AUSTRALIAN
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Doctors see red over budget squeeze

Government challenged on incentives, e-health - Pages 5-7

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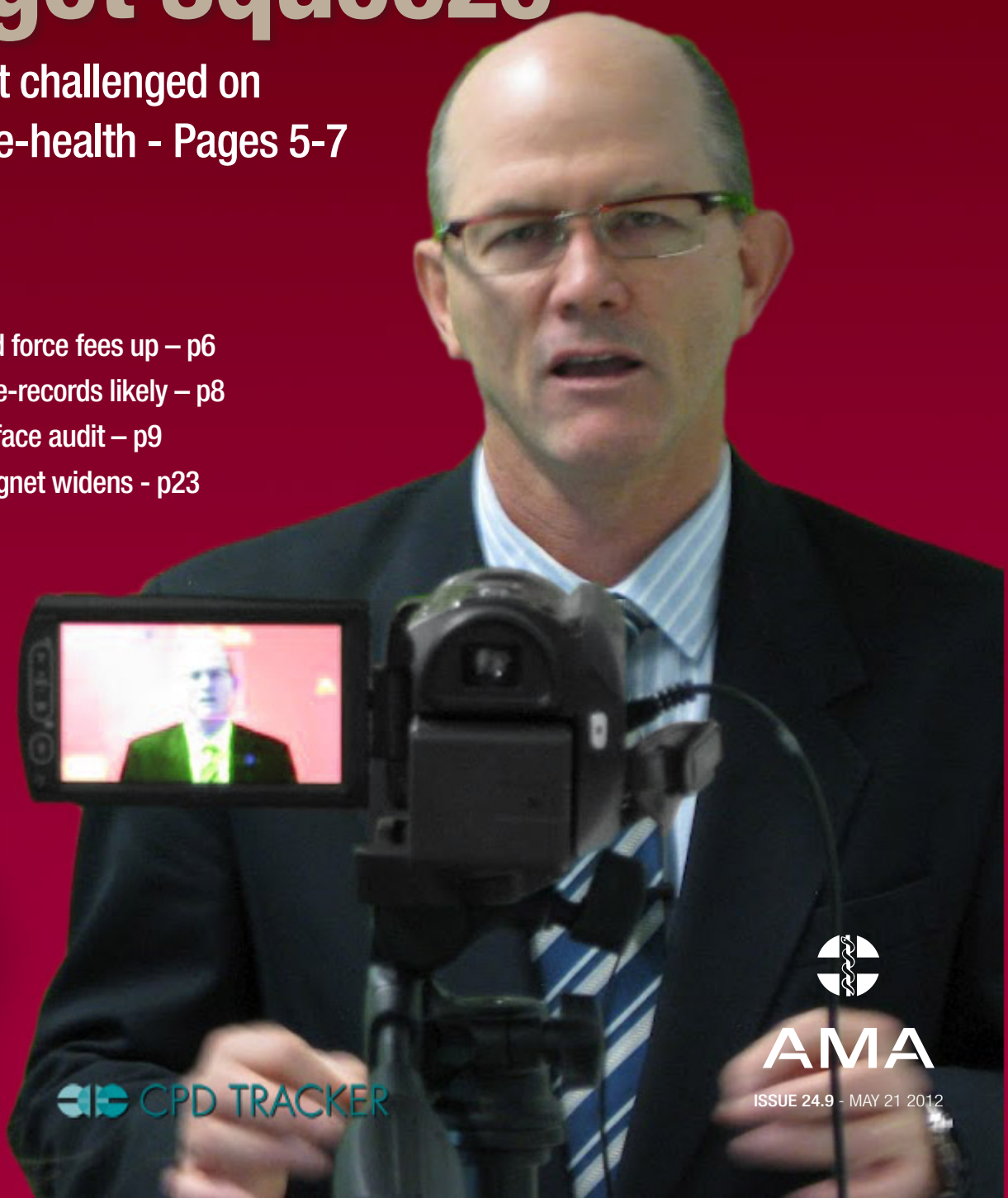

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REGULAR FEATURES

Budget bludgeon for battling GPs

BY AMA PRESIDENT DR STEVE HAMBLETON

While health came out of the Federal Budget relatively unscathed when compared to the slash and burn experienced by other sectors, there were some casualties – with GPs near the top of the list.

First, let's acknowledge the positives from the Budget – which, by necessity, was a Budget for tough financial times. And you have to look more broadly than just the Health portfolio.

There was the aged care package, some new Indigenous health funding, upgraded bowel cancer screening, new dental services, rural health infrastructure, and a commitment to the National Disability Insurance Scheme (NDIS).

We support all these initiatives. They will deliver good health outcomes to the community.

But when funding was found for one area of the health system, other areas of the health system felt the squeeze. Once again it is GPs who have been left footing the bill.

The Budget cuts to Practice Incentive Payments (PIP) to GPs – totalling $83.5 million over four years (that is $83.5 million being ripped out of general practice) - will have a significant negative impact on the health system.

They will penalise GPs for not meeting new higher targets for cervical cancer screening and specialised diabetes care, and they remove incentives for immunisation.

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

The decision to discontinue the GP Immunisation Incentives Scheme kicks another leg out from the tripod that supports this good work.

Similarly, there was no consultation on the increase in targets for the PIP Cervical Screening Incentive and the PIP Diabetes Incentive either. This may put the brakes on successful prevention and care programs that are helping thousands of people.

These cuts are a big hit to the viability of general practice and its responsibility to deliver quality patient care.

This Budget follows the cuts made in recent Budgets to joint injection rebates and mental health rebates, the loss of Medicare practice nurse rebates and the earlier cuts to the GP Immunisation Incentives Scheme, and the imminent loss of the after hours PIP.

These measures, along with changes to the e-health PIP, could potentially undermine successful preventive health programs that are providing health benefits to many Australians.

These cuts go against the Government's stated objectives of championing preventive health and being a world leader in electronic health.

They also place an even greater burden on the engine room of the Australian health system – hardworking GPs under pressure in suburbs and towns across the country – by making their practices less viable.

To make things worse, the Government introduced a requirement that general practices must choose to participate in the Personally Controlled Electronic Health Record (PCEHR) system if they are to continue receiving e-health PIP funding.

This is not a requirement - it is a threat. And it comes on top of the Government's failure to provide any new funding for the new clinical service that GPs are being asked to provide in helping patients prepare a shared health summary as part of the PCEHR.

This represents a substantial roadblock to the effective implementation of the PCEHR and threatens Australia's efforts to be a world leader in e-health.

We need to remember that the PCEHR is an opt-in system, so the Government is going to make funding to a general practice contingent on the decision of a third party over whom they have no control.

GPs are the public face of the health system. GPs are trusted and respected by their patients and their communities. They are the lifeblood of the system.

Sadly, the valuable service provided by GPs appears undervalued and under-appreciated by the Government. GPs are being asked to do more – much more – for less.

Australia's general practice workforce is understandably becoming demoralised.

GPs are propping up the health system by offering significant discounts to their patients when they bulk bill. Already, many GPs have concluded that, in order to maintain their provision of a quality service, widespread bulk billing may no longer be possible.

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AMA warns budget cuts could push GP fees up, crunch bulk billing

"The Government expects to save $83.5 million over the next four years by scrapping the GP Immunisation Incentives Scheme – which provided incentive payments of up to $4500 to practices that pushed immunisation rates among child patients above 90 per cent – as well as pushing up the threshold for other incentive payments"

The AMA has ramped up the pressure on the Federal Government to overturn Budget cuts to practice incentive payments, warning the move could force GPs to increase fees and reduce bulk billing.

AMA President Dr Steve Hambleton has put the Government on notice that its decision to scrap practice incentives for immunisation and increase treatment targets for pap smears and diabetics is likely to increase out-of-pocket expenses for patients and cut bulk billing rates.

"When the support for GPs falls, you really have got two choices: you can either close up shop, or you can charge patients a fair fee, and I think GPs will choose to charge fair fees, which means that out-of-pocket costs will rise," Dr Hambleton said, adding that "we have seen the bulk-billing rate fall before, and I am suspicious that the bulk-billing rate will start to fall again."

The blunt warning comes amid mounting anger over the hit to doctors in the Budget, and concern about the effect of the cuts – particularly to immunisation incentives – on public health.

The Government expects to save $83.5 million over the next four years by scrapping the GP Immunisation Incentives Scheme – which provided incentive payments of up to $4500 to practices that pushed immunisation rates among child patients above 90 per cent – as well as pushing up the threshold for other incentive payments.

Under the changes, practices will have to ensure 70 per cent of eligible patients are given pap smears – up 5 percentage points - to qualify for the payment of a incentive, and prepare care plans for at least 50 per cent of diabetic patients, up from 40 per cent.

Analysis of the Budget commissioned from Kilham Consulting by the AMA and available by clicking here, shows that although health was spared large spending cuts, the Government nonetheless expects to save a net $225 million in health expenditure in the next four years.

Kilham Consulting said the thrust of many budget measures, particularly cuts to practice incentives and changes to the Extended Medicare Safety Net – with caps imposed on all consultations and a much wider range of procedures than previously – was to shift costs onto doctors.

"These changes seek to move the goalposts to extract greater performance from the primary healthcare system," the Kilham report said. "It does mean that GPs are being expected to do more work for less reward".

Dr Hambleton said the AMA was seeking urgent talks with Health Minister Tanya Plibersek to try to have the incentive cuts reversed.

The AMA President said that by axing the immunisation incentive, the Government had ripped away one of the key remaining supports for comprehensive national immunisation.

Dr Hambleton said that the successful drive to lift immunisation rates above 90 per cent had been based on incentives for parents, practices and doctors.

"A couple of budgets ago they removed the incentive for doctors. This [budget] has removed the payment for practices. The Government has effectively kicked one more leg out of that tripod [of measures]," he said.

"The GP is central to immunisation for this country," Dr Hambleton said. "GPs will, of course, continue to immunise, but the incentive for practices to get their rates over 90 per cent has now gone.

"We need to work together on this. We do need to make sure we maintain that funding."

But the Government so far shows no sign of reversing its budget cuts.

In a post-budget speech Health Minister Tanya Plibersek said the savings made were "based on clinical and economic evidence of what's good for patients and what's good for the long term sustainability of our health system".

The Kilham Consulting report can be found at: http://ama.com.au/healthbudget2012

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Budget measures heighten e-health concerns

The AMA is taking aim at the Federal Government over the requirement that doctors participate in the personally controlled electronic health record (PCEHR) scheme or lose their eligibility for e-health incentive payments worth up to $50,000 a year for urban practices.

AMA President Dr Steve Hambleton said the threat was of "great concern" to the AMA, not least because the scheme is yet begin operating.

"My software at my practice, for one, won't even communicate with the PCEHR. This is the wrong time to bring this in," the AMA President said. "We have asked for a meeting with the Minister to discuss this. We need to absolutely delay this to make sure there is something that we can sign up to before we actually introduce a penalty such as this."

But Health Minister Tanya Plibersek has defended the move, arguing that Australian medical practices were among the most advanced in the world in the use of IT and were well-prepared for the scheme's introduction.

"Government support has helped more than 96 per cent of practices get the IT they need for e-health – Australia's GP workforce is now the fifth most computerised in the world," she said.

"Now [that] many practices have most of the IT in place, we want to make sure Government focuses its support on the roll-out and take up of the e-health record," Ms Plibersek said.

According to an analysis of the Budget commissioned by the AMA from Kilham Consulting, the Government has drawn the extra $234 million committed to continuing its e-health program from other areas of the health portfolio, including almost $184 million withdrawn from telehealth funding and $74 million cut from the National Health Information Network.

In the Budget, the Government failed to address complaints that no provision has been made in the introduction of the PCEHR to compensate practitioners for the resources and time required to help establish and maintain electronic health records.

Ms Plibersek dismissed the AMA's concerns.

"For the profession, we have clarified that GPs will be able to factor in the creation of, or addition to, a shared health summary when making a judgement which Medicare item to bill," she said.

The Government went live with its e-health webpage, ehealth.gov.au, on 11 May, inviting expressions of interest in registering for an electronic health record, though actual registrations will not open until 1 July.

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Government faces slow start on electronic health records

AMA President Dr Steve Hambleton has warned the Federal Government there may be little take-up of personally controlled electronic health records without significant changes to its scheme.

In a speech to a major health policy forum attended by Health Minister Tanya Plibersek in Melbourne last week, Dr Hambleton cautioned that although doctors were enthusiastic about the potential for electronic health records to substantially improve care, the Government was endangering support for their introduction by rushing ahead with a system that was little understood and inadequately resourced.

The AMA President said that under government arrangements, the cost burden for introducing personally controlled electronic health records (PCEHRs) would fall most heavily on GPs and other medical practitioners.

"General practice will have to make the most investment in the PCEHR both in time and money, and will realise the least amount of benefit from it," Dr Hambleton said. "The legislation underpinning the PCEHR carries a lot of new obligations for medical practices, hospitals and other organisations providing health care."

"Medical practitioners who decide to use the system will have to adapt their clinical workflows and train their staff to work within the requirements of the legislation," he added, warning that doctors would have to take these additional costs into account in deciding what fees to charge their patients.

"As things stand, GPs are being asked to provide a new service for free," Dr Hambleton said. "Without specific MBS items for this work, it will have to be absorbed into the standard consultations."

"GPs will work with their patients to ensure that a complete and accurate summary is available to be used by other health care providers in their clinical decisions," he said. "It is only reasonable that patients should receive an additional Medicare rebate for this very important additional service."

Dr Hambleton said the Government had to provide support for medical practices that are private businesses to invest in the infrastructure that is needed to make the PCEHR work.

"There needs to be a business case," he said. "Doctors need greater support than that what is on offer if the PCEHR is going to truly work to improve patient care and reduce waste and risk in health care."

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Private health cover holds steady despite surging premiums

The proportion of Australians with private hospital cover is holding steady despite a big rise in premiums and fears rebate means testing would convince many to dump their health insurance.

Figures released by the Private Health Insurance Administration Council show that almost 46 per cent of the population had private hospital cover in the March quarter – unchanged from the previous three months – while 53 per cent had general treatment insurance.

Health Minister Tanya Plibersek seized on the results to rebut fears the introduction of means testing for the private health insurance rebate would trigger a plunge in the number with insurance cover.

While the proportion of the population with private hospital cover held steady in the March quarter, there was an additional 51,782 people with insurance, lifting the overall total of insured to 10,455,462 people.

The biggest increase in coverage was among those aged between 65 and 69 years, while there was a small fall in the number of 45 to 49 year-olds with insurance.

Ms Plibersek said the fact that the increase occurred during the height of the parliamentary debate on the rebate means test was significant.

"During the income testing debate in February, Tony Abbott and Peter Dutton were among dozens of Coalition MPs who told the

CONTINUED ON PAGE 10

GP Super Clinics program under scrutiny

The Australian National Audit Office has launched an investigation into the Federal Government's troubled GP Super Clinics Program, in a move applauded by the AMA.

The ANAO earlier this month began an official audit of the scheme, which has been dogged by financial difficulties and delays, with signs the program is falling well behind schedule.

The Government had originally planned that 36 GP Super Clinics would be in operation by the end of June this year but, according to the Department of Health and Ageing website, so far there are just 24 clinics operating, some of them only partially.

The National Audit Office will examine the effectiveness of the Department's administration of the program, which was intended to support improved community access to integrated GP and primary health care services.

The audit comes seven months after the AMA first urged the ANAO to examine the program amid reports of financial problems and, in some instances, stalled implementation.

It follows an internal audit conducted by the Department, without consultation with outside organisations or stakeholders, whose findings have not yet been revealed.

AMA President Dr Steve Hambleton said that while doctors were not opposed to GP Super Clinics per se, the program as devised by the Government was "a failed initiative in concept, design and implementation", and a proper audit was overdue.

"The AMA is not opposed to the establishment of GP Super Clinics in areas where there is a clear need for them," Dr Hambleton said. "However, in terms of planning, the location of clinics appears to be largely a political process that is not necessarily linked to community need."

Dr Hambleton said that not only did the Government appear to be falling behind on its target for opening clinics, but a number of other problems had arisen.

"The Government had to financially bail out the Redcliffe GP Super Clinic in Brisbane and made a decision not to proceed with the planned Sorell Clinic in Tasmania.

"The $25 million GP Super Clinic in Modbury, SA, opened with no doctors and, more recently, the provider that had been staffing the Clinic for the past 12 months withdrew from the contract, leaving no permanent doctors working at the Clinic.

"These are just some examples of the problems with the Program. The public deserves answers about what is happening with a significant investment of taxpayer money. Hopefully the Auditor-General will get to the bottom of these problems."

Dr Hambleton said that if the audit showed the program was failing, unspent funds should be re-directed to support new infrastructure and services for existing general practices.

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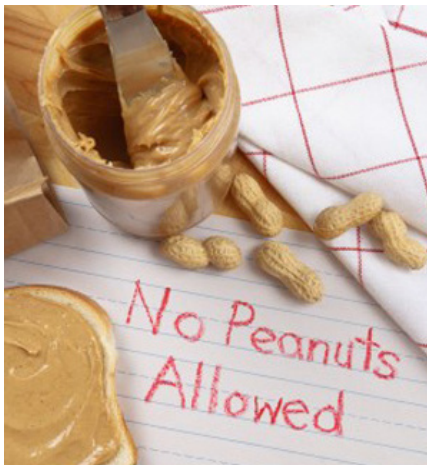
Awareness of food allergies needs to increase

The AMA has pledged to back campaigns aimed at increasing public awareness of food allergies.

AMA President Dr Steve Hambleton said initiatives like last week's Food Allergy Awareness Week were important in building community recognition of the issue, but more needed to be done to increase public knowledge and recognition of allergies and potentially risky foods.

Dr Hambleton said there were 170 different foods known to trigger an allergic reaction, but often people were unaware of their presence in meals.

"Milk, eggs, peanuts, tree nuts, sesame, wheat and soy are the most common,



causing 90 per cent of all allergic reactions," Dr Hambleton said.

"Many of these foods can be present in unlikely food sources, and this is an important reason for more comprehensive public education about these possibilities."

Dr Hambleton said the Australian Food and Grocery Council was right to highlight the importance of food labelling in helping consumers make healthy choices, and measures to increase public awareness had the AMA's support.

"The AMA will back public education programs to build community awareness of food allergies and to help the many thousands of Australian families dealing with the effects of food allergies every day," Dr Hambleton said.

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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		

Private health cover holds steady despite surging premiums

CONTINUED FROM PAGE 8

Australian Parliament 175,000 would drop out of private health insurance within a year," the minister said. "Well, during the first three months of this year another 50,000 people actually joined up."

But the bigger test for the robustness of private health insurance numbers is likely to come in the September quarter, when the rebate means test comes into effect.

Even if there is a drop in coverage, information gathered by the Council shows the private health insurance industry is in a strong financial position.

They show there was a 2.2 per cent fall in hospital benefits paid out in the March quarter, though this was offset by a 12 per cent jump in ancillary payments over the same period.

Average hospital benefits increased by 5.8 per cent to $992 per person in the 12 months to the end of March, while ancillary benefits grew 4 per cent to $312 over the same period.

The average out-of-pocket payment for a hospital stay reached $308 in the March quarter.

While benefit payments grew, premium revenues surged much higher, rising 8.7 per cent (up $1.31 billion) in the 12 months to the end of March, outstripping an 8.3 per cent lift in benefit payouts over the same period, to help boost profits before tax by 6.5 per cent to reach $1.33 billion.

"Margins from core health insurance operations remain strong, continuing at levels above the long-term industry average," the Council report said, adding that the industry held capital $3.6 billion in excess of minimum requirements. "The strong margin and capital position of the industry means that it is well placed to meet the needs of policyholders and withstand considerable business stress."

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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

Immunisation incentive cuts a blow to doctors

The Sydney Morning Herald, 10 May, 2012

Australian Medical Association President Dr Steve Hambleton warned budget cuts to immunisation incentives for medical practices presented a "public health risk of the highest order".

Push for Gillard to review gay marriage

The Age, 14 May 2012

AMA President Dr Steve Hambleton rejected claims by the group Doctors for the Family that heterosexual marriage is healthier for children. He said there was no evidence that children of same-sex parents were any different in their psychological development, general health and sexual orientation than those with heterosexual parents, and the views of Doctors for the Family did not reflect those of the broader medical community.

Pain expert calls for GP opiates ban

The Age, 14 May 2012

AMA President Dr Hambleton dismissed the suggestion of a visiting US anaesthesiology professor that GPs should be stripped of their power to prescribe opioids.

Caring mums at mercy of flu bug

Daily Telegraph, 16 May 2012

AMA President Dr Hambleton advised that families should consider getting vaccinated against influenza, and emphasised the need for attention to personal hygiene to help stop the spread of the virus.

Auditor-General begins scrutiny of GP super-clinics

The Australian, 17 May 2012

AMA President Dr Steve Hambleton said the association had been calling for an audit of the Government's GP Super Clinics since last October, describing the program as a "failed initiative in concept, design and implementation".

Cigarette giant British American Tobacco chops up the prices

Daily Telegraph, 17 May 2012

The AMA is "very concerned" that giant tobacco company British American Tobacco is offering cut-price cigarettes. AMA President Dr Steven Hambleton said price sent a very strong signal affecting overall rates of smoking: "Every time the price goes up, consumption goes down. [So], that the opposite is occurring is very concerning for the AMA".

Alternative therapies cash to fund cancer tests

Weekend West, 5 May, 2012

AMA President Dr Hambleton welcomed a Government review of alternative therapies that are subsidised through the private health insurance rebate, arguing that there should not be subsidies for treatments that are not scientifically proven to be effective.

Radio

Dr Hambleton, *ABC Radio*, 14 May 2012

Dr Hambleton rejected claims by the group Doctors for the Family that heterosexual marriage is healthier for children. He said there was no evidence that children of same-sex parents were any different in their psychological development, general health and sexual orientation than those with heterosexual parents, and the views of Doctors for the Family did not reflect those of the broader medical community.

Dr Hambleton, *ABC Radio*, 17 May 2012

AMA President Dr Steve Hambleton warned a lack of adequate software meant there would be little take up of the Federal Government's personally controlled electronic health record scheme when it is scheduled to commence on 1 July.

The latest from AMSA

AMSA calls on Government to honour election promise on foreign aid

The Australian Medical Students' Association (AMSA), worried by speculation aid spending would be cut in the 8 May Budget, urged the Federal Government to maintain its commitment to boost national spending on aid to 0.5 per cent of gross national income. President James Churchill said that a backdown from the commitment would be an insult to the health of the world's poorest people.

CSU 'game plan' for a medical school deeply worrying – AMSA

The Australian Medical Students' Association (AMSA) is deeply concerned by recent moves by Charles Sturt University (CSU) to gain support for a new medical school in rural New South Wales.

AMSA President, Mr James Churchill, said that the University's 'game plan' defies the reality of a severe shortage of medical training places.

"The recently released Health Workforce 2025 report shows that there is likely to be a critical shortage of training positions for the medical students already in the system," Mr Churchill said.

Internships before new medical schools, says AMSA

The Australian Medical Students' Association (AMSA) voiced concern about WA Premier Colin Barnett's endorsement of Curtin University's proposed medical school.

Premier Barnett's support came only days after AMSA warned medical students to prepare for internship shortages, and follows the release of the Health Workforce 2025 report, which highlights critical bottlenecks in the medical training system.

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AMA in action

AMA President Dr Steve Hambleton and other AMA officials have been busy pushing forward the AMA agenda across a range of areas, including challenging the Federal Government on budget cuts to practice incentives and the introduction of personally controlled electronic health records. Dr Hambleton also took part in forum on the marketing of food to children, advised an expert committee on measures to help prevent alcohol-related harm and attended a *Medical Journal of Australia* industry forum. The AMA's Executive Council met in Canberra and Dr Hambleton, along with the chair of the AMA's rural medicine committee Dr David Rivett and senior official Warwick Hough, gave evidence at a Senate committee inquiry into rural health and medical services.

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Sydney Harbour provides a scenic backdrop for AMA President Dr Steve Hambleton's teleconference with other members of the Australian National Preventive Health Agency's Expert Committee on Alcohol

AMA President Dr Steve Hambleton talks to the Canberra Press Gallery on Budget night at Parliament House

AMA President Dr Steve Hambleton with SA Health Minister John Hill at the National Seminar on Food Advertising and Marketing to Children in Adelaide

AMA President Dr Steve Hambleton meets with Dr Corinna Hawkes, international expert on food marketing and public policy, in Adelaide

AMA President Dr Steve Hambleton gives a post-budget interview to online news service *6 minutes*

AMA President Dr Steve Hambleton talks to the Canberra Press Gallery on Budget night at Parliament House

Members of the AMA's executive council meet in Canberra, (l to r) Doug Travis, Roderick McRae, Geoffrey Dobb, Steve Hambleton, Liz Feeney, Peter Ford

AMA rural medicine committee chair Dr David Rivett and senior official Warwick Hough give evidence before the Senate Community Affairs Committee inquiry in Canberra

AMA President Dr Steve Hambleton marshals evidence to presented to a Senate Community Affairs Committee inquiry into rural health and medical services

AMA President Dr Steve Hambleton puts the AMA's position on the PCEHR to a Committee for Economic Development of Australia forum in Melbourne, attended by Health Minister Tanya Plibersek

AMA President Dr Steve Hambleton is interviewed by media at a Committee for Economic Development of Australia forum in Melbourne

Budget cuts increase burden on health 'engine room'

BY **DR BRIAN MORTON**

"GPs want e-health to work, but at every turn the Government seems to be sending the message that GPs will be the ones to absorb all the costs and the risks"

It's May, the month of the Federal Budget. While health has come through relatively unscathed, it appears that GPs have been hit again – although not to the same extent as last year.

In the Government's rhetoric, they acknowledge that GPs are the backbone of primary health care. You wouldn't know it from recent decisions.

On Budget night, the Government announced it would cease the GP Immunisation Incentives Scheme. The funding equates to about $80 million per year across 5600 general practices. As AMA President Dr Steve Hambleton noted after the Budget, the decision to discontinue the GP Immunisation Incentives Scheme is a public health threat of the highest order.

Australia's immunisation program is renowned worldwide for its track record in maintaining high immunisation rates across all the ages covered by the Immunisation Schedule. The program has been effective because of the broad range of policy inititiatives that support it and make sure it works. It has increased immunisation rates in Australia from 60 to 90 per cent for kids less than seven years of age. This decision, however, could undo all that hard work, and the rate may fall again as general practices lose incentives that encourage practices to be very active in making sure parents have their children immunised.

Part of the Budget also includes a requirement that general practices must participate in the personally controlled electronic health record (PECHR) system if they are to continue receiving e-health Practice Incentive Program (PIP) funding. The AMA made it clear after this announcement that it was not so much a requirement as a threat. GPs want e-health to work, but at every turn the Government seems to be sending the message that GPs will be the ones to absorb all the costs and the risks.

The Government also took the opportunity to announce on Budget night that practices will need to meet higher targets for the PIP Diabetes Incentive (from 20 per cent to 50 per cent) and in the PIP Cervical Screening Incentive (from 65 per cent to 70 per cent). There was no consultation about these changes, just an undisguised criticism of the hard work that GPs have been doing in these areas.

These cuts to the Practice Incentive Program, together with cuts in recent Budgets such as those to Medicare rebate for GP mental services, are placing an even greater burden on the engine room of the Australian health system – hardworking GPs in suburbs and towns across the country. GPs have had enough of the Government's continued attacks on the general practice.

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Health workforce planning: the search for a crystal ball continues

BY **DR ROB MITCHELL**

Australia's ignominious history in regards to workforce planning took a step towards recovery last month with the release of *Health Workforce 2025 (HW2025).* Regular readers of *Australian Medicine* will be aware that the last edition featured a news article based on the report's findings. The AMA played an instrumental role in ensuring Health Workforce Australia undertook this critical piece of work, which was commenced in the wake of the 2010 AMA Medical Training Summit.

While other medical publications have also published commentary on the report, references in mainstream media have been relatively limited. Notwithstanding the significant competition for airtime in recent weeks, this is somewhat surprising: the report has major implications for the future delivery of healthcare in Australia.

The headline figures relate to the nursing workforce. Based on complex supply and demand modelling, *HW2025* suggests that Australia is facing a shortfall of 109,490 nurses by 2025. This figure is derived from the report's base-line projection, and blows out considerably under a self-sufficiency scenario.

The figures for the medical profession are nowhere near as staggering. A shortfall of 2,701 doctors is predicted by 2025, which balloons to 15,240 with the application of a "high self-sufficiency" model. Interestingly, under a "low demand" scenario, *HW2025* suggests there could be a surplus of doctors to the tune of 18,000.

In terms of the training pipeline, *HW2025* predicts a shortfall in first-year vocational training positions (and therefore an excess of applicants) of 404 by 2015 and 1,265 by 2025. This is based on the assumption that current levels of access to medical services are maintained, despite the fact that the community expects improvement. The report also makes projections on the requirements for medical graduates, suggesting that the number of students currently in the system is approximately in balance. More detail on the training pipeline will be available when specialty-specific data is released in Volume Three of the report in June.

The wide variation in the figures generated by the sensitivity analysis illustrates that workforce modelling is an inexact science and producing accurate predictions is exceedingly difficult. Making assumptions, some of which will be proven spurious, is a necessary part of the process.

Invariably, therefore, the methodology of *HW2025* will be criticised. Some will dismiss the numbers as mythical, and others will interpret (and/or manipulate) them in a way that suits their requirements. But it remains that it is the best data we have.

So what do the numbers mean? The report, in all its 448-page glory, provides some analysis. It clearly makes the point that workforce reform is essential and Australia cannot afford to tolerate a status quo approach to work practices, productivity, training, geographical distribution and immigration.

In terms of medical education, there are a few immediate implications. For one, the report provides evidence of a looming bottleneck at the point of entry into vocational training. Regardless of whether capacity can expand in line with projected demand, it is likely that competition for registrar posts will increase. More graduates will face the prospect of never gaining a position in their first choice of training program. For these and other reasons, the report provides little ammunition for those angling for new medical schools. It also clearly justifies the AMA's efforts to focus governments' attention on the need to fund a significant expansion in pre-vocational and vocational training places.

HW2025 really highlights some much bigger challenges, however. Dealing with a predicted nursing shortfall of 100,000 is a major one, which training alone will not be able to remedy. Although implicit, the costs involved in creating a self-sufficient health workforce have also been made evident, and Australia will need to determine if it is genuinely prepared to address the 'brain drain' from developing nations. Further, the predictions that the increasing number of graduates will not itself fix workforce maldistribution means that current approaches to rural recruitment and retention need a rethink.

These challenges are compounded by the stark reality of modern healthcare: that demand, costs and expectations are rising at an unsustainable rate. Although much has been said about the need for rationalisation of health expenditure, this report will undoubtedly stoke the fire.

HW2025 demands a response from the nation's health ministers, and the challenge now is to ensure a satisfactory one. They have indicated that reform is necessary, but how that agenda will be advanced remains unclear. The AMA is on the record calling for a dedicated Council of Australian Governments meeting to facilitate intergovernmental agreement on the required number of postgraduate training places and beyond.

Irrespective of this process, governments (acting on advice from medical colleges) have their work cut out for them in identifying and funding new training positions. The AMA has already started thinking about how it can report on progress against the growth targets implied by the report.

HW2025 may not be a crystal ball, but at least it has brought the challenges and opportunities sharply into focus. The report offers some useful insights and it should form part of the evidence base for determining future workforce requirements. Importantly, it also provides a lever to encourage meaningful investment in medical training, which is an opportunity that should not be passed up.

TO COMMENT CLICK HERE

Peckers and Pollies

BY **DR DAVID RIVETT**

"Hopefully this Senate Committee will deliver robust recommendations to government which can be enacted through the Council of Australian Governments"

I spent a recent Friday afternoon assisting our President as we jointly addressed the Senate Committee enquiring into rural medical workforce shortages.

The AMA had put forward an excellent paper to the committee outlining the many facets of change needed to solve the worsening workforce crisis in rural Australia.

My personal situation is pretty typical, with my own practice needing at least another three doctors, and relying on older doctors like myself - who should be reducing their hours - to instead crank up their throughput to maintain a very basic standard of care. Patients are let down badly by inadequate access to timely care in such circumstances, and agreement on a national solution is of the utmost urgency. If I cannot attract doctors to a locale as pleasant as Batemans Bay, I can but wonder how towns west of the divide are going to do so.

Any solution needs State and Federal governments working together, and committing serious funds. Both levels of government need to agree on a robust national solution and get started on it immediately, as it will take years to flow through, even if we bring in nationwide rurally-orientated generalist courses for substantial numbers of post-graduates now, backed up with real fiscal incentives to go bush for five years at a minimum.

Australia should not be relying on international medical graduates to keep rural care alive, and instead should be training enough of our own students to enable provision of adequate core numbers at all rural and regional locations. By adequate core numbers I mean enough to provide for an attractive work-life balance, with on-call no more rigorous than one in every three nights.

The rural rescue package agreed by the AMA and Rural Doctors Association of Australia (RDAA) needs to be part of any solution, and the Australian Standard Geographical Classification system consigned to the bin. A national blueprint detailing what numbers of differing medical professionals, with what skill sets, are needed where, is a key foundation to underpin any workforce planning for a sound solution. Conscription of international medical graduates and medical students is not acceptable.

Hopefully this Senate Committee will deliver robust recommendations to government which can be enacted through the Council of Australian Governments.

Back to the personally controlled electronic health record (PCEHR), and the budget announcement that participation would be essential to continue to gain the IT component of Practice Incentives Program (PIP) payments.

This really was a major disaster for GPs. All GP groups must work in unison to overturn this imposition of a huge workload for no remuneration. I trust the Royal Australian College of General Practitioners will now see the folly of their decision to embrace an unfunded PCEHR, apologize to members for their lack of sense and fight furiously with the AMA, the RDAA, and the Australian College of Rural and Remote Medicine to reverse the situation.

However, just as a solution to the rural workforce crisis is almost a dream, so too is the thought that the RACGP chiefs will have the grace to admit they have got it badly wrong.

TO COMMENT CLICK HERE

A decade of AMA Report Cards on Indigenous Health - assessing the outcomes

BY DR STEVE HAMBLETON

Each year since 2002, the AMA has produced a high profile Report Card bringing to public attention outstanding problems in Aboriginal and Torres Strait Islander health. Each report has made well-considered and practical recommendations to governments about how these problems should be resolved, and also highlighted success stories where improvements have been made. The issues reported on over the last decade have ranged from child and maternal health and the importance of appropriate primary care and workforce, through to models of best practice service provision to close the gap in health and life expectancy between Aboriginal peoples and Torres Strait Islanders and other Australians.

The development of the Report Cards has benefited from the guidance and expertise of the members of the AMA, which includes representatives from Aboriginal and Torres Strait Islander peak bodies and health organisations, as well as AMA doctors who work at the coalface providing services to Aboriginal people. As a result of this guidance, many of the recommendations that the AMA has made for change and improvement in its Report Cards have been acted on by the Federal Government or other governments through the Council of Australian Governments (COAG) and other forums. While many would agree that some of the measures implemented have not been completely well-considered or sufficiently funded, or targeted in exactly the right ways, there has been a recognition that the problems that the AMA has identified over the years have been real ones, and the solutions proposed have been robust.

A key question that the AMA is now asking itself is: what progress has been made overall by governments in improving the health of Aboriginal peoples and Torres Strait Islanders, when measured against the AMA's recommendations over the last decade? Also, where do the challenges remain?

To coincide with its 50th anniversary National Conference, the AMA is producing an "Audit Report" that tracks government activity in the light of AMA recommendations in the areas of:

- provision of primary health care to Aboriginal people and Torres Strait Islanders commensurate with their level of need;
- the availability of a skilled health and medical workforce for Aboriginal and Torres Strait Islander health;
- the provision of high quality and best-practice primary care, including support for the Aboriginal community controlled sector;
- how well the risk factors and social determinants of poor health have been tackled; and
- how well governments have performed in engaging Aboriginal peoples and Torres Strait Islanders in genuine partnership in the planning and implementation of policy and programs.

In many of these areas, the government track record over the last decade has been variable, and in some cases disappointing. The AMA believes this is changing, however, and that the $1.6 billion commitment made by governments through COAG in 2008, has added a significant and proportionate impetus to the prospect for closing the gap within a generation.

A major focus of the COAG National Partnership on Closing the Gap is better provision of quality primary care, including through the mainstream health sector. There is also a concerted focus on chronic disease and tackling health risk factors and social determinants. The AMA welcomes all of this, and recognises how well it resonates with the recommendations made over the last decade in AMA Report Cards. However, with this said, the AMA believes there are still gaps and weaknesses, and challenges that remain. In particular:

- much greater effort is needed to build the necessary health and medical workforce for Aboriginal and Torres Strait Islander health;
- greater priority must be given to building the potential of Aboriginal community-controlled health services to provide even better primary care;
- the rate of incarceration of Aboriginal peoples and Torres Strait Islanders (with its compounding health effects) is a national shame, and must be addressed;
- greater support must be given to Aboriginal and Torres Strait Islander communities to develop workable solutions to local health-related problems; and
- the partnerships and funding levels that have been established through the COAG agreements must be maintained after these agreements end in 2013. Otherwise the momentum to close the gap will dissipate.

The full details of these observations and the government track record over the last decade will be provided in the *AMA Aboriginal and Torres Strait Islander Health Audit Report 2012 – Progress to date and Challenges that Remain,* which will be launched at the AMA 2012 National Conference on Saturday May 26.

The AMA's Aboriginal and Torres Strait Islander Health Report Cards for the last ten years can be accessed at http://ama.com.au/aboriginal-reportcards

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Government sends mixed signals on video consultations for the aged

BY **DR PETER FORD**

"The AMA will work hard to ensure these measures are implemented to improve access to medical care and quality care for older Australians living at home and in residential aged care"

The Government's much anticipated aged care reform package released on 20 April 2012 received warm accolades from the aged care sector. While the AMA also welcomed the new aged care policy after such a long period of neglect, it was disappointing that access to medical care did not feature more prominently in the reforms.

There have been some wins in the package for issues that the AMA has been lobbying for.

Grants are available to develop models of service to improve access to complex health care services for aged care recipients, and to encourage aged care providers to work more closely with health care providers. The AMA proposal for specific financial support to encourage and subsidise retainer arrangements between aged care providers and medical practitioners could be covered by these grants.

Much of the Government's aged care package is centred around the concept of people living at home for longer. Living at home allows individuals to age with dignity as an active participant in the community. However, there will need to be some effort to ensure that the quality of care for this group of individuals is not diminished. There are aspects of the aged care reform package that present the opportunity to address quality of care in the home setting. The Government has allocated $58.5 million over five years to enhance multidisciplinary care and access to primary health care for aged care recipients

There is also $54.8 million allocated to expanding access to respite services and other carer support. The AMA has been lobbying for more respite places and medical practitioner authorisation of access to subsidised respite care in emergency circumstances. The additional funding for respite care could cover both these measures.

The Government announcement on the aged care reform package included an express commitment to improve access to general practitioners through the use of video consultations. But the commitment in the Budget papers is less clear, with the Government instead referring to trials that may simply reflect the existing funding allocated under the National Broadband Network Telehealth Pilots Program. The AMA will continue to seek specific Medicare Benefits Schedule items for general practitioner video consultations in aged care.

The Government has also provided $1.2 billion over five years to address workforce pressures. This should result in sufficient numbers of registered nurses to monitor, assess and adequately care for residents of aged care facilities, and to liaise with medical practitioners.

The AMA will work hard to ensure these measures are implemented to improve access to medical care and quality care for older Australians living at home and in residential aged care.

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Alcohol consumption dropping, but drinkers go for the harder stuff

Australia is a long way short of becoming a nation of wowsers, but people are cutting down on how much they drink, and are increasingly likely to turn to a bottle of wine or a nip of spirits rather than a glass of beer, according to the latest official snapshot of alcohol consumption.

Official figures indicate there was a sharp fall in the amount of beer drunk last financial year, helping drive the first decline in overall alcohol consumption in almost a decade.

While the Australian Bureau of Statistics does not record the actual amount of alcohol that is drunk, it uses estimates of alcohol supplies to indicate apparent consumption.

According to the ABS, there were 182 million litres of pure alcohol available for consumption from alcoholic beverages in 2010-11, down two million litres from the previous year – a 1.1 per cent fall.

But although the overall supply of alcohol dropped, the figures confirm there is a sustained shift away from beer toward drinks with higher alcohol content, including wine and spirits.

The amount of pure alcohol consumed in the form of beer dropped 3.4 per cent in 2010-11, and in per capita terms has fallen from the equivalent of 4.63 litres of pure alcohol in 2006 to 4.23 litres last year – an 8.6 per cent drop.

Over the same period per capita consumption of pure alcohol as wine has climbed almost 6 per cent from 3.53 litres to 3.74 litres, and for spirits from 1.16 to 1.32 litres – nearly a 14 per cent jump.

In a more encouraging sign for those who supported the Federal Government's move to increase the excise on so-called alcopop drinks, the ABS figures show that has been an almost 30 per cent fall in apparent consumption of ready-to-drink beverages.

Despite the small decline in overall alcohol consumption in 2010-11, Australians remain some of the world's heavier drinkers, consuming on average 2.2 standard drinks a day, which is slightly more than recommended. Overall this amounts to 10 litres of alcohol consumed per person in 2010-11 over the age of 15.

AMA President Dr Steve Hambleton said official guidelines advise that healthy adults should consume no more than two standard drinks on any day.

"The 'safe' level of consumption for both men and women – if there is such a thing as a safe level - is two standard drinks in any one day," Dr Hambleton said.

"Alcohol affects every part of the body and causes many health problems," he said. "These include poor nutrition, memory disorders, difficulty with balance and walking, liver disease, high blood pressure, muscle weakness, heart rhythm disturbances, anaemia, clotting disorders, decreased immunity to infections, gastrointestinal inflammation and irritation, acute and chronic problems with the pancreas, low blood sugar, high blood fat content, interference with reproductive fertility, increased risk of cancer of the liver and oesophagus, weakened bones, sleep disturbances, anxiety, and depression. And that's just a start.

"Urgent reform is needed to address the estimated $36 billion in social and excess health costs that excessive alcohol consumption causes each year."

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Budget snippets

Smokers hit by duty-free cut

The Federal Government has won plaudits from anti-smoking campaigners for its decision to slash the amount of cigarettes and other tobacco products that can be brought into the country duty-free.

From September, the duty-free allowance for travellers will be cut dramatically, from 250 cigarettes or 250 grams of cigars or other tobacco products, to 50 cigarettes or 50 grams.

The measure, detailed in the 8 May Budget, is expected to raise $600 million over the next four years, including $115 million in 2012-13.

Health Minister Tanya Plibersek said the duty-free crackdown was in line with the Government's "tough stand" on reducing smoking.

"Smoking means death, disease and distress," Ms Plibersek said. "All are preventable. [Smoking] kills an estimated 15,000 Australians a year, taking a tragic toll not only on smokers themselves, but on their families and friends."

The Minister said the Government was determined to cut the national adult daily smoking rate to 10 per cent by 2018, and to halve it to around 25 per cent among Aboriginal and Torres Strait Islander people over the same period.

The cut to the duty-free allowance for tobacco comes as the Government is embroiled in a High Court challenge to its landmark plain packaging legislation for tobacco products, including cigarettes.

Tobacco companies argued before the court earlier this month that the laws, which are strongly backed by the AMA, amount to an acquisition of their brands and logos by the Government, and should be thrown out.

The High Court has reserved its judgement in the case, and is expected to make a ruling in coming months.

In the meantime the Government, which is confident of winning the case, has allocated $3 million in the Budget to enforce the plain packaging laws.

GP Super Clinics cut

The Government has withdrawn $44 million of uncommitted funds from its GP Super Clinics program as it redirects money in the constrained Budget to other priorities.

The cut reduces the amount available for the program to a little more than $600 million, but the Government claims it will not affect plans to build 64 clinics across the nation.

Instead, according to the Budget, the Medicare Local Network will fill the shortfall in development, networking and other operational activities caused by the cutback.

Change of priorities in Indigenous health

The Government has re-directed $75 million earmarked for hospitals, clinics and other infrastructure projects serving Indigenous communities into front-line health services.

In a strategy it hopes will go a long way to closing the gap in health between Indigenous Australians and the rest of the community, the Government has cut infrastructure spending to help boost the delivery of specialist and allied health services in the Northern Territory.

Under its Stronger Futures in the Northern Territory program, the Commonwealth aims to spend $3.4 billion over 10 years to reduce Indigenous disadvantage, including providing almost $714 million for primary and allied health care services, $695 million to help reduce alcohol abuse and improve community safety, $583 million for improved education and $442 million to boost the safety and wellbeing on Aboriginal children and their families.

The Government has allocated $58.5 million towards health services under the program in 2012-13, but funding in later years was not revealed in the Budget.

The Government said the amount to be committed to the program by the Commonwealth in 2013-14 and beyond was subject to negotiations with the Northern Territory Government.

CONTINUED ON PAGE 21

Circumcision to go under the knife?

The Department of Health and Ageing has put Medicare benefits for circumcision procedures under review as part of a broader appraisal of paediatric surgery items.

In a move the *Sydney Morning Herald* predicted would re-ignite debate over the controversial practice, the department has instituted a specialist review of circumcision to recommend whether or not it should remain a listed item on the Medicare Beneifts Schedule.

The scheduled fee for circumcisions performed on babies younger than six months is $43.95, rising to $102.20 for children between six months and 10 years, and up to $175.45 for older patients.

The review, revealed by the *SMH* earlier this month, reflects ongoing debate about the procedure, particularly whether it is medically justified and beneficial.

AMA President Dr Steve Hambleton told *ABC* radio that although he does not recommend the operation, it was a decision that should be made by well-informed parents.

Dr Hambleton said there were arguments for and against the procedure on health, religious and cultural grounds that are dififcult to resolve, and doubted that the department's review would settle the issue.

The *SMH* reported that circumcisions are no longer performed at most public hospitals but, according to the Circumcision Foundation of Australia, it is a low-risk operation that provides significant potential health beenfits.

A review of the scientific literature conducted by foundation members including University of Sydney medical school Professor Brian Morris, prominent public health advocate Professor Stephen Leeder, professor of sexual health medicine Adrian Mindel, HIV expert David Cooper and University of New South Wales emeritis scientia Professor Eugenie Lumbers, found evidence that infant male circumcision provides "strong protection" against a range of illnesses and conditions including urinary tract infections and sexually transmitted diseases in men, with flow-on benefits for sexual partners.

"[Male circumcision] has no adverse effect on sexual function, sensitivity, penile sensation or satisfaction and may enhance the male sexual experience," the study found. "Adverse effects are uncommon (less than 1 per cent), and virtually all are minor and easily treated. A risk-benefit analysis shows benefits exceed risks by a large margin."

But opponents claim there is little reason to circumcise infants, and Medicare coverage should be withdrawn unless it was shown to be medically necessary.

The review will be conducted by a sub-committee of the Medical Services Advistory Committee this year, and is due to deliver its findings in 2013.

It will investigate the procedure to ensure that it reflects contemporary evidence, offers improved health outcomes, and represents value for money.

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Budget snippets

CONTINUED FROM PAGE 20

MBS billing crackdown

The Government expects to save a net $13 million through new compliance measures for Medicare Benefits Schedule billing.

Almost $8 million will be spent in the next three years to help develop and trial a "new compliance approach" to billing, including more stringent assurance processes.

But the Department of Human Services will also use some of the funds to beef up practitioner reviews and "educate larger medical practices about appropriate MBS billing".

With Commonwealth finances tight, practitioners under coming under increasing scrutiny over claims for rebates, incentives and other funds.

The Budget tightened access to telehealth incentives, setting a minimum distance of 15 kilometres for telehealth consultations, and has capped rebates for some cardiac tests and cosmetic procedures under the Extended Medicare Safety Net.

PBS changes

More than $72 million has been allocated over five years to fund the listing of several medications under the Pharmaceutical Benefits Scheme, including treatments for leukaemia, arthritis and high blood pressure.

The new and amended listings include Orencia, for the treatment of rheumatoid arthritis, Sprycel and Tasigna for chronic myeloid leukaemia, high blood pressure treatment Flolan, and Brilinta medication for unstable angina and myocardial infarction.

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Surgery loses ground to general practice, specialities among graduates

More than a third of aspiring surgeons entering medical school change their mind by the time they graduate, while the proportion planning to enter general practice virtually doubles over the same period.

In an intriguing insight into changes in the preferences of medical students as their studies advance, a survey has found that both surgery and paediatrics lose their lustre for many undertaking post-graduate qualifications.

Work by the Medical Schools Outcomes Database & Longitudinal Tracking Project, which began in 2004, has found that 34 per cent of students entering medical school who ranked surgery as their most preferred future medical practice, instead opted for other specialities such as anaesthesia and emergency medicine by the first year of post-graduate studies.

Over the same period, the popularity of adult/internal medicine virtually doubled from 8 to 15 per cent, and the preference for general practice ballooned from 10 to 17 per cent, while the proportion seeking to practice in paediatrics and child health fell from 11 to 5 per cent.

Asked why their preference had changed, 84 per cent nominated the "atmosphere [and] work culture typical of the discipline" as a factor influencing the decision.

The project, which is the first nationally coordinated study of its kind in the world, tracks medical students through university and subsequent medical career, and recently conducted its inaugural survey of those who had completed their studies three years ago.

The project is hosted by Medical Deans Australia and New Zealand and is supported by the AMA, the Australian Medical Students Association and other medical organisations.

Dr Rob Mitchell, chair of the AMA's Council of Doctors in Training, said the research would provide a rich source of data to guide decisions about medical education and future workforce planning.

"We fully support the project because it will provide unique insights into the needs and aspirations of medical students and junior doctors," Dr Mitchell said. "It will also help answer important questions about the success or otherwise of various workforce initiatives."

The importance of medical training and workforce planning was underlined earlier this month by a report warning the nation faced a shortage of almost 3000 doctors by the middle of next decade without a major boost to training places for medical graduates.

The report, by Health Workforce Australia, 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 showed there was a "desperate need" for Governments to urgently invest in more pre-vocational and specialist training places for medical graduates.

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International students stay put

Almost 80 per cent of graduating international medical students stay on in Australia to do their hospital internship, a study has found.

An analysis of the Medical Schools Outcomes Database shows that international medical students, who pay their own tuition fees, are likely to practice in Australia, particularly those from North America.

The study, led by Professor Lesleyanne Hawthorne of Melbourne University's Faculty of Medicine, found that more than one in four international medical students came from Malaysia, while 21 per cent originated from Singapore, 18 per cent were Canadian and 5 per cent came form the United States.

It showed that retention rates were highest among North American students, with 90 per cent choosing to stay in Australia following graduation, compared with an average of 75 per cent among the rest.

Professor Hawthorne said students from Malaysia, Singapore and Botswana were the most likely to return to their home country, not the least because many of them have been sponsored.

Underlining the propensity of many students to want to work in the country in which they studied, the research found that the proportion of international medical students who hoped to stay in Australia swelled from 45 per cent among those in the first year of their studies to 78 per cent by the final year.

Professor Hawthorne said the findings underlined the need for a significant boost to intern places, warning that if international students were denied opportunities for further training, countries like New Zealand and Singapore would quickly step in to lure them away.

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HEALTH ON THE HILL

Rural doctor crisis needs urgent action

Federal and State governments need to take urgent, and coordinated, action to begin to address the critical shortage of doctors in rural and regional practices, the AMA has told a Senate inquiry.

AMA President Dr Steve Hambleton and Chair of the AMA's Rural Medical Committee, Dr David Rivett, warned that the nation could not rely on overseas-trained doctors to fill the gap in rural and regional medical services, and Federal and State governments needed to work together on measures to put rural medical workforces on a sustainable footing.

Dr Hambleton and Dr Rivett issued the call for urgent action during an appearance earlier this month before a Senate Community Affairs Committee inquiry into health services and medical professionals in rural areas.

Dr Hambleton told the inquiry that there were "no easy solutions in this area, and certainly no one size fits all".

"There are a range of things that we need to do," the AMA President said. "There are a whole lot of things that make a difference. If we can build all those in, we can actually make a difference."

Dr Rivett said there was a "real crisis" underway in rural practices because of the ageing of the workforce, and it was not good enough to rely on overseas-trained doctors to fill the gap in rural care.

"We have got enough medical graduates coming through in Australia now that we can solve the problem," Dr Rivett said. "But it is going to mean some dollars spent by government to get people there in core numbers, so that they have a good lifestyle and provide a good service to those rural populations.

"We need more robust facilities, with specialists and GPs. It is not just a GP issue. We need general specialists to bolster those big regional hospitals right throughout rural Australia. We need more generalists. They need to be well paid and to have decent rosters so it is an attractive working life," Dr Rivett said.

"There needs to be a single body that is empowered to put solutions in place. These are multi-factorial solutions that cannot just be done by the state government or the federal government alone. They need to be working in sync and they need to have a strong desire to actually solve the problem. I think that is lacking badly."

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Peer review of dodgy doctors to be expanded

Allied health professionals accused of rorting Medicare will be subject to formal peer review and doctors suspected of "inappropriate" practices can be referred for investigation by the chief executive of Medicare, under legislative changes set to be passed by Parliament.

The Federal Government has Opposition support for amendments that greatly expand the scope of Professional Services Review (PSR) Scheme and the Medicare Participation Review Committee (MPRC) process to encompass a much broader range of medical practitioners.

At present the scheme, under which practitioners alleged to be rorting the MBS or the PBS can be investigated though a peer review process and their right to continue to participate in Medicare can be withdrawn, is restricted to medical practitioners, dentists, chiropractors, physiotherapists, podiatrists, optometrists, midwives, nurse practitioners and osteopaths.

But last year alone practitioners not covered by the PSR and the MPRC provided more than four million services costing Medicare $383 million.

Provisions of the *Health Insurance Amendment (Professional Services Review) Bill 2012* are intended to close this gap, expanding the scope of the PSR and MPRC to encompass allied health professionals who provide Medicare services, including audiologists, dieticians, exercise physiologists, mental health nurses, occupational therapists, psychologists social workers and speech pathologists.

The Bill also includes changes that require the Medicare chief executive to request a review by the Director of the PSR of doctors engaged in a "prescribed pattern of services".

The amendment follows the outcome of the case *Daniel v Health Insurance Commission 2003*, and provides that a prescribed pattern of services may be the sole reason for the chief executive's request.

"This request must be made because a 'prescribed pattern of services' is deemed to be inappropriate practice, unless a PSR committee is satisfied that exceptional circumstances exist," the Bill's explanatory memorandum said. "The final determination that a 'prescribed pattern of services' constitutes inappropriate practice can only be made under the PSR Scheme. It is not a decision that can be taken by the [Medicare] chief executive."

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RESEARCH

Updated guidelines for hepatitis C testing

The National Hepatitis C Testing Policy has been updated for the first time since 2007.

The updated policy provides health professionals with quick access to relevant information and advice on hepatitis C virus (HCV) tests.

It has been estimated that over 280,000 people have been exposed to HCV since the introduction of testing, with approximately 10,000 new infections each year.

In Australia, hepatitis C is mainly contracted through sharing used needles.

The updated policy includes a clear and concise statement of the tests available to make hepatitis C diagnosis and how best to use the tests to screen and define an infection.

Significant differences in the new policy include:

- change in terminology from pre-test discussion to informed consent;
- communication of a HCV-negative test result;
- web-based provision of policy, allowing for regular revision to provide consistent management of emerging technologies such as Point of Care (PoC) testing and viral resistance testing; and
- access to related resources (such as related policies, operational guidelines, and evidence of best practice).

Professor Bob Batey, Director of The Australasian Society for HIV Medicine, said the updated policy, by providing clear information on the HCV tests available, will provide better outcomes for patients, with fewer repeat visits for additional testing to confirm a diagnosis.

Hepatitis Australia CEO Helen Tyrrell said that she expected the updated policy would result in an improved testing experience for people who are at risk of hepatitis C.

The policy has been developed by a joint Blood Borne Virus and Sexually Transmissible Infection Subcommittee and the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections subcommittee, and signed off by the Department of Health and Ageing.

The policy will be updated on a six-monthly basis.

The policy is available via testingportal.ashm.org.au

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Encouraging outcome to meningococcal vaccine trial

Australia researchers have reported promising results from the trial of a vaccine that appears to protect against a range of strains of meningococcal B.

More than 500 adolescents from Australia, Poland and Spain participated in the trial of the vaccine, which was seen to generate a strong antibody response. Further tests indicated that the vaccine would be able to fight off meningococcal B infection between 80 and 100 per cent of the time, depending on the dosage level.

The results provide hope that there may soon be protection against what has the potential to be a devastating infection.

There were 241 reported cases of meningococcal B infection last year, with a fatality rate of between 5 and 14 per cent, depending on the strain. Many meningitis survivors have permanent neurological damage or limb or hearing loss.

While children in Australia have been vaccinated against meningococcal C since 2003, there is currently no similar protection against type B infections.

Lead author of the study, Associate Professor Peter Richmond of the University of Western Australia, said the development of a vaccine to protect against multiple strains of meningococcal B is particularly important.

"Meningococcal B can cause meningitis and blood poisoning and can progress very quickly, with devastating effects," Associate Professor Richmond said.

Meningitis is an inflammation of the lining around the brain and spinal cord and mostly targets infants and teenagers.

"Children between the ages of one month and one year are most at risk of meningococcal [infections], with a second peak in adolescents," Associate Professor Richmond said. "This is the last major cause of meningitis for which we don't have a vaccine, so we are very excited about the progress towards developing a safe and effective vaccine."

So far, the trials have found the potential vaccine to be safe, with minimal side effects. Dr Richmond said the research would now progress to involve bigger trials in a wider range of age groups.

The findings were reported in the online publication *The Lancet Infectious Diseases*.

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Fertility treatments increase risk of birth defects

A University of Adelaide study has found that there is a higher risk of defects among births conceived using assisted reproductive technology such as in vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI) compared with those resulting from unassisted conception.

The researchers found that ICSI resulted in the highest risk of birth defects, at 9.9 per cent of all births, followed by IVF at 7.2 per cent, compared with only a 5.8 per cent risk for babies conceived naturally.

The researchers said that the extra risk attached to use of IVF techniques could be explained by patient characteristics such as age or weight. But the authors could not explain the increased risk resulting from the use of ICSI to assist conception.

The researchers conducted a population-wide cohort study, comparing data from more than 6100 assisted conception births with a registry of more than 300,000 births and 18,000 recorded birth defects. The data were used to determine the incidence of birth defects associated with infertility treatments, as compared with those from unassisted pregnancies.

Lead author of the study, Associate Professor Michael Davis, said that the cryopreservation [freezing] of embryos was associated with a substantially reduced risk of birth defects, particularly for ICSI. He speculated this might be due to failure of developmentally compromised embryos to survive the freeze/thaw process.

Associate Professor Davis said the results of the study would enable couples considering fertility treatment to make more informed decisions.

Another major finding of the study was the discovery that women using clomiphene citrate – a low-cost fertility treatment used to stimulate ovulation – tripled their risk of having a baby with a birth defect.

Associate Professor Davis said this was of particular concern because clomiphene citrate is widely available.

The results of the study, the first to compare birth defects across all forms of fertility treatment with the risk in women with no record of infertility, were published in the *New England Journal of Medicine*.

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Pre-eclampsia test on the horizon

New research has instilled hope in pregnant women by finding an indicator that can detect pre-eclampsia before symptoms occur.

Researchers from the University of Sydney found the thymus – an organ of the immune system, which sits behind the breastbone – was significantly smaller in foetuses where mothers went on to develop pre-eclampsia.

Pre-eclampsia affects an estimated 5000 to 10,000 Australian women every year, with symptoms causing high blood pressure, kidney and liver damage and severe blood changes. Delivering the baby is the only way to prevent the disease.

Lead author of the study, Professor Ralph Nanan, said that doctors have no clinical marker to predict the condition before onset, though first pregnancies and obesity were risk factors.

"We think pre-eclampsia is an immune disease, as the mother's immune system rejects the foetus for unknown reasons," Professor Nanan said. "So it is quite exciting to find that the thymus, the central immune organ of the foetus, is much smaller in pre-eclampsia children than children from healthy pregnancies.

"This is a very interesting finding, as the thymus plays a central role in shaping a child's immune system and protecting it against the development of allergies, auto-immune disease and cancers later in life.

"But we don't yet know what causes the thymus to be smaller in some children."

The study examined 53 pre-eclamptic and 120 healthy pregnancies and measured foetal thymus size between 17 and 21 weeks of gestation.

The researchers are now conducting a study with more than 1200 women to confirm the findings, with the long-term hope of developing a test for pre-eclampsia. They will also look at the relationship between the thymus and immune diseases and allergies.

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Cholera threat re-emerges in Haiti

Health workers fear thousands of lives are at risk following outbreaks of cholera in the impoverished Caribbean nation, Haiti.

International medical humanitarian organisation Medicins Sans Frontieres (MSF) has warned that the country, which is still recovering from the devastating 2010 earthquake that killed more than 300,000 people according some estimates, was inadequately prepared to contain the deadly disease.

The organisation said cases are multiplying rapidly since the onset of the wet season, with the number of infections treated by MSF in the capital, Port-au-Prince, alone quadrupling last month to 1600 cases.

MSF's head of mission in Haiti, Gaetan Drossart, expressed fears of a repeat of last year's outbreak – when 200,000 were infected during the wet season between May and October. Since the earthquake, there have been 535,000 cholera cases, and more than 7000 people have died from the illness, according to the Haitian government.

"Too little has been done in terms of prevention to think that cholera would not surge again in 2012," Mr Drossart said.

MSF described the island nation's infection surveillance system as "dysfunctional", and doubted government claims that it was in control of the situation.

"It is concerning that the health authorities are not better prepared, and that they cling to reassuring messages that bear no resemblance to reality," Mr Drossart said. "There are many meetings going on between the government, the United Nations and their humanitarian partners, but there are few concrete solutions."

MSF found that in one region, where 20 per cent of cholera cases have been reported, preventive measures had been downgraded since last year.

"More than half of the organisations working in the region last year are now gone," the organisation said. "Additionally, health centres are short of drugs and some staff have not been paid since January."

Around 500,000 survivors of the 2010 earthquake are still living in temporary camps set up following the disaster, and less than a third are reported to have access to clean drinking water.

MSF said vaccination may provide some temporary protection from the disease, but it was only 70 per cent effective, and called for major improvements in Haiti's water and sanitation systems to provide a more durable solution to the epidemic.

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HIV prevention pill closer to reality

A pill to prevent contraction of HIV may soon be approved for use in the United States, raising hopes that it may eventually be available as preventive treatment in Australia.

A panel of experts advising the US Food and Drug Administration has recommended that the antiviral medication Truvada, which is already used as a treatment for HIV, be given as a preventive measure to healthy individuals at high risk of contracting the illness.

The recommendation follows studies showing that people who take Truvada daily have a greatly reduced risk of infection.

The advisory panel recommended that Truvada be prescribed for people at high risk of contracting HIV, including homosexual men with multiple sexual partners and people whose partner is HIV-positive.

The medication is intended to be used in addition to, rather than a replacement for, condoms and other safe-sex measures, but is seen as a way to help reduce the rate of new HIV infections.

In Australia the rate of HIV infections has stabilised since the mid-2000s at around 1000 cases a year, with about 10 per cent of those developing into AIDS.

The Australian Federation of AIDS Organisations has hailed the expert panel's recommendation, and has urged Australian health authorities to act swiftly on looming official US approval for a HIV prevention pill.

AFAO executive officer Rob Lake said US approval for the use of Truvada would be an "historic step forward" in the fight against HIV/AIDS worldwide.

"The [prospective] approval of the use of Truvada for high risk, HIV-negative people is an extremely significant development in the prevention of HIV worldwide," Mr Lake said. "If, as expected, the expert recommendation leads to approval by the FDA in America, it could change the lives of people living with the risk of HIV infection."

"The preventive use of Truvada in Australia has the potential to put a significant dent in Australia's total infection rate."

The US Food and Drug Administration is yet to decide whether or not to accept the expert panel's recommendation.

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NEWS BRIEFS

More medicine price cuts

The cost of well-known cancer and nausea treatments will be cut by up to almost 80 per cent under pressure from price disclosure arrangements in the Pharmaceutical Benefits Scheme.

The Federal Government has announced that the cost of 13 medicines, including the anti-nausea drug ondansetron and the cancer treatment oxalyplatin, will be cut by between 11 and 77 per cent from August 1.

The latest price reductions follow cuts to the cost of 74 medicines that took effect on April 1, which the Government estimated would save patients $1.6 billion over 10 years.

Among the changes coming into effect at the beginning of August are an 18 per cent reduction in the cost of amisulpride, a 33 per cent cut to cost of doxorubicin, a 37 per cent drop in the price of escitalopram and a 25.5 per cent reduction in cost of prochlorperazine.

TGA clears PIP breast implants of abnormal risk

The Therapeutic Goods Administration has advised against the "routine" removal of PIP breast implants despite an international recall of the devices following evidence they were made using sub-standard materials.

In an update issued on 18 May, the TGA reported that tests carried out on implants had "not found evidence that the risks involved with the use of PIP breast implants are any greater than those for any other brand of silicone gel-filled breast implants".

"The Australian Government's advice remains that removal of PIP breast implants in the absence of evidence of rupture is not routinely required," the authority said.

Around 13,000 PIP implants were supplied in Australia between 1998 and the international recall in April 2010.

The TGA said that, as at 17 May, there had been 284 confirmed cases of rupture involve the implants, with a further 56 instances yet to be verified.

Women who know they have PIP implants, or where clinical advice is that they might have them, are eligible for Medicare rebate on MRI examinations used to accurately assess the state of their implants until March next year.

Relief hope for arthritic young

Young people suffering a rare form of arthritis have improved access to treatment following the listing of the medicine Actemra on the Pharmaceutical Benefits Scheme.

The listing of the drug has been welcomed by Royal Children's Hospital, Brisbane paediatric rheumatologist Dr Navid Adib, who said it was one of the most effective medicines to treat the rare but difficult condition systemic juvenile idiopathic arthritis.

Dr Adib said only about one in every 50,000 children developed the potentially debilitating disease, but did not respond well to common treatments like steroids and methotrexate.

He said Actemra was an effective biologic treatment in eliminating active inflammation in the joint, preventing crippling seizure.

The drug was listed by the PBS on May 1.

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INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

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Zoom, Zoom, Zoom

BY **DR CLIVE FRASER**

Mazda 3 Neo

With $25,000 to spend on a new car for my father, I knew I would have no trouble finding him some affordable and reliable wheels.

There are some big sellers in this price bracket, and top of the list is the Mazda 3.

Not only does it outsell the Toyota Corolla, Mitsubishi Lancer, Hyundai i30 and the Kia Cerato, but it is also Australia's top-selling car.

In early 2012 there has been some very keen pricing from manufacturers, with the best equipped package coming from Mitsubishi, who were recently offering a Platinum Edition Lancer with heated leather seats, a body kit and a reversing camera with the screen ingeniously located in the rear view mirror.

While I'm not a big fan of continuously variable transmissions (CVTs), I was impressed with all of the Lancer's fruit, but my father had never owned a car with leather seats, let alone a body kit, and wasn't about to change that.

The Toyota Corolla is a pleasantly styled car and, for those who find parking difficult, the hatchback is one foot shorter than the sedan.

But the Toyota's test-drive drive left me wanting. With only four speeds in the auto and only 100 kW under the hood, it felt lethargic and really couldn't keep up with the competition.

Undoubtedly, Toyota owners keep buying Toyotas, but the Corolla drove like a tortoise and did not impress me.

For geographical reasons I purposely didn't take my father to the Hyundai dealer, but he somehow found himself having a test drive with a very nice Korean sales lady.

The fact that the i30 model was about to be superseded didn't faze my Dad, and somehow the i30 always seemed to be a magical $1,000 cheaper than the competition.

It had a real spare and even though there were only four speeds in the automatic my father's comments were that "it seems to go OK".

Suddenly the i30 became irresistible when my father saw it advertised for $14,888 on the road, drive-away.

I pointed out that was for a 2011 non-metallic manual model with only six months registration and that we'd have to find a driveable wreck to get the $3,000 guaranteed minimum trade-in allowance which was part of the deal.

At the end of the day it didn't really seem like such a good deal after all.

All of this led us to the local Mazda dealership, where an overwhelming number of Aussie motorists have been finding their wheels.

The base model Mazda 3 Neo automatic has five speeds, alloy wheels and cruise control and, at $23,990 on the road, drive-away, it looked like a steal.

It was easily the nicest car to drive, even though I'm not fond of the hatchback's styling.

Some of the competitors may have longer warranties, better fuel economy or more cogs in the gearbox, but the Mazda 3 was a podium finisher in most areas, and overall it was easily the best car we drove.

After making the decision to purchase the Mazda 3 I was able to further negotiate another 10 per cent off the already discounted sticker price, which meant my father's car was $21,700 all up on the road, including a normal steel rim in lieu of the space-saver spare.

Who knows, maybe with the change from my $25,000 I could have bought a Hyundai as well!

Mazda 3 Neo Hatchback Automatic	
For	Nice to drive and great build quality.
Against	Thirstier than the opposition.
This car would suit	Retirees
Specifications	2.0 litre 16 valve 4 cylinder petrol 108 kW power @ 6,500 rpm 182 Nm torque @ 4,500 rpm 5 speed automatic 8.2 l/100 km (combined)

Safe motoring,
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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:

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