AUSTRALIAN
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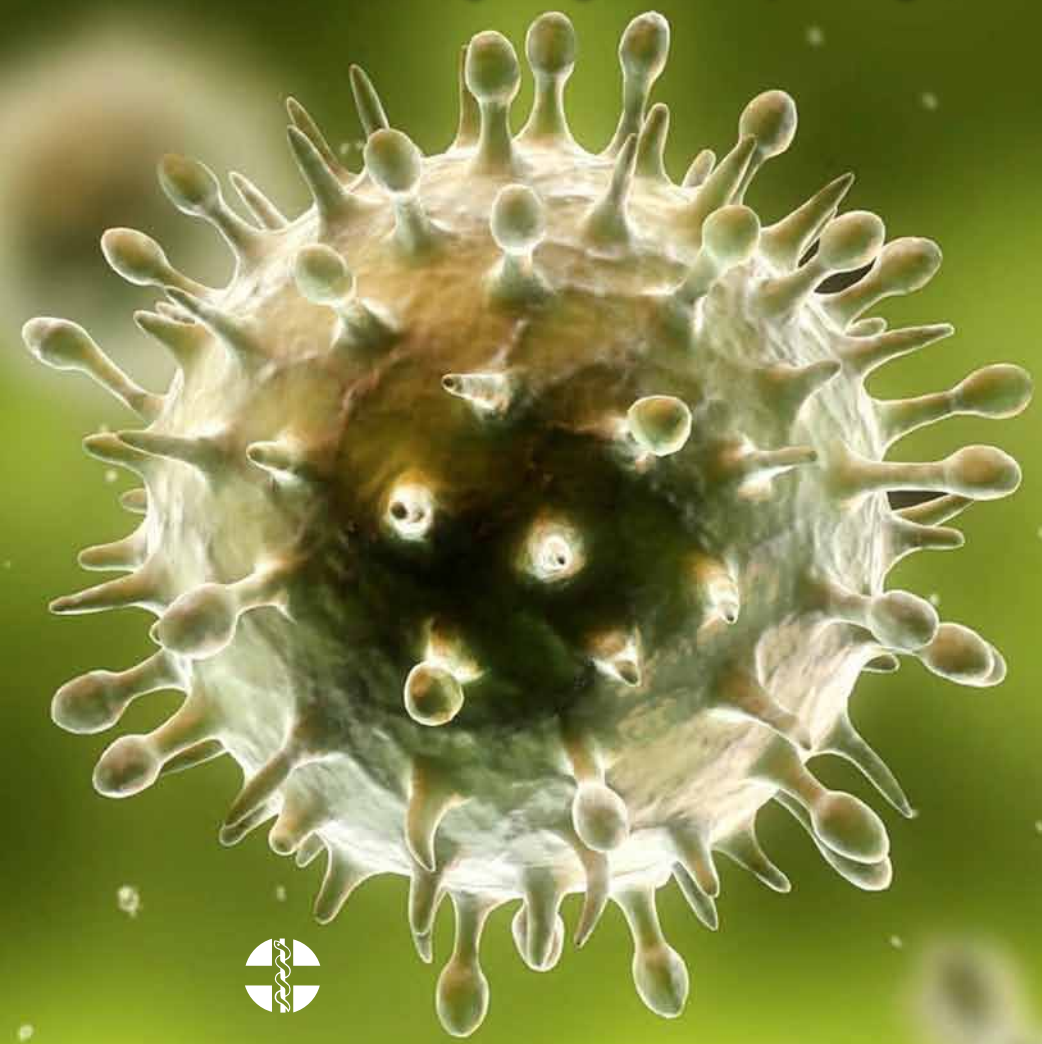
Here come the bugs

Doctors lead fight against superbugs, measles, flu, pp6-9



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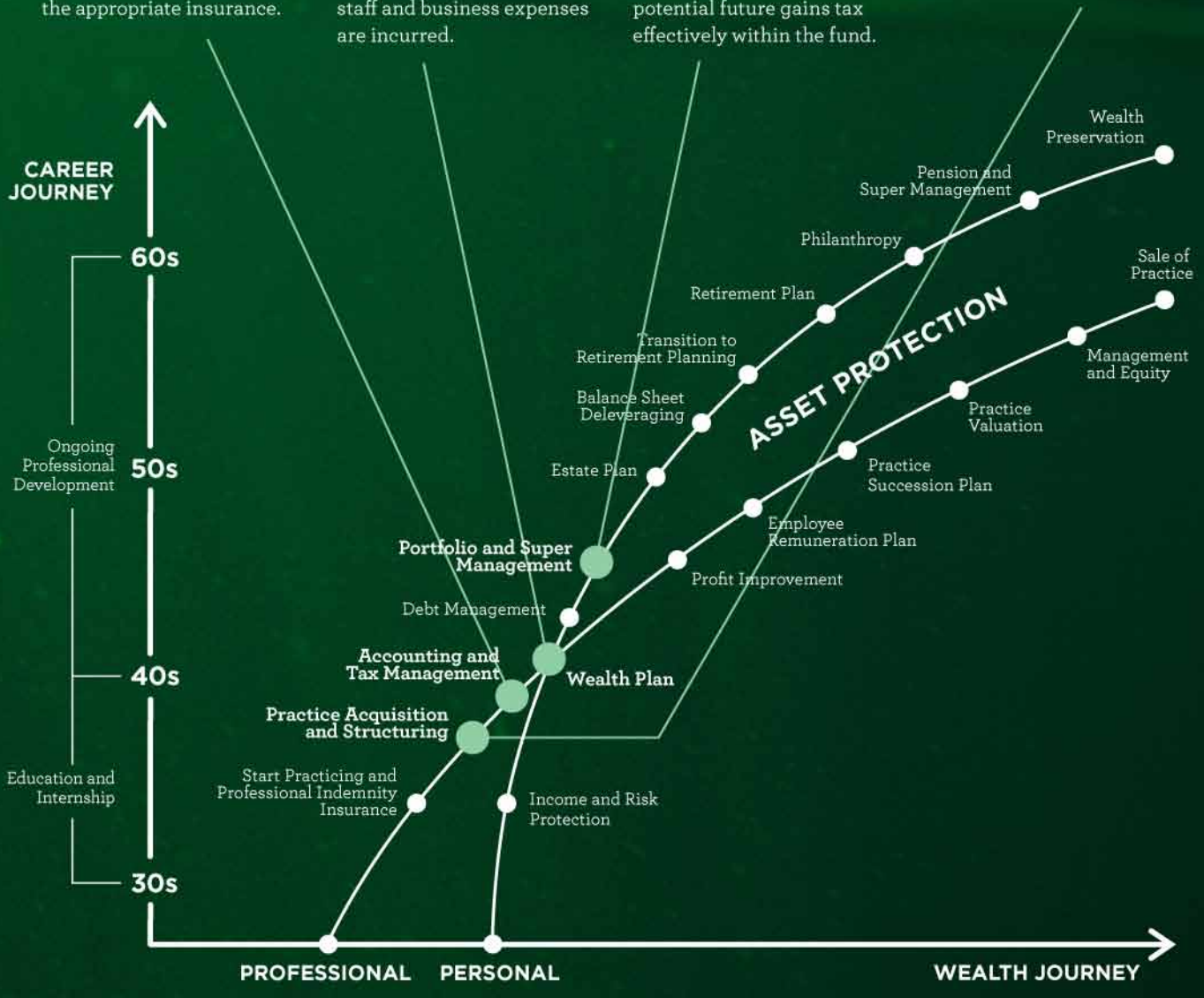

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REGULAR FEATURES

Hospitals on the edge - or over it?

BY AMA VICE PRESIDENT PROFESSOR GEOFFREY DOBB

Over the last few months several of my columns for *Australian Medicine* have reflected on innovations from the British National Health Service (NHS) that have been introduced to Australia.

The Australian and British health systems have many similarities, not least of which is the position of general practice as the foundation of medical care. But there are also many important differences.

The fundamental differences certainly haven't prevented concepts such as the four hour rule for emergency departments and elective surgery targets being introduced, arguably with benefits to patients' experience of health care.

However, a report from the Royal College of Physicians in London, *Hospitals on the edge? The time for action,* suggests that the real state of affairs within the NHS is not as rosy as many would wish.

The report received remarkably little coverage in Australia, perhaps because it makes for fairly solid reading, and any relationship to Australia's hospital system is unclear.

The report has some factual background: the UK has 2.4 acute hospital beds for every 1000 people; 65 per cent of hospital admissions involve patients 65 years and older; and patients older than 85 years account for 25 per cent of bed days.

They've had a 37 per cent increase in emergency hospital admissions over the last 10 years; the largest volume of hospital clinical activity at weekends is associated with emergency medical admissions; and when the Royal College of Physicians did a snapshot survey in 2010, the most senior medical cover in 63 medical teams at night was a doctor in their first two years after graduation.

"Any politician who doesn't understand that cuts to health budgets will impact on frontline services is living in dreamland"

The challenges facing acute hospitals were identified as:

- increasing clinical demand;
- changing patients and their changing needs, related to an ageing hospital population;
- fractured care, with loss of continuity of care because movement between inpatient units and rostering arrangements (this was identified by doctors as their biggest concern);
- breakdown of after hours care, with weekend emergency admissions experiencing a 10 per cent increase in mortality; and
- a looming crisis in the medical workforce, with those involved in acute medical services coming under increasing pressure, and over a quarter of medical registrars reporting an unmanageable workload.

It would be interesting to see what a similar review in Australia might turn up, because these issues appear to be affecting UK health outcomes.

More recently, the Francis Report into the Mid Staffordshire NHS Foundation Trust received massive media attention in the UK, and was covered in *Australian Medicine* (see *Hundreds die as budget targets come before patient care,* 25 Feb 2013 http://ausmed.ama.com.au/hundreds-die-budget-targets-come-patient-care).

As long ago as 2001 the first signs of problems with clinical outcomes in Mid Staffordshire became public with publication of standardised hospital mortality ratios (SMRs) for 1998-99. Mid Staffordshire had SMRs that were above the 95 per cent confidence limit all the way from then through to 2007-08.

In 2007, the Trust's Medical Director asked the Royal College of Surgeons to review surgical outcomes. The report was highly critical, but the College's recommendations were not followed up or implemented.

Instead, activity was directed towards re-coding in ways that would favourably affect SMRs, and questioning of the validity of SMRs as an outcome measure.

In 2009, a follow-up review by the College of Surgeons found the surgical service was "inadequate, unsafe, and at times dangerous".

In February 2010, the first report by Robert Francis found appalling failures in patient safety and care caused by inadequate training of staff, staff cutbacks and over-emphasis on government targets by senior management of the Trust.

The latest Francis report is from the public inquiry into the problems that were identified.

The lessons from this report should be recognised by all involved in Australian health care, and particularly governments and bureaucracies, because many of the pressures now being placed on our hospital system are all too similar.

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World faces 'catastrophic threat' from superbugs

Australian experts have added their weight to global warnings that antibiotic resistance poses a "catastrophic threat" that could make even minor and routine operations deadly.

Australasian Society for Infectious Diseases President, Associate Professor David Looke, has joined with several other infectious disease experts in urging doctors and governments to re-regulate the use of antibiotics if the nation and the international community are to avoid a "plague" of multi-drug resistant bacteria.

"Unfettered use [of antibiotics] in both humans and animals has seen rates of antimicrobial resistance rise alarmingly, especially in the developing world," said Associate Professor Looke and co-authors in an editorial in the *Medical Journal of Australia*. "It is now estimated that up to 200 million people in India may harbour gram-negative bacteria that carry the New Delhi metallo-beta-lactamase enzyme that renders the bacteria virtually untreatable."

Their warning came soon after England's Chief Medical Officer Professor Dame Sally Davies captured international attention with dire predictions that unless urgent action is taken to tighten infection controls and curb antibiotic use, basic medical procedures could soon become potentially deadly.

In her annual report to the British Government, Dame Sally said humanity risked losing the war against disease unless greater care and effort was expended regarding the use of existing antibiotics and the development of new drugs.

"Antimicrobial resistance poses a catastrophic threat," Dame Sally said. "If we don't act now, any one of us could go into a hospital in 20 years for minor surgery and die because of an ordinary infection that can't be treated by antibiotics.

"New infectious diseases are emerging every year, and older diseases which we managed to control are re-emerging as they become resistant to our antimicrobial drugs."

Dame Sally lamented a "discovery void" in the development of new antibiotics in the last 20 years.

"Resistance of micro-organisms to our drugs is increasing, and organisms are emerging with resistance to a wide variety of agents, rendering them ineffective, so we risk losing the 'war'," she said. "The supply of new replacement antimicrobial agents has slowed dramatically, and we face the prospect of a future where we have far fewer options in the treatment of infectious disease."

Underlining the extent of the problem, the US Centers for Disease Control and Prevention (CDC) reported a steady increase in the prevalence of carbapenem-resistant Enterobacteriaceae (CRE) infections, associated with high mortality, in the past decade, mostly in hospitals.

The US agency said that although the distribution of CREs was currently limited, they can spread rapidly in health care settings, have mortality rates close to 50 per cent, and pan-resistant strains have been reported.

About 4 per cent of US acute care hospitals and 18 per cent of long-term acute care hospitals have reported CRE infections, and the CDC cautioned that although they remained relatively uncommon in most areas, "CRE[s] could spread into the community among otherwise healthy persons".

Associate Professor Looke and his colleagues said doctors, governments and the community had to act to control the threat posed by superbugs, including through more prudent use of antibiotics and improved infection control measures.

"We need to be brave enough to make difficult decisions to re-regulate antibiotics," they wrote. "Without intervention, many of the greatest advances in the practice of medicine – such as transplantation, joint replacement surgery or critical care medicine – will be under significant threat."

Their call was echoed by Britain's Chief Pharmaceutical Officer, Dr Keith Ridge, who has warned of the need for judicious use of antimicrobials to preserve their effectiveness.

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World faces 'catastrophic threat' from superbugs

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Dr Ridge said multi-drug resistance was accumulating in gram-negative species in Europe, and particularly in India and China, where cephalosporin resistance in E. coli had reached as high as 80 per cent.

"This cephalosporin resistance drives use of carbapenems, which previously were reserved [for use as a last resort antibiotic]," he wrote in a chapter in Dame Sally's report. "This, in turn, is selecting for carbapenem-destroying enzymes. Very few antibiotics remain active against carbapenemase producers, and those that do have toxicity or limited efficacy."

Dr Ridge said the rise of these carbapenemase producers posed a much more serious challenge than MRSA, and there was little in the way of new medicines to fight it.

"There are only five new antibiotics in the potential drug pipeline that will help combat multi-resistant gram-negative bacteria, and none of these is a new type or class of antibiotic," he wrote.

The results of a study into the effectiveness of steps to control the use of antibiotics at Melbourne's Alfred Hospital, reported in the *MJA*, provide some grounds for hope.

The study, led by Associate Professor Allen Cheng, deputy head of the infection prevention and epidemiology unit at The Alfred, found that the introduction of an antimicrobial stewardship program led to an immediate 17 per cent drop in the use of broad-spectrum antibiotics in intensive care, and a 10 per cent fall in their use in other areas of the hospital.

But Associate Professor Cheng and his study co-authors said that because the program required a full-time pharmacist, supported part-time by infectious disease physicians, it could only be sustained if there was an on-going commitment to provide the necessary resources.

They warned that without this, the gains made would soon be lost.

"Concerningly, in the ICU, we found some evidence of a rebound in the overall use of antimicrobials and, specifically, in the use of carbapenems, fluoroquinolones and glycopeptides," the study authors wrote. "Further work is required to improve the quality of prescribing."

Dr Ridge said use of antibiotics could also be "radically" improved by speeding up the process of identifying pathogens.

Traditionally, it can around 48 hours to identify the infection, during which time antibiotic therapy is 'blind', and the tendency is to over-treat through the use of broad spectrum antimicrobials, to prevent the under-treatment of a few, Dr Ridge said.

He said the development of techniques to identify pathogens without the need to develop culture held out the promise of much shorter periods of diagnosis, which could dramatically cut the use of broad spectrum antimicrobials.

Dame Sally and Dr Ridge also recommended improved government support and incentives to encourage the development of new antibiotics.

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Noose tightens for anti-vax group

The New South Wales Government has stepped up the pressure on an anti-vaccination lobby group amid concerns its campaigning has undermined public health.

The NSW Minister for Fair Trading Anthony Roberts has rejected five names proposed by the Australian Vaccination Network (AVN) after it was ordered to change its title or face deregistration.

Among the names rejected by Mr Roberts were the Australian Vaccination Information Network and Australian Vaccination Choice.

Mr Roberts told the *Daily Telegraph* the proposed names did not reflect the organisation's anti-vaccination stance, which he said was unbalanced and not based on medical evidence.

The organisation had until 21 March to make an acceptable name change or be de-registered.

The campaign group could also finds itself in the cross hairs of NSW's Health Care Complaints Commission (HCCC) after it was given new powers to initiate investigations.

In 2010 the HCCC publicly condemned the AVN for promoting incorrect and misleading information about vaccination, but its ruling was quashed by the NSW Supreme Court, which found that it had exceeded its authority in launching an investigation without a specific case of poor patient care.

But earlier this month the NSW Parliament passed legislation that would allow the HCCC to launch investigations on its own cognisance where it believed a significant issue of public health or safety was involved.

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Chiropractor accreditation from anti-vaccination campaigner

Revelations that chiropractors are getting accreditation points for attending a course run by an anti-vaccination campaigner have highlighted concerns about the regulation of the profession.

AMA President Dr Steve Hambleton has expressed alarm that the Chiropractic Board of Australia (CBA) approved an eight-hour course called the Science of Immunology and Vaccination to count towards the profession's annual 25-hour continuing professional development (CPD) requirement.

The course, run by US-based chiropractor Tim O'Shea, promises participants will "learn why more and more parents are opting out of vaccines these days [and] why the response is an increasingly hysterical marketing of vaccines".

In his book *The Science of Immunology and Vaccination*, Mr O'Shea claims vaccines are the "proven cause of [making] over one million children hypersensitive to peanuts", and condemns the "shaken baby industry [as] a possible cover-up for vaccine injury".

The *Sydney Morning Herald* revealed earlier this month that the Chiropractic Board had outsourced approval of CPD courses for chiropractors to the Chiropractors' Association of Australia, which in turn claimed to have assessed and approved Mr O'Shea's course.

Dr Hambleton said the incident showed the Board was failing in its duty to protect the public.

"The Chiropractic Board's primary role is not to promote the profession, it's to protect the public, and they should step up and make sure they do that," he told the *Sydney Morning Herald*.

Dr Hambleton said there had been concerns at the time that including chiropractic in the 14 areas of medical practice overseen by the Australian Health Practitioner Regulation Agency could lend legitimacy and weight to unscientific treatments.

"Each profession will be judged by its weakest link, and that's why we had concerns about adding potentially unscientific professions, and having them given the imprimatur of nurses and doctors," he said.

Dr Hambleton said it was particularly concerning if chiropractors were working on young children.

The AMA President said that although there was "some evidence" that chiropractic could help adults with musculoskeletal conditions such as back pain, its use on very young children was cause for alarm.

"There is some evidence it can be of value there [on adults with musculoskeletal complaints], and I'm not concerned if [a GP] is confident they are providing good care," Dr Hambleton told the *SMH*. "But the fact that zero to four [year olds] is a growth area raises very serious concerns".

"There is evidence that it can be dangerous, and manipulation in particular is a sharp, short movement that can actually lead to adverse outcomes," he told Channel Seven's *Today Tonight* program.

The Chiropractic Board told the news website *Six Minutes* that it had been unaware of Mr O'Shea's course, and had launched an investigation because vaccination was not within chiropractic's scope of practice.

"The Board is looking at how this happened, and what might need to change in the future in order to keep the public safe," a Board spokeswoman told *Six Minutes*.

The Chiropractors' Association of Australia (CAA) announced that it supported the investigation by the Chiropractic Board.

A CAA board member, Dr Tony Croke, told the *SMH* chiropractors undertook five years of university study to become accredited, and he did not meet chiropractors who were anti-vaccination.

"The Chiropractors' Association of Australia's stance on that is really clear … and that is for any medicine, whether it's a vaccine or blood pressure medication or anything, we recommend people go and talk to their GP and make an informed choice," he said.

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Spotty immunisation rates raise disease risk

AMA President Dr Steve Hambleton has warned the nation faces the threat of sustained measles outbreaks because of mounting objections to immunisation in pockets of the community.

Speaking as infection disease experts met in Canberra last week to discuss emerging threats, Dr Hambleton told ABC radio that campaigns by anti-vaccination groups were undermining efforts to rid the country of serious diseases such as measles.

The AMA President said measles was a highly contagious and potentially deadly infection, and a recent outbreak in New South Wales showed that claims it had been eliminated from the country were premature.

"Our elimination status is under threat because there are pockets of decreasing immunisation of our children," Dr Hambleton said. "And it's northern New South Wales, it's south-east Queensland, where immunisation rates are dropping because of conscientious objectors, and because of people actively working against immunisation."

Groups campaigning against immunisation have claimed that vaccines are linked to autism and other adverse outcomes in children, though a 1998 study that allegedly showed a vaccine for measles, mumps and rubella could cause autism has since been discredited.

The Australian Academy of Science has published a booklet *The Science of Immunisation: Questions and Answers*, to dispel myths and misinformation about the dangers of vaccination.

Government figures show that rates of immunisation overall remain high, though there is concern that in pockets of the population where they have dropped there will be a sufficient pool of vulnerable children to feed a sustained outbreak.

Dr Hambleton warned that "we will see outbreaks in areas where immunisation rates are falling, and they will be sustainable, and we'll have to close schools, we'll have all sorts of things that we'll need to do to actually decrease and stop these outbreaks".

Underlining the highly infectious nature of measles, research was presented at an Australasian Society of Infectious Diseases conference showing that it could be easily transmitted by an infected person arriving from overseas.

The study showed that anyone travelling on an aeroplane with a person infected with measles was vulnerable to catching the disease.

The study found that measles transmission occurred on 19 per cent of international flights where there was an infected person, and "risk was not clearly related to seating proximity".

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A jab the only real protection from the flu

People are being urged to get an influenza vaccination as soon as possible amid concerns the nation could be hit by a severe outbreak of the disease following a killer season in the United States and Europe.

Chair of the Influenza Specialist Group Dr Alan Hampson said there had already been an "unusually high" number of influenza cases so far this summer, and people should act now to protect themselves and those around them from the potentially deadly disease.

Dr Hampson said 87 children in America had died as a result of complications after being infected with the flu, and New York was plunged into a state of emergency in January by the diagnosis of more than 19,000 cases – five times the number recorded in 2012.

"The flu virus struck hard and early in the Northern Hemisphere winter, and has spread quickly," he said. "While the timing of the main influenza outbreak in Australia is unpredictable, we could well follow the same trend."

The flu vaccine for 2013 has been formulated to include the H3N2, H1N1 and B viruses, which are closely related to those experienced in the recent Northern Hemisphere winter.

Flu vaccinations are free for pregnant women, the elderly, and those suffering asthma, respiratory problems, heart and kidney disease, and diabetes.

Dr Hampson said no amount of vitamin supplements would provide protection from the infection, and the single best preventive measure that could be taken was vaccination.

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New front opens in Defence contract battle

A shortage of accredited supervisors may be compromising the training that Australian Defence Force medical officers receive, potentially undermining the safety and quality of services.

The AMA has learnt that several civilian accredited supervisors who have worked with the ADF for many years have refused to accept controversial contractual terms offered under the new arrangements put in place by Medibank Health Solutions, undermining the training of Defence Force GP registrars.

In a sign that the standoff between MHS and specialists over ADF medical service contracts is now starting to affect the training and supervision of ADF GP registrars, practitioners and regional training providers have contacted the AMA to warn there has been a loss of accredited supervisors.

In the absence of properly qualified supervisors, ADF health facilities face the prospect of losing their training accreditation, increasing the challenge for ADF GP registrars in satisfying their training requirements.

In addition to the loss of accredited supervisors, there is concern that new contracts for Defence Force GPs focus on service delivery rather than training and supervision.

The AMA understands these issues have been raised with the ADF's Joint Health Command, but have yet to be resolved.

The Association warned that if the problem becomes widespread, it could leave many registrars in the difficult position of failing to satisfy relevant College training requirements – which is already challenging for ADF GP registrars because of the complex environment in which they work.

A *Medical Journal of Australia* study published two years ago found that those undertaking military medical training faced a "complex array" of military and civilian primary health training programs that were conducted concurrently, often with little coordination between them.

According to the study, registrars received "variable support" from their ADF and civilian supervisors, who often struggled to understand their counterpart systems. Their training was further complicated by regular overseas postings, and the need to adapt to working in a military primary health care setting rather than in a civilian hospital-based system.

The AMA said that, given these existing training challenges, the last thing ADF GP registrars needed was uncertainty about the availability of accredited supervision.

The Association warned the issue had the potential to compromise patient safety and quality of care, and has sought clarification from both MHS and General Practice Education and Training about the extent of the problem, and action being taken to address it.

MHS, which is Medibank Private's health provider offshoot, last year won a $1.3 billion, four-year contract to provide on-base health services to 80,000 ADF personnel and their families.

An AMA survey of members has found widespread objection among practitioners to the terms offered by MHS to be recognised as a preferred specialist provider.

The AMA found that less than one in 10 specialists had accepted the MHS offer, which involved a dramatic cut in fees, onerous reporting requirements and compromised referral authority.

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Time to bring energy drinks into line

AMA President Dr Steve Hambleton has intensified his call for tougher regulation of energy drinks following evidence that they are rapidly overtaking soft drinks in convenience stores and supermarket sales.

Industry figures show energy drink sales are growing by more than 8 per cent a year, and in convenience stores they made up more than 35 per cent of all beverages sold last year – outstripping soft drinks at 31.5 per cent.

Dr Hambleton said that if energy drinks were going to continue to be sold alongside soft drinks in supermarkets, service stations and convenience stores, then they should be subject to the same regulations, including lower caffeine content.

Under Food Standards Australia New Zealand regulations, the caffeine content of soft drinks cannot exceed 145 milligrams per kilogram, while for energy drinks the maximum caffeine or caffeine equivalent that they can contain is 320 milligrams per litre.

"If they are being sold like soft drinks, then regulate them like soft drinks and bring the caffeine content down," Dr Hambleton told the *Sunday Age*. "Or, if they are, as manufacturers say, only suitable for adults, then sell them in outlets that are only accessible to adults."

The AMA President said energy drinks contained enormous quantities of caffeine, and caused cardiac and neurological side effects in some users, particularly children and teenagers.

A study found there has been a big jump in calls to the NSW Poisons Information Centre regarding the consumption of energy drinks. There were almost 300 such calls to the Centre between 2004 and 2010, of which at least 128 resulted in hospital admission.

Overseas, the US Food and Drug Administration is investigating a series of deaths and illnesses linked to energy drinks.

While concerns about the health effects of energy drinks are growing, so are their sales.

A report by Commonwealth Bank of Australia has found that not only are energy drinks increasingly outselling soft drinks, they are delivering a much better profit margin.

It is a combination that the Australasian Convenience and Petroleum Marketers Association (ACPMA) said made them "highly attractive to stock and sell".

In its report, the Commonwealth Bank predicted energy drinks, which made up 6.7 per cent of all beverages sold in supermarkets in 2010, will jump to 14.5 per cent by 2020.

In a provocative analysis, the ACPMA likened energy drinks to tobacco, in that both carry health warnings, have high turnover and higher gross profits compared with other products, and it warned retailers of the need to exercise care if they were to ward off increased government regulation of their marketing.

Association Chief Executive Officer Nic Moulis warned his members that, given the health concerns linked to energy drink consumption, it was "only time before the Government would try to get involved by taxing, regulating labelling or controlling the sale of these products".

"As an industry, we can put this off if we self-regulate, by making people aware of the fact," Mr Moulis advised. "It is a fine line because we don't want to annoy people, or tell them what they should do.

"We also don't want people to stop buying energy drinks, we just want to provide the public with the information they need to make their own decision."

But the AMA has warned that self-regulation in the alcohol industry has failed, and there are concerns that relying on self-regulation by energy drink retailers will be similarly ineffective, and instead the Government must step in and make energy drinks subject to the same regulations as soft drinks.

The Legislative and Governance Forum on Food Regulation (formerly the Australia New Zealand Food Regulation Ministerial Council) has ordered a full review of policy guidelines on caffeine, and is awaiting advice from the Intergovernmental Committee on Drugs regarding the mixing of energy drinks with alcohol.

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Hospital tax concession changes could undermine health

The AMA has warned that any move to tighten tax concessions for public hospitals and charities could leave vulnerable communities without adequate medical care.

AMA President Dr Steve Hambleton and Australian Salaried Medical Officers' Federation President Dr Tony Sara told Assistant Treasurer David Bradbury during a meeting on 18 March that tax concession changes for the not-for-profit sector could undermine the ability of public hospitals to attract and retain medical staff, undermining care and potentially crippling training.

Dr Hambleton and Dr Sara told the Minister that public hospitals, particularly those in rural and regional areas, relied on not-for-profit sector tax concessions to be able to offer staff competitive salary packages and work benefits.

"The current system supports the recruitment of staff in institutions that would not otherwise be able to compete against the income available in the private sector," they told the Minister. "Collective agreements have been structured accordingly, with their negotiation taking into account the benefits of salary packaging.

"In the absence of additional Government funding, public hospitals would not have the funds to compensate staff for the loss or curtailing of salary packaging arrangements."

The medical leaders met with Mr Bradbury ahead of the completion of a report by Federal Treasury's Not-for-profit Sector Tax Concession Working Group, which was formed last year to review the entire range of tax concessions provided to the not for profit sector and suggest reforms.

In a joint submission to the review last year, the AMA and ASMOF argued that the current framework of tax concessions for the NFP sector had developed over 25 years and reflected good public policy, enabling public hospitals and the charitable sector to offer competitive employment conditions for medical staff.

The submission warned that the review was particularly important to salaried doctors working in the public hospital and charitable sectors, as it has the potential to affect the salary packaging arrangements that helped support their recruitment and retention.

Dr Hambleton and Dr Sara told Mr Bradbury that the review needed to proceed with caution and take into account potential adjustment costs of any diminution in tax concessions, as well as the downstream effects on access to services, patient care, teaching, training and research.

The ability to supervise and train the existing number of junior doctors may be compromised if senior doctors devote less time to the public system as a result of any changes, eroding the capacity of our public hospital system to teach and train the next generation of medical practitioners, they told the Minister, adding that "regional public hospitals will be particularly susceptible [because] they are extremely reliant on salary packaging to attract visiting and locum medical staff".

In their submission to the review, the AMA and ASMOF pointed out that the ability to attract visiting and locum staff was essential for regional hospitals in providing a break for local medical staff.

"If this is disturbed there is a significant likelihood that, not only will these hospitals struggle to attract visiting and locum medical staff, they will also struggle to recruit and retain medical practitioners in general due to concerns over workload and the potential for burn out," the submission said. "This may leave vulnerable individuals and communities without quality ongoing health care."

> "… the ability to attract visiting and locum staff was essential for regional hospitals in providing a break for local medical staff"

Mr Bradbury told Dr Hambleton and Dr Sara that the review was yet to report to the Government, and the Government was yet to move forward on any policy proposals.

The Assistant Treasurer committed to further consultation with the AMA and ASMOF, and Dr Hambleton said the AMA would continue to talk with the Government to ensure that any reforms to not-for-profit sector tax concessions do not unfairly penalise doctors or undermine the ability of hospitals and charities to recruit and retain medical staff.

The AMA submission to the review can be viewed at: https://ama.com.au/amaasmof-submission-tax-concessions-nfp-sector

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Health gap narrowing, but not yet closed

Governments must commit to a long-term plan on Aboriginal and Torres Strait Islander health to build on gains already made in reducing child mortality and improving chronic disease care, according to the AMA.

AMA President Dr Steve Hambleton used National Close the Gap Day 2013 to call on Federal, State and Territory governments to renew their commitment to closing the gulf in health outcomes between Indigenous Australians and the rest of the community.

Dr Hambleton said the governments should agree on a five-year strategic plan that tackled outstanding areas of health disadvantage, including elevated Aboriginal and Torres Strait Islander child mortality and lower life expectancy.

The existing Council of Australian Governments National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes expires this year, and the AMA President said a fresh commitment was needed to ensure recent gains were not lost, and further progress was made.

Mr Hambleton said that, under the current Agreement, the nation was on track to halve mortality rates for Aboriginal and Torres Strait Islander children younger than five years, there had been a significant improvement in the access of Indigenous people to chronic disease health services, work was underway in partnership with Aboriginal and Torres Strait Islander peoples to develop a long-term health plan, and targets for access to early childhood education in remote communities had been met.

"The momentum of goodwill and tangible action to close the gap must continue and grow, so that we can build on these significant achievements," Dr Hambleton said.

He said the next five-year strategic plan must include action to address the causes of elevated Indigenous child mortality and lower life expectancy, the development of a funding strategy based on a fair share of public health resources, improved coordination between national and regional initiatives, and a binding commitment to a concrete and practical implementation plan.

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AMA to help shape the future of Medicare

AMA President Dr Steven Hambleton has been appointed to help advise the Federal Government on the delivery of essential health and welfare services in coming decades.

Dr Hambleton is among 17 health, welfare and IT experts who have been enlisted to form a Council on Strategy and Innovation, set up to advise the Government on strategies, innovations and research to guide development in the delivery of services such as those provided by Medicare and Centrelink.

Human Services Minister Senator Kim Carr said work needed to begin now on ways to change and improve the delivery of Government services in coming decades as the scope and scale of demand increased.

"In less than 15 years, Australia's population is projected to be about 28 million people, and every single one of them will use the services provided by the Department of Human Services," Senator Carr said. "When they visit the doctor, look for a job, start a family, or are affected by a natural disaster, the Department's agencies, such as Medicare and Centrelink, will be serving them."

Senator Carr said the Government's current reform agenda to improve the delivery and accessibility of services had just two years to run, and work needed to begin now on what would come after.

"So that we can continue to innovate and be more effective, we are now bringing together people with diverse expertise to help us shape the agenda for the next 10 years and beyond," the Minister said.

Alongside Dr Hambleton, the Council will include a range of representatives and experts from health, welfare and digital technology, including Dr John Falzon of the Society of St Vincent de Paul, Dr Megan Clark from CSIRO, Martin Stewart-Weeks from software giant CISCO, Professor Adam Graycar from the Centre for Public Innovation, Carol Bennett from the Consumer Health Forum and Gerd Schenkel from Telstra Digital.

Senator Carr said the Council faced a huge task in working out how to best use emerging technologies, including more systematic collection of data from service users.

"The challenge is enormous," he said. "We don't know exactly what kinds of technology will be available in 10 or 20 years, but we need to consider how new technologies can be adapted and used to improve services."

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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

Standards for doctors, *The Age,* 14 March 2013

New Zealand's former health watchdog claimed up to 1000 doctors in Australia could be failing to meet acceptable standards of practice and Australia's regulation system needed to change, including the introduction of revalidation. But AMA President Dr Steve Hambleton said he was unclear what purpose revalidation would serve, and suggested regulation could be improved through better use of existing mechanisms.

Coalition 'will abolish' all Medicare Locals, *The Australia*, 14 March 2013

The Coalition has announced it would abolish Medicare Locals in favour of new links between GPs and public hospitals. The AMA has urged the Coalition not to abolish Medicare Locals just for the sake of it, and instead seek to use the structure to improve outcomes in primary care.

Jobs for foreign students, *The Adelaide Advertiser*, 16 March 2013

Prime Minister Julia Gillard has announced a crack down on 457 visas. AMA President Dr Steve Hambleton said the health system would crumble without the 475 visa workers, with rural and remote regions, in particular, relying on overseas doctors.

Radio

Dr Hambleton, Radio National Canberra, 18 March 2013

A recent study into a Northern Territory health program has found it has cut the prevalence of the hookworm parasite in Indigenous populations. AMA President Dr Steve Hambleton said the results were encouraging, but added it was disappointing the infection still existed in Indigenous communities.

Dr Hambleton, 3AW Melbourne, 19 March 2013

AMA President Dr Steve Hambleton discussed whether a 'do not resuscitate' tattoo is enough to stop paramedics from reviving a person.

Dr Hambleton, Radio National Canberra, 20 March 2013

AMA President Dr Steve Hambleton discussed measles and the impact it can have on families. He said that the progress Australia has made in eradicating this disease was under threat, largely because of anti-vaccination campaigns.

TV

Dr Hambleton, Today Tonight, 20 March 2013

AMA President Dr Steve Hambleton spoke out about children and babies receiving chiropractic care. He said there was evidence chiropractic work can be dangerous, despite chiropractors claiming their techniques can help treat behavioural disorders and pain and improve general wellbeing.

Dr Hambleton, Today Tonight, 15 March 2013

The Medical Board of Australia has started formal discussions on revalidation with doctors. AMA President Dr Steve Hambleton said he was not sure revalidation was the correct process to monitor doctor performance.

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AMA in action

AMA President Dr Steve Hambleton spent the majority of his fortnight in Canberra rubbing shoulders with politicians and meeting with the senior officials of other medical associations. Dr Hambleton and Australian Salaried Medical Officers' Federation President Dr Tony Sara met with Assistant Treasurer David Bradbury to argue that public hospitals should retain tax concessions enabling them to provide competitive salary packages to doctors. The AMA President also had dinner with Shadow Health Minister Peter Dutton.

Dr Hambleton participated in the Breathing New Life into General Practice leaders' forum hosted by General Practice Registrars Australia, and was joined by Professor Richard Murray, President of the Australian College of Rural and Remote Health, Dr Patricia Baker, Chair of the National General Practice Supervisor's Association, Dr Liz Marles, President of the Royal Australian College of General Practitioners, Dr Ian Kamerman, Vice President of the Rural Doctors Association of Australia, and Sharon Flynn, Chair of the Association of Chief Executives of Regional Training Providers.

Dr Hambleton also met with Dr Graeme Killer, the Principal Medical Adviser to the Repatriation Commission, and the Commission's Primary Health Group National Manager Judy Daniel, and found time to attend AMA Queensland Foundation's 'Thank you to Donors' event, which officially relaunched the new-look AMA Queensland Foundation.

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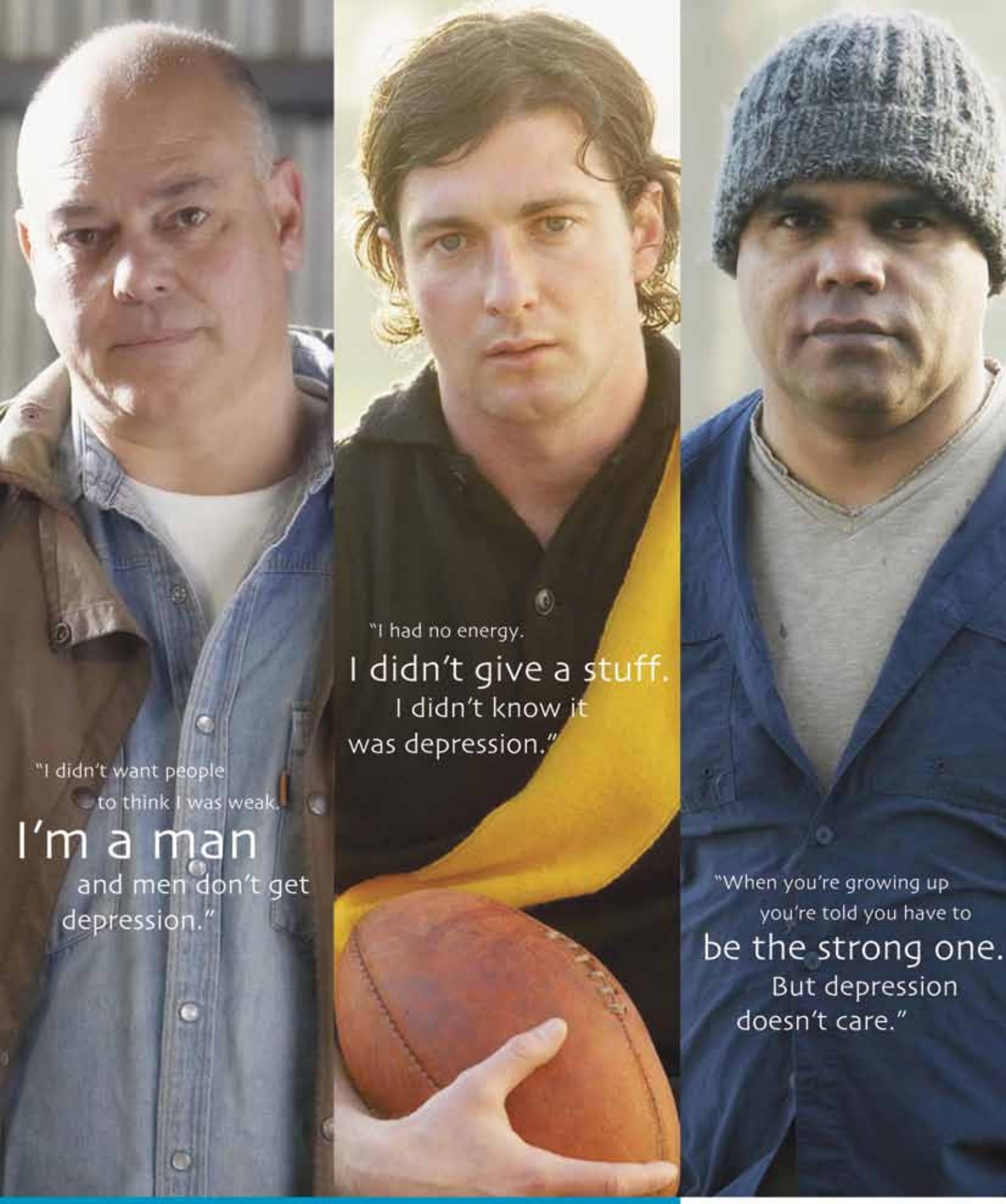
(L to R) Colleen Harper, Katharine Philp, Dr Hambleton, Jane Schmitt, Dr Alex Markwell, Ross Noye, Lisa Story and Tim Fairfax

AMA President Dr Steve Hambleton (centre) with other Breathing New Life into GP leaders' forum participants

AMA President Dr Steve Hambleton(right) with David Bradbury MP and Dr Tony Sara

Dr Hambleton (right) with Dr Graeme Killer and Ms Judy Daniel



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Hospitals on the edge - or over it?

...CONTINUED FROM PAGE 5

Staff cutbacks and emphasis on government targets are starting to have a familiar ring. While Francis doesn't over-emphasise the financial pressures on the Mid Staffordshire Trust, a need for the Trust to save money fast to meet its budget targets was probably one of the root causes behind poor clinical performance.

Francis described "a culture focussed on doing the system's business, not that of the patients".

The Francis report provides a case study of what can go wrong when hospitals' culture doesn't focus on quality health care.

Any politician who doesn't understand that cuts to health budgets will impact on frontline services is living in dreamland.

While there may be scope for improvements in productivity, in health care these are limited.

The evident outcome is simple: less can be done at the same quality or – unacceptably - the same or more can be done at lower quality, with the outcomes seen in Mid Staffordshire.

If there isn't the money to meet Australia's health care needs, as recent budget cutbacks imply, it's time the politicians came clean.

The implications are reduced access - rationing - or greater costs at the time of health care delivery to the individual.

Health care funding will be one of the topics at this year's AMA National Conference. Let the debate begin.

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GPs bulk billing at near record levels

General practitioners are bulk billing more than 80 per cent of services they provide, and those patients facing out of pocket costs pay an average fee of $27.70, Federal Government figures show.

According to the Department of Health and Ageing, there were almost 120 million GP services provided in 2012, and of these around 80.5 per cent were bulk billed.

Health Minister Tanya Plibersek said the figures showed that the Government was achieving its goal of ensuring that all Australian had access to quality and affordable health care.

"While bulk billing rates can fluctuate, the Government is pleased bulk billing rates for GP services have returned to record highs [of close to 82 per cent in the December quarter] set mid last year," Ms Plibersek said.

The data show that 76 per cent of all Medicare services delivered last year were bulk billed, ranging from almost 100 per cent of practice nurse items and optometry services, to 9 per cent of anaesthetic procedures.

The biggest out of pocket expenses were for obstetric services, where patients were charged on average $202, the figures showed.

Ms Plibersek highlighted that bulk billing rates for diagnostic imaging services remained at a record high of 74.5 per cent in the December quarter, and were at 88 per cent for pathology services.

Overall, there were 340 million Medicare services provided last year, costing more than $18 billion.

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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

GP clinics can ease pressure on emergency care

Locating general practice clinics at hospitals will do more to reduce the waiting time for emergency care than adding more emergency departments, a Monash University study has found.

In a timely report, the University's Centre for Health Economics found that co-located GP clinics cut emergency department (ED) waiting times by 19 per cent, while providing more emergency departments in an area actually added to the time emergency category 2 patients had to wait for treatment.

The lead author of the study, Dr Anurag Sharma, said the counter-intuitive finding showed that simply adding more EDs did not relieve the demand pressures many hospitals were experiencing.

Figures compiled by the Australian Institute of Health and Welfare show hospitals in most states and territories are struggling to cut emergency department waiting times, with more than a third of ED patients taking more than four hours to complete their visit – well short of the national target that at least 90 per cent of patients are to be admitted, transferred or discharged from EDs within four hours by the end of 2015.

"It was believed that by providing more emergency departments in a region, there would be more choice for patients, thereby reducing overcrowding and waiting times in emergency departments," Dr Sharma said. "However, our study found that more choice of emergency departments actually increased the waiting time for emergency category 2 patients, who are suffering from a critical illness or very severe pain and need urgent attention, as it generated more demand from non-urgent patients."

Instead, he said, co-located GP clinics provided an alternative place for non-urgent patients to be treated, freeing up EDs to concentrate on emergency cases.

Co-located GP clinics are special purpose services located near or adjacent to public hospital emergency departments, and provide acute, episodic primary care such as medical consultations, fracture management, and treatment of minor injuries and trauma.

Dr Sharma said diverting non-urgent patients to alternative care meant EDs had more resources for treating those who needed emergency care.

"Co-located GP clinics provide timely, safe and accessible services for patients seeking primary medical care outside business hours, and are a good alternative for patients who don't need urgent attention," he said.

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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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Fake puff could be deadly

Electronic cigarettes may leak lethal doses of nicotine, endangering users and those around them, especially children, the medicines watchdog has warned.

The devices, which are being marketed internationally as an aid in helping quit smoking, have not been approved for sale in Australia, and the Therapeutic Goods Administration has advised that their safety and efficacy is unproven.

"Some overseas studies suggest that electronic cigarettes containing nicotine may be dangerous, delivering unreliable doses of nicotine, or containing toxic chemicals or carcinogens, or leaking nicotine," the TGA said. "Leaked nicotine is a poisoning hazard for the user, as well as others around them, particularly children. Dangerous and lethal doses of nicotine can be absorbed through the skin."

The regulator said there was concern about the use of electronic cigarettes in Australia, particularly because almost nothing was known about what affect their wide scale use might have, warning "the outcome in the community could be harmful".

The TGA said that, unlike nicotine replacement therapy products - which had been rigorously assessed for their effectiveness and safety before receiving regulatory approval – the safety and efficacy of electronic cigarettes was yet to be tested.

The authority has warned that anyone considering buying and importing the devices, either for personal use or for commercial sale, faced having them seized because they were illegal.

"The importation and supply (including sale) of therapeutic goods is illegal in Australia unless authorised by the TGA. No electronic cigarette has been authorised by the TGA," it said, adding that some states and territories had laws prohibiting the marketing of products that resembled cigarettes or other tobacco products.

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Doctors get guide to venemous bites and stings

A comprehensive guide to help doctors accurately diagnose and treat venomous bites and stings has been developed.

Responding to doctor concerns that most victims cannot identify the creature that bit or stung them, BioCSL has produced a 330 page handbook – greatly expanded from its original 69-page edition – to provide practitioners with access to best practice diagnosis and treatment techniques for Australian venomous animals.

Each year there are more than 3800 hospital admissions from venomous bites and stings in Australia. One third of the admissions involve spiders, most commonly red back spiders, and 15 per cent of admissions involve venomous snakes.

BioCSL has released *A Clinician's Guide to Australian Venomous Bites and Stings: incorporating the updated CSL Antivenom Handbook*, designed to educate and provide emergency reference material to doctors.

Lead author and toxinologist Professor Julian White said the challenge doctors face is that most patients present with an unidentified bite or sting, and therefore require specific direction that allows them to better diagnose the venomous source and to treat it appropriately.

The authors worked with an expert panel to compile the latest diagnosis and treatment information to present it in a way that follows the normal steps a doctor would take in clinically managing a patient.

Associate Professor White said the updated diagnostic algorithms and flowcharts provide doctors with essential information to provide the best outcome in the treatment of envenomed patients.

BioCSL's Senior Vice President John Anderson said the handbook is a truly comprehensible catalogue for the identification, diagnosis and treatment for bites and stings. He said the handbook encompasses everything from basic first aid, to the specific and detailed best-practice treatment of even the less common land, marine and fresh water creatures.

Medical professionals can get a free copy of the handbook by emailing ih@biocsl.com.au and providing their postal address and AHPRA number.

KW

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Kids get heavy salt serve

Food marketed towards children continues to have too much salt in it, the consumer watchdog has found, with breakfast cereals and lunch box snacks among the worst offenders.

The results have prompted calls from health and nutrition experts for tougher controls on the food industry, as well as warnings for parents to look more closely at labels when they are shopping.

CHOICE reviewed the nutritional content of more than 240 products aimed at, or likely to be consumed by, children.

Using data provided by The George Institute for Global Health, it found that of the products reviewed, 20 per cent, or one in five, were classified as high in salt, nearly 60 per cent had medium levels and only 20 per cent were classified as low in salt.

Seventy two of the kids' products reviewed had more sodium than Smith's Original Chips.

The review found that high salt levels were not confined to savoury foods aimed at children, with some sweet snacks also containing considerable levels of sodium. A lunch-box pack of Tiny Teddies biscuits had 87 milligrams of sodium, compared with 91 milligrams of sodium in a lunch-box pack of Smiths Original Chips.

CHOICE food policy advisor Angela McDougall said children need very little salt to stay healthy, and should be eating much less of it than adults.

"Experts say the taste for salt is learned, and feeding children food that is high in salt is setting them up for a lifetime of poor and unhealthy habits," she said.

The survey found that of 36 breakfast cereals examined, 60 per cent had medium levels of salt, with Kellogg's Crispix Honey Cereal and Coles Rice Puffs having high levels.

Two-thirds of the 64 savoury snacks surveyed were high in sodium, with pre-packaged cheese dips and crackers the worst.

And about 80 per cent of 70 sweet snacks studied were found to have medium sodium levels.

Ms McDougall said it was also worrying that some kids' foods were being marketed as 'healthy' when they were not.

"Woolworths has launched a kids' range, and even though many of the products are in the health food aisle, some have more salt than the adult alternative," she said. "These organic products are marketed as a good choice for hungry little mouths yet many do not deserve this healthy halo."

The 2007 National Children's Nutritional and Physical Activity Survey found salt consumption among children aged two to 16 years was well above the recommended level.

Professor Bruce Neal from The George Institute for Global Health said salt was a leading cause of ill health in Australia, pushing up blood pressure from childhood.

"Recommended intake levels for children are much lower than for adults, so this data is very concerning," he said.

"This calls for much tougher action to control the food industry, so it is not profiting at the expense of our children's health."

CHOICE recommended that parents look carefully at food labelling and to remember that food located in the 'health' aisle many have just as much sodium, sugar or saturated fat as products in the rest of the supermarket.

DV

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Almost half of women not screened for cancer

Australia's breast cancer and cervical screening programs are reaching just over half of the women they seek to target, new figures show.

The Australian Institute of Health and Welfare (AIHW) has issued a web update with the latest national participation data for Australia's breast cancer and cervical screening programs for 2010 and 2011.

Under the screening program, women aged between 50 and 69 years are actively targeted by BreastScreen Australia for free mammograms every two years. In addition, although they are not actively targeted, all women aged 40 years and older are eligible to receive free mammograms.

Breast cancer was estimated to be the most common cancer diagnosed in Australian women in 2012, and was the second most common cause of cancer-related death in 2010.

The screening program aims to reduce illness and death from breast cancer by screening to detect cases of unsuspected breast cancer in women, enabling intervention at an early stage.

The AIHW report shows there has been little change in the number of targeted women being reached since the last study, and that the participation of Aboriginal and Torres Strait Islander women continues to lag behind the rest of the target population.

Just more than half (55 per cent) of women aged 50 to 69 years in Australia had a mammogram through BreastScreen Australia in 2010 and 2011, equating to almost 1.4 million women. The participation rate for Aboriginal and Torres Strait Islander women in the same age bracket was just 36.2 per cent or 12,000 women.

"In 2010 and 2011, participation rates for mammograms were highest in outer regional areas, at 59 per cent, but BreastScreen Australia also reached 46 per cent of women in very remote areas," said AIHW spokesperson Justin Harvey.

The web update also showed that under the National Cervical Screening Program, 57 per cent of Australian women in the target age group had at least one Pap test in 2010 or 2011.

"This led to the early detection of around 32,000 serious abnormalities, which may have otherwise led to cervical cancer," Mr Harvey said.

The National Cervical Screening Program recommends Pap tests every two years for women aged 18 to 20 years or older who have ever been sexually active—including women who have been vaccinated against the persistent human papillomavirus (HPV) infection.

Participation in cervical screening was similar across all areas, although slightly higher in major cities and inner regional areas than in other areas.

"Of the factors analysed, socioeconomic status appeared to affect cervical screening participation the most, with women living in areas of higher socioeconomic status more likely to screen," Mr Harvey said.

Australia also has a public screening program for bowel cancer, although its participation rates for 2010 and 2011 were not included in this web update.

DV

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Private health insurers' natural therapy rebates in the spotlight

BY **KEN HARVEY, ADJUNCT ASSOCIATE PROFESSOR OF PUBLIC HEALTH, LA TROBE UNIVERSITY***

This article first appeared in The Conversation on 8 March 2013, and can be viewed at: http://theconversation.edu.au/private-health-insurers-natural-therapy-rebates-in-the-spotlight-12706

Significant growth of natural therapy benefits subsidised by private health insurers, coupled with concerns about the poor evidence base for some of the services offered, has apparently resulted in the announcement of the Natural Therapies Review in the 2012-13 federal Budget.

Services subsidised under Medicare by health professionals regulated under the National Registration and Accreditation Scheme are not affected by this review.

Most Australians with private health insurance receive up to a 30 per cent rebate from the federal government.

This controversial policy was designed to encourage uptake, but it also gives the government responsibility for ensuring that benefits paid through the rebate are for services that have a credible evidence base.

As at 31 December 2012, 47 per cent of the Australian population had purchased a private health insurance product covering all or part of the costs related to hospital treatment, while 54 per cent had purchased some form of ancillary (extras) cover.

Comparing 2011-2012 to the previous year, the greatest increases in ancillary services were for natural therapies (an 18 per cent increase).

Still, this currently represents a relatively small proportion (5.6 per cent) of services provided. Around half of all ancillary benefits are for dental services, with a significant proportion of the remainder related to optical and physiotherapy services.

The private health insurance market is dominated by a small number of large insurers: Medibank Private and BUPA have 54 per cent of the market share; HCF, HBF and NIB have 26 per cent, while the remaining 20 per cent is shared between 30 funds.

The ancillary benefits provided by different funds are currently a commercial decision, they take no account of clinical effectiveness and vary widely with respect to the services covered and the maximum money refunded per service per person per year.

The review into natural therapies is administered by the Department of Health and Ageing (DoHA), with the National Health and Medical Research Council (NHMRC) conducting the evidence review.

Health funds were asked to identify the natural therapies for which they offered benefits. Submissions were sought from key stakeholders, primarily organisations representing natural health practitioners.

Submissions not subject to confidentiality restrictions will shortly appear on the DoHA Natural Therapy Review website, though some are already in the public domain.

The NHMRC is currently organising an overview of systematic reviews published between April 2008 and April 2013 for the natural therapies identified.

Effectiveness and, where considered, the safety, quality and cost-effectiveness, of the relevant therapy for a clinical condition will be assessed. A homeopathy review is already underway.

A Natural Therapies Review Advisory Committee has been set up to review the findings of the NHMRC, and provide advice to the government as to which therapies should continue to attract a rebate.

The Advisory Committee held its first meeting in Canberra on March 6, 2013, and each committee member has been asked to canvas the views of their constituency.

The timetable is tight, with implementation scheduled for 1 January 2014, after which DoHA will assess therapies that do not attract the rebate, but may be considered for inclusion based on credible evidence of efficacy, cost effectiveness, safety and quality.

Consumers may still be able to purchase natural therapy services that do not attract the rebate and insurers will be able to offer cover for these therapies under policies that do not attract the rebate.

This review is clearly controversial.

More than 70 per cent of Australians use a form of natural therapy as a regular part of their overall health care, with close to 2 million professional consultations conducted annually.

The removal of natural therapy practices from private health insurance will exacerbate the pressure on already overburdened GPs and increase Medicare and Pharmaceutical Benefit Scheme costs.

It also threatens the future viability of Australian natural therapy practices, and the health and the wellbeing of thousands of Australians who use the services.

There a*re fundamental differences between the underlying philosophies of biomedicine and natural therapy, and the NHMRC review process is too narrow to accommodate these important differences.*

No doubt other issues will arise when all submissions are made public.

**Dr Harvey is one of two members of the Natural Therapies Review Advisory Committee representing the Consumers Health Forum. He has been paid travel expenses and (very occasionally) sitting fees for his involvement in government inquiries and working groups concerning aspects of natural therapies including complementary medicines and pharmaceutical promotion. He has accepted travel expenses to talk about complementary medicine regulation to industry associations and pharmaceutical companies.*

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Chronic Disease Review – What's the objective?

BY **DR BRIAN MORTON**

"The AMA has stressed to the Department that the primary focus of any review of the chronic disease items should not be budget savings at the expense of GPs and their patients"

Recently I wrote about how the Government was looking at making changes to the current chronic disease management items.

While there is potential for some positive outcomes from a review of these items, such as a reduction in red tape and better support for patients to access the care they need, it is important to remain cautious about the primary objective of any review.

If Budget savings are the primary objective then the Government will face a real backlash from the profession.

We all know the difficulty the Government has encountered in its attempts to wind back the Budget deficit and its desire to fund new spending programs such as the Gonski education reforms and the disability insurance scheme. The Federal Health Department has a long track record of targeting faster growing areas of health expenditure for savings. Enter chronic disease management items.

We can't allow the Department to peddle a view that the growth in the usage of chronic disease management items, and expenditure on related allied health services, is unsustainable.

The recently abolished Medicare Chronic Disease Dental Scheme accounted for half of all services, and 60 per cent of benefits paid, on the related allied health items.

Over the three years to 2011-12, the volume of dental services increased by an average 43 per cent a year, compared with an average 17 per cent a year for the other allied health items related to GP chronic disease management. Year by year, growth is slowing.

After surging by 44 per cent in 2006-07, the pace of increase has steadily moderated, up 26 per cent in 2007-08 and 29 per cent in 2008-09 before dropping to just 13 per cent in the first seven months of this financial year. This is before impact from the removal of the General Practice Chronic Disease Management items related to dental kicked in.

The chronic disease management scheme is approaching the mature growth phase for a program aimed squarely at the aged population.

Nevertheless, there are indications the Government is looking for even more savings, and it is not unreasonable to think that their target may be GP planning and team care arrangement items. The patsy could once again be general practice.

While the AMA believes that the existing chronic disease management items could be improved to more effectively support structured, well-coordinated multidisciplinary care, any changes should not be about cutting access or reducing rebates for services for which there is a clinical need.

The items need to be restructured so as to eliminate clinically irrelevant red tape and better align with clinical practice. The AMA's Chronic Disease Plan outlines our thinking on this score.

The AMA has stressed to the Department that the primary focus of any review of the chronic disease items should not be budget savings at the expense of GPs and their patients. Any restructure of items should be undertaken with a view to improving the quality of chronic disease management.

Intelligent design of the MBS items increases the return on the investment (the years of healthy life enjoyed by the population as a result of well targeted prevention and intervention).

Failure to invest in chronic disease management at the primary care end inevitably means much higher, yet avoidable, tertiary health care costs.

We have made this message clear to the Health Minister in writing, and the President will also raise the issue when we next meet her on 26 March.

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Medical students worldwide unite behind AMSA call for marriage equality

BY **AMSA PRESIDENT BEN VENESS**

A tall brunette purposefully approached me.

"I'm Miriam, from Spain," she said, offering her hand. "We want to help you."

For a week, Baltimore's city centre Sheraton Hotel was teeming with medical students from every continent of the world.

Brought together by the International Federation of Medical Students' Associations (IFMSA), representatives from each National Member Organization (NMO) would stay working until minutes before midnight, debating policies and, more tediously, by-laws, in the hotel's ballroom.

Never one to shy from a fight, the Australian delegation proudly brought from home not only a flag, Tim Tams and Vegemite (for the infamous National Food and Drink night), but also an adapted version of our Marriage Equality and Health policy.

In the lead-up to the plenary, members of the Australian delegation had casually discussed the policy with other delegates, and in just a couple of days it would be debated.

Given the broad membership of the IFMSA, and the significant hurdle of a two-thirds majority for the adoption of new policy statements, there would be delegates from a lot of countries to convince.

"Is it okay if we make a speech?" Miriam Blanco asked. "On behalf of NMOs in Europe."

I was taken aback. What an ingenious proposal.

"Of course!" I replied, thrilled that this beautiful stranger shared our passion and had taken such initiative. "I'd love you to."

As the idea percolated, its potential to help our policy grew.

What if other blocs followed suit? Students from North and South America had already expressed support; the USA was seconding our policy. Maybe Asia? We didn't know where they would stand.

The Middle East and Africa would certainly be challenging. The five countries in the world that still have a death penalty for homosexuality are Mauritania, Sudan, Iran, Saudi Arabia and Yemen. (Parts of Nigeria and Somalia do, too.)

The vote was scheduled for Tuesday night, 12 March. Pop star Rihanna had coincidentally contracted laryngitis and cancelled her concert in the nearby 1st Mariner Arena, which a lot of students had planned to attend.

Even though just one student is the designated voter for each NMO, the ballroom was filling up as everyone had heard about the marriage equality policy. Lines of supporters congregated around the plenary table, which is usually reserved for the voting students.

The first to speak was Canadian delegate Charles Marois. Microphone in hand, Charles made a passionate call on behalf of North America in favour of the policy.

Speakers from Colombia, Lebanon and Taiwan also expressed support.

Asia turned out to be extremely helpful and well-aligned, with a Taiwanese student later telling me how grand their annual pride march has become.

By contrast Malaysia, a country that has even gone so far as to ban the television programme Glee because of its homosexual characters, was a notable non-African signatory to Sudan's polite but firm opposition to the proposal.

Miriam, meanwhile, had been hard at work at the European regional meeting enlisting support. At the outset of her address she listed all the NMOs on whose behalf she spoke: Austria, Belgium, Catalonia, Croatia, Czech Republic, Denmark, Estonia, Finland, Germany, Greece, Israel, Italy, Lithuania, Luxembourg, Malta, The Netherlands, Norway, Poland, Portugal, Russia, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, and the UK.

"As an international federation, we believe in achieving acceptance and equality for everyone. Everyone in this plenary, every IFMSA member, and everyone in the world," Miriam said. "We strongly believe that this policy statement is one of the few, but necessary, steps that remain towards progress, evolution and freedom."

In the end, Miriam's belief was shared. 59 votes were cast: 40 for, 11 against, eight abstentions. With a cheeky proclamation from the chair, medical students around the world joined AMSA in our call for marriage equality.

Benjamin Veness is the President of the Australian Medical Students' Association (AMSA) and is studying medicine and a Master of Public Health at Sydney Medical School. Follow Ben on Twitter @venessb and @yourAMSA. The hashtag for the meeting in Baltimore was #MM2013USA

TO COMMENT CLICK HERE

Support rural hospitals, don't sideline them

BY **DR DAVID RIVETT**

"Elderly patients unable to handle the rigors of long distance travel to access care simply forgo care provision, and the rural and regional health statistics get worse"

Role delineation for small rural hospitals is a persistent and thorny issue, constantly in the background and often hanging threateningly over the heads of rural doctors.

In an ideal world, all our patients would have speedy seamless transport and immediate access to best facilities in the world in centres of excellence.

Such a situation, however, does not exist - and will not exist in the foreseeable future.

We also have an increasingly numerous ageing population that includes many people with multiple co-morbidities - very many of whom have limited ability to travel the considerable distances required to access care, even were it ever to become freely accessible in such centres of excellence.

When city based 'experts' start to decree that service provision in small rural hospitals must be dumbed down and kept to ever more minimal basics - despite there being a proven skilled workforce capable of quality care provision - then the system starts to fall apart.

Rural hospitals become clogged with patients awaiting transfers to 'centres of excellence' for simple procedures, often to have these performed by inexperienced trainee staff. I well remember the fractured forearm coming back from just such a centre with a plaster on the limb opposite that fractured.

Elderly patients unable to handle the rigors of long distance travel to access care simply forgo care provision, and the rural and regional health statistics get worse.

Hospital staff become disgruntled with the dumbing down and over-restrictive limitations on the care they provide, and leave to return to the cities. In addition, skills vital for emergency care provision are grossly downgraded by such personnel losses.

If city-centric bureaucrats have a real interest in rural health, they need an alternative approach. That is to ensure locally provided rural care is of a high standard. This means freely accessible, fully-funded training stints for rural specialists and GPs in centres of excellence, which are well organised and user friendly. This needs to be supported by rotations of city specialists to fill the posts of those accessing such training refreshers and updates.

It also means providing quality equipment to small rural hospitals, and continuing education for rural allied health and nursing personnel, again in a user-friendly, easily accessible format.

I am not proposing that small rural hospitals should overstep their mark and engage in providing services beyond their capacities. Such action rightfully deserves condemnation.

Rather, there needs to be a balanced approach in which skills are assessed and fully utilised and outcomes audited.

If shortcomings are found, they should be remedied, so that local service provision is enhanced and grown, rather than have health bureaucrats take a "ship them out at all costs" mentality toward rural patients.

In any solution, patients must come first. If we lose sight of this dictum, our health care provision plans all too often go astray.

Secondly, the professionalism of the rural medical workforce, and their judgement in what services they can provide locally in a timely and quality manner, must be respected.

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Involuntary or coerced sterilisation of people with disabilities: a confronting issue

BY **DR LIZ FEENEY**

The AMA's Ethics and Medico-Legal Committee (EMLC) discusses difficult, often emotionally divisive, issues facing the medical profession and society more generally.

Occasionally, the EMLC is confronted with an issue that we have not considered in depth before, such as the forced or coerced sterilisation of people with disabilities in Australia, the current subject of a Senate Committee on Community Affairs' Inquiry.

In 2011, the United Nations Human Rights Council's Working Group on the Universal Periodic Review raised concerns with Australia about the non-therapeutic sterilisation of people with disabilities.

In response to the Working Group's report, the Australian Government established an inquiry to examine the legal, regulatory, and policy frameworks and practices around the country; types and prevalence of sterilisation practices; why sterilisations were being sought by others for people with disabilities; and the impact on people with disabilities. Currently, Australian law allows for authorisation by a court or Guardianship Tribunal of sterilisation for children and adults who have insufficient capacity to make their own informed decision.

In preparing a submission to the Inquiry, the EMLC deliberated long and carefully over the interests of those most heavily involved - the patient (the disabled person), the carer or carers, and the wider community.

As a result of these deliberations, the EMLC enunciated a set of principles that formed the basis of its submission.

Competent patients, regardless of disability, have the right to make their own informed decisions regarding sterilisation. Consent to sterilisation should be free from material or social incentives which might distort freedom of choice, and should not be a condition of other medical care, social, insurance, institutional, or other benefits.

"Consent to sterilisation should be free from material or social incentives which might distort freedom of choice, and should not be a condition of other medical care, social, insurance, institutional, or other benefits"

In relation to decision-making for patients who have impaired capacity, surrogate consent must be in the best interests of the patient, not the interests of others, including carers, other family members, or the wider community. Doctors serve as patient advocates and have a vital role in ensuring the patient, or the surrogate decision-maker, makes a fully informed decision regarding sterilisation. Patients lacking decision-making capacity (regardless of disability) have a right to be treated with respect and dignity, and should be encouraged to participate in the decision-making process as much as possible.

The determination of what constitutes a patient's best interests requires clinical advice from the patient's doctor or doctors regarding current (and possibly future) health conditions, decision-making capacity, and health needs. The doctor can discuss the risks and benefits of contraception, including sterilisation, with the surrogate and the patient (where appropriate), and advise on the treatment that best serves the patient's health needs.

Temporary and reversible methods of contraception, such as oral or injected contraceptives, should be considered before sterilisation. There may be extreme, rare circumstances, however, where sterilisation is the best therapeutic option and last resort.

There should be appropriate education and support for people with disabilities in relation to managing sexual and reproductive health, as well as for parents with disabilities who require assistance in caring for their children.

Carers play an important role in the Australian community and also require education and support. They often experience poorer health and well-being than the general population, and face financial, emotional, and other difficulties related to their caring responsibilities.

The AMA's submission focuses heavily on the role of the doctor and the principles of the medical profession, as applied to the issue of sterilisation of disabled patients.

To consider the perspectives of human rights advocates, carers, and others, I strongly encourage members to read the submissions received by the Senate Committee, which can be viewed at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/involuntary_sterilisation/submissions.htm

The AMA's submission will shortly be available on the Committee's website.

TO COMMENT CLICK HERE

Involving doctors integral to improved aged care

BY **DR PETER FORD**

On 13 March the Minister for Ageing Mark Butler tabled five Bills, amounting to 241 pages of legislation, in the Parliament to give effect to the *Living Longer Living Better* package of aged care reforms.

In his speech to Parliament, the Minister explained the four key reforms:

- end to end aged care;
- greater choice and control for consumers;
- more sustainable and modernised financing arrangements; and
- independent advice and oversight to support the changes.

The most topical aspect of the package of legislation for the AMA Committee for Healthy Ageing is the greater emphasis on home care.

The Committee recently finalised a new position statement on community aged care services, emphasising the importance of timely access to community services to support older Australians and their carers through critical times.

The position statement, which was considered by the AMA Federal Council at its meeting on 22 and 23 March, recognises that older Australians will have the confidence to live in the community if they have access to adequate services. Their carers will feel supported if respite care is available when it is needed.

However, a greater focus on assisting people to age at home does bring risks. The quality of care for individuals living in the community may deteriorate and become more fragmented. This can be avoided if comprehensive community aged care services are available; they meet the specific needs of individuals; and they are coordinated and managed to have the optimal effect for the individuals receiving them.

The *Living Longer Living Better* package will make consumer directed care a condition of the allocation of home care places. Minister Butler says this will mean that consumers will work with their home care provider to choose the elements of care that best suit their needs and their home care budget.

The AMA position statement is not entirely aligned with this philosophy. Instead, it highlights that early medical assessment is critical to ensuring older Australians receive home support to maintain their level of independence before their social and health situation deteriorates.

The AMA argues that medical practitioners should make an assessment of a patient's needs, and refer the patient to a service that would then co-ordinate the provision of the required service – and that the ongoing need for, and provision of, community care services must be overseen by general practitioners.

The Committee will keep an eye on this disconnect to ensure that we can secure better arrangements for our patients to make sure they are getting the home care that they need.

Last year the Minister for Ageing rejected the AMA's proposal that he set up a clinical advisory group of doctors and nurses to advise him on the clinical aspects of aged care. The lack of first hand clinical advice is showing in the Minister's implementation of his aged care reforms. The AMA will continue to advocate for the role of the medical practitioner as integral to the aged care sector.

"The lack of first hand clinical advice is showing in the Minister's implementation of his aged care reforms. The AMA will continue to advocate for the role of the medical practitioner as integral to the aged care sector"

Failing that, the legislation provides for a review after three years to determine, among other things, whether:

- unmet demand for residential and home care places has been reduced;
- the number and mix of places for residential care and home care should continue to be controlled; and
- whether further steps could be taken to change key aged care services from a supply driven model to a consumer demand driven model.

To end on a positive note, there are two additional supplements in the Government's package for home care for people with dementia and for veterans.

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Health on the hill

Political news from the nation's capital

Australia not a soft touch for drug companies: Govt

The Federal Government has rejected claims taxpayers are being over-charged $1.3 billion for medicines purchased through the Pharmaceutical Benefits Scheme.

Health Minister Tanya Plibersek said the Government had driven a hard bargain with pharmaceutical companies over the cost of drugs supplied through the PBS, and had secured substantial price drops that freed up funds to spend on new treatments.

"Australia has made very substantial savings in the area of generic medicine in recent years," Ms Plibersek said. "We'll save around $9 billion between 2010 and 2015 on the basis that generics will drop in price, and also because we've made price changes to high volume drugs like some statins."

The Minister made her comments in response to the release of a Grattan Institute report which claimed that the nation was paying far more through the PBS for prescription drugs compared with public hospitals and other countries, such as Canada and New Zealand.

The report's author, Dr Stephen Duckett, said more than $1.3 billion was wasted each year on inflated prices.

For example, he said, the Government contributed $31.44 toward the cost of a box of 30 40 milligram tablets of the cholesterol-lowering drug Lipitor. But in New Zealand the wholesale price for a box of 90 tablets was just $5.80.

Dr Duckett said that one of the problems was that when a drug comes off patent, Australia only requires a 16 per cent price cut, whereas other countries and buyers drive much harder bargains.

He said that Australia's drug pricing body includes representatives from the pharmaceutical industry, while in New Zealand a panel of independent experts negotiates the supply of drugs within a fixed budget.

"Huge savings are possible, and good models are even closer to home than New Zealand," Dr Duckett said. "Public hospitals in at least two states get much lower prices than the PBS.

"[But] the Government has a sweetheart deal with pharmaceutical manufacturers that slows the winds of competition," he said.

But Ms Plibersek rejected the analysis.

She said that although New Zealand did negotiate good prices for generic medicines, this was at the cost of choice.

The Minister said it took much longer in New Zealand for new medicines to become available, and "they have a much smaller range of medicines. There are about 84 medicines that we use here that simply aren't available in New Zealand".

Ms Plibersek said it was not sufficient simply to focus on the cost of generics.

"We need to make sure that we have a wide variety of medicines available for patients, we need to make sure that the newest, most innovative medicines are also available," she said.

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Hospitals put on notice about hiring overseas doctors

Prime Minister Julia Gillard has condemned as "absurd" the nation's reliance on doctors and nurses from overseas working on temporary visas to fill hospital vacancies in a sign the health sector will be included in a Government crackdown on the use of 457 visas.

Broadening the scope of the Federal Government's argument about the need to curb the use of 457 visas, Ms Gillard told an ACTU conference in Canberra earlier this month there were 12,700 temporary workers from overseas who had ongoing employment in health and social care – almost as many as in construction.

"This is an absolutely damning failure of long-term national economic policy," the Prime Minister said. "It is absurd to rely on temporary overseas labour to fill ongoing skilled work in public hospitals while contracted labour cleans those same hospitals in the middle of the night for around $20 an hour.

"We don't want to be a nation which can't care for its own sick, and can't provide jobs for its own kids."

Ms Gillard made her comments following concerns raised by the AMA about the recruitment of thousands of doctors from overseas to fill positions in public hospitals.

As reported in *Australian Medicine* last month (Flood of foreign doctors to come under scrutiny http://ausmed.ama.com.au/flood-foreign-doctors-come-under-scrutiny), the Government has undertaken to monitor the recruitment of Resident Medical Officers from overseas following concerns raised by the AMA.

AMA President Dr Steve Hambleton contacted the-then Immigration Minister Chris Bowen late last year to voice disquiet at State and Territory government recruitment of RMOs from offshore even as hundreds of locally-trained doctors were missing out on such positions.

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Dr Hambleton said at the time "it seems untenable that locally-trained graduates and junior doctors face potential unemployment while we continue to recruit large numbers of RMOs directly from overseas".

Immigration Department figures show 1260 doctors entered Australia on 457 visas in 2011-12, rising to more than 2000 by the end of August last year.

More recent figures show 720 GPs from overseas applied for 457 visas between July and November last year – a jump of almost 30 per cent.

"The 457 Class visa is intended to fill workforce gaps, not displace locally trained and highly skilled graduates and junior doctors," Dr Hambleton said. "The current data suggests the visa is not being used as intended."

Dr Hambleton said the nation's current heavy reliance on international medical graduates to fill shortfalls in the medical workforce highlighted failings in the medical training system, particularly in the provision of internships, pre-vocational and vocational training positions.

The AMA President told the *Adelaide Advertiser* the "457 visa issue is the red flag, and it…tells us we've really got to make a decision to be self-sufficient".

Critics have accused the Prime Minister of using the issue as a desperate gambit to shore up her leadership and improve the electoral standing of the Government, saying there is little evidence the 457 visa program has been abused.

But Immigration Minister Brendan O'Connor said a recent jump in the number of people applying for, and working on, 457 visas at a time of flat jobs growth, showed that employers were exploiting "loopholes" in the program.

Mr O'Connor said there were more than 105,000 people working on 457 visas as at 31 January – 22 per cent more than the same time last year – while applications for 457 visas were up 9.5 per cent.

As part of its measures, the Government plans to give the Fair Work Ombudsman powers to monitor and enforce the compliance of employers with the conditions of 457 visas, including ensuring visa holders are being paid at market rates, and that the work they are doing conforms with that approved under the terms of their visa.

Ms Gillard, buoyed by a positive response from the union movement and in opinion polls to her call to prioritise job opportunities for Australians above those of foreign workers, said the Government plans to tighten rules governing the use of 457 visas.

The Prime Minister said it was an issue about jobs and wages more than immigration management, and the Government was putting in place a package of reforms "to ensure that temporary skilled workers only come from overseas when there is genuinely no local worker who can fill the job".

Under the planned new arrangements, employers seeking 457 visa workers will be required to demonstrate that there is a genuine shortage of local workers.

The Government also intends to increase English language requirements for overseas workers filling certain, as yet unspecified, positions; strengthen the enforcement of training requirements; increase the market salary exemption from $180,000 to $250,000; and restrict on-hire provisions.

Ms Gillard said the Government would also work with stakeholders to "ensure market rate provisions more effectively protect local employment".

"Naturally, we will work with business to make sure genuine skill shortages can be addressed, but we will not allow Australian workers to be denied the opportunity to fill Australian jobs," the Prime Minister said.

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Aged care reforms before Parliament

The Federal Government has introduced legislation for its $.7 billion aged care reforms into Parliament.

The package of measures includes an $880 million boost for home care support, $1.2 billion for higher wages and better employment conditions for aged care workers, $480 million to upgrade aged care home facilities and funding for an extra 30,000 places in the next five years.

Minister for Ageing Mark Butler said the reforms were aimed at modernising aged care and would given older Australians and their carers "more choice, easier access and better care".

Debate on the legislation is underway.

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Allied health chief yet to be appointed

The Federal Government has yet to appoint the nation's inaugural Chief Allied Health Officer.

In a decision welcomed by allied health groups as long overdue, Health Minister Tanya Plibersek has announced the establishment of the post of Chief Allied Health Officer, to complement the work done by the Chief Medical Officer.

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Ms Plibersek said that, in addition to providing support to the allied health sector, one of the key reasons for creating the Chief Allied Health Officer was to improve the delivery of allied health services in rural and regional areas.

Ms Plibersek said the position had its genesis, in part, in a recommendation from the Senate Community Affairs References Committee following the findings of its inquiry into factors affecting the supply of medical professionals and health services in rural areas.

"The Committee found that allied health professionals face additional challenges in delivering services in regional, rural and remote Australia," the Minister said. "The Chief Allied Health Officer will have improving the delivery of allied health services in the bush as a key focus."

The Australian Physiotherapy Association was among allied health groups that welcomed the move.

"The announcement [of a Chief Allied Health Officer] is long overdue, and is an important recognition of the valuable role that physiotherapists and other allied health professionals play in our health system," APA President Marcus Dripps said.

The Dietitians Association of Australia said the appointment was welcome recognition of the important role all health professionals, including dieticians, played in achieving bette rhealth outcomes for Australians.

Associaiton Chief Executive Officer Claire Hewat said it was pleasing that allied health professionals were now being recognised as crucial pieces of the healthcare puzzle, alongside doctors and nurses.

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Govt spreads bets on problem gambling

Online gamblers would have to pre-commit to spending limits and gambling time under proposals developed by the Federal Government.

Communications Minister Stephen Conroy has approached the states and territories to adopt a uniform national standard to regulate online gambling.

Senator Mr Conroy said the Government was proposing a set of conditions aimed at minimising harm and protecting consumers as the basis for consistent regulation across the country.

The Minister said the national standard would include pre-commitment measures, such as limits on total spending, time played and deposits, stricter rules regarding lines of credit, and limits on the inducements that can be offered by online gambling providers.

"As the way Australians use gambling services shifts online, we need to ensure that protections for consumers remain robust and relevant," Senator Conroy said.

The Minister said he was also asking industry about measures being taken to protect children from casino-style gambling simulations being offered online, including through social media.

But prominent anti-gambling campaigner Senator Nick Xenophon accused the Federal Government of ducking its responsibilities regarding the regulation of online gaming.

Senator Xenophon said the Government already had the authority to clamp down on online gambling, which would be the "next tidal wave of problem gambling",and should not be relying on action by the states and territories.

"The Commonwealth has the power to intervene now and fix up the current loopholes in the legislation," Senator Xenophon said. "Instead, it has adopted a fence-sitting approach of waiting for the states and territories to come on board – that's a recipe for delay and inaction."

The AMA has highlighted the serious health and social problems caused by problem gambling, and its position has been endorsed by the Victorian Responsible Gambling Foundation.

The Foundation's Chief Executive Officer Serge Sardo said concern about gambling-related harm was firmly on the national agenda.

"We support the AMA's contention that problem gambling has significant health implications for individuals, their families and friends and the wider community," Mr Sardo said. "We are particularly concerned that many problem gamblers don't seek help early, before their gambling leads to major dysfunction in their lives, including family breakdown, financial ruin and the development of mental health issues. This is where the problem impacts on the health system."

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Medibank Private's new boss faces old problems

Experienced corporate player Elizabeth Alexander has been thrust into the middle of controversy over Australian Defence Force health care contracts after being promoted to Chair of the Medibank Private Board.

Ms Alexander, who has been promoted to the role after serving as a non-executive director on the Board, comes to the position as Medibank Private is engaged in a controversial and troubled push into becoming a health services provider through its offshoot Medibank Health Solutions.

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MHS last year won a $1.3 billion contract to provide health services to around 80,000 ADF personnel, but it has so far struggled to enlist the doctors it needs to meet its obligations.

An AMA survey has found that the vast majority of specialists approached by MHS have rejected the terms of its offer to be listed as a preferred provider, including substantial fee cuts, onerous reporting obligations and restrictions on patient referrals.

Ms Alexander's tenure is also likely to be marked by ongoing speculation about the possible privatisation of Medibank Private, particularly if there is a change of government at the 14 September Federal election.

Announcing the appointment, Finance Minister Penny Wong avoided reference to any privatisation plans, but said Ms Alexander brought to her role "extensive experience" on a number of corporate boards and government committees that could prove invaluable in helping navigate the insurer through a period of significant change.

"Her expertise will be of great benefit as Medibank continues its transformation from a private health insurer to an integrated health solutions provider," Senator Wong said.

Ms Alexander, current University of Melbourne Chancellor and former Chair of CSL Limited, has been promoted to fill the vacancy left by the departure of Paul McClintock, and her initial appointment is for three years.

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NDIS close to reality following landmark vote

The Federal Government has cleared its last major hurdle in the establishment of the National Disability Insurance Scheme after the House of Representatives passed amended legislation.

An emotional Minister for Disability Reform, Jenny Macklin, hailed the 14 March vote as an "enormous step" in giving people with a disability, as well as their families and carers, peace of mind.

"It will bring an end to the tragedy of services denied or delayed, and instead offer people with disability the care and support they need over their lifetimes," Ms Macklin told Parliament. "It will end the cruel lottery that besets people today, where the care and support they receive depends on where they live or how they acquired their disability."

The Bill now goes to the Senate, where it is expected to pass with the support of the Government, the Opposition and the Greens.

The decision means the trial of the scheme at launch sites in five states and territories, and covering 26,000 people, is set to go ahead as planned from 1 July.

The NDIS embodies a shift the basis of funding for disability services from welfare to social insurance, with contributions from all taxpayers.

Under the scheme, the disabled and their carers will receive funds – rather than care providers – giving them choice and control over the care and support they receive.

Ultimately, the scheme is expected to cover 360,000 people with a profound or severe disability, and will be complemented by a separate National Injury Insurance Scheme for those who suffer a catastrophic injury.

The Government gained support from the Opposition and the Greens for a number of amendments made following a Senate committee inquiry.

Under the amended legislation, the NDIS Launch Transition Agency will be given the power to launch compensation action on behalf of a person with a disability who does not want to make such a claim.

This could apply where harm may have been caused by the negligence of a company, and the costs arising from that harm should be borne by the company, and not by the taxpayer, Ms Macklin said.

The Minister said any damages awarded would be given to the person with the disability, though the Agency would recoup the money spent on care and support, as well as "incidental" costs.

Attempting to assuage concerns raised by disability groups, the Bill also included amendments that clarify that NDIS participants can choose to remain in the scheme after they reach 65 years of age.

This became an issue after the Productivity Commission recommended that there be a 65 year age limit on access to the NDIS, on the basis that the elderly should be able to get the care they need through the current aged and disability care systems.

The Government accepted this advice, but Ms Macklin was at pains to assure that "people who are NDIS participants will be able to choose to remain in the scheme after they turn 65".

Ms Macklin said the legislation had also been changed to make it clear that people who need early intervention and support, and who are not adequately supported by the health care system or other arrangements, can use the NDIS.

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Members' Forum

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

The suggestion made by Dr Brian Morton, Chair of the AMA Council of General Practice, that consideration be given to employing pharmacists within general practices (see Time for a new take on where pharmacists work?) has drawn considerable interest. Doctors who have already gone this path say it has been a success and, unsurprisingly, pharmacists themselves say they are keen. A call by GP leaders for chronic care to be spared from any budget cuts (Shield chronic care from Budget knife: united GP call) stirred debate about the usefulness of care plans, while reports of a Medicare crackdown on public hospital billing (see Medicare crackdown public hospital billing) had some questioning billing arrangements that left doctors vulnerable.

GP clinic pharmacists

I couldn't agree more with the following comment: "We shouldn't waste their skills and expertise. Maybe it is time to look more closely at employing pharmacists in general practice." Four years ago the doctors at Camp Hill General Practice, decided to improve its quality use of medicines by engaging the services of a non -dispensing pharmacist. The pharmacist works as part of a multidisciplinary team. He assists with the provision of Home Medicine Reviews (HMRs), up -to -date medication information, and quality prescribing activities that enhance the skills of all clinicians. Our practice has greatly benefited from this workforce innovation.

Ian Williams - General Practitioner

As a pharmacist, I can confidently say that pharmacists do have a lot to offer, and would bring a useful skill set to general practice. Also, many pharmacists would be very interested in being employed in this setting. My background is hospital pharmacy, where pharmacists work on the ward as a valued team member, with a focus on medication safety and education.

Anonymous

Chronic care

High Medicare rebates for care plans compared with rebates for consultations are distorting the medical care landscape. For many practices, the income from care plans forms an important part of their business model. Government is increasingly promoting activities, which provide measurable outcomes, which of itself is not an unreasonable aim. But, in essence, this results in box-ticking behaviour and not necessarily an improvement in patient care. Promotion of high quality medical practice should be the ultimate aim, with the acknowledged difficulty being how to assess quality. There is no substitute for time spent with the patient, by an ethical, well-trained medical practitioner, but there has been very little support for this in Medicare rebates over the years.

Anonymous

I agree major changes need to happen to care plans. I spend quite a bit of time (an average of 20 to 30 minutes) writing up the plan, writing it all again for the team care arrangement, and get paid an amount which seems totally out of step with other rebates. They are cumbersome, unclear and mostly sit in the notes and never referred to again till the next time. They are about the only thing I make any money on as I have long complex consults and bulk bill a lot and I still want to get rid of them. The system is open to major rorting.

Anonymous

Medicare crackdown

It is fair enough that doctors are advised to "keep adequate ... medical records", but what about cases where tests/services are ordered under a doctor's provider number when the request did not come from that doctor, and quite possibly the doctor is unaware that the service is being requested?

I have worked at several hospitals where all tests and services are billed under the provider number of the consultant officially responsible for the patient. More often than not, the ordering of the test or service is a decision made by the registrar or resident. The junior doctors do have their own provider numbers, but despite this, and regardless of the doctor's name, signature and provider number written on the order form, the order gets recorded under the provider number of the consultant.

Is this practice even legal? How is the consultant supposed to defend himself, years down the track, for ordering investigations "inappropriately" if he never even knew they were being ordered?

Anonymous

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Research

Dairy can deliver health boost: study

Children who eat the recommended amounts of dairy food are at no greater risk of becoming overweight than those who don't, and could in fact lower their blood pressure level, new research shows.

A study, partly funded by Dairy Australia and conducted by the Boden Institute of Obesity, Nutrition, Exercise and Eating Disorders at the University of Sydney, found that children's dairy consumption had no impact on their Body Mass Index (BMI), but was linked to lower blood pressure.

The study, involving 335 toddlers, aimed to examine the association between dairy consumption at 18 months and BMI and blood pressure at eight years of age.

The researchers found there was no difference in the BMI of children, regardless of the number of serves of dairy consumed. However, in those children who consumed 2.9 serves of dairy or more each day, there was an added benefit of lower blood pressure.

Those children who had the highest dairy consumption at 18 months of age had lower systolic and diastolic blood pressure at eight years than those who consumed the least dairy foods. Systolic blood pressure was lowest among children with the highest intake of calcium, magnesium and potassium.

Furthermore, blood pressure was lowest in the group of children who consumed at least two serves of dairy per day at both 18 months and nine years.

Associate Professor and Principal Research Fellow from the University of Sydney, Tim Gill, said the study showed that dairy consumption in childhood could have a protective effect on blood pressure.

"Our research shows eating the recommended amounts of dairy foods, including milk, cheese and yoghurt, is not linked to weight gain and is associated with lower blood pressure in 8-9 year old children," he said.

This reduced blood pressure is associated with a 12 per cent reduced risk of cardiovascular disease.

The research was published in the *European Journal of Clinical Nutrition.*

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Vaccine slashes chicken pox cases

The number of children ending up in hospital with severe chicken pox has plunged by almost 70 per cent and is now considered mostly preventable, following the widespread introduction of a vaccine for the disease.

A national study of chicken pox admissions at four Australian children's hospitals, found the number of children hospitalised with chicken pox or shingles had dropped by 68 per cent since the vaccine came into widespread use in 2006.

Before the vaccine became available there were an estimated 240,000 chicken pox cases in Australia each year, with 1500 hospitalisations and between one and 16 deaths.

The research was led by Associate Professor Helen Marshall from the University of Adelaide and the Women's and Children's Hospital, and researchers of the Paediatric Active Enhanced Disease Surveillance (PAEDS) project.

The results of the study show that no children died of chicken pox in the participating hospitals between 2007 and 2010, following the widespread introduction of the varicella vaccine.

Of the children that did need hospitalisation for severe chicken pox, 80 per cent had not been immunised.

"These results are a very strong endorsement of the impact of chicken pox vaccine being available for children through the national childhood immunisation program, and of the need to immunise all children against chicken pox," Professor Marshall said.

"A higher level of immunisation would have spared most children from severe chicken pox, which in a few cases required intensive care treatment. Based on the results of our studies, this is now mostly preventable."

Chicken pox is a highly contagious infection spread by airborne transmission or from direct contact with the fluid from skin lesions caused by the disease.

In its most serious form, chicken pox can cause severe and multiple complications, including neurological conditions, and even death.

"At least one dose of varicella vaccine in eligible children and in other members of their household has the potential to prevent almost all severe cases of chicken pox in Australia," Professor Marshall said.

"Not only does this have the potential to save lives, it also saves millions of dollars in hospital admission costs each year."

The results of the study have been published online in the *Paediatric Infectious Disease Journal.*

DV

TO COMMENT CLICK HERE

...CONTINUED ON PAGE 34

Research

...CONTINUED FROM PAGE 33

Whooping cough vaccine halves risk of infection in newborns

University of Sydney researchers have found that children born to mothers who had been immunised are 50 per cent less likely to get whooping cough in the first four months of their life.

In 2009, NSW implemented a publicly funded initiative for preventing pertussis (more commonly known as whooping cough) in young infants by vaccinating relatives of the child – known as the cocoon strategy.

The study examined the effectiveness of the strategy by examining 217 cases of whooping cough in infants younger than four months of age in NSW, and matching them to 585 controls.

Overall, 75 per cent of mothers whose child contracted whooping cough, and 77 per cent of control mothers, received the whooping cough vaccine. However, only 27 per cent of mothers whose child contracted whooping cough, and 41 per cent of control mothers, were vaccinated at least four weeks before the onset of whooping cough in the infant.

The researchers found that there were significant risk factors for infants contracting whooping cough, including large households and less favourable socio-economic areas. After adjusting for these risk factors, the researchers found that vaccination of the mother before birth caused a reduction in whooping cough risk by almost 50 per cent.

The study, led by Dr Helen Quinn from the National Centre for Immunisation Research and Surveillance for Vaccine Preventable Diseases, said timely maternal vaccination was associated with a significant decrease in risk of whooping cough prior to eligibility for the second dose at four months of age, with the greatest benefit found in infants of mothers who received the vaccine before delivery.

"This is the first evidence of protection from maternal pertussis vaccination prior to the current pregnancy," Dr Quinn said. "It suggests that vaccination as part of pre-pregnancy planning would have the greatest impact on whooping cough infection.

KW

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Dementia forgotten diagnosis in hospitals

Almost half of hospital patients with dementia are going undiagnosed, and caring for those with the condition is up to three times as costly as other patients.

An Australian Institute of Health and Welfare report found that of 21,000 people with dementia hospitalised in New South Wales in 2006-07, just 53 per cent had their condition recorded as either a principal or additional diagnosis.

The study showed that, overall, people with dementia stay in hospital longer, and are costlier to care for, than the general patient population.

Typically, a patient with dementia will stay in hospital for 16.4 days, compared with an average of 8.9 days among other patients, according to the research.

Where dementia was the principal diagnosis, the Institute found that the average cost was $13,434 per episode, compared with $5,010 for people without dementia, a difference of $8,424.

The average cost of care for all patients with dementia, including those cases where it was not diagnosed, was also higher than the broader patient population, working out at $7720 per episode.

Institute Director David Kalisch said caring for people with dementia can be challenging, particularly in a busy hospital ward, but better coordination between carers and improved planning and training could cut the cost and length of time they stay in hospital.

"Our review suggests the greatest potential benefits to patients lie in a combined approach by hospital, mental health, residential aged care and community services," Mr Kalisch said. "Simple measures taken in the hospital setting that appear to reduce length of stay for dementia patients, and improve outcomes, include staff training, discharge planning, dementia-friendly ward adaptations, and mental health and ageing liaison services."

Alzheimer's Australia President Ita Buttrose said it was "unacceptable" that so many hospital patients with dementia were going undiagnosed, and the report confirmed concerns about the inadequacy of care.

"Current approaches to the identification and provision of care for Australians with dementia are inadequate," Ms Buttrose said. "As a society we would be concerned if a report was released indicating that cancer was not identified in 50 per cent of people with a cancer diagnosis who entered hospital.

"It is distressing and unacceptable that so many people are slipping through the system without dementia being noted in their hospital records."

Combined with predictions the number of people suffering dementia is likely to treble to around 900,000 by the middle of the century, the results add urgency to efforts to improve the care and treatment of those with dementia while researching how to prevent or slow its onset.

...CONTINUED ON PAGE 35

Research

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Alzheimer's Australia has warned that the nation's annual bill from dementia was likely to soar from $5 billion to $83 billion by 2060 unless progress was made on prevention and treatment.

The National Health and Medical Research Council has allocated $165 million to dementia research in the past decade, including $26 million in 2012-13, but Alzheimer's Australia said this paled in comparison with the funds devoted to research on cancer, heart disease and diabetes.

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Mummies bust modern lifestyle myth

Hardening arteries might not be the modern disease it has been assumed to be.

A study involving CT scans of more than 100 human mummies up to 4000 years old has found that thickening of arterial walls spans cultures, epochs, diets and climates, casting doubt on the theory it is a peculiarly modern affliction linked to poor diet, inactivity and stress.

The research, published in *The Lancet* earlier this month, drew upon the findings of a previous study that had found evidence of arthrosclerosis in Egyptian mummies.

The researchers, lead by Dr Randall Thompson, a cardiologist from St Luke's Mid America Heart Institute, broadened the focus to include 137 mummified remains from ancient Egypt, Peru, south-west United States and the Aleutian Islands, Alaska, in an attempt to address claims that the high status of Egyptian mummies meant they were likely to have indulged in diets high in saturated fats.

Scans found that about a third of all remains showed signs of vascular calcification, most commonly in older people.

The fact that the condition was identified in mummies from a range of cultures, diets and environments has led the researchers to cast doubt on the assumption that arthrosclerosis is mainly linked to modern lifestyles.

"The diets of these people were quite disparate, as were the climates," the authors said.

"A common assumption is that the rise in levels of arthrosclerosis is predominantly lifestyle-related, and that if modern humans could emulate pre-industrial or even pre-agricultural lifestyles, that arthrosclerosis, or at least its clinical manifestation, would be avoided," Dr Thompson said. "Our findings seem to cast doubt on that assumption."

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A little dose of sunshine may help keep TB away

A spike in the incidence of tuberculosis during spring has fuelled speculation that activity of the debilitating disease may be linked to levels of vitamin D.

Researchers from the Victorian Infectious Diseases Reference Laboratory found that notifications of active TB cases peaked between September and December, the months immediately following winter when, because of reduced sunshine exposure, levels of circulating vitamin D are typically at their lowest.

Drawing on data from the National Notifiable Disease Surveillance System covering the period from 2002 to 2011, researchers Jennifer MacLachlan and Dr Ben Cowie reported there was "significant seasonality" in the number of cases reported per month, particularly in Victoria and Tasmania, where the cyclical variation was about double that in the rest of the country.

They found that, nationally, TB notification rates were 24 per cent higher between September and December than between January and August.

The variation was even more striking in the southern states, where seasonal swings in sunlight exposure are greatest, with 37 per cent more cases were reported between September and December than in the rest of the year.

Seasonal variation in the incidence of TB has been observed in other countries, including the United Kingdom and South Africa, and a relationship between incidence of the disease and latitude has been reported in India, though not in the United States.

Ms MacLachlan and Dr Cowie admitted that the study did not establish causation, but said it supported the hypothesis that there was an association between vitamin D deficiency and the incidence of TB in Australia.

"This has implications for the tailoring of sun exposure messages to Australians most at risk of both vitamin D deficiency and TB, such as those born overseas and Aboriginal and Torres Strait Islander people," the researchers said. "Blanket recommendations regarding reducing sun exposure for all Australians, particularly in winter months, may not be optimal. We need to balance the risk of skin cancer from too much sun exposure with maintaining adequate vitamin D levels."

There are around 1300 cases of active TB reported each year in Australia, 85 per cent of which are in the immigrant community.

The study's authors said there findings suggested that clinicians should provide individualised advice regarding vitamin D levels to patients at higher risk of TB, "especially those who have migrated from tuberculosis-endemic areas and those whom latent tuberculosis has already been diagnosed".

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Police and industry unite in war on fake drugs

International law enforcement agency Interpol has formed an alliance with major pharmaceutical companies to crackdown on a burgeoning and deadly global trade in fake medicines.

Enormous growth in the purchase of drugs online has stoked fears that the lives and health of millions could be put at risk from trade in counterfeit medicines, which are often made using substandard or even lethal ingredients.

Until now, the danger posed by counterfeit medicines has been largely confined to countries with poor regulatory systems.

There have been eight mass poisonings associated with the use of counterfeit cough syrup and other medicines laced with diethylene glycol, including in Panama, where more than 100 people died in 2006, and last year 109 heart patients in Pakistan died after taking fake medicine.

But the burgeoning online trade in medicines has fuelled concerns that the threat posed by counterfeit medicines will become much more widespread.

Last year, an international law enforcement operation spanning 100 countries resulted in the seizure of 3.75 million units of a potentially life-threatening medication worth, and the arrest of 80 criminals.

In Australia, widespread internet use and the strong currency have helped drive rapid growth in the online purchase of medicines, often from dubious sources.

At the beginning of the decade, Customs officers were seizing about 260 parcels of drugs that breached the Therapeutic Goods Act each year, but in the past two years that number has spiked to more than 700 as Australian online shoppers buy everything from pills for erectile dysfunction to slimming products and tanning drugs.

The World Health Organisation has estimated that up to 50 per cent of medicines bought online from websites that conceal their physical address are counterfeit.

Interpol General Secretary Ronald Noble said an alliance with the world's top 29 pharmaceutical companies was integral to efforts to combat the rising tide of fake medicines.

"With no country, no drug, no medical product immune from counterfeiting, a global effort is needed to combat this threat, which puts the lives of millions of people at risk every single day," Mr Noble said. "This support from a group of 29 companies from the pharmaceutical industry forms a bridge between the public and private sectors, and will assist Interpol and each of its 190 members countries to more effectively tackle the problem of medical product counterfeiting."

Interpol's Pharmaceutical Crime Program, which aims to prevent counterfeiting of both branded and generic drugs and the disruption and break-up of organised crime gangs involved in the trade, will include training, capacity building and targeted enforcement actions.

Pharmaceutical industry group Medicines Australia urged consumers only to buy medicines sold in Australia.

"Don't buy medicines on the internet because you just don't know what you are getting," Medicines Australia Chief Executive Dr Brendan Shaw said. "There is no regulation of medicines sold over the internet, so you risk serious side effects, allergic reactions or interactions with your existing medication."

Dr Shaw said there was "clear evidence" that thousands of websites were being used to sell counterfeit medicines.

"It's alarming that millions of doses of pills falsely claiming to be antibiotics, anti-cancer, anti-depression, pain killers or treatments for erectile dysfunction from rogue internet sites are finding their way into the marketplace."

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Doctors face pay cut as politicians bicker

Almost 800,000 jobs are set to be dumped from the US health system when looming cuts to Medicare spending come into force at the end of March.

Research commissioned by the American Medical Association, the American Hospital Association and the American Nurses Association indicates that up to 766,000 health care jobs will disappear or fail to materialise – including almost 500,000 this year alone - when a 2 per cent cut to Medicare funding kicks in on 1 April.

The massive $11 billion hit to health spending is part of a package of cuts set to come into effect automatically because of a political stand-off over how to reduce the country's massive Budget deficit.

Republican politicians in Congress have rejected White House plans to increase taxes on the wealthy – alongside spending cuts – to help bring the nation's rampant public debt under control.

The impasse has meant that $1.2 trillion package of cuts legislated in 2011 – the so-called sequester – will come into effect, progressively crippling government funded services and programs.

The American Medical Association (AMA) has warned that the 2 per cent reduction in Medicare spending would not only force hundreds of thousands out of work, but also undermine the availability and quality of health care.

AMA President Dr Jeremy Lazarus said Medicare pay rates for physicians were already woefully inadequate, and the looming cut would make the situation worse.

> "As reported in the 11 March edition of *Australian Medicine*, there are concerns the cuts imposed on the National Institutes of Health will deliver a huge setback to medical research"

Dr Lazarus said that since 2001 the cost of operating a medical practice had jumped more than 20 per cent, while the rates paid by Medicare had risen by just 4 per cent.

"At the same time that Medicare physician payment rates have been frozen, physicians need to make investments in their practices to design, lead and adopt new model of care delivery that can increase quality and reduce costs, now and in the future," he said. "Further cuts are counterproductive and stifle important progress, while placing an unsustainable burden on physician practices."

Health care analysts said that the cuts came at a crucial time in the implementation of reforms intended to improve the quality of care, and warned that they could be derailed as a result.

The US Department of Health and Human Services plans to spread the funding cuts across a wide range of programs, though much of the pain will fall directly on frontline services. Medicare inpatient and outpatient programs have each been earmarked for more than $5 billion of cuts this year, while the National Institutes of Health, which funds medical research, will lose $1.5 billion, the Medicare prescription drug program almost $590 million, the Centers for Disease Control and Prevention $290 million and the Food and Drug Administration $210 million.

As reported in the 11 March edition of *Australian Medicine*, there are concerns the cuts imposed on the National Institutes of Health will deliver a huge setback to medical research.

Much planned research into the prevention of chronic disease has been put on hold, while support for dozens of existing projects will be reduced, not only severely hampering research but threatening jobs for thousands of researchers.

The American College of Physicians held out the "distant hope" of a last-minute deal between Republicans and Democrats to avert the pending Budget cuts, but President David Bronson admitted that there was little apparent enthusiasm among Congressional leaders to negotiate a deal.

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Take the fags if you must, but don't touch the booze

The United Kingdom could soon join Australia in adopting tobacco plain packaging laws, but there is mounting concern the British Government will abandon plans to introduce a minimum floor price on alcohol.

In mixed signals on public health, *The Guardian* newspaper has reported that the British Government is set to unveil a Bill that would require all cigarettes and other tobacco products to be sold in plain packages emblazoned with health warnings.

But, at the same time, rumours are circulating the Government might dump plans to introduce a 45 pence unit price for alcohol as a way to tackle problem drinking amid growing resistance from several senior Conservative ministers.

According to the BBC, there is now "significant pressure" within the Government to drop the measure, which has been publicly championed by Prime Minister David Cameron, following 10 weeks of consultations.

A minimum unit price would push up the cost of cheap alcohol, which health campaigners argue would help reduce the abuse of alcohol, which is a major health and social problem in the UK.

While the Cameron Government may be wavering on increasing the cost of cheap booze, there are signs it is keen to tackle the harm caused by smoking, which claims about 100,000 lives a year.

Speculation that plain tobacco packaging legislation will soon be introduced has come two years after the British Government began consultations on plain packaging measures, inspired by action taken by the Australian Government.

Late last year, Australia became the first country in the world to require tobacco products to be sold in uniform plain packaging with prominent health warnings after successfully beating off a legal challenge mounted by the major tobacco companies.

The new laws, which are still the subject of a challenge mounted by several countries through the World Trade Organisation, have been hailed by public health advocates as a major advance in helping existing smokers quit and deterring young people from adopting the habit.

A number of countries have expressed interest in adopting plain packaging laws, and the New Zealand Government announced last month that it would introduce legislation before the end of the year.

According to *The Guardian*, the British Government will not only move to enforce plain packaging, but also to ban smoking in cars when children are present.

The moves come amidst mounting evidence that smoking is exacting an enormous toll on British health and finances.

According to a recent study in *The Lancet*, about 12 per cent of the nation's disease burden was due to tobacco use, helping push measures of health and wellbeing in the United Kingdom below that of Australia, the United States and much of the rest of Europe.

The Guardian quoted an unnamed senior UK Government official as saying that: "We are going to follow what they have done in Australia. The evidence suggests it is going to deter young smokers".

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Big Soda, community groups unite to beat soft drink ban

The decision of a New York State court to throw out a proposed ban on super-sized soft drinks has laid bare an unlikely web of alliances between major beverage manufacturers and civil rights campaigners, health advocates and community service organisations.

Groups including the National Association for the Advancement of Colored People (NAACP) and the Hispanic Federation (a coalition of Hispanic service agencies in the New York area) supported major soft drink companies including Pepsi and Coca-Cola when they successfully fought off an effort by New York Mayor Michael Bloomberg to limit the size of soft drink serves to 16 ounces (450 millilitres) at restaurants, theatres and food carts.

Earlier this month, New York Supreme Court judge Justice Milton Tingling criticised the limits – which had been championed by Mr Bloomberg as a vital step in tackling increasing obesity in the city – as "arbitrary and capricious", and ruled that the Board of Health that had approved the plan had over-reached its authority.

The ruling was soon as an important victory for the soft drink industry, which has come under increasing fire from public health advocates for marketing enormous serves of their sugary beverages.

Soft drinks have been identified as an important contributor to the increasing incidence of overweight and obesity, particularly among children and young adults, and within ethnic minority communities.

But the *New York Times* has reported that several organisations formed to advance the interests of minority groups, including African Americans and Hispanics, backed the soft drink industry in its fight to have the laws scrapped after receiving substantial donations and sponsorships from beverage companies.

The newspaper reported that soft drink companies have contributed tens of millions of dollars in conference sponsorships, scholarships, financial literacy classes and programs to organisations including the National Hispana Leadership Institute, NAACP, the National Puerto Rican Coalition and the National Hispanic Medical Association.

"These connections came to the fore when the New York chapter of the NAACP, along with the Hispanic Federation, filed an amicus brief in support of the beverage industry's effort to block Mayor Bloomberg's proposal," the newspaper said.

Hispanic Federation President Jose Calderon told the *New York Times* that although he shared Mayor Bloomberg's concern about rates of obesity in the Latino community, he disagreed with the proposed ban on super-sized drinks, arguing education would be more effective than legislation in changing eating habits.

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Call for an end to face-eating disease that kills thousands

An global campaign has been launched calling for concerted international action to eradicate a devastating illness that kills about 100,000 children a year and leaves hundreds of thousands more horribly disfigured.

The disease, Noma, is a devastating necrosis that primarily affects children between 2 and 6 years of age, and is most common in sub-Saharan Africa, as well as in poor communities in Asia and Latin America.

Noma is a rapidly progressive, polymicrobial, opportunistic infection that occurs during periods of compromised immune function, and is often associated with malnutrition, poor oral hygiene, unsafe drinking water and poor sanitation.

In many instances the infection begins as necrotizing ulcerative gingivitis, and can quickly spread through both soft tissue and bone.

According to the World Health Organisation, there are about 140,000 new cases every year, and the mortality rate is estimated to be between 80 and 90 per cent.

Those that do not succumb to the illness are usually left horribly disfigured and experience severe problems, eating, speaking and even breathing, normally.

Campaigner Jean-Baptiste Dieumo said the disease was all the more unacceptable because it could be quickly and effectively treated at an early stage with a simple and inexpensive antibiotic treatment costing about $2.50.

The campaign Stop Noma is urging the WHO, the World Bank, developed countries and political leaders and health ministers in developing countries to renew an international commitment to eradicate the disease through concerted and co-ordinated action.

"If we manage to alert and rally the health authorities of the countries afflicted by this scourge, train health care workers, and educate the affected populations on how to detect the first symptoms, and how to implement the various preventive measures, hundreds of thousands of children's lives will be saved," Mr Dieumo said.

He said that although several charities were already working to treat the disease, its eradication required government action coordinated at the national and international level.

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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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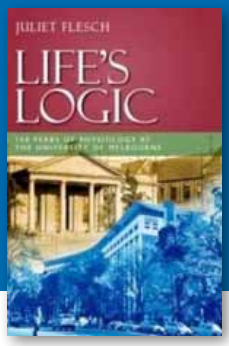
BOOK REVIEW



Life's Logic: 150 years of physiology at the University of Melbourne

By Juliet Flesch

Australian Scholarly Publishing, RRP $49.95, pp280, ISBN 978-1-921875-69-4

Reviewed by John Donovan*

Until about 1980, a notably high proportion of National Health and Medical Research Council research grants went to the University of Melbourne. Many investigators from other universities felt the proportion was undeservedly high, and eventually a Sydney-based Health Minister was persuaded by his constituents that the system might be unfair. So, instead of following precedent and immediately approving the grants recommended by the NHMRC, he did nothing.

Soon it was late in the year, and many grants were about to expire, potentially leaving those supported by them without income, and a lot of bad publicity for the NHMRC. The Minister held his ground, and asked for advice on what his powers in the matter might be. He was advised that he had the power to accept or to reject the NHMRC Council recommendations, but not to vary them. He signed off on the recommendations and made sure that the system was reviewed for fairness.

That account may not be exactly what happened, but it is close.

Reading *Life's Logic* made me wonder whether the envy of the University of Melbourne was fairly based. Its Department of Physiology had a record of an emphasis on research going back to the 1890s. Moreover, in that time it had hived off Departments of Anatomy and Pathology and of Pharmacology, and the Howard Florey Institute, all of which had continued the research tradition of the parent Department.

The Department started with the appointment of George Britton Halford in 1862 as Professor of Anatomy, Physiology and Pathology. His interests had included the action and sounds of the heart, and he was to add treatment of snakebite to them. He was also an advocate, an opponent of Darwin and Huxley, and became involved in public dispute over similarities and differences between the feet of gorillas and of humans.

Curiously, Halford had been appointed for life, and he remained in post until 1896 when, aged 72, he was persuaded to retire on half pay following concern over his capacity, and the scandal of relating an indecent story to a mixed class. The cost of his pension was met from a cut in the salary of his successor, Charles James Martin FRS, who was thus never able to be appointed Professor! He was, however, granted a special increase in salary in 1897 to encourage him to stay in Melbourne.

Martin led the move to research, publishing 16 papers between 1897 and 1902, but it was inevitable that he would move on, and in 1903 he returned to London as Director of Preventive Medicine at the Lister Institute. His successor, William Alexander Osborn, arrived early in 1904, and the research activity increased under both him and his successor, Roy Douglas 'Pansy' Wright. The history up to the end of the Second World War makes fascinating reading.

The later chronology was, to me at least, less interesting. It is not that it is not well written, because it is, but that the text gradually comes to resemble a series of curricula vitae in narrative form; there were simply so many people who passed through the Department, so many of whom contributed significantly to the science.

On the evidence presented, I remain to be convinced that the allocation of research grants up to 1980 was significantly unfair.

** John Donovan was a C J Martin Fellow of the NHMRC from 1969 to 1971. Later he worked in the Commonwealth Department of Health from 1974 to 1988. He is now retired and lives in Canberra.*

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Coonawarra cool

BY **DR MICHAEL RYAN**

The Coonawarra region in South Australia is, in a geo-social sense, next to nothing and close to nowhere. As a wine producing area, it almost faded into oblivion.

But a fateful turn of events has lead it to become Australia's premier Cabernet Sauvignon producer. The visionary, John Riddoch, first planted grapes in 1890 and, up until the 1950s, cheap, bulk wine was produced and used in the distillation of brandy.

Then the Government at the time implemented a vine pull system to drive a reduction in vine acreage to pave the way for an increase in the dairy industry.

Going against this trend, in 1951 David Wynn bought the 'stone winery' of John Riddoch, and commenced producing a more palatable table wine.

In time, demand for this wine grew and other major producers became interested in the area. Penfolds and Yalumba were quick to realize the potential. Since then, others have moved into the area and become well-established names, such as Lindemans, Brands, Balnaves, Leconfield, and Majella.

One of the biggest controversies was caused by trying to define the extent of the Coonawarra Geographical Index of Coonawarra, and a multi-million dollar lawsuit has seen its area expanded.

The original definition of the Coonawarra region was based on its strip of Terra Rosa soil. This iron-abundant red soil, overlaying a slice of limestone formed from an old sea bed, is only 20 kilometres long and 2 kilometres wide.

Despite a general lack of water, there is a constant layer of subterranean water that old vines can tap into. In wine speak; it is comparatively cool, with 1430 units of heat ripening. To give some idea, The Barossa is, by comparison, more than 1500 units, and Swan Valley in Western Australia is about 1700 units. Burgundy in France is 1190.

Ninety per cent of grapes grown in the area are red. Cabernet Sauvignon is king, with Shiraz and Merlot trailing. Chardonnay and Riesling are the more common whites. Small amounts of Cabernet Franc, Pinot Noir, and Sauvignon Blanc are also grown.

The Cabernet Sauvignon from Coonawarra is considered to be of an elegant style, with limited tannin structure. Fruit characters range from red currant to deep, brooding black currant flavors. They probably never get to the prominent cassis strength of Margaret River.

An interesting characteristic that has waxed and waned has been a eucalypt and mint aroma. Mildara, in 1963, created a Cabernet Sauvignon that was christened "Peppermint Patty", with an obvious chocolate mint bouquet.

In general, this is a most wine friendly place to visit. Riding the push bike around is fun, but caution at the end of the day is needed.

In recent times plush accommodation has been developed in the township of Penola. I can recommend the Oak Hotel for middle of the road standards, and The Menzies Homestead of Yalumba for an up market treat.

Wines Tasted

all 2008, a hot, well ripening year.

1. 2008 Orlando St Hugo Coonawarra Cabernet Sauvignon

A medium garnet color, looking youthful. The nose has red currant spice and mint aromas. The palate is full, with fruit and a medium bridge of tannins that are integrating nicely. It will get better in the next three to five years. Overall, a great, sturdy wine to be enjoyed with scaloppini et fungi.

2. 2008 Wynns Black Label Coonawarra Cabernet Sauvignon

A perennial favorite, with the 1996 and 1998 vintages being outstanding. A deeper garnet color is noted. The richer blackcurrant fruits waft on a trail of spicy oak and typical Coonawarra mint. The palate is a little fuller, with elegant structure, and there is less Cabernet "doughnut" effect. Continuing to develop in five to seven years, and good with duck in cassis liquor sauce.

3. 2008 Di Giorgio Francesco Coonawarra Cabernet Sauvignon

A darker red to purple colour. The nose has dark black currant offerings, but has complex oaky, liquorice aromas, with hints of spearmint. The palate is generous, and the tannins more evident, with much more new French oak exposure. This is a serious wine that will develop over 10 years and should be enjoyed with young rare lamb rack, with a hint of star anise in the jus.

4. 2008 Wynns John Riddoch Coonawarra Cabernet Sauvignon

A true Coonawarra icon, this was first made in 1982. A very deep, dark purple is displayed. The nose is youthful but impressive, with brooding dark fruits and cigar box aromas. Spicy chocolate notes indicate the seriousness of this wine. The palate is full, with a rising meter, latching onto thoughtfully arranged tannins. A super wine, as it often is, that will cellar for 10 or more years. It needs my old favorite, aged rib eye on the bone with a celeriac mash.

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

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