

A U S T R A L I A N

Medicine

The national news publication of the Australian Medical Association

Expense cap outrage

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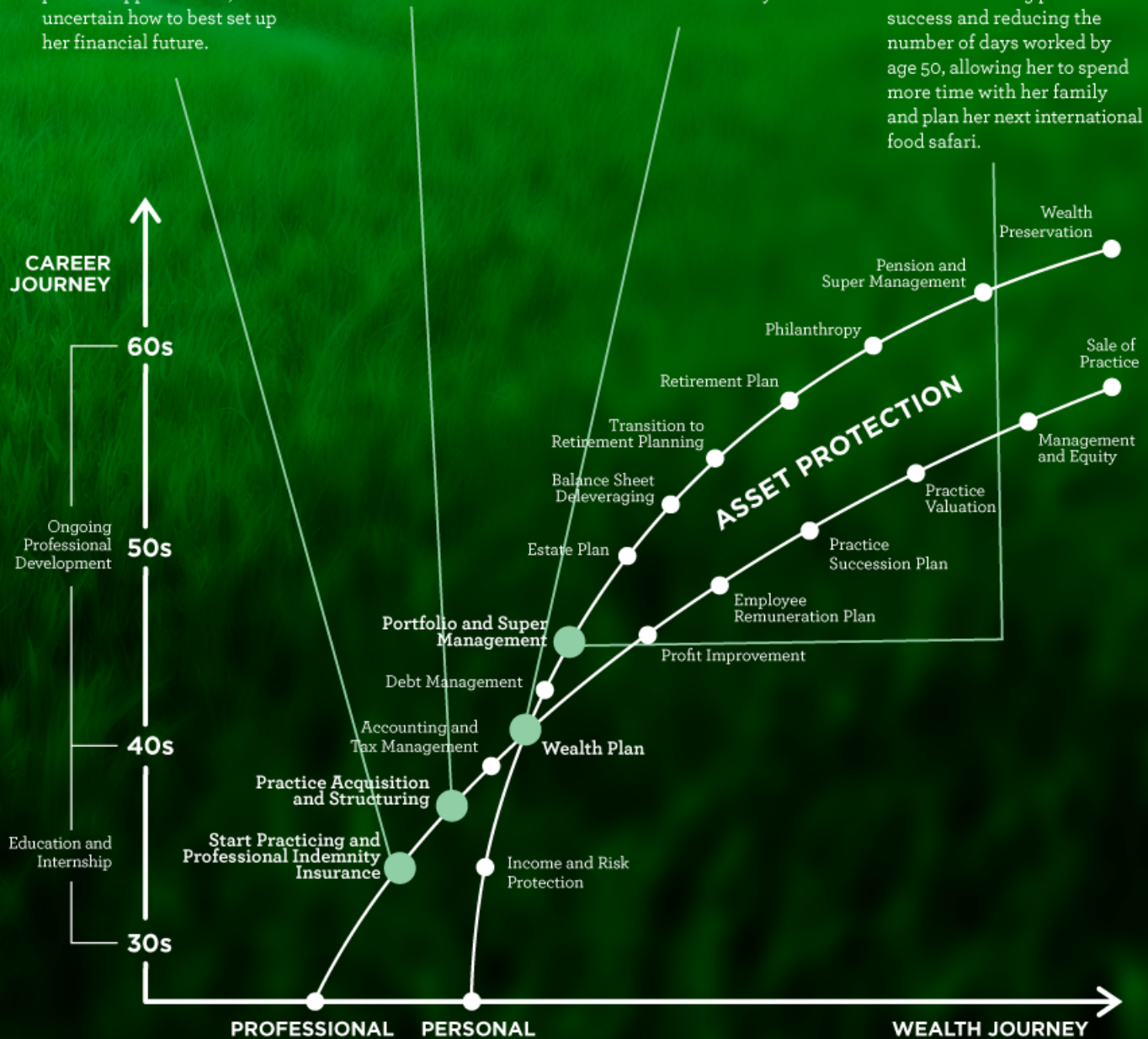
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Crippling medical education is a big FAIL

BY AMA PRESIDENT DR STEVE HAMBLETON

Amid the avalanche of Government media releases about the Gonski education reforms last month, a release was quietly issued by the Treasurer's office during the media 'dead zone' of Saturday afternoon, April 13.

Nobody was supposed to notice, because the Treasurer was announcing a political time bomb – a cap of \$2000 a year for tax deductions on work-related self-education expenses.

It did not take long for the AMA to grasp the potential devastating consequences of this change for doctors and for other professions.

But it was not just the substance of the proposed reforms that was offensive; it was some of the language used to describe the Government's decision.

The Treasurer's media release stated:

"...under current arrangements these deductions are unlimited and provide an opportunity for people to enjoy significant private benefits at taxpayers' expense."

It went on:

"Without a cap on the amount that can be claimed under this deduction, it's possible to make large claims for expenses such as first class airfares, five star accommodation and expensive courses."

Class warfare? Maybe. Political miscalculation? Definitely.

The AMA went public with its concerns about the changes and how they would affect the ability of doctors to upgrade their skills and improve their medical knowledge throughout their careers.

We sought and were granted a meeting with the Treasurer's advisers at Parliament House in Canberra.

We asked for a form of words in writing – by close of business – from the Treasurer or Treasury to assure us that genuine professional development activity would be quarantined from this decision, or the AMA would have no choice but to start a campaign on behalf of its members.

The advisers were given a couple of days, a week, and then two weeks to reply.

In the meantime, I sent a letter to all members explaining the situation to them, asking them to vote in our website poll, and to give us feedback on how the changes would affect them personally.

The floodgates opened. Rarely has there been such an overwhelming response from doctors in the field. At time of writing, we had received more than 4300 responses to our poll – with 98 per cent saying they will be hit hard by the changes – and hundreds of doctors detailed the impact on their professional development. Read their stories here <https://ama.com.au/node/9046/results>

Contrast the language of your colleagues with that of the Treasurer.

"As a remote rural GP, my CPD expenses are in the region of \$6000-8000 per year. A \$2000 per year cap on this will make my training unsustainable. I do not abuse the self-education system by claiming overseas holiday junkets, my training is critical for competence in the work I do and for regional hospital credentialling. Unhappy."

"As an emergency doctor in a public hospital, I attend 2-4 courses or conferences a year to keep my critical care skills up to date. All of these cost between \$2000 - \$4000 each unless they are in my home town, which most aren't. I fly economy and stay with friends or relatives if possible. While I can understand the Government wanting a cap in this current fiscal environment, \$2000 is out of touch with the cost of our ongoing medical education."

"As a teaching GP near retiring age I may be forced to work out the next triennium without much further education and then retire. I know many are of the same mind as me."

The Treasurer wrote to me on 29 April noting the AMA's concerns and informing us that a consultation process will commence later this month. But the damage has already been done.

Too often the Government has adopted the strategy of announcing the policy first, then consulting after the event. It hasn't worked before, and it is certainly not working on this occasion.

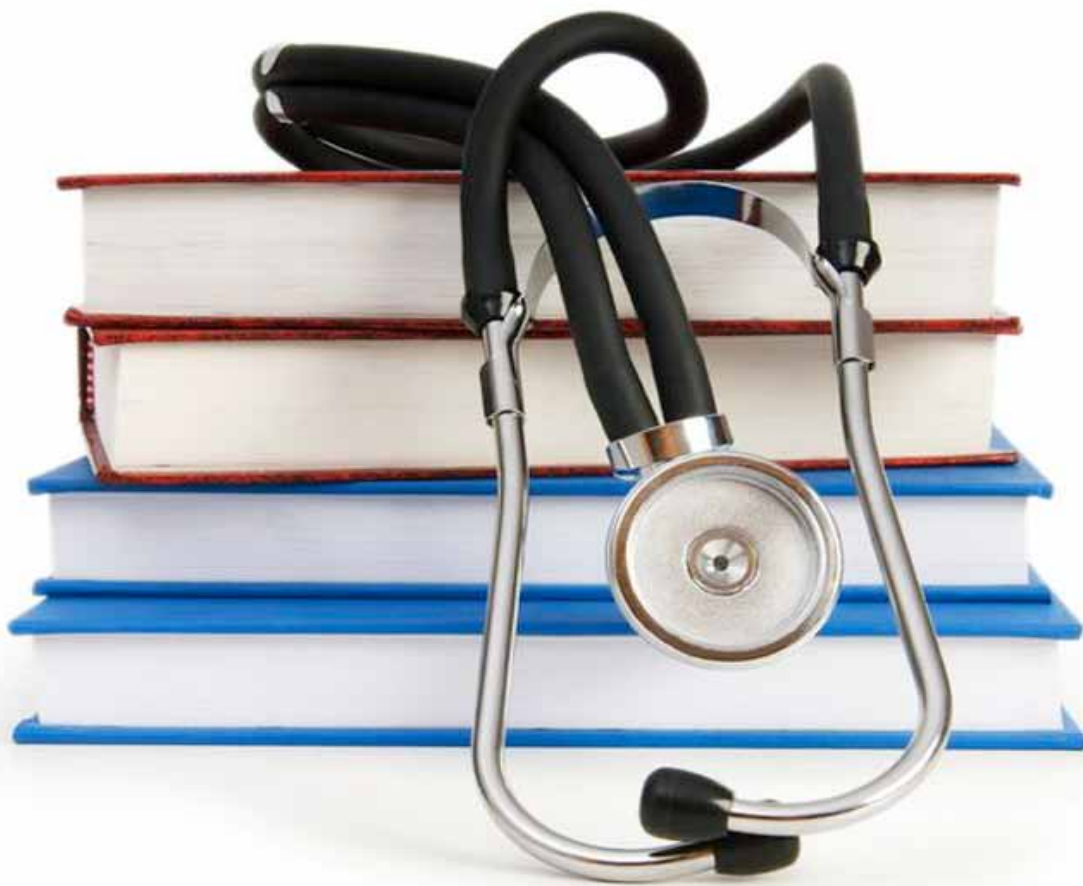
This is a serious issue that affects all doctors and their patients. It is a threat to quality health care in this country. As such, it is an election issue.

Your AMA will be doing all in its power to have this decision reversed. Join us in the fight.

Keep an eye on our website and on your email inbox. We will keep you informed and we will ask for your help.

[TO COMMENT CLICK HERE](#)

Doctors condemn ill-considered education expenses cap



Doctors have warned medical training will be compromised and patients are likely to suffer if the Federal Government pushes ahead with controversial plans to cap tax deductions for self-education expenses.

In an unprecedented outpouring of dismay, more than 4200 concerned practitioners have responded to an AMA online poll regarding proposals to cap the tax deduction for self-education expenses at \$2000 a year, with 98 per cent warning the change would seriously impair their professional development and potentially undermine the quality of care they can provide for their patients.

A rural GP doctor providing emergency, obstetric, surgery and anaesthetic services warned it would be “impossible”

to comply with all accreditation requirements within the \$2000 limit, “so I reduce my services to my rural community and who suffers? Not the Federal Government, but my isolated rural patients”.

A surgical trainee said that since January she had spent \$6500 on training and \$6400 in examination fees, as well as attending two interstate conferences, with compulsory training expenses accounting for about 20 per cent of their annual income, making a mockery of the \$2000 cap.

Another trainee warned bluntly that the proposed cap would force him to curb his education expenses, which would eventually “impact on the quality of care that I can provide to my patients”.

AMA President Dr Steve Hambleton said the overwhelming response underlined the grave concern many felt about the changes, which were sprung unexpectedly on the profession by the Government last month.

Dr Hambleton presented the AMA’s concerns to Department of Health and Ageing Secretary Jane Halton at a meeting on 1 May, and senior AMA officials have met with representatives from the Treasurer’s office to highlight the damaging effects of the tax change.

But Dr Hambleton said the Government’s offer to consult was unsatisfactory and wrong-headed, coming as it did after the change had already been announced.

“The Government has offered to consult

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after the event. They should be consulting before they make these decisions," he said. "The AMA believes that the Government needs to revise its starting point for negotiation – a \$2000 cap defies reality."

The AMA President said doctors had to spend many thousands of dollars each year on education and training, both to fulfil rigorous professional development and accreditation standards, as well as to keep abreast of the latest advances in diagnosis, medication and treatment in their fields of practice.

He said trainee doctors, and those working in rural areas, faced particularly high self-education costs, and would be put at a severe disadvantage by the \$2000 cap on tax deductible expenses.

"I don't think the Government has thought through the impact of these changes on doctors and a whole range of other professionals who must continually update their skills and knowledge throughout their careers, at their own expense," Dr Hambleton said. "Doctors must learn new about new technologies, surgical techniques, treatments, and pharmaceuticals if they are to provide the best possible care to save lives and improve quality of life for their patients."

In announcing the changes, which are due to come into force from 1 July 2014, Treasurer Wayne Swan said they had been carefully devised to crackdown on what the Government viewed as excessive claims.

Mr Swan said that while the Government valued self-education, the current uncapped arrangements were open to abuse.

"Without a cap on the amount that can be claimed as a deduction, it's possible to make large claims for expenses such as first class air fares, five star accommodation and

expensive courses," the Treasurer said.

Mr Swan's comments outraged several doctors, who said that, far from taking first class flights and staying in luxury accommodation, they often scrimped to ensure they kept their expenses down.

"As an emergency doctor in a public hospital, I attend two to four courses or conferences a year to keep my critical care skills up to date," one said. "Unless they are in my home town, which most aren't, I fly economy and stay with friends or relatives if possible."

Another AMA member, an infectious diseases physician, noted: "the proposed limits make it impossible to self-fund further education. Given that the largest conferences in the infectious diseases are overseas and involve travel to either Europe or the USA, there is no possibility of attendance within the proposed cap."

The Government announced the cap, which is expected to save about \$520 million in its first three years of operation, as part of a package of measure to help pay for its ambitious \$14.5 billion Gonski schools reform package.

But Dr Hambleton said the Government had "seriously underestimated" the effect it would have on medical training and the ability of doctors to keep themselves up to date with the latest advances in medicine.

"The level that this change has been set at doesn't even allow a student to gain his specialty," he said. "It certainly doesn't allow specialists to stay at the front of the wave."

"We have one of the best health systems on the planet, and we rely on our specialists, our GPs and our students being able to keep their education up to first rate levels."

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What AMA members are saying about the \$2000 tax deduction cap for self-education expenses:

"As a surgical trainee, our training fees are approximately \$6000 dollars alone. In addition, we are required to attend numerous courses that range from \$1000 to \$4000 each. The proposed changes, coupled with the enforced reduction in overtime, will be financially devastating for junior doctors who wish to develop their skills and obtain further qualifications."

"As a psychiatric registrar, my College fees, lecture program fees and exam fees far exceed \$2000 a year, without even taking into account textbooks, seminars, conference fees and so on. Given that psychiatrists are in short supply already, it is foolish to further increase the barriers."

"Remote doctors are required to keep their credentialling and skills up to date in many fields. The impossibly low restriction proposed will seriously impact remote medicine."

"Working part-time as a GP trainee, with a preschooler and a baby is not very lucrative after paying for childcare! But I want to remain a part of our profession and continue to contribute. College membership, textbooks and exam fees will still have to be paid."

"Tax-deductibility was making me feel better about that."

"As a GP in remote Australia who has recently started a new practice, CPD will become completely unaffordable. By the time you pay travel to larger regional centres or major cities, accommodation, course costs and then add a locum fee, you come out well behind as it is. I am disappointed that the Government has even considered it. Thank you AMA for defending our basic needs."

Disability levy set to pass with bipartisan support

The AMA has thrown its support behind the Government's plan to increase the Medicare levy to help fund the national disability insurance scheme, which is set to come into effect with backing from the Coalition.

"The legislation to give effect to the Government's increase to the Medicare levy and the full NDIS package must be introduced and voted on in the current parliament"

AMA President Dr Steve Hambleton said the Association "absolutely supports" a proposed 0.5 percentage point increase in the Medicare levy from 1.5 to 2 per cent to partially fund the scheme, which has been dubbed DisabilityCare Australia (DCA), arguing it was the fairest and most sustainable way to pay for the scheme.

In a major back flip less than two weeks before the 14 May Budget, the Federal Government on 1 May announced it would introduce the levy – expected to raise \$3.3 billion in 2014-15 and a total of \$20.4 billion between mid-2014 and mid-

2019 – to help pay for DCA, which is one of the major policy commitments of its second term in office.

Prime Minister Julia Gillard lauded the disability insurance scheme as "the most fundamental social policy reform since the introduction of Medicare", and said the proposed levy would provide it with a "strong and stable" funding stream.

"Every dollar raised by the levy will go directly to fund DisabilityCare Australia," Ms Gillard said. "To ensure this, the Government will create in legislation a special DisabilityCare Australia Fund, through a dedicated special account. Revenue from the additional levy will be paid into the fund, which will only be drawn down to meet expenditure directly related to DisabilityCare."

Dr Hambleton said the introduction of the scheme was a "defining moment in social equity" in Australia, and increasing the Medicare levy to help fund it was an effective way to spread the cost across the community.

"An insurance system is where we share the expenses," he said, "and making it through a Medicare levy actually allows Australians all to share those expenses".

"We're glad that the funding has been found in a mechanism that actually does distribute the costs across the widest possible base."

Ms Gillard committed to introducing legislation for the levy into the current parliament before it rises prior to the forthcoming Federal election after the Opposition gave its conditional support for the proposal.

She made the commitment after being challenged by Opposition leader Tony Abbott to present the legislation to parliament in the five sitting weeks left

before the 14 September poll.

"The legislation to give effect to the Government's increase to the Medicare levy and the full NDIS package must be introduced and voted on in the current parliament," Mr Abbott said.

Such a move would not only help neutralise the NDIS as an election issue, but would spare a future Coalition Government the need to introduce the levy itself – a move which would run counter to its low tax rhetoric.

In a shift in the Coalition's position, the Opposition leader dropped plans to fund the scheme solely from consolidated revenue.

"We know that the state of the Budget [does] not currently allow for the NDIS to be funded from consolidated revenue without further borrowings," Mr Abbott said. "People with a disability should not have to wait any longer than is necessary for the support they need."

"For these reasons, the Coalition is prepared to consider providing support for the Government's proposed increase in the Medicare levy."

But Mr Abbott added that the levy would only be a temporary measure.

"If elected to Government, the Coalition would resolve to ensure that the increase to the Medicare levy is a temporary increase, and will be removed when the Budget returns to strong surplus and the NDIS can be funded without it."

Dr Hambleton said it was important for both sides of politics to provide funding certainty for DCA.

"The disabled people in this country really have had a raw deal," he said.

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Fewer choices in medical outlook

Future doctors will have fewer choices in their choice of specialty, where they practise and how they treat their patients, AMA President Dr Steve Hambleton has warned.

In a major speech to the Medical Board of Australia National Conference last month, Dr Hambleton outlined two fundamental shifts likely to occur in the way medicine was practised in the next decade that had the potential to turn what was an immensely rewarding career into just another job, unless handled well.

The AMA President said that in the future, those embarking on a medical career were likely to face more constrained choices in the type of specialty they entered, and where they would work.

“Up to now, medical practitioners have chosen their specialties based on their personal interests,” he said. “[But] our future medical graduates will face a very different set of career choices.”

Health Workforce Australia has predicted that shortages will emerge in a number of specialities including obstetrics, ophthalmology, psychiatry, diagnostic radiology and radiation oncology in the next 12 years, and Dr Hambleton said this would shape the choices open to aspiring doctors.

“Future medical graduates will no longer have the complete range of specialty choices that we have become accustomed to in the past,” he told the conference. “We will need to encourage entry into those specialties where potential future shortages are predicted, with a consequent reduction in choice.”

Medical trainees will not only have a narrower range of fields of expertise to choose from, they will also face growing barriers and inducements regarding where they practise.

“Graduates will need to look beyond the major cities, and consider a career in regional and rural Australia,” he said.

But the AMA President warned there

was a danger increasing constraints on the choice of medical career path could lead to professional dissatisfaction and disengagement unless they were deftly handled.

He said the expectations of future medical graduates would need to be carefully managed, and it was critical that there be well-conceived policies that rewarded career choices and ensured they were not seen as a “last resort option”.

The second major shift identified by the medical leader was the likely effect of efforts to curb health funding growth on the clinical choices open to doctors and their patients, with significant implications for this fundamental relationship.

Health spending is projected to grow from 9.4 per cent of gross domestic product in 2009-10 to 12.4 per cent by 2030, driven in large part by increases in the volume of treatment for each episode of care rather than the ageing of the population or the rise in chronic disease.

Dr Hambleton said the medical profession had an important role to play in helping to control the upward spiral in health costs, and would find its choices of treatment increasingly constrained.

He predicted that governments were likely to narrow or withdraw Medicare rebates for some treatment options, or at the very least make benefits payable only in a very prescriptive set of clinical circumstances at the end of a long clinical pathway.

Doctors would “effectively be constrained to provide only those treatments that attract funding, not the treatments that [they] might consider are clinically appropriate”, he said.

Dr Hambleton warned that, unless handled sensitively, this had the potential to strain the vital doctor-patient relationship.

He said patients had come to expect that doctors would do everything in their power to ensure all test and treatments

that could be performed were carried out, but under increasing prescriptive funding arrangements, practitioners would have to do with what was available.

“Patients’ expectations may not be able to be met, and they would be more likely to be dissatisfied with their health care experience,” the AMA President said. “They might blame their doctor, not the funding scheme.”

The AMA was actively participating in efforts to ensure the best possible use was made of health funding, he said, including contributing to Government reviews of the Medicare Benefits Schedule and looking at ways to expand the role of other health practitioners.

But Dr Hambleton warned that unless this was managed “properly and sensitively”, it potentially exposed patients to harm and increased medico-legal risks for doctors.

The AMA has raised concerns about the decision by the Optometry Board to give optometrists the authority to independently prescribe anti-glaucoma medication, and castigated the Chiropractic Board over revelations that chiropractors gained accreditation points for attending a course conducted by an anti-vaccination campaigner.

Dr Hambleton said such incidents underlined doubts about how practitioner boards were setting guidelines and standards, and called for a much more active and prominent oversight role for the Medical Board.

“We accept that health professions will have changing roles over time and may want to expand their scopes of practice,” he said. “We accept that politicians can see the financial merits of allowing [this]. But we cannot accept that this can be done by stealth, by a board whose primary role is to protect the public without mandatory reference to our own Medical Board.”

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AMA goes to the top with doctor concerns



Meeting with Jane Halton

AMA President Dr Steve Hambleton has raised doctor concerns about the introduction of electronic health records, moves to cap tax deductions for self-education expenses and the Government's review of chronic disease items with the nation's top health bureaucrat.

Dr Hambleton reinforced the AMA's position on a wide range of issues affecting health care and the medical profession during detailed talks with the Secretary of the Department of Health and Ageing Jane Halton on 1 May.

The discussions were held against the backdrop of final preparations for the 14 May Federal Budget.

The Government has flagged the Budget is likely to contain further spending cuts and possible tax increases amid estimates of a \$12 billion plunge in revenue, and Dr Hambleton and Ms Halton discussed the implications of the fiscal outlook for the health sector.

The AMA President informed the departmental secretary of AMA concerns about the inadequate support being provided to many medical practices around the country as they try to prepare themselves to support the creation and maintenance of Personally Controlled Electronic Health Records.

During the talks, Dr Hambleton also reiterated warnings that the proposed \$2000 cap on tax deductions for self-education expenses would undermine doctor training and potentially compromise the quality of care.

He also reinforced to Ms Halton the AMA's views on the Government review of chronic disease items, proposed changes to collaborative care arrangements for midwives, projected shortages of places for medical interns and specialist training positions, and discussed aspects of the patient-centred Medical Home initiative.

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AMA Executive Officer election results

AMA President Dr Steve Hambleton and Vice President Professor Geoffrey Dobb have been re-elected to their positions unopposed.

Dr Hambleton, a Brisbane GP, is due to be elected unopposed at the AMA National Conference in Sydney later this month for a third term as President.

Professor Dobb, Director of Critical Care at Royal Perth Hospital, is set to be confirmed in the Vice President role he has filled for the past two years.

But the position of Chairman of Council is being contested, after Dr Iain Dunlop, Canberra ophthalmologist and AMA Executive Council member, nominated

for the position, standing against the incumbent Dr Roderick McRae, an anaesthetist from Victoria.

Currently, NSW anaesthetist Dr Elizabeth Feeney, an AMA Executive Council member, is the only nominee for the Treasurer position being vacated by Adelaide GP Dr Peter Ford.

But there is a possibility Dr Feeney could face an election, should the unsuccessful candidate for Chairman of Council choose to contest the Treasurer position.

Meanwhile, internationally respected public health expert and *Australian Medicine* columnist Professor Stephen Leeder has been appointed Editor in

Chief of the *Medical Journal of Australia*.

Professor Leeder brings enormous experience and knowledge to the position, gained from 35 years of involvement in epidemiological and public health research, educational development and policy.

In a statement, the MJA Board said Professor Leeder was "ideally suited to steer the MJA as it embraces new media and new strategies to bring world-leading Australian medical research and commentary to a broad national and international audience".

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Blame govt, not doctors, for out of pocket expenses

AMA President Dr Steve Hambleton has called for a factual and mature debate about out of pocket health care expenses amid misleading claims that doctors are responsible for much of the impost on patients.

Dr Hambleton said out of pocket payments for health services was a serious and sensitive issue for families, and the public deserved to know the factors that were driving such charges, and what could be done to stem their rise.

The AMA President said that out of pockets expenses had become “a reality” in health care, largely because of the failure of successive governments to ensure that Medicare rebates kept pace with the rising cost of providing health care.

“Out of pocket expenses are a reality in health care, primarily because Medicare Benefits Schedule fees, and therefore rebates, have fallen well behind the true cost of providing quality health services to the Australian community,” Dr Hambleton said.

Government figures show that doctors are shielding a majority of their patients as much as possible from the need to impose top-up charges, with 80 per cent of GP consultations in 2011-12 bulk billed, while more than 88 per cent of privately insured medical services were provided without a gap payment.

Furthermore, Dr Hambleton pointed out, where doctors do charge out of pocket expenses, they are generally less than for other forms of health care.

The average out of pocket charge for medical services was \$125 a year, just 11.5 per cent of the average \$1082 of out of pocket expenses paid by patients for all health services each year.

By comparison, patients incur out of pocket costs of \$357 a year for ‘other medications’, and \$203 a year for dental services.

The AMA President said these facts belied suggestions from the Consumers Health Forum that the bulk of out of pocket expenses were for medical services.

In an article in the Forum’s *Health Voices* magazine, Chief Executive Officer Carol Bennett claimed that out of pocket expenses was creating a two-tiered health system discriminating against those less able to pay for their health care.

In comments that Dr Hambleton condemned as a “blatant attack on doctors”, Ms Bennett said, “our fee for service, throughput system is clearly not delivering for consumers. It is time we started considering alternatives...that focus more on the needs of the consumer than the needs of those providing services”.

The AMA President said that rather than blaming doctors, attention should be on what could be done to boost rebates and improve access to health care for all.

“We agree that out of pocket costs for overall health care are a concern, and we acknowledge that some patients – especially those with multiple, complex and chronic conditions – are doing it tough,” Dr Hambleton said. “But the solution lies in fixing the system, not attacking the hardworking professionals who provide quality health care.”

He called for an informed and credible discussion of the issue in the lead-up to the 14 September Federal election.

“Going into an election, we need a mature policy debate around a properly indexed MBS and improved safety nets that do not let people fall into hardship because of their health conditions,” Dr Hambleton said.

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**Australia's Health System:
What's the treatment?**
AMA National Conference 2013
24-26 May 2013, The Westin, Sydney

Conference highlights

- Revalidation, Finding ways to provide the best possible end-of-life care
- The Politics of Health
- A Market Economy for Health and Health has a Postcode - Society's ills and Individuals' health.

Speakers
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The National Conference is open to all medical professionals, join us for what is sure to be an outstanding event!

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Face to face with *facebook*



AMA President Dr Hambleton with Facebook Communications and Policy Director Mia Garlick

AMA President Dr Steve Hambleton last month visited *facebook*'s Sydney offices to chat with the social media giant's Head of Policy and Communications Mia Garlick about alcohol marketing to young people and other new media issues.

One of the issues that emerged from last year's National Summit on Alcohol Marketing to Young People, convened by the AMA, was the way that alcohol companies were using new methods to lure young people to use alcohol, including clever promotions through social media.

Concerns were raised that children could be exposed to alcohol marketing messages through platforms such as *facebook*.

The Summit called on the Government to implement a parliamentary Inquiry into the extent to which young people are exposed to alcohol marketing and promotion in Australia.

Dr Hambleton referred Ms Garlick to the Summit Communiqué and the AMA report, *Alcohol Marketing and Young People: Time for a new policy agenda*, and reiterated the AMA's broader concerns about all forms of alcohol promotion to young people.

Ms Garlick said she had read the AMA report and shared many of the AMA concerns. She explained that the media often wrongly attributed inappropriate online activity to *facebook* because the name *facebook* had almost become a generic term for social media.

The Australian National Preventive Health Agency (ANPHA) late last year released an issues paper on the regulation of alcohol advertising, and interested parties were asked to make submissions in response to the paper.

The Interactive Advertising Bureau (iab), of which *facebook* is a member, made a submission.

Ms Garlick told Dr Hambleton that *facebook* has systems in place to monitor, track, report and remove any unwarranted or unsuitable content on its site, including in relation to alcohol.

She said that *facebook* has a 'zero tolerance' policy in this regard,

and has an ongoing policy of building in safeguards to protect young people from unsuitable messages or content. There are age restrictions and country restrictions.

Instead, she said, *facebook* actively seeks to promote health information, and conducts school talks on the safe and responsible use of social media.

The iab submission to ANPHA states:

"Alcohol branded content on *facebook* includes official pages, posts, sponsored stories and adverts. This content is not visible to people under the age of 18 in Australia. The content is age-gated and this prevents both paid-for and organic sharing with people under the age of 18 ... *facebook* uses highly effective ad targeting techniques. By being able to only reach a specific audience, you are by definition able to exclude others. In other words, *facebook* is one of the safest places within which to ensure that young people do not see alcohol advertising."

Ms Garlick said that *facebook* would be happy to work with the AMA on initiatives that promote healthy attitudes and behaviour among young people through social media.

JF

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

Notice of Annual General Meeting

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

Business

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

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

Mr Warwick Hough
Company Secretary
11 February 2013

Right on cue on Q&A



AMA President Dr Steve Hambleton on the set of Q&A with AMSA representatives

AMA President Dr Steve Hambleton was in the audience for last month's health policy debate between Health Minister Tanya Plibersek and Shadow Minister Peter Dutton on ABC TV's *Q&A* program – and had the honour of bowling up the first question to the political panellists.

Dr Hambleton's question on public hospital funding and the 'blame game' got the show off to a fiery start with fingers pointing, heads shaking, and statistics being batted backwards and forwards between the two combatants.

Many topics were covered including health spending, primary care, palliative care (adult and children), medical training,

Medicare Locals, rural health, broadband and telehealth, medical research, the private health rebate, Indigenous health, and organ donation.

The audience – which included a strong delegation of medical students, led by AMSA President Ben Veness – was intelligent, attentive, and at times feisty.

Host Tony Jones made sure the questions kept coming and that they found answers, and both the Minister and Shadow Minister performed strongly.

The biggest challenge of the night was finding new policy.

While the Government is intent on bedding down the things they already have in train, Mr Dutton gave some clues about what to expect if the Coalition wins Government.

He hinted at a restructure, not abolition, of Medicare Locals, cuts to the Federal health bureaucracy, and a commitment to 'rebuild general practice'.

Mr Plibersek urged people to look at the Government's record – 'more doctors, more nurses, smoking reform, improved cancer care, and better kids' dental services'.

As they shuffled from the *Q&A* studio that night, health sector audience members welcomed the spotlight on health policy, but agreed that they had heard very little from the debate that was new or unexpected.

JF

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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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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

Hospital Pass, *The Daily Telegraph*, 2 May 2013

AMA President Dr Steve Hambleton came out in support for the Government's proposed Medicare levy rise to fund the National Disability Insurance Scheme. Dr Hambleton said, "It is an opportunity for truly transformational reform for the benefit of the most vulnerable people in our community".

Gonski reforms will cost professionals more if self-education, *The Australian*, 1 May 2013

The AMA is fighting a Government proposal to cap tax deductions for self-education expenses at \$2000.

Move to reveal doctor drug deals, *The Age*, 30 April 2013

The AMA, previously opposed to increased disclosure of financial relationships between practitioners and companies, is now supporting the scheme. AMA President Dr Steve Hambleton said continued secrecy could undermine confidence in the integrity of doctors.

Plibersek's Medicare warning, *The Australian*, 30 April 2013

The AMA has urged the Government to protect chronic disease and structured care Medicare rebates.

Keep baby sex secret, *The Sunday Times*, 28 April 2013

AMA President Dr Steve Hambleton said women had the right to know everything about their pregnancy. His comments followed calls for doctors to withhold information on the gender of foetuses from expectant parents as a way to prevent abortions.

Air pollution linked to heart disease: study, *The Sydney Morning Herald*, 24 April 2013

The AMA told a Senate inquiry Australia needed to tighten and improve its regulations for air pollution to protect future health, particularly regarding ultra-fine particles.

Fluvax jabs worry AMA, *The Canberra Times*, 22 April 2013

The AMA voiced concern that public confidence in vaccination could be undermined if reports that children had been injected with a banned flu vaccine were correct.

Radio

Dr Hambleton, ABC NewsRadio, 1 May 2013

AMA President Dr Steve Hambleton said the AMA supported the Government's plans to increase the Medicare levy to partially fund the National Disability Insurance Scheme.

Dr Hambleton, 2UE Sydney, 30 April 2013

Dr Hambleton commented on flu vaccination shortages in Australia.

Dr Hambleton, 666 ABC Canberra, 29 April 2013

Dr Hambleton rejected claims that doctors were to blame for high health care costs in Australia. Dr Hambleton said providers were left out of pocket by Medicare.

Dr Hambleton, ABC News Radio, 26 April 2013

AMA President Dr Steve Hambleton

discussed recommendations that the abortion drug RU486 be publicly subsidised. Dr Hambleton said there would be doctors who preferred not to prescribe the drug, and the AMA supported their decision.

Dr Hambleton, 2GB Sydney, 19 April 2013

The AMA warned people to get vaccinated against the H3N3 flu strain. Dr Hambleton said it had caused the worst flu outbreak since 2009 in the US.

Television

Dr Hambleton, The Project, 1 May 2013

AMA President Dr Steve Hambleton said more Australians were killed each year by pollution than by car accidents. Dr Hambleton talked about the threat of particulate matter, and said Government needed to toughen air pollution regulations.

Dr Hambleton, Channel 7, 1 May 2013

Dr Hambleton said the AMA supports the Government's plan to increase the Medicare levy to help fund the National Disability Insurance Scheme.

Dr Hambleton, The Project, 30 April 2013

Dr Hambleton talked about the relationship between doctors and pharmaceutical companies.

Dr Hambleton, Channel 10, 21 April 2013

Dr Hambleton urged parents to vaccinate their children against influenza.

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AMA in action



AMA President Dr Steve Hambleton at the set of ABC's Q&A program

AMA President Dr Steve Hambleton joined the political debate this past fortnight, appearing on ABC's *Q&A* program for its forum on health policy. Dr Hambleton was invited to ask the first question posed to the panel, which comprised Health Minister Tanya Plibersek and Shadow Health Minister Peter Dutton. Dr Hambleton met with Facebook in Sydney to discuss alcohol advertising to young people via social networks. Dr Hambleton also held a media doorstop at Parliament House, at which he discussed the Government's plan to increase the Medicare levy to fund the National Disability Insurance Scheme, and expressed the strong objection of doctors to the Government's announcement that tax deductions for work-related self-education expenses would be capped at \$2000 from mid-2014. He warned the plan would compromise doctor education and potentially undermine the quality of health care. Dr Hambleton also testified at a Senate hearing into proposals to ban pharmaceutical company payments for doctors to attend seminars and conferences. He told the inquiry that although the AMA embraced increased transparency of the relationship between doctors and drug companies, this had to be managed so as not to undermine public confidence in the medical profession. Late last month the AMA Federal Executive met in Canberra to develop plans and strategies for the AMA, including preparations for the National Conference to be held in Sydney on 24 to 26 May.

[TO COMMENT CLICK HERE](#)



AMA Federal Executive Dr Rod McRae, Dr Steve Hambleton, Dr Iain Dunlop, Dr Liz Feeney, Professor Geoffrey Dobb and Dr Peter Ford



AMA President Dr Hambleton with Facebook Communications and Policy Director Mia Garlick



Dr Steve Hambleton discusses the National Disability Insurance Scheme with the media



PCEHR set to make life easier for doctors, improve care

BY DR MUKESH HAIKERWAL, FORMER AMA PRESIDENT AND NATIONAL CLINICAL LEAD, NATIONAL E-HEALTH TRANSITION AUTHORITY

“The biggest problem faced regarding both “in-hospital” and “out of hospital” IT systems is a lack of interoperability, where multiple different systems are not able to talk to each other, they require multiple log-ins, and there is no common place to view and collate information”

I was asked to write an article regarding the Personally Controlled Electronic Health Record (PCEHR), also known as the Electronic Health Record System.

I state up front that these views are my own personal views, based on my own journey.

This is the progress towards the brave new world of shared personal patient health information, the electronic exchange of patient information between practitioners using secure email - Secure Messaging Delivery (SMD) - built on nearly 20 years of increasing expertise in the use and deployment of clinical information systems (CIS) in the general practice sector, in particular.

The PCEHR evolved from the 2009 recommendations of the National Health and Hospitals Reform Commission, which in turn was informed by the Booz & Co. paper, *E-Health: Enabler for Australia's Health Reform* published in 2008, and Deloitte's National E-Health Strategy report of the same year.

The PCEHR was funded in the 2010 Federal Budget for \$446.7 million over two years. It built upon previous national infrastructure for e-health programs, the foundations of which were provided by the National E-Health Transition Authority, set up by the Council of Australian Governments in 2005.

From these foundations arose the Healthcare Identifiers (HI) service, to identify all participants in the health care system – consumers and health practitioners alike. Unfortunately, that take-up of the system has been slow, even though it has been developed to obviate, or at least minimise, identification errors for patient information. To me, the HI service is the “flagship” product, underpinning any advance in health care technology.

There has been other continuing work, including

the production of a National Products Catalogue (NPC) for health products, the Australian Medications Terminology (AMT) compendium, a consistent clinical terminologies system – Systematized Nomenclature Of Medicine Clinical Terms (SNOMED CT), a National Authentication System for Health (NASH) to provide access for participants to a national system and, most usefully, right here, right now, a system for confidential electronic clinical information transfer known as Secure Messaging Delivery (SMD). These are all components of a national electronic health system.

The current situation, in which health information is sent or received by letter or fax is greatly improved by the use of SMD. The receipt of pathology and radiology results in practice today uses a secure messaging delivery system that I term “Classic”. It uses a mechanism of authentication provided by the Department of Human Services/Medicare known as PKI (Public Key Infrastructure).

In time, this will be superseded by an enhanced SMD version that uses the HI service to identify patients and the providers communicating about their care, authenticated with a NASH that can be sent to any compliant software product, as they will “inter-operate”. Currently, a “Classic” SMD product can only share messages with providers with that brand (rather like a smartphone that cannot receive calls from a different type or brand of phone).

Proof of concept and deployment work is almost complete on arrangements that will allow all five main products able to exchange messages.

The PCEHR is a key enabling technology for health care, as it allows multiple practitioners to share clinical information about a patient, ensuring better coordination of care, less duplication and better health outcomes, as more pertinent information from ‘trusted’ sources occurs, guaranteeing “provenance” of that information, upon which care pathways can then be based.

...CONTINUED ON PAGE 17

...CONTINUED FROM PAGE 16

The “go-live” for the PCEHR system was 1 July last year, and since then there has been a gentle rise in the number of participants in the system, with more than 125,000 consumers registered.

The uptake of practitioners using the system was given a boost through the requirement that general medical practices participating in the electronic health Practice Incentives Payment scheme (ePIP) had to meet five eligibility criteria, including the ability to connect to the PCEHR system.

That process was fraught, as GP practices did not receive the multiple paper forms involved in applying for HI service organisation identifiers and NASH tokens until December, and were only given until 1 February to complete them. Of course, all this work had to be completed during what was the peak holiday season of the year.

The need is, however, that many more than the current 27 per cent of non-GP specialists, allied health practitioners and nurses, among others, need to get “e-enabled” for the system to have any chance of reaching the critical mass needed to achieve the goals of better, joined up care, enhanced by access to good, pertinent health information.

As a proponent of e-health to support the way I provide care, to streamline care by allowing access to key health information, and to potentially to make life easier

and break down barriers, I connected my practice to the PCEHR system in December 2012.

As one of the 98 per cent of GPs using technology for clinical purposes, I have already experienced the benefits of the computer in my consulting room, which have improved, evolved and enhanced with time. These include dealing with the complexities of prescribing, receiving pathology reports, diagnostic imaging results and some specialist letters by Classic SMD.

The biggest problem faced regarding both “in-hospital” and “out of hospital” IT systems is a lack of inter-operability, where multiple different systems are not able to talk to each other, they require multiple log-ins, and there is no common place to view and collate information.

The PCEHR is far from perfect. It has to develop more capability to allow it to enhance current care provided by practitioners with their own home systems. What can be said, and is not stated or recognised, is that despite the significant shortcomings, the very fact that the system is now able to be written to and read, from multiple GP, pharmacy, aged care and some hospital Clinical Information Systems (CIS), is a massive shift in inter-operability. It means there is the ability to gather and share information regardless of the CIS used, and disproves the idea that joined-up patient care is an unachievable goal.

So, there is now a vehicle which has been rolled onto the start line, and given a very gentle push.

There are a few drivers and a few passengers in the vehicle today, which is not perfect.

It does exist and has some function. It is no longer vapourware and a figment of someone’s imagination, spoken of but never seen.

It can be and must be “tweaked” – especially in these early days, as use increases and faults are visible. To that end, a Clinical Useability Program is being rolled out by NEHTA to address currently known difficulties with PCEHR, and to ensure product builds are made cognisant of clinical utility and useability, and that there is a mechanism to improve the methodology used for development of new products. This is part of how technology develops: from the crystal radio to digital, from the valve television to LED, from the Bell telephone to the coolest Smartphone.

In the same way as the customer base informed and drove these developments, it is up to the professions to now be part of the evolution of this technology.

We need to ensure that the health professions help design and build the technology they need and have called for, rather than having technology drive the way in which the professions do their work.

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Don't let her drink dirty water

malaria, typhoid, dysentery, cholera, diarrhoea, intestinal worm infection, ... dirty water can kill.

6,000 children are dying every day – and it's because they don't have clean water. So they're forced to drink water that could make them sick with diarrhoea, cholera and typhoid.

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World Vision

No relief for depleted flu vaccine stocks before end of month

Fresh locally made batches of the influenza vaccine are not expected to be available until late this month after a rush of demand for inoculation depleted existing stocks of the vaccine.

The nation's only maker of influenza vaccine, bioCSL, has restarted production of its influenza virus types A and B vaccine after stocks were plundered early last month amid warnings that the nation was at risk of a severe outbreak of the disease following a killer season in the United States and Europe.

So far this year there have been more than 3000 laboratory confirmed cases of influenza infection, with concerns the disease could hit "hard and early" as Australia moves toward winter.

But BioCSL General Manager Dr John Anderson warned additional doses of the vaccine would not be ready for delivery until the end of May, and priority would be given to those considered to be the most at-risk, including the elderly, children and pregnant women.

AMA President Dr Steve Hambleton confirmed that a rush to vaccinate has caused some short-term shortages of the vaccine, which had been formulated to provide effective protection against the major flu strains currently circulating internationally.

"We know there is a particularly severe H1N1 strain that hit China in the winter last year," AMA President Dr Steve Hambleton told ABC News. "We also know there is a H3N2 strain which caused most of the problems in the United States. Both of those thankfully are in our vaccine so we should have some protection from both of those."

Calls from the AMA and health authorities urging people to vaccinate themselves against influenza have been heeded, with doctors and clinics reporting a rush to inoculate, particularly in the first two weeks of April, which had led to short-term shortages in some areas.

"All our customers are reporting a much earlier and much higher uptake of influenza vaccine this year, compared to the last few years," Dr Anderson said.

He said bioCSL was currently in the midst of producing influenza vaccine for the forthcoming flu season on the Northern Hemisphere, and restarting production of the formulation for the current Southern Hemisphere season was a major undertaking.

"But, as Australia's only on-shore manufacturer, we are committed to responding to local needs," Dr Anderson said. "Should the extraordinarily high demand for influenza vaccine persist, we are very pleased to be able to support the Government in ensuring additional doses are available for age-

appropriate, at-risk groups."

Meanwhile, the outbreak of the H7N9 avian flu virus in China shows no signs yet of abating.

As at 29 April, the Chinese health authorities had notified the World Health Organisation of 126 laboratory-confirmed cases, 24 of which have so far proved fatal.


The WHO warned that until the source of the infection was identified, the number of cases was likely to continue to grow.

But, promisingly, the WHO reported that there were no indications of sustained human-to-human transmission of the infection.

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CME Points on Application

Pathology guide for ED physicians as Medicare cracks down

Emergency department doctors and pathologists have been issued with new pathology testing guidelines amid a Medicare crackdown on public hospital billing practices for pathology and diagnostic imaging services.

The Australasian College of Emergency Medicine (ACEM) and the Royal College of Pathologists of Australasia have jointly issued the guide to promote appropriate pathology test requests in emergency departments.

The groups said the need for the guide had become increasingly apparent as the number of pathology tests being ordered has soared in recent years.

Pathology tests are commonly requested for most emergency department patients, the groups said, but “there has been continued growth in both requests for, and costs of, pathology tests in recent years, and clinicians have a responsibility to use these resources appropriately”.

ACEM President Dr Anthony Cross said, “it is important that the right test is performed for the right condition to improve the timeliness and accuracy of the diagnosis while reducing the ordering of unnecessary tests”.

The guidelines include a table setting out suggested tests for a range of common emergency department patient complaints, details of best practice blood collection and labelling techniques, and a run down of the basic information that should be included in service agreements between emergency departments and pathology labs.

Among their recommendations, the medical groups suggest that all appropriate tests be ordered based on a single specimen collected early in a patient's visit to the emergency department, that they be guided by patient history and clinical examination and that, where possible, the test results should be viewed and acted upon while the patient is in the emergency department.

The guidelines are the result of a joint initiative of working groups from both colleges.

The new guidelines have been issued as Medicare investigates billing practices for diagnostic tests ordered by emergency department physicians at 70 public hospitals.

As reported in *Australian Medicine* last month (<http://ausmed.ama.com.au/doctors-urged-look-hospital-assurances-medicare-cracks-down-billing-practices>), the Department of Human Services has flagged concerns that Medicare has been effectively double-billed for diagnostic imaging and pathology tests requested for public patients in public hospital emergency departments.

The AMA last month urged doctors to seek written guarantees from public hospitals that any tests ordered using their provider

number have not been in breach of the law.

It advised members that, where Medicare claims for services rendered in public hospitals were being billed using their name and provider number, they must be made fully aware of, and be prepared to accept responsibility for, that billing.

The guidelines can be viewed at: <http://www.acem.org.au/home.aspx?docID=1>

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INFORMATION FOR MEMBERS

AMA Fee List Update – 1 April 2013

The AMA List of Medical Services and Fees (AMA List) has been updated to include new items for radiofrequency ablation for the treatment of Barrett's oesophagus, cervical artificial intervertebral disc replacement, and testing for germline mutations of the von Hippel-Lindau gene. Changes have also been made to items for the removal of rectal tumours. These items are provided in the Summary of Changes for 1 April 2013, which is available from the Members Only area of the AMA website at <http://www.ama.com.au/feelist>.

The AMA Fees List Online is available from <http://feelist.ama.com.au>. Members can view, print or download individual items or groups of items to suit their needs. The comma delimited (CSV) ASCII format (complete AMA List) is available for free download from the Members Only area of the AMA Website (www.ama.com.au). To access this part of the website, simply login by entering your username and password located at the top right hand side of the screen and follow these steps:

- 1) once you have entered your login details, from the home page hover over Resources at the top of the page;
- 2) a drop down box will appear. Under this, select AMA Fees List;
- 3) select first option, AMA List of Medical Services and Fees - 1 April 2013; and
- 4) download either or both the CSV (for importing into practice software) and Summary of Changes (for viewing) detailing new, amended or deleted items in the AMA List.

If you do not have Internet access, the AMA produces the AMA List on CD. If you wish to order a copy of this CD, please complete the following form and return to:

Ms Melanie Ford - AMA, PO Box 6090, KINGSTON ACT 2604

PLEASE PRINT CLEARLY

Name: _____

Address: _____

I wish to order the AMA List of Medical Services and Fees on CD for \$52.



AMA

Indigenous Peoples' Medical Scholarship 2013

For the assistance and encouragement of Aboriginal and Torres Strait Islanders studying for a medical degree at an Australian University

Applications are now sought for the Australian Medical Association (AMA) Indigenous Peoples' Medical Scholarship for 2013. Applicants must be people of Aboriginal or Torres Strait Islander background.

Applicants must be currently enrolled full-time at an Australian Medical School and in at least their first year of medicine. Preference will be given to applicants who do not already hold any other substantial scholarship.

The Scholarship will be awarded on the recommendation of an advisory committee appointed by the AMA. The value of the Scholarship given in 2013 will be \$9,000 per annum, paid in a lump sum each year of the course.

The Scholarship will be awarded for a full course of study, subject to review at the end of each year.

Applications close 10 May 2013

To receive further information and an application package, please contact Sandra Riley, Administration Officer, AMA on 02 6270 5452 or email sriley@ama.com.au. An application package can be downloaded from the AMA website www.ama.com.au/indigenous-peoples-medical-scholarship-2013.

The Indigenous Peoples' Medical Scholarship Trust Fund has been established with a contribution from the Australian Government. The Trust Fund is administered by the Australian Medical Association.

The Australian Medical Association would also like to acknowledge the contribution of the Reuben Pelerman Benevolent Foundation to the Indigenous Peoples' Medical Scholarship.



Chiropractors out of joint at Macquarie



Macquarie University is seeking to offload its chiropractic program as the focus of its academic effort shifts to "research intensive" disciplines.

In an unheralded move, the University – the first in the country to offer chiropractic degrees - announced on 24 April it was seeking interest from other higher education institutions about acquiring all of its Department of Chiropractic teaching units, degrees and "relevant capital assets", potentially involving the transfer of chiropractic academic staff and their entitlements.

The move has come as scope of chiropractic practice has come under increased scrutiny following revelations that chiropractors have been able to gain accreditation points for attending a course run by a US-based anti-vaccination campaigner.

Earlier this year AMA President Dr Steve Hambleton voiced grave concern about the rapid growth in chiropractic treatments for very young children, arguing that although there was "some evidence" it could be beneficial for adults with musculoskeletal conditions, its efficacy and suitability for infants and toddlers, in particular, was unproven.

Macquarie University was at pains to stress that its 23-year-old chiropractic school was very much a going concern, claiming that its degrees were "extremely popular" with students.

But the University's Executive Dean of Science Professor Clive Baldock said it no longer fitted in with the institution's strategy.

Professor Baldock said the move to offload the chiropractic program reflected the need for the Faculty of Science to build upon recent investments in research-intensive disciplines such as biomedical science and engineering.

"Macquarie University has recently invested significantly in a postgraduate medical school and a state-of-the-art private hospital," he said. "We naturally want to focus our efforts on supporting these initiatives with our teaching and research."

Professor Baldock said that while the chiropractic program no longer met the university's research-intensive focus, "we believe our chiropractic degrees to be of the highest teaching quality, and they remain extremely popular with students".

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[TO COMMENT CLICK HERE](#)

Rising violence fuels calls for grog limits

Aboriginal elders are pushing for tougher alcohol restrictions in the Northern Territory after a woman died following an alleged assault near a remote community after drinking with a group of people.

Health workers and community elders have approached the Northern Territory Liquor Commission to restrict sales of takeaway alcohol after a 29-year-old woman who had been drinking with friends was found dead near a remote community 500 kilometres south-west of Katherine early this month.

Katherine West Health Board Chief Executive Officer Sean Heffernan told the ABC that the consequences of alcohol-fuelled violence was taking a toll on community and health workers, and a curb on liquor sales was long overdue.

"We know a justice group of elders from the Lajamanu community have gone to the Commission and asked for restrictions of a common sense level," Mr Heffernan said. "One

slab or one carton per day, per person, not someone walking in there like they did two days ago and bought \$1300 worth of alcohol."

Earlier this year, Prime Minister Julia Gillard warned that "the rivers of grog that wreaked such havoc among Indigenous communities are starting to flow once again" after the NT Government scrapped the controversial Banned Drinkers Register put in place by the previous Labor government.

Ms Gillard said that since the decision, "former banned drinkers are now again on the long list of alcohol-related offences coming before the Alice Springs Magistrates Court each day".

Mr Heffernan told the ABC that health worker in remote communities were often left traumatised by the level of alcohol-fuelled violence they were confronted with.

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Involving pharmacists in general practice

BY DR BRIAN MORTON

“Part of the problem quoted by pharmacists is that they don’t get access to a patient’s medical file, and often they do not get to talk directly to a patient’s GP”

In March I wrote an article proposing that it was time to give consideration to having more pharmacists employed in general practice (see <http://ausmed.ama.com.au/time-new-take-where-pharmacists-work>).

I was amazed at the level of response to the article, with views both for and against the idea.

Given the interest in the topic, I thought a second article warranted.

One of the supporters of the idea has been the organisation that represents the interests of professional pharmacists, the Pharmaceutical Society of Australia (PSA). I suppose this is not too surprising given the statistics.

Currently, there are more than 5000 pharmacies in Australia. This number is pretty static, given the well-known hold that the Pharmacy Guild has in limiting the number of pharmacies in operation.

There are around 26,500 pharmacists, and many more are coming through the training pipeline, so it does not take much of a maths calculation to note that there are plenty of skilled pharmacists in the country, and not many pharmacies for them to work in.

What could pharmacists do in general practice?

The home medicines review (HMR) program might be a model to build on.

Pharmacists able to conduct HMRS must undergo additional training accreditation (there are about 2000 accredited pharmacists currently). As part of the home medicines review, the (accredited) pharmacist interviews the patient and reviews their medications to identify any drug related problems. A report is then provided to the patient’s GP.

A recent study has compared the results for

HMRS in the home environment with a HMR in the patient’s general practice. One of the current problems with the HMR is that only a proportion of recommendations made by pharmacists to GPs are actually implemented.

Part of the problem quoted by pharmacists is that they don’t get access to a patient’s medical file, and often they do not get to talk directly to a patient’s GP.

One of the findings of the study was that significantly higher rates of recommendations were implemented by GPs when the pharmacist was integrated into the medical centre, and not just doing a review in isolation at the patient’s home.

Don’t misinterpret me – pharmacists have their skills and they have their job and GPs have ours. Our work cannot be substituted.

To quote our President Dr Steve Hambleton, “doctors are trained to diagnose and prescribe, and pharmacists to look at pharmacology”.

For the sake of having an open mind, however, I am happy to test out a model or have a trial with pharmacists working - most likely on sessional basis - with GPs on medication reviews, and working out ways to minimise drug related problems.

It might be a win-win for everyone.

If the funding was right, GPs would benefit from the expertise of their pharmacist colleagues, the increasing number of trained pharmacists coming through the system would have another source of employment and, if there are improvements in medication and a reduction in drug related problems, patients and the health system will benefit too.

[TO COMMENT CLICK HERE](#)



Better support needed for implementation of PCEHR

BY DR STEVE HAMBLETON

Terms of reference

At its meeting on 16 February, the Economics and Workforce Committee (EWC) updated and revised its terms of reference. EWC's new terms of reference, as agreed by Federal Council at its meeting on 23 March, explicitly include the following topics:

- expansion of roles of non-medical practitioners;
- safety and quality of clinical services;
- Australian and international trends in health care financing and delivery;
- accessibility and affordability of health care;
- clinical and economic implementation of e-health; and
- legal framework for practice.

If you wish to make any comments or suggestions in relation to any of the above, please use the online comment opportunity here.

PCEHR

One ongoing focus for the EWC, and an agenda item for future meetings, relates to the implementation of e-health.

As I recently put to the Minister for Health Tanya Plibersek, and to her Department, the AMA is concerned that medical practices are receiving inadequate support for the implementation of the Personally Controlled Electronic Health Record (PCEHR). This applies to general practices, and even more so to other specialist medical practices.

As far as the AMA can tell, the \$50 million announced by the Minister in May 2012 for Medicare Locals to help rollout e-health records is providing piecemeal support activities to medical practices to become 'PCEHR ready'.

Most of the current activity seems to be about 'training the trainer', or simply contacting practices and providing initial e-health readiness assessments.

It appears that there has not been much activity yet to go directly into medical practices and get them started providing PCEHR services.

There is little tangible information about the number and location of general practices that have actually received direct support to provide PCEHR services. From what AMA members tell us, the number appears to be very small.

We also know that Medicare Locals are making their own decisions about the type and level of support they will provide. So there is no consistency around the country in the support that is being provided by Medicare Locals.

The Royal Australian College of General Practitioners' practice training program, funded by the Government for \$2.55 million, began running two-hour peer-to-peer education seminars on using the PCEHR system throughout the country last month, and will continue to the end of June. Because this program has just begun, its effectiveness across general practice remains to be seen.

In the meantime, the AMA understands that patients are being actively pursued to sign up for the PCEHR, such as through promotions in shopping centres and through disease support groups.

The AMA believes a serious mismatch is being created between the patients that have signed up and are expecting their general practice to engage with their PCEHR, and the general practices that are actually ready to use the PCEHR.

This will create unnecessary tension between patients and their general practice, and is counter-productive to the

long-term adoption and success of the PCEHR. I have made this point directly to the Minister in a recent face-to-face meeting.

The AMA has urged the Government to ensure that, from this point on, patient sign-up activities are targeted (and limited) to areas where the Department of Health and Ageing can confirm that practices have actively been supported and are PCEHR ready.

We have also reminded the Government that there is no activity to support other specialist practices to even begin to engage with the PCEHR, let alone become ready to use it to its full capacity. It is time for the Government to focus on this area.

Given these serious limitations on implementation, it is hardly surprising that, at this point, the uptake is insufficient to form any judgement on the value of PCEHR, whether from a clinical or economic perspective.

One thing is clear, however. There needs to be a robust and effective arrangement for clinical consultation and input, both on current implementation and on future functionality, firmly grounded in how doctors might use the PCEHR as a clinical tool.

One spin off from the PCEHR that might prove both clinically useful and increase efficiency is the combination of the common coding system that we will adopt as the Australian Standard, and secure messaging. The two together should improve the quality and utility of communication between medical practitioners and hospitals and other healthcare providers.

I look forward to the EWC's consideration of PCEHR and e-health implementation at future meetings.

[TO COMMENT CLICK HERE](#)



Medical leadership for the next generation

BY CHAIR DR WILL MILFORD

Recent reports have highlighted the challenges in managing health expenditure.

The Grattan Institute has revealed that government spending on healthcare has grown by 74 per cent in the last decade, significantly greater than the expansion in gross domestic product over the same period.

Escalating costs are predicted to consume an increasing proportion of State and Federal budgets already under political pressure following dire predictions of deficits for years to come.

In the immediate future, more attention will be focussed on rectifying inefficiencies, and there is already speculation about the need to ration services. Doctors must be prepared to not only participate in, but also lead these discussions.

Unfortunately, few doctors have been trained for this task. Unlike other professional fields of endeavour, leadership does not feature heavily in undergraduate or postgraduate medical curricula.

This is not for a lack of evidence of the value of sound leadership in medical practice, particularly in the clinical sphere.

The data speaks for itself: organisations in which clinicians actively take part in financial, structural and strategic decision making deliver higher quality care, with improved patient outcomes. Across a range of measures, including staff engagement, they tend to perform better.

In her recent book *Reconstructing Medical Practice*, Christine Jorm highlighted the challenges that doctors face in engaging in leadership. These included the priority given to clinical activities, a lack of adequate training and support, the absence of defined career paths, and a culture within the health

system that does not reward excellence.

Internal barriers such as self-doubt, cynicism, a lack of ownership and poor peer acceptance, have also been cited as explanations as to why clinicians tend to shy away from leadership opportunities.

Associate Professor Jorm also links medical leadership to patient safety. In the United Kingdom, this relationship has been highlighted by the recent Francis Report into the Mid-Staffordshire hospital scandal, and in columns by Chris Ham of The King's Fund. These reiterate the risks that can arise when doctors and other clinicians are disengaged from health system management.

Despite the lessons from the Mid-Staffordshire scandal, in which up to 1200 patients were found to have died unnecessarily because of neglect and cost-cutting driven by a management culture that put meeting budget and performance targets ahead of patient care, Ham laments that medical leadership remains a minority focus on the margins of the National Health Service.

The case for reform is self-evident.

Australian health systems must attach a high priority to medical leadership. The provision of support, rewards and defined pathways should be a priority. Not only must there be the expectation that the best and brightest occupy leadership roles, but they must be actively encouraged to do so.

For its part, the AMA promotes leadership across the spectrum of its membership. The Council of Doctors in Training continues to be a valuable proving ground for future health leaders, as evidenced by the representation of its alumni in senior positions, both within the AMA and in the health system more generally.

As part of its ongoing professional development program, AMACDT will

again host a Leadership Development Dinner (LDD) this year. The event will take place on Friday 24 May in Sydney as part of the AMA's National Conference.

By providing the opportunity to hear from exemplary leaders, CDT hopes to inspire doctors to think a little more broadly about how they can contribute to Australia's health system.

“Australian health systems must attach a high priority to medical leadership”

This year's guest speaker is Dr Sam Prince, an inspirational doctor who has used his entrepreneurial and business skills to develop a program aimed at eliminating scabies in the Northern Territory. He will reflect on his leadership experiences to date, and provide some strategies for effecting change as a medical practitioner and public health advocate.

In a period of health care reform, the case for enhanced medical leadership is self-evident.

It is essential that doctors have the capacity to articulate a vision for the future of the public health system, and the advocacy skills to make it a reality. The 2013 LDD should help realise this objective.

Follow Will on Twitter @amacdt or Facebook (<http://www.facebook.com/amacdt>)

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The Budget that we need

BY PROFESSOR STEPHEN LEEDER

Where would I be without my accountant? In gaol, probably - not necessarily by virtue of deliberate criminality, rather due to financial incompetence. So when it comes to the forthcoming Federal Budget, I want to know what accountants think is likely to happen.

The website of the Australian Institute of Chartered Accountants offers this opinion (<http://www.charteredaccountants.com.au/Industry-Topics/Tax/Current-issues/Federal-Budget-hub>): “The recent announcement of the timing for the next Federal election, along with the concession by the Government in December 2012 of the difficulty of delivering a budget surplus in the current fiscal year, has allowed all stakeholders to begin focusing again on the important public policy issues that we need to be addressing as a nation.”

My view about the pursuit of a balanced budget, and the hand-on-the-heart devotion to that mission from both sides of politics, was that we were all behaving as though in pursuit of an imaginary feral rabbit that was threatening to overwhelm our economic pastures and crops as it reproduced at a stupendous rate. That economics journalists such as Ross Gittins felt the same way was a comfort. The accountants are saying that, having given up the rabbit chase, we can get down to business.

It is hard to predict what will surface in the budget in relation to health. A strong argument can be mounted for “leave it alone”, given that we have had reformist upheavals for the past five years and the

system is still re-stabilising. Reforms are necessary occasionally but sizeable ones are like war, in terms of disruption and cost. Could we please have a budget that, for good or ill, leaves activity-based funding (ABF) in place, does not seek to change the configuration of the new hospital networks and does not fiddle or try to micro-manage - according to lotus-leaf fantasies - the new Medicare Locals? For goodness sake, let them sort themselves out. Of course, they are not all yet on top of their game, but many are doing a really good job.

A budget that clarifies a continuing commitment to education and research within the health service, in line with the recently published review of research, conducted by CSIRO’s Simon McKeon and colleagues, would be welcome.

It is an article of faith for extreme activity-based funding advocates that everything can be hammered into an ABF box. The experience with three decades of ABF in the UK is that it cannot. Thirty or more per cent of what the National Health Service does is funded other ways, including for rehabilitation and aged care. Just because you have a hammer, everything is not a nail.

I realise that every dollar spent on health is a dollar less for education and other worthy social pursuits. The opportunity cost must be calculated. But (and here I know colleagues will disagree with me), I consider we are still under-investing in IT in health. Specifically, we have not factored in the huge amount of change management needed to get IT record systems fully functional.

The list of areas where additional funding would be beneficial is long, and includes Indigenous health care. Christine Bennett, chair of the Health and Hospitals Reform Commission, and now Dean of the Notre Dame Australia Medical School, recently reviewed how things had gone with the recommendations made by the Commission several years ago. Not bad in general, she said, but she pointed to fact that the only recommendation that the Commission made that was not accepted was the one extending Gold Card-type coverage to Indigenous people. She knows full well that health services are but part of what is needed: environmental, and educational and employment elements also being critical. Alcohol and tobacco remain major killers. But a Gold Card would be one thing we could offer them to ensure access to the very best in medical care. And, given that the Indigenous community is only about 520,000, the additional costs would not be great.

It is probable that sweeteners will be included in the Budget. By tradition, these have related to waiting lists, beds and nurses. It will be interesting to see if the ‘entals’ – dental and mental – gain anything from this Budget. Although not necessarily popular, both matter.

But now that the toxic rabbit is dead, or at least in captivity, rationality may return. This is an immensely prosperous country in need of visionary investment policies. May the Budget be the turning point?

[TO COMMENT CLICK HERE](#)



Health on the hill

Political news from the nation's capital

No health cuts but Medicare Locals on notice

The Coalition has pledged there will not be any cuts to health spending should it win the Federal election, though the future of Medicare Locals remains under a cloud.

As the Federal Government warned next week's Budget could include tough spending cuts and possible tax hikes following revelations a \$12 billion black hole in revenues, Opposition health spokesman Peter Dutton committed the Coalition to matching Labor's health expenditure if it wins office.

Challenged on ABC's *Q&A* as to whether or not he would guarantee to spend the same amount on health as Labor was projecting, Mr Dutton responded: "Yes. Yes, I can."

"We spent a considerable amount in the health portfolio when we were in Government, and we'll do it again if we win the election," he said.

But the Opposition health spokesman was much more equivocal about prospects for Medicare Locals under a Coalition Government, and flagged interest in the possibility of engaging private providers to operate public hospitals.

Health Minister Tanya Plibersek, who also appeared on the program, said Medicare Locals had developed as a "natural successor" to divisions of general practice and were performing a vital role in promoting and coordinating primary care at the local level.

But Mr Dutton said that although the Coalition accepted the need for organisations to coordinate care, "I don't want to see \$1.2 billion eaten up by ever-

growing structures".

"We want to enhance the front line spend, not withdraw it, and that's why we're saying if we think that bureaucratic structures are creeping up in number, we want to get that money back to the front line service," he said.

The Coalition is also likely to investigate opportunities to increase private sector involvement in running public hospitals.

Mr Dutton noted with approval arrangements at Queensland's Mater Hospital and Western Australia's Joondalup Health Campus where private organisations operated hospitals.

He said that although a Coalition Government would not seek to privatise public hospitals, it would investigate the scope for greater efficiency and productivity in the delivery of public hospital services by private operators.

"I want to make sure that we are doing things as effectively and as productively as we can, and if we can do that through public ownership and public management and delivery of those services, we should pursue it," Mr Dutton said. "But, equally, if it can be demonstrated that we can get a better outcome for our patients through other service delivery models, then I think we shouldn't be afraid of looking at that."

AMA President Dr Steve Hambleton was in the studio audience for the program, and asked the first question put to Ms Plibersek and Mr Dutton.

Dr Hambleton challenged both sides of politics to detail how the planned to end the health funding 'blame game' between the Federal, State and Territory governments and restore to public hospitals the resources they need to

provide reliable quality care and secure medical training.

Ms Plibersek said the Government had injected 7000 extra doctors and 16,000 more nurses into the hospital system since 2007, and the move to activity-based funding would improve the effectiveness and transparency of hospital funding by rewarding institutions based on the care they provided.

Mr Dutton pledged bipartisan support for activity-based funding, but promised a Coalition Government would not engage in the sort of stand-off over funding that developed between the Commonwealth and several State governments, particularly Victoria, late last year.

"One of the ways that we won't operate, if we win the election, is to retrospectively take money out, [which last year] sent a real shockwave through public hospital administrators," he said.

The two politicians also sparred over tax concessions for private health insurance, which is likely to be a hotly contested issue in the lead-up to the Federal election.

The Gillard Government last year pushed through controversial measures to means test the 30 per cent private health insurance rebate, and is under vociferous attack from some quarters over its plans to remove the rebate on the Lifetime Health Cover component of premiums paid by high income earners.

Ms Plibersek said the rebate had become the fastest-growing area of expenditure in the health budget, and applying the means test would free up \$100 billion in the next 40 years to be spent on areas of need such as palliative care, new medicines, more doctors and upgraded

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Health on the hill

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hospitals.

But Mr Dutton accused the Government of “attacking” private health insurance, which could convince many to drop their cover and add to the burden on the public health system – though Ms Plibersek pointed out that since the introduction of the rebate means test the proportion of the population with private cover had climbed to its highest level in 37 years.

While Mr Dutton condemned the Government's measures, he balked at suggestions a Coalition Government would immediately unwind the changes, citing concerns about the level of public debt.

“The Government has racked up close to \$300 billion worth of gross debt,” he said. “If we can afford to do it, at the first available opportunity we will reinstate [the rebate for high income earners], so that we can get people back into private health coverage”.

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Rural training boost part of intern crisis solution

Health Minister Tanya Plibersek has flagged plans to boost “end-to-end training” in country areas as part of efforts to improve opportunities for medical graduates and build the rural workforce.

Appearing on the ABC's *Q&A* program, Ms Plibersek said that expanding the range of training settings for medical interns was part of the solution to the medical training crisis that at one stage last year threatened to derail the careers of almost 200 trainee doctors.

Only a last-minute deal brokered by

the Commonwealth with several State and Territory governments averted a breakdown in the medical training system and ensured that almost all medical graduates were offered an intern place.

But there are fears of a repeat this year as the number of medical graduates continues to swell, increasing the pressure on all levels of government to boost intern places.

Opposition health spokesman Peter Dutton said only a Coalition Government would have the capacity to resolve the issue.

“The way that it's played out over the course of the last 12 months has been quite shameful,” Mr Dutton said on *Q&A*. “I believe that we have, if we can win the [Federal] election in September, a greater capacity to negotiate with the states and to sort this mess out than what the Minister has presided over.”

Ms Plibersek said an important step to addressing the problem was to compile an accurate national tally of medical graduate numbers “so that we know how many places we have to find each year”.

The Health Minister said it was vital to avoid a repeat of last year's chaotic situation when the states and territories could not identify exactly how many internships were needed to satisfy the demand from graduates.

Ms Plibersek said there also needed to be clear delineation of the funding responsibilities of the various levels of government, declaring that the states should pay for the training of interns working in state public hospitals because “they're delivering services in those hospitals, they're actually seeing patients”.

But the Health Minister said hospitals alone should not be relied upon to provide internships, and there was an urgent need to develop other training opportunities.

“There are settings outside public hospitals that we should be exploring,” she said. “In the last round we worked with the private hospital sector to find places and accredit them in private hospitals, and I think we can also look in other settings.”

She said these should include not only smaller hospitals, but also GP clinics and opportunities in rural areas.

“Now that we've got more rural medical schools and more clinical training facilities in rural areas, I think we should be looking at much more end-to-end training in rural and regional areas, so that you pick students who come from those areas, who are going to want to stay in that area and practise, and you give them a whole training pathway in their rural area,” Ms Plibersek said.

Mr Dutton said that for some rural communities, especially those in remote areas, fly-in, fly-out health worker arrangements “are perhaps the only answer, at least in the short term”.

But Ms Plibersek rejected this, and argued that a growing reliance on locums to provide health services in rural areas was not only expensive, but also led to disjointed care for patients.

She said the answer was to make sure that “we're picking the right people to study medicine, giving them the opportunity to study in regional and rural areas, and supporting them to stay there.”

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Health on the hill

Political news from the nation's capital

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Heavy-handed disclosure laws could undermine confidence

The AMA is committed to increased transparency about dealings between doctors and pharmaceutical companies, but opposes moves to make such interactions illegal.

AMA President Dr Steve Hambleton told a Senate inquiry that the Association embraced moves toward greater transparency as a way to buttress confidence in the doctor-patient relationship.

But Dr Hambleton said a Bill proposed by the Australian Greens to ban drug companies from paying for doctors to attend seminars and conferences or sponsoring meetings went too far and would serve to undermine the confidence of patients in their doctors.

"In health, the overriding relationship is and always will be between the doctor and the patient, and any transparency must maintain the confidence in that doctor-patient relationship," the AMA President said.

"Making the relationship with pharmaceutical companies illegal, and putting a law around it, really sends a message that any relationship is negative.

"I think that is a bad message to send to the Australian people when we are trying to build confidence in the doctor-patient relationship."

Dr Hambleton made his remarks as evidence was released indicating that public trust in the medical profession

remains high.

A Roy Morgan survey of 645 people found that doctors were rated second highest out of 30 professions in terms of honesty and ethics, with only nurses held in greater regard.

The AMA President said that although there were mounting concerns about the influence of drug companies on doctors in other countries, there were no signs of similar issues in Australia, where robust regulatory arrangements and ethical codes served to ensure a high degree of integrity in the conduct of doctors.

But he said the potential for offshore scandals to undermine confidence in the conduct of doctors in Australia meant it was prudent for the AMA to support greater transparency regarding the dealings pharmaceutical companies had with practitioners.

"I am pleased to lead the AMA at a time when it is changing its view about transparency," Dr Hambleton told the inquiry at a hearing on 29 April. "It has been as a result of the [international] reports we have all heard about undue influence and people not following our own code of conduct."

Dr Hambleton told the Senate Finance and Public Administration Legislation Committee he had directed the AMA's ethics committee to review the issue, and it had recommended the AMA engage in the process toward greater transparency.

The AMA is a member of the Therapeutic Goods Administration's Codes of Conduct Advisory Group, and is a member of the Medicines Australia Transparency

Working Group, which is developing a framework for the public disclosure of payments to individual health practitioners by drug companies.

"The AMA does not shy away from further transparency measures about the relationship that pharmaceutical companies have with medical practitioners," Dr Hambleton said. "We are designing the transparency arrangement to ensure that it is workable, is useful and meaningful to patients. Once implemented, it can be reviewed and refined as we better understand how patients use the information."

Dr Hambleton said doctors already abided by a stringent code under which they had a duty to disclose any sponsorships or payments they received that were of specific relevance to their individual patients' clinical circumstances and treatment options.

He said the AMA was opposed to any extra regulation that would increase the red tape doctors had to deal with, not least because it would add to the cost both to practitioners and their patients, and said the Greens Bill in its current form would not necessarily achieve the desired outcome.

"The industry is making good and solid steps towards uniform codes of conduct and transparency measures," the AMA President said. "If the Bill is passed, the work being done now to get the best arrangements in place would have to shift to implementing a system that may not actually make the grade from the patient perspective."

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Supplement regulation by TGA is completely cactus

BY DR MICHAEL VAGG, CLINICAL SENIOR LECTURER AT DEAKIN UNIVERSITY SCHOOL OF MEDICINE AND PAIN SPECIALIST AT BARWON HEALTH

This article first appeared in The Conversation on 12 April 2013, and can be viewed at: <https://theconversation.com/columns/michael-vagg-1771>

Few readers would have seen the story in the Fairfax media about how vitamin company Swisse evaded an attempt by TGA to ban its appetite suppressant product by registering a new product with the exact same ingredient, an extract of Indian cactus. Oh, and Nicole Kidman has been named as the company's US ambassador. But the fact that the story was buried in the business pages is no measure of its health-related importance.

The Checkout team on ABC TV has already highlighted the problem of supplement manufacturers gaming the legislation using the very example reported in the Sydney Morning Herald. This Indian cactus extract has no scientific validity as an appetite suppressant. Swisse is taking advantage of the loophole in the legislation that permits pseudomedicines to be promoted for their "traditional uses". Just think about the implications of this story for a minute.

A swag of dodgy products have their listings on the ARTG cancelled by TGA due to the fact they don't work and are being promoted in a misleading way. This is potentially annoying for Swisse, which has already sunk elephant dollars into hiring celebrities to endorse one of the cancelled products (I assume the celebrities didn't seek Swisse out and offer their services for free because they are so convinced about the benefits of their various concoctions). One doesn't need to be a PR genius to work out it

would be a bad look to have Our Nic and the crew promoting stuff overseas that is banned at home.

Straight away, with no change at all to the ingredients or the formulation (presumably because they have warehouses full of the stuff ready to go) Swisse changes the label and is allowed to re-register the product because the approval for such products is done by a piece of software. Presumably the computer program involved lacks an irony detector.

"They have a superb working knowledge of how to operate within the clownish absurdities of our current regulations"

As if that's not absurd enough, check out what the effect of this "ban" will be. I promise I'm not making this up, but here is some advice from Swisse to their retailers, quoted directly from the information circular sent out to stockists:

WHAT DOES THIS MEAN FOR YOU, THE RETAILER?

The only impact brought about by this change is that from now, Swisse will sell you the product labelled and listed

as "Hunger Control" rather than as "Appetite Suppressant". This is not a new line of Swisse product, rather a new name for the same product.

You may continue to sell through existing stock of the Swisse Ultiboost Appetite Suppressant with its current name (and TGA listing) after the 4th April. The TGA has confirmed this.

WHAT DOES THIS MEAN FOR YOUR CUSTOMER?

Any customers that wish to purchase the Swisse Ultiboost Appetite Suppressant should be directed to purchase the Swisse Ultiboost Hunger Control instead. Customers can be told that Hunger Control contains the same formulation as the Appetite Suppressant, but has different labelling due to regulatory requirements.

So there you go. It stays on the shelves and can be legally sold until current stocks are exhausted, while continuing to make the very claims that TGA has already decided are misleading for consumers. No ceasing, no desisting, just sales as usual.

As the business pages remark with approval, the expensive gamble of buying in celebrity clout has been costly but very effective for Swisse as a business. I strongly suspect the comparative pittance they pay their regulatory compliance department is worth much more to their operation. They have a superb working knowledge of how to operate within the clownish absurdities of our current regulations, and that gives the celebrities something to sell after all.

TO COMMENT CLICK HERE



Members' Forum

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

AMA President Dr Steve Hambleton called for tougher action against groups making misleading claims about the dangers of vaccination amid evidence that thousands of children are being left vulnerable to deadly diseases. Many agreed with Dr Hambleton, and some members debated the idea of compulsory immunisation.

This is a quote: States in the US mandate immunisation, or obtaining exemption, before children can enrol in public school. Exemptions are typically for people who have compromised immune systems, allergies to the components used in vaccinations, or strongly held objections. All states but West Virginia and Mississippi allow religious exemptions, and 20 states allow parents to cite personal or philosophical objections. A widespread and growing number of parents falsely claim religious and philosophical beliefs to get vaccination exemptions, and an increasing number of disease outbreaks have come from communities where herd immunity was lost due to insufficient vaccination. Why not make immunisation mandatory for children prior to entrance to schools?

Anonymous

As an infectious diseases physician, I fully support any measure which ensures that infants, children and teenagers receive their full complement of vaccines according to the national immunisation schedule. Yes, it is true, a number of US states have passed legislation mandating vaccination as a prerequisite for school enrolment. I believe the time has come to consider similar measures in this country. I am sure that the anti-vaccine lobby will scream "individual rights", but unvaccinated children present a threat to themselves and others which is so easily prevented, and it should be the responsibility - indeed, the obligation - of

parents, to minimise this threat. It's time for the legislators to step in and make sure this is done.

Paul Georghiou (not verified)

Many members were happy to see that a morbidly obese patient had his compensation claim against a NSW doctor thrown out by a court. The NSW Court of Appeal overturned a Supreme Court decision to award the man \$364,000 in compensation because his GP did not refer him for bariatric surgery.

A win for common sense. Several years ago I had a complaint against me for telling a patient she needed to lose weight and that her health was at risk, presenting natural and technical hazards in acute management in an emergency. I indicated that she was the only person who could make the decision to do something.

Anonymous

Indeed, a win for common sense. What a ridiculous decision in the first place. I'm not responsible for ensuring patient compliance. The patient MUST take some responsibility for his or her own health.

Anonymous

Australian patients are languishing on some of the longest waiting lists for elective surgery in the developed world despite expensive government funding blitzes to boost treatment. Members suggested solutions to reduce the waiting lists.

This doesn't come as a surprise to anybody who has worked in public hospitals. The chance of the facts getting in the way of any political/managerial decisions is so remote as to be laughable. While the concept of universal health cover should be inviolable, it should be recognised that the way we deliver it is far from perfect.

Some years ago I visited Taiwan. There, everyone pays a health care levy, but it is set at the cost of providing health care - it was about 9 per cent of salary when I was there. There were no free services; every healthcare service incurred a small fee, discounted for those on social services, but NEVER nothing. This even extended to a charge for every day in hospital (capped after a few days). But what really made the system work is that health care could be bought from either a private hospital or a public (Government-run) hospital. This forced the private hospitals to keep charges affordable for all and, more importantly, forced the public hospitals to be efficient. Unlike in Australia, where there is no real incentive to perform efficiently, in Taiwan, if the public hospital cannot compete for the public's services, it closes down - just as a private facility will if it cannot compete. True competition.

Ray McHenry (not verified)

The Dutch also revamped their system completely in 2006, on the basis that universal tax-funded care would eventually consume the entire government budget. Sadly, there is no debate about such approaches in insular Australia.

Anonymous

Perhaps it is time to have an honest political debate about the 'tragedy of the commons' that a completely free (at the point of service) health care system encourages. It is no surprise that a free system has unlimited demand. We are probably in the last few decades of such an arrangement before the budgetary pressures are so severe as to cause its eventual collapse. Whether this happens in a controlled fashion or in a more chaotic manner as it has in other countries probably depends on politicians having some dialogue with the public sooner rather than later.

Dr Simon (not verified)

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Research

Broken heart repaired in less than a minute



A new technique that can replicate human heart tissue in under a minute has been developed by researchers.

Scientists from the University of Sydney and Harvard University have developed an elastic patch that can repair damaged heart tissue.

The patch is made from a natural elastic protein called tropoelastin, which is found in all elastic human tissues.

The researchers bathed the protein in bright light, developing an elastic patch that can stretch up to four times its original length. This process also increased the protein's ability to support cell growth inside and on its surface. Researchers reported that the process to create the elastic patch took less than a minute.

Professor Tony Weiss from the University of Sydney said the patches were patterned to direct the growth of heart muscle cells, and allow the cells to beat in synchrony.

"No other elastic material behaves in this way," Professor Weiss said. "It is so powerful because it uses a natural elastin protein, and we can surgically stitch it to help repair tissue."

Through testing, the researchers found the protein patch assisted the attachment, spread, alignment, function and intercellular communication of heart cells by providing an elastic mechanical support that mimics their dynamic properties. The patch was also found to beat in synchrony on the elastic substrates, and to respond to electrical stimulation.

The research team have applied for a patent.

The research was published in *Advanced Functional Materials and Biomaterials*.

KW

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Blood test may detect Alzheimer's disease

A blood test that can detect Alzheimer's disease years before symptoms appear could soon be developed.

Australian researchers have identified blood-based biological markers that can signal the developing stages of Alzheimer's disease.

Researchers from the CSIRO identified nine markers associated with the build up of the toxic protein, amyloid beta, which deposits in the brain as plaques early in the development of the disease.

Lead researcher Dr Noel Faux from the Florey Institute for Neuroscience and Mental Health said the progressive build up of the toxic protein is one of the earliest changes in the brain associated with the development of Alzheimer's disease.



"Amyloid beta levels become abnormal about 17 years before dementia symptoms appear," Dr Faux said. "This gives us a much longer time to intervene to try to slow disease progression, if we are able to detect cases early."

CSIRO scientist Dr Samantha Burnham told ABC News that a blood test is an accessible form of screening for the disease.

"We're hoping that in a few years, maybe five to 10 years, that we could be able to roll this out as frontline screening for Alzheimer's disease, giving those at risk a much better chance of receiving treatment earlier, before it's too late to do much about it," she said.

"One quarter of a million Australians currently suffer from dementia, and Alzheimer's is the leading cause," Dr Burnham said.

It is predicted that by 2050 one million people in Australia will have the disease.

KW

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Research

...CONTINUED FROM PAGE 31

War on warts being won

Australia is well advanced in the battle to eliminate genital warts following the establishment of a nationwide human papillomavirus vaccination program.

A study in the British Medical Journal has identified a sharp slide in rates of genital wart infections since the HPV vaccine was first introduced in 2007.

Researchers from the University of New South Wales, the Sydney Sexual Health Centre, the Melbourne Sexual Health Centre and the University of Melbourne's School of Population Health found that the proportion of women diagnosed with genital warts plunged from between 8.9 per cent and 9.6 per cent between 2004 and 2007, to just 2.7 per cent in 2011, while the percentage of men with the infection slid from almost 12 per cent in

2007 to 7.4 per cent in 2011.

Even more striking was the downturn in the rate of infection among women younger than 21 years, from 11.5 per cent in 2007 to just 0.85 per cent in 2011 – a fall of almost 93 per cent.

The result is seen as a stunning endorsement of the effectiveness of the decision in 2007 to begin one of the world's first national HPV immunisation programs for girls.

“The greatest decline in the proportion of women diagnosed as having genital warts was seen in the youngest age group, under 21 years, and all these women were eligible for the free quadrivalent human papillomavirus vaccine” the researchers said.

The findings lend weight to the

Government's decision in mid-2012 to extend the HPV vaccination program to boys, the first such initiative in the world.

The study's results suggest the virus could be all but eliminated for all practical purposes within a generation.

“The study shows that the proportion of young women diagnosed as having genital warts has continued to decline since the vaccination program started in 2007,” the authors said. “Less than 1 per cent of women aged under 21 years presenting at sexual health services were found to have genital warts in 2011, compared with 10.5 per cent in 2006, before the vaccination program started. By 2011, no genital warts were diagnosed in women aged under 21 who reported being vaccinated.”

AR

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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 performance 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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Your AMA Federal Council at work

Name	Position on council	Activity/Meeting	Date
Dr Richard Kidd	Queensland Area nominee	NeHTA PCEHR Release 3 User Acceptance Testing	3/4/2013
		NeHTA PCEHR Release 3 Presentation (webinar)	3/4/2013
		NeHTA Stakeholder Product Consultation Group	24/4/2013
Dr Bernard Pearn-Rowe	Convenor of AMACGP	NeHTA PCEHR Release 3 Presentation	3/4/2013
Dr David Rowed	AMA representative in e-health standard processes	NeHTA PCEHR Release 3 Presentation	3/4/2013
Dr Elizabeth Feeney	AMA executive and Anaesthetists craft group nominee	Medicines Australia Transparency Working Group	8/4/2013
Dr Peter Ford	Treasurer	Aged Care Gateway Advisory Group	10/4/2013
Dr Gino Pecoraro	Obstetricians and Gynaecologists craft group nominee	TGA Codes of Conduct Advisory Group	23/4/2013
Dr Omar Khorshid	Orthopaedic Surgeons craft group nominee	MSAC Consultation Review Committee	23/4/2013
Dr Steve Hambleton	President	NeHTA eMedication Management Governance Group	24/4/2013
		Speech to Medical Board of Australia National Conference: The medical profession in Australia – the next ten years	18/4/2013
		Australian Financial Review Roundtable on health	30/4/2013
Dr Brian Morton	General Practitioners craft group nominee	DoHA to the concept of a patient centred medical home	5/4/2013
		PIP Advisory Group	2/5/2013
Prof Geoff Dobb	Vice President	Optometry Board of Australia re guidelines for independent optometry prescribing	24/4/2013

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British Government dumps plain packaging push



Health groups have reacted with dismay to reports the British Government is abandoning plans to follow Australia's lead in introducing tobacco plain packaging laws.

Prime Minister David Cameron has reportedly gone cold on the issue and ordered that a reference to plain packaging laws be pulled from the speech to be delivered by Queen Elizabeth to Parliament this week in which she is due to set out the Government's legislative agenda.

According to the reports, Mr Cameron was concerned the issue was a diversion from the Government's core legislative agenda.

Public health campaigner Deborah Arnott from the group Action on Smoking and Health told the *Financial Times* plain packaging enjoyed widespread public support, and it would "take of lot of explanation" by the Cameron Government if the measure was not included in the Queen's Speech.

The shadow health secretary Andy Burnham said the British Government had "completely lost its way" on public health.

The apparent Government backdown has been cautiously welcomed by tobacco companies, who have been campaigning vigorously to try and prevent other countries following Australia's lead in introducing tobacco plain packaging laws.

A number of European countries have taken interest in the Australian laws, and similar provisions are being introduced in New Zealand.

AR

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Researcher jailed for false test results

A British medical researcher is the first to be jailed in the United Kingdom for faking test results under tough new scientific safety laws.

Steven Eaton, a 47-year-old researcher at US-based pharmaceutical firm Aptuit, has been sentenced to three months imprisonment after investigations found that he had been falsifying test results since as far back as 2003, forcing a review of many hundreds of safety studies conducted by the company since that time.

Suspicions about Mr Eaton's activities were first raised in early 2009, when an Aptuit supervisor noticed "irregularities" in his work stemming from as early as 2001.

Mr Eaton resigned from the company soon after the concerns were raised, and Britain's Medicines and Healthcare Products Regulatory Agency (MHPR) commenced a formal investigation which took two-and-a-half years and included a study-by-study assessment of the effect of his actions.

The investigation found that Mr Eaton had selectively reported figures on whether analytical methods to assess the concentration of drugs in blood samples were working properly. The manipulation meant that experiments appeared successful when in fact they had failed.

The company was cleared of any complicity in the researcher's actions.

MHPRA's Director of Inspection, Enforcement and Standards Gerald Heddell told the *Financial Times* that Mr Eaton's actions "directly impacted the validity of clinical trials, and delayed a number of medicines coming to market, including one to treat depression. This conviction sends a message that we will not hesitate to prosecute those whose actions have the potential to harm public health".

The potentially fatal consequences of scientific fraud have been highlighted recently by a severe measles outbreak in Wales that has infected hundreds of children, and which has been linked to widespread aversion to vaccination for the disease during the mid-1990s and early 2000s following the publication of a study, since discredited, that claimed a link between the inoculation and autism.

AR

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Facebook face-off!

BY DR CLIVE FRASER

Those doctors who are fond of computers know just how much practice software has streamlined a day at the surgery.

Gone are the days of illegible notes on folded pieces of paper which, if misfiled, are lost forever.

We're on our way to e-health and a personally controlled medical record via the information super-highway.

I, for one, would need an army of secretaries if it weren't for word processing, and I'm not averse to putting my textbooks on my smartphone and catching up with the latest guidelines on disease management from the internet.

A few years ago, we all became accustomed to our patients arriving with a wad of printouts from their computers for explanation and interpretation.

Now, an internet search and a few hours of reading can make some patients better informed about obscure conditions like Marchiafava-Bignami disease than most of us who rely on what we learnt at medical school.

There is always, of course, the down side to all of this information sharing, and I'd put the website www.ratemds.com at the top of my list for providing a forum for defamatory rants.

Shielded by anonymity, and with an axe to grind, this site allows anyone to slander their doctor to their heart's content without an ounce of accountability.

The motoring public are not averse to using social media either.

To give you some indication of just how potent this medium has become, I'd like to tell you about an incident that occurred recently in Brisbane.

A young woman by the name of Ms Mali Hannun on 29 March posted a quotation from her local Wynum Hyundai dealership for work on her car on the Facebook page of Hyundai Australia.

The problem with the quote was that it seemed to include some items that were a bit far-fetched.

The most obvious of these was the recommendation to flush her power steering fluid for \$95.

Believing that she was being taken for a ride by the dealership, Ms Hannun took her car to two other mechanics for a second opinion.

Both of them pointed out to her that her Hyundai i30 had electronic power-steering and there was no need to flush the hydraulic fluid, as there was no hydraulic fluid to flush.

Ms Hannun went back to the Wynum Hyundai dealership to complain.

There were some weak excuses about a "typo" on the quote.

Dissatisfied with their explanation, Ms Hannun reached for the social media remedy and posted 505 words about her experience on Facebook.

Within five days there were 17,500 shares, 10,000 comments and 37,000 likes related to her post.

To borrow a medical term – her post had gone "viral".

Needless to say, stronger apologies were then offered by the dealer principal, and by Hyundai Australia itself.

I'd had a similar experience myself 20 years ago when I took my Ford Falcon in for a service.

My complaint was more serious than Ms Hannun's, as I was actually charged for the so-called "work".

My bill showed that they'd replaced my spark plugs, all six of them.

But a quick check under the bonnet cast some doubt on this.

I showed the service manager that they had somehow managed to change the spark plugs without removing the old ones.

I was also told that there must have been a "typo" on my account, but I'd have been none the wiser if I hadn't checked.

In the days before social media, my only forum was the theatre tea room and my story back then didn't spark any real interest as my colleagues were busy answering their pagers, and the nurses were equally busy smoking and catching up on all the gossip between cases.

In real terms the purchase price of cars has never been cheaper.

The Service Department is easily the most profitable part of most dealerships, and service personnel are under pressure to up-sell - some even receive a commission on sales.

Dealers and car companies are taking notice of feedback from customers, particularly when it can't be ignored and is seen by thousands of people on web pages.

PS

As of 20 April, Ms Hannun's post on Hyundai Australia's Facebook page had 18,577 shares, 10,512 comments and 40,114 likes (and is still growing).

The total population of Wynum is 11,719.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

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