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Medical training shortfall looms

Health Workforce 2025 report - Page 7

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AMA

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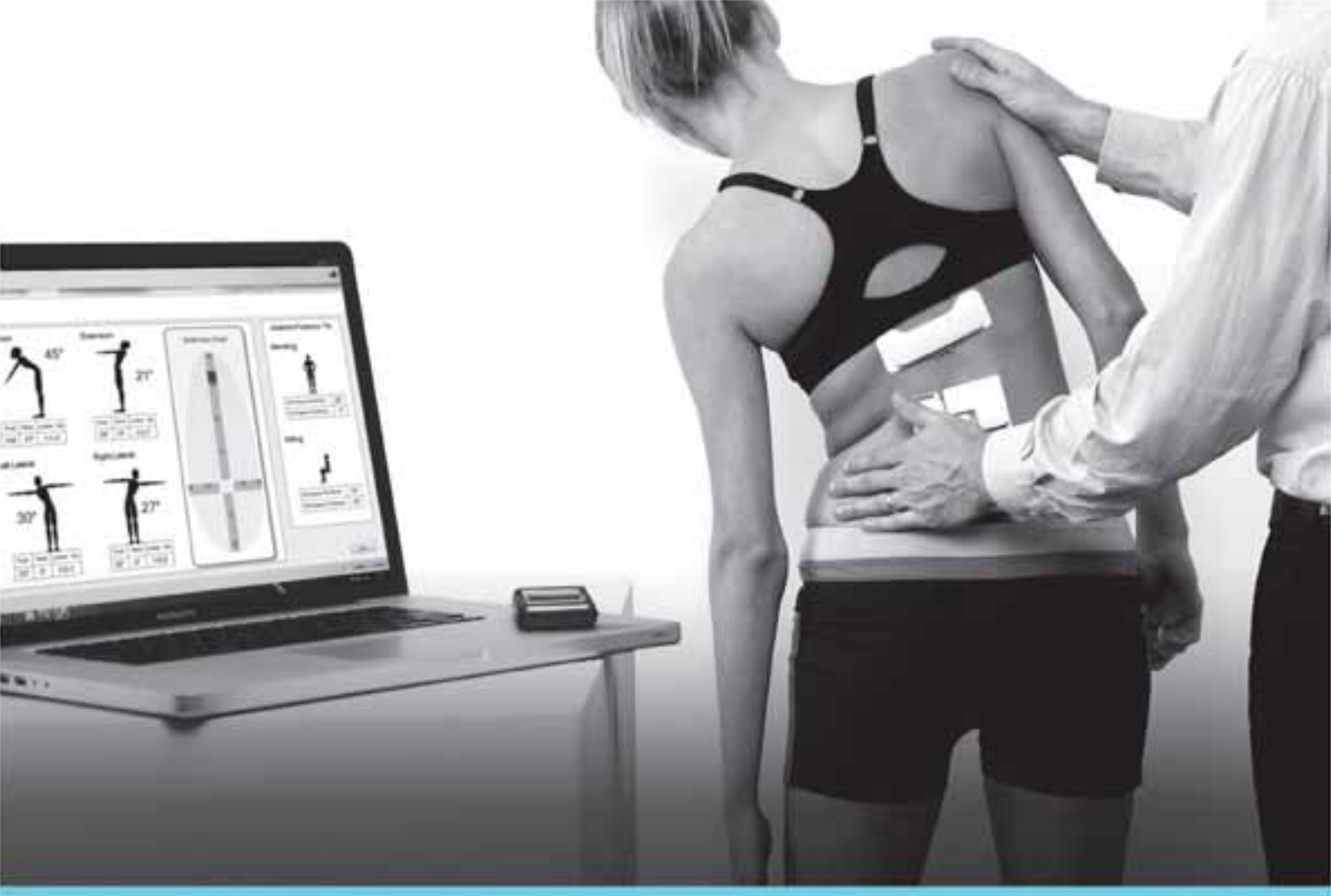

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IN THIS ISSUE

NEWS

REGULAR FEATURES

Will the PCEHR get up?

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

With less than two months to go before the personally controlled electronic health record (PCEHR) is scheduled to go live, it looks set for a soft opening. I think it's true to say that those with past experience with e-health projects in Australia, and those with an eye to the roll out of similar projects in the UK and elsewhere, have anticipated that resolution of technical issues would create difficulties during implementation. Indeed, many of our colleagues are still providing advice on how these may be overcome.

The practice of medicine is information rich and, in the twenty first century, electronic information management is the normal standard. Pathology providers and general practice have lead the way in shifting their records to computer-based platforms - with radiology practices and some specialist practices following. Regrettably, the public hospital sector, with just a few exceptions, has lagged behind the shift to electronic health records. Nevertheless, the potential advantages of linking this information within a shared health record seems clear in terms of providing access to health information, especially when a patient needs to see a medical practitioner other than their usual general practitioner – perhaps as a fly-in-fly-out worker, a 'grey nomad' journeying around Australia, or when a medical or surgical emergency makes a visit to a hospital emergency department imperative.

For these reasons the AMA has supported the concept of an electronic health record.

The reality of what will be available from July 1 falls well short of the AMA's vision for an electronic health record. The 'Personally Controlled' part will make it difficult for medical practitioners to rely on the information as a complete record. The 'opt in' system means that, at least at the outset, it is likely only a small minority of patients will have a PCEHR. This is fortunate because it will give an opportunity for significant problems to be resolved before the number of records is large.

It also gives time for the implications of the PCEHR's existence to be worked through. For example, will there be a duty of care for medical practitioners to try to access information that might be in a shared health summary? And to what extent should they rely on this information?

The AMA has assisted the roll out of the PCEHR by drafting a Code of Practice under the expert leadership of our Chairman of Council, Roderick McRae. But doubts remain. A recent article for the Medical Journal of Australia by Professor Coiera and colleagues raised issues about the safety of relying on the PCEHR. They asked, "What would happen, for example, if drug allergies were incorrectly uploaded from clinical systems or if medication names and doses were somehow incorrectly imported and displayed?". So who is responsible for the veracity of the information and what governance arrangements will be applied?

Clearly there is a huge task of awareness and education for medical practitioners, other health professionals and the community in general to make the PCEHR functional. This is going to take a lot of time, effort and resources.

Other bumps remain to be smoothed out. The draft proposals for GPs wanting to take part in the PCEHR required them to sign a contract that, among other things, would allow the Department of Health and Ageing to, "…. access your premises, access your information technology systems, require the provision by you of records and information [etc]". While there has been further comment that a revised draft contract is being developed, and will be released for consultation in response to the AMA's advice that the original draft contract was unacceptable, it was not a good starting point.

Finally, despite the obligations on medical practitioners, and especially general practitioners, if the PCEHR is to fly, Government support for the work involved seems minimal or absent. The AMA has already published a scale of indicative fees for preparation and maintenance of a shared health summary, but current feedback suggests such items are unlikely to attract Medicare rebates for our patients.

Comment from the Department of Health and Ageing seems to make it clear that GP attendance items can't be used either, because the current item descriptors will continue to apply. Further plain language advice from the Department of Health and Ageing is needed so everyone is clear on this matter and expectations are not created that may not be fulfilled.

In the absence of Government support are people prepared to pay for preparation and maintenance of their shared health summary? Or are GPs going to do this work for nothing?

These constraints seem likely to limit uptake of the PCEHR after July 1. Over $467 million has been invested in the project. In an era when achieving a budget surplus is the priority it would be easy to kill it off, but it's too important for that. Instead, it needs further real investment so that it can be developed and modified to ensure as many Australians as possible have an electronic health record. It will be an investment for the future.

TO COMMENT CLICK HERE

Beware the cost of cuts to health spending

BY AMA SECRETARY GENERAL FRANCIS SULLIVAN

A tight parliament and a tight Federal Budget make for constrained times. So, too, does the economic uncertainty brewing to our north.

The determination to achieve a budget surplus begs the ominous question: are we facing even tighter times in the years ahead? If so, what will be the balance between community responsibility and individual contribution in the evolving social policy debates.

In an interesting speech recently delivered at the Institute for Economic Affairs in London, Shadow Treasurer Joe Hockey called for an "end of the age of entitlement". In short, he was re-igniting the classic economic debate over intergenerational debt transfers to pay for current generational social benefits. This means pushing today's costs of health, education, housing, social security and aged care out to 'the long term'.

Mr Hockey situated his case within the financial collapse in some European economies and the austerity measures being adopted in those countries. His thesis, though far from new, stressed that countries, mainly through the weakness of the populist politicians, continued to fund lifestyles beyond their means. He called for more rigorous spending cuts, lower taxation for individuals and business, and a shift towards self-sufficiency from reliance on government handouts.

Mr Hockey's speech gives some indication of the thinking inside the Coalition. It may well also reflect the current Government's mindset, as this is standard fare from the Commonwealth's Treasury and Finance departments.

Budget 2012 may well embrace stronger austerity measures across pensions, social security payments, and safety nets. They are always targets, but never more so than when a surplus becomes such a heightened political goal.

From the health perspective, the debate over entitlements can become very confused.

Firstly, Medicare is a genuine entitlement scheme. All contribute to it, and all have access to it. It is not a safety net program in the sense that access is determined once a level of impoverishment has been assessed. So, to wind back Government expenditure on Medicare in the name of improving the intergenerational debt problem can only be justified on the grounds of a restructuring in how we seek to cover individuals for their health cost risks.

Health is not a welfare program. Rather, it is increasingly being understood as a vital component of human capital that leads to economic productivity and performance. Thus, it is far better to categorise health funding as investment that leads to a social and economic return than it is to call it a cost that contributes to a burden on public revenues.

Seen in this light, the 'tinkering' that happens over access to Medicare safety nets and pharmaceutical benefits can be counterproductive.

The evidence is compelling that price signals deter people from accessing services. This may be fine if those services are surplus to need. But it is a very different case when services are more essential and enable people to maintain a productive life.

It can be common for advocates to overcook this argument in an attempt to resist any fiscal tightening at Budget time. Of course, Budgets need to be tailored toward affordability. But they must also be designed to bolster the social fabric of the community. Promoting self-reliance is one thing, but overly stressing individual responsibility at the expense of the common good is dangerous.

In Australia, the entitlement to health care is considered to be a social benefit, even a social right by some. It is predicated on an individual's capacity to contribute through both the tax and 'pay as you go' systems.

It has been designed to contain the growth in expenditure within the constraints of an ageing population and a rapidly developing, technologically-driven system.

It doesn't warrant being a target for the fiscal hawks hellbent on overlaying a small government agenda, for no other reason than that those who will be affected the most are the very same people who rely on the system the most.

We will know more about how this plays out once we have examined the entrails of this week's Federal Budget.

TO COMMENT CLICK HERE

Severe shortage of doctor and nurses looms without urgent action

There could be national shortage of almost 3000 doctors by the middle of the next decade without a major boost to training places for medical graduates.

A report by Health Workforce Australia has found that, under current training and immigration arrangements, there will be 2700 fewer doctors than needed by 2025, with the shortage of nurses even more acute, reaching almost 110,000 positions over the same period.

The AMA said the sobering assessment, made in a report released by the Australian Health Ministers' Conference on April 27, showed there was a "desperate need" for governments to urgently invest in more pre-vocational and specialist training places for medical graduates.

While there has been a sharp increase in the number of medical students, with enrolments doubling in recent years and the graduating class of 2014 set to reach 3700, there has been no corresponding boost to the training places they need following graduation to develop specialities or prepare them for practice.

AMA President Dr Steve Hambleton said governments needed to act quickly to ensure the nation's workforce would be adequate to meet future health needs.

"The report provides a compelling case for governments to commit the extra resources needed to ensure that medical graduates have access to quality training places in the future," Dr Hambleton said.

In its report, *Health Workforce 2025* Health Workforce Australia warned that "continuing to use the same policy parameters and models to deliver health services into the future may not be sustainable."

"Choices will be required in terms of the level of investment which can be made and the policies which can be implemented."

Responding to the findings, the Health Ministers said the modeling used in the report might be open to question.

But, they said in a communiqué, "it [nonetheless] identifies indicative broad trends well into the future and, without strong reform intervention, these estimates will mean services may be unsustainable".

"The report presents the need for essential, coordinated, long-term reforms by governments, professions and the higher education and training sector to ensure Australia has an affordable and sustainable health worklforce to meet the changing health needs of the Australian community," the communiqué said.

Health Workforce Australia will use the report to inform the development of a training plan, which Dr Hambleton said was a "crucial piece of work that the AMA strongly supports".

He said significant funds and inter-government cooperation will be needed to develop and implement the training plan, and urged the Federal Government to convene a Council of Australian Governments meeting specifically to reach agreement on boosting pre-vocational and specialist medical training places in line with the findings of the report.

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Change booze tax to reduce harm and boost budget

The AMA is pushing for a sharp increase in tax on alcohol that will help reduce drink-related health problems and other harm while adding $1.5 billion to the budget bottom line.

The AMA, along with Cancer Council Australia, the Foundation for Alcohol Research and Education and the McCusker Centre for Alcohol and Youth, has written to Prime Minister Julia Gillard urging the Government to overhaul and simplify the taxation of alcohol to a regime based on volume.

At present four categories of taxes apply to alcohol, including the 10 per cent Goods and Services Tax, a wine equalisation tax, and customs and excise duties that involve a combination of volume and value-based levies.

The leading health groups, which have consistently advocated the change for many years, argue the reform will not only simplify the taxation regime but, by pushing up the cost of some alcohol products, act to help reduce over-consumption and misuse.

They estimate the reform would deliver a $1.5 billion boost to tax revenue, which should be directed to more health spending.

AMA President Dr Steve Hambleton said alcohol and the harm it caused cost the community $36 billion a year.

"It's unfair on our emergency departments who deal with the sharp end, unfair on other health professionals whose huge workloads are inflated by harmful alcohol use, and unfair on the taxpayer," Dr Hambleton said. "Ultimately, it's unfair on problem drinkers who could change their behaviour through price controls on products like cheap wine, which are not taxed according to the harms they cause."

Foundation for Alcohol Research and Education Chief Executive, Michael Thorn, said over the past decade at least eight separate government reviews had recommended overhauling the anomalous wine equalisation tax, which floods the market with cheap wine.

"It's the most inefficient, inequitable component of the alcohol taxation system. That's not just our view, it's also the view of the Henry tax review and some of Australia's leading wine companies," Mr Thorn said.

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A special Budget edition of Australian Medicine will be published on Wednesday, providing a detailed analysis of the Budget and what it means for the health sector.

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Better support needed for overseas-trained doctors

The AMA has called on the Federal Government to boost assistance and supervision for international medical graduate doctors, particularly those working in rural and regional areas.

AMA President, Dr Steve Hambleton, has written to Health Minister Tanya Plibersek, urging the Government to provide extra, specialised support for such doctors, who often struggle to get the assistance and supervision they need despite frequently working in difficult and isolated environments.

The AMA Federal Council has recommended that new funds be allocated to General Practice Education and Training Ltd, which has the capacity and infrastructure required to provide additional support for international medical graduate (IMG) doctors working in general practice.

Dr Hambleton said the AMA has a long-standing interest in the role of IMG doctors in Australia, who were making a "substantial" contribution to the health system, "particularly over the last 15 years or so while our own locally produced medical workforce has been in undersupply".

He said the AMA has been especially concerned about poor access to supervision and oversight experienced by many such doctors, particularly those working in regional and rural general practice.

"This lack of support is unfair on IMGs, who are often working in very challenging environments and are professionally isolated," Dr Hambleton said. "The AMA has for many years been working with IMG doctors to help them navigate the Australian health system, and we have supported measures that ensure IMG doctors are fully competent and qualified to practice in Australia."

The AMA Federal Council, on the recommendation of the AMA's Rural Medical Committee and the AMA Council of General Practice, says the extra funding to be given to GPET should be sufficient to ensure international medical graduates get the supervision they need to comply with Medical Board of Australia guidelines.

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Aged care progress but more needs to be done

Federal government reforms to aged care will help the elderly live in home for longer but fall short of ensuring they have the access to the doctors that they need.

The Australian Medical Association has welcomed measures in the Government's $3.7 billion *Living Longer Living Better* package that will enable more elderly people to stay at home for longer, including the addition of 40,000 Home Care packages from mid-2014, with a total increase of 80,000 packages by 2021-22.

AMA President, Dr Steve Hambleton, said the plan was an important response in an area of policy that has been long neglected.

"Living at home allows individuals to age with dignity as an active participant in the community with a sense of place, and this is very important," Dr Hambleton said.

But he said he was disappointed that the reforms failed to properly address ways to improve elderly access to quality medical care.

The plan includes $14.2 million provided over five years to support multidisciplinary care, some of which will be used to improve the availability of GP video consultation facilities and services.

Dr Hambleton said the AMA had highlighted the need for such a step in its discussions with Government regarding the Telehealth initiative.

He said there were other significant measures in the package, including $268 million over five years to help tackle dementia - $41 million of which will be allocated to help GPs make more timely diagnosis of the debilitating condition.

A further $22 million will be provided over five years to provide specialist palliative care advice to GPs and aged care providers.

But the AMA President said there were still significant shortcomings in the Government's plan.

"The funding for the health care aspects of the package falls well short of what is needed, and many areas of primary care for older Australians have not been addressed in this package," Dr Hambleton said.

"We will be seeking more details from the Minister for Health and Ageing about the health care aspects of this package, especially access to primary care services," Dr Hambleton said.

Under the government's plan, spending on aged care will increase but become more targeted, with means testing for home and residential care assistance from 1 July, 2014.

While full pensioners will be exempt from Home Care fees, singles whose annual income exceeds $43,186 ($66,134 for couples) will have to contribute up to $10,000 a year toward the cost of their care.

A means test will also be applied to residential care assistance.

Individuals with an annual income above $23,543 and/or assets worth at least $40,500 will be liable for means testing, though the family home will not be counted toward the asset test as long as it is occupied by a "protected person", usually a spouse. Where a house is included, its value will be capped at $144,500 for the purposes of the test.

The Government estimates means testing will free up around $550 million that can be directed to other areas of the aged care package, while tightening payments to aged care providers is expected to liberate a further $1.6 billion.

With means testing, the Government predicts its share of funding for Home Care packages to slip from 84 per cent to 76 per cent.

Dr Hambleton said it was pleasing that package included a safety net for "the many older Australians who don't have the financial capacity to pay for aged care".

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Disability insurance to start from mid-2013

The Federal Government has fast-tracked the introduction of its National Disability Insurance Scheme in a move welcomed by the AMA, which has been pushing for nationwide long-term support for the severely disabled and their carers for almost a decade.

AMA President Dr Steve Hambleton said the scheme was an "investment in the future and in the quality of the lives of people with disabilities," and would be of enormous benefit for them, their families and their carers.

The Federal Government is expected to make provision in its May 8 budget for support for 10,000 people with significant and permanent disabilities in four locations from July next year as the first installment of its commitment to the scheme.

The number of people who will be able to access the scheme is expected to double in 2014 to 20,000.

Prime Minister Julia Gillard said the Government was "stepping up" to its responsibilities to those Australians with a disability, and urged the States and Territories to deliver on their share of the funding.

"For the first time in Australia's history, people with significant and permanent disability will receive lifetime care and support, regardless of how they acquired their disability," she said. "Whether or not you get the help you need can depend on the circumstance s in which a person got their disability, whether they got it at work or whether they were born with it. We want to make a difference to that through a National Disability Insurance Scheme."

Federal, State and Territory governments committed to the key principles underpinning the scheme at a meeting on April 13.

Dr Hambleton said the scheme was a "transformational reform for the benefit of the most vulnerable people in our community".

"When fully implemented, the NDIS will provide fairness, equity, and a better quality of life for people with a disability, their families, and their carers," Dr Hambleton said.

He added that the AMA was preparing to work closely with the Government in developing and implementing a National Injury Insurance Scheme for people who are severely injured and require the same levels of support.

"Over time, there is scope for both schemes to be integrated so that all Australians have access to early intervention and support, based on need, regardless of the cause or type of disability," Dr Hambleton said.

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AMA in action

AMA President Dr Steve Hambleton, together with AMA Northern Territory President Dr Paul Bauert, psychiatrist representative on the AMA Federal Council Dr Choong-Siew Yong and AMA policy officer Corrine Dobson met with Department of Immigration officials in Canberra last month, and lobbied successfully to have an ambulance stationed at Palmerston, about 20 km south of Darwin, where it can serve the Wickham Point Immigration Detention Centre. During his visit, Dr Hambleton also attended a dinner to honour the out-going chair of the AMA Council of Doctors in Training, Dr Rob Mitchell, as well as meeting with Dr Tony Sara and other delegates of the Australian Salaried Medical Officers Federation. Last week he attended a thanksgiving service organised by the University of Queensland's School of Biomedical Sciences to recognise the generosity of those who donate their bodies for use in anatomical teaching and research, and to publicly thank their families and friends. He attended the service with AMA Queensland President Dr Richard Kidd and Dr Eleanor Chew, chair of the Royal Australian College of General Practitioners' Queensland faculty.

Dr Hambleton outside Parliament House

Dr Hambleton speaks to the media outside Parliament House

Dr Hambleton meets with Dr Tony Sara

Dr Hambleton with Dr Paul Bauert, Dr Choong-Siew Yong and Corrine Dobson following the meeting with Immigration Officials

Dr Hambleton with Dr Richard Kidd and Dr Eleanor Chew at the University of Queensland thanksgiving service

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AMA IN THE NEWS

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

Print

Coffee shock: Gen-Y most likely to get caffeine withdrawals, survey finds

The Herald Sun, 30 April 2012

Australian Medical Association President Dr Steve Hambleton said society was becoming increasingly dependent on caffeine, not just from coffee but also from chocolate and energy drinks.

Push to change alcohol tax

The West Australian, 30 April 2012

The AMA, Cancer Council Australia, the Foundation for Alcohol Research and Education and the McCusker Centre for Action on Alcohol and Youth have written to Prime Minister Julia Gillard calling for a volumetric alcohol tax in the Federal Budget.

Doctors versus chemists in war over flu shot

The Sunday Telegraph, 29 April 2012

AMA President Dr Hambleton said vaccinations, including the annual flu jab, should only be administered by a GP and not performed in a local chemist.

The high cost of our depression

WA Today, 29 April 2012

AMA President Dr Hambleton said Australians take a lot of antidepressants, but advances meant they no longer had the sedating effect they once had, though there was the potential for side effects including potential to trigger side effects including blurred vision, dry mouth, nausea and sometimes dizziness

Are online medical records safe?

The Herald Sun, 28 April 2012

The AMA has concerns about patient control of medical records, with the usefulness of electronic health records potentially compromised by the inclusion of only partial information.

Nurse shortfall to hit 100,000

The Australian, 28 April 2012

The AMA said a health workforce report showed the need for governments to boost funding for vocational training to enable medical graduates to qualify as surgeons, physicians, anaesthetists and other types of medical specialist.

AMA in warning on health budgets

The Australian, 20 April 2012

Smaller States will be unable to fund their health budgets within five years, the AMA President Dr Hambleton warned.

Vitamins deal poses conflict,AMA warns

The Age,19 April 2012

AMA President Dr Hambleton said he had concerns about doctors "selling anything to their patients for a mark-up", which was a conflict of interest requiring full disclosure.

Radio

Dr Hambleton, *2UE* Sydney, 19 April 2012

Dr Hambleton talks about the symptoms of toxic waste after road workers potentially uncovered some on the Pacific Highway. He says exposure can be measured.

Dr Hambleton, *6PR* Perth, 30 April 2012

AMA President Dr Steve Hambleton says the AMA, with other organisations, is lobbying the Government to introduce new taxes on alcohol based on volume not price.

The latest from AMSA

AMSA slams Victoria's unfair public transport concessions

In response to the Baillieu Goverment's request for public feedback to improve Victoria's troubled Myki system, the Australian Medical Students' Association argued for fairer access to Victorian public transport concessions.

AMSA brands NSW's transport concessions as discriminatory

The Australian Medical Students' Association has slammed NSW transport concession rules they claim discriminate against postgraduate, interstate and international students.

AMSA demands action on landmark Health Workforce 2025 report

The Australian Medical Students' Association (AMSA) welcomes the release of the *Health Workforce 2025* report. The medical workforce is ageing and action is needed now to curb looming workforce shortages without compromising quality.

Recent news from the *MJA*

Experts call for more commitment to bowel cancer screening

Australia's cancer experts say hundreds of lives could be saved every year if the Government ramped-up its commitment to bowel cancer screening.

Action needed to deal with length of training and ageing medical workforce

Doctor's office is a safety regulation-free zone

More and more major surgery is taking place in the doctor's office yet, unlike hospitals and day surgeries, these settings are not governed by safety regulations.

Specialised centres could improve pancreatic cancer outcomes

Surgery provides the best chance for people with pancreatic cancer, but new data show we could be doing it better.

TO COMMENT CLICK HERE

At last - a look at GP non-contact time

BY **DR BRIAN MORTON**

"The AMA hopes that valid data on non face-to-face activities performed on behalf of the patient will help guard against cuts in the future to services listed in the Medicare Benefits Schedule"

Following the Government's decision to slash rebates for GP mental health items, Bettering the Evaluation and Care of Health (BEACH) researchers have taken the cue and for the first time will be measuring the amount of non-contact time GPs spend on patient care.

This new line of investigation by BEACH is in its infancy, but it is a welcome start. The information to be collected in the first year will be basic but, if the response to it is good, the line of questioning will remain and could be further expanded.

The AMA applauds this step taken by Associate Professor Helena Britt and her team. Greater recognition needs to be given to the non face-to-face time that GPs spend caring for their patients. Prior to last year's Federal Budget the AMA had written to BEACH, suggesting that there was a need for a reliable measure of the non-contact time that GPs spend on their patients.

The move seems to be welcomed by GPs, with feedback confirming it's not before time, and that there is increasing frustration with the amount of unpaid work required of GPs. Of course, in this instance "unpaid" really means "unrebated", because GPs who bill patients for the quality care they provide do inevitably factor in the non-contact component.

The AMA hopes that valid data on non face-to-face activities performed on behalf of the patient will help guard against cuts in the future to services listed in the Medicare Benefits Schedule. Time in front of the patient is not the only component of the service.

The GP mental health plan is one of those items where the time spent fulfilling the requirements and preparing the plan may be not be done in one time block, or entirely with the patient present. The item is specifically for the service of preparing the plan, and was constructed on the basis that GPs would spend time without the patient in front of them completing the requirements of the item. A key example of this is making arrangements for required referrals, treatment, appropriate support services, review and follow-up.

Unfortunately, BEACH data was used to justify cuts to the rebates for these items. BEACH at that time only recorded the face-to-face time and not the time spent on associated paperwork and making arrangements for the patient with other health care workers.

Perhaps with BEACH now looking at time spent on non-face to face services, the Government will have to give greater acknowledgement to it.

TO COMMENT CLICK HERE

Pharmacist push could threaten collaborative care

BY **PROFESSOR GEOFFREY DOBB**

"In the interests of patient safety, any prescribing by non-medical practitioners should only be carried out within strict co-management regimes"

The AMA opposes the growing trend to grant prescribing rights to more non-medical health professionals, outside of a medically delegated environment.

In the interests of patient safety, any prescribing by non-medical practitioners should only be carried out within strict co-management regimes.

Unfortunately, under 'continued dispensing' legislation passed by Federal Parliament, pharmacists will be able to dispense medicines under the PBS without a prescription and without reference to the patient's treating doctor, on the basis of a previous prescription. This represents a significant change in the professional role of pharmacists within a health care team.

Medical practitioners place a high value on the professional role of pharmacists, and work with them to improve the medication management of patients and their clinical outcomes. However, continued dispensing will allow pharmacists to operate autonomously.

Initially, pharmacists will only be able to dispense 'eligible' medicines: the contraceptive pill and lipid modifying agents. However, we can expect strong lobbying by the pharmacy sector to expand that list over time.

The most recent draft guidelines for continued dispensing prepared by the Pharmaceutical Society of Australia (PSA), state that after dispensing an eligible medicine "pharmacists must provide written communication to … the most recent prescriber advising of the supply of the medicine to the consumer".

However, unless a pharmacist checks with the treating doctor, he or she has no way of knowing whether the patient's medical practitioner intended to continue the medication, to adjust it, or to cease that treatment. It is a concern that a professional organisation such as the PSA has seen fit to turn back the tide on collaborative care by guiding the pharmacist to inform the relevant medical practitioner after the event.

This arrangement will compromise medical practitioners' care of their patients. Who will be responsible if something goes wrong after the pharmacist has given the patient more medication without review by the patient's medical practitioner?

The guidelines state that the pharmacist must provide written advice to the patient's medical practitioner within 24 hours of the supply of the medicine, together with information covering: the patient's name and address; date medicine dispensed; medicine details such as the strength, form and instructions provided for use; and reason for continued dispensing. The information must also include a declaration co-signed by the consumer indicating their understanding of, and consent to, the supply.

I welcome your views and comments on how you see this working for you in practice. If you receive this information will you feel compelled to review the patient's file and call the patient in for review?

Please forward your comments to ama@ama.com.au.

In the meantime, I encourage AMA members to maintain strong working relationships with local pharmacists. This is critical to ensuring patient safety and avoiding fragmentation of care.

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Planning a future medical workforce

BY **JAMES CHURCHILL**

"Producing graduates who are unable to work as interns in Australia is a futile response to workforce shortages and represents a significant waste of taxpayer (and significant private) investment and valuable teaching time"

On Friday, 27 April, Health Workforce Australia presented the *Health Workforce 2025* report to the Australian Health Ministers' Conference.

The report, formerly known as the *National Training Plan*, has long been needed to fill the void of robust national data on the numbers of medical, nursing and midwifery trainees in the training pipeline, with the goal to inform planning and ensure Australia produces the right number of doctors, nurses and midwives to meet future health needs.

The medical training system has been subject to poorly coordinated and deficient workforce planning over the past two decades. Successive periods of rapid contraction and expansion have left the system vulnerable to threats to quality training.

While medical student numbers were steady between the 1970s and the mid-1990s, in 1995 the Federal Government reduced medical school intakes from 1,200 to 1,000 at a time when the health needs of an ageing Australian population had already begun to rise.

Just a few years later, expansions in student numbers and new medical schools were back on the Federal Government's agenda. Since 2000, 10 new medical schools have been created and the total number of medical students has doubled.

The pressure that these recent increases in numbers, together with chronic underfunding, have placed on the clinical training system, is significant. This year, it's anticipated that 3,512 doctors will graduate; for the first time, it's likely that many will not find an internship.

It is for these reasons that the *Health Workforce 2025* report is so urgently needed. Producing graduates who are unable to work as interns in Australia is a futile response to workforce shortages and represents a significant waste of taxpayer (and significant private) investment and valuable teaching time.

In a few short years, the wave of medical students currently flooding the system will be looking for vocational training places. We hope that there is still time to alleviate the bottleneck in the system and allow it to function at its maximum efficiency. Governments and medical schools need to do everything in their power to ensure all medical graduates from Australian universities are able to complete an internship.

AMSA has called for Health Ministers to agree on a way forward and use the *Health Workforce 2025* data to commit to the planning, funding and policy decisions that are urgently needed to create a sustainable future health workforce.

TO COMMENT CLICK HERE

National registry of implants and other devices needed

The global recall of PIP breast implants and the recent withdrawal of DePuy hip replacements has highlighted the critical need for national registries of medical devices, according to the AMA.

The Association has told a Senate inquiry into medical devices that the country must have Government-funded clinical registries to help medical practitioners and the Therapeutic Goods Administration to track the use of devices and respond early to evidence of unusual failure rates.

In its submission to the inquiry, the AMA argued that although a certain proportion of implanted devices were always likely to fail, clinical registries would enable robust assessment and comparison of their performance.

"They allow medical practitioners and the TGA to respond appropriately when there is a clear failure of a device that is beyond that of like products," the submission said. "Clinical registries allow medical practitioners to identify problems early, respond appropriately in a coordinated manner and support clinical decisions about which devices are delivering the best patient outcomes."

The AMA cited the National Joint Replacement Registry as a "premium example" of what could be achieved.

"The [Registry] was instrumental in Australia being the first country to withdraw the DePuy metal-on-metal hip joint replacement device after a high rate of failure," the association said.

The AMA said national registries would also help to track devices to individual patients in the event of a recall.

The Joint Replacement Registry is funded by a levy on device suppliers, a cost which the AMA said was ultimately passed on to patients.

It said it would be fairer if the Government, through the Therapeutic Goods Administration, funded the establishment and maintenance of registries, in cooperation with medical craft groups.

"We believe this is a cost that it is reasonable for the entire Australian community to share, rather than imposing it on those individuals whose lives have been saved or improved by medical devices," the submission said.

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INFORMATION FOR MEMBERS

Guidelines and resources on prescribing drugs of addiction

The AMA Therapeutics Committee has developed a 'one-stop-shop' webpage for AMA members, providing links to key guidelines, resources and other information to support medical practitioners prescribing drugs of addiction.

The links include:

- the latest independent drug information about opioids and treatments provided by the National Prescribing Service;
- the 'Dr Shopper Line' operated by the Department of Human Services;
- Royal Australian College of General Practitioners' guidelines on prescribing benzodiazepines;
- steps to follow when ending the doctor-patient relationship, produced by MDA National;
- statistical information on pharmacotherapy for opioid dependence, produced by the Australia Institute of Health and Welfare; and
- State and Territory government-funded drugs of dependence units.

You can view the *Prescribing drugs of addiction support page* at: http://ama.com.au/prescribing-drugs-addiction-members-support-page. (Remember you need to log in with your member details first.)

A direct link to the page is also located on the AMA members' home page in the box titled *AMA information and resources.*

Comments are welcome. Just use the section at the bottom of the page.

TO COMMENT CLICK HERE

Killing and kidnapping of doctors in Syria and Bahrain must stop

The world's peak medical group has issued an emergency call for an end to attacks on doctors in Syria and Bahrain, where physicians and health workers have been killed and injured while treating patients.

The World Medical Association, of which the AMA is a member, has declared that the governments of Syria and Bahrain should fulfill their obligations under the Geneva Conventions to respect and protect medical practitioners.

The emergency resolution, passed by the Association's Council at a meeting in Prague late last month, follows mounting evidence that doctors, health workers and patients – many of whom have been injured during protests against incumbent regimes – have been killed, injured, kidnapped and tortured during uprisings that have left thousands dead.

Association President Dr Jose Gomes do Amaral said physicians and other health care workers must be treated as neutral in armed conflicts, and has called on the governments of both countries to investigate violations of the Geneva Conventions, and bring those responsible to justice.

"We denounce these appalling attacks on physicians, health care workers and patients," Dr Amaral said. "Every time a physician is kidnapped, attacked or killed, the delivery of health care is damaged, often destroyed altogether, and patients suffer.

"Governments have an obligation to ensure that health care facilities, and those working in them, can operate in safety and without state interference."

An investigation by the organisation Physicians for Human Rights documented numerous cases where doctors have been abducted by Bahrain government security forces from hospitals and their homes, as well as being beaten and abused.

In Syria, physicians have reported being seized, assaulted and tortured by government security forces that accuse them of treating people wounded in that country's uprising.

Turkey de-registers peak doctors group

The Turkish government has been condemned for attacking the independence of the country's peak medical body.

The World Medical Association (WMA) said it was "extremely concerned" by the Turkish Government's move to undermine the autonomy of the medical profession and drastically reduce its powers of self-regulation.

Meeting in Prague, the WMA's Council was told of Government decrees robbing the Turkish Medical Association of the authority to establish and issue ethical guidelines, investigate allegations of malpractice, impose disciplinary sanctions and develop core curricula for medical education.

WMA Chair, Dr Mukesh Haikerwal, called on the Turkish Government to restore the medical association's powers, and urged all Turkish physicians to "join actively in promoting and supporting professional independence".

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Doctors and patients to be just a click away

Patients will be able to consult with general practitioners and specialists over the web through a system being trialled by health fund Medibank Private.

The fund's Anywhere Health program, which will undergo testing at three medical clinics this month, is expected to give patients – particularly those in remote areas or seeking after-hours care – access to on-line medical services.

Medibank's head of clinical quality, Ian Boyd, said practitioners joining the system had full control over who they served, including the ailments they were interested in treating, while giving patients access to an on-line network of doctors and specialists.

Dr Boyd said the program, which is adapted from the American Well online care system, was a simple yet secure web-based platform that did not require any specialised hardware or expensive software to operate.

He said it was compatible with the software used in most practices, and could take patients through the whole treatment process from registration and pre-appointment checks to video consultation, online payments, prescribing and updating electronic health records.

Dr Boyd does not expect the system to become a substitute for face-to-face consultations between patients and practitioners, but believes there is a market for the service among corporations, hospitals, medical practices and individual practitioners.

The development of the system has come amid concerns that medical services in remote, resource-rich regions are being put under strain from a big increase in demand driven by the rapid expansion of mining workforces.

The Australian Medical Association of Western Australia told a federal parliamentary inquiry last month that there had been an increase in cases of sexually transmitted diseases, alcohol and drug abuse, mental health and risk-taking behaviour associated with the proliferation of fly-in, fly-out workers at major mining sites.

More than 80 per cent of 290 practitioners surveyed by the association thought mining companies using such work arrangements should make a financial contribution to health services in these areas.

Medibank expects the Anywhere Health program to come into operation from July 1, initially providing an adjunct to its GP after hours hotline, which is expected to have handled up to 170,000 inquiries in the 12 months to June 30.

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Swisse vitamin deal poses ethical conflict

The AMA has criticised vitamin company Swisse Vitamins for offering doctors incentives to sell their products.

In an email sent to doctors last month, Swisse invited them to sell its "practitioner range" of products through their practices in exchange for a percentage of each sale, and offered to pay for them to attend a course from the National Institute of Integrative Medicine.

According to *The Age*, a Swisse spokesperson said the range was currently sold by other practitioners, including physiotherapists, and did not believe the arrangement was unethical.

But AMA President Dr Steve Hambleton said that he had concerns about doctors selling anything to their patients for a mark-up, indicating that it was a conflict of interest and would require full disclosure.

Dr Hambleton said the deal sounded very similar to that offered by another supplements maker, Blackmores, to doctors last year.

In that deal, pharmacists received computer prompts to promote Blackmores supplements when selling certain prescription drugs to customers.

The deal was withdrawn after pressure from the AMA and other groups.

Dr Hambleton said the AMA's major criticism of the Blackmores deal was that products were intended to be sold to patients at the point of sale by a professional health worker, with virtually no evidence to back-up their efficacy.

"The AMA has the same cautions for medical practitioners with the Swisse deal," Dr Hambleton said.

"The level of evidence for the products needs to be clearly explained and disclosed.

"The principle of prescribing and dispensing has traditionally been kept separate for a very good reason."

Greens' Senator Dr Richard Di Natale said that it was completely inappropriate for Swisse to be offering incentives to doctors for the sale of its vitamin range.

"I am pleased to see the AMA come out strongly against incentives for health professionals," Senator Di Natale said.

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Butting out cuts pulmonary death rates

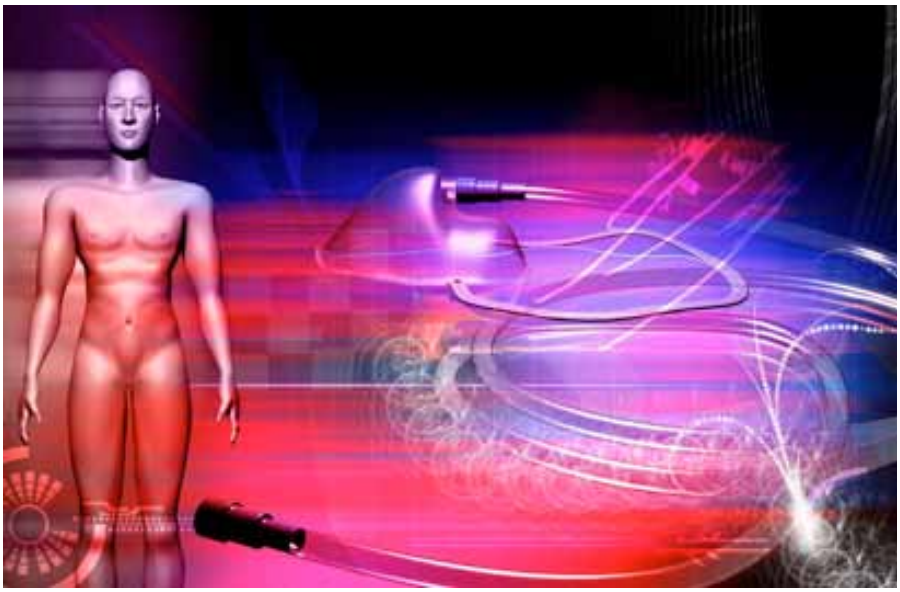
Death rates among men from diseases that obstruct airways have plummeted as the prevalence of smoking has receded, but the improvement in mortality among women has been much more modest, according to a report by the Australian Institute of Health and Welfare.

Figures collected by the institute show that the proportion of men dying from chronic obstructive pulmonary disease dropped from 95 per 100,000 in 1970 to 29 per 100,000 in 2009.

The big decline coincided with a steady fall in rates of smoking among men, from 45 per cent in 1974 to below 30 per cent in the late 1990s and 16.4 per cent in 2010.

Among women, the mortality rate from the condition peaked much later, reaching 23 per 100,000 in 1997, and has since declined only moderately to 17 per 100,000.

The narrowing gap in death rates between the genders reflects in part the more modest decline in smoking among women, from 30 per cent in 1974 to 25 per cent in 1998 and 13.9 per cent at the end of last decade.



Institute spokesman Adrian Webster said smoking was the main, but not only, cause of chronic obstructive pulmonary disease, which includes emphysema and chronic bronchitis.

The institute said the condition was a major cause of mortality in Australia, accounting for about 4 per cent of all deaths in recent years – though it admitted attributing death among the elderly to the disease was "often difficult".

It reported that in 2009, 5293 people were recorded as having died from the condition – 2979 men and 2314 women – about 8 per cent of all respiratory deaths.

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Wait on High Court in tobacco case

The High Court is expected to keep the Federal Government and major tobacco companies waiting for months for a decision following a landmark hearing af a challenge mounted against laws enforcing plain packaging for cigarettes.

Big tobacco companies launched the action following the introduction of new laws, strongly supported by the AMA, which demand the removal of trademarks and brand colours from cigarette packets by the end of the year.

The laws are a world-first, and cigarette makers are desperately trying to kill them off before other countries are encouraged to follow suit.

In their High Court challenge, the tobacco companies argued that the plain packaging laws amount to the acquisition of their brands and logos by the Government, and should be thrown out.

Government lawyers countered that although the laws require the removal of trade marks from all cigarette packets, they do not weaken the companies' exclusive ownership of the trademarks.

The New Zealand Government, which has been watching proceedings in Australia closely, recently announced that it planned to introduce similar plain packaging legislation, and the UK Government has also flagged interest in taking similar action.

AMA President Dr Steve Hambleton said Australia's reputation as a world leader in public health initiatives that save lives and improve people's health has been significantly enhanced with Government's pioneering tobacco plain packaging legislation.

"Smoking kills people and smoking destroys people's health," Dr Hambleton said.

"The AMA strongly supports Government action to stop people smoking and discouraging others, especially young people and children, from taking up the killer habit.

"Introducing plain packaging is a significant achievement in public health.

"This legislation will save lives."

Attorney General Nicola Roxon, who was formerly Health Minister when the plain packaging laws were developed, said she was very confident that they would stand up in court.

Continuing the Government's efforts to crack down on smoking, Health Minister Tanya Plibersek has indicated she is seeking legal advice on a national class action lawsuit to be taken against tobacco companies to recover costs forced on health budgets by smoking-related diseases.

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RESEARCH

More to breast cancer than it seems

Breast cancer is not one disease, but 10 distinct and separate conditions, according to the largest study of its kind to investigate the genetics of breast tumours.

The research, published in the journal *Nature* last month, involved the examination of breast cancer samples from almost 2000 women in the United Kingdom and Canada, and identified a series of "novel sub-groups" of the affliction.

While current tests break the classification of breast cancer down into a small number of large groups, the study's co-lead author, Professor Carlos Caldas, told science and technology news service *Scicasts* that the findings provided a far finer taxonomy of the disease than was currently used.

"Our results will pave the way for doctors in the future to diagnose the type of breast cancer a woman has, the types of drugs that will work, and those that won't, in a much more precise way than is currently possible," Professor Caldas said.

He said the research had "drilled down" into the biological causes of breast cancer through a comprehensive genetic study.

"Essentially we've moved from knowing what a breast tumour looks like under a microscope to pinpointing its molecular anatomy – and eventually we'll know which drugs it will respond to," the professor said. "This research won't affect women diagnosed with breast cancer today. But in the future, breast cancer patients will receive treatment targeted to the genetic fingerprint of their tumour."

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Plant could cut risk of Parkinson's disease in diabetics

A study has found that a substance in the French lilac plant can reduce the risk of Parkinson's disease in people living with Type 2 diabetes.

Monash University research involving more than 800,000 Taiwanese over a 12-year period found that having diabetes doubles the risk of developing Parkinson's disease, and using the anti-diabetic drug sulfonylureas heightens the risk by a further 57 per cent.

However, the researchers also found that when metformin, from the French lilac plant, was included in therapy, the risk among diabetics of developing Parkinson's disease was no greater than in the general population.

Metformin is used to help control blood sugar levels in diabetes patients and was originally introduced into France and Britain in the 1950s, and both it and sulfonylureas are used orally to treat Type 2 diabetes.

Lead author of the study, Emeritus Professor Mark Wahlqvist from Monash University's Asia Pacific Health and Nutrition Centre, said the new research identified that metformin works to protect the brain against neuro-degeneration, which contributes to Parkinson's disease.

"This means that it may be considered a relevant therapy for the prevention of dementia as well," Professor Wahlqvist said.

The study was carried out in conjunction with Taiwan's National Defence Medical Centre, National Health research Institutes and the China Medical University and Hospital.

The study was published by *Elsevier*.

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Health should be spared budget pain

The AMA has called for the key pillars of the health system to be shielded from painful spending cuts amid concerns Labor plans to slash programs across most areas of government in a desperate drive to achieve its promised budget surplus in 2012-13.

But there is intense speculation tomorrow's budget – the fifth for Treasurer Wayne Swan - will include measures to tighten access to the Medicare safety net and cuts to subsidies for cholesterol-lowering medication, as the government searches for ways to offset unexpectedly weak company tax revenues.

The *Australian Financial Review* has reported that subsidies for the high potency statins Crestor and Lipitor, which are expected to cost the Federal Government more than $910 million this financial year, are under review and could be cut in the budget while, according to the *Sydney Morning Herald,* Medicare subsidies for cosmetic genital surgery may be wound back.

AMA President Dr Steve Hambleton warned the Government might also be aiming for savings by tightening access to health safety nets, with the Medicare safety net that provides for an additional rebate covering out-of-pocket expenses for some who have already reached their limit seen as a likely target, along with the cap on spending for Pharmaceutical Benefits Scheme-listed medicines.

Mr Swan warned last week that the Government would have to save $10 billion more than earlier thought necessary because of a projected $5 billion shortfall in revenue collections from company tax and superannuation funds in each of 2012-13 and 2013-14.

Department of Finance figures show that as at February this year the budget was on track to reach a deficit of almost $29.4 billion – nearly $2 billion bigger than forecast in November last year.

The blow-out makes it unlikely the Government will be able to contain the deficit in 2011-12 to $37.1 billion, as earlier expected, making the task of achieving even the narrow promised surplus of $1.5 billion in 2012-13 increasingly tough.

The Government has so far withstood pressure, including from key political allies such as independent MP Rob Oakeshott, to let its promised return to surplus slip back a year or two rather than making draconian cuts to spending that are likely to add to the pressure on struggling parts of the economy.

Prime Minister Julia Gillard has insisted that a return to surplus next financial year is vital in giving the Reserve Bank of Australia room to cut official interest rates – though the central bank itself cited the strength of the dollar and unexpectedly low inflation as key reasons for last week's 0.5 percentage point official interest rate cut.

But Mr Oakeshott has put the government on notice that he may seek to block budget cuts made solely to achieve the "political pledge" of a budget surplus.

"I don't support a surplus at all costs, and it is disappointing that we are at the point where deficit is all bad and surplus is all good," Mr Oakeshott told Sky News late last month. "If they are going to make some hard budget cuts, I would hope they are very explicit and specific about why they are doing that, and why it is in the interests of a more resilient Australia and a stronger economy."

Prominent market economists and ratings agencies have called into question the need to deliver a surplus in 2012-13 as long as the government demonstrates a commitment to tightening fiscal policy, and the Greens have pledged to oppose any cuts to family benefits, research funding or the public service in the name of achieving a surplus next financial year.

In its budget submission, the AMA said that although it recognised times were tight, the government must not do anything to undermine the progress that had been made, particularly in the Council of Australian Governments' health reform package.

In the submission, Dr Hambleton argued that while the government's reforms had "not quite hit the mark", there was nevertheless significant extra funding from the Commonwealth and activity-based funding.

"The AMA wanted more from the COAG Agreement, but we acknowledge that that has been promised," Dr Hambleton said. "The single funding pool is a step in the right direction and there is now greater transparency in the system. The States are now unable to pass the blame for the performance or non-performance of their hospitals."

The AMA has proposed that money devoted to the GP Super Clinics program be diverted instead to additional infrastructure grants for existing clinics, and it wants cuts to the Better Access program for GP mental health services reversed.

"The 2012-13 Federal Budget must ensure that the important pillars of health care – the parts of the health system that work well and which patients and communities rely on – are recognised and funded accordingly," Dr Hambleton said.

But the signals from the government are not altogether encouraging.

Finance Minister Penny Wong has acknowledged there are "legitimate calls" for spending on initiatives including dental reform, the aged care overhaul, environmental spending and the proposed National Disability Insurance Scheme.

"But the reality is that not all of these demands can be responded to immediately," Senator Wong warned last month. "Just as it took time to deliver Medicare and paid parental leave, we have to prioritise."

There will be a special edition of Australian Medicine published on Wednesday analysing what the budget means for health care and the medical profession, with expert opinion from the AMA.

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Government must be at forefront in battling superbugs

The Federal Government needs to establish a high-level body bringing together doctors, researchers, industry and community representatives to tackling the mounting threat posed by antibiotic resistance, according to the National Prescribing Service.

Service board chair Dr Janette Randall told the National Press Club late last month that government needed to coordinate efforts across industry, the health sector and the community to promote the development of new antibodies and improve antibiotic use.

Dr Randall said Australians were among some of the highest users of antibiotics in the developed world, with about one prescription dispensed per person last year – well above the Organisation for Economic Co-operation and Development average.

Dr Randall said that some doctors contributed to the problem by, in some instances, issuing unnecessary scripts, while patients putting pressure on practitioners by demanding antibiotics shared some of the blame.

"Most antibiotic prescribing in Australia occurs without scrutiny," Dr Randall said. "Our system is lacking in its ability to track antibiotic usage in an effective way, and to provide feedback to doctors on their prescribing decisions.

"There is also insufficient information, such as local resistance patterns, to help doctors make informed treatment decisions. And prescribers are often responding to patient expectations and demand."

She warned that the nation was "fast approaching a situation where, by the time our children have become adults, we may have run out of effective antibiotics".

Dr Randall said a committee recently established by the Australian Health Ministers' Advisory Council to address the issue of antibiotic resistance would be fundamental in focusing political attention on the issue.

But she said more needed to be done by government to support investment in research and development, and to establish an effective regulatory framework to "preserve and safeguard the way we use these medicines".

"Government needs to take the lead and recognise where cooperation across portfolios is needed," she said. "This issue is not restricted to the health sector. The veterinary, agriculture and manufacturing sectors also have prime roles to play. A high level body involving all stakeholders is urgently needed to ensure a coordinated approach and to make the best use of available resources through collective and focused effort."

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New drug body head

Well-regarded pharmacologist and administrator Dr John Skerritt has been appointed head the Therapeutic Goods Administration.

Dr Skerritt, who is currently Deputy Secretary of Victoria's Department of Primary Industries, will become the TGA's National Manager late this month.

Department of Health and Ageing secretary Professor Jane Halton said Dr Skerritt brings to the position extensive experience in medical, agricultural and environmental policy, regulation and research, as well as demonstrated abilities negotiating and leading major international technical and commercial collaborations and overseeing regulatory reform.

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Time to get smart about phones

BY **PROF STEPHEN LEEDER**

I own a smart phone. I am generally regarded as an un-smart owner, especially by my younger generation. This may be rampant ageism but it is also correct. My iPhone is largely wasted on me, the youngsters say. At least I can phone, send and receive text messages, send and receive email and on rare occasions, when need overtakes concerns about cost, I access Google, Wikipedia and other brain aids for the feeble and dementing. Hey, guys, I am not that bad.

Not so many years ago I recall a debate in *The Economist* about the future of the mobile phone. If I recall correctly, that paper thought (though as usual it hedged its bets) that the search for a phone that would have computer-like features was an aberration. Too much complexity. People would not fiddle around with tiny keyboards and fiddly screens. Bad investment. Well: welcome to 2012.

When in India last year, I met with an executive of one of the Scandinavian mobile phone companies that are finding their fortunes in that highly electronically-literate country. Pyramid Research estimated that the addition of 125 million net new phones each year between 2010 and 2015 will "bring the total number of mobile subscribers to 1.2 billion in 2015".

The Pyramid report on India continued: "The exponential mobile subscription rates are driven primarily by the increasing adoption of 3G and mobile services such as music, video and broadband access," and mobile data services revenue is predicted to grow by 27.3 percent. No wonder the woman from Scandinavia was smiling.

I was in India helping review a program focussed on maternal and child survival, a principal component of which was the deployment of many hundreds of thousands of minimally-trained women to assist other women during their pregnancy, encouraging them to give birth near or in a facility that could managed haemorrhage, and basic neonatal support. They were paid virtually nothing, but what they were paid came to them through their phone accounts. They were able to cash in the credit at a store. No bank was necessary, which was lucky because in remote regions there were none.

The mobile phone put these support women in immediate touch with specialists for advice, transport and help. They were also given bicycles.

It is easy now to imagine or indeed, see, how smart phones could hold personal medical records, monitor basic physiological functions in those, say, with a cardiac pacemaker, calling for appropriate help automatically in a crisis, and to remind owners about medications and clinic appointments. Photos taken with a phone camera can be transmitted to physicians and used diagnostically.

Californian health care provider Kaiser Permanente makes extensive use of mobile telephony among its millions of subscribers and their carers. A pesky rash can be photographed by the patient at home and emailed to the primary care physician, who may diagnose directly or seek the advice of a dermatologist.

When I visited two years ago, an orthopaedic surgeon asked my group how much we thought it cost to review a patient six months after hip surgery. We offered a comment based on an x-ray and a consultation – let's say $500-$800.

"Well," he asked us, "How much does it cost the patient – half a day's work to get to the appointment, wait for the consultant, see him or her for five minutes and then probably not go back to work that day. That all adds up – for someone. And while the consultant is seeing the patient and telling them all is well, they are not doing something else that matters."

He then told us what happens at Kaiser. Near the six-month mark, the patient receives an SMS text gently reminding them to get an x-ray. The radiology services (they have no appointments – just turn up) closest to where they live and work is identified for them. A questionnaire is emailed to the patient seeking information about pain, mobility and other concerns.

The x-ray image is emailed to the surgeon, who reviews it with the questionnaire responses on line. If all is well the surgeon texts the patient, giving them an encouraging report. No-one has wasted time on things that do not need to be done, especially inefficiently. But notice this: the physician is central to this process and all the electronics do nothing but enhance the importance of his or her role in the care of the patient.

The use of smart phone applications is increasing daily and can be used preventively. Bruce Neal and colleagues at the University of Sydney's George Institute for Global Health have developed a really tricky app with BUPA called FoodSwitch, http://www.bupa.com.au/health-and-wellness/tools-and-apps/mobile-apps/foodswitch-app, that enables the food-wise purchaser to see exactly what they are buying. By pointing the phone camera at the bar code of a can of beans or whatever, immediate information about fat, salt and sugar content, and alternative choices, shows up on the screen.

Bruce Neal was quoted as saying, "FoodSwitch's three-step approach marries the latest technology with cutting edge research. Australians can now scan barcodes, see what's in a food, and switch to a healthier choice in an instant. The application makes recommendations based on the nutritional value of more than 20,000 packaged food products found in Australian supermarkets."

My health, and the health of billions, is coming to depend on smart phones.

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INFORMATION FOR MEMBERS

Making the most of e-health opportunities

Medical practice managers and staff are being offered insights into how to use electronic health communications to boost efficiency and cut costs.

The Australian Association of Practice Managers Ltd is conducting workshops around the nation in coming months designed to help practices, large and small, to take full advantage of the opportunities offered by advances in electronic communications and record keeping.

According to the association, there is far more to e-health than the Personally Controlled Electronic Health Record initiative, and the workshops - conducted by AAPM members Marina Fulcher and Jan Chaffey – aim to show how technology can be used to "make your practice run more efficiently and effectively, saving you time and resources".

Workshops have already been conducted in Melbourne, Launceston, Alice Springs and Darwin, but in coming weeks they will be held in cities including Newcastle, Sydney, Brisbane, Hobart, Perth, Gold Coast, Rockhampton and Cairns.

For a full list of dates and places, visit:

https://www.aapm.org.au/media/the-aapm-national-ehealth-roadshow.aspx

Attendance costs $60 for AAPM members ($75 for non-members), and is limited to one person per practice.

For more information, contact AAPM e-health marketing director Hugh Miller: (03) 9095 8714 or hmiller@aapm.org.au

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Australia part of international primary health care study

Australian doctors are being invited to take part in a landmark study using data from 34 countries to enable accurate international comparisons of primary health care systems.

Researchers at the Australian National University and the University of Western Sydney are calling for doctors, specialists and other primary health care providers to take part in the study, which will begin later this year.

The project's designers said it will "gather data from across the world on the quality, equity and costs of primary health care".

"Using this information, we will then be able to make international comparisons of primary health systems, enabling us to learn from our international counterparts".

The Australian Primary Health Care Research Institute at the ANU is planning to mail surveys to health care providers in coming months.

For further information, contact Dr Alison Gee or Dr Ian McRae on 02 6197 0072 or QUALICOPC@anu.edu.au

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INFORMATION FOR MEMBERS

Deadline fast approaching for practices offering Medicare-funded diagnostic imaging

Practices intending to offer Medicare-funded diagnostic imaging beyond 30 June this year need to act urgently to ensure they have the necessary accreditation, the Department of Health and Ageing has warned.

The Department has revealed that a number of medical practices that since 2008 have been able to provide Medicare-funded diagnostic imaging services under the first stage of the Diagnostic Imaging Accreditation Scheme are in danger of losing their authority unless they obtain full accreditation by 30 June.

In its initial stages the scheme, established to ensure nationally consistent access to quality radiology and non-radiology services, required participating practices to obtain accreditation against entry level standards.

This accreditation is due to expire at the end of the financial year, and practices that want to continue to provide the Medicare-funded service need to gain accreditation against the full suite of 15 standards before 30 June.

"Practices that do not have accreditation under the scheme cannot provide Medicare-funded diagnostic imaging services and must inform clients prior to carrying out these services," the Department warned.

"It is an offence under the *Health Insurance Act 1973* for a proprietor of a practice not to notify patients that the practice is not accredited, and a Medicare benefit is not payable, before providing diagnostic imaging services."

The Department called on practices that want to continue participating in the scheme but have not yet obtained their full accreditation to urgently contact one of the following to arrange testing:

Health and Disability Auditing Australia – 1800 601 696; www.hdaau.com.au

National Association of Testing Authorities Australia – 1800 621 666; www.nata.com.au

Quality in Practice – 1300 888 329; www.qip.com.au

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Life injected into drug testing

There are early signs that investment in medicine research is strengthening following a following the first rise in the number of clinical trials undertaken in Australia in four years.

Therapeutic Goods Administration figures show 635 drug trials commenced in Australia last year, a 10.6 per cent increase from the previous year.

But the number of tests is still well down from levels reached before the global financial crisis struck, with last year's reading more than 26 per cent lower than the recent high of 865 studies begun in 2007.

Medicines Australia said the 2011 rise was encouraging, but warned that governments needed to act to cut red tape and reform regulations if the nation was to take full advantage of its world-class drug research expertise and infrastructure.

The country has been losing ground in the face of stiff international competition to host clinical trials, but the Federal Government is yet to implement the findings of a review it established to recommend ways to arrest the decline.

AR

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EDITORIAL

Germany-Australia health links strengthen

Ties between Australian health firms and Germany's advanced medical technology sector have been strengthened following a series of events held in Sydney and Melbourne as part of a international initiative by German manufacturers to increase their global market.

The "Health – Made in Germany" program, which included talks and receptions held between March 13-15, brought together leaders of major German medical technology companies with more than 60 specialists in health care and commerce to explore opportunities to boost trade and industrial development in the Australian and German medical technology sectors.

Germany is already Australia's second largest supplier of medical technology products, behind the United States, and firms such as Fresenius Medical Care, which makes kidney dialysis equipment, have significant operations in the country.

Fresenius managing director Margot Hurwitz, who attended the "Health – Made in Germany" program, said her company had made a long-term and significant investment in Australia, setting up manufacturing facilities and providing high-level educational programs, with a local workforce of more than 500 people.

The Medical Technology Association of Australia (MTAA) helped organize the events, which it said would help apply the use of high quality German made products to improve local health care.

MTAA chief executive officer Anne Trimmer said Australia's population was ageing, and older patients were "increasingly willing to pay out-of-pocket expenses to access services that might not be fully-funded".

"As the size of the market increases, so will the demand for innovative and high quality products capable of addressing new healthcare challenges, [including] using remote monitoring technology to overcome inequities in access to healthcare services in rural and remote Australia," she said.

AR

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MAY HEALTH EVENTS

The dates and events listed are major awareness days, conferences, weeks and months related to health. If you know of an upcoming national health event please email the details to ausmed@ama.com.au

Sun	Mon	Tue	Wed	Thur	Fri	Sat
		1 Heart Week World Asthma Day Osteopathy Awareness Week Jelly Baby Month Crohns & Colitis Awareness Month	**2** National Mothering Week	**3**	**4**	**5**
6 International No Diet Day National MND Week	**7**	**8** World Red Cross Day	**9**	**10** World Lupus Day	**11**	**12**
13 Mothers Day	**14** Schizophrenia Awareness Week Food Allergy Awareness Week	**15**	**16**	**17**	**18**	**19**
20	**21** Drug Action Week	**22** Macular Degeneration Awareness Week	**23**	**24**	**25** **AMA National Conference 25-27 Melbourne** 65 Roses Day	**26** Multiple Sclerosis Awareness Week
27 Kidney Health Awareness Week	**28**	**29**	**30**	**31** World No-Tobacco Day		

Nature's own spectacular – the Italian Dolomites

BY **ADRIAN ROLLINS, *AUSTRALIAN MEDICINE* EDITOR**

I should have known when I saw a beaming Fiat driver madly gesticulating at me as he drove past in the opposite direction. I was left in no doubt when I saw the bemused looks on the faces peering out from a passing Austrian tourist coach.

No-one cycles up one of Europe's highest paved passes the morning after a major snow storm.

Unless, that is, you are an Australian who has just traveled half way round the world to fulfill a decades-long dream to ride the fabled passes of the Italian Dolomites.

With just six days to explore the region and scale its impressive heights, I had no time to spare, and snow drifts, black ice and sub-zero temperatures were not going to deter me.

Organisers of major bicycle races try to engineer routes that take competitors – and the TV cameras that follow them – through the most spectacular terrain possible.

So it is no surprise that the Dolomites mountain range, perched just north of Venice near the Italo-Austrian border, has featured in just about every edition of the famed Giro d'Italia cycle race of the modern era.

This year's Giro, which began – oddly enough – in Denmark yesterday Australian time, moves to Italy tomorrow and wends its way down and up the Italian peninsula in the next fortnight before a brutal final week in the Dolomites.

The area is home to some of the toughest and most famous climbs in cycling, including the Passo dello Stelvio, the Campolongo and the Pordoi, but it has been a magnet for travelers and adventurers of all types over the centuries, drawn by its wild and spectacular landscape.

It might seem incongruous to describe as wild anywhere in a country as densely populated and heavily cultivated as Italy.

But by timing my visit between the peak of the winter ski season and the height of summer, when hordes of mountain bikers, climbers and trekkers invade the area, I not only avoided the crowds but managed (like any self-respecting bargain-hunting Australian tourist) to stay at a luxurious, top line hotel for a fraction of the usual price.

The Lagacio Mountain Residence, in the small village of San Cassiano, was a perfect base from which to explore the region.

The hotel consists of very modern and well-designed, self-contained and fully-furnished apartments.

Most importantly, for a cyclist intent on torturing himself on some of the toughest climbs in Europe, the road leading to many of the iconic passes in the region goes right past the front door – as will the Giro d'Italia race later this month.

The passes I rode involved grinding my way up inclines that would last for anywhere between six and 22 kilometres, with gradients usually hovering between six and 12 per cent – though at times rearing up to an insane 18 percent.

The reward for what could be up to two hours of hard toil was an exhilarating and, at times, nerve-wracking decent through endless hairpin bends and switchbacks that tested bike brakes – and the hands that pulled on them – to the limit.

After a hard day's cycling, there are few better ways to end it than to sit on the hotel balcony, glass of local vino in hand, watching the full moon rise over Passo di Falzarego, happy in the knowledge that you can do it all again tomorrow.

Details

Accommodation:
Lagacio Mountain Residence
San Cassiano Alta Badia
http://www.lagacio.com

Rates: shoulder season (September 8-October 13, 2012)

Start from $A230 per day for a two bedroom apartment, incl breakfast

Getting there:
There are several gateways from Australia, but the two closest airports are Milan and Venice.

From these airports, the simplest and most convenient way to get to Alta Badia in the heart of the Dolomites is to hire a car and drive to Verona. From here, take E45 [A22] north through Trento and Bolzano, then take to turnoff for the SS242.

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Biodynamic wines of Beechworth, Part One

BY **DR MICHAEL RYAN**

You would wonder what a former money broker, an engineer, a film producer and a former pear farmer have in common. They all praise the concept of biodynamic or organic farming.

Developed by Rudolf Steiner, the concept was seen as a way of enhancing production and quality. Various bacterial cultures are mixed into the soil and, by being in tune with nature's forces and cycles, one can dramatically elevate the final produce.

So, to Beechworth in the north-east of Victoria which, with a good Mediterranean climate, an elevation of 400 metres and decomposing granitic and clay soils, has become a serious producer of iconic, and potentially iconic, wines.

The ex-money broker is Keppell Smith from Savaterre. Though well-schooled, with a stint in the police force and an almost finished law degree, these careers did nothing for his ambitions. In 1996, after extensive research, a sheep farm where the Kelly boys once roamed became home.

Chardonnay and Pinot Noir varieties are planted on a southerly aspect to help reduce extremes of heat exposure. Old world techniques with the classic grape varieties, combined with the biodynamic influence, result in individual wines of great personality. No pesticides, close planting, hand pruning and picking, plenty of wild yeast influence and generous balanced oak exposure are the norm.

Keppell has been also experimenting with Shiraz. So far, two vintages have been made – though not yet for public release as he tweaks the style. Keppell's philosophy is simple: "I want to create a wine of great character, expression and excellence".

The barrel samples are magnificent; cool climate Shiraz with stalk exposure and judicious oak influence. Juicy red fruits, with pepper and spice nuances and a lingering tight tannin structure, aid the ever-aging backbone of this wine. Final words from Keppell on this year's vintage: "2012 looks great! All I have to do is not manage to stuff it up in the winery!"

The next stop is Giaconda, created by former mechanical engineer Rick Kinzbrunner in 1980. Rick worked vintages in America and France after developing his passion for wine. His scientific background has made some aspects of winemaking less turbid, but the application of his art is founded in the resolute belief in the organic soul of the vineyard. His wines, including Chardonnay, Pinot Noir and Shiraz, are legendary in Langton's wine classification guide, and sell out before release every November "en-Premiur".

Rick was kind enough to let me barrel sample the outstanding 2010 and 2011 Chardonnays as we visited his new iso-climatic underground ageing room, which is a big tunnel dug into granite. The 90 per cent humidity and constant 15 degrees Celsius makes for a slow and undisturbed maturation process that allows the wines to retain freshness with complexity. They are cracking good wines, and it is astounding to think that those I sampled are only "half cooked." Rick's baby looks like being Nebiollo, which is from his Red Hill site in Beechworth. We barrel sampled the 2011 Nebbiolo and Rick's eyes sparkle like a proud father. Another potentially stunning wine.

The Wines

2009 Savaterre Beechworth Chardonnay

Pale lemon/straw colour. An exuberant nose of lemon citrus, hints of grass and honeysuckle, even spice, it glides across the palate with white peach flavours, curt acidity but a lingering mouth feel. Try with spanner crab brie soufflé`.

2009 Savaterre Beechworth Pinot Noir

Ruby/garnet colour. A complex nose of dark cherries, mushrooms, rose petals and cheeky stalks. The palate is layered; initially with subdued fruit, then a silky mid-palate, followed by a crescendo of a back palate joyride that jolts the senses.

2010 Giaconda Yarra Valley Beechworth Pinot Noir (available November 2012)

This is a complex wine with aromas of dark berries/cherries, funky earthy notes and hints of stalk and spice. The palate is luscious and balanced by acid and tannin, with moderate oak influence. Any game meat with berry jus would match. Stock still available but maybe not for long, as demand will be high.

2010 Giaconda Estate Vineyard Chardonnay (available November 2012)

Whiffs of white peach/lemon float seamlessly over a bouquet of mineral scents and flavours [often referred to in wine parlance as minerality] and "meal". The palate is a joy, even at this early stage, and is balanced by acidity that will ensure longevity. Burgundy influence is strong and it would go well with a rabbit ballotine.

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AMP

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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.

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