AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

GP leaders' Budget warning

No cuts for chronic care, p6

Inside

AMA
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CPD TRACKER

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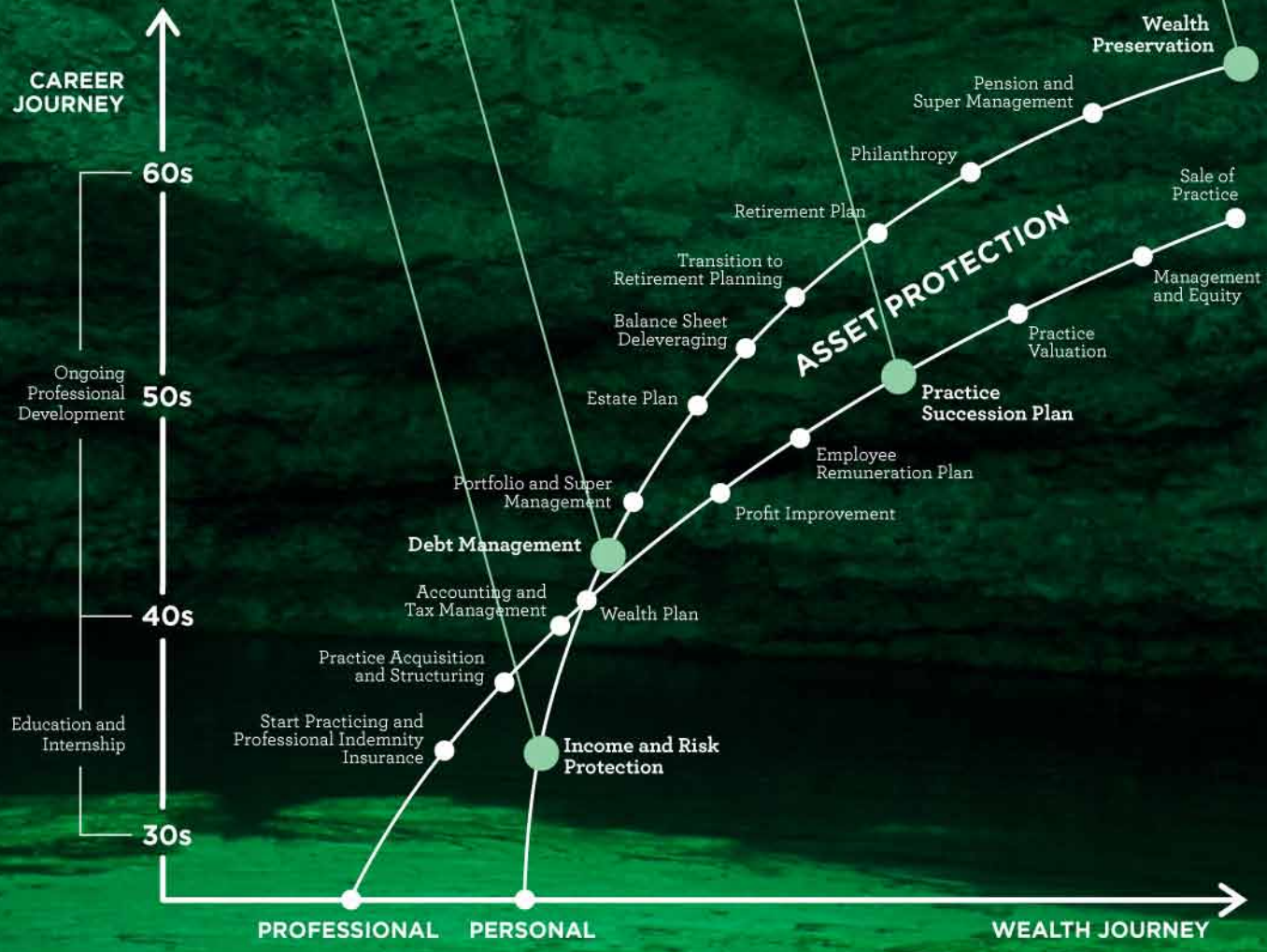

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IN THIS ISSUE

NEWS

REGULAR FEATURES

Cover: The nation's GP leaders, attending the United General Practice Australia meeting in Canberra on 6 March, are (from l to r): Dr Tony Lembke, Chair, Australian Medicare Local Alliance; Associate Professor Richard Matthews, Chair, Australian General Practice Training; Marita Cowie, Chief Executive Officer, Australian College of Rural and Remote Medicine; Amit Vohra, Chief Executive Officer, General Practice Registrars Australia; Megan Cahill, Chief Executive Officer, Australian General Practice Training; Dr Steve Hambleton, AMA President; Dr Liz Marles, President, Royal Australian College of General Practitioners; John O'Dea, Federal AMA; Dr Sheilagh Cronin, President, Rural Doctors Association of Australia; Professor Richard Murray, President, Australian College of Rural and Remote Medicine; Dr Trish Baker, Chair, National General Practice Supervisors' Association; Dr Zena Burgess, Chief Executive Officer, Royal Australian College of General Practitioners; Jenny Johnson (obscured), Chief Executive Officer, Rural Doctors Association of Australia; and Dr Edward Vergara, Chair, General Practice Registrars Australia.

Kicking goals for general practice

BY AMA PRESIDENT DR STEVE HAMBLETON

An important part of Federal AMA advocacy is the work done by our Committees. Too often their contribution to policy development is overlooked.

Their development of Policy Position Statements and responses to Government policy provide the AMA leadership with the messages to take to the media and the intellectual capital to use in negotiations with Ministers and Departments.

A good example of this process came out of the most recent meeting of the AMA Council of General Practice. The AMACGP has produced solid positions on a number of current issues. I will highlight two.

The AMACGP passed a motion calling on the major political parties to commit to an independent review of Medicare Locals ahead of the September election.

The AMACGP wants a bipartisan election promise to ensure that Medicare Locals improve the delivery of primary care services in a cost-effective away, and do not become yet another layer of health bureaucracy.

An independent review would analyse and assess the administration of Medicare Locals to check on the appropriateness and effectiveness of their role in coordinating primary health care delivery.

We need to know how they intend to identify local health needs and fill service gaps, drive improvements in primary health care, and ensure that services are best tailored to meet local community needs.

Pushing program funding through Medicare Locals if there is no 'value add' is a waste of precious resources.

Many Medicare Locals have indicated they will simply act as a conduit for the after hours funding that is being directed towards them. This simply duplicates administration.

It is clear from both the Government and the Opposition that we are now living in an environment where funding for health is limited. Every dollar spent must be well spent, and the opportunity cost of a better spend elsewhere should be taken into account.

The AMA bottom line is that Medicare Locals must enhance the role of GPs in delivering quality patient care.

For this to happen, we need evidence of close consultation with local GPs, which can only be achieved by having majority GP representation on the Medicare Local Boards.

To be fair, we hear anecdotes of good work coming out of some Medicare Locals – that work, if it exists, should be highlighted and replicated.

To maximise their utility and minimise the risks, a bipartisan independent review is needed to give substance, purpose, meaning and direction to Medicare Locals.

The AMACGP also provided the policy impetus for the most recent announcement from United General Practice Australia – the coalition of peak GP groups, of which the AMA is a member – about GP care for people with chronic diseases.

UGPA took on board the essence of an AMACGP motion seeking Government assurances there would be no chronic care cuts in the May Budget.

The Government must recognise the key role that general practice plays in caring for patients with chronic diseases.

The Medicare chronic disease rebates were introduced to support well-structured care for patients with their usual GP, and to facilitate appropriate access to other health care professionals.

Patients currently have good access to quality and structured chronic disease management. Withdrawing funding for the care of patients with complex and chronic disease cannot be justified.

Many of these patients are among the most vulnerable in society, and we cannot support any measure that might reduce their access to quality GP care or lead to higher out-of-pocket costs for patients.

The care of these patients is complex, requires additional time, and involves more non-face-to-face work than the average patient.

The viability of the general practice team – including general practice nurses – needs to be maintained and strengthened to support these patients and manage their care.

Any attempt to achieve short-term Budget savings would lead to increased long-term costs to the health system, including through increased costs to Medicare, the PBS, and the hospital system.

Based on the work of the AMACGP, UGPA has recommended that the Government review of chronic disease care items should focus on:

- better supporting long-term structured care for patients;
- strengthening the role of the usual GP;
- better linking access to allied health services with the clinical needs of the patient; and
- reducing red tape.

Good thinking, AMACGP. I will report on the work of other Committees in future columns.

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Shield chronic care from Budget knife: united GP call

The nation's GP leaders have demanded that the Federal Government quarantine Medicare chronic disease rebates from any cuts in the forthcoming Budget.

United General Practice Australia (UGPA), a coalition of peak medical groups including the AMA, the Royal Australian College of General Practitioners, the Australian Medicare Local Alliance and four other peak medical bodies, has called on Health Minister Tanya Plibersek to rule out Medicare cuts in the May Budget amid concerns about the outcome of a Government review of rebates for patients with chronic and complex conditions.

In a joint statement issued following a UGPA meeting in Canberra on 6 March, AMA President Dr Steve Hambleton and other medical leaders said GPs were at the forefront in caring for patients with chronic diseases, and warned that any reduction in the Medicare rebate would lead to increased costs for the health system in the longer-term.

"While the UGPA recognises the fiscal pressures that the Government faces, withdrawing funding for the care of patients with complex and chronic disease cannot be justified," the GP leaders said. "Any attempt to achieve short-term Budget savings would lead to increased long-term costs to the health system, including through increased costs to Medicare, the PBS, and the hospital system."

The UGPA cautioned that any increase in out-of-pocket expenses for chronic disease care heightened the risk that some patients would reduce or stop their treatment, and would undermine the work done by doctors and nurses in helping manage serious conditions.

"Many of these patients are among the most vulnerable in society, and we cannot support any measure that might reduce their access to quality GP care or lead to higher out-of-pocket costs," the alliance of peak medical groups said. "The viability of the general practice team – including general practice nurses – needs to be maintained and strengthened to support these patients and manage their care."

This backs the stance adopted by the AMA Federal Council last year, when it declared that, "in the interests of patient safety, any prescribing by non-medical practitioners should only be carried out within strict co-management regimes, with the relevant medical professional groups working with the relevant non-medical groups."

"The AMA has had long-standing concerns about the implications for patient safety arising from the extension of prescribing rights, and UGPA last week stressed that it should only occur in a medically led and delegated team environment"

At its meeting the UGPA also addressed concerns about the push in some quarters to extend prescribing rights to non-medical health professionals.

Pharmacists and physiotherapists are among those lobbying to be granted prescribing rights, arguing that it would add to the efficiency and flexibility of the health system.

Health Workforce Australia is currently examining the issue of non-medical prescribing, including safety fears and the need to make the most effective use of health care services.

The AMA has had long-standing concerns about the implications for patient safety arising from the extension of prescribing rights, and UGPA last week stressed that it should only occur in a medically led and delegated team environment.

"This ensures quality and safety, minimises fragmentation of care, and at the same time is cost effective for the health system," it said.

Dr Hambleton urged the Government to delay any decision on extending prescribing rights until after Health Workforce Australia had completed its work.

At its 6 March meeting, UGPA also tackled the issue of GP training.

There is mounting concern about adequacy of current GP training arrangements and the scope to cater for the training needs of a growing number of medical graduates.

UGPA highlighted the need to increase the capacity of general practice to support training, including greater recognition of the role of supervisors, backed by funding.

The coalition of peak medical organisations unanimously called for the intake to the GP training program to be increased.

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Too many doctors? You're kidding

Claims that the nation is suffering an over-supply of GPs have been dismissed by AMA President Dr Steve Hambleton as "science fiction".

Dr Hambleton said Monash University demographer Dr Bob Birrell used a simplistic and discredited approach based on the wrong type of data to try to support his argument that the nation was being "over-serviced" by GPs.

In his report, *Too Many GPs*, Dr Birrell used an increase in Medicare billing rates to claim there had been a 17 per cent jump in the number of full-time equivalent general practitioners between 2006-07 and 2011-12, and a rise in the number of GP services billed per person.

But Dr Hambleton said the claims flew in the face of the struggles many faced trying to get in to see a doctor because of a shortage of GPs, adding that billings figures could not be used to draw conclusions about doctor numbers because it was not only GPs who billed Medicare.

"If you look at Medicare billing, you don't know whether they're coming from GPs or hospital outpatients or a number of other sources," the AMA President told the *Weekend Australian*. "Some of these figures won't be GP work."

Dr Hambleton said the approach taken by Dr Birrell in his research had been discredited in the past, when government had used similar conclusions to justify cutbacks in GP training – leading to the shortages currently being experienced.

He said other analyses of GP numbers by Health Workforce Australia and the Australian Institute of Health and Welfare had used much more robust methodologies, and had come to far different conclusions to those made by Dr Birrell.

"The [*Too Many GPs*] report's conclusions do not sit well with the recent AIHW report, *Medical Workforce 2011*, which found that the supply of GPs fell from 111.9 to 109.7 full-time equivalent per 100,000 population between 2007 and 2011," Dr Hambleton said. "[And], in its most recent report, [Health Workforce Australia] confirmed that Australia is in the middle of a GP workforce shortage.

"Indeed, if Australia is to reduce its reliance on International Medical Graduate GPs, then we must lift our training effort even further."

Dr Hambleton also took issue with Dr Birrell's assertion that GPs were expensive to the public purse.

He said the current Medicare rebate of $35.60 for a standard consultation was "well below the true worth" of a GP service, and the demographer failed to take account of the enormous contribution GPs made to population health.

"Dr Birrell's report fails to recognise the role that GPs play in ensuring our health system delivers high quality health care in a cost effective way," Dr Hambleton said. "Funding for GP services represents a relatively small part of the health budget, yet GPs deal with around 90 per cent of the problems they encounter."

The AMA President also disputed Dr Birrell's policy prescription for increasing the number of GPs working in rural and regional areas.

In his report, Dr Birrell urged the Federal Government to use Medicare provider numbers as a way regulate the spread of GPs, withholding numbers in areas deemed to be in "over-supply" and instead allocating them to areas where there was a doctor shortage.

But Dr Hambleton said this was not a workable solution.

"Addressing GP shortages, particularly in rural areas, requires a comprehensive approach that includes appropriate incentives, professional support, and takes into account the needs of a GP's family member with respect to access to education and other family needs," he said.

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Health help for doctors wherever they are

Doctors will be able to get help for health complaints, including rehabilitation services for mental or physical disabilities and substance abuse, under plans outlined by the Medical Board of Australia.

The MBA has announced that it will fund a national health program for doctors to ensure that practitioners, wherever they are, can get access to the help they need.

The Board resolved at its 6 March meeting to act on concerns about the ad hoc nature of health services for doctors and begin provide funding for a uniform program – to be paid for out of its existing budget – from 2013-14.

"We are committed to establishing a health program for doctors, separate from the Board's regulatory function, that is useful for the profession and accessible fairly to doctors in Australia, wherever they live," Board chair Dr Joanna Flynn said. "The Board is now focussed on planning what model of external health services it will fund, and does not foresee the need to increase registration fees for this purpose."

AMA President Dr Steve Hambleton said the Association would work closely with the MBA in designing a sustainable health service for doctors.

Dr Hambleton said health services for doctors were important both for the profession and the general public, because practitioners needed to be in good health to deliver quality health care.

"Research has consistently shown that doctors with healthy personal lifestyle habits are more likely to impart healthy behaviours to their patients," he said. "The experience of existing doctors' health advisory services, and the available evidence in the literature, supports structured and accessible programs to assist doctors to maintain their health and to have access to appropriate health services."

In coming to its decision, the MBA took into account the variable access doctors had to health services nationwide.

It said that although most states and territories provided health services for practitioners, "there is currently significant variation in the type and level of service offered, ranging from telephone advisory services through to assessment and case management".

"There is also significant variation in funding of these services. Many operate on the goodwill of volunteers, while others have more substantial funding."

The Board said a founding principle of its planned health program was to provide equitable access for all practitioners.

The AMA has previously proposed that the MBA provide funds to existing doctor health advisory services, to take advantage of their established networks and strong local knowledge.

In announcing its decision, the MBA was at pains to emphasise that its proposed doctor health program would be held separate from its regulatory role, and it has clearly defined its responsibilities under the National Law regarding the management of impaired practitioners.

"Clear delineation between the regulatory role of the Board in managing impaired practitioners, and the role of an external health program in supporting doctors and promoting doctors' health, is critical to managing risk to the public and avoiding confusion for practitioners," Dr Flynn said, a view backed by Dr Hambleton.

"It is important that the MBA funds the services, but equally important that the funding arrangements remain independent from the MBA and the Australian Health Practitioner Regulation Agency," the AMA President said. "This is essential to ensure privacy, and to allow doctors to trust these services and use them at an early stage in their illness."

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Australian Medical Association Limited ACN 008 426 793 ABN 37 008 426 793

Notice of Annual General Meeting

Notice is hereby given that the Fifty-Second Annual General Meeting of members of the Australian Medical Association Limited will be held at 4pm on Friday 24 May 2013 at The Westin hotel, 1 Martin Place, Sydney, New South Wales.

Business

1. To receive the Minutes of the Fifty-First Annual General Meeting held in Melbourne, Victoria, on Friday 25th May 2012.
2. To receive and consider the Annual Report of the Australian Medical Association Limited for the year ended 31 December 2012.
3. To receive the audited Financial Reports for the Australian Medical Association Limited and its controlled entities for the year ended 31 December 2012.
4. To appoint auditors for the Australian Medical Association Limited and its' controlled entities.
5. To transact any other business which may properly be transacted by an Annual General Meeting.

A member eligible to vote at the Annual General Meeting may appoint a proxy in accord with Clause 22 of the AMA Articles of Association.

Mr Warwick Hough
Company Secretary
11 February 2013

NDIS could yet sell disabled short

Australia could end up with a disappointingly narrow and limited National Disability Insurance Scheme under the terms of draft legislation currently before Parliament, the AMA has warned.

In its submission to a Senate inquiry into the NDIS Bill, the Association said the Federal Government had left open the possibility of a scheme that only covered those who could not obtain compensation through the legal system.

"As it currently stands, the Bill makes it possible for the Government to implement either of two very different schemes," the submission said. "[Either] a safety net only for people who do not have alternative avenues for lifetime care and support [or] a comprehensive, person-centric, no fault scheme that upholds the dignity of people with a disability and provides certainty."

"It would be very disappointing for the medical profession and the disability community if incremental implementation meant that the former is how the NDIS will operate."

The AMA raised concerns that, under the proposed legislation, the Chief Executive Officer of the National Disability Insurance Scheme Launch Agency could direct a person with a disability to launch a compensation claim, and deny them access to the Scheme if they refuse.

The Association said this would effectively undermine the idea of the NDIS as a no fault scheme.

"Together, [these] clauses work against generating a cultural shift that Australians with disabilities and their families do not need to pursue compensation for the costs of support," the AMA submission said. "Under a truly no fault scheme, disabled Australians should not have to take action – or be required by the CEO of the Agency to take action – against medical practitioners for the costs of lifetime care and support."

The Association said the Bill should be amended to ensure the NDIS was "truly an insurance-based approach".

The AMA's call came as the Government said preparations for the launch of the scheme were advancing, with locations for NDIS Launch Transitional Agency regional offices secured in each of the initial trial sites in Charleston, NSW, Geelong, Victoria, Elizabeth and St Mary's in South Australia, and Devonport, Launceston and Hobart in Tasmania.

Minister for Disability Reform, Jenny Macklin, said some staff were already on the ground and recruitment was proceeding.

Ms Macklin said about 220 Agency staff and contractors were expected to be in place at the regional offices by the middle of the year.

While the Government is pushing ahead with its program, the Senate Community Affairs Legislation Committee has heard concerns that in developing the NDIS the Federal Government has failed to tackle pressing workforce issues.

Both the Health Services Union and United Voice warned that the Government had yet to address problems of low pay and high turnover that were endemic in the disability care industry.

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Australian Medical Association Limited ABN 37 008 426 793

ELECTION OF EXECUTIVE OFFICERS
Call for nominations

The four Executive Officers of the Australian Medical Association Limited for 2013/2014 will be elected at the 2013 National Conference of the AMA to be held on
24-26 May 2013 in Sydney.

The positions to be filled are **President, Vice President, Chairman of Council** and **Treasurer**.

Each will hold office until the conclusion of the National Conference in May 2014.

Any Ordinary Member of the Association may nominate for one or more of these offices.

The electors are the delegates to the National Conference.

Members who wish to nominate are now invited to do so.

Nominations must:

1. Be in writing and addressed to the Secretary General (marked "Private and Confidential");
2. State the position or positions for which the candidate is nominating;
3. Indicate the nominee's willingness to accept the nomination or nominations;
4. Include the names of two Ordinary Members who are nominating the candidate; and
5. Be delivered to:

Secretary General
Australian Medical Association
Level 4, 42 Macquarie Street
BARTON ACT 2600
By 1.00pm (AEST) on Friday 3 May 2013

For a copy of a nomination form or any general enquiries please contact Jennifer Thomas, Office of the Secretary General and Executive (tel: 02 6270 5460 or email: jthomas@ama.com.au).

Mr Warwick Hough
Returning Officer
14 January 2013

Future Fund stubs out tobacco investment

AMA President Dr Steve Hambleton has hailed the decision of the Future Fund to stop investing in tobacco products as an important advance in the campaign to stop people smoking.

"Tobacco kills people," Dr Hambleton said. "Governments and government agencies should not invest in, or have business dealings with, the tobacco industry."

The AMA President was speaking after the Future Fund Board of Guardians announced that it would exclude "primary tobacco producers" from its $82 billion investment portfolio.

The decision follows an outspoken campaign by the AMA and public health groups urging the Fund to divest itself of tobacco company investments.

Board Chairman, David Gonski, said the move followed careful consideration of the issues.

"The Board noted tobacco's very particular characteristics, including its damaging health effects, addictive properties and that there is no safe level of consumption," Mr Gonski said. "In doing so, the Board also considered its investment policies and approach to environmental, social and governance issues.

"As a result, the Board determined that, in this instance, it is appropriate to exclude primary tobacco product manufacturers."

The decision means the Fund will sell about $222 million of shares held in 14 companies including British American Tobacco, Imperial Tobacco Group, Philip Morris International, Swedish Match, Gudang Garam Tbk, Lorillard and Japan Tobacco.

Dr Hambleton said the Future Fund's decision showed sound corporate responsibility, and sent the community and tobacco industry a strong message about public health.

"Every act that withdraws support for Big Tobacco will save lives and improve the health of the community," he said.

The latest move follows the introduction of Australia's world-first plain packaging legislation for tobacco products, which came into force late last year.

Dr Hambleton said the passage of the plain packaging laws, which the tobacco companies sought unsuccessfully to have overturned by the High Court, were a significant national – and international – milestone in tobacco control.

Last month the New Zealand Government unveiled plans to to introduce similar laws, and the AMA President said other countries were also looking to follow Australia's lead.

"But governments must remain vigilant as the tobacco industry tries new and tricky ways to market its killer products, especially to young people," Dr Hambleton said. "We have come a long way in tobacco control, but there is still more to do as long as the tobacco industry continues to use legal challenges and misleading advertising to lure people into a deadly tobacco addiction, and keep people smoking."

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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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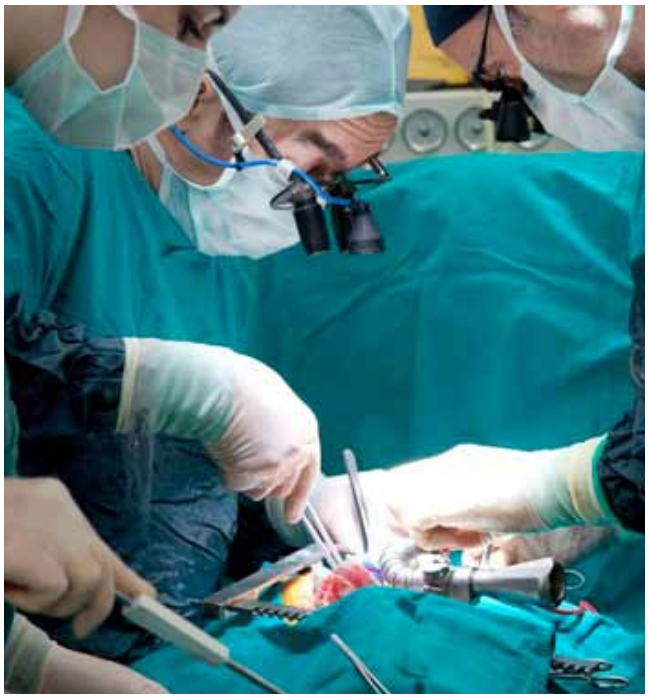
Push to build faith in organ donation



Hundreds are languishing on transplant waiting lists despite a pick up in organ donation rates.

Official figures show that although 354 people donated organs last year, giving 1052 people a fresh chance in life, about 1600 people are waiting for transplants, highlighting the urgent need to lift donation rates.

AMA Vice President Professor Geoffrey Dobb said that while organ donation was becoming increasingly accepted – the number of donors and recipients reached a record high last year – there was still a long way to go to achieve broad support in the community.

According to the DonateLife website, less than 60 per cent of families where organ donation is possible give their consent for it to proceed, and 44 per cent of people are unaware of the donation wishes of their loved ones.

Professor Dobb said a campaign by the Australian Organ and Tissue Donation Authority to increase awareness of, and openness to, organ donation among religiously and culturally diverse groups was commendable.

"For some people, their perception, values and attitudes towards death, as well as organ and tissue donation and transplantation, are influenced by a particular religious, spiritual or cultural belief or value," the AMA Vice President said. "A culturally-sensitive approach that respects the rights, beliefs, perceptions and cultural heritage of individuals is essential when discussing organ and tissue donation or transplantation."

Professor Dobb said that almost all religions allowed for individual choice on organ donation, or supported it, if it would help improve the life of another.

He said family doctors had a role to play in providing information about organ donation, and encouraging informed discussion within communities and families.

Professor Dobb said increased awareness of organ donation had to be accompanied by heightened public confidence in the nation's donation and transplant system.

It was little known that only a tiny fraction of the people who die in hospital – less than 2 per cent – pass away in circumstances where organ donation is even possible, and families are always asked for consent before donation can proceed.

Professor Dobb said this underlined the importance of people informing their families of their wishes.

The AMA recently updated its Position Statement on Organ and Tissue Donation and Transplantation, which can be viewed at: https://ama.com.au/position-statement/organ-and-tissue-donation-and-transplantation-2012

The AMA also has two brochures on organ donation – *You don't have to be a doctor to save a life! and Doctors and Organ Donation,* which can be found at: https://ama.com.au/node/4018

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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 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

Medical fees rise despite increase in doctors, *Sydney Morning Herald*, 23 February 2013

AMA President Dr Steve Hambleton rejected suggestions from health economist Dr Stephen Duckett that interns and junior doctors should charge lower fees than specialists, work in rural and regional areas, and be directed to train in specialties where there are shortages. Dr Hambleton said interns provided a valuable service and should not face extra conditions on their training.

Big risk in letting sleeping drugs lie, *Adelaide Advertiser,* 27 February 2013

AMA President Dr Steve Hambleton explains how the Therapeutic Drug Administration monitors the use of drugs such as Stilnox, which was linked to inappropriate behaviour by members of the Australian Olympic swimming squad at the London Olympics. Dr Hambleton said the TGA collects reports on adverse drug reactions and tries to strike a balance between ensuring patient safety while ensuring those who need it have access to required medication.

Phone use warning: don't risk the health of kids, *Adelaide Advertiser*, 4 March 2013

AMA President Dr Steve Hambleton backed advice from the radiation watchdog that the use of mobile and cordless phones by children, and proximity to baby monitors, be limited. Dr Hambleton said that although the health risks were small, it was desirable that the exposure of children to mobile phones be controlled.

Prescription drug alarm: Suzie-Q a killer, *Sunday Herald Sun*, 3 March 2013

AMA President Dr Steve Hambleton said a rise in the misuse of the tranquiliser Seroquel was "a very disturbing trend". Dr Hambleton said the AMA would consider whether Seroquel was being over-prescribed and smaller doses were warranted, following evidence of a huge increase in the number of cases involving the misuse of the medication. "This is a major tranquilliser, and is almost as bad as taking street drugs if not tailored to you," Dr Hambleton said.

Dentists beg for uni limits, *Weekend Australian*, 2 March 2013

AMA President Dr Steve Hambleton questioned the methodology used by Monash University demographer Dr Bob Birrell to back his claim that there was an oversupply of GPs. Dr Hambleton said the Medicare billing data used by Dr Birrell did not provide information on doctor numbers.

Radio

Dr Steve Hambleton, 4BC, 27 February 2013

AMA President Dr Steve Hambleton said the Medicare rebate had not kept pace with the cost of providing care, leaving a funding gap that patients had to fill. Dr Hambleton said a shift toward user pays is underway, and the AMA is closely monitoring shifts in private health insurance coverage following changes to the federal rebate.

Dr Steve Hambleton, 2GB, 26 February 2013

AMA President Dr Steve Hambleton said a Victorian council was "probably right" to put restrictions on the food that children can bring to school because of the prevalence of allergies and intolerances such as those to nuts and eggs.

Dr Steve Hambleton, 2GB, 24 February 2013

AMA President Dr Steve Hambleton has urged people to speak to their families about organ donation, warning that Australia had a "desperate need" for more organ donors. Dr Hambleton said there was a particular focus on faith and culture during Donate Life Week this year in order to assure religious and ethnic groups that organ donation spanned religious and cultural outlooks.

Dr Steve Hambleton, 2SM, 1 March 2013

AMA President Dr Steve Hambleton said a report claiming there was an oversupply of GPs was inaccurate. Dr Hambleton said the report was mistaken in basing its findings on Medicare billing system numbers, which could not be used as a guide to the actual number of practitioners. He said the issue was much more complex than that, which was why the agency Health Workforce Australia had been established.

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AMA in action

(l to r) Dr Lara Wieland, Dr Robert Parker, Dr Steve Hambleton, Lisa Briggs, Dr Richard Kidd, Justin Mohamed, Dr Brad Murphy

Dr Hambleton and CSL Vice President of Scientific Affairs, Dr Jane Leong

AMA Council of GP meeting, Canberra

AMA Council of GP meeting, Canberra

AMA Public Affairs general manager John Flannery with eminent politcal journalist Michelle Grattan

Dr Hambleton with Dr Jane Leong outside CSL's Melbourne headquarters

It has been a busy time for the AMA and its officials advancing the interests of doctors and patients in a wide array of forums spanning the country. The AMA Council of General Practice met late last month in Canberra to discuss the many issues affecting GPs at the moment, including the push by pharmacists to expand their role, the Government's review of chronic disease management, steps to formalise the medical home approach to medical care, and the need for a review of the performance of Medicare Locals. AMA President Dr Steve Hambleton chaired a meeting of the AMA Taskforce on Indigenous Health Committee, which heard presentations from leading Indigenous figures Tom Calma and Pat Dudgeon, discussed processes and problems with the National Aboriginal and Torres Strait Islander Health Plan, and considered opportunities to draw increased attention to issues affecting the health of Aboriginal people and Torres Strait Islanders in the lead-up to the federal election in September. Attending the meeting were Justin Mohamed, Chair of the National Aboriginal Community Controlled Health Organisation (NACCHO), NACCHO chief executive officer Lisa Briggs, AMA Queensland member Dr Richard Kidd, AMA Northern Territory member Dr Robert Parker, prominent GP Dr Lara Wieland and Dr Brad Murphy from the Royal Australian College of General Practitioners. Dr Hambleton also visited one of the world's leading biotech companies, CSL Limited, where he met with CSL's Vice President of Scientific Affairs, Dr Jane Leong, and toured the company's global headquarters in Melbourne. AMA Public Affairs general manager John Flannery was invited by eminent political journalist and University of Canberra professorial fellow Michelle Grattan to address a policy forum at the university for public health students.

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Signs of progress on Indigenous health

The birth weight of Indigenous babies is increasing and the incidence of maternal drinking and smoking is declining in a sign that progress is being made in improving the health of Aboriginal and Torres Strait Islander people.

An initial assessment of the Healthy for Life program – established in 2007 to improve Aboriginal and Torres Strait Islander child and maternal health and the management and care of chronic disease - has documented notable gains in key measures of health.

The review, conducted by the Australian Institute of Health and Welfare (AIHW), found that between 2007 and 2011 the proportion of Aboriginal and Torres Strait Islander babies with normal birth weight rose from 80 per cent to 84.2 per cent, while the percentage of those with a low birth weight fell from 15.2 per cent to 13.5 per cent.

Reflecting these trends, the average birth weight increased from 3015 grams to 3131 grams, the AIHW reported.

In addition, the study showed that efforts to reduce maternal drinking and smoking, and to encourage pregnant women to seek medical care, were meeting with some success.

It found that 18 per cent of women in the third trimester of their pregnancy in 2011 consumed alcohol, down from 21.4 per cent four years earlier.

More expectant mothers were also heeding health advice as their pregnancies advanced.

The proportion who smoked, drank alcohol and took illicit drugs fell between the first trimester (55.1 per cent, 25 per cent and 23.8 per cent, respectively) and the third (52.4 per cent, 17.9 per cent and 17.2 per cent).

But AIHW researchers said that although there had been "a very small drop" in recent years in the proportion of pregnant Aboriginal and Torres Strait Islander women who smoked – from 53.4 per cent in 2008 to 52.4 per cent in 2011 – "there is scope for considerable further improvement".

AIHW spokeswoman Dr Fadwa Al-Yaman said there had also been an improvement in the extent to which pregnant Indigenous women were seeking medical care, with two-thirds of them attending their first antenatal visit in the first 20 weeks of their pregnancy.

> "Improving the health of Aboriginal people and Torres Strait Islanders is a real problem that needs practical solutions that transcend party-political differences"

The report showed that in another critical area of care, the early detection and management of chronic health conditions such as type 2 diabetes and coronary heart disease, gains were also being made.

It found that the proportion of Aboriginal and Torres Strait Islanders with type 2 diabetes who had a GP management plan jumped from less than 25 per cent in 2008 to almost 32 per cent in 2011, and among those with coronary heart disease, the proportion with a GP Management plan rose from less than 23 per cent to more than 33 per cent over the same period.

AMA President Dr Steve Hambleton, who earlier this month chaired a meeting of the AMA Taskforce on Indigenous Health Committee, said that although some progress was being made, much more needed to be done.

Dr Hambleton said the track record in the past decade had been "varied", but momentum had been built in recent years and should not be squandered.

In 2008, the Council of Australian Governments (COAG) made a commitment to close the gap in life expectancy between Aboriginal and Torres Strait Islander people and the rest of the population, and last month Prime Minister Julia Gillard delivered a report to Parliament on progress that had been made.

But Dr Hambleton warned that recent gains could be lost if COAG did not make a long term funding commitment to a National Aboriginal and Torres Strait Islander Health Plan to replace the existing National Partnership Agreement, which is due to expire this year.

"The plan needs to be a real road map to measure outcomes with timelines and interim targets," the AMA President said. "Improving the health of Aboriginal people and Torres Strait Islanders is a real problem that needs practical solutions that transcend party-political differences. All political parties should make a commitment to health equality."

Justin Mohamed, chair of the National Aboriginal Community Controlled Health Organisation – which represents majority of the services who provided information for the AIHW report – said recent improvements were welcome, and showed that health trends among Aboriginal and Torres Strait Islander people were improving in many areas.

"For the first time, this report provides information on both quantitative and qualitative indicators over the lifetime of the Healthy for Life program, collated at the national level," Mr Mohamed said. "Overall, there have been several improvements in health and healthy behaviours."

"We also agree with a key finding that more people with chronic disease are being well managed through our primary health care services," he said.

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Genes being put to test like never before

The number of genetic tests being carried out in Australia has skyrocketed in the last five years, prompting pathologists to call for a national policy to manage a revolution in the nation's laboratories.

A nationwide study of trends in genetic testing, undertaken by the Royal College of Pathologists Australia (RCPA) at the behest of the Department of Health and Ageing, found that both the volume and number of different types of tests being conducted has jumped dramatically.

"Our research shows that the number of types of tests has increased by 5 per cent per year, that is, 25 per cent over the past five years, which means that labs are constantly growing their test repertoire," said Professor Graeme Suthers of the RCPA.

"In terms of volume, the number of assays has increased by 25 per cent a year - that is 280 per cent over the past five years.

"This is an extraordinary increase in the number of tests being carried out, in both diversity of testing and volume of testing."

The survey documented medical genetic testing performed during 2011 by accredited cytogenetics, biochemical genetics and molecular genetics laboratories. The information was sought on volumes and types of testing available, the purposes of testing and sources of funding.

The 2011 survey followed the first nationwide survey carried out in 2006.

"What we've found is that genetic testing is expanding dramatically across the country," Professor Suthers said.

"The RCPA is working with the Department of Health and Ageing to develop a national framework for genetic testing to manage the major structural changes that are needed throughout the profession."

The survey showed that close to 580,000 medical genetic tests were performed across all disciplines in 2011. Despite the increases since 2006, the proportion of tests funded by the Medicare Benefits Schedule had changed little, and only a small percentage of samples were sent to laboratories overseas for testing.

It also found that the numbers of genetic tests being done varied significantly depending on where patients lived.

"From a functional point of view, there are major issues to be addressed," Professor Suthers said. "When making comparisons between states – looking at factors such as the number of tests done, the types of tests available, and also who paid for the tests - we found that numbers vary dramatically depending on where the patient is located. Put simply, this is unfair and untenable."

Professor Suthers called for a national policy and program to address the massive jump in genetic testing.

He said that currently there is no national coordination for genetic testing and, therefore, no mechanism for doctors to find out about testing.

In addition, most types of DNA tests are provided by only one or two laboratories, and there are no accredited medical genetic laboratories in the Northern Territory.

"We need a system in place where people are trained to meet this transition," he said. "There is a revolution happening inside the laboratory and we need to adapt to this change."

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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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Emergency care falls short

Large numbers of patients are facing lengthy delays in emergency treatment and elective surgery as public hospitals fall behind national performance targets.

Figures compiled by the Australian Institute of Health and Welfare (AIHW) show that just 65.5 per cent of emergency department patients completed their visit within the four-hour target last year, leaving most hospitals with a large amount of ground to make up if they are to achieve the national goal under which at least 90 per cent of patients are to be admitted, transferred or discharged within four hours by the end of 2015.

The AIHW report showed that hospitals in Western Australian were alone in meeting their 2012 performance target, with 78.5 per cent of emergency department patients dealt with within four hours – 2.5 per cent more than expected.

All other states and territories fell short of their performance benchmark, none more so than New South Wales, where just 61.1 per cent of patients were seen within the four-hour limit, massively undershooting the target mark by 7.9 per cent.

The Institute's study confirms the findings of the A*MA Public Hospital Report Card 2013*, released on 13 February, which showed that hospital performance has barely improved despite a large injection of Federal funding.

AMA President Dr Steve Hambleton said the results of the Report Card highlighted the need for Federal, State and Territory governments to work together to increase funding and support for public hospitals, rather than blaming each other for the widespread failure of institutions to meet agreed performance benchmarks.

Since late last year health funding has increasingly become the focus of intense political wrangling between the Commonwealth and the states, particularly Victoria, Queensland and New South Wales (see *Funding threat dangles* ... on p27).

The AIHW report also found that thousands are continuing to languish for extended periods of time waiting for elective surgery, despite some signs of progress.

It showed that the national median waiting time for elective surgery was 37 days, with patients in the ACT having to wait the longest (55 days) while those in Queensland faced the shortest delay (27 days).

Disturbingly, the report found that more than 7400 patients died while waiting for elective surgery.

But, in a promising sign, five states and territories achieved the goal of providing treatment or referrals to the top 10 per cent of most overdue patients.

The AIHW said those patients waiting for coronary artery bypass surgery faced the shortest wait, while those in line for a full knee replacement suffered the longest delays – up to an average of around half a year in Tasmania, the ACT and the Northern Territory.

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Unlocking the secrets of patient demand

In a telling scene from the *Yes Minister* show, departmental head Sir Humphrey Appleby advises his political master that the nation's best performing hospital was able to achieve its goals because it was not hampered by having patients.

It is often seen as inevitable that busy public hospitals will have emergency wards clogged with patients and an enormous backlog of surgery – not least because the number flocking to their doors for treatment ebbs and flows as the prevalence of disease and illness in the community waxes and wanes.

But, according to a leading Commonwealth Science and Industry Research Organisation researcher, Dr Sarah Dods, the peaks and troughs of patient demand are not entirely random.

In fact, Dr Dods and her team believe they can, with a reasonable degree of accuracy, predict rises and falls in the number of cases coming through hospital doors – a major breakthrough in helping hospitals manage their workload and lift their performance.

"People working in hospitals often have a gut feel for when things are likely to get busy, but they can't quite tell you why," Dr Dods said. "But with our research, we have been able to provide an evidence-based explanation."

Working with 27 major Queensland hospitals, the CSIRO team led by Dr Dods, has been able to examine the peaks and troughs of patient demand, pinpointing choke points and blockages that have delayed treatment and caused hospitals to miss performance targets.

At Gold Coast Hospital, for instance, they were able to identify a spike in demand for emergency department services during Schoolies Week.

In response, the hospital set up an external clinic during that period that helped treat many Schoolies-related incidents, reducing the pressure on the emergency department.

At each hospital they worked with, the CSIRO team was able to identify patterns in the flow of patients, depending on the time of day, the day of the week, the time of the year, and associated with special events.

"What we can say is that arrivals at hospital emergency departments are not random. We can account for about 90 per cent of the variation [in the flow of patients]," Dr Dods said.

Many public emergency departments are dogged by slow throughput times, perceived long waiting times, limited surge capacity, efficiency bottlenecks, and challenges integrating new technology.

An Australian Institute of Health and Welfare report found that last year just 65.5 per cent of emergency department patients nationwide were seen and admitted or discharged within four hours – well below the 90 per cent National Emergency Access Target (NEAT) set for 2015.

But Dr Dods said emergency departments were often carrying the can for broader systemic problems within hospitals that helped slow down and block the processing of patients through emergency care.

"Meeting performance targets such as the NEAT is not solely the responsibility of emergency or surgery departments," she said. "Instead, whole-of-hospital engagement is essential in ensuring obstacles to effective patient flow are removed."

Her analysis is backed by AMA President Dr Steve Hambleton, who earlier this month told radio 3AW that emergency departments were frequently hampered by an inability to get sick patients transferred to other departments within a hospital.

Dr Hambleton said this created a logjam that often caused long delays in treatment, and underlined the need to ensure that all departments in a hospital had sufficient beds.

Dr Dods said that, in addition to more beds and medical staff, hospitals would benefit greatly from system evaluation and redesign.

For instance, her team found that treatment times for emergency department patients blew out in the early hours of the morning, and during periods of low emergency department occupancy, often while patients were waiting for beds in other specialties to become available.

Dr Dods said many problems with hospital capacity stemmed from the practice of admitting most patients in the morning but leaving the main discharge period to the afternoon.

She said a simple swap in processes – discharging most in the morning and admitting most in the afternoon, could help smooth peaks in demand for beds.

Dr Dods said that, after doing their initial work in Queensland – including the development of the Patient Admission Prediction Tool – the CSIRO was now extending its work to hospitals in other states, including Victoria and South Australia.

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Medicare crackdown on public hospital billing

The Federal Government has launched an investigation into allegations Medicare has been effectively double-billed for pathology and diagnostic imaging services conducted at public hospital emergency departments.

The Department of Human Services is examining billing practices at Hunter New England Area Health, and has flagged its intention to broaden its investigations nationally amid concerns inappropriate billing is more widespread.

"We've identified that in some cases Medicare claims made through some public hospitals may have been made for services that were already paid for under the National Healthcare Agreement," a Department spokeswoman told *6 Minutes*. "When these services are billed to Medicare, it amounts to double dipping; in essence, taxpayer funds are being used twice for the same service."

The Medicare crackdown has come against the backdrop of Commonwealth accusations that governments in several states have cut back on their health spending and failed to live up to their responsibilities under the National Health Reform Agreement.

Medical defence organisation Avant has warned that doctors may be drawn into the crackdown, which could include a Medicare audit of claims made by practitioners.

Avant warned members they could be left vulnerable if hospitals made inappropriate claims under their provider number.

"If you bill under your provider number, you are legally responsible, even if the billing has been done by hospital administration," the medical defence organisation said.

It advised members to "keep adequate and contemporaneous medical records that support your use of the item number, and that would allow another practitioner to take over care of the patient – your ability to defend your decision-making relies on doing so, and the consequences of not doing so can be severe."

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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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Child vaccines approved as killer flu season looms

As Australia braces for a severe flu season, the Federal Government has reaffirmed its ban on the use of Fluvax for children younger than five years as part of updated advice on influenza vaccines approved for use in children.

The flu hit hard in North America over the northern winter, with the US Centers for Disease Control and Prevention (CDC) recording more cases, and of greater severity, than usual.

The CDC found that hospitalisation numbers for children with flu were high compared to last season, though well below the rates seen in the 2009 pandemic. More than 20 children were reported to have died from flu in the US through to the beginning of January, about 80 per cent of whom had not been vaccinated.

Australia's Therapeutic Goods Administration (TGA) has registered four different flu vaccines for use in children from the age of six months. They are:

- Agrippal (Novartis Vaccines and Diagnostics);
- Fluarix (GlaxoSmithKline);
- Influvac (Abbott); and
- Vaxigrip (Sanofi-Pasteur).

The TGA has also approved the use of Fluvax (bioCSL), but only for children aged fiver years or older. It further advises that special care should be taken when administering Fluvax to children aged between five and nine years.

"Fluvax is not approved by the TGA for use in children under the age of 5 years because of an increased risk of fever and febrile convulsions," the Agency said.

"Febrile events have been observed in children aged 5 to under 9 years after immunisation with Fluvax.

"Therefore, in this age group, a decision to vaccinate with the 2013 Fluvax vaccine should be based on careful consideration of potential benefits and risks to the individual child."

The warnings come after a public health scare in 2010 when 101 Australian children were reported to have suffered from convulsions after receiving the Fluvax shot. Fluvax was subsequently banned for use in children aged under the age of 5.

The TGA said the vaccines approved for use in children for 2013 had been updated to combat new strains of the flu that have emerged.

The vaccines for 2013 will guard against the H1N1 Swine Flu, as well as the seasonal influenzas H3N2 and B, which have swept across the United States this northern winter.

"The influenza strains in the 2013 vaccines are the same as the strains in the influenza vaccines used in the recent Northern Hemisphere winter," the TGA said.

"The TGA is reviewing surveillance data from the Northern Hemisphere to ensure there have been no unexpected adverse events related to the strains in the 2013 vaccines, and, in conjunction with the states and territories, will be closely monitoring adverse event reports once the influenza vaccination program commences."

Adult vaccinations have also been updated to take in the new strains of flu, with the TGA emphasising the need to get a new vaccination every year.

The TGA has approved Agrippal, Fluarix, Influvac, Vaxigrip for all people aged six months and over. Fluvax is approved for people aged five years and over. And Intanza (Sanofi-Pasteur) is approved for adults aged 18 to 59 years.

But an alert has been issued about the use of the flu vaccine Fluarix following reports that a pre-prepared syringe was contaminated by a "glass-like" substance that blocked the syringe action.

The TGA has directed that doctors should visually inspect all Fluarix pre-filled syringes before administering, but has stopped short of issuing a recall of the product.

The medicines watchdog said the defect, which did not cause any harm to the patient, appeared to be an extremely rare event – there has been just one complaint per 10 million doses worldwide.

In a statement, manufacturer GlaxoSmithKline said initial investigations and extensive manufacturing experience suggested that "this is an extremely rare event".

"There have been no other product quality complaints related to this batch of syringe in Australia or other markets where this year's Fluarix has been distributed," the company said, adding that "it has been agreed with the Therapeutic Goods Administration that Fluarix vaccine should continue to be used in accordance with the prescribing information and administered by a health care practitioner."

For more information go to www.tga.gov.au.

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Australians in blissful denial on diabetes, obesity

Australians are largely apathetic about the threat of diabetes and the effect sedentary lifestyles and poor diet can have on future health.

Less than 7 per cent of people surveyed for the *Facing the Health of Australians* report saw diabetes as a future health concern for them or their children, and even fewer – 5.6 per cent – were worried about the effects of obesity, despite the fact that 42 per cent admitted to leading a sedentary lifestyle.

The study, conducted by the peak body for pharmaceutical manufacturers and distributors, The Australian Medicines Industry, was based on the "views and opinions" of 5000 adults, and was conducted in October last year.

Among its other findings, it showed that the most common health concern was cancer, with more than 27 per cent reporting they feared such a diagnosis, followed by experiencing a heart attack (15.5 per cent), and the biggest concern held for the health of our spouse was stress (27.3 per cent).

But Australian Medicines spokesman, Dr Brendan Shaw, said the most worrying finding from the survey was the blasé attitude many held regarding the threat of diabetes.

Dr Shaw said it was alarming that more than 90 per cent of those interviewed did not consider diabetes to be a major health problem despite the likelihood that the incidence if type 2 diabetes would treble by 2031.

Even more worrying, he said, was ignorance about the link between type 2 diabetes and obesity.

"There is a clear disconnect between our views on health, particularly in relation to weight, and the implications of that in regard to serious and potentially life-threatening disease," Dr Shaw said. "The long term consequences of obesity are still little understood."

The survey found that just 7.4 per cent of parents were worried about their own children being overweight or obese, even though a quarter rated it as the biggest health concern confronting their children's generation.

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New rules for critical diagnostic tests

Companies, labs and practices that conduct in vitro diagnostic tests have been warned that new regulations are set to come into effect in mid-2014.

The Therapeutic Goods Administration is trying to contact organisations involved in the manufacture, supply or use of in vitro diagnostic (IVD) devices – commonly used to test blood for glucose, liver enzymes, levels of electrolytes such as calcium, sodium, and potassium, and for drugs – to inform them of the forthcoming changes to the regulatory regime.

A new regulatory framework came into effect in mid-2010 but, under transitional provisions, many IVDs were given a four-year exemption from the new rules.

The TGA is attempting to contact all IVD users, suppliers and manufacturers to ensure that, when the new regulations come into force in July next year, "all essential products are available for diagnostic services".

The medicines watchdog said it wanted to talk with all "relevant organisations, seeking advice on any matters that need to be addressed to ensure a smooth transition to the new framework".

In particular, the TGA wants to gather information on how many IVDs have not yet been brought within the scope of the new regulatory framework, which users and services might be affected by the possible withdrawal of an IVD from the market, and any other issues that may arise from next year's transition.

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A long ride to Laos

The sun-scorched hills that loom above Adelaide's eastern fringe are a long way from the steamy forests and paddy fields of Laos.

But for the next two months Dr Rene Zimmerman, who works at a GP practice in the sleepy hamlet of Littlehampton, about 27 kilometres east of the city, will be spending as much time as work and family commitments allow cycling up and down the local hills in preparation for what is shaping to be an unforgettable trip.

In May, Dr Zimmerman will join nine other Australians, including doctors, nurses and therapists, in cycling through northern Laos as part of a fundraising drive to build a new medical clinic in the country's Luang Prabang district.

The journey, organised by the charity Save the Children Australia, is part of efforts to improve health services and medical care for Laotian children and their families.

Dr Zimmerman and the other participants will be each required to raise $7000 for the trip – with a little more than half of that to be donated directly to the charity's Laos Primary Health Care project.

Organiser Janita Suter said there was an urgent need to improve health services in the poor East Asian country, with estimates that about 36 Laotian children younger than five years of age die from preventable and treatable illnesses every day.

Dr Zimmerman, 39, is preparing himself for what he expects to be a confronting experience, both physically and mentally.

Before getting on their bikes, Dr Zimmerman and his fellow cyclists will spend several days visiting village health clinics and small local hospitals in rural Laos, getting the chance to see first-hand the sort of injuries and illnesses local inhabitants suffer, and the standard of health care they have access to.

According to Ms Suter, one such clinic – staffed by four nurses trained under the Save the Children's Primary Health Care Program - provides essential primary health care services to more than 11,750 people living in eleven surrounding villages, including nearly 5,000 children.

Dr Zimmerman himself is not unfamiliar with the challenges of providing health services in remote and disadvantaged areas.

After graduating from the University of Adelaide he moved to Darwin for his internship, and while there visited several Indigenous communities in the Northern Territory.

"I haven't done any overseas voluntary work, but I did do some placements up in the Northern Territory in Indigenous communities, and certainly in some communities, you could say the conditions are almost Third World," Dr Zimmerman said.

Dr Rene Zimmerman training for the Laos ride in the Adelaide Hills

He plans to take along some basic medical equipment so he can lend assistance to local medical staff where possible.

But Dr Zimmerman expects the most lasting impression he can make from the trip - besides the money he will contribute to building local health services – is the knowledge he will bring back regarding the gulf in the standard of health care expected by Australians and that experienced by Laotians.

"In Australia, you can walk into a GP clinic or a hospital and expect to get good quality health care," he said. "But in Laos there is no guarantee that you could get to see a doctor, let alone that they would have the equipment and medication to treat you."

Dr Zimmerman said working in such straitened circumstances forced doctors to fall back on skills and techniques they had not used for a long time.

"In those areas you cannot simply order a test," he said. "You have to use much more of the clinical and examination skills that you don't tend to use very often."

Dr Zimmerman and his fellow adventurers leave Australia for their 13-day journey on 12 May, and expect to spend five of those days cycling between Luang Prabang and the Laotian capital Vientiane – a distance of about 390 kilometres.

For a weekend cyclist from rural South Australia, it promises to be the adventure of a lifetime.

Ms Suter there were still four places available on the trip. For more information, and to register, visit: www.savethechildren.org.au/laos

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What the Government didn't tell you about the electronic health record

BY **DR EDWIN KRUYS***

Patients and health professionals currently face the difficult decision of whether or not to sign up for the Personally Controlled Electronic Health Record (PCEHR).

To balance all the positive spin from Government sources, here are some of the issues you usually don't hear about:

Privacy

This is by far the biggest issue. We all know that many, heavily secured cloud systems around the world have been hacked, and millions of passwords, credit card data and other information has been leaked all over the internet. Government websites have been attacked and data has been changed by hackers.

The Queensland practice that was recently hacked by Russian cyber criminals is one example of what can go wrong.

The PCEHR is not immune to these attacks. The national PCEHR is a very attractive target for hackers, and breaches could happen on a larger scale than ever before.

Other countries using e-health records have experienced all sorts of security breaches.

But the risks are not just coming from the outside: Medicare employees have been reprimanded in the past for unauthorised access to files of celebrities.

Patient control?

Most GPs I know are not happy with the fact that all the information can be "reproduced, copied, modified, adapted, published and communicated" by the government to anyone, anywhere in the world "for the purpose of the PCEHR" (clause 7.3 of the participation agreement). What if this purpose changes over time when the government changes its mind – after we've all uploaded all our confidential data?

Sure, patients can add information to their records and restrict access, but is the PCEHR patient-controlled?

If we were talking about a shared record between the patient, the GP and other health professionals, including the hospital, I would agree, but the fact that we have to sign our patient's private data away to the government is a big worry.

Risk mitigation

Medicare offices are handing out glossy brochures to patients explaining how to sign up, and Medicare Locals are actively assisting doctors to sign up, but they won't tell us what can go wrong, and it's too complex for most of us to fully understand the risks.

If the PCEHR were a medical intervention, I would have to tell my patients not only about the benefits, but also about the risks.

The fact that the government has not been open about the errors, bugs, shortcomings and potential risks for patients and doctors, has caused fear and scepticism.

Responsibility and liability

So, the Government controls the data, the patient is allowed to add data and change who can view it, but guess who is responsible and liable if things go wrong?

Right, the nominated healthcare provider – usually the GP.

Doctors may be held liable if the PCEHR data is incomplete or flawed.

If a patient decides to limit access to certain data and a complication occurs, doctors can also be held liable.

Fines of up to $1.1 million now exist for healthcare professionals who breach privacy rules (including breaches via software design loopholes – which is out of our control).

This may have consequences for indemnity insurance premiums, potentially resulting in higher consultation fees.

And indemnity insurance may not cover all the risks associated with the PCEHR.

There is also the time spent uploading information and maintaining the shared health summary, and keeping up with the amendments made by others.

Again, the GP will most likely be responsible for this.

Complexity and lack of support

In our practice, we've so far spent about 100 management hours on the PCEHR to make sense of the complexity of guidelines, rules and regulations. Our managers complain about the lack of support.

Only in the last few weeks has the Medicare Local come onboard to assist, though we really need a team of independent lawyers.

Conclusion

The Government is paying practices up to $50,000 to sign up for the PCEHR. Doctors in our practice – like so many Australian GPs – hold patient confidentiality very high, and that's not for sale, no matter what the Federal Government offers.

That means that we will not be able to generate shared health records – but I am sure our patients will understand if we take some time to explain the bits and pieces that the government conveniently left out of their glossy brochures.

**Dr Edwin Kruys is a rural doctor in Western Australia. His blog can be viewed at: http://www.panaceum.com.au/author/edwinkruys*

TO COMMENT CLICK HERE

Time for a new take on where pharmacists work?

BY **DR BRIAN MORTON**

"A family doctor is trained to treat the whole person, not just some parts of the body or specific diseases, and is able to interpret the results in the context of a person's full medical history and treatment regime"

At the recent AMA Council of General Practice (AMACGP) meeting, we had a good discussion about pharmacists. It is always good fodder for a healthy debate.

The arguments go something like this: all GPs rely on the professionalism of pharmacists to get it right when dispensing the medications we prescribe. This is particularly the case when it comes to people who are taking multiple medications and those in residential aged care facilities - the extra assistance pharmacists provide through making up Webster packs, delivery services and a good old-fashioned double-check on prescriptions is invaluable.

The other side of the argument sounds like this: GPs want pharmacists to stick with what they are good at and stop trying to be a GP. In recent years we have seen pharmacists move into vaccination, blood pressure checks and international normalised ratio (INR) testing to monitor patients receiving warfarin.

In many ways this is not surprising. The dispensing side of pharmacy is not what is used to be.

With most medications coming pre-packaged and ready to dispense direct from the shelf, many pharmacists don't get to use the full extent of their chemistry knowledge on a daily basis.

In most pharmacies now you have to walk past aisles and aisles of retail goods to get to the dispensing area. No wonder many professional pharmacists want a bit more of the 'medical action'.

However, as GPs, we know that it is never "just a vaccination" or "just a blood pressure check", or "just an INR test" for patients.

Not only should all of these occur with a suitable degree of privacy (which many pharmacies cannot provide), there are complex safety issues. GPs have stringent requirements for vaccine safety, and for treating adverse reactions, and often a complex web of health history that puts a blood pressure reading into context.

A family doctor is trained to treat the whole person, not just some parts of the body or specific diseases, and is able to interpret the results in the context of a person's full medical history and treatment regime.

We do need to use our medical workforce in the best way we can.

There are many more pharmacy graduates coming through the university system, and the protected nature of pharmacy ownership in Australia means that we are going to have many more trained pharmacists than pharmacy jobs.

We shouldn't waste their skills and expertise. Maybe it is time to look more closely at employing pharmacists in general practice.

Pharmacists would be an asset in general practice teams, working with GPs in discussing prescriptions and medication, as well as being able to get involved with some of that extra testing.

Their skills would be an asset to the GP, and to the primary care team, and provide a legitimate context in which pharmacists can get more of the 'medical action'.

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A National Internship Summit with no interns?

BY **DR MICHAEL BONNING, PAST CHAIR OF THE AMA COUNCIL OF DOCTORS-IN-TRAINING**

"That the summit brought together a singular collection of those capable of fixing this issue was impressive, but no mechanism was provided to turn conversation into solutions"

It is strangely ironic that a National Internship Summit convened by the NSW Health Department to solve the problem of internship shortages was bereft of interns, given that medical graduates themselves created much of the media attention generated by this issue.

It is testament to the success of the AMA's long campaign on the issue, both highlighting the impending training pipeline bottlenecks and creating government embarrassment by unmasking the political brinksmanship, that it has finally received cooperative ministerial attention.

Health ministers do not gather for nothing, and the increasing pressure on federal and state governments to find a solution to internship shortages and broader training pipeline issues, provided the impetus for the National Internships Summit recently convened by the NSW Minister for Health, Jillian Skinner.

While a lack of internships was the trigger, Federal Health Minister Tanya Plibersek and other attendees were clear about the larger context; that the many disconnects in medical training are endangering not only Australia's drive for medical workforce self-sufficiency, but possibly the continuation of the existing high quality health care enjoyed by most Australians.

Recognising that a self-sufficient, high quality health system stems from training, participants developed recommendations and suggestions that were all about getting the right number of doctors in the correct specialties and the correct localities.

Removing the disjuncture between pre-vocational and vocational training would greatly streamline and shorten the current training pipeline in many specialties. The provision of intern and wider prevocational training in general practice and the private sector was also an idea that met with support.

It remains to be seen if these ideas and, importantly, the costs associated with them, will be palatable to number crunchers and bureaucrats. Ideas such as individuals paying for internship are more likely to curry favour with this crowd. The day's conclusion was a "scientific" representation of the opinions of the audience, with no concern for the relative absence of clinicians and the over-representation of health bureaucrats.

That the summit brought together a singular collection of those capable of fixing this issue was impressive, but no mechanism was provided to turn conversation into solutions.

Master of ceremonies Adam Spencer is a talented host. However, his pre-scripted questions limited debate and the ability for the audience to interact with the panels. The significant question of how internships should be structured was clearly antiquated, and it only served to revive arguments from the Medical Board's Internship consultation process. That the registration standard was signed off by the Ministerial Council 12 months ago was missed by many.

The Summit outcome, that a paper would be drafted for the Standing Committee on Health, leaves attendees with a concern that their hard work, thoughtful input and careful lobbying will be cannibalised into something that fits more effectively with the political outcomes required. Will this be viewed as an opportunity well taken or just another chance gone begging?

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Time to abandon blame game and reinvigorate health reform

BY **DR STEVE HAMBLETON**

One of the AMA's biggest aspirations for health reform was an end to the health funding blame game that governments all-too regularly indulge in – a 'game' that can have toxic consequences for the funding, capacity and performance of the Australian public hospital system.

Core performance indicators show that our public hospitals are not keeping pace with demand:

- while 872 new beds were opened across Australia in 2010-11, these merely offset previous closures, as evidenced by the fact that the number of beds per 1,000 people has remained steady at 2.6;
- in 2011-12, just 66 per cent of emergency department Category 3 patients were seen within 30 minutes, well below the 80 per cent target;
- just 65.5 per cent of all emergency department visits in 2012 were completed within the National Emergency Access Target of four hours or less, far short of the 2015 goal of at least 90 per cent; and
- nationally, less than 75 per cent of elective surgery category 2 patients were admitted within 90 days, well below the 100 per cent target.

In the current public hospital environment, it is clearly unacceptable for any government to introduce reductions in funding, as it can only further reduce capacity in the system, putting patients' health and wellbeing at risk.

At the clinical level, reductions in funding by any government for any reason, directly and inevitably result in bed closures, operating theatre shut downs, closing of outpatient clinics and reductions in emergency services. All of this is to the detriment of patient access to care and treatment and, ultimately, to the quality of care provided.

The performance of public hospitals provides clear evidence that the Australian public hospital system is under-funded: public hospitals do not have the capacity to meet the clinical demands being placed on them, even before the Commonwealth adjusted its funding and the states imposed their own budget reductions.

In the second half of February we had a conjunction of events that highlighted these issues: the AMA Public Hospital Report Card 2013 was released; there were submissions to, and hearings of, the Senate Committee on Finance and Government Administration's Inquiry into the implementation of the National Health Reform Agreement; and there was the Commonwealth Government's $107m 'rescue package' for Victorian public hospitals (now also being sought by other governments).

The Economics and Workforce Committee held its first meeting for the year on 16 February, in the midst of all this clamour.

In this context of blame, confusion and on again/off again budget reductions, the AMA's position has been clear: there should be no reduction in the funding of public hospitals by *post hoc* adjustment of the health funding agreements.

Related to this is concern that the National Partnership Agreements (NPAs) provide an unstable funding stream.

For example, the NPA on Improving Public Hospital Performance provided $1.6 billion in funding to the states and territories for sub-acute beds, but this runs out in 2013-14.

Without recurrent funding, the affected services will likely close, which will lead to increased demand on hospitals and place additional pressure on their performance.

There is a strong argument that this NPA should be revisited, and that there should be ongoing funding for any sub-acute beds that have been established, which will help make existing acute beds more available.

The Economics and Workforce Committee believes this should be an issue in the forthcoming Federal election, and is seeking commitments from the major political parties to continue funding under the NPA.

The Committee also identified hospital funding issues that should be raised directly with the Independent Hospital Pricing Authority, including the extent to which constraints on state spending acts as a brake on growth in Commonwealth funding under activity-based funding (ABF) arrangements, and the application of ABF to services such as pathology, diagnostic imaging and outpatient services.

The National Health Reform Agreement was expected to increase the capacity of the public hospital system and improve the ability of public hospitals to provide safe and timely health care and meet clinical demand.

The AMA urges governments to abandon the blame game and redirect their efforts into making the National Health Reform Agreement achieve these outcomes, and make sure funding gets to the bedside.

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The power of the way we pay for health care

BY **PROFESSOR STEPHEN LEEDER**

"We have serious bother in Australia coordinating care for people with long-running health problems in hospital and in general practice"

The way that we pay for health care shapes that care.

If health care is chopped up into pieces and paid for by different agencies, then a health system develops in which skill in moving costs from one payer to another is a neat game with high stakes.

That's what we have in Australia, and it shows.

I am not writing here about the parallel private and public systems.

This is about the way tax dollars are distributed by governments to pay for health care.

The Commonwealth is the agency that collects the taxes and the Medicare levy that pay for publicly-funded health care.

Traditionally, at least until the current round of reforms, the Commonwealth distributed money to the states to run public hospitals. In addition, the Commonwealth directly funds Medicare services and the Medicare Benefits Scheme.

The reforms introduced under the current federal government provide, in the longer term, for more direct funding of hospitals from the Commonwealth coffers, based on the activity profile of each hospital and growth in their use.

Although the current arrangements require a lot of negotiation and are subject to political flux, they work reasonably well. They allow for checks and balances to play out between the Commonwealth and the states and territories so that the more bizarre policy mutations die early.

Nevertheless, there are weaknesses, and these add up to a strong argument for having one source of funding for all forms of publicly-supported health care. Successful examples of single-payer arrangements are there for us to see.

The health service provided by the Department of Veterans Affairs covers all costs for all forms of care for its enrolled members – veterans and their families. This means it has a strong interest in ensuring there is good quality of care in hospitals and in the community, because it works out cheaper in the long run. It takes account of what happens to individual members by linking their experience in all health services electronically. It collects data that allows it to measure service quality and cost.

Much has been made of similar arrangements in the US that operate in the private sector, under the aegis of an insurer who carries the risk for all health care costs for enrolees.

It is no surprise to find that these conglomerates of insurers and providers are interested in preventing illness wherever possible, both before illness happens (through quit classes and nutrition support, for example) and ensuring that every opportunity in clinical practice to initiate or support preventive measures is seized. Thus. Kaiser Permanente in California offers its several million members health care that covers the spectrum from primary care through to hi-tech specialty services. It operates efficiently, and the health status of its enrolees - and the outcomes of their care - is top of the list.

When one agency pays, it has to minimise costs inside its own system. It does not have the luxury of being able to shift the burden to another payer.

We have serious bother in Australia coordinating care for people with long-running health problems in hospital and in general practice. Because resources cannot be moved from one care modality to another, coordination depends on goodwill alone.

The advent of Medicare Locals, in tandem with local hospital networks, is slowly addressing that problem, but it will take ages.

Any move to renege on the current plan to make the Commonwealth the major direct payer for most public health care will, in the long run, only exacerbate these problems of coordination.

Marching into the future facing backwards is a health hazard.

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Health on the hill

Political news from the nation's capital

Funding threat dangles over Queensland health plans

The Queensland Government could be hit with financial penalties if proposals to outsource public health services lead to cost shifting or a dip in hospital performance.

As the health funding stoush between the Commonwealth and several state governments continues to simmer, Federal Health Minister Tanya Plibersek warned she could withhold reward payments from Queensland if changes to the State's health system hurt the standard of care or pushed more of the funding burden onto the Commonwealth.

"We are very closely watching what's happening in Queensland," Ms Plibersek said. "I'm very concerned that in privatising some of the essential services in hospitals, you will see a decline in services to patients."

A Commission of Audit led by former Federal Treasurer Peter Costello has advised the Queensland Government to consider engaging private companies and not-for-profit organisations to operate many health services, noting that in some instances they cost $1000 more to deliver than in Victoria.

Responding to the report, Queensland Treasurer Tim Nicholls did not automatically endorse the privatisation of some health services, but he told Fairfax Media it was something that should be considered.

"What we want to concentrate on is making sure people who go to hospitals get a good outcome," Mr Nicholls said. "The report says the Government should be an enabler of services, not necessarily the doer of services.

"It says that we have to do things differently, and we should consider looking at working with the private sector to deliver services across a range of areas. Whether that's private companies or not-for-profits is something the Government has to consider."

But Ms Plibersek condemned the report as a "blueprint for job cuts and massive savings," and repeated warnings from Federal Treasurer Wayne Swan that the Commonwealth would oppose any changes that compromised care and shifted costs.

"If the Queensland Government is seeking to cost-shift, then we have a way of dealing with that in a formal process. If the Queensland Government fails to meet its targets when it comes to elective surgery or emergency departments, then we have a way of dealing with that through the withholding of reward payments," the Minister said.

Ms Plibersek also reiterated the Commonwealth's threat to by-pass the Queensland Government and provide extra funding direct to hospitals and other frontline services.

"It's something that I'm considering," the Minister said. "I'm watching what's happening in the Queensland system very carefully, I've got a range of options available to me, [and] dealing directly with frontline services is one of them."

The flare-up in Queensland followed a protracted stand-off over health funding between the Federal and Victorian governments, which the Commonwealth sought to resolve by restoring an extra $107 million to the state's original funding allocation.

But both the Victorian and Queensland governments complain that the Federal Government still intends to scale back the size of its contribution to both states in coming years.

Victorian Health Minister David Davis said $368 million could be "stripped" from the State's hospitals in the next three years, while his Queensland counterpart, Lawrence Springborg, said his State faced a $278 million shortfall in the next two years, in addition to a reduction of $103 million this financial year.

But Ms Plibersek said the Commonwealth was providing an extra $155 million in health funding to Queensland this year, and an extra $600 million over the next four years.

AR TO COMMENT CLICK HERE

Hospital pricing tsar sets cost increase

The Independent Hospital Pricing Authority has allowed for a 3.8 per cent rise in the cost of providing public hospital services next financial year.

The Authority, which has responsibility for determining what should be paid for public hospital services under the shift to activity-based funding, has set the national efficient price for 2013-14 at $4993 per national weighted activity unit (NWAU), up from $4808 this financial year.

The increase affects the total cost of a wide range of public hospital services, which are estimated based on the NWAU.

For example, a hip replacement has a NWAU of 4.1742, meaning the national efficient price for the procedure will increase from $20,069 this financial year to $20,841 in 2013-14, while the cost of a coronary bypass will rise from $27,323 to $28,375 over the same period.

IHPA chair Shane Solomon said activity-based funding constituted payment for services that a hospital actually provided.

"Activity-based funding creates a new transparency and better value for public money spent on public hospital services," Mr Solomon said.

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Health on the hill

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For the first time the IHPA, which was established at the end of 2011, has extended activity-based funding to include sub-acute services such as rehabilitation, and has also determined a national efficient cost for small rural hospitals and other services not suitable for activity-based funding.

This national efficient cost will determine the size of the contribution made by the Commonwealth to block-funded hospitals, and is the first time it will be based on a nationally-consistent approach, Mr Solomon said.

The IHPA has set the national efficient cost for 2013-14 at $4.738 million, the average cost of block-funded hospitals across the country.

The actual funds provided will be determined according to a system of weightings taking into account size and location, Mr Solomon said, adding that it reflected wide consultations with governments and the general public.

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Medication costs pushing some to financial brink

Alarm has been raised that the cost of some medicines is being pushed out of the reach of patients despite Federal Government subsidies.

In a result that shows failings in the nation's prescription medicine safety net, the Pharmaceutical Benefits Scheme, a study in the journal *Australian Health Review* found that almost a third of consumers were struggling to cope with out-of-pocket costs associated with their prescription medication.

Almost 10 per cent of the 1502 randomly selected participants surveyed said they faced heavy to extreme financial burdens caused by the cost of their prescription medicine, while a further 19.5 per cent said the expense caused a moderate financial burden.

Study leader, Associate Professor Andrew Searles of the Hunter Medical Research Institute, said the results highlighted shortcomings in the PBS that could lead to greater costs for the health system.

"The PBS safety net and co-payment thresholds are supposed to protect consumers with high medication expenses," Associate Professor Searles said, but added the survey results showed that in a significant proportion of cases these arrangements were failing.

"Many people report problems with the cost of their prescription medicines," he said. "Cost can be a barrier to accessing medicines, and a lack of access can result in adverse health outcomes for patients.

"Ultimately, the costs to consumers and the health system can be higher if health conditions become more serious and require more intensive and expensive treatment, such as hospital admission."

Associate Professor Searles said the study's findings should be used to help systematically evaluate the affordability of prescription medicine, and ongoing surveillance of co-payments and safety net thresholds to ensure equitable and affordable access to medicines.

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Work begins on national medical training plan

The country's chief health workforce adviser has begun work on plans for a nationally coordinated medical training system.

As leading politicians, medical trainers, health bureaucrats and health profession representatives gathered in Sydney for a one-day summit on the medical intern crisis, Health Workforce Australia (HWA) released a discussion paper on plans to establish the National Medical Training Advisory Network.

The Network is the brainchild of the Council of Australian Governments, and is intended to end the mismatch between the supply and distribution of practitioners and community health needs.

HWA Chief Executive Officer Mark Cormack said that despite "major efforts" to train more doctors, many people still struggled to find a doctor when they needed one, particularly in rural areas.

"Looking at the training of doctors as a whole – from university right through to specialists – is the key to finding a solution to this problem," Mr Cormack said.

In its Health Workforce 2025 report, HWA warned that the country was facing significant shortages of doctors and nurses that could compromise access to quality care.

"What the data revealed is a problem with alignment – the number and type of doctors we are producing is not matching up with the health care requirements of communities," Mr Cormack said. "The National Medical Training Advisory Network will be the mechanism for planning a more balanced supply and demand scenario."

But the more immediate problem of ensuring there are sufficient internships to accommodate the nation's growing number of medical graduates was the focus of National Medical Intern Summit convened by NSW Health Minister Jillian Skinner.

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The meeting, which was addressed by Federal Health Minister Tanya Plibersek and attended by Ms Skinner, Victorian Health Minister David Davis, as well as officials from 18 universities with medical schools, the AMA and post-graduate and undergraduate student representatives, was organised following last year's debacle, when only a last-minute intervention by the Commonwealth prevented around 180 medical graduates being left stranded without an internship place.

"The issue of internship positions has become a perennial cause for concern for the states, territories and Commonwealth, one which causes unnecessary heartache for medical graduates," Ms Skinner said. "While demand for intern positions continues to grow each year, the funding models have not evolved to keep pace."

The NSW Minister said she convened the Summit to discuss long-term and sustainable solutions, not just for the number of internships, but also ensuring in future the nation has the medical workforce it needs.

AMA NSW President Associate Professor Brian Owler said the meeting was a "good first step" in stimulating national discussion of the issue.

"We need every graduating medical student to go on to become a fully-trained doctor," Associate Professor Owler said. "The only way they can do that is by completing an intern year, followed by pre-vocational and then vocational training.

"The focus is on interns, but the other two stages in a junior doctor's career are just as important, and could just as easily become training bottlenecks."

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THE NATION

What is making news in medicine around the country...

QUEENSLAND

Private hospital plans

The Queensland Government is considering getting the private sector to operate a hospital on the site of the former Royal Children's Hospital in Brisbane.

Health Minister Lawrence Springborg told *The Australian Financial Review* the Government would invite expressions of interest from private organisations to establish a new private hospital at Royal Children's once its current operations are phased out and transferred to the Queensland Children's Hospital.

Mr Springborg raised the possibility as Federal Treasurer Wayne Swan launched a blistering attack on proposed health reforms that would see the private sector play an increasing role in the provision of Queensland health services, pledging the Gillard Government would do everything in its power to block such moves.

But Mr Springborg said the State Government simply did not have the money to make much-needed investments in health infrastructure, and engaging the private sector was "a very attractive option".

Princess Alexandra woes

Princess Alexandra Hospital has detailed plans to close more than 60 beds in a memo to staff.

The memo, obtained by the *Courier Mail*, shows the hospital is struggling to sustain its operations, and outlines plans, from 30 June, to close 28 surgical beds, 24 geriatric care beds, four infectious disease unit beds, six brain injury rehabilitation beds and two each from intensive care and the spinal injury unit.

Hospital administrators have blamed the cuts on an unexpected $19 million reduction in Commonwealth funding.

WESTERN AUSTRALIA

Nurses win pay rise

The Western Australian Government has bowed to pressure and agreed to a pay claim from the State's nurses amid concerns that threatened rolling stoppages could have at lives at risk.

In its backdown, the Government agreed to a 14 per cent pay rise for nurses over three years, at an estimated cost to the Budget of $71 million.

Premier Colin Barnett told the *West Australian* that he had no choice but to accept the wage demand after fears were raised that planned industrial action by the State's nurses would have endangered lives.

"When you are faced with clear professional advice that lives could be lost – and they probably would be – I think I had a responsibility to act on that," Mr Barnett said.

VICTORIA

Surgery wait blow-out

The Victorian Government has been accused of suppressing information showing a massive blow-out in the State's elective surgery waiting lists even before the Federal Government announced a reduction in Victoria's health funding allocation.

State Government last month released figures showing the number of patients waiting for elective surgery surged to 47,463 in September last year, up from 37,194 in mid-2010.

Health Minister David Davis blamed most of the increase on Federal funding cuts, including the announced withdrawal of $107 million (since reinstated) last October.

ACT

Hospital IT security upgrade

Canberra Hospital is implementing new security measures in its emergency department IT system to prevent a repeat of its notorious data-doctoring scandal, according to the *Canberra Times*.

The upgrade includes the introduction of rapid log-on technology to enable supervisors to track who enters data, and when.

Under the old system there was widespread use of generic log-on codes in the emergency department, making it very difficult to identify who entered information.

The move to individualised log-on codes had been delayed until the introduction of rapid log-on technology, because of concerns that slow log-on and log-off processes would have brought the busy emergency department to a grinding halt.

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Members' Forum

Here's a selection of what AMA Members have been saying about the latest issues affecting the profession:

Revelations that up to 1200 patients at a major British hospital died unnecessarily because of negligence and misplaced priorities (see *Hundreds die as budget targets come before patient care*) had several *Australian Medicine* readers reflecting poorly on the quality of hospital management in Australia.There was also considerable discussion about the merits of the Personally Controlled Electronic Health Record system (see *Weak start for PCEHR*).The nation's reliance on International Medical Graduates to help fill gaps in the medical workforce – and concerns that they are being recruited at the expense of locally-trained doctors (see *Flood of foreign doctors to come under scrutiny*) - prompted vigorous debate.

UK hospital scandal

This situation is so predictable. Management continues to increase while front line services are pruned. When I first worked in the Queensland public hospital system in the 1970s, there was a Hospital Superintendent, a Matron and a Hospital Board who made the decisions. Simplistic perhaps, but mostly efficient. When I left in 2009 there were so many levels of administration that, even as a senior doctor, it was incredibly difficult to know who I was answerable to.

Liz Culliford (not verified)

Direct patient care is now always the lowest priority at any hospital. Getting the sums right has become number one. Very sad, but true.

Anonymous

Coming to a public hospital near you.... cost-based health care is what public health has come to, and it's sad that doctors are directly complicit as the heads of large public hospitals (in Queensland at least).

Anonymous

PCEHR

The statement that "The Opposition's e-health spokesman Dr Andrew Southcott told the *Sun Herald* that information supplied by the Government in answer to a Question on Notice showed that, of 560,000 practitioners nationwide, just 1325 had registered so far", really needs to be put into context. In order to interact with the PCEHR the practitioner does not need to register individually. The registrations will occur at a practice level, so this statistic is entirely useless and meaningless. This statistic is not indicative of the take up of the PCEHR system as the Opposition would have you believe.

Anonymous

The PCEHR has a great deal to offer the patients that I look after in the remote Kimberley. They are in isolated communities. Care is through multiple agencies, many of which do not communicate. When they go to Perth or Darwin for tertiary care, very little information goes with them and almost none comes back. I have been trying for three years to give my patients an opportunity to have access to the PCEHR. We have had no support at all. The very people who have the most to gain have [had] the gate shut in their face.

Trevor Lord

Overseas RMO recruitment

It is mindless and a waste of money and human resources to increase the output of Australian medical schools to produce doctors trained to a high standard and then lack training positions for them immediately following graduation. It makes no sense at all that State health authorities can recruit and employ FMGs of uneven quality on 457 visas ahead of LMGs.

Anonymous

This is not FMG-bashing - I recognise the contribution many high-quality FMGs make to our health system. But we can't only remember the good and forget the bad. While there is nothing wrong with most FMGs, if they are to be employed there needs to be an effective way of filtering out the underperformers. Continuation of their employment should be contingent on performance commensurate with what they have claimed they will deliver; this often seems not to be the case.

Anonymous

It is ludicrous to recruit from abroad when there are local doctors without jobs. However I am a little tired of the FMG bashing. We are not all crap you know! I was trained as a GP to very high standards in the UK and was, frankly, a little bit appalled at the ethics and varying clinical standards of 'local' GPs that I have worked with.

Anonymous

As a doctor trying to recruit Australian doctors to the country, I must say that the increased supply of Australian graduates has not made my job any easier. We continue to face significant shortfalls, particularly in specialty registrar positions.

Anonymous

TO COMMENT CLICK HERE

Research

Ancient mouths put the bite on modern eating habits

Plaque from the teeth of ancient human skeletons has revealed bacterial evidence to prove what our mothers always told us – that eating refined sugar and processed food will rot your teeth.

An international team, led by the University of Adelaide's Centre for Ancient DNA (ACAD), has uncovered a genetic record revealing the cavity-causing changes in oral bacteria as humans have evolved from prehistoric hunter-gatherers to farmers and then consumers of refined and processed food.

They found that the mouths of ancient humans from the Stone Age were teeming with different kinds of bacteria, compared with modern mouths.

"This is the first record of how our evolution over the last 7500 years has impacted the bacteria we carry with us, and the important health consequences," study leader Professor Alan Cooper said.

"Oral bacteria in modern man are markedly less diverse than in historic populations, and this is thought to contribute to chronic oral and other disease in post-industrial lifestyles."

The researchers extracted DNA from the dental plaque of 34 prehistoric northern European human skeletons.

They then traced changes in the nature of oral bacteria from the last hunter-gatherers, through the first farmers, to the Bronze Age and Medieval times.

"The composition of oral bacteria changed markedly with the introduction of farming, and again around 150 years ago," Professor Cooper said.

"With the introduction of processed sugar and flour in the Industrial Revolution, we can see a dramatically decreased diversity in our oral bacteria, allowing domination by caries-causing strains.

"The modern mouth basically exists in a permanent disease state."

Professor Cooper has been working on the project with archaeologist and co-Leader Professor Keith Dobney, now at the University of Aberdeen, for the past 17 years.

"I had shown tartar deposits commonly found on ancient teeth were dense masses of solid calcified bacteria and food, but couldn't identify the species of bacteria," Professor Dobney said. "Ancient DNA was the obvious answer."

However, the team was not able to sufficiently control background levels of bacterial contamination until 2007, when ACAD's ultra-clean laboratories and strict decontamination and authentication protocols became available.

Dr Christina Adler, of the University of Sydney, who conducted the research while a PhD student at the University of Adelaide, said that dental plaque represents the only easily accessible source of preserved human bacteria.

"Genetic analysis of plaque can create a powerful new record of dietary impacts, health changes and oral pathogen genomic evolution, deep into the past," she said.

The research team is now expanding its studies through time, and around the world, including other species such as Neanderthals.

DV

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Illness forces many to retire early

People living in regional or rural Australia are more likely to be retired from the workforce due to ill health than their counterparts in the cities, and cancer is one of the leading causes of illness leading to retirement for both men and women, new research shows.

Against the background of an ageing workforce, the research, led by the University of Sydney's Dr S. W. Pit, and published in the journal *Public Health*, set out to investigate to what extent common health problems and geographical location are linked with early retirement.

The study found that men and women living outside major cities were more likely to be fully retired due to ill health. And men from outer regional areas were also more likely to be partially retired because of illness.

Women who had suffered cancer (except melanoma, skin and breast cancer), a stroke, osteoarthritis, depression, osteoporosis, thrombosis or anxiety were more likely to be fully retired, compared to those without those ailments.

Women who reported having been told by a doctor that they had depression, breast cancer or osteoarthritis were more likely to be partially retired due to ill health than those without those problems.

Men who had been diagnosed with cancer, heart disease, anxiety or depression were more likely to be fully or partially retired than others, while men who reported having had a stroke, diabetes, thyroid problems, osteoarthritis or osteoporosis were more likely to be fully retired.

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Research

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The study found that slightly more men than women retired early due to ill health.

"The cause may be lower labour force participation rates for females relative to males, meaning that there is more scope for men to retire than for women," Dr Pet and her co-authors said.

"Alternatively, men tend to seek medical advice later than women, which may result in more serious conditions being left untreated, which may in turn lead to early retirement."

The higher rate of retirement in regional areas could be attributed to a lack of employment opportunities in the bush, reduced access to health services, or a tendency for many country people to delay going to the doctor.

The authors also suggested it was possible that many people might have moved to rural areas following retirement due to ill health.

The study authors drew on previous research to show that early retirement hits the hip pocket of individuals, as well as the national economy.

They pointed to a 2008 *Medical Journal of Australia* article which showed that 663,235 older Australians were not working because of ill-health, reducing Australia's GDP by around $14.7 billion per annum.

"Health plays a vital role in the decision to retire," Dr Pet and her co-authors said. "Providing healthy ageing for the mature age workforce is therefore important to reduce early retirement."

Dr Pit and her team proposed that new approaches were needed to try and keep older workers in the workforce.

"Employers and occupational health and safety officers could target people with the above-mentioned health problems to make work environments more suitable, allowing people to continue working if they wished," they said.

And superannuation funds could target people who are at higher risk of early retirement by subsidising health promotion programs.

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Superbug lives on long after initial infection

Patients can take more than a year to be clear of the superbug CRE after initial diagnosis, underlining the risk that they could spread the infection.

A study in the March issue of the *American Journal of Infection Control* shows patients who tested positive for carbapenem-resistant Enterobacteriaceae (CRE) – a multi-drug resistant bug recently linked to the deaths of six patients at a US hospital – took an average of 387 days following hospital discharge to be clear of the organism.

The study, conducted at the Shaare Zedek Medical Center in Jerusalem, Israel, involved analysis of cultures taken from 97 CRE-positive patients who had been discharged from the medical centre between January 2009 and December 2010.

The average time until cultures became negative was 387 days. At three months, 78 per cent of patients remained culture positive; at six months, 65 per cent remained positive; at nine months, 51 per cent, and at one year 39 per cent of patients remained positive, meaning they could potentially become re-infected or transmit the germ to others.

Researchers identified a number of factors influenced the length of time patients took to rid themselves of the infection, including the length of hospitalisation, whether and how often the patient was re-admitted to hospital, and whether the patient had an active infection as opposed to colonisation without signs of active disease.

Elsevier, who published the research, said the study was one of the first to determine the persistence of CRE following hospital discharge, providing a vital insight into how to treat formerly CRE-positive patients upon readmission "so as to limit the spread of this virulent and often deadly pathogen".

The authors said their results showed that "patients with multiple hospitalisations, or those who were diagnosed with clinical CRE disease, should be assumed to have a more extended duration of CRE coverage, and should therefore be admitted under conditions of isolation and cohorting until proven to be CRE-negative".

"These measures will reduce the hospitalisation of CRE-positive patients among the general patient population, potentially preventing the spread of CRE."

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Promising signs for ovarian cancer test

A simple blood test to provide early detection of ovarian cancer could be edging closer to reality according to preliminary results from a team of researchers at Sydney's Garvan Institute.

The research team, led by Dr Goli Samimi, is working on identifying the genes that cause the development of ovarian cancer, and using this information to identify new ways of diagnosing and treating the disease.

"Our major focus remains to identify better ways of diagnosing early stage ovarian cancer, preferably as a simple blood-based test," the team said in a statement on the Garvan Institute website.

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Research

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Tumour suppressor genes are critical for preventing unrestrained growth of cells, and their switching off is one of the key and early events in the development of cancer.

However, these important genes can be silenced by a change to their DNA called methylation.

"Preliminary evidence from our group and others suggests that such DNA methylation changes may be detectable in the blood of patients with early stage ovarian cancer," Dr Samimi and her team said.

"We have now discovered a number of candidate tumour suppressor genes that are silenced in ovarian cancer by methylation, and that are detectable in blood samples from ovarian cancer patients.

"Our current work focuses on identifying a panel of these methylated markers that may have potential as diagnostic markers for early stage ovarian cancer."

A blood test that could provide an early diagnosis for ovarian cancer would help save many lives each year.

"Early detection is key to improving survival," Dr Samimi told AAP on Ovarian Cancer Awareness Day.

But diagnosing ovarian cancer can be difficult. Unlike the Pap smear test, which tests for cervical cancer before symptoms appear, there is no screening test for ovarian cancer.

"The symptoms are extremely general," she said. "Bloating, change in appetite, fatigue – symptoms women deal with all the time."

The Garvan Institute says that every year, about 1200 Australian women are diagnosed with ovarian cancer.

"Due to the lack of adequate screening techniques and non-specific symptoms, most women are diagnosed in the advanced stages of the cancer, meaning that the survival rates of ovarian cancer are low in comparison to other cancers, such as breast cancer," it said.

Treatment is most commonly an individualised combination of surgery and chemotherapy. Unfortunately, up to 30 per cent of ovarian cancer patients do not respond to chemotherapy, and another 40 per cent can develop resistance to the chemotherapy during treatment.

Apart from its research aimed at developing an early detection blood test, the Garvan team is also investigating the mechanisms to resistance in chemotherapy, with the aim of offering better treatments to patients with late-stage ovarian cancer.

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Children of the overweight born with thicker artery walls

Babies whose mothers are overweight or obese are born with the walls of their major artery, the aorta, already thickened, according to an Australian study.

University of Sydney researchers have found the aorta walls of children born to overweight or obese mothers were on average 0.06 of a millimetre thicker than those whose mother was of a normal weight, and that the arterial thickening occurred irrespective of the baby's own birth weight.

The study involved 23 women with an average age of 35 years who were initially examined when they were 16 weeks pregnant.

The body mass index of women included in the study ranged from 17 to 42, and those with an index above 25 were classified as either overweight or obese.

In the first seven days following birth, researchers scanned the abdominal aorta of each newborn, and measured the thickness of the aorta's internal walls – the intima and media.

They found that intima-media thickness ranged from 0.65 to 0.97 millimetres, and was associated with the mother's weight – the greater it was, the thicker the artery wall was, irrespective of birth weight.

The study's authors said the discovery was significant because thickening of the main artery is an indicator of early atherosclerosis, which can lead to heart attacks and stroke.

Co-author Dr Michael Skilton, from the University's Boden Institute, said aortic intima-media thickness was considered the best non-invasive measure of the structural health of the vasculature in children.

"We already know that the children of overweight or obese mothers are more likely to become overweight or obese themselves, which will potentially increase their risk of heart attack and stroke in adulthood," Dr Skilton said.

"[But] to our knowledge, this is the first study demonstrating that being an overweight or obese mother can itself potentially lead to poor health of the blood vessels [in the child], which is consistent with higher risk of heart disease and stroke later in life."

Dr Skilton said this pointed to an intergenerational effect of overweight and obesity irrespective of whether or not children themselves were overweight or obese.

He said the researchers had begun work with a much larger sample of mothers to see whether the results were replicated across a larger population.

"At this stage, the broader public health awareness focus should be on the promotion of measures that will assist women of childbearing age to maintain a healthy weight," Dr Skilton said.

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Trade treaty could undermine public health

Governments, doctors and consumers face the threat of more expensive medicines and curbs on health regulations under the proposed terms of a major trade treaty, experts have warned.

The Trans Pacific Partnership (TPP) being negotiated between 11 countries including Australia, the United States and New Zealand, could greatly expand the patent rights of pharmaceutical companies while undermining the ability of governments to regulate dangerous and unhealthy products, according to health campaigners and academics.

International President of Medecins Sans Frontieres, Dr Unni Karunakara, said the TPP – which has been negotiated behind closed doors in Singapore for the past week – contains provisions that could dismantle public health safeguards and push the cost of vital medicines even further out of the reach of many in developing countries that need them.

"Too many people already die needlessly because the medicines they need are too expensive, and we cannot stand by as the TPP threatens to further restrict access to medicines in developing countries," Dr Karunakara said.

According to MSF, provisions in the TPP being pushed by the United States would prolong monopoly protection for medicines under patent, delaying the release of more affordable generics.

Of particular concern, one provision would require governments to grant new 20-year patents for modifications of existing medicines, such as new forms, methods or uses, even without any improvement in their therapeutic benefits.

Dr Karunakara said the availability of affordable medicines had been crucial to MSF's work in tackling the ravages of HIV and other diseases in countries like Thailand.

"Now Thailand is on the cusp of joining a dangerous deal that could jeopardise its ability to maintain, let alone scale up, vital, life-saving health programs for its people."

In an article published in *Lancet*, La Trobe University public health expert Dr Deborah Gleeson said the TPP also threatened to inhibit the ability of governments to act to protect the health of their populations, such as the Australian Government's landmark plain packaging tobacco laws.

Dr Glesson said the TPP and similar treaties sought to "privilege investors over governments, and provide avenues for international corporations to challenge democratically enacted public health policies".

She said investor-state dispute settlement provisions in the Australia-Hong Kong preferential trade agreement were being used by Philip Morris Asia to challenge Australia's plain packaging laws, and highlighted what could happen under the type of arrangements being considered as part of the TPP.

Dr Gleeson said the TPP was likely to affect public health in two ways: by rationing access to drugs by raising their cost, and by reducing the ability of government to regulate harmful products.

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WINNER

Australian Medicine's A Day in the Life of the AMA competition

The *Australian Medicine* 'A Day in the Life of the AMA' photo competition has been won.

Congratulations, Dr Kevin Kwan, (pictured with one of his winning photos), who has won a 64GB iPad Mini with full Wifi capability.

Dr Kwan will be presented with his prize later this month.

Huge rich-poor divide in global health

Africans suffer a quarter of the world's total disease burden but are cared for by just 5 per cent of the total global medical workforce, according to the President of the World Medical Association, Dr Cecil Wilson.

In a major speech on international inequality in health care, Dr Wilson told those attending the All Nepal Medical Conference in Kathmandu that while those living in the world's 40 most economically developed countries had access to organised health care systems, "the majority of people worldwide never see a doctor in their whole life".

He said that Africa had to cope with the largest share of global disease burden – 25 per cent – with a fraction of the number of doctors and other health workers working in the United States, and with "miniscule" government spending on health care.

"At the other end [of the scale], the Americas, with only 10 per cent of the disease burden, have 38 per cent of the global workforce, and spend a lot on health care," Dr Wilson said.

The WMA President noted that wealthier countries tended to recruit a large proportion of their doctors from poorer parts of the world, noting that 34 per cent of New Zealand's physicians were trained abroad, as were 32 per cent of those working in Great Britain and 28 per cent of those in the US.

"But South Africa has 38 per cent of its physicians working abroad, Ghana 29 per cent, Angola 19 per cent and Nigeria 12 per cent," he said. "All of these are countries in which the disease burden is high and the health care workforce inadequate. In short, the countries least able to afford this brain drain."

Dr Wilson said many countries that lacked organised health systems were looking at how to achieve universal health care for their citizens, but there was so far no evidence that one particular model was superior to any other.

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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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US budget sequester deals heavy blow to research, regulation

Medical research and regulation in the United States is set to be crippled by deep budget cuts triggered by a political standoff in Washington.

Key agencies including the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) are set to have hundreds of millions of dollars slashed from their budgets this year following the failure of negotiations between the White House and Congress over ways to rein in galloping national debt.

Under the terms of the Budget Control Act, which came into effect on 1 March and which aims to reduce the federal budget deficit by $1 trillion by 2021, the NIH is expected to lose $2.4 billion from its budget in 2013 alone, while the FDA faces a $318 million cut, and the CDC will have up to 10 per cent of its spending slashed.

Research and consultancy firm GlobalData warned the savage and indiscriminate cuts would hamper the review and approval of new medicines and could undermine the United States' international standing in medical research.

GlobalData analyst Adam Dion said all 27 agencies and centres funded by the NIH would be affected, with the National Cancer Institute alone expected to lose almost $400 million.

Mr Dion said the NIH was the world's pre-eminent medical research agency, supporting about 432,000 jobs and fuelling around $60 billion of economic activity each year.

The Office of Management and Budget has estimated that, as a result of the Budget Control Act, there will be 2300 fewer medical research grants issued by the NIH this year – about a quarter of its total competitive grant allocation.

The budget cut the FDA faces virtually equals the amount it spent on reviewing and approving biologics, and exceeds its total budget for examining medical devices.

Mr Dion said success rates for winning government-funded research grants were already at record lows, and the budget cuts could be "potentially devastating" for biomedical researchers.

"This would also set a dangerous precedent for the country, and potentially jeopardise American leadership in science and innovation," he said. "It could lead to a brain drain as researchers flee the US to countries like Britain, Germany, China and India."

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The diplomatic doctor

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

Dr Mark Hampson

Almost a decade ago country GP Dr Mark Hampson decided to pack in his Byron Bay practice, join the foreign service and see the world.

In the following nine years he has, among many other experiences, witnessed first-hand the difficult early years of the one of the world's newest countries, Timor Leste; trekked for days through the jungles of northern Laos helping search for a lost Australian tourist; and been on hand for Myanmar's hesitant steps toward democracy and re-engagement with the international community.

But it almost didn't happen.

In 2003 Dr Hampson chanced upon an advertisement from the Department of Foreign Affairs and Trade about work as a doctor attached to the Australian embassy in Yangon (Rangoon), Myanmar.

At the time, he was feeling a "bit burnt out" after 15 busy years working as a GP and in obstetrics in and around Byron Bay.

"It was probably the most challenging and professionally rewarding time, but my partner and I were looking for a change," he said.

Dr Hampson underwent an exhaustive assessment process involving mountains of paperwork and several interviews, at the end of which he was offered a position as doctor attached to the Australian embassy in Jakarta.

He knocked back the offer, but soon got a call asking if he'd be interested in a similar position at the embassy in Dili, the capital of Timor Leste (East Timor).

He and his partner arrived in Dili in January 2004 and so began what Dr Hampson said was a very challenging but extremely rewarding period.

Working in a big bureaucracy with very strict rules about how things were done took a lot of getting used to, as did the very basic level of services and infrastructure the nascent country had to offer.

"Every Monday morning meeting [at the embassy] would start by going through what I had done wrong the previous week," Dr Hampson said. "Getting used to working in a bureaucracy was probably the toughest adjustment."

But it was also interesting and exhilarating.

"In Timor you dealt with all the big players, like Xanana [Gusmao], and you had to think quickly on your feet and make the best use of what facilities you had available," he said.

Shwedagon Paya

After two-and-a-half years in Dili, Dr Hampson was posted to Vientiane, the capital of Laos, where he found himself caring not only for embassy staff and their families, but also Australian tourists and other travellers.

His consular work often involved travelling to different parts of the country, including 11 days spent tramping through a Laotian forest as part of a massive search for a lost Australian tourist.

"When we eventually found him, he was in pretty bad shape. He had to spend five months in intensive care," Dr Hampson said, but added that it was the sort of experience that made him love his job.

"That is why the work is so interesting," he said. "It is not just sitting at the desk all day. It really is a privilege to be able to work and live in another country."

After six years in Vientiane, Dr Hampson transferred to Yangon, where he runs the Australian Embassy Medical Clinic.

It is a fascinating time to be in Myanmar, which is desperately poor after decades of economic and political isolation.

The country is undergoing a difficult political transformation toward democracy and greater openness to the outside world, while at the same time managing a legacy of severe under-investment and negligible development.

Yangon itself is a very green city, studded with big parks, lakes and tree-lined boulevards.

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Traffic Infringements: "Just the ticket!"

BY **DR CLIVE FRASER**

I've always had a great deal of respect for traffic police.

They're out there come rain, hail or shine, making sure we obey those important road rules.

I've always been happy to excuse their occasionally over-zealous attitude because, after all, the rules are the rules.

Most of them have been hardened by years of attending car crashes where recklessness and stupidity have all played a part.

But my confidence in the boys in blue was tested recently when a colleague told me of his 19-year-old daughter's recent traffic infringement(s).

She'd been pulled over for doing 70 kilometres an hour in a 60 kilometres an hour zone which, everyone will agree, was a fair cop.

But it was the officer's next question, about her name and address, which got me thinking.

You see, she'd just moved in with her boyfriend some six weeks earlier.

This had happened with the full knowledge and consent of both sets of parents, who were very happy to see her with a young man who loved her.

So my colleague's daughter proudly advised the officer that she was living with her boyfriend at Taringa.

That was a big problem, because her licence said that she was living with her parents at Toowong.

In my state it is an offence to fail to notify the Department of Transport of a change of address within 14 days, punishable with a fine of $110 (one penalty unit) and one demerit point, and her oversight earned her a second infringement notice from the officer.

Had the girl lied to the officer about her current address she might have also been charged with a more serious offence of making a false and misleading statement, which carries a fine of $6600 (60 penalty units).

But honestly, in this situation, the policeman would be none the wiser whatever address the young woman gave, and no ticket would have been issued if she'd simply said that she was still living with her parents.

And anyway, my colleague's daughter still visited her parent's home most days, and ate there four nights a week.

The issuing of the second infringement just seemed a little heavy-handed to me.

The officer might have handled it better by educating the young offender about the importance of notifying the relevant authorities of her change of address, so she did not overlook it again next time she moved.

So, the next time you're pulled over by a policeman, it may be worth giving a little thought to what you say when he asks you where you live.

Safe motoring,
Doctor Clive Fraser
doctorclivefraser@hotmail.com

TO COMMENT CLICK HERE

The diplomatic doctor

...CONTINUED FROM PAGE 38

The legacy of colonial Burma is visible everywhere.

Massive Victorian-era public buildings – including The Strand Hotel, the former Customs House and massive warehouses – line the Yangon River waterfront, while sprawling colonial-era mansions – many of them in advanced decay - sit in massive gardens.

Yangon is a sprawling city, much of it low-lying and prone to flooding, but the geography means that the massive Shwedagon Paya (pagoda) is visible from many parts of town.

The gold-encrusted dome, which sits on a hilltop, soars 100 metres above its base.

Archaeologists believe the first stupa was erected on the site between the sixth and tenth century AD, and the tradition of gilding the dome began in the 15th century when the-then queen donated her weight in gold, which was beaten into gold leaf and applied to the structure. A succession of rulers continued the practice, including one who extravagantly donated four times the weight of he and his wife.

Preserving its ancient and colonial-era heritage while accommodating much-needed economic development will be a great challenge for the Myanmar Government, and Dr Hampson will be able to see first-hand how this intriguing country progresses.

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