian and New Zealand Journal of Public Health*, Dr Justin Denholm and colleagues from Victorian Infectious Diseases Service argued that people with latent TB infection posed no immediate risk to the community, and may never develop active tuberculosis.

"Therefore, any attempt to exclude or defer potential immigrants on the basis of latent infection would be disproportionate and unjustified," Dr Denholm and his colleagues said.

While there was little risk involved in testing for latent TB, Dr Denholm said treatment was potentially deleterious, depending on the overall health and age of the patient.

"While testing and medical review could be mandated, a decision to be treated for latent infection should be voluntary, just as it is for citizens," he said.

Dr Denholm said it could also be deemed discriminatory if screening was applied only to immigrants from countries where TB was highly prevalent.

"Such limitations could be discriminatory, but could also be argued as justifiable," he said adding that issues surrounding the accuracy of any screening program would also need to be considered.

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TO COMMENT CLICK HERE

The stethoscope maketh the doctor

Forget the hundreds of hours spent studying anatomy and training in medical techniques, or the years involved in honing skills and developing expertise.

If doctors really want to earn the trust of their patients, all of this effort counts for little unless they wear a stethoscope, according to a study by the Curtin Health Innovation Research Institute.

Just as truckies have their blue singlets and construction workers their hard hats, so too doctors must have their stethoscopes, an investigation into patient responses to online consultations has found.

The researchers, led by Professor Moyez Jiwa, set out to discover ways to enhance the online consultation experience of patients.

Professor Jiwa said in traditional face-to-face consultations patients were able to engage all five of their senses, while in online consults they had to rely on just two – sight and sound.

"If we are to see doctors online, the five senses are not engaged," Professor Jiwa told online newsletter *eHealthspace*. "So, in order to get the best experience online, the doctor must make the most of the traditional medical symbols available."

The researchers asked 168 patients to rank traditional medical symbols including stethoscopes, surgical scrubs and reflex hammers according to the extent to which they inspired feelings of trustworthiness.

"The stethoscope was king," Professor Jiwa said, with 95 per cent of respondents reporting it inspired the greatest feelings of trust.

He recommended that doctors conducting consultations online consider using props, particularly stethoscopes, though he admitted they could be abused by unscrupulous operators.

"It could be very easy to deceive people online," Professor Jiwa said. "You don't need a licence to buy a stethoscope."

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TGA comes down hard on male pills

Authorities are taking a big stick to a black market in illegal male pills they warn pose a "serious risk" to users.

The Therapeutic Goods Administration has warned any shipments of the illegal medications Rock Hard for Men, Ultra for Men and Extra Power detected at the border will be seized and destroyed, and has urged anyone with the products to immediately stop taking them and discard unused doses.

"Rock Hard for Men [and Ultra for Men and Extra Power] poses a serious risk to your health and should not be taken," the TGA said in a safety advisory issued on 29 August.

The watchdog said testing showed that the products contained undeclared prescription substances tadalafil and glibenclamide, despite claiming to be composed entirely of herbal extracts.

Tadalafil is a PDE5 inhibitor, currently marketed in pill form for treating erectile dysfunction under the name Cialis, while glibenclamide is commonly used to control blood sugar levels in people with type 2 diabetes.

The TGA said none of the products had been assessed by it for quality, safety or efficacy, and were being manufactured in a place "not approved" by the regulator.

It said the commercial supply of the products was illegal, and a number of people who had them had bought them online.

The watchdog said it was working with the Australian Customs and Border Protection Service to help stop future shipments entering Australia, and urged people to exercise "extreme caution" when buying medicines from offshore Internet sites, warning they may contain undisclosed or potentially harmful ingredients.

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Former Health Minister faces end to corporate life, Patel gets re-trial

Former Federal Health Minister Michael Wooldridge is facing an indefinite ban from corporate appointments over allegations of a breach of director's duty while at the helm of failed retirement village group Prime Retirement and Aged Care Property Trust.

The corporate watchdog, the Australian Securities and Investments Commission, has launched legal action against Dr Wooldridge and other directors of Australian Property Custodian Holdings, alleging they breached their duties to investors by authorising the payment of a $33 million fee to managing director Bill Lewski when the trust listed on the Australian Securities Exchange in 2007.

According to the *Sydney Morning Herald*, investors pumped $550 million into the float, only to see Prime Trust collapse into administration in late 2010.

If the legal action succeeds, Dr Wooldridge faces having to relinquish his position on the board of a number of other organisations, including the Vision Eye Institute, Australian Pharmaceutical Industries and the Royal Melbourne Tennis Club.

By contrast to Dr Wooldridge's travails, notorious doctor Jayant Patel has won a High Court challenge to his conviction on three manslaughter charges and one count of unlawful grievous bodily harm arising from his conduct as a surgeon at Bundaberg Base Hospital.

An official commission of inquiry led to findings that Dr Patel had negligently caused 13 deaths and, after he was found guilty by a Supreme Court jury, he was sentenced to seven years jail.

But, in a stunning result, the High Court found that there had been a miscarriage of justice at his original trial because the prosecution changed the focus of its case during the proceedings, and had ordered a re-trial.

The prosecution had originally alleged that Dr Patel had generally incompetent and grossly negligent in his treatment of patients.

But after evidence showed that he had performed surgery "competently enough", the prosecution changed its focus to the decision by Dr Patel to undertake surgery.

The High Court ruled that the earlier evidence about the surgery was prejudicial and not relevant to the prosecution's revised case.

Meanwhile, tributes have flooded in for GP and Australian National University academic Marjan Kljakovic, who died following a heart attack last month.

Professor Kljakovic, 57, was Professor of General Practice at the ANU Medical School.

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Ask the AMA first

BY **DR BRIAN MORTON**

"The AMA was successful in obtaining an undertaking from the DHS that they would continue to process claims on the current paper vouchers to allow practitioners time to exhaust their existing supply"

At the recent AMA Parliamentary Dinner every political speaker noted in their speeches the contribution that the AMA makes in its advocacy to health policy development and implementation. Not consulting us and taking actions where unintended consequences have not been guarded against usually results in backflips and political embarrassment.

The Department of Human Services (DHS) recently learned the consequences of not asking the AMA first when they announced that they would cease to provide printed bulk billing forms and by the end of the year would cease processing them. Despite having the opportunity at the June Stakeholders Consultative Group meeting to consult with the AMA on the effect of doing this, they failed to even raise it as something they were considering.

As a result, the announcement was met with some resistance from medical practitioners who typically use paper forms. The feedback DHS received from the AMA and from those directly affected, such as non-computerised practices, locums, after hours doctors, and doctors providing home and residential aged care facility visits, was sufficient for DHS to meet with the AMA to broker better arrangements.

Electronic claiming is a convenient option for patients and practitioners alike; facilitating faster payments claimed at the point of care. It also allows DHS to streamline processing. However it is not an option that works for everyone. Currently, around 7 per cent of bulk bill claims are still made by paper. The DHS is still keen to move as many providers as possible to electronic claiming, but has acknowledged that provisions are needed to support those for whom it is not a viable option.

The AMA was successful in obtaining an undertaking from the DHS that they would continue to process claims on the current paper vouchers to allow practitioners time to exhaust their existing supply. The DHS will also be making some changes to facilitate use of the new online voucher template, and will provide printed copies to those practitioners without access to a computer or printer. In addition, the requirement on practitioners to keep a paper copy of the assignment of benefit for up to two years will be lifted.

This situation has further highlighted to the Department of Health and Ageing that the Health Insurance Act 1973 which governs the assignment of benefits will need to be updated to take account of the electronic environment in which the majority of practitioners now work. Hand signed signatures in this brave new world are inconvenient and fast becoming impractical.

By not consulting with the AMA on the vouchers the DHS created a lot of grief for itself and for affected practitioners as well. Still, some of the best lessons in life are learnt the hard way. Let's hope they've learnt this one.

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Revision of the Medicines Australia Code of Conduct

BY **PROFESSOR GEOFFREY DOBB**

"It must not be forgotten that there is a public benefit in medical practitioners continuing ethical relationships with the pharmaceutical industry"

There has been considerable debate about the transparency of relationships between the pharmaceutical industry and health professionals, including medical practitioners.

The AMA supports transparency of relationships between pharmaceutical companies and health professionals.

The Medicines Australia Code of Conduct already requires its members to publicly report total payments related to educational events. The revised Code submitted to the ACCC for approval will extend the reporting requirement to total payments to health professionals to attend and/or speak at educational events, to participate on advisory boards, or to provide consulting services.

Medicines Australia recently announced a Working Group to examine a range of models that would increase transparency further. The AMA has been invited to participate and we welcome the opportunity to work with Medicines Australia and the other stakeholders to get an outcome that is respected by consumers and the health care community.

Some commentators have called for transparency measures similar to the Sunshine Act adopted in the US, which requires public reporting of payments or benefits to individually named health professionals.

The US is currently the only country that has taken this step, and it has not been smooth sailing to implement this legislation in practice. Reporting has still not begun more than two years after it was passed.

Other countries are considering models that require each health professional to make information available to their patients that describes any relationship with pharmaceutical companies. This way, relevant information is provided directly to individual patients. This approach appears similar to the current model in Australia. The AMA Code of Ethics requires medical practitioners to disclose relevant financial interests to their patients.

I don't want to pre-empt the findings of the Working Group, but if individuals were to be named in a public record, there would need to be strong governance arrangements so that it contains only correct, complete and current information which is presented in a way that allows the public to make accurate and informed judgments about individual practitioners.

It must not be forgotten that there is a public benefit in medical practitioners continuing ethical relationships with the pharmaceutical industry.

Medical practitioners' involvement in, and provision of advice about, the development of medicines contributes to a product that is not only efficacious in a laboratory but also in real-life practice settings.

Medical practitioners involved in the development of medicines are often then best placed to pass on knowledge to their colleagues to ensure they are used appropriately.

Pharmaceutical companies also seek medical practitioners to be on clinical advisory committees to ensure they have access to independent advice and medical expertise.

It is in the best interests of patients that medical practitioners are fully informed about new or improved medicines.

Any new transparency model must be appropriately implemented so that it does not risk discouraging legitimate and ethical relationships.

I welcome your views. Please forward them to ama@ama.com.au.

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Leadership and professionalism in medical education

BY **JAMES CHURCHILL**

"In the interests of the highest quality health care, it is important that Australia's future doctors are equipped with these skills to lead change through health system and workforce reform"

It has been recognised that strong clinical leadership produces better performing health systems, greater clinician engagement and higher quality care. So why have medical schools not been focussed on teaching their students to be leaders?

Australia is in the midst of the biggest health reform since Medicare, with significant initiatives including the implementation of national e-health systems, a restructuring of primary care through Medicare Locals, and a transition to activity-based public hospital funding.

Government agencies including the Independent Hospital Pricing Authority and the National Hospital Performance Authority have been established to maximise the efficiency and performance of health systems.

In addition, there currently exist significant challenges to the maintenance of a sustainable health workforce, including training capacity bottlenecks and a current heavy reliance on international migration.

Continuing with the status-quo has been labelled "untenable", and health workforce reform will no doubt play a central role in shaping the future medical workforce.

In this context, clinician leadership is crucial to lead reforms for a sustainable system which maintains the quality of health care and medical training in Australia. In order to produce sustainable solutions, the medical profession simply must be engaged in these processes of health system and workforce reform.

Recognising this challenge, 100 of Australia's future medical leaders came together to develop their leadership capacity at AMSA's recent National Leadership Development Seminar in Canberra.

Delegates heard from prominent leaders in health and politics, and were challenged to realise their responsibility, as young professionals, to be agents of change for better health.

To date, few Australian medical schools have prioritised the education of medical students in leadership skills and 21st century medical professionalism.

Australian medical education is on the cusp of a revolution, of sorts. The Australian Medical Council's recent review of medical schools' accreditation standards proposed numerous changes which, if endorsed, would significantly increase the profile of social accountability, professionalism and leadership training in medical curricula.

The review proposed, among other things, that there be new graduate outcomes regarding health and society, professionalism and leadership. Skills in health advocacy and systems-thinking form the building blocks for the education of effective 21st century medical professionals, who are responsive to population health needs.

In the interests of the highest quality health care, it is important that Australia's future doctors are equipped with these skills to lead change through health system and workforce reform. A greater focus on leadership and professionalism in Australia's medical curricula is a very positive step in the right direction.

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Reserve Bank in no rush to cut interest rates

BY *AUSTRALIAN MEDICINE* EDITOR ADRIAN ROLLINS

"In a sign that the central bank sees no immediate need to loosen monetary policy, Reserve Bank Governor Glenn Stevens told a parliamentary committee last month that the economy was in a "very respectable position""

The Reserve Bank of Australia appears unlikely to cut official interest rates tomorrow despite a slowdown in China, continuing ructions over sovereign debt in Europe and the lowest inflation in years.

Speculation that further interest rate cuts are imminent were pushed along last month when the decision by BHP Billiton to shelve its massive Olympic Dam project led to declarations that the mining boom was over.

But, even though the terms of trade have peaked (and have actually been gradually dropping for 12 months) and the rate of investment growth is slowing, mining production is continuing to expand and global commodity demand remains solid.

The boom in commodity prices might have ended, but resource investment as a share of gross domestic product is not expected to peak until 2013 or even 2014, and growth in mining exports has a long way to run yet.

The boom in prices might be over, but the resources sectors will remain a strong support for growth for a considerable time yet.

In a sign that the central bank sees no immediate need to loosen monetary policy, Reserve Bank Governor Glenn Stevens told a parliamentary committee last month that the economy was in a "very respectable position".

"We have an unemployment rate of a bit over five per cent; core inflation is two per cent; our government is AAA rated—that is a smaller and smaller set of governments in the world today—our banks are strong; and we have been given, by the global economy, a huge gift by the terms of trade rise," Mr Stevens said. "In the history of the Australian economy, in the time I have been working as an economist, that is a pretty good set of outcomes, I must say. That is not to say we should not try to do even better, but, on a historical reading, you would have to say that is a very respectable position."

Some private sector economists, including Westpac's Matthew Hassan, expect that subdued conditions in much of the domestic economy, combined with volatility associated with a possible break-up of the eurozone and negligible growth in Europe and the United States, will eventually give the RBA little choice but to ease local interest rates further.

So far this year the central bank has cut its cash rate from 4.25 to 3.5 per cent, and it now down 1.25 percentage points from where it was this time last year.

At this level, said Mr Stevens, interest rates were "a little below" their medium-term average.

"With growth close to trend and inflation consistent with the target, but the global outlook weaker than it was and confidence a bit on the subdued side, we have judged this to remain the appropriate stance," the Governor said.

But Mr Hassan said persistent gloom among consumers would undermine domestic growth and eventually convince the RBA it has to reduce interest rates further, predicting the cash rate will eventually have to be cut to 2.75 per cent.

The low inflation rate – the RBA preferred measure of underlying inflation is just below 2 per cent (at the bottom end of its 2 to 3 per cent target band) and headline inflation is growing at just 1.2 per cent – suggests the central bank has room to cut interest rates and stimulate growth if it feels it is necessary.

But it is wary that inflation pressures could build if it presses down harder on the growth accelerator.

Mr Stevens noted that the effect of the strong dollar in dampening price pressures is waning.

"The more moderate growth of domestic costs and prices will need to continue, in order for inflation to remain consistent with the monetary policy objective," he said.

Those do not sound like the words of a central banker on the verge of brining in an interest rate cut.

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More Than Just A Union – a history of the AMA

This is the third 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 David Weedon and Keith Woollard recount their experiences and achievements at the helm of the organisation during Paul Keating's prime ministership and subsequent defeat, and the arrival of Michael Wooldridge as Health Minister in the first Howard Government. 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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Reluctant conductor

BY **DR DAVID WEEDON, AMA PRESIDENT, 1995-96**

In the latter years of my term as President of the Queensland Branch (1983–84), I had the opportunity to attend the Federal Assembly of the AMA. The highlights of the meetings (for a newcomer) were the enforcement of strict rules of debate, and the humour associated with the daily motion to "suspend so much of the standing orders that would allow smoking to occur" for the remainder of the afternoon.

In my early years as a delegate I was surprised that this motion passed, let alone that it was even being considered. Eventually, after several years, I was pleased to be present when the motion was lost and smoking was outlawed.

After an absence of about 12 months from the Federal scene, I was surprised to receive a call in 1988 from Dr Bruce Shepherd, who urged me to nominate for a position on the Federal Council. I accepted, probably because of my susceptibility to flattery, rather then based on any real desire to start a 'career' in the Federal arena. Such was not to be. A few years later, I joined the Federal Executive. As Vice-President from 1993–95, I watched in awe as Brendan Nelson as Vice-President, and then President, captivated his audiences on numerous occasions, even cynical members of the medical profession. His handling of the press was truly amazing, and I marvelled at his ability to think on his feet, and handle all situations. This job was not for me, I remember thinking on numerous occasions.

All was to change. Brendan decided to throw his hat into the political ring by nominating as a candidate for the Liberal Party for the federal seat of Bradfield in 1995.

Nominations for the presidency of the AMA closed on the Friday, a day before the selection of the candidate in Bradfield. I agreed to nominate, along with Brendan Nelson, for the position of President of the AMA. If Brendan was unsuccessful the following day (for which I prayed), I would withdraw my nomination and he would continue on as a very effective AMA President. I thought I was reasonably safe, particularly when some sections of the media turned on the prospective Liberal Party candidate, for reasons that are probably best not canvassed here.

To my surprise and horror, I received a call from Bruce Shepherd at noon on the Saturday. He said he had "good news": Brendan had won preselection and I would be AMA President.

The reluctant President was soon filling very big shoes. I hated every second of the ensuing year, but tried not to show it. Only two incidents of that 'hell year' remain in my mind – the first, a visit to Kirribilli House to meet the Prime Minister of the time, Paul Keating. He was so different to his public image. I will always remember his informal manner, his politeness to a potential thorn in his side, and his frank assessment of all Health Ministers that he had encountered; and second, becoming lost in Parliament House and the then Health Minister, Dr Carmen Lawrence, asking me if she could "show me the door" (in good humour).

I have a personal rule that I try to keep. Never return to an organisation that one

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has previously served. Accordingly, I will not be at the launch of this book, for which I apologise in advance. I broke that rule once in the AMA, and regret very much my brief return to Chair an Extraordinary Meeting of the AMA. Each 'side', including me as Chair, had legal advisers in attendance and the meeting achieved little, and soon was adjourned.

Hopefully after serving for 23 years in AMA politics, I have learnt one thing – how to Chair a meeting. It is like conducting an orchestra – if the wind instruments are too loud, it is essential to silence them; if the violins are too soft one needs to bring them in (to the discussion). There is no place for the beating of drums in an orchestra or meeting. My baton has now been laid to rest.

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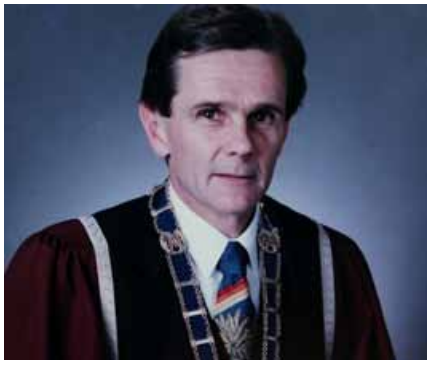
Medical Politics

BY **DR KEITH WOOLLARD, AMA PRESIDENT 1996-1998**



My pathway to the Presidency commenced on a fateful Thursday evening when I went home to have dinner with my family rather than attend a clinical staff meeting at Fremantle Hospital. In my absence, I was appointed the AMA Hospital Representative.

My eyes were opened to the world of medical politics. It quickly became clear that Government was not our friend, but a serious competitor in directing the future of medicine.

The requisite training program to deal with the awesome structures of Government included a long period of training by Peter Jennings, a remarkable State AMA employee who spent his professional career representing our interests to Government and other bodies.

The move into the Federal AMA was not straightforward, given the lack of any direct flights between Perth and Canberra. I settled into a regular pattern of catching the midnight horror to Melbourne with the aid of Temazepam, one hour in the lounge to breakfast and shower, then a short hop to Canberra where I would usually be the first person to turn up for the morning meeting!

There was only one serious hiccup, when I called the renowned Rohan Greenland to ask why he was not there to pick me up at the Canberra airport, only to be told that the meeting was at Sydney airport. Fortunately, the shuttle got me to that meeting on time as well.

I remember my sense of surprise when Brendan Nelson, our best-known President, approached me at a social function and encouraged me to look towards a position as Federal President. With his sudden elevation to serious political life, I was then elected to follow David Weedon.

Not unexpectedly, the main issues during my terms involved conflict with Government, to the extent that the Health Minister, Michael Wooldridge, eventually closed down communications.

Junior doctors had the provider number issue to deal with. They rightly perceived this as a setback for their career prospects, and there was a broader concern within the profession that the restrictions on medical practice held by Government would be used to conscript doctors to unattractive positions. Junior doctors were magnificent in responding to calls for industrial action, and came close to defeating the legislation, but were undermined at the last minute by the Australian Democrats. However, as a result of the strength of their protests, a series of governments since have trod warily in attempting to coerce Australian graduates. The Australian Democrats disappeared subsequent to that betrayal!

To my surprise, the other great issue that arose was the attempt by the health funds to introduce US-style managed care into the private hospital system. Fortunately, the surgeons had been well trained by Bruce Shepherd to protect their interests (and those of their patients). What started off as an offer of substantially higher payments in return for a degree of control over surgical practice by the health funds, ended up being no more than higher payments from the health funds - not a bad outcome for the medical profession.

But my best moment came at a dinner with Michael Wooldridge and representatives of the private hospital industry. We took to him the concept of lifetime health cover, whereby health insurance premiums would be steadily increased for late entrants to the system. To his credit, Michael introduced the proposal (despite advice that focus groups hated it). That single component of the changes to health insurance produced a 50 per cent increase in membership in private health funds and helped underwrite the future of our private hospitals and private surgical colleagues.

My period as President ended when I was defeated by my Vice President. My disappointment at missing out on another year of travelling to Canberra once or twice a week was modest. I remain a proud supporter of the AMA and am especially pleased that we have had such a magnificent variety of Federal Presidents to add flavour and diversity to the organisation.

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HEALTH ON THE HILL

Coalition plays down health plans amid budget concerns

The Liberal Party has taken aim at GP Super Clinics and the health bureaucracy as it seeks to dampen hopes for a major lift in health spending from an incoming Coalition government.

As the Opposition seeks to refine its political message ahead of next year's federal election, Shadow Health and Ageing Minister Peter Dutton has flagged plans to wind back some Government health programs and re-direct funds from the federal public service.

"The Coalition at the next election is committed to taking money away from the ever-growing health bureaucracy," Mr Dutton told the annual AMA Parliamentary Dinner last month. "There will be no Super Clinics, there will be no new health bureaucracies, under a Coalition government."

His comments echoed remarks from Opposition leader Tony Abbott that the Coalition would aim to run a government "slimmer" than that operated by Labor.

Mr Abbott told *The Australian* that more than 20,000 public servants had been added to the federal bureaucracy since 2007.

"I think we can run a slimmer and more effective government in Canberra," he said.

The comments come at a sensitive time, with the Queensland Government coming under increasing attack over massive cuts to its public service and spending, including the controversial decision to axe a statewide influenza immunisation program for health professionals that has come in the midst of one of the state's worst flu seasons on record.

Under the change, local health boards will continue to be offered a subsidy of $8 for doses of the vaccine, but will have to cover the cost of administering the vaccination from within their own budgets.

But in his speech to the AMA Dinner, Mr Dutton was unapologetic about the need for cuts, and indicated that budget austerity would limit scope for spending on health initiatives until government debt was reduced.

"If you consider the burden of debt when John Howard came in, in 1996 - which Campbell Newman has faced coming into Queensland - it makes it very difficult to invest in the sorts of places, particularly in health, that you would want to," the Shadow Minister said.

But, in a more hopeful message, Mr Dutton said that, once the debt was "paid down", there was scope for Government to invest "in a number of areas that you would want".

His comments came as a leading economist, Chris Richardson of Deloitte Access Economics, warned the scale of spending commitments being made by both of the major political parties – most recently the Federal Government's $4 billion Dental Health Reform package – made a return to Budget surplus this financial year increasingly unlikely.

In a sign that Budget concerns are weighing increasingly heavily on the Coalition's health plans, Mr Dutton has refused to set a time frame for the repeal of laws subjecting the private health insurance rebate to means-testing, citing Budget constraints. The Coalition has been a dogged opponent of the change.

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Almost half GP Super Clinics sent back to drawing board

Almost half of the GP Super Clinics in operation had had their official operational plans rejected, figures released by the Federal Government show.

In answer to a question from Liberal MP Dr Andrew Southcott, Health Minister Tanya Plibersek admitted that, as at 11 October last year, 10 Super Clinics were found to have submitted operational plans that were unacceptable and required amendment, while the plans of a further 14 had been accepted.

So far there are 27 GP Super Clinics in operation, with a further five approaching full operational capacity.

But this is short of the Federal Government's original target for 36 clinics to be up and running by the end of June this year, and has underlined concerns about the program since its conception.

AMA President Dr Steve Hambleton said that although the organisation was not opposed to the establishment of GP Super Clinics in areas of demonstrated need, it was concerned the selection of clinic locations was largely a political process.

The Australian National Audit Office is investigating the operation of the program, and the Federal Government withdrew $44 million from the $650 million scheme in the May Budget.

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Future Fund free to invest in tobacco

The Federal Government is resisting a push by the Australian Greens to direct the Future Fund to withdraw investments in tobacco companies.

Greens Senator Dr Richard Di Natale has proposed a Bill calling for the Future Fund, whose portfolio has reached a value of $77 billion, to immediately divest itself of about $200 million worth of shares in tobacco companies including British American Tobacco, Philip Morris and Imperial Tobacco.

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HEALTH ON THE HILL

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But Finance Minister Senator Penny Wong said that although the Government was a world leader in taking action against tobacco products and smoking, it did not support proposals that would infringe on independence of the Future Fund and the conduct of its investments.

"We do not believe that it is appropriate for governments to be hands-on directing investments for the Future Fund," Senator Wong told Palrliament last month. "The Future Fund should exercise its discretion regarding investment independently of the Government and independently of the wishes of particular ministers, senators or MPs."

Otherwise, she said, "you could get to a rather odd position where you might have a politician - for example, Senator [Ron] Boswell – saying that they should not invest in renewable energy because he does not believe in climate change".

The debate followed a second legal defeat for the major tobacco companies when the High Court rejected their application for special leave to appeal a Freedom of Information decision.

British American Tobacco had been seeking access to legal advice provided to Government regarding plain packaging laws.

Both the Administrative Appeals Tribunal and the full bench of the Federal Court had agreed with the Government that the advice was covered by legal privilege, and the High Court refused to hear the case, awarding costs against the tobacco company.

Despite the legal setback, the fight against Australia's landmark plain packaging laws is far from over, an Australian National University trade and legal expert has warned.

Dr Kyla Tienhaara said the laws faced challenge under the terms of the Hong Kong-Australia bilateral trade agreement, as well as through the World Trade Organisation.

Dr Tienhaara said action through the Hong Kong treaty could be particularly dangerous.

"The investor-state dispute under the Hong Kong treaty is particularly concerning for supporters of the [plain packaging] legislation," she said. "Unlike the WTO, there's no exception under the treaty for public health measures. And, unlike in the Australian Constitution, 'exproporiation' is defined very broadly."

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Families lose out for skipping doctor visits

The families of more than children have had their welfare payments docked for failing to take their offspring to see a doctor before starting school.

In a tough new approach to child health, the Federal Government has carried through on its threat to withhold a payment of $726.35 per child from families on income support payments and Family Tax Benefit Part A who did not take their four-year-olds to see a doctor last financial year.

Figures released by the Government show almost 67,000 four-year-olds received a check-up, while a further 27,402 missed out.

The Department of Human Services wrote to 77,000 families late last month reminding them of their obligation to ensure any child turning four years in 2012-13 has their health checked.

Human Services Minister Senator Kim Carr said the health checks, which can be undertaken from three years of age, were important in helping identify and address problems at an early stage.

"Everyone knows how important education is to increasing opportunities in life," Senator Carr said. "Getting a health check will help children's chances of being successful at school. Problems can be identified early, and solutions sought."

But AMA President Dr Steve Hambleton has expressed reservations about a proposal from Deakin University academics for a program to weigh and measure children in schools as a way of combating obesity.

Researchers from the university said there was a need for routinely collected data to monitor the problem, and suggested an opt-out schools program as a way of ensuring extensive coverage and participation.

But Dr Hambleton was among a number of health experts who expressed concerns that weighing and measuring children, unless handled sensitively, could exacerbate problems around body image.

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Watchdog gets extra teeth

The nation's health ministers have moved to strengthen the health practitioner watchdog by increasing the size of its management committee.

Effective today, three extra officials will join the Australian Health Practitioner Regulation Agency's management committee, expanding its membership from five to eight people.

The ministers decided to reappoint all five existing members of the committee, including one-year extensions for Chair Peter Allen and Professor Genevieve Gray, an extra two years for Professor Merrilyn Walton, and an additional three years for Michael Gorton and Professor Con Michael.

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HEALTH ON THE HILL

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They will be joined from today by Ian Smith, of the Western Australia Country Health Service, former Department of Health Victoria Secretary Fran Thorn, and New South Wales Health Deputy Director-General Karen Crawshaw.

In a statement the ministers said staggering the timing of appointments would help ensure continuity and overlap in the committee's membership, while the committee's expansion would play a role in "strengthening and guiding the work of AHPRA in further embedding the safe delivery of the National Registration and Accreditation Scheme".

The appointments followed the selection of 105 practitioners and community representatives to fill vacancies on boards for 10 industry and specialty groups under the National Registration and Accreditation Scheme.

The Australian Health Workforce Ministerial Council, which is comprised of the nation's Federal, State and Territory health ministers, reported there were 274 applicants for 105 vacancies on the boards covering practitioners groups and occupations including the Medical Board, the Nursing and Midwifery Board, optometry, pharmacy, psychology, dentistry, chiropractic and physiotherapy.

About 90 per cent of current board members sought reappointment, and 72 health practitioners were selected from 134 applicants, while 33 community representatives were appointed from the 140 who applied.

Among those reappointed was Dr Joanna Flynn, who is Chair of the Medical Board, while Anne Copeland was reappointed as Chair of the Nursing and Midwifery Board.

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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

More information: Australasian College of Medicine, 02 4573 0775

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INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

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RESEARCH

Male pill hopes rise

The long hunt for an effective and hormone-free birth control pill for men may soon end with the discovery of a compound that cuts sperm counts without affecting the sex drive.

United States researchers have identified a small compound, known as JQ1, which produces a rapid and reversible decrease in sperm count and movement.

When tested on mice, the compound did not affect sex drive or the ability to reproduce later – when doses of the compound were withdrawn, sperm counts rebounded and the mice involved were able to produce healthy offspring.

Lead researcher Dr James Bradner, of the Dana-Farber Cancer Institute in Boston, said he was working on creating an inhibitor molecule that could make cancer cells forget they were cancer, leading to potential new treatments for lung and blood cancers, when he stumbled across the JQ1 compound.

Dr Bradner found that JQ1 inhibited a protein in the testes, BRDT, that is integral to sperm production.

"In mating studies, JQ1 accomplishes a complete and reversible contraceptive effect in males without adversely affecting testosterone levels or mating behaviours, and without prompting obvious birth defects in offspring," Dr Bradner said.

"The cells effectively forget how to make mature sperm, resulting in a profound decrease in sperm count and impaired motility, leading to a complete contraceptive effect. It's really stunning."

Dr Bradner said that although the drug had so far been only tested on mice, it would probably work in humans due to their reproductive similarities.

"As early as next year, we may have a sense of how well this works in humans," Dr Bradner said.

"What was initially a side project in our laboratory has become a major focus of research.

"We're still aggressively advancing a derivative of it as a cancer drug."

The research was reported in the medical journal *Cell*.

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TO COMMENT CLICK HERE

Tai Chi lends balance to the breathless

The Chinese martial art Tai Chi can boost the strength and overall wellbeing of patients with chronic obstructive pulmonary disease, a University of Sydney study has found.

The researchers found that Sun-style Tai Chi is more effective than standard medical care in fostering rehabilitation among those suffering the debilitating condition.

For the study, 42 people with chronic obstructive pulmonary disease (COPD) were divided into two groups: half attended Tai Chi classes twice a week and practiced at home, while the remainder followed usual medical management protocols, which did not include exercise.

The researchers tested the exercise capacity of all participants with a walking test and measured muscle strength and balance, and all participants completed a questionnaire.

Patients who attend the Tai Chi classes performed 75 per cent better in the walking test and had a significantly higher score in the questionnaire than those in the control group.

Lead researcher Regina Leung, a physiotherapist at the Concord Repatriation Hospital, said the study showed that regular Tai Chi improved muscle strength and balance, contributing to an overall increase in exercise capacity and quality of life – results not identified in previous studies of Tai Chi and COPD.

"Improvement in balance and muscle strength of the lower limbs in very important in reducing the risk of falls for people with COPD, who are generally more at risk as their balance tends to be worse than others in the same age group," Ms Leung said.

The study was published in the *European Respiratory Journal*.

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Daily dose of chocolate good for the heart

The self-serving claim of chocaholics that eating chocolate is as good for them as going to the gym may have some substance after all.

A study by University of Adelaide researchers has found that eating dark chocolate may be as effective in lowering blood pressure as increasing exercise or eating a healthier diet.

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RESEARCH

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The researchers reviewed 20 studies examining the benefits of consuming cocoa daily and discovered it could reduce blood pressure by 2 to 3mm of mercury.

Lead author Dr Karen Ried, of the National Institute of Integrative Medicine, said "the reduction in blood pressure achieved with cocoa is somewhat comparable to other lifestyle modifications such as diet and exercise, and may serve as a complementary treatment option".

Dr Ried said the benefits of eating dark chocolate may stem from the flavanols it contains.

"Flavanols are responsible for the formation of nitric oxide in the body, and nitric oxide causes blood vessel walls to relax and open wider, thereby reducing blood pressure," she said.

"High blood pressure is an important risk factor for cardiovascular disease, contributing to about half the cardiovascular events, such as strokes and heart attacks, worldwide and around a third of cardiovascular-related deaths. Evidence from epidemiological studies has suggested that cocoa might reduce this."

However, not everyone is convinced of the benefits. The National Heart Foundation warned that chocolate, despite its antioxidant properties, had high levels of sugar and saturated fat.

The review was published by The Cochrane Library and involved 856 people who consumed 3g to 100g of dark chocolate or cocoa powder each day for between two to eight weeks.

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Research busts redhead pain myth

Research from the Australian and New Zealand College of Anaesthetists has found no evidence that redheads feel more pain than patients with other hair colours.

The study examined the effect of hair colour on anaesthetic requirements and recovery time after surgery. More than 450 patients undergoing general anaesthesia for elective surgery were examined.

Lead author, Melbourne anaesthetist Professor Paul Myles, said the study was prompted by previous research that suggested redheads were less sensitive to general anaesthetics due to variants of the melanocortin-1 receptor gene.

"We expected to find a small difference, with redheads waking up faster after surgery," Professor Myles said. "Although there was an apparent effect, it was not due to hair colour, but to gender.

"We already know that women are less sensitive to general anaesthetics and, once we accounted for gender imbalance, the effect of hair colour was negligible.

"The basic science is quite compelling and is still likely to be true.This is because the genes that determine both the hair colour and pale skin of redheads probably influence how anaesthetic drugs act on the brain."

The research was published in *Anaesthesia and Intensive Care*.

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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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Trade laws may stump plain packaging push in New Zealand

A United States Government push for stronger intellectual property protection in international trade treaties threatens to derail a push for plain tobacco packaging in New Zealand.

NZ Prime Minister John Key has warned that the introduction of plain packaging laws in his country was not "a slam dunk by any chance", despite strong support within the Government and the broader community for measures to curb smoking, according to a report in *The Conversation* by Professor of Population Health at the University of Auckland, Alistair Woodward.

Professor Woodward said that the NZ Government was torn between a desire to follow the Australian Government in taking strong action against smoking, and concern that plain packaging laws could breach existing trade rules and complicate its negotiations for inclusion in the proposed Trans Pacific Partnership Agreement (TPPA).

The US is pushing for stronger intellectual property and investor protections in the Agreement, which the NZ Government is keen to be a party to.

In a high-profile campaign in NZ against the proposed plain packaging laws, the tobacco industry has warned that the policy would infringe its intellectual property rights, which is the argument it unsuccessfully put to the Australian High Court last month.

In their legal challenge to the Australia's world-leading plain packaging laws, the tobacco companies had claimed the new measures amounted to an 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 trademarks from all cigarette packets, they did not weaken the companies' exclusive ownership of their trademarks.

But the Australian laws are still being challenged at the World Trade Organisation, and the NZ Government appears wary of being the subject of similar action.

Greens parties in Australia, NZ and Canada have issued a joint warning that proposed provisions in the TPPA could restrict the ability of governments to introduce laws to protect and enhance public health.

They claim that a draft investment chapter of the Agreement, which is currently being negotiated by governments from Australia, the US, Canada, New Zealand, as well as several other nations, contained proposals that would severely limit the ability of governments to act to protect public health and ensure access to safe and affordable medicines.

"Leaked details of the TPPA reveal that foreign investors and firms could sue Canada or New Zealand in a private international tribunal if their parliaments or local councils pass laws that reduce their profits or adversely affect their businesses," Australian Greens Senator Peter Whish-Wilson said. "This could include laws such as a requirement for large graphic warnings or plain packaging of cigarettes and other tobacco products."

In his article, Professor Woodward cites concerns that the threat of action alone may be enough to discourage other governments following Australia's lead, given the cost of defending such actions and the uncertainty of outcomes.

Professor Woodward said the issue is shaping as a key test of the NZ Government's resolve in meeting its target to make the country smoke-free by 2025.

"This is the importance of plain packaging," he said. "It is a test of government commitment to tighten the screws on supply, to continue the shift from viewing tobacco as a consumer commodity to treating it as a hazardous substance, and to balance the virtues of global trade against what is needed for health protection at home."

Meanwhile, the Australian Government has rejected a push by health insurers to charge a higher premium for smokers.

Reaffirming the principle of community rating, Health Minister Tanya Plibersek told the *Sun Herald* people should be charged the same premium regardless of the state of their health, and cannot be charged more based on genetic conditions or other factors affecting their wellbeing.

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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, Coogee Beach, New South Wales, on 10-11 October.

For registration and further details, visit:

www.suicidepreventionaust.org/conferences

TO COMMENT CLICK HERE

Spike in UK measles cases triggers vaccination warning

Britain is experiencing its worst measles outbreak in years, adding urgency to calls for parents to ensure their children are vaccinated against the potentially deadly disease and other harmful infections.

Official figures show the number of measles cases in England and Wales virtually doubled in the first half of this year compared with the same period in 2011, with more than 960 children infected.

According to a report from the *BBC*, most cases have been linked to travel to other European countries.

According to British health authorities, 93 per cent of children younger than 13 months have been vaccinated against measles, mumps and rubella, while 87 per cent of older children have been administered a follow-up dose.

Head of immunisation at the United Kingdom's Health Protection Agency, Dr Mary Ramsay, said rates of vaccination against the illnesses had improved in recent years, though sufficient gaps in coverage remained to allow the disease to flourish in pockets of the population.

"Some children do not get vaccinated on time and some older children, who missed out when uptake was lower, have not had a chance to catch up," Dr Ramsay told the BBC. "Therefore, there are still enough people who are not protected to allow some large outbreaks to occur among unvaccinated individuals."

In Australia, where rates of immunisation are similar to those in Britain, the incidence of the disease has been much lower.

There were just nine cases of measles in the country in the first four months of this year, with the annualised rate of incidence just 1.8 per 1 million people – well down from last year when there were 192 cases and the incidence rate reached 8.5 people per 1 million.

Across Europe, the average rate of incidence of measles in the first six months of the year was close to 30 per 1 million, and ranged from almost 275 per 1 million in the Ukraine, to 79 per 1 million in Ireland, between 20 and 26 per 1 million in France, Belgium, Italy and the United Kingdom, and 4.1 per 1 million in Germany.

In Australia, WHO figures show that last year measles were most common among infants and toddlers less than two years old, and in children aged between 12 and 15 years. In almost all instances those infected had not been immunised.

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Kiwi chemists take on the chronically ill

Australian pharmacists are being briefed on a controversial scheme under which their New Zealand colleagues are to manage patients on chronic therapies in exchange for forgoing dispensing fees.

According to the New Zealand Government, all 947 of the country's pharmacists have signed up for a three-year transitional agreement under which they are guaranteed an incremental rise in revenue in exchange for taking on a greater role in managing patients.

Details of the scheme will be presented to the Pharmaceutical Society of Australia Congress next month.

Announcing the event, the Society said the scheme offered a way for pharmacists to "better use their clinical skills and expertise within the primary health care team".

"The deal is aimed at moving pharmacy from being paid solely by a medicine dispensing fee, to a patient-focused payment model," the Society said in a statement.

"The new agreement rewards pharmacists for providing support and advice so patients can better manage their medicines and medical conditions.

"This will benefit patients, especially [the] approximately 200,000 New Zealanders with long-term conditions."

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TO COMMENT CLICK HERE

Are conscientious objectors wrecking our immunisation program?

BY **PROFESSOR STEPHEN LEEDER**

There is an ineradicable mystique about immunisation.

The mystique occurs because, by immunisation, biologically active material is introduced into the body of the recipient that is destined to alter his or her body's functions.

In symbolic and real ways, immunisation is unnatural. Occasionally things go wrong and, because the population being immunised is healthy and these side effects are caused not by a treatment but by a preventive agent among otherwise fit people, concern runs high.

Immunisation coverage is currently around 94 per cent for two year olds nationally. But resistance to immunisation is intense enough among perhaps 1 to 2 per cent of parents to drive a decline in overall immunisation. These parents may worry that they are not doing the right thing for their child by agreeing to have him or her immunised. The worry may grow as more vaccines are added to the list of those required.

A new approach to encouraging immunisation shifts responsibility and reward from the doctor to the patient or parent. As of May 2013, all GP immunisation-related payments will cease, with the exception of the Australian Childhood Immunisation Register (ACIR) notification payment. From that date, the incentives will be directed at parents. Unless they either immunise their children on time or declare themselves to be conscientious objectors (COs), the majority will forfeit up to $2178 in the Family Tax Benefit Part A.

Incentives for immunising one's child are not new in Australia. But in the past they were smaller, and it took time for parents who did not want their children immunised to become aware of what was on offer. Consequently, there has been a small increase – from 0.23 per cent in 1999 to 1.44 per cent this year – in the proportion of parents registering as COs.

The new system – of linking the Family Tax Benefit Part A with full immunisation – still has a get out clause. COs do not have to have their children immunised, and yet they will still receive the payment. Should we be worried?

Dr Julie Leask, a research fellow and public health academic at the National Centre for Immunisation Research and Surveillance in Sydney, writes: "Prospectively, the registered conscientious objector rates will increase as the new larger incentives come into play – possibly to 2 or 3 per cent. This will be because more parents (who were otherwise not bothering to register as conscientious objectors for just $200) will now make the effort to register because they stand to lose up to $2178."

How far should we go in pressing the case for universal immunisation? Three observations are pertinent in forming a policy response.

First, you don't need everyone to be immune to prevent an epidemic occurring. If 90 per cent or more are immune, they create sufficient fire breaks to prevent the easy transfer of most infectious diseases. So, good levels of public health could be maintained even if the CO rate climbed substantially – which it is not likely to do in real terms.

Second, the ethical context is complex. Strong incentives may raise the immunisation rates but damage voluntarism, just as paying for blood for transfusion in other countries erodes the ethic of giving gifts. While incentives have helped maintain high immunisation coverage, reservations exist about highly disadvantaged groups missing out because it's just too hard to get vaccinated on time.

Third, with regard to compulsory immunisation, a distinction exists between compelling parents to immunise their child for their child's sake and compelling them to be immunised for the sake of the community – to assure herd immunity.

The essence here is about ensuring all groups can get easy access to immunisation.

The erosion of provider incentives may be unfair by not removing the 'push', and depending only on the 'pull' to encourage immunisation.

The last words belong to Dr Leask: "I would warn people to be very careful about over-interpreting increases in CO rates and coverage drops in the next year or two. "Next year, varicella, meningococcal C and pneumococcal vaccines will be included in the 'fully vaccinated' algorithm for children aged less than five. This may create an appearance of a decline in immunisation rates as the criteria for full vaccination become stricter."

I agree. In practical terms we are not facing an immunisation crisis.

TO COMMENT CLICK HERE

The Return To Terroir - Organic Champagne

BY **DR MICHAEL RYAN**

One of the reasons I find wine so alluring is the sense of existence it creates. The reflection of its terroir and the wine makers guiding hand amalgamate to form an often indescribable libation that truly is a living thing. Organic Champagne fits these criteria and stamps its own indelible mark on the consumer's senses.

Organic Champagne producers are tiny in the scheme of things. Some may make only 3000 bottles from single vineyards, whereas larger houses like Moet may make several million bottles that are sourced from up to 80 vineyards. These grandiose houses believe in the continuity of style and expression, whereas terroir-focused vintners let a wine's idiosyncrasies shine.

The use of natural yeasts is encouraged to aid in forming a wine with soul. There is a sense of honesty from these growers. On their labels you can find relevant information such as the percentage of the blends, the date of disgorgement, whether a dose of liqueur is added after disgorging, and if they are organic or biodynamic.

An importer with a bent towards organic Champagne is Nesh Simic, based in Noosa. He has a strong interest in health and well being, having Bachelor's degree in Health Science from his native country in the former Yugoslavia, and this has transferred to all things organic. He works in the organic food industry and exudes a palpable sense of passion for things organic – one fuelled by his inclination to sail against convention.

Nesh has visited many organic Champagne producers, and he tells me of their "Return to Terroir" campaign. This group includes Champagne producers such as Fleury, Bedel, Frank Pascal, Courtin and David Leclapart and they, together with many other growers from different appellations, want the wine to be as natural as it can be.

A criticism levelled at these producers is the variability of their vintages. But this tests the skill of the grower and the maker, who are often one and the same. Some years may be dull in comparison to others, but some are simply stellar. Personally, in this world of homogenous processed taste, I welcome this philosophy.

Nesh proudly credits organic Champagne for meeting the woman who has since become his wife. She was looking for a bottle of wine in a shop he worked at. He simply gave her a bottle of 95 Fleury Organic Champagne to her free of charge, and this led to a whirlwind romance. Who knew a bottle of Champagne could have such consequences? Nesh's wares can be found at www.organicchampagne.com.au

Wines Tasted

Fleury 2004 Cepage Blanc de Blancs

This is 100 per cent Chardonnay, and displays bread and yeast-like notes, with hints of candied lemon. The palate is full and generous. This is a rich wine that would suit duck liver pate.

Fleury NV Champagne

Strawberries and citrus notes with floral influences combine to give a lifted crisp palate. This is a very clean yet complex Champagne that I would pair with Sashimi.

Francois Bedel NV Entre Ciel ET Terre

There is an alluring, delicate light yellow colour that is ironic, as this is made from the black grapes of Pinot Mineur (80 per cent) and Pinot Noir (20 per cent). The nose is a delicate blend of apples, figs and almonds. As the wine opens up, smokey bread-like characteristics emerge. The palate is uplifting, with a citrus-like burst of acid, followed by a sustained structure. Try with a plate of charcuterie meats.

Jose Ardinat 2004 Blanc de Blancs

Floral nuances abound on a platform of apple and pears. Subtle yeast notes help give this Champagne a complex but crisp palate. Creamy Sydney rock oysters are perfect.

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