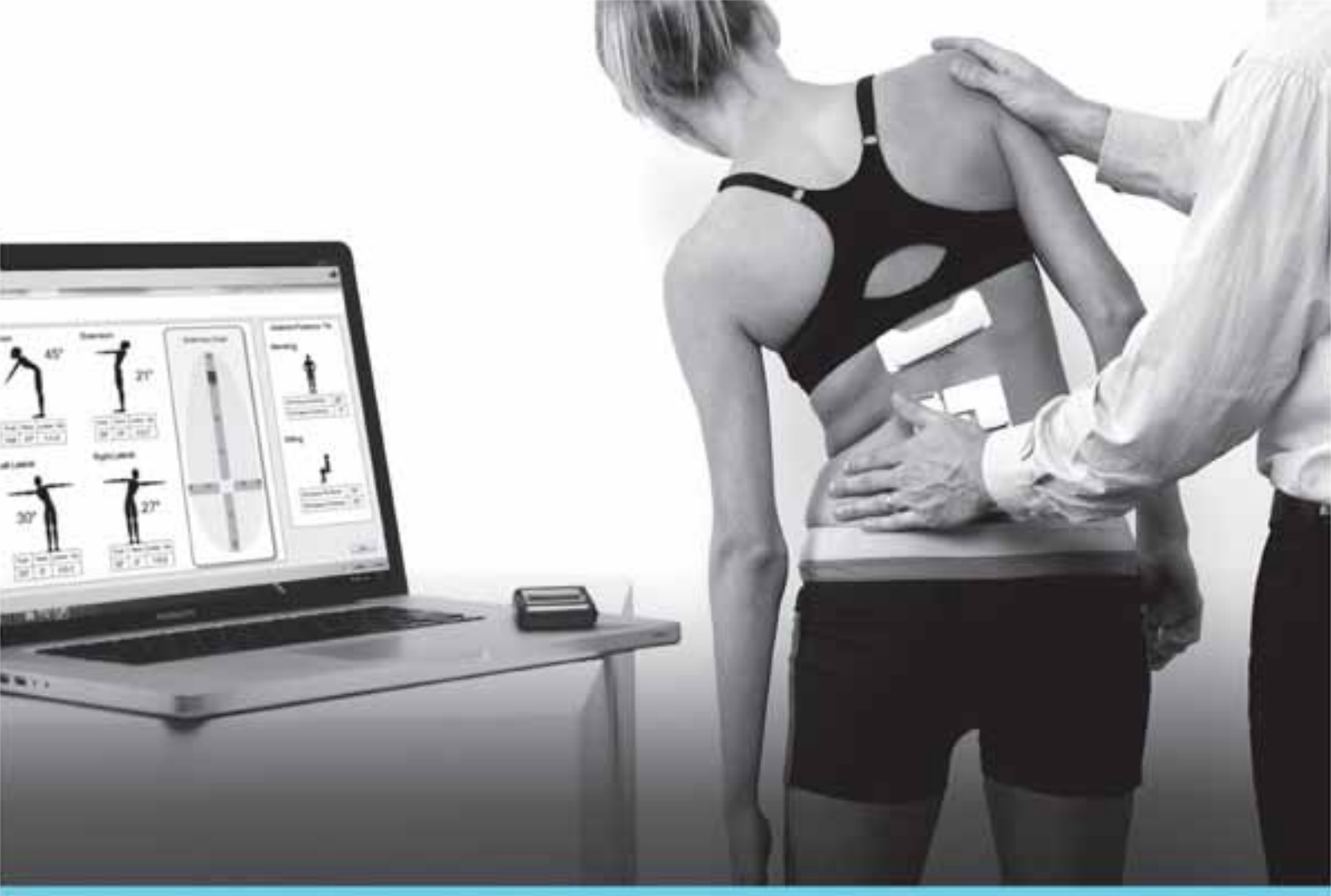
AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Doctors dudded on e-health

No new MBS funding for PCEHR - Page 6, 11

Inside

ISSUE 24.7 - APRIL 16 2012



Making Low back pain less complex

Advance your low back assessment and treatment to a new level with Vi Move

Imagine if one system enabled you to:

- Receive clinically validated objective data on how your patients move both in the clinic and throughout their normal daily activities
- Gain insights into what movements and postures may be aggravating their pain
- Provide a visual snapshot to your patients as to why they have Low back pain
- Show progression and functional improvements over time
- Evaluate the effectiveness of treatment regimes
- Manage low back pain better and more efficiently

And do this easily and efficiently yourself or through your practice nurse.

NEW World first wireless sensor technology

Vi Move

dorsaVi
Inspiring the world to move

For more information on dorsaVi's new system:
www.dorsavi.com | info@dorsavi.com | 03 9652 2198

www.peugeot.com.au

New Peugeot 508.
Quality time.

AFTERCare
ASSURED
SERVICE PLAN

There's no substitute for a little indulgence. And the meticulously crafted 508 range is no exception. The perfect balance of luxury and contemporary design, it delivers an unparalleled driving experience in both sedan and Touring wagon forms. With an exquisitely contoured exterior and advanced Euro 5 petrol or HDi diesel engine technology, the drive is as responsive to you as it is to the environment. Add to that our Assured Service Plan, guaranteeing a remarkably low price for each of the required services in the first three years of the car's life, and you have a range of luxury cars that impress at the very highest level. Schedule yourself a little quality time every day with the new Peugeot 508.

AMA Members now eligible for National Fleet Rebates.

MORE ABOUT 508

WATCH TV AD

PEUGEOT
MOTION & EMOTION

AUSTRALIAN
Medicine

Managing Editor: John Flannery
Contributing Editor: Dominic Nagle
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford
Writer: Debra Vermeer

Graphic Design:
Streamline Creative, Canberra

Advertising enquiries
Streamline Creative
Tel: (02) 6260 5100 Fax: (02) 6260 5200

Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

42 Macquarie St, Barton ACT 2600

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

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

IN THIS ISSUE

NEWS

REGULAR FEATURES

Alternative therapies not fitting the 'bill'

BY AMA VICE PRESIDENT PROF GEOFFREY DOBB

Registration of medical practitioners was started in Britain in 1858 so the public could identify those who had undergone medical or surgical training sufficient to become 'registered medical practitioners'.

It was a means of protecting the public from untrained or partially trained 'quacks' at a time when there were many charlatans claiming to have medical credentials or have a 'cure'. The *Medical Act* didn't prevent others from providing alternative treatment, but it did provide penalties if the alternative practitioners pretended to be 'registered'.

In Australia, medical registration and regulation are now undertaken through Australian Health Practitioner Regulation Agency (AHPRA) - subsumed into the same body as osteopathy, chiropractic and Chinese medicine practitioners. It is unclear if this has caused confusion to health consumers, and I can't find any research that suggests they have been asked.

The blurring of boundaries between evidence-based health professionals and the complementary or 'alternative' health practitioner seems set to become ever greater. Supplements extolling the virtues of unproven treatments fill our newspapers and afternoon radio time-fillers by breathless marketers of their own 'natural' or homeopathic cures give these products an unjustified patina of respectability.

Supporters of 'quack' therapies suggest it is just a matter of personal choice. In any case, it is said that even if seeking out 'alternative' health solutions does no good, at least they do no harm, and that the 'alternative' health consultation provides people with an opportunity to talk about their health issues to a sympathetic ear.

If only the diversion to complementary and 'alternative' therapies did not harm! I think of the young man with insulin dependent diabetes who was convinced to stop his insulin and instead rely on a very special diet - so special he was brought unconscious to our Emergency Department with an arterial pH less than 6.8 and severe diabetic ketoacidosis. I think of two ladies already this year - one 'treated' by a Chinese medical practitioner - who have needed hospital admission with thyrotoxicosis so out of control that in one instance it had progressed to severe heart failure from tachycardia-induced cardiomyopathy.

I think of the toxicities and drug interactions from 'complementary' treatments that have also resulted in hospital admission, and added considerably to the costs of health care.

When a patient's diagnosis is delayed or denied by spurious substitution of non-existent 'allergies', 'mineral imbalance' or other 'quack' explanation, the results can be tragic. The widely reported critical delays in the treatment of Apple founder Steve Job's pancreatic cancer while he had 'alternative' therapy may have shortened his life and shows us that no one is immune from the temptation to hang on to fantasy when confronted with a life-changing diagnosis.

I find it interesting that there are so few complaints against 'alternative' and complementary therapists. Is it because when the 'treatment' fails people are ashamed to admit to their gullibility?

The costs to mainstream health provision are only a part of the story. The many dollars diverted into complementary and 'alternative' treatments - and this is an industry worth over $1 billion a year - reduce the economic input available for proven life improving or life extending treatments.

Some of our universities are also on the gravy train of complementary and 'alternative' therapies. Is it just fiscal pressure or a desire to offer 'trendy' courses? Whatever the motivation, it undermines the universities' credibility in the eyes of many.

'Alternative' therapies that are shown to work are rapidly incorporated into mainstream medicine.

The supporters of 'alternative' medicine will point to everything from aspirin to anti-malarials and antibiotics that can be shown to have a link, however distant, to 'natural' products. The fact that new medicines need to have considerable evidence for efficacy and safety before they are approved by the Therapeutic Goods Administration (TGA) is then rarely contrasted with 'alternative' or complementary medicines. These are listed by the TGA without any assessment of efficacy with the companies supplying them merely having to state to the TGA that they hold evidence to support the claims they make. These claims can be as vague as, 'You'll feel better'.

Nevertheless, the pseudo-respectability of a TGA listing seems all too easy to obtain despite Ken Harvey stating in *Australian Prescriber* that this has led to "a proliferation of products of dubious efficacy, with promotional claims that cannot be substantiated."

CONTINUED ON PAGE 8

AMA items for the PCEHR

The AMA has introduced its own items for preparing and managing a shared health summary for the Personally Controlled Electronic Health Record (PCEHR).

AMA President Dr Steve Hambleton said that the Government had not created new items for doctors' time and work with patients on the PCEHR and had not allocated any new funding in the Medicare Benefits Schedule (MBS) to cover this new clinical service to be provided by doctors.

"The public announcements from the Government suggest that patients will only get a Medicare rebate if the shared health summary is prepared as part of an existing MBS consultation," Dr Hambleton said.

"GPs are being asked to do more work in their consultations for no reward. We have sought more information and clarification but no formal public response has been forthcoming.

"So the AMA has taken the initiative to give doctors and their patients some certainty by setting items that realistically reflect the time, the work and the expertise required to ensure that shared health summaries are thorough, up-to-date, and useful across healthcare settings.

"The items provide guidance to AMA members on medical fees for this important clinical service for their patients. It is not a recommended fee. The AMA encourages its members to set their own fees based on their practice cost experience.

"The AMA items are time-tiered and can be billed in addition to any consultation that is provided to the patient on the same day.

"The AMA is a strong supporter of the PCEHR and the benefits for patients and the healthcare system – but we have to get it right the first time," Dr Hambleton said.

The AMA items for preparing and managing a Shared Health Summary for the PCEHR are as follows:

AMA Number Fee	Description of Medical Service
AA340 $53.00	Professional service initiated by the patient and rendered by a medical practitioner to prepare and/or manage a Shared Health Summary for the patient's Personally Controlled Electronic Health Record – A service of not more than 15 minutes duration
AA341 $104.00	A service of more than 15 minutes duration but not more than 30 minutes duration
AA342 $154.00	A service of more than 30 minutes duration but not more than 45 minutes duration
AA343 $210.00	A service of more than 45 minutes duration

Background:

While the Government has acknowledged that preparing the Shared Health Summary will require extra work for the medical practitioners who take on this role, it has not said that separate Medicare rebates will be available to assist patients with the costs of this medical service.

At this time, Medicare rebates will only be available if the Shared Health Summary is prepared as part of a consultation. In other words, the costs of this service will have to be absorbed by existing consultations.

The Shared Health Summary is a key feature of the PCEHR. It is also a new clinical service for medical practitioners that will need to be factored into current clinical practice. It is appropriate for medical practitioners to raise separate charges for it.

Last week, the AMA released the draft *AMA Guide to Using the PCEHR* to assist medical practitioners and their practices to consider if, and how, they might use the PCEHR in their day-to-day practice.

JF

TO COMMENT CLICK HERE

Doctors' health services

In a submission to the Medical Board of Australia (MBA), the AMA has called on the Board to fund better access to doctors' health services across the country.

AMA President Dr Steve Hambleton said that the AMA's submission to the MBA highlights evidence that doctors are at greater risk of mental illness and stress-related problems and are more susceptible to substance abuse than the general population.

"In order to deliver high-quality health care to their patients and the community, and to experience medicine as a rewarding and satisfying career, doctors need to be well," Dr Hambleton said.

"Research has consistently shown that doctors with healthy personal lifestyle habits are more likely to impart healthy behaviours to their patients.

"The experience of existing doctors' health advisory services and the available evidence in the literature supports structured and accessible programs to assist doctors to maintain their health and access appropriate health services.

"This would be good for doctors and patients alike, and it could encourage doctors to engage earlier with high quality care.

"The AMA believes that doctors' health advisory services are in the public interest and, as such, should be funded by the MBA from the existing pool of doctor registration fees," Dr Hambleton said.

The AMA proposes that the MBA provide funding for existing doctors' health advisory services, which have established networks and strong local knowledge. Prior to the introduction of national registration, the MBA funded services in some States.

While the MBA has a role to play in funding external doctors' health advisory services, funding arrangements must be structured so as to guarantee independence from the MBA and the Australian Health Practitioner Regulation Agency. This is essential if doctors are to trust these services and utilise them at an early stage in their illness.

Medical registration fees have increased dramatically since the introduction of national registration arrangements, so the AMA recommends that these services should be funded from the existing registration fees paid by the profession.

Prior to lodging the submission, the AMA surveyed members to get their views on doctors' health services.

Nearly 75 per cent of the 2057 survey respondents agreed that doctors' health advisory services are an essential support for medical practitioners, particularly in times of distress.

The AMA submission to the Medical Board of Australia is available at http://ama.com.au/node/7695

JF

TO COMMENT CLICK HERE

Genetic testing and human cloning

The AMA has updated and split the content of its *Position Statement on Human Genetic Issues 1998. Revised 2000. Revised 2002.* to produce the AMA *Position Statement on Genetic Testing 2012* and the AMA *Position Statement on Human Cloning 2012.*

The AMA Position Statement on Genetic Testing 2012 is more contemporary and reflects current issues relevant to genetic testing.

The AMA *Position Statement on Genetic Testing 2012:*

- recognises that genetic testing is now increasingly part of mainstream health care;
- provides greater detail on the types of genetic tests currently available;
- advocates for appropriate education and training of the medical (and other health care) professions on the clinical and social issues related to genetic testing;
- advocates for a sufficient workforce and infrastructure to support the use of genetic testing in mainstream health care;
- recognises the role of genetic support groups and community organisations;
- recognises the uncertainty around incidental findings – including the need for appropriate call back;
- addresses direct-to-consumer genetic tests;
- promotes the need for public education and awareness campaigns;
- maintains the AMA's position on gene patents; and
- maintains the AMA's position on genetic selection ('eugenics').

The AMA *Position Statement on Human Cloning 2012* retains the existing AMA policy of opposing cloning for the purposes of creating a human being (reproductive cloning), while permitting cloning for other (non-reproductive) purposes (eg., cloning of human tissue for therapeutic purposes).

The AMA *Position Statement on Genetic Testing 2012* is at http://ama.com.au/node/7663

The AMA *Position Statement on Human Cloning 2012* is at http://ama.com.au/node/7664

JF

TO COMMENT CLICK HERE

Rural workforce plan

The AMA last week released the *AMA Position Statement on Regional/Rural Workforce Initiatives 2012*, which sets out a practical, achievable plan to attract doctors and medical students to live and work in rural and regional Australia.

The AMA has for some time identified medical workforce shortage as a major health issue, particularly in regional and rural Australia.

While the Government has made additional investments to encourage more locally trained doctors to work in these areas, rural and regional communities are still overly reliant on international medical graduates (IMGs) to fill workforce gaps.

The *AMA Position Statement on Regional/ Rural Workforce Initiatives 2012* builds on earlier AMA work in this area and identifies possible solutions to help attract and retain more doctors to regional and rural areas.

AMA President Dr Steve Hambleton said that the AMA plan outlines a range of factors that influence doctors to choose to work in regional and rural areas and offer a range of solutions that would relieve current pressures and entice more doctors to work outside metropolitan areas.

"We also address undergraduate, post-graduate and continuing education," he said.

"Remuneration issues are raised, along with a range of other influences such as hospital and general infrastructure, family support, and rostering and locum services.

"The specific needs of IMGs are also covered."

The Position Statement highlights five key priority areas for Government policy development that would help attract medical practitioners and students to regional and rural areas. The AMA urges the Government to:

- provide a dedicated and quality training pathway with the right skill mix to ensure GPs are adequately trained to work in rural areas;
- provide a realistic and sustainable work environment with flexibility, including locum relief;
- provide family support that includes spousal opportunities/employment, educational opportunities for children's education, subsidy for housing/relocation and/or tax relief;
- provide financial incentives including rural loadings to ensure competitive remuneration; and
- provide a working environment that would allow quality training and supervision.

The Position Statement also highlights significant ongoing concern at the way in which the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) is being applied to determine the distribution of financial incentives.

Dr Hambleton said that the AMA welcomes the fact that more areas are eligible for incentives, but the current ASGC-RA system is resulting in perverse outcomes in some situations.

"A proper ASGC-RA review is needed to sort out these problems."

Dr Hambleton said that the Position Statement has been sent to the Minister for Health and Ageing, Tanya Plibersek.

"Our Position Statement contains practical solutions that are based on local needs, local thinking, and local realities.

"We urge the Government to give it serious consideration," Dr Hambleton said.

The *AMA Position Statement on Regional/ Rural Workforce Initiatives 2012* is at http://ama.com.au/node/7681

JF

TO COMMENT CLICK HERE

Alternative therapies not fitting the 'bill'

CONTINUED FROM PAGE 5

We also risk providing 'alternative' health practitioners with false credibility by registering or regulating them through the same agency as mainstream health professionals. Just as it was over 150 years ago, the public needs to be protected from the sellers of snake oil and 'quacks'.

There is a fine line to tread in reaching the best solution that respects people's choices and beliefs but ensures that these are guided by sound, evidence-based, information.

It is certain that any controversy will be fuelled by those profiting from the billion-dollar 'alternative' medicine industry. Nevertheless, answers need to be found to help minimise the waste that is fed by people's fears.

Criticism of complementary or 'alternative' medicine has become almost politically incorrect as they have become more trendy and fashionable. Perhaps it's that they retain the mystery that is being stripped away from medicine by its ever more scientific foundations. Accountants will tell their clients when they have been seduced by a taxation scheme and lawyers act professionally in telling theirs if they look like getting into a shonky deal.

As registered medical practitioners perhaps we owe it to our patients to tell them that if a treatment they are receiving looks like a duck, and feels like a duck, then it probably quacks. It definitely won't fit the 'bill'.

TO COMMENT CLICK HERE

Specialist training spots filled

The AMA has welcomed Health Minister Tanya Plibersek's announcement that all training positions in the federally-funded Specialist Training Program have been fully subscribed.

This comes on top of February's announcement that all 1000 first year GP training places had been filled.

AMA President Dr Steve Hambleton said that, while most specialist training takes place in the public hospital system, the Commonwealth had progressively increased funding to support more specialist training in non-traditional settings, including private hospitals.

"More training in these settings is good for patients as it allows trainees to gain hands-on experience in treating health conditions that are often rarely seen in the public sector," Dr Hambleton said.

"We now have to build on this strong investment in our future medical workforce, especially at the State and Territory level.

"Medical students numbers have more than doubled.

"By 2014, there will be more than 3700 students graduating from medical schools across the country.

"These graduates still need to be able to progress through prevocational and specialist training, and this will require more training places in our public hospitals and other clinical settings than are currently available – and this is largely the responsibility of the State and Territory Governments," Dr Hambleton said.

Health Workforce Australia is expected to deliver the National Training Plan (NTP) to Health Ministers at the end of this month. Renamed *Health Workforce 2025*, the Plan will set the number of prevocational and vocational medical training positions required to match the increased output of medical schools and enhance the capacity of the health system to meet the community's needs through until 2025.

Dr Hambleton said that the implementation of *Health Workforce 2025* will require significant funding, planning, and coordination, which can only be achieved if there is support at the highest levels across all governments.

"The Commonwealth could maximise the benefit from its medical training investment by convening a specific COAG meeting to reach agreement with the States and Territories on the way forward for *Health Workforce 2025*," Dr Hambleton said.

JF

TO COMMENT CLICK HERE

Medical Trainee Position Statement

The AMA earlier this month released its *Position Statement on Supervision and Assessment of Hospital Based Postgraduate Medical Trainees (2012).*

AMA Vice President Professor Geoffrey Dobb said that achieving high quality supervision and assessment of trainees must be a top priority for the Australian health system.

"Our hospitals are currently busier than ever, we have an increasing number of medical graduates, and the total amount of time and resources that can be dedicated to supervision activities is stretched to the limit," Professor Dobb said.

"This all means that maintaining quality clinical supervision and assessment presents a significant challenge – to governments, to hospitals, to supervisors, and to trainees.

"The AMA Position Statement outlines the key requirements for effective supervision and assessment of trainees to ensure that the quality of medical education and training remains at a high standard.

"It reflects what trainees need to navigate in their training and what they need to be properly supported in their training, and it sets out what supervisors need in terms of support, time, and payment to provide the training.

"It can be used by doctors, policymakers and organisations to ensure that appropriate policy, processes, and infrastructure exists to support high quality supervision and assessment of hospital based postgraduate medical trainees.

"The information and experiences that underpin this Statement come from doctors who work and teach in our hospitals every day," Professor Dobb said.

The AMA's Position Statement, which can be found at http://ama.com.au/node/7670, covers:

- structures supporting effective supervision and assessment;
- supervision;
- assessment; and
- resourcing effective supervision and assessment.

JF

TO COMMENT CLICK HERE

Dear Editor

Need for medical Ombudsman

In return for our ethical and excellent performance in the delivery of medical services to the community, society accords us trust, respect and financial rewards.

But that is not enough for overseas trained doctors (OTDs), who also need fair - not lenient - treatment from medical regulatory authorities. This has been a contentious issue for a long time.

The Australian Indian Medical Graduate Association (AIMGA) has deep concerns about medical boards, councils and tribunals which adopt exceptionally hard measures out of proportion to the offense committed in order to discipline overseas trained doctors.

AIMGA believes that the system is not transparent or flexible enough to allow a reasonable defence once an OTD is deregistered. We believe that there is denial of natural justice and there is no mediating body like an ombudsman with a neutral position to influence a justified outcome.

There are numerous cases where the initial charges against an overseas trained doctor were dismissed by the courts, but medical boards, councils and tribunals continued to pursue the matter for decades, unjustifiably maintaining there was an untreatable serious flaw in the personality of the doctor, and the accused is burdened by allegations irrespective of their true or false status. This has destroyed many doctors and their families with death, desertion, disease and divorce almost reaching to the definition of human rights violation.

AIMGA will never advocate anything less than the best possible clinical care and reprimand for those doctors who fail to do so.

We have so far sought without success dialogue on a transparent and fair process, though the current health minister has agreed in personal communication on the need for an ombudsman.

The influx of new graduates may not immediately fulfill the demands of 'Area of Need' hospitals, so the Australian Government's recruitment policy to invite OTDs is likely to continue.

With repeated representations, employment conditions for overseas trained doctors may improve. But to severely penalise a doctor who is not convicted of the allegations leveled against them will remain a separate and serious issue, which needs urgent and comprehensive review.

Shailja Chaturvedi
President, Australian Indian Medical Graduate Association (AIMGA)

TO COMMENT CLICK HERE

Draft AMA Guide to using the PCEHR

The AMA has produced a draft guide for doctors on how to use the personally controlled electronic health record (PCEHR), which is due to commence implementation from 1 July 2012.

The draft guide has been circulated for feedback from doctors and is available on the AMA website for professional and public comment prior to final publication.

The guide will assist medical practitioners to make choices about participating in the PCEHR system and explains how they might use the PCEHR in their day-to-day practice.

AMA President Dr Steve Hambleton said that the AMA supports patients taking responsibility for their own health and recognises that 'personal control' of their health information could empower and encourage them in this role.

"The PCEHR system will put the patient in the 'driver's seat' for managing their health information," Dr Hambleton said.

"But the PCEHR has practical clinical limitations for medical practitioners in the treatment of patients in respect of the content, accuracy, and accessibility of the information.

"We accept that the intention is for people to be able to register for the PCEHR from 1 July, but we have advised the Government that there will be very few medical practitioners who will have the capability to interact with the system from that date.

"The AMA would have preferred the PCEHR to be an opt-out system, rather than opt-in, to ensure the success of the system in healthcare delivery.

"Nevertheless, the AMA considers the PCEHR will become a valuable addition to quality health in Australia over time and will work with the Government to ensure that the best possible PCEHR is available for patients and health professionals."

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

Members of the public can comment on the draft guide at http://ama.com.au/node/7650

Public consultation is now open on this site until Friday, 27 April 2012.

In January 2012, the AMA surveyed members for their views on the PCEHR ahead of producing the draft guide. The survey results are at http://ama.com.au/node/7649

The AMA acknowledges the cooperation of the National Electronic Health Transition Authority (NEHTA) in the production of the Draft AMA Guide to Using the PCEHR.

JF

TO COMMENT CLICK HERE

Minister admits no new money for PCEHR work

During an interview on *ABC Radio's* 'AM' last week, Health Minister Tanya Plibersek added some clarity to the PCEHR debate by admitting there was no new money for GPs to provide shared health summaries for the PCEHR.

This is what the AMA has been saying all along.

The Minister said "that the idea that they [GPs] would, during a longer consultation, be paid extra for recording that information in a computer program that many of them are already using is probably not the best use of extra health funds."

"Look, I think it's important for any union to stick up for its members," she said.

"I think what GPs on the ground will find is that many of them are using software at the moment that will simply be upgraded to include an integration with the personally controlled e-health record summary and their work will not change dramatically."

On the same program, AMA President Dr Steve Hambleton said that "if we can have an accurate, up-to-date, medication summary we'll save lives".

"But the Government has made it clear that they've not created any items for doctors' time and work with patients," he said.

"They've not allocated any funding in the Medicare schedule to cover this new clinical service.

"We've got to remember that it's opt-in for doctors, opt-in for practices and opt-in for patients. So there needs to be drivers to make it work."

JF

TO COMMENT CLICK HERE

Inquiry into child sexualisation needed

The AMA is calling for a new Inquiry into the premature sexualisation of children in marketing and advertising.

AMA President Dr Steve Hambleton said that self-regulation by the advertising industry is clearly not working.

Dr Hambleton said that there had in recent times been renewed debate in the media and in the community sparked by advertising that features young children in images and with messages that were disturbing and sexually exploitative.

"These are highly sexualised ads that target children, and the advertising industry is getting away with it," Dr Hambleton said.

"There is strong evidence that premature sexualisation is likely to be detrimental to child health and development, particularly in the areas of body image and sexual health.

"The current self regulatory approach through the Advertising Standards Bureau is failing to protect children from sexualised advertising.

"Stronger action is needed to stop this practice of pushing adult themes to young children, especially pre-teen girls.

"We urge the Government to start a new Inquiry with the view to introducing tougher measures, including legislation, to protect the health and development of our children by shielding them from sexualised and other inappropriate advertising."

Background:

- In 2008, the Senate Standing Committee on Environment, Communication and the Arts undertook an Inquiry into the Sexualisation of Children in the Contemporary Media Environment. The Committee recommended another Inquiry 18 months later. That recommendation has not been acted upon;
- In 2009, a Private Members Motion was moved in the House of Representatives highlighting concerns about the premature sexualisation of children in the media. The motion had the support of Members from the major Parties; and
- There were complaints last year about an ad for *Oh, Lola!* perfume, which references Lolita. The ad was banned in Britain but deemed suitable for Australian audiences by the advertising watchdog.

The AMA has subsequently been joined by media commentators and social policy advocates in calling for an Inquiry.

JF

TO COMMENT CLICK HERE

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

AMA proposes Medicare rebates for e-health records

The Australian, 10 April 2012

Australian Medical Association President Dr Steve Hambleton expressed frustration with the Government's inaction on time and work concerns, and introduced the AMA's own Medicare Benefits Schedule of fees.

GPs demand separate fees for e-health work

The Herald Sun, 10 April 2012

The AMA has released a guide that encourages its members to charge between $53 and $210 to prepare and manage a shared health summary.

Sex sells, but we're selling out our children

Brisbane Times, 9 April 2012

The AMA called for an inquiry into the premature sexualisation of children in marketing and advertising.

AMA ads anger over sexualisation of kids

The Sydney Morning Herald, 3 April 2012

The AMA has called on the Government to crack down on ads that sexualise children, saying such images and messages are damaging children's health.

Radio

Dr Hambleton, *ABC Radio National*, 11 April 2012

Dr Hambleton says the Government is making the personally controlled electronic health records too complex, with too much red tape. He said the system could save lives, but highlights that no money has been allocated in Medicare to cover the new service.

Dr Hambleton, *ABC 666*, 3 April 2012

Dr Hambleton is supporting calls for a rethink to tackle the illegal drug trade. He says we all know young people have a range of illicit drugs available to them and it is time to examine the issues surrounding their use.

Television

Dr Hambleton, *Channel 9*, Sydney 4 April 2012

The AMA is calling for a crackdown on ads that sexualise children. Dr Hambleton says he is concerned about eating disorders, depression and blurred sexual development.

Dr Hambleton, *ABC 24*, 3 April 2012

Dr Hambleton comments on claims that Australia's anti-drug campaigns have not worked and warrant a new direction. He says it is time to have a debate about illicit drugs.

Dr Hambleton, *Channel 7*, Brisbane, 1 April 2012

Dr Hambleton comments on the Government's price cuts to prescription medicines listed on the Pharmaceutical Benefits Scheme. He said the cuts will allow the Government to purchase new drugs.

The latest from AMSA

AMSA warns of impending internship crisis

AMSA President Mr James Churchill said that a sharp and sustained increase in the number of medical graduates is putting significant pressure on the clinical training system.

More funding needed to train future doctors

The Australian Medical Students' Association released its formal response to the Higher Education Base Funding Review (BFR).

Recent news from the *MJA*

New anticoagulant may pose risk to elderly

The oral anticoagulant dabigatran poses as an attractive alternative to warfarin, but it's not the right option for every patient.

E-health safety slipping through the cracks

Australia currently has no governance system to ensure the safety of e-health initiatives such as the personally controlled electronic health record.

Mental illness linked to pregnancy complications

Pregnant women with severe mental illness are at a higher risk of obstetric and neonatal complications compared with other women.

Guidelines on blood clot prevention flawed

Current guidelines on preventive treatment for blood clots in hospitalised patients are flawed and result in over-medication.

University academics fail transparency test

Australian universities fall short of their obligation to disclose the competing interests of academic staff.

TO COMMENT CLICK HERE

All care, no responsibility

BY **DR BRIAN MORTON**

"The AMA does not want to see the indicators removed from the standards. It wants practices to remain responsible for ensuring appropriate arrangements are in place to support access to out of hours care"

The AMA Council of General Practice at its last meeting considered whether Medicare Locals' responsibility for out of hours services affected the ability of practices to meet the accreditation requirements under Criterion 1.1.4 of the Royal Australian College of General Practitioner *Standards for general practices: 4th edition* related to the provision of out of hours care.

The Council considered whether a practice should be held accountable for decisions that from 1 July 2013 would no longer be in its hands. Medicare Locals from this date will become responsible for planning and supporting local out of hours GP services, and funding to assist practices in providing out of hours care through the Practice Incentive Program (PIP) will cease.

This will create a new environment – one where the level of support for general practices will be uncertain and the availability of local out of hours services will be largely dependent on the decisions of Medicare Locals.

It raises the question of whether it remains appropriate for the College to retain flagged indicators requiring a practice to provide care or access to care outside normal operating hours.

The AMA, as a result of the Council's concern on this issue, has raised the matter with College and is awaiting its advice.

Our concerns go beyond the provision of out of hours care and the potential loss of financial support for practices. Flagged indicators are critical to practice accreditation, the latter being a fundamental prerequisite for eligibility for payments under the PIP. If the flagged indicators requiring practices to either provide care or access to care outside normal operating hours are retained, then there is the real potential for practices to lose their accreditation status and, consequently, all PIP payments.

The AMA does not want to see the indicators removed from the standards. It wants practices to remain responsible for ensuring appropriate arrangements are in place to support access to out of hours care. However, the AMA has asked the College to consider whether it would be more appropriate for the status of after hours indicators to be amended from 'flagged' to 'desirable'.

Changing arrangements for funding and coordinating access to out of hours care are a reality, and the AMA will seek to work with the College to ensure general practices can continue to comply with the RACGP standards for practices.

Improve registration for international medical graduates: report

BY **DR DAVID RIVETT**

"I cannot see Australian medical school graduates meeting rural Australia's needs in the foreseeable future, unless the urban politicians who dominate the major political parties start taking the needs of rural Australia seriously"

The *Lost in The Labyrinth* report was released recently after an extensive and prolonged House of Representatives committee investigation.

It has put forward 45 recommendations for the support and registration of international medical graduates (IMGs) by making the process more transparent, streamlined, demonstrably fair and to help IMGs – particularly those moving to rural areas - in gaining registration. The AMA presented an extensive submission to the committee, as did most professional bodies governing accreditation and registration.

The recommendations are almost universally praiseworthy, calling for greater transparency, efficiency, and accountability of certifying bodies while maintaining Australia's current high standards of care provision. They also call for the provision of better information for doctors coming to Australia, and improved support, supervision and more robust assessment on their arrival - all key outcomes the AMA has sought. The report has proposed workplace assessments rather than formal exams for those with considerable relevant practice experience.

Sadly, some international medical graduates were reportedly fearful of addressing the taskforce because of concerns they would be treated adversely by accrediting bodies for doing so.

IMGs provide a very considerable and still growing proportion of the rural workforce, and will do so into the foreseeable future. They deserve our respect and ongoing support.

Hopefully the changes recommended will be fully funded by Government and enacted swiftly by all responsible entities.

I cannot see Australian medical school graduates meeting rural Australia's needs in the foreseeable future, unless the urban politicians who dominate the major political parties start taking the needs of rural Australia seriously. All too often they simply discard the rural workforce crisis to the too hard basket.

Any solution would mean multiple changes to our current, failing system, with real incentives for periods of non-urban practice. Junk solutions such as unfunded bonded medical school places to areas of need, be they urban or rural, must be discarded and replaced with generously financed scholarships with an obligatory commitment to rural care provision.

The report is easily accessible on the net, just type in the title "Lost in the Labyrinth".

On another note, no joy regarding the role of GPs in having over-sight of electronic health records seems likely, with Government refusing to recognize the extra workload entailed, and intent on achieving a budget surplus at any cost.

If a GP sees 35 patients a day and each consultation is lengthened by 5 minutes, as studies tell us, putting data into the PCEHR will take 175 minutes a day. Who has that time to spare? Certainly not rural GPs. The work-life balance has to be a sane one, and spending such time on a grand vision that has been tried and yet has been seen to have failed ingloriously in many other countries, is not a wise choice for time-poor GPs.

TO COMMENT CLICK HERE

Decision time for hospital funding looms

BY **DR STEVE HAMBLETON**

"Importantly, the authority appears to have accepted the AMA's advice that ABF should not be used to address adverse events"

By June this year, State and Territory governments need to make important decisions that will affect how public hospitals are funded. At least they have been informed by AMA advice.

All governments agreed at the Council of Australian Governments meeting in August 2011 that they would implement a nationally consistent activity based funding (ABF) system in two phases. The first phase – applying ABF to acute admitted services, emergency department services and non-admitted patient services (initially using the Tier 2 outpatient clinic list) – will start on 1 July this year. The second phase – applying ABF to any remaining non-admitted services, mental health and sub-acute services – will start on 1 July 2013.

In preparation, the Independent Hospital Pricing Authority sought views from the AMA about the pricing framework that will form the basis for a 'national efficient price' and in turn determine the Commonwealth Government's contribution to public hospital funding under the national ABF system.

Informed by Economic and Workforce Committee (EWC), and a reference group I established to provide additional expert advice, the AMA provided first-hand input to the authority.

At a meeting with the chief executive officer of the authority, Dr Tony Sherbon, in January, we provided advice about the:

- need to emphasise quality and access to health care;
- scope of non-admitted services that should be eligible for Commonwealth funding;
- loadings that should be incorporated into the ABF cost model;
- inappropriateness of using ABF as a tool to address so-called hospital acquired conditions;
- critical role of teaching, training and research;
- importance of maintaining public-private neutrality; and
- appropriate funding of post-hospital services, including mental health, to ensure continuity of care.

The AMA confirmed its verbal advice in a written submission in February (see submission at ama.com.au/node/7579).

This consultation is now complete and the authority's final recommendations reflect many of the suggestions made by the AMA.

Recommended non-admitted public hospital services eligible for Commonwealth funding will be independent of the service setting and support continuity of care. For example, Aboriginal Health Clinic services, mental health step-down services, mental health chronic disease services, falls prevention services and hospital avoidance program services are included in the recommended list of eligible non-admitted hospital services.

The recommended design specifications of the ABF cost model reflect several AMA recommendations including loadings for Indigenous patients, regional-remote patients and designated specialist paediatric services. The loadings will be cumulative, so that a patient can attract the sum of all three loadings. Importantly, the authority appears to have accepted the AMA's advice that ABF should not be used to address adverse events.

The authority has advised that testing of the proposed ABF cost model shows it delivers a sound statistical fit to the actual cost data. However, the authority is meeting with State and Territory Health Officials this month to discuss the recommended model in detail, including the potential impact on individual hospitals.

This is an important opportunity for State and Territory AMAs to examine the impact of the cost model on their jurisdictions and lobby their Health Ministers.

TO COMMENT CLICK HERE

Dietary and clinical guidelines for managing overweight and obesity under review

BY **PROFESSOR GEOFFREY DOBB**

"Many patients are aware that they are overweight or obese, but the road to permanent weight loss can be difficult because of unrealistic expectations and the need for sustained behaviour change"

Obesity is one of the priority areas for the AMA Public Health and Child & Youth Health Committee. This priority is shared by other organisations involved in public and preventative health. It is AMA policy to provide submissions to these organisations when drafts of guidelines or policy documents are made available for public comment. Recent work has included preparing comment on dietary guidelines and the management of overweight and obesity.

"Diet is the single most important behavioural risk factor that can be improved to have a significant impact on health," according to the latest revision of the National Health and Medical Research Council's Australian Dietary Guidelines.

Most Australian adults are overweight or obese. Not only do Australians eat too much, many eat too much of the wrong foods and not enough of the right foods. Poor nutritional literacy, marketing of energy dense, nutrient poor foods and confusing labelling all contribute to the problem.

Australia's dietary recommendations need to be evidence-based as well as practical and easy to adopt. If the recommendations are unsuitable, they will be quickly disregarded.

The AMA's Submission on the Australian Dietary Guidelines therefore highlighted the value of doctors as a prominent source of weight related information and dietary advice, and recommended the development of practical resources and tools that would assist doctors to support patients with weight related concerns.

About 88 per cent of all Australians visit a general practitioner at least once a year, giving doctors significant opportunities to discuss health issues relating to body weight. Their unbiased, and often frank, advice provides many patients with the motivation that they need to engage in a program of weight loss and healthier lifestyles.

The NHMRC has now released a revised draft of the *Management of Overweight and Obesity in Adults, Adolescents and Children: Clinical Practice Guidelines for Primary Care Health Professionals*.

As well as having a strong evidence base, the clinical practice guidelines will need to be realistic about what doctors and their patients can achieve. Many patients are aware that they are overweight or obese, but the road to permanent weight loss can be difficult because of unrealistic expectations and the need for sustained behaviour change.

The AMA's submission on clinical guidelines will advocate improving support for doctors who engage with their patients around weight loss. This includes the development of practical resources such as regularly updated evidence summaries and short-term eating plans for patients who are at risk of common diet related health problems, such as prediabetes and hypertension.

Doctors also need to be able to refer their patients on to dieticians and community programs such as walking groups and cooking classes. This means that doctors need to be kept informed about the programs that are available in the local area.

In relation to children, there will be less focus on weight loss, but doctors play a key role in supporting parents to adopt family-based strategies that improve eating habits and increase physical activity.

The AMA's Public Health and Child & Youth Health Committee, in consultation with the Council of General Practice, will coordinate this submission. The AMA has a long history of advocacy in relation to reducing overweight and obesity in Australia. Through these submissions the AMA continues its advocacy efforts.

TO COMMENT CLICK HERE

Future proofing medical education: challenges and opportunities in financing reform

BY **DR ROB MITCHELL**

In an era of reviews, reports and reforms, funding for medical education is set to undergo a substantial reconfiguration. As with any restructure, this presents both challenges and opportunities.This is well illustrated by three active consultations, the outcomes of which will profoundly influence the ongoing resourcing of clinical training.

The first of these is the Higher Education Base Funding Review.The report recently handed down by the Review's chair, Dr Jane Lomax-Smith, was explicit in its assessment that primary medical education (predominantly through undergraduate degree programs) remains underfunded. It would seem that the Review's findings were heavily influenced by the submission from Medical Deans Australia and New Zealand, which concluded that the finding shortfall was in the magnitude of $23,000 per student, per annum. The Deans' (compelling) argument was based on international comparison and a national benchmarking study of course costs.

The Government is currently consulting on the Review and is expected to release its response in the second half of this year. AMSA has recently published its own analysis, which offers resounding endorsement of the report's call to "place a high priority on increasing the funding to those disciplines that are demonstrably underfunded." The challenge now, of course, is to translate the Review's assertions into remedial action and public policy.

The case for investing in primary medical education is a strong one, but in the current economic climate (and in the era of alternative funding via Health Workforce Australia) seeking inflation of the Commonwealth contribution to MBBS and MD programs may be an uphill battle. One of the challenges is that medicine already receives a higher allocation than most other courses, and some players in the higher education sector will discourage further increases. Another major risk is the Review's suggestion that the student contribution for all courses be lifted to 40 per cent of total costs, which for medicine would constitute a substantial and, in the case of many, prohibitive rise.

The second consultation is the draft pricing framework for public hospitals, recently released by the Independent Hospital Pricing Authority. As noted in this publication previously, the IHPA has initially proposed a block-funding model for teaching, training and research activities. The paper asked questions, however, about the feasibility of shifting to an activity based model in years to come.

The issue with activity based funding for education activities is that it is nearly impossible to separate clinical training from service delivery. Various groups have already tried, and failed, to tease out the constituent costs. A major risk is that an ABF system might fund the obvious educational infrastructure (eg. libraries and tutorial rooms) but not the essential aspects of clinical teaching (eg. teaching ward rounds, procedural supervision and bed-side instruction).

In this fundamental shake up of health financing arrangements, there are other important questions that must be asked. What formulae will determine the quantum of funding for teaching training and research activities? How will health services be held accountable for moneys earmarked for clinical training? What is the best way of measuring performance and ensuring that quality in medical education is maintained?

Fortunately, the installation of the new financing arrangements won't occur for some years yet. This provides the medical community with an important opportunity to develop a transparent funding model that offers value for taxpayers, trainees and educators alike.

The third activity of note is the National Training Plan (recently rebadged *Health Workforce 2025*) currently being developed by Health Workforce Australia. In its short life to date, HWA has been become a very significant player in the medical education landscape, not least because it holds $1.6 billion of government funding. Although the AMA has been critical of the extent to which HWA consults with the medical profession, it has had the opportunity to contribute to the governance committee for the NTP.

While the NTP is not, in fact, a plan, it will establish with relative certainty the future training pipeline for medicine, nursing and midwifery. It is likely that the projections will form the basis for future COAG funding commitments for training places. Given that the NTP is based on relatively robust supply/demand modelling (that has been subject to some sensitivity analyses), it will provide a reasonable blueprint for the required investments in training and workforce.

On this basis, the AMA has called for the Medical Training Review Panel to monitor, on an annual basis, clinical training growth targets based on NTP data. This should prove a useful lever by which to encourage governments to adequately invest in teaching and supervisory capacity.

As these examples illustrate, funding models for medical education and training are set to change. What is critical is that the profession advocates for financing reforms that are evidenced based and constitute good value for money. Accountability and transparency must also be assured. While there is always a strong case for investing in the future health workforce, the means by which that is achieved requires ongoing thought and discussion.

TO COMMENT CLICK HERE

Diet and lifestyle put majority at risk of chronic disease

Chronic disease risk is built into the Australian lifestyle, with most people exposed to at least one risk factor for chronic disease because they do not exercise enough or eat the required amount of fruit and vegetables.

In the most comprehensive report of its kind, the Australian Institute of Health and Welfare (AIHW) has found typical lifestyles are contributing to the prevalence of chronic diseases like arthritis, Type 2 diabetes, depression, asthma and osteoporosis.

AIHW spokesperson Ann Hunt said diet is a very common risk factor for chronic disease, with over 90 per cent of Australians failing to eat the recommended amounts of vegetables each day, and only half consuming enough fruit.

"This is important because we know that people with low fruit and vegetable intake have higher risks of chronic diseases such as heart disease and Type 2 diabetes," Ms Hunt said.

The report also found that about 60 per cent of Australians do not do enough physical activity to gain health benefits, such as maintaining healthy body weight and a healthy musculoskeletal system. Sufficient activity is defined as at least 150 minutes in one week over at least five sessions.

More than 80 per cent of Australians spend more than three hours each day sitting during their leisure time, regardless of whether they undertake sufficient physical activity.

Ms Hunt said the report shows that as the number of lifestyle risk factors increase, so too does the likelihood of chronic diseases developing.

For example, men with five or more risk factors are twice as likely to report depression as men with two or fewer risk factors. And men with five or more risk factors are three times more likely to report chronic obstructive pulmonary disease than men with two or fewer risk factors.

Similarly, women with five or more risk factors were three times more likely to report stroke, and two and a half times more likely to report depression, than women with two or fewer risk factors.

Men were more vulnerable to developing chronic disease than women, with 17 per cent likely to have five or more risk factors, compared with 11 per cent of females.

The report showed that certain risk factors commonly occur together.

"People who consume alcohol at risky levels are more likely to report daily smoking than those who don't, and daily smoking is also more commonly reported by those who have insufficient levels of physical activity," Ms Hunt said. "For people who are obese, high blood pressure is more common as a co-risk factor than for people who are not obese."

The analysis shows that people who live in poorer areas are more likely to take part in risky health behaviours and are also more likely to have combinations of risk factor behaviours.

DV

TO COMMENT CLICK HERE

Delusion of demonic possession needs to be exorcised

The AMA has dismissed claims by exorcists that depression and schizophrenia are demons that can be cast out.

Exorcisms are a religious rite that some believe can remove demons from a person.

Dr Choong-Siew Yong, who represents psychiatry on the AMA Federal Council, said he was concerned about untrained practitioners making claims that contradict science.

He told the *Herald Sun* that claiming someone was possessed could reinforce their delusions and stop them from getting proper care.

"There is an enormous amount of research that has discredited the idea that people with psychiatric conditions such as depression and schizophrenia are because of demonic possession." Dr Yong said. "That is a very old idea, not held up by science."

"We'd be concerned that people were missing out on reliable, well-evidenced, modern medical treatment," he said. "Some people with psychotic illnesses do believe that they're possessed, or have strange religious ideas, but when they're assessed by a doctor there will be a diagnosis of mental illness."

Michelle Peccoult from non-denominational Christian ministry Set Right, said they exorcise four to five people daily and have preformed exorcisms on children as young as two.

KW

TO COMMENT CLICK HERE

$20 million on offer for ideas to link doctors and patients

The Government has called for expressions of interests for new telehealth pilot projects supported by the National Broadband Network (NBN).

The pilots have the potential to improve access to quality medical services for people in rural, remote, and outer metropolitan areas over time.

Health Minister Tanya Plibersek and Minister for Broadband, Communications and the Digital Economy Senator Stephen Conroy have invited applications for funding for the NBN-Enabled Telehealth Pilots Program, which will provide up to $20.6 million for innovative telehealth pilot projects over the next two years.

Ms Plibersek said that the Government wants patients to get the health care they need, when they need it, and where they need it.

"Telehealth can solve the tyranny of distance by using technology to bring health services that are sometimes only provided hundreds of kilometres away from the patient's home right into their living room," the minister said.

The AMA has previously spoken about the use and uptake of telehealth services.

AMA President Dr Steve Hambleton said the AMA welcomes the slow but steady uptake of telehealth services, which were given a boost following the introduction of MBS items in July last year.

"Telehealth services are meeting the goal of providing access to specialist care for people living in remote and rural communities," Dr Hambleton said.

"We like the idea of a gradual increase, rather than a sudden burst.

"For GPs and patients, as confidence in the technology grows, we will see the number of telehealth services being used increase."

Applications are encouraged from all interested organisations including those that specialise in the delivery of telehealth, aged care, cancer care, or palliative care services.

To download the invitation to apply and for further information on the pilots program, follow the links from: http://health.gov.au/ehealth-nbntelehealth

The closing date for all applications is 2pm on Thursday 17 May 2012.

KW

TO COMMENT CLICK HERE

Cheaper PBS drugs from April 1

Millions of Australians will save up to $15 per packet for generic drugs to treat common medical conditions under reforms to the Pharmaceutical Benefit Scheme.

Health Minister Tanya Plibersek said the reforms, which came into effect on April 1, applied to generic versions of 60 different types of medicines. She added that many patients with concession cards who pay a premium for their brand will also see savings.

"This is great news for millions of Australian patients who will see additional money in their pockets," Ms Plibersek said. "The Gillard Government is making sure patients have greater access to the medicines they need at reduced prices – for conditions such as high blood pressure, high cholesterol, diabetes, epilepsy, depression and pain."

Ms Plibersek said under the PBS Price Disclosure program the price paid for the cholesterol lowering drug Simvastatin, sold under many brand names, will be up to $14.64 cheaper for a packet of 30, 40mg tablets.

It is estimated the changes could save patients up to $1.6 billion over the next 10 years.

The Minister said that as part of the reforms, price disclosure and other price reductions will also deliver over $1.9 billion in health savings for taxpayers over five years, ensuring the PBS remains sustainable and that health dollars can be spent adding new drugs to the scheme.

"Previously, when medicines came off-patent, they could be sold far more cheaply under different brand names, but they were still eligible for the full reimbursement amount under the PBS," she said.

"Price disclosure means the price the Gillard Government subsidises medicines for is being brought into line with the market price, ensuring the cheapest possible prescriptions for patients."

Ms Plibersek said some of the most commonly used medicines on the PBS are significantly cheaper. For example, non-concessional patients will save:

- up to $8.83 for Alendronate, for osteoporosis;
- up to $8.23 for Baclofen, a muscle relaxant;
- up to $8.25 for Ciprofloxacin, an antibiotic;
- up to $8.66 for Citalopram, for depression;
- up to $7.32 for Gemfibrozil, for high cholesterol;
- up to $9.48 for Omeprazole, for reflux and ulcers;
- up to $7.97 for Paroxetine, for depression and anxiety;
- up to $12.90 for Pravastatin, for high cholesterol; and
- up to $8.49 for Sertraline, for depression and anxiety.

Concessional patients will continue to pay a $5.80 co-payment only for their PBS prescriptions.

The price of an additional 12 medicines, including the commonly used Atorvastatin and Olanzapine, have been cut by 16 per cent following the listing of new generic types on April 1.

The Minister said these savings enabled the listing of new medication. Six new medicines treating conditions including rheumatoid arthritis, chronic myeloid leukaemia, kidney failure, HIV and pulmonary arterial hypertension have been added to the PBS from April 1.

The Medicines Partnership of Australia, comprising The Pharmacy Guild, Medicines Australia, the Generic Medicines Industry Association, the Australian Self-Medication Industry, the Pharmaceutical Society of Australia and the National Pharmaceutical Services Association, said the pharmaceutical industry had worked well together to ensure continuity of supply of important PBS medicines at the time of the April 1 price drop.

They said the price cut was the largest set of reductions in the history of the PBS, which created stock management challenges for all pharmacies, wholesalers and manufacturers. But all worked together to ensure there was an uninterrupted supply of PBS medicines for customers.

Full details of all changes to the PBS are available at:

http://www.pbs.gov.au/info/industry/pricing/eapd/price-disclosure-info-for-consumers

DV

TO COMMENT CLICK HERE

Spike in health insurance complaints caused by a few

Consumer complaints about private health funds surged last financial year following changes by some larger insurers that caught their policyholders out.

The Private Health Insurance Ombudsman reported a 17 per cent jump in complaints it handled in 2010-11 from 2618 to 3070 cases, with much of the increase stemming from a breakdown in communication between a number of funds and their members over policy changes.

But Ombudsman Samantha Gavel said consumer concerns were not widespread and much of the spike in complaints was confined to a narrow range of funds and issues.

Ms Gavel said there had been poor communication by some larger funds with members on a small number of concerns, and these were not reflected across the industry as a whole.

"The increase in the number of complaints was due to increases in complaints about a small number of sub-issues, namely level of cover, delay in payment and general service issues," she said. "It should be noted that the increase in complaints about these issues was not across the industry as a whole, but rather confined to a small number of funds."

Ms Gavel said the funds, which she did not name, had made a number of policy changes that had upset their members, including imposing exclusions to existing policies, altering excess levels and exclusions for certain services and moving major dental treatments into the general dental category, reducing benefit entitlements.

The ombudsman said her office had worked hard with the funds concerned to improve their communications processes.

"The majority of the increased number of complaints resulted from consumers not being aware of changes to their policy until they tried to claim for a benefit," she said. "In these cases, my office requested that funds send additional information to members about any changes."

Ms Gavel said there was only a small 4.7 per cent increase to 716 in the number of complaints requiring more detailed investigation. This rise, which coincided with a 3 per cent lift in private hospital and general treatment coverage, showed many funds were successfully dealing with referrals from the Ombudsman without further action being required.

Ms Gavel urged consumers to read the report and assess the information on the performance of funds.

"I cannot stress enough how important it is for consumers to be diligent on their own behalf when it comes to private health insurance, both in terms of assessing the level of cover they need and the level of cover they actually have," she said. "Too often, we find that for many people, private health insurance is 'out of sight, out of mind' until they get sick."

She said she was encouraged by the 17 per cent increase in use of the Ombudsman's consumer website at www.privatehealth.gov.au.

The State of the Health Fund Report can be views on the PHIO website at www.phio.org.au.

DV

TO COMMENT CLICK HERE

2012 RACGP awards

Nominations for the 2012 RACGP awards are now open and close on 8 June 2012. Nominations may be made for the following categories: Rose-Hunt Award, Life Fellowship, Honorary Fellowship, Honorary Membership, General Practitioner of the Year, General Practice Registrar of the Year, General Practice Supervisor of the Year, General Practice of the Year, National Rural Faculty Brian Williams Award and National Faculty of Aboriginal and Torres Strait Islander Health Standing Strong Together Award. Visitwww.racgp.org.au/awards.

TO COMMENT CLICK HERE

Influenza Vaccine Reminder

ADVICE FROM THE COMMONWEALTH CHIEF MEDICAL OFFICER

- Providers are reminded that Fluvax® is not registered for use in children under 5 years of age in Australia and should not be given in this age group due to an increased risk of febrile convulsions.
- The Australian Technical Advisory Group on Immunisation (ATAGI) recommends the use of Fluarix® and Vaxigrip®, for children between 6 months and 10 years of age eligible for immunisation under the National Immunisation Program. If necessary, providers should contact their State or Territory Health Department for supplies of Fluarix® and Vaxigrip®.
- Children between 6 months and 10 years who are not eligible under the national immunisation program may also use Influvac® and Agrippal®.
- All influenza vaccines may be used for anyone aged 10 years or oolder.
- Providers should note that there may be a small increase in the risk of fever and febrile convulsions with the co-administration of trivalent influenza and pneumococcal conjugate vaccines in children 12-35 months of age. These vaccines may still be given together but providers should discuss this small risk with parents prior to vaccination. If the vaccines are given separately, there should be an interval of at least three days between each vaccination.

Recommendations for the use of 2012 seasonal influenza vaccine by brand and age group

TO COMMENT CLICK HERE

Age group	Fluvax®	Vaxigrip®	Fluarix®	Influvac®	Agrippal®	Intanza®
≥6 months to 5 years	X	✓	✓	✓	✓	X
>5 years to <10 years*	Note 1	✓	✓	✓	✓	X
≥10 years	✓	✓	✓	✓	✓	Note 2

Note 1: The use of *Influvac, Vaxigrip, Fluarix* or *Agrippal* in children aged 5 years to less than 10 years is strongly preferred, however, *Fluvax* may be used when no timely alternative vaccine is available and parents are informed of the potential increased risk of fever.

Note 2: Do not use in children under 18 years of age (approved for adults aged 18-59 years only).

For further information, see Immunise Australia website www.immunise.health.gov.au.

TO COMMENT CLICK HERE

Morphine breaks through pain barrier

Morphine users may be freed from side effects caused by the pain relieving drug following a discovery by Australian and American researchers.

In an advance that could prevent increased sensitivity to pain, drug tolerance and other side effects, the researchers have found a way to block the brain immune receptor which, once activated by opioid drugs such as morphine, creates an inflammatory response in the brain that causes side effects.

Lead author Dr Mark Hutchinson said that for some time it had been assumed that the inflammatory response from morphine was being caused via the classical opioid receptors.

"However, we found instead that morphine binds to an immune receptor complex called toll-like receptor 4 (TLR4), and importunately this occurs in a very similar way to how this receptor detects bacteria," Dr Hutchinson said.

"Our experiments in mice have shown that if this relationship with the immune receptor is disrupted, it will prevent the inflammatory response.

"This study is showing that we can give a lot less morphine if we block these immune receptors and we get loads more pain relief.

The study has been published in the *Proceedings of the National Academy of Sciences (PNAS).*

KW

TO COMMENT CLICK HERE

Driving in Denmark
Bluetooth – bridging connections

BY **DR CLIVE FRASER**

The Oresund Bridge connecting Denmark and Sweden is undoubtedly an engineering marvel.

For millennia the only way across the Baltic Sea had been by boat.

But on 1 July 2000 the world's longest cable-stayed roadway bridged the gap between Malmo and Copenhagen, and the rest of Scandinavia finally joined mainland Europe.

For 285 Danish Kroner ($48.50 AUD) you can pay the toll plus a cab fare and travel across a Scandinavian border.

And from the deck of the bridge the water doesn't seem that far below.

That was until I mistakenly asked the Danish taxi driver how far exactly above the Baltic we were.

I should have been happy with his first answer, which was that the bridge was tall enough to allow the Queen Mary 2 to pass underneath.

But I knew that the Queen Mary 2's funnels were 62 metres above the water-line and it just didn't seem that far down as we made a steady pace across the bridge.

It was at that point that the Danish taxi driver told me that he'd check straight away while he mumbled something about the Queen Mary 2's funnels being able to be lowered.

Well, we all know how dangerous it is to talk on a mobile phone while driving, even in Denmark.

And texting while driving is arguably even worse.

But my taxi driver seized upon the opportunity to Google up the answer on his 3G smart-phone (while driving).

With both hands and his brain fully occupied on his iPhone, it was left up to his knees and lower limbs to keep the taxi's steering wheel on track.

Picturing us plunging into the Baltic, I suddenly announced that my question about the height of the bridge didn't really matter. But the taxi driver's belief that his country had built the biggest and best bridge in the world would not allow him to sit back and just drive the cab.

His persistence reminded me of how many other drivers that I had seen in Denmark talking, texting and surfing on their phones while driving.

You see, in Denmark there is a hefty fine of 1,500 Danish Kroner ($255 AUD) for doing any of the above, but the offence is not policed strongly and the Danes don't like to be interfered with.

Another example of this is the fact that they don't have fixed speed or red light cameras in Denmark.

Apparently attempts to introduce them in 2008 were met with guerrilla warfare. The devices were quickly disabled in midnight raids by free-spirited Danes.

This seems incongruous with the fact that the Danes happily register almost every other aspect of their lives in government databases, which provide a rich source of data for demographers and epidemiologists.

So how did I get the taxi driver to put his smart-phone down and concentrate on driving the cab?

Well, I asked him another question about the cultural significance of the Oresund Bridge's construction and he told me about the last attempt to bridge the divide between Denmark and the rest of Scandinavia.

You see King Harald of Denmark (aka "Bluetooth") united the Danes with the Norwegians in the 10th century in an attempt to stave off domination from the Germans.

In retrospect "Bluetooth" may have been a sufferer of the autosomal recessive disease alkaptonuria, one of the four in-born errors of metabolism described by Sir Archibald Garrod in 1902.

In modern times Bluetooth became the name that the Swedish company Ericsson used to describe a short-range wireless technology that connected PCs and mobile devices, with the logo reflecting the stylized initials of King Harald.

And, looking more closely at the silhouette of the Oresund Bridge, I noticed that it mimicked the Bluetooth logo as well.

With the iPhone still in his hand, I didn't dare debate any of this with the Nordic taxi driver!

The Oresund Bridge

Specifications:
Total length = 7,845 metres
Longest span = 490 metres
Width = 23.5 metres
Clearance below = 57 metres

Meaning that the captain of the Queen Mary 2 would shave five metres off his funnels (which don't lower) if he attempted to sail underneath the Oresund Bridge, but please don't try to argue this point with your Danish taxi driver!

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

TO COMMENT CLICK HERE

General Enquiries:
1300 133 655
Web:
www.ama.com.au/amex

General Enquiries:
1800 658 679
Web:
www.ama.com.au/onepath

General Enquiries:
1300 360 525
Web: www.ama.com.au/memberservices

Bookings:
13 30 39
Web: www.ama.com.au/memberservices-hertz

General Enquiries:
1300 133 655
Web: www.ama.com.au/powerbuy

General Enquiries:
1300 133 655
Web: www.ama.com.au/memberservices-qantas

General Enquiries:
300 133 655
Web: http://www.ama.com.au/memberservices-vw

General Enquiries:
1300 553 399
Web: www.ama.com.au/fitnessfirst

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

General Enquiries:
1300 788 215
Web:
www.ama.com.au/memberservices

GREAT MEMBER DEALS

Discounts off new Volkswagen and Skoda vehicles for AMA Members*

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

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

To access this exclusive offer simply contact AMA Member Services on 1300 133 655 or email memberservices@ama.com.au.

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

Great Qantas Club Rates for AMA Members

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

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

Call AMA Member Services on 1300 133 655, email memberservices@ama.com.au or login to the AMA website http://ama.com.au/memberservices-qantas to obtain an application form.

powerbuy

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

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

RENT FOR 5 DAYS, PAY FOR 4 - FROM HERTZ

There is no better way to explore Australia than by road and now Hertz is offering AMA members the opportunity to do just that. Rent for 5 consecutive days or more before 30 April and you will receive 1 free day*.

This offer is in addition to your exclusive discounted AMA rate, and free membership to Hertz #1 Gold which offers priority service for frequent renters.

To find out more or to make a booking, call Hertz on 13 30 39 or visit hertz.com.au and quote CDP Number 283826 and Promotion Code 161615.

* Offer is available at participating domestic locations on groups C,S,D,P,E,T and is subject to availability on rentals before 30th April 2012 (excluding the 6th to 9th of April) . Min 5 days, max 1 free day per rental. Hertz standard terms, conditions and credit qualifications apply.

Let AMP Bank take the stress out of buying property

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

Borrowing for an investment property

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

Some things to consider

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

Making the most of your home loan

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

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

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

AMP Bank Limited ABN 15 081 596 009, AFSL No/ACL. 234517.