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Governments must end the hospital funding blame game

AMA Budget Submission offers solutions, pp3-8

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Governments must work together

BY AMA PRESIDENT DR STEVE HAMBLETON

"We must build capacity in our public hospitals. Funding must be better targeted, patient-focused, and clinician led. This will require unprecedented cooperation between the Federal and State Governments"

We are just a month into 2013, but already we are seeing signs of a fractious relationship between the Federal and State Governments over health funding.

It is an election year, and the blame game is back. No surprises there.

As we draw closer to Election Day – tipped to be in the second half of the year – we will witness aggressive and passionate politics from the Government and the Opposition. At the same time, there will be battles between the various levels of government.

The AMA does not want to see health funding and health programs fall victim to the political point scoring.

We recently released our Budget Submission 2013-14, which we are using as a call on all governments to put the health of Australians ahead of politics.

In tough economic times, governments have to make tough choices about funding. Money can be cut, diverted or re-prioritised. Health is not immune from this process.

Our call on governments is simple – work together to make every health dollar count.

The Federal Government has put more money into health - through current public hospital funding under the *National Healthcare Agreement*, and future funding under the *National Health Reform Agreement* and other more targeted agreements, all of which have been signed by all governments.

It is important in this environment to get back to basics. We must protect and support the fundamentals of the health system.

If new funding is limited, then it must go towards building on the things that work.

We must build capacity in our public hospitals. Funding must be better targeted, patient-focused, and clinician led. This will require unprecedented cooperation between the Federal and State Governments.

The complete pipeline of medical training needs to be properly funded to ensure we have a medical workforce in sufficient numbers to meet future community need. This will involve some long-term vision and planning, not stopgap year-by-year solutions.

Money should be going to GP Infrastructure Grants, not GP Super Clinics. The Grants are delivering real benefits to general practices and their local communities. The Super Clinics are a bad idea that is getting worse and wasting valuable health dollars.

Planning is needed to allow primary care, led by general practice, to cope with the growing demands of chronic disease in the community.

The Government has announced major policies in the areas of aged care and mental health. Where there is evidence that things can be done better, the Government must take the advice of clinicians at the front line and shift or re-prioritise funding accordingly.

This same principle should be applied to e-health.

The AMA supports the PCEHR – it can make a real difference to the continuity of care for patients.

But the legal framework for the PCEHR has imposed additional red tape on practices. The Government can alleviate this by assisting practices to navigate the complex pathways and requirements necessary for them to participate.

We must also proceed consultatively on the National Disability Insurance Scheme (NDIS). The priority must be on timely quality care, not litigation. The AMA has some concerns that are still to be resolved.

The Government must preserve and build on its commitment to improving Indigenous Health outcomes.

We may not have the environment for significant new health funding, but we have an urgent need for some smarter thinking on how precious health dollars are allocated and spent. The funding must find its way to the patient.

The AMA Federal Budget Submission 2013-2014 is at https://ama.com.au/federal-budget-submission-2013-14-lets-make-every-health-dollar-count

The Submission is covered in this edition of *Australian Medicine*.

TO COMMENT CLICK HERE

Let's Make Every Health Dollar Count

The AMA last week lodged its Budget Submission 2013-14 with Treasury in Canberra. Here is a summary of the policies and funding that the AMA wants to see implemented to allow the health system to best meet the healthcare needs of the community.

The full submission is at https://ama.com.au/federal-budget-submission-2013-14-lets-make-every-health-dollar-count

Medical workforce and training

The AMA calls for the 2013 update to HW2025 to set out the number of intern, prevocational, and specialist medical training positions required to match the increased output of medical schools and, following this, for the Government to convene a specific COAG meeting to:

- reach agreement on the number of quality intern, prevocational and specialist medical training places needed, based on the analysis provided by HWA;
- reach agreement on the respective financial contribution of each government;
- agree on robust performance benchmarks to measure achievement against HW2025 targets and COAG commitments, with regular reporting by HWA on progress against these targets; and
- commit to the development, in consultation with the profession, of performance benchmarks to ensure that the quality of medical training is sustained.

The AMA also notes that the Federal Government generally has responsibility for the funding of medical training places in general practice and in non-traditional settings such as the private sector. In this regard, the AMA calls on the Government to:

- increase the Practice Incentive Payment for teaching medical students to $200 per teaching session so that it better reflects the costs to general practice of teaching medical students;
- commit to the ongoing funding of at least 100 intern places a year in expanded settings, including private hospitals;
- increase the number of places in the Prevocational GP Placements Program to 1500 places a year by 2016, supporting more junior doctors to have a quality general practice experience;
- increase the GP training program intake to 1500 places a year by 2016; and
- expand the Specialist Training Program, which is currently oversubscribed, so that it provides 1500 places a year by 2016.

Public Hospitals

Public hospital beds

The Performance and Accountability Framework should include bed numbers and average bed occupancy rates as critical indicators of public hospital capacity. The National Health Performance Authority should track bed numbers to ensure that additional Federal funding provided to State and Territory governments actually results in the opening of new beds, and that new beds are not offsetting bed closures.

Elective surgery waiting lists

Public waiting lists must be nationally consistent and provide clear and accurate information about the number of people who have been referred by a general practitioner for assessment, the number of people who are waiting for elective surgery, the length of time people wait, and the number of elective surgeries performed.

Public hospital funding

The goal of hospital funding systems should be to support effective health care services, rather than the cheapest

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services. The national efficient price has been set using cost data from the under-performing hospital system of 2009-10. In the price setting process, the complexity of hospital services across different hospitals and different geographical areas may have been underestimated and oversimplified. As a result, the new funding arrangements could have the following adverse impacts:

- a real reduction in the number of services provided – because the funding amount does not cover the cost of providing timely and effective care;
- a change in the types of services provided – with a focus on the more 'lucrative' activities;
- a reduction in the quality of care; and
- a diminution in the number of training places, and the quality of the training experience for junior doctors – with a focus on higher throughput in order to attract more funding for activity.

These impacts must be carefully monitored in real time so that adjustments can be made in order for public hospitals to meet the demand for their services. Medical practitioners must be involved in this process.

The National Health Reform Agreement allows State and Territory governments to pay public hospitals less than the full efficient price determined by the Independent Hospital Pricing Authority (clause A65).

The Federal Government must ensure that State and Territory governments publicly report whether they have paid hospitals the full price set by the Independent Hospital Pricing Authority, or the actual amount paid if it is less than the national efficient price, so that it is clear when poor performance is linked to insufficient funding.

Secure funding for teaching, training and research in public hospitals

Teaching, training and research are integral parts of the role of public hospitals in improving patient care and in training junior doctors.

The Government must ensure that:

- there is sufficient funding allocated for teaching, training and research undertaken in public hospitals;
- medical practitioners are involved in determining how this funding is distributed and used at the local level;
- funding for teaching, training and research in public hospitals is linked to transparently reported and independently audited performance indicators; and
- funding for rural and remote hospitals reflects the cost of providing services in those locations.

Health and Medical Research

The Government must increase its support for health and medical research by at least 10 per cent each year over the next four years. This should provide additional funding to:

- enable the National Health and Medical Research Council to provide stronger support for research to address rising rates of conditions such as diabetes, cancer and dementia, and to build workplace productivity and address population ageing;
- build health research infrastructure and increase program and project grant funding to improve the evidence base for heath care, and to ensure that high quality evidence is implemented as an integrated component of routine clinical care. This is essential to the evaluation of health reforms, and will provide evidence to drive excellence and continuous improvement in the health system;
- support an arrangement where groups conducting research that produces cost savings for the community can share in a proportion of those savings in order to fund future research;
- provide stronger support for clinical trials to capitalise on the results of basic research. This would be best achieved by central infrastructure support for the non-cancer clinical trials group of the same type that is provided to the cancer clinical trials groups coordinated by Cancer Australia;
- increase funding to enable innovative ideas and new technologies from Australia to be marketed internationally in an environment where the available venture capital support is discordant with the quality of publicly funded science; and
- reform tax and other relevant arrangements to provide an environment for greater and more effective philanthropic contributions to medical research.

Funding of research within hospitals is often lost because it is not separated out from the cost of clinical care (and can be used to fund clinical care). Funding for research is also not appropriately coordinated across areas of need when it is allocated at hospital level.

To avoid these problems, the Government must:

- explicitly identify the research component within the cost of health care, and
- establish a health system-wide process for distributing such funding so that it has maximum impact.

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Aboriginal and Torres Strait Islander health

The AMA believes the Federal Government should renew its commitment to a COAG *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* for a further five years from 2013, with the same level of funding allocation as provided in 2008.

The renewed COAG agreement should include funding for improved infrastructure capacity for primary health care in the Aboriginal Community Controlled service sector to enable these services to:

- provide mentoring and training opportunities to Indigenous and non-Indigenous health and medical students and vocational trainees; and
- provide a comprehensive core set of primary care services to patients, including through outreach services and community visiting.

The COAG Agreement should also include funding to develop a network of Centres of Excellence in Aboriginal and Torres Strait Islander Health across Australia, to act as training and research hubs for medical professionals seeking high quality practical experience and accreditation in Aboriginal and Torres Strait Islander health.

Linking and coordinating services is important to maintaining high quality and continuous care. The Government should facilitate systematic engagement between Aboriginal community-controlled services and mainstream general practices within Medicare Local regions.

Getting a healthy early start in life is crucial to health later in life. Aboriginal and Torres Strait Islander children are particularly susceptible to risks and stressors that lead to poor outcomes later in life.

The Government needs to focus greater funding on best practice programs in early childhood development that evidence shows are meeting with success.

There is also great need for a new COAG National Partnership Agreement to include targets and corresponding funding relating to Aboriginal people and the criminal justice system.

The rate of incarceration of Aboriginal people and Torres Strait Islanders across Australia is totally unacceptable, and must be addressed through a national commitment based on specific goals backed with adequate resources.

In some communities, alcohol abuse has a major effect in undermining family wellbeing and the healthy development of children. The AMA encourages the Government to ensure that:

- communities are empowered to inclusively develop effective alcohol management plans, to address the particular harms and risks of excess alcohol use; and
- funding is provided to enable action to recognise and prevent foetal alcohol spectrum disorder.

Priorities in preventive health

The AMA calls on the Government to support the following measures to tackle harmful alcohol use and excess weight:

- make it easier for doctors to provide the best health and medical advice and interventions to patients at risk of overweight and obesity, by making it a priority for the Australian National Preventive Health Agency to sponsor research on best-practice interventions and support for doctors treating patients who are overweight or obese;
- prohibit the targeted marketing of alcohol products to adolescents and teenagers, and ban the sponsorship of sporting events by alcohol manufacturers;
- mandate pricing arrangements for the sale of alcohol (through volumetric taxation and/or minimum floor pricing) to help reduce excessive alcohol consumption;
- prohibit the broadcast advertising of energy-dense and nutrient-poor food products (i.e. junk food) to children, particularly at child television viewing times;
- target a reduction in the national consumption of sugary carbonated beverages through a restriction on advertising and a review of applicable taxation; and
- implement a system of simple and informative nutritional labelling on food products that evidence shows will encourage behavioural change in consumers toward choice of healthy products.

Mental health

Support for all people with mental illness must be multifaceted and provided in the following ways:

- prevention, reducing stigma and enhancing community understanding, including through sustained national community awareness campaigns to increase mental health literacy and reduce stigma; public education campaigns for prevention and a reduction in substance abuse; and promotion of good health and resilience in young people at school and in the community;

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- early identification and intervention, including through support for more online and phone counselling and support services, comprehensive information about local referral pathways to ensure that patients get linked to the right service at the right time, more child-, adolescent- and youth-friendly services, and mental health screening for infants, children, and adolescents to identify symptoms as early as possible;
- community-based care, including through improved Medicare Benefits Schedule (MBS) rebates and streamlined MBS arrangements to improve access to psychiatrists and GPs for patients treated in community-based settings; improved access to mental health assessment facilities and mobile outreach; access to specialised community-based programs to treat specific clinical conditions including eating disorders, perinatal depression, personality disorders, suicide and self-harm; improved access to specialised mental health assessment and care and dementia care services for the elderly in residential aged care; and improved access to community-based mental health care services in rural and urban communities to meet local needs;
- sub-acute care, including through more capital and recurrent funding for sub-acute beds for long-stay patients and for residential rehabilitation; step-up and step-down residential care as an alternative to inpatient admission, or for a period of transition after hospital discharge; and more respite care for people with mental illness and their families; and
- acute care, including through funding to open and continue to operate additional acute care beds in public hospitals; increased access to public patient mental health outpatient services; specialised mental health and dual diagnosis spaces in public hospital emergency departments; and additional capacity to provide patients with the option of being treated in single sex mental health wards in public hospitals.

Aged Care

Medicare Benefits Schedule (MBS) rebates for services provided by medical practitioners and practice nurses must reflect the time and complexity of providing ongoing medical and dementia care to older people living in aged care facilities and in the community. The current Medicare rebate for these services should be doubled.

Additional funding should be provided to encourage and subsidise arrangements between aged care providers and medical practitioners to ensure ongoing access to medical care in residential aged care.

Efficiency gains in providing medical care can be achieved by extending Medicare items for video consultations by general practitioners to consultations with residents of aged care facilities and patients who are immobile.

Palliative care in residential aged care and the community must be improved through the introduction of dedicated Medicare rebates specific to the medical care provided to people at the end of their lives.

Aged care must make appropriate facilities available – including adequately equipped clinical treatment areas that afford patient privacy, and information technology to enable access to medical records and improve medication management.

Nursing care in the aged care sector must be adequate to meet the needs of residents and support the ongoing medical care of residents.

Community care, including domiciliary services for older people, is of crucial importance. Services should be matched to the needs of each individual, be comprehensive, linked to the medical services received by the patient, and coordinated at the practice level.

Tackling chronic disease

The AMA has a comprehensive plan to manage chronic disease by improving GP-coordinated access for patients to multi-disciplinary care and other support services. This plan can be found at http://www.ama.com.au/node/5519.

Under the AMA plan, existing Medicare arrangements would be enhanced so that patients would have streamlined access to GP-referred allied health services and a range of other support services such as mobility aids. The plan focuses on the clinical needs of patients and will help improve their quality of life.

The AMA also supports a more proactive approach to the coordinated management of patients with chronic and complex disease. The Department of Veterans Affairs (DVA) has initiated the Coordinated Veterans Care (CVC) program that provides additional funding support for GPs to provide comprehensive planned and coordinated care to eligible veterans, with the support of a practice nurse or community nurse. This program is designed to reduce avoidable hospital admissions and deliver overall savings to the health system.

The DVA CVC program was developed with strong clinical input and has broad stakeholder support. The AMA supports the development of a broad coordinated care program to tackle chronic and complex diseases based on the model of care and funding arrangements developed for the CVC program.

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GP infrastructure

The Government should provide for an additional 600 GP infrastructure grants at current funding levels (on average, approximately $300,000 each) enabling a third round of GP infrastructure grants.

Private health insurance coverage of coordinated care

Private health insurance should extend to primary care coordination services provided by medical practitioners.

Medicare rebates for GP video consultations

Extending MBS telehealth items to GP consultations for remote Indigenous Australians, aged care residents, people with mobility problems, and rural people who live some distance from GPs would considerably improve access to medical care for these groups.

Climate change

The Government must develop a National Strategy for Health and Climate Change to ensure that Australia can respond effectively to the health impacts of climate change, extreme weather events, and to people's medium and long-term recovery needs.

This National Strategy should incorporate:

- strong communication links between hospitals, major medical centres, general practitioners, and emergency response agencies to maximise efficient use of health resources in extreme weather events;
- localised disaster management plans for specific geographical regions that model potential adverse health outcomes in those areas;
- nationally-coordinated surveillance measures to prevent exotic disease vectors from becoming established in Australia,
- development of effective interventions to address mental health issues arising from extreme events, including those involving mass casualties and from longer-term changes, including drought, and
- a register of recently retired competent medical practitioners who are willing to assist in providing medical services during a national emergency.

The AMA also believes that climate change is a health and medical research priority, and should form a core part of a National Strategy for Health and Climate Change, supported by strong, long-term funding grants.

National Disability Insurance Scheme

Clause 104 of the *National Disability Insurance Scheme Bill 2012* does not facilitate an Australian system of disability support based on need.

The clause works against generating a cultural shift in which Australians with disabilities and their families are supported by the community, and do not need to pursue compensation for the costs of care and support.

The *National Disability Insurance Scheme Bill 2012* should be amended to ensure the NDIS is truly an insurance-based approach to provide and fund care and support for Australians with disabilities and their families.

e-Health

Shared Electronic Health Records must:

- contain reliable and relevant medical information about individuals;
- align with clinical workflows and integrate with existing medical practice software;
- be governed by a single national entity; and
- be fully funded by Government, and supported by appropriate incentives, education and training.

The Government should provide a single set of standardised template policies and protocols detailing what is required to participate in the PCEHR, which medical practices can adjust to suit their own practice arrangements.

This would save significant administrative time and resources for medical practices, which would otherwise have to prepare these documents from scratch. Government funding should be provided to an entity that understands the clinical and administrative operations of medical practices to prepare these template documents.

The Government should provide a standardised step-by-step toolkit to streamline the processes that medical practices will have to put in place to meet the administrative and technological requirements of the PCEHR.

A clinical advisory group that represents the views of practising clinicians should be established to oversee and advise the Government on the practical implementation of the PCEHR and its use in clinical practice.

The clinical advisory group should also work with the Systems Operator on the technical adjustments that need to be made to the system, based on experience with its use in clinical practice.

PBS authority prescriptions

The Government can make a significant improvement to the productivity and efficiency of the medical workforce in Australia by removing the PBS Authority system.

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Medical workforce up, GP supply down

"We need to start planning for this now and setting aside the necessary funding if the community is to have access to the medical workforce it needs into the future"

AMA President Dr Steve Hambleton said the recent *Medical Workforce 2011* report – produced by the Australian Institute of Health and Welfare – shows encouraging signs of growth in Australia's overall medical workforce, but a relative decline in the supply of general practitioners raises serious concerns about patient access to quality primary care.

Dr Hambleton said that the report provides further evidence about the uneven distribution of the medical workforce around the country and highlights decreases in the supply of some key specialty areas.

"The good news is that there was a 17 per cent increase in the number of doctors between 2007 and 2011," Dr Hambleton said.

"There was also an increase in the supply of doctors working in rural and remote areas, but the rural medical workforce is still lagging well behind the metropolitan workforce.

"On the downside, the report shows that general practice is still not getting its fair share of the growth in workforce numbers.

"The supply of specialists-in-training, specialists, hospital non-specialists and other clinicians all increased, but the supply of GPs fell from 111.9 to 109.7 full time equivalent per 100,000 population between 2007 and 2011.

"The AMA has called for further investment in general practice, including an increase in the first year intake to the GP training program to 1500 a year (currently 1100) by 2016, to help build the GP workforce to sufficient numbers to meet community need.

"The report shows decreases in the supply of physicians, pathologists and surgeons.

"We will be encouraging all governments and Health Workforce Australia (HWA) to address the need for more specialist training positions in the future, particularly as HWA is predicting that there will be an inadequate number of specialist training places for the growing number of medical graduates.

"We need to start planning for this now and setting aside the necessary funding if the community is to have access to the medical workforce it needs into the future," Dr Hambleton said.

Key statistics from the report include:

- in 2011, there were 87,790 medical practitioners registered in Australia, and about 85 per cent of them responded to the workforce survey;
- between 2007 and 2011, the number of medical practitioners employed in medicine increased by just over 17 per cent, from 67,208 to 78,833;
- the overall supply of clinicians across all States and Territories increased 11.4 per cent between 2007 and 2011, from 323 full-time equivalents per 100,000 people in 2007 to 360 in 2011;
- between 2007 and 2011, there was also a rise in the supply of employed medical practitioners in all regional areas, including *Major cities* up by 60 FTE, *Inner regional* areas up by 60 FTE, *Outer regional* areas up by 69 FTE, and *Remote/Very remote* areas up by 45 FTE;
- about 94 per cent (73,980) of employed medical practitioners were working as clinicians, of whom 34 per cent were general practitioners, 33 per cent specialists, 17 per cent specialists-in-training, and 13 per cent hospital non-specialists.
- of those employed as non-clinicians (6 per cent of all employed medical practitioners), more than half were researchers or administrators;
- physician was the largest main speciality of practice among both clinician specialists and total specialists (5,157 and 5,689 respectively);
- the second-largest main speciality for clinician specialists and specialists (3,951 and 4,125 respectively) was surgery;
- women are increasingly represented in the medical practitioner workforce, up from 34 per cent in 2007 to 38 per cent in 2011. Among clinicians, women accounted for 48 per cent of hospital non-specialists compared to 26 per cent of specialists;
- the average age of medical practitioners has fallen slightly from 2007 to 2011, from 45.9 to 45.5 years; and
- the average weekly hours worked by employed medical practitioners remained stable between 2007 and 2011. In 2011, male medical practitioners worked an average of 45.9 hours per week, while female medical practitioners worked an average of 38.7 hours per week.

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Heatwave health warning

As the nation sweltered throughout January, the AMA, the Climate and Health Alliance (CAHA), and the Climate Commission issued a warning about the health effects of heatwaves.

Heat is the silent killer. Most Australians do not realise that heat is the leading cause of weather-related death.

The three organisations urged people to take care of themselves in the hot conditions, to be aware of the dangers of extreme heat, and encourage people to follow health and medical advice about how to stay cool as Australia experienced another scorching heatwave.

AMA President Dr Steve Hambleton said that climate change and its effects were hitting Australia in a dramatic and devastating way this summer.

"Extreme weather events like the heatwaves and devastating fires being experienced across Australia will unfortunately become more frequent," Dr Hambleton said.

"It is crucial that we plan ahead to minimise their adverse health effects.

"At a policy level, we need a comprehensive and coordinated national strategy for climate change and health that includes local disaster management plans and active communication links between hospitals, major medical centres, local weather forecasters, and emergency response agencies."

Climate and Health Alliance President Dr Liz Hanna said there was no doubt that the heatwaves were posing serious risks to health, particularly among people who are unable to modify their exposure to the elements.

"Heat kills more Australians than the road toll each year," Dr Hanna said.

"Everyone working or playing outdoors is at risk of overheating on very hot days.

"Heat can also worsen existing illnesses. People with heart conditions, in particular, should take care to keep cool and not exert themselves.

"Those caring for vulnerable people and small children should be aware of their higher risks of dehydration and heat stroke. Health care providers should also be prepared for increased demand on their services and resources," Dr Hanna said.

The Climate Commission released a new resource on heatwaves this month highlighting the need to reduce greenhouse gas emissions and to put measures in place to prepare for more extreme weather.

Climate Commissioner, Roger Beale, said that it is important that people are alerted to the risks that climate change poses so that, as a community, we can take appropriate action to reduce greenhouse gas emissions and respond to extreme weather.

"Although Australia has always had heatwaves, hot days and bushfires, climate change is increasing the risk of more frequent and longer heatwaves and more extreme hot days, as well as exacerbating bushfire conditions.

"The length, extent and severity of the current Australian heatwave is unprecedented in the measurement record," Mr Beale said.

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INFORMATION FOR MEMBERS

$10,000 prize on offer for creative clinicians, managers

The nation's most innovative and successful clinicians and practice managers could be in line for a $10,000 prize under a competition launched by the National Lead Clinicians Group (NLCG).

As part of its efforts to foster clinical best practice and interdisciplinary collaboration, the NLCG has instituted a national Awards for Excellence program.

Clinicians and managers from across the spectrum of health services who have developed creative and cost-effective ways to improve the quality of the care they provide are invited to submit entries for the Awards, which are to be held as part of the National Clinicians Network Forum in June next year.

The Award organisers said that those who had developed innovations that could be applied across disciplines and sectors were particularly encouraged to enter.

Entries will be judged according to several criteria, including innovative approaches to implementing clinical guidelines, demonstrated success in overcoming existing barriers to the use of clinical guidelines, greater efficiency in the use of clinic resources and applicability across disciplines.

Finalists will be sponsored to attend next year's Forum to present their approach to implementing clinical guidelines, with the winner or winners to receive $10,000 each.

A guide to preparing an application for the Award can be found at http://leadclinicians.health.gov.au

Entries close at 5pm on Friday, 16 March, 2013.

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Getting the truth on food labels

Breakfast cereals, cereal bars and soft drinks will find it harder to make claims such as '*a good source of calcium*' after new laws were introduced to tighten restrictions on voluntary health claims on food packets.

The laws, introduced earlier this month, mandate basic standards that products must meet to promote the benefits of ingredients.

This will prevent products from claiming 'high in calcium for healthy bones' when the product is also high in saturated fat, sugar and salt.

Food companies have three years before they will be forced to comply with the new standards.

The Parliamentary Secretary for Health and Ageing Catherine King said the new standards would give consumers confidence that nutrition content claims and health claims on food labels and in advertising are backed by scientific evidence.

"It aims to support industry innovation and help consumers make informed food choices," Ms King said.

Research by the Cancer Council reviewed over 1000 products in Australia and found more than 60 per cent of the products carried a nutrition content or health claim.

The Cancer Council's Clare Hughes said the new laws would see more than 30 per cent of the products reviewed that currently carry a health claim taken off the shelves because they don't pass the mandatory health criteria.

"The introduction of these laws is great news for consumers," Clare said.

"But the new standard leaves the door open for ambiguity, allowing about a third of products reviewed to continue to use 'nutrition content claims' on unhealthy foods including snacks, and sugary breakfast cereals."

A spokeswoman for Food Standards Australia and New Zealand told the *Canberra Times* that nutritional claims would still need to meet high standards.

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Killer flu season predicted

Experts predict Australia is in for a killer flu season after more than 20 children have died in the United States from the H2N3 strain of the virus.

There have been five times as many cases reported in New York as there was in the entire flu season last year, and it is yet unclear if the season has peaked yet.

Vaccines are in short supply and New York Governor Andrew Cuomo has declared a state of emergency.

AMA President Dr Steve Hambleton said often the flu season overseas presented as a warning for Australia.

"We do tend to parallel the Northern Hemisphere in the South, so it's a forewarning that we need to get in early and vaccinate this year," Dr Hambleton told News.com.

Dr Hambleton said the flu would still come in our winter, but that widespread vaccination would protect the vulnerable and reduce the effects in the healthy.

So far there have been reports of outbreaks in Hong Kong and South-East Asia. The flu vaccine will be available in Australia in March and will protect against Influenza A (H2N3), Influenza B, and swine flu.

Dr Hambleton said we would have ample supply of the vaccine in Australia from March and encouraged the more vulnerable in our community - older people, Indigenous Australians, pregnant women and anyone with an underlying health problem - to consider getting the injection.

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Students to get cyber safer

Students will be encouraged to become safe and respectful digital citizens under a new cyber education program announced by the Government earlier this month.

Prime Minister Julia Gillard launched the *bCyberwise* program, which was developed by Life Education and McAfee. The program teaches primary school students about cyberbullying, keeping passwords private, and the dangers of posting embarrassing photos and videos online.

The Prime Minister said that, generation after generation, kids have been taught how to be streetwise and about stranger danger but now we have to teach our kids about new dangers.

Life Education already provides lessons on health, safety and drugs to school children and will now expand their program to include positive digital behaviour. The *bCyberwise* program will travel around the country to schools in Life Education mobile vans.

The program will include interactive videos and discussion among classmates.

President of McAfee Asia Pacific Andrew Littleproud said the focus was on preventive measures.

"Online risks are growing every day," Mr Littleproud said. "We need to help prepare students to tackle those risks every day."

AMA President Dr Steve Hambleton said bullying in all its forms should not be tolerated.

"The Government's program is a positive step forward in combating cyberbullying," he said.

"It is good to see the Government busy in this policy area.

"It is important we educate our children on how to safely use the Internet and ensure they have the resources and resilience to make informed decisions when using the web."

Online social networking giants Facebook, Google, Yahoo and Microsoft have agreed to promote user safety as well as undertake education and awareness about combating antisocial behaviour online under new guidelines developed by the Government.

The Government is encouraging other social networking sites, including Twitter, to sign up to the guidelines.

The Coalition, while supporting the Government's announcement, said the new cyber education measures were five years too late and did not go far enough.

The Australian Greens took a cautious approach to the announcement, raising concerns about the Government's role in regulating the way that Australians communicate online.

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INFORMATION FOR MEMBERS

AMA Careers Advisory Service

From graduates preparing their first resume to experienced doctors seeking to carve out a new career path in the Commonwealth public service, the AMA Careers Advisory Service has been on hand to provide practical advice and information.

Since the Service was launched in September, AMA Careers Consultant, Kathryn Morgan, has handled dozens of inquiries from members looking for help and advice on advancing their careers, both within medicine and beyond.

The Careers website, which is at: http://careers.ama.com.au/, gives members access to both general and specific careers advice and information. In addition to direct links to external websites and specific sources of information, the Service also offers practical advice for medical professionals as their medical careers advance.

The Careers Service provides information and support relevant to all stages of an individual's career, from medical students looking for assistance preparing internship applications - particularly writing resumes and covering letters - through to doctors in training who want to brush up their interview skills to give them a competitive edge at all-important medical college interviews.

But the Service is not only there for those in the early stages of their medical careers. It has also helped qualified medical professionals looking to apply their skills and expertise in jobs beyond medical practice. Among these have been those looking for non-clinical roles in Commonwealth and State public services that take advantage of their skills and experience.

The Service is constantly updating content on its website, including listings of career-related events being staged across the country, and uses feedback from members to help add and develop resources.

Members are encouraged to visit the website, if they haven't done so already, and we welcome feedback, which can be submitted via the online feedback form on the website.

There will be further updates on developments in the Careers Service in coming months as we develop more ways to assist members along their medical career path.

If you or your colleagues would like to convene a skills workshop facilitated by Kathryn, please contact her at:

Phone: (02) 6270 5410
1300 884 196 (toll free)

Email: careers@ama.com.au

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Sugary drinks not so sweet

Health organisations have banded together with a new campaign to tackle Australians' love affair with sugary drinks.

The *Rethink Sugary Drinks* campaign, coordinated by the Cancer Council, Diabetes Australia and the Heart Foundation, is pushing for a tax on soft drinks and restrictions on advertising directed at children in an attempt to curb obesity rates.

The campaign features a TV ad, borrowed from a similar New York campaign, warning people of the dangers of sugary drinks.

The Cancer Council's Craig Sinclair said that it's time for Australians to rethink sugary soft drinks and switch to water or low-fat milk.

"Soft drinks seem innocuous and, consumed occasionally, they're fine, but soft drink companies have made it so they're seen as part of an everyday diet," Mr Sinclair said.

"They are often cheaper than bottled water and are advertised relentlessly to teenagers."

A regular 600ml soft drink contains about 16 packs of sugar and, based on US estimates, consuming one can of soft drink per day could lead to a 6.75kg weight gain in one year.

AMA President Dr Steve Hambleton said soft drinks are an occasional food and shouldn't be consumed all the time.

"Sugary drinks should be consumed in moderation and only for special treats," Dr Hambleton said.

"Sugary drinks don't need to be banned, but we should be educating people about the negative effects, such as tooth decay.

"Our children especially need to be protected from the harms of sugary drinks, which is why the AMA fought so hard to remove them from school tuck shops."

KW

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Going somewhere this summer?

Planning to go away soon for some much needed R and R?
Or have you been somewhere spectacular recently?

Whether it be an expedition across the other side of the world or a brief sojourn down the road, here's the chance to share your thoughts and experiences, from the exhilarating and glorious to the tedious and disastrous.

It can be anything from travel advice and how-to hints to hotel and restaurant reviews, and everything in between.

Australian Medicine invites readers to write and submit travel stories of up to 550 words, with two bottles of fine wine sent to the author of each article published. Pictures welcome.

Please send stories, with your contact details, to: ausmed@ama.com.au

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AMA IN THE NEWS

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

Print/Online

Patient care put at risk as Campbell Newman offers an olive branch to boards, *The Courier Mail,* 24 January 2013

AMA President Dr Steve Hambleton called for detailed discussions with clinicians before changes were made to ensure either a doctor or a nurse serve on each of the State's health boards.

Ritalin linked to growth delays in adolescent boys, *The Australian*, 22 January 2013

Dr Steve Hambleton said the study's findings should prompt parents and medical experts to reconsider the treatment currently provided to children with ADHD.

Doctors to reduce painkiller prescriptions, *The Courier-Mail*, 19 January 2013

Australian Medical Association President Dr Steve Hambleton confirmed that some patients with non-cancer pain would have to be weaned off the drugs because they were too expensive and were no longer clinically appropriate.

Greens push to ban drug company perks for doctors, *The Sydney Morning Herald*, 19 January 2013

President of the Australian Medical Association Dr Steve Hambleton said he wanted to examine the Greens' proposal before commenting, but said "engaging with pharmaceutical companies was an important form of education" for doctors who rarely experienced lavish hospitality.

Radio

Dr Hambleton, 2SM Sydney, 22 January 2013

New research has found teenage boys medicated for ADHD could experience a delay in puberty. Dr Steve Hambleton says research in the past has found a decrease in appetite among boys on the drug.

Dr Hambleton, ABC Radio National, 19 January 2013

The Australian Greens want to make it illegal for drug companies to pay for doctors to attend conferences or to offer them gifts and other hospitality, but Dr Steve Hambleton says the Greens are going too far, and a balance needs to be struck.

Dr Hambleton, ABC News Radio Sydney, 16 January 2013

Dr Steve Hambleton discusses the risks of heat stroke. He says it is important to be prepared and that extreme weather can exacerbate existing medical conditions.

TV

Dr Hambleton, Today Tonight Adelaide, 16 January 2013

President of the Australian Medical Association Dr Steve Hambleton wants restrictions to be placed on energy drinks.

Dr Hambleton, Sky News, 16 January 2013

Dr Steve Hambleton, President of the Australian Medical Association, is urging parents to give their children a flu shot as early as March, after 20 children were killed by a virulent strain in the US.

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

The Science of Immunisation

The AMA has available copies of the booklet *The Science of Immunisation: Questions and Answers,* which has been produced by the Australian Academy of Science to dispel myths and misinformation about the dangers of vaccination.

To obtain copies of the 16-page booklet, please contact the AMA, either by email at: media@ama.com.au

or by writing to:

AMA Public Affairs
AMA House
42 Macquarie Street
Barton, ACT 2600

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AMA in action

AMA President Dr Steve Hambleton spent a large proportion of his time in Canberra this past fortnight. Here he was able to catch up with AMA NSW President Dr Brian Owler and met with the AMA Executive for the first time this year to strategise for the year ahead.

Dr Hambleton met with NACCHO CEO Lisa Briggs and discussed the AMA's Indigenous activities over the past year and for the future. Dr Hambleton was also busy talking to the media about the influenza outbreak in the US and providing advice on how to avoid heat stroke.

While in Canberra for the AMA Executive Meeting, Dr Liz Feeney caught up with the AMA Conference team to hash out a few details. The AMA Conference is on from 24-26 May 2013 at the Westin in Sydney. For more details go to https://ama.com.au/nationalconference

TO COMMENT CLICK HERE

The AMA Executive from Right to Left, Dr Steve Hambleton, Dr Liz Feeney, Professor Geoff Dobb, Dr Iain Dunlop and Dr Peter Ford

Dr Hambleton was interviewed by Sky News on the Influenza outbreak in the US

AMA President Dr Steve Hambleton met with NSW State President Dr Brian Owler

AMA in action

The AMA Conference Committee from left to right Annabel Reid, Elona Rabinovitch, Dr Liz Feeney and Janene Wardrop

Dr Hambleton with NACCHO CEO Lisa Briggs

Dr Liz Feeney and Dr Iain Dunlop busy at work at the AMA Executive meeting

Dr Hambleton with Warwick Hough at the AMA Executive meeting

Chronic Disease Items – time for a rethink?

BY **DR BRIAN MORTON**

"It is good to see that the AMA's chronic disease plan has at least got the Government thinking about a new approach to CDM items"

The number of our patients with chronic diseases and complex care needs is increasing and the current system does not support the provision of well-coordinated multidisciplinary care.

Existing Medicare funded chronic disease management (CDM) arrangements are too limited, cumbersome, and difficult for patients to access, and are wrapped up in red tape and bureaucracy.

The great failure of current arrangements is that they were designed by bureaucrats with little understanding of how day-to-day general practice works.

It is well known that governments are happy to use red tape to try and control program expenditure and many GPs would share my suspicions that this is the real reason why the current CDM items have so many compliance requirements that are in no way linked to good clinical care.

There is no evidence to demonstrate that the compliance requirements involved in CDM items are leading to better outcomes for patients, although there is plenty of evidence that GPs are very frustrated at the lengths they must go to ensure that patients can access the care they need.

The AMA believes there is a better way and last year revised its chronic disease plan.

The revised plan proposes arrangements that would better support GPs to provide patients with chronic and complex disease with access to multidisciplinary care and essential support services. The AMA plan recognises how GPs work at the coalface and what type of care patients need.

The AMA has been pushing this plan and recent talks with the Department of Health and Ageing (DOHA) indicate that the Department, too, is coming to the view that it may well be time to have a closer look at the CDM items to see if there are possibilities for a less prescriptive approach that fits more closely with accepted clinical practice.

DOHA is about to embark on a consultation process and the AMA will be very much engaged in this process.

We also know that, based on MBS data, the number of CDM review items (732) claimed is much lower than the number of GPMP (721) and TCA (723) items claimed.

This highlights to me that, while GPs review patients on a regular basis, they are billing the normal consultation items so as to avoid the red tape requirements of the review items.

It is good to see that the AMA's chronic disease plan has at least got the Government thinking about a new approach to CDM items.

While it is very early days in this discussion, and we have seen past efforts at reform achieve very little, including MBS simplification, there may prove to be an opportunity to deliver sensible changes that recognise quality GP care and better support patients to access the care they need.

TO COMMENT CLICK HERE

A new year, a new plan

BY **DR DAVID RIVETT**

"Needs of practitioners' families must be given priority in any solution, particularly in respect to access to employment, health, and education"

Welcome to 2013, which is hopefully going to be the year that our governments address the rural workforce crisis in a structurally sound and solid manner.

We await the outcomes of Health Workforce Australia's deliberations, which are soon to be announced, and particularly the Review of Australian Government Health Workforce Programs.

The AMA has submitted excellent detailed and comprehensive submissions highlighting that any lasting solution must be multifaceted, with particular emphasis on early and continuing exposure to rural practice for undergraduates and graduates alike. Such must be a high quality and enjoyable positive experience, with enhanced funding.

Stressing that adequate core numbers in rural locations are essential to enable attractive sustainable work rosters, and that fiscal incentives must be enhanced and better focused, the AMA-RDAA Rural Rescue Package, based on a new sound geo-demographic formula, more accurately recognising degrees of rurality, would be a great start to any lasting solution.

ASGC-RA has been shown to be riddled with anomalies and must be replaced.

Needs of practitioners' families must be given priority in any solution, particularly in respect to access to employment, health, and education.

IMGs must be better assessed, mentored and supported and their path through the tedious and protracted sea of red tape must be streamlined to ensure quality doctors are not turned away by the lengthy delays to access clinical assessment that are currently inherent in our systems.

Bonding of medical students without scholarships must go; as such penal servitude will not produce a long lasting happy rural workforce.

On the local front, the Christmas holiday influx of huge tourist numbers bearing smart phones, tablets, pads, and laptops has brought internet services, which are now a vital cog in both providing care and allowing patients to get Medicare rebates back into their accounts, crashing down in our area on the NSW South Coast.

Access is now patchy and slow, and will doubtless remain so until tourist numbers ease in February, thus making a strong case for speeding up the NBN network rollout to rural Australia.

Locally, we remain bushfire-free but on high alert as the bush is tinder dry and it has been an extremely hot summer.

Hopefully some prolonged rain will ease this threat soon. On the farm, I have had a great calving season with the new bull fathering calves, both easily birthed and thriving.

I trust the New Year will see a similar outcome from the Government, with regulations passed and enacted to establish sound and lasting foundations for better rural healthcare provision.

May I wish you all a successful, prosperous and healthy 2013.

TO COMMENT CLICK HERE

NACA Gateway Advisory Group

BY **DR PETER FORD**

"In general, medical practitioners know the patient's requirement, but not necessarily the appropriate source or agency, of which there are many in the community service arena"

A new Aged Care Gateway website called 'My Aged Care' will be established by 1 July 2013 to provide information about available services in the aged care system. Over time, it is envisaged that the site will build to provide a comprehensive system of information enabling Australians to find what they need.

The Aged Care Gateway proposal was originally labelled in the 2010-11 Budget as the One Stop Shop initiative.

The Government announced that it would provide $36.8 million over four years to establish a network of one-stop shops across Australia supported by telephone and web-based systems. The AMA considered the website to be an opportunity to enhance general practitioner coordination of services for elderly patients living in the community.

The measure was envisaged to be a single front end to the aged care system, providing clients, carers, and medical practitioners with:

- Information on the full range of community and residential aged care services, and carer support services;
- Assistance in assessing options and filling out forms, such as those for income assessment;
- Centralised intake assessment, including eligibility assessment for basic maintenance and support services and a more detailed eligibility assessment for subsidised aged care services;
- Referral to basic maintenance and support services;
- Access to a capacity database and care coordination service to enable the public to find service providers who have the aged care services available to meet their assessed care needs.

The AMA advocated for additional components to the website element, including listing information about residential aged care facilities in the area (including where all the low, high, and mixed care facilities were located), listing information about local community based aged care services in the area (including descriptions of eligibility criteria for those services), and functional integration with GP desktop software such as Medical Director.

In general, medical practitioners know the patient's requirement, but not necessarily the appropriate source or agency, of which there are many in the community service arena.

A well-designed system would provide uniformity, integrate with existing IT systems, and would avoid the situation where medical practitioners are pushed from one service to another (which is time-consuming for doctors and their staff, and distressing for patients and carers).

As part of the *Living Longer. Living Better* package announced last year, the One Stop Shop initiative has been rebranded as the Aged Care Gateway.

As the success of the Gateway will rely on engagement with medical practitioners, the AMA is participating in the Gateway Advisory Group.

The Group has been established to provide advice to Government on:

- the purpose and objectives of the proposed Gateway;
- the key design elements and implementation arrangements for the Gateway with an initial focus issues including a national assessment framework to provide consistent needs assessments and an Aged Care Client Record which will allow a 'single view' of each client's current aged care needs and associated history;
- other aspects of the implementation arrangements including communication materials, monitoring and evaluation; and
- longer-term strategies and resources needed to support consumers, carers, providers and the aged care workforce in relation to the changed arrangements.

TO COMMENT CLICK HERE

Direct to consumer genetic testing

BY **DR LIZ FEENEY**

"Ideally, a patient will talk to their doctor about their desire or intention to have a DTC genetic test prior to actually having it done"

In my last column, I highlighted some of the challenges posed by direct-to-consumer (DTC) genetic testing more broadly. In this column, I ask the question: *As a medical practitioner, what should you do if a patient brings in a DTC genetic test result and requests you to interpret and act on it (eg. provide a diagnosis and/or therapeutic advice)?*

The National Health and Medical Research Council (NHMRC) recently released a consultation document entitled, *Assessing the direct-to-consumer (DTC) genetic testing results of your patient – a quick guide for general practitioners.*

In our submission to the NHMRC, the AMA advocated that genetic testing for health care reasons should only be undertaken with a referral from a medical practitioner. This assures that the correct test is ordered and the patient has made a fully informed decision to undertake it.

As DTC genetic testing is a reality, however, we do agree that doctors need guidance on what to do when faced with one.

In our submission, we highlighted a very important issue that was missing in the consultation document - the potential risk to patient safety of acting on a DTC genetic test result.

The AMA advised that doctors are not obliged to accept such results and they should carefully consider whether or not to try and interpret and/or act upon them because of the inherent risk of DTC genetic testing.

Commercial companies that offer DTC genetic tests are generally located offshore and it's difficult to assess their quality control standards, including those related to privacy. If a test is not performed, analysed, and interpreted appropriately, the results may be misleading, unclear, or inaccurate. A patient may be placed at risk of harm should the doctor attempt to interpret and/or provide therapeutic advice based on an erroneous test result.

In our submission, the AMA advised that if a doctor has any doubts about the efficacy of the test and/or the accuracy of the test result, he or she might wish to reorder the test through an accredited Australian laboratory or refer the patient to another practitioner or counsellor.

The doctor should explain to the patient their reason for not accepting the DTC genetic test and document the suggested course of action in the patient's medical record.

Ideally, a patient will talk to their doctor about their desire or intention to have a DTC genetic test prior to actually having it done.

If the opportunity to have such a discussion arises, the doctor should advise the patient of the potential risks of DTC genetic testing, including issues of quality, safety, and privacy.

The doctor can assist the patient in clarifying their reason for wanting a genetic test and determine which test (if any) suits the patient's health care needs.

The risks and benefits, as well as ethical, legal, and social implications, of genetic testing more broadly can be discussed so that, with the doctor's guidance and support, the patient comes to a truly informed decision.

TO COMMENT CLICK HERE

Medical students want to be doctors, not museum exhibits

BY **AMSA PRESIDENT BEN VENESS**

Bangkok is well known for its unique attractions, but one of the more obscure is the Medical Museum tucked away within Siriraj Hospital, on the western bank of the Chao Phraya River.

A horribly difficult place to find, and perhaps an even more horrible place to find, the museum is macabre. Why anyone should want to show school children the mummified remains of a serial killer, leaning, stiff and sinewy, within a glass box, mystifies me. Likewise, the extensive collection of photographs and specimens of heads and hearts brandishing bullet wounds.

The images of elephantiasis, as grossly manifest in Asian male anatomy, were surely included for light relief. More affecting was the display profiling Siriraj Hospital's role after the 2004 Boxing Day tsunami.

I visited the Museum at the start of the month, on the way home from a medical elective in Myanmar. Thinking about it now, I'm reminded of an autumn day in Sydney some three-and-a-half years prior, at a medical school information evening, where a young man wiser than me raised his hand and asked a question about another kind of tsunami – one I'd never heard of – a "medical student tsunami".

His forecast proved accurate, which isn't surprising given last year's "internships crisis" was entirely predictable, and therefore preventable. And so, too, will the 2013 crisis.

But there's more light on the horizon this time.

The Department of Health and Ageing does not want a repeat of last year's shemozzle, and will be joining the call for better coordination the whole way through the application process.

Part of the trouble we had in 2012 was the difficulty in simply knowing how many internships were required. Each jurisdiction ran its own application process, and with no unique, common identifier for applicants, it was apparently impossible to work out how many of them were unplaced at any point in time. I suggested using mobile telephone numbers, but a fancier solution is being sought. Better data will help immensely.

Secondly, there's political will dotted around the place.

New South Wales, for instance, has scheduled a full-day forum for 22 February to discuss internships specifically, and has invited all the Health Ministers, medical schools, the AMA, AMSA, and other stakeholders.

The program is a mystery, but it's great that this kind of discussion will be starting so much earlier in the year.

During Federal Parliament's first sitting week, AMSA will also be continuing discussions in Canberra with politicians who have expressed an interest in developing policy to prevent a recurrence of the 2012 scenario and, importantly, address the medical workforce issues further up and down the line.

An internship is one thing, but ultimately what we want is more fully-trained doctors, and already some States are shaping up for an "RMO crisis".

Perhaps our trump card, though, is not that the 2013 Federal Election may make both parties more sensitive and approachable, but that medical students demonstrated such formidable strength, solidarity and smarts during the #interncrisis campaign last year.

Domestic students fought extremely hard for resolution of a problem that (so far) only afflicts their international student peers, despite the fact that success would increase competition for jobs down the line.

We want a fair go for our mates, and will fight again to get it. But, more than that, we believe Australia needs these doctors. We've all studied the same lectures, practised the same clinical skills, sat the same exams, and now we want to serve, side by side, the growing demand in Australian society for high-quality health care.

To send people like Haley Cochrane – a colleague at Sydney Medical School who works tremendously hard and gives so much of her time to tutor fellow students as they study for the USMLE – home to Canada at the end of this year, rather than making every effort to retain her, would be a great loss to Australia.

Meanwhile, all across the country, about 3,700 new medical students are facing the same excitement I remember fondly from three years ago.

Many of them will right now be coming back from places like Bangkok, their last big trip before med, a Littmann on mail order. Four to six years of study at university await, and then hopefully a job at the end.

The sensible question for them to be asking is, is it worth it? I can unreservedly attest that med school is, but as for internship, I'll have to defer to others. And so it was reassuring recently to read the Facebook status of a friend who just graduated from Monash and is at the end of day four on the job: I can't believe I get paid to do this :)

Benjamin Veness is the President of the Australian Medical Students' Association (AMSA) and is studying medicine and a Master of Public Health at Sydney Medical School. This year, the National Executive of AMSA is based in New South Wales, and comprises 15 exceptional students brought together from five medical schools. Many more medical students are involved with AMSA in other volunteer roles, and the AMA is one of AMSA's major sponsors and supporters. Follow on Twitter @venessb and @yourAMSA

TO COMMENT CLICK HERE

RESEARCH

Childhood obesity hits health later in life

New research has found that obese children are nearly twice as likely than kids who are not overweight to have three or more medical, mental or developmental conditions growing up.

Researchers from the University of California examined the immediate consequences of childhood obesity. They analysed data on more than 43,000 children between the ages of 10 and 17 using the 2007 National Survey of Children's Health. They assessed associations between weight status and 21 indicators of general health, psychosocial functioning, and specific health disorders.

The study found 15 per cent of the children were overweight and 16 per cent were obese.

The study found obese children were more likely than those not overweight to have poorer health, more disability, a greater tendency towards emotional and behavioural problems, higher rates of grade repetition, depression, learning difficulties, developmental delays, asthma, headaches, and ear infections.

Lead researcher Dr Neal Halfton said the study paints a comprehensive picture of child obesity.

"We were surprised to see just how many conditions were associated with childhood obesity," Dr Halfton said.

"The findings should serve as a wake-up call to physicians, parents and teachers who should be better informed of the risk for the other health conditions associated with childhood obesity so that they can target interventions that can result in better health outcomes."

KW TO COMMENT CLICK HERE

Getting rash to beat melanoma

New research indicates that 'rashies' may save children from developing skin cancer.

Rash vests worn outdoors for water activities may reduce the number of children with melanocytic naevi (MN) or moles, which can be precursors to developing melanoma.

Researchers from James Cook University examined if skin cancer prevention programs had resulted in greater sun protection. They compared two groups of children aged 12 months to 35 months in Townsville - one cohort from 1991, the other from 1999-2002.

They found the amount of sun exposure did not decrease between the cohorts, but the amount of sun protection did.

Almost all (97 per cent) of the 1991 cohort had at least one MN compared with 83 per cent in the later group. Interestingly, the researchers found that only 19 per cent of children in the later cohort had MN on their back compared with 57 per cent of the 1991 group.

The authors said increased use of rash vests might explain the reduced number of MNs on the back.

The researchers found 69 per cent of the later cohort routinely wore them for swimming outdoors compared with 43 per cent of the 1991 group.

"It is particularly relevant that fewer children in cohort 2 than cohort 1 developed MN on the back of the trunk, especially as children raised in Townsville … develop more MN earlier in life than children raised elsewhere," the authors said.

KW TO COMMENT CLICK HERE

Good news in 3D for diabetics

A discovery by Melbourne researchers could mean diabetics may no longer need to use injections to receive insulin.

Researchers have captured the intricate way by which insulin uses the insulin receptor to bind to the surface of cells, a process scientists have been trying to solve for more than two decades. This binding is necessary for the cells to take up sugar from the blood as energy.

Lead researcher Associate Professor Lawrence from the Walter and Eliza Hall Institute said the team was excited to reveal for the first time a three-dimensional view of insulin bound to its receptor.

Associate Professor Lawrence said the research found that the insulin hormone engages its receptor in a very unusual way. Both insulin and its receptor undergo rearrangement as they interact – a piece of insulin folds out and key pieces within the receptor move to engage the insulin hormone.

"Understanding how insulin interacts with the insulin receptor is fundamental to the development of novel insulins for the treatment of diabetes," Associate Professor Lawrence said.

"Until now, we have not been able to see how these molecules interact with cells. We can now exploit this knowledge to design new insulin medications with improved properties, which is very exciting.

"Insulin is a key treatment for diabetics, but there are many ways that its properties could potentially be improved.

"This discovery could conceivably lead to new types of insulin that could be given in ways other than injection, or an insulin that has improved properties or longer activity so it doesn't need to be taken as often.

"It may also have ramifications for diabetes treatment in developing nations by creating insulin that is more stable and less likely to degrade when not kept cold, an angle being pursued by our collaborators."

The three-dimensional molecular structure of the insulin hormone and receptor was analysed using the Australian Synchrotron.

The research was published in the journal *Nature*.

KW TO COMMENT CLICK HERE

EU 'roaming doctor' problem

The European medical registration system is being fiercely criticised after a Dutch neurologist was found to have worked in five German hospitals, even though he was disqualified from practising in his home country.

The incident has resurrected concerns about the European Union's perennial 'roaming doctor' problem – the absence of EU-wide regulation that allows doctors disqualified from practising in one jurisdiction to move to and practise in another.

The doctor is facing a number of criminal charges in The Netherlands for a number of alleged malpractices, including intentionally misdiagnosing and so harming patients, "ignoring the results of validated medical examinations" and falsifying scripts for his own use. He is accused of falsely diagnosing patients – one of whom committed suicide – with such conditions as Alzheimer's, MS and Parkinson's.

Though he is facing these charges, he was not brought before a disciplinary board in The Netherlands or struck off. Instead, in 2003, he was allowed to withdraw registration and retire early from his post at a hospital in Enschede.

But, in 2008, Dutch journalists found him working in a clinic near Cologne in Germany. In 2009, a Dutch investigation of his employment record described him as 'dysfunctional'.

Despite all this, he was discovered working in Germany again, this time at a hospital near Stuttgart, having been recruited by Doctari, a medical employment agency.

The hospital said that he had given it all the necessary documentation. It had also inquired about him to a previous German employer, though "no negative points that could have aroused any distrust" had been found as a result.

The incident has resulted in calls for reform of the registrations systems in Germany and The Netherlands, plus EU-wide action, including a central register of all doctors working in Europe, legislation requiring doctors to inform their home medical registration authorities if and when they leave to practise in other countries, and a system in which the 27 separate jurisdictions share information about the doctors practising in the areas of their responsibility.

DN

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NZMA: New liquor law 'inadequate'

The New Zealand Medical Association (NZMA) has protested at the inadequacy of the new anti-liquor legislation passed by the Parliament just before Christmas.

The legislation restricts promotion of alcohol products in supermarkets and convenience stores and requires parental consent to minors consuming alcohol.

But, according to the NZMA, it falls well short of what is needed to combat "the pernicious effects of excessive alcohol consumption that we see every day in New Zealand".

In a submission on the legislation to the Parliament, the NZMA had called for increased taxation on alcohol, a return to the minimum purchase age for alcohol to 20 years, and regulation against "irresponsible" promotions that encouraged excessive consumption or purchase of alcohol.

NZMA President Dr Paul Ockelford said that the Association was hugely disappointed that Parliament had gone against this and other informed advice. "An opportunity has been missed to make a substantial difference to the toll of human misery that alcohol takes on our society," he said.

"The NZMA remains strongly committed to raising the level of professional awareness of medical practitioners to achieve early detection and treatment for patients who may have problems with alcohol.

"Patients suffering from alcohol dependence need early detection and full diagnosis for treatment to be effective.

"But all the treatment in the world can't make up for the lack of leadership shown on this matter by Parliament."

DN

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British GP torture misconduct charge

A British GP – formerly an army medical officer in Iraq – has been struck off by a General Medical Council panel that found him guilty of misconduct during the torture and death of an Iraqi man at the hands of British soldiers in 2003.

The man – suspected wrongly by the soldiers to be an insurgent – died after being beaten for 36-hours. A post mortem found that he had 93 separate injuries. The incident was found out by the media and became a cause *célèbre* in Britain.

Throughout a court martial of the soldiers and a public inquiry into the incident, Dr Derek Keilloh maintained under oath that, in trying to resuscitate the man, he had observed no injuries, though he had seen some dried blood around the man's nose. But the public inquiry found that (among other things) he and other officers of the soldiers' unit must have known what was going on.

The Medical Practitioners Tribunal Service reached its decision "with regret". Dr Keilloh had not himself harmed the man, it said, and he had done what he could to save the man's life in a "highly charged, chaotic, tense and stressful setting". In addition, he was regarded as an excellent doctor and was respected by colleagues and patients as an "honest, decent man of integrity".

But he had engaged in repeated dishonesty, giving false evidence about the man's treatment. Moreover, knowing about this treatment, he had not done enough to protect other detainees who were also being mistreated.

The GMC supported the panel's decision. "We recognise that this has been a particularly challenging case with difficult and unusual circumstances," Chief Executive Niall Dickson said. "But patients and the public must be confident that the doctor who treats them is competent and trustworthy."

Dr Keilloh's registration has not been suspended immediately. This means that he can continue to practise while he decides whether or not to appeal the panel's decision.

DN

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INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

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Health experts join US gun debate

Leading American health authorities have weighed into the guns debate, producing a report showing that gun violence is a major factor in an extraordinary difference in life expectancy rates between young people in the US and other developed countries.

A panel of experts convened by the National Research Council and the Institute of Medicine reviewed a large number of health studies to determine the causes of death in the US and compare them with those in 16 other developed countries, mainly in Europe but also including Australia.

It found that, in life expectancy, American males ranked last and females second last. Deaths occurring before age 50 – a large percentage of them involving the use of guns – accounted for about two-thirds of the difference in life expectancy of the males.

The experts were impressed not so much that violent acts happened more often in the US as their lethal consequences. "One behaviour that probably explains the excess lethality of violence and unintended injuries in the US is the widespread possession of firearms and the common practice of storing them (often unlocked) in the home," their report said.

But violence was not the only reason for the discrepancy in life expectancy rates. The size of the health disadvantage was also "pretty stunning", according to panel leader Dr Steven Woolf of Virginia Commonwealth University.

The news was not all bad. Death rates from cancers were lower, adults had better control of cholesterol and HBP, and Americans tended to live longer than their counterparts. But the US had the highest infant mortality rate, the second highest rate of heart disease, the third highest rate of lung disease, the highest rate of diabetes among adults and, among young people, the highest rates of STDs and substance abuse.

The reasons for this, it said, included that the US had a highly fragmented health care system, with limited resources devoted to primary care and a high percentage of uninsured people, plus the highest poverty rates in the countries studied.

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Mass medical resignations in Spain

More than 300 directors of Madrid's nearly 150 health centres have resigned in protest over plans by the regional government to privatise part of its public health service.

Late last year, specialist doctors working in the service went on strike for a month over the plans, causing more than 6,000 procedures and 4,000 consults to be suspended.

The Madrid region's part-privatisation plans include outsourcing six of the capital's 20 public hospitals and 27 of its 270 health centres and increased charges for health services.

The major doctors' union, AFEM, is considering a legal challenge to the plans and has organised a national congress next month to consider what should be done to maintain the health system nationally.

Health care in Spain is not a responsibility of the national government but that of the Madrid and 16 other semi-autonomous regions.

The current Madrid regional government is controlled by the conservative People's Party.

The opposition Socialist Workers' Party says that it will reverse the privatisation changes if it wins the next election. But that is not expected to be before 2014.

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US uproar over psychiatric terminology

The latest update of the American Psychiatric Association's (APA) diagnostic manual has – as expected - aroused furious controversy in the speciality in the US, despite the fact that it does not differ radically from its predecessor, which was published in 2000.

Probably the most argument over the changes proposed in *Diagnostic and Statistical Manual of Mental Disorders* (known as DSM5) concerns autism.

DSM5 accepts the already widely-used, umbrella term autism spectrum disorder. But it demotes Asperger's as a distinctive condition and includes it under the umbrella term, along with Disruptive Mood Dysregulation Disorder (DMDD), the new term for temper tantrums, and Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS).

PTSD has been defined as a trauma- and stressor-related disorder, which means that the new criteria will be more sensitive to children and adolescents, who the American Medical Association believes can develop the disorder much earlier than previously thought. Hoarding, previously considered obsessive compulsive behaviour, is now a disorder. So also is premenstrual dysphoric disorder, which was just an appendix item in DSM4.

The APA says that the changes reflect important advances in understanding psychiatric disorders since 2000, but they have not been universally welcomed.

Establishing DMDD, for example, has been criticised as "medicalising" what could be just a symptom of an underlying condition. Advocacy groups worry that the Asperger's and other autism proposals would act to deny targeted educational and other services to people who need them, especially children. Dr Fred Volkmar of Yale quit a DSM committee, saying that DSM5 criteria would rule out 45 per cent or more of people who now had an autism or related diagnosis. Dr Allen Frances, chair of a previous DSM drafting committee, said that DSM5 was "the saddest moment in my 45-year career of practising, studying and teaching psychiatry".

DSM5 is the first major revision of the manual since 1994, the 2000 edition being just a "term revision". Its proposals will be confirmed in May, when the APA publishes the final version.

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INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

The AMA Council of General Practice has developed a resource that brings together in one place all the forms, guidelines, practice tools, information and resources used by general practitioners in their daily work.

The GP Desktop Practice Support Toolkit, which is free to members, has links to around 300 commonly used administrative and diagnostic tools, saving GPs time spent fishing around trying to locate them.

The Toolkit can be downloaded from the AMA website (http://ama.com.au/node/7733) to a GP's desktop computer as a separate file, and is not linked to vendor-specific practice management software.

The Toolkit is divided into five categories, presented as easy to use tabs, including:

- online practice tools that can be accessed and/or completed online;
- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

In addition, there is a State/Territory tab, with information and forms specific to each jurisdiction, such as WorkCover and S8 prescribing.

The information and links in the Toolkit will be regularly updated, and its scope will be expanded as new information and resources become available.

Members are invited to suggest additional information, tools and resources to be added to the Toolkit. Please send suggestions, including any links, to generalpractice@ama.com.au

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Spinal surgical device recalled

Zimmer Spine has issued an urgent worldwide recall of the PEEK Artis Inserter, the spinal surgical device used to implant its PEEK Ardis Interbody Spacer.

It had received reports that the Spacer implant had broken when too much lateral and/or off-axis force on the Inserter had been used in the procedure. "Intra-operative complaint reports received to date indicate an occurrence rate of 0.52 per cent," the company said.

The US Food and Drug Administration said that these breakages could cause surgical delays of up to an hour, dural tears and blood loss and, in the long term, disability, dysfunction or death.

It says that the Spacer cannot be implanted without the Inserter, which means that the implant system will not be available until it approves a redesigned inserter.

Zimmer Spine says that it is notifying distributors and customers of the recall and arranging for the return of the Inserters.

Surgeons and hospitals should stop using the Inserters and return them to the company.

Meanwhile, it is working on the problem with the FDA and other regulatory agencies around the world.

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UK GPs mobilise against GP contract changes

The British Medical Association has asked the more than 35,000 GPs practising in England and Wales for their views on the Cameron Government's intention to impose non-negotiated changes to the GP contract.

As reported in *Australian Medicine* (January 14), doctor-government relations have been upset by the abrupt way in which the Government made its decision.

Changes to the GP contract for doctors in Scotland (where the health system is different) were agreed in a consultative atmosphere. But the Government walked away in October from five months of negotiations with the BMA over the GP contract for England and Wales, opting instead to force the changes through.

Doctors have also been infuriated by the Government's decision to scrap the Cabinet subcommittee, promised by it in Opposition and set up by it soon after winning office specifically to tackle major health problems such as obesity, smoking, alcohol abuse, and health inequality.

Research conducted by the BMA suggests that the average practice could lose the equivalent of $47,000 in funding because of the changes and face substantial extra demands on workload "at a time when many are already struggling with years of contracting practice budgets".

It has sent doctors a questionnaire asking what actions practices will need to make because of the changes, particularly affecting patients' services and staffing levels, whether or not the new regimen will force doctors to change their personal circumstances – even to the extent of leaving the NHS – and how the Government's decision affects their view of the future of general practice.

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Toolangi Vineyards

BY **DR MICHAEL RYAN**

Toolangi State Forest is a wonderful natural attraction that draws campers, hikers and four-wheel drive enthusiasts from around Australia.

For wine soldiers who don't want to see the forest for the trees, there are always magnificent vineyards nearby. Toolangi Estate vineyard is one such place. The owners, Garry and Julie Hounsell, have spared no expense to deliver premium quality wines. Chardonnay and Pinot Noir take pride of place with Shiraz emerging from their shadows.

Garry was CEO of Arthur Anderson accountants and Julie was a secondary teacher who both felt the sting of unrequited vinous love. The former old cattle property was purchased in 1995, 0.5 hectares planted, and wine produced in 2000.

Today, 13 hectares are planted to vines and expertly tended by professional viticulturists. Some fruit is sourced from Hamer and Willow Lake vineyards, each adding tiers of flavour as needed.

Their vineyard management exemplifies the passion and belief that great wine is seeded from great fruit - with 1-2.5 tonnes per acre cropping with heavy pruning ensuring lower yields and hence more complex intense fruit characteristics. Viognier has been planted and has been a success with recent vintages selling out.

With this great fruit, exemplary handling is a necessity to arrive at a high end product.

The Hounsells are shrewd in enlisting the services of great Victorian winemakers.

Rick Kinzbrunner from the icon Giaconda Estate has led the charge, being responsible for the Reserve Chardonnay. The 2012 Reserve Shiraz will also be under his care.

Yering Station, Hoddles Creek Estate, and Oakridge all play a part in their production of Chardonnay. Shadowfax took charge of previous vintages of Shiraz, but transporting issues punctuated that. It is certainly a mark of respect when each year other winemakers have asked if they could produce their wines.

I have had the pleasure of meeting Garry and Julie for the past three years at the Noosa Food and Wine Festival.

They exude a viticultural camaraderie and always enthuse with any of the tasters at their stall.

They see their future held steadfast as premium wine producers with many levels of wine that suit all palates and fiscal cliffs. The formula works and their sense of longevity and commitment will see a great legacy formed.

Wines Tasted

1. 2010 Toolangi Chardonnay Yarra Valley

This is a surprise packet that punches above its low $20 range price tag. White peaches, some lemon citrus and nutty lees and French oak aromas merge into a fascinating nose. The palate has a burst of the mentioned aromas but has a creamy fulfilling mouth feel, with great structure. It will develop intensity and complexity with cellaring for 3-4 years, but is a treat to drink now with thyme-infused roasted poussin.

2. 2008 Toolangi Reserve Chardonnay Yarra Valley

After four years, this is still a lively wine with some light green tinges on a deepening light yellow colour. The classic Yarra fruit nose of white peaches shows some grapefruit notes. Complex second tier notes develop that show nuttiness and toasty oak. Ric Kinzbrunner has crafted this and added the complex charcuterie aromas typical of Giaconda wines. The palate opens with broad rich fruit that hang of structural acidity. Drink now or cellar for eight years and enjoy with a duck citrus terrine.

3. 2010 Toolangi Pinot Noir

This is a bright young thing with alluring cherry and plum aromas. As this wine matures in the glass and its hedonistic youthfulness subsides, nice examples of forest floor and spice start to mature. The palate is mostly anterior and latches on to some fine but well constructed tannins. Drink now or in 2-3years with a chacuterie plate.

4. 2008 Toolangi Estate Pinot Noir Yarra Valley

Brooding deep crimson in colour, the maturity of the bouquet elevates the complex cooked strawberry and spicy notes. Wafts of gaminess show through and help the soft generous palate shine. Integrated tannins give longevity to the taste and leave the palate very satisfied. Super now with smoked quail and root vegetables.

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