

A U S T R A L I A N

Medicine

The national news publication of the Australian Medical Association

Govt sharpens scalpel for cuts to health jobs, agencies

Dutton warns that jobs will go as programs cut, merged, p5



Inside

Disclose drug co. payments above \$500, p7

Greater role for pharmacists poor prescription for rural ill, p8

Chiros told: hand off kids, p9

Drs warned, beware privacy pitfalls of mobile pics, p16

UQ rocked by study scandal, p19

Obamacare survives US Govt shutdown, so what is it exactly? p27

A U S T R A L I A N
Medicine

Managing Editor: John Flannery
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford
Contributors: Sanja Novakovic, Debra Vermeer

Graphic Design:
Streamline Creative, Canberra

Advertising enquiries
Streamline Creative
Tel: (02) 6260 5100 Fax: (02) 6260 5200

Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

42 Macquarie St, Barton ACT 2600

Telephone: (02) 6270 5400

Facsimile: (02) 6270 5499

Web: www.ama.com.au
Email: ausmed@ama.com.au

Australian Medicine welcomes diversity of opinion on national health issues. For this reason, published articles reflect the views of the authors and do not represent the official policy of the AMA unless stated. Contributions may be edited for clarity and length.

Acceptance of advertising material is at the absolute discretion of the Editor and does not imply endorsement by the magazine or the AMA.

All material in *Australian Medicine* remains the copyright of the AMA or the author and may not be reproduced without permission. The material in *Australian Medicine* is for general information and guidance only and is not intended as advice. No warranty is made as to the accuracy or currency of the information. The AMA, its servants and agents will not be liable for any claim, loss or damage arising out of reliance on the information in *Australian Medicine*.

EXECUTIVE OFFICERS



President
Dr Steve Hambleton



Vice President
Prof Geoffrey Dobb



Chairman of Council
Dr Iain Dunlop



Treasurer
Dr Elizabeth Feeney



Executive Officer
Dr Brian Owler



Executive Officer
Dr Stephen Parnis

IN THIS ISSUE

NEWS

5-21

REGULAR FEATURES

3 PRESIDENT'S MESSAGE

4 SECRETARY GENERAL'S REPORT

5 HEALTH ON THE HILL

22 GENERAL PRACTICE

23 RURAL HEALTH

24 AMSA

25 THERAPEUTICS

26 PUBLIC HEALTH & CHILD
AND YOUTH HEALTH

27 OPINION

29 RESEARCH

32 MEMBERS' FORUM

33 WINE

34 MEMBER SERVICES



Reform will continue

BY AMA PRESIDENT DR STEVE HAMBLETON

The Coalition took a very conservative set of health policies to the election. There were no big spending promises, and no pledges of major reform. The talk was more about getting rid of waste and doing things more efficiently.

This does not mean that health reform should cease under the new Government.

In fact, Prime Minister Tony Abbott has committed to supporting general practice and getting rid of red tape, which continues the sort of health reform that should be very beneficial to the medical profession – and that means it will benefit patients.

The AMA supports practical and affordable changes that help improve frontline health services. This is what we will work towards with the new Government.

I told the National Press Club in July that, if we want to drive real health reform, we must first define the problem.

I said that our health system is perfectly designed to get the results that it gets. The problem is, it was designed for a different set of problems.

It is set up to focus on acute care needs - with the ability to rapidly escalate to secondary and tertiary services.

We do this very well, but is it enough? Are people getting easy access to the quality health care they need?

Genuine practical health reform must recognise the changing needs of our society and redesign the system to meet the new challenges.

This can be achieved with new policy based on sound advice from the people who know what is going on in the health

system on a daily, even hourly, basis – the doctors at the front line. That is us.

The economic environment means that the Government will want to do more with less. We see the same challenges the world over. We can help with that strategy.

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

If new funding is limited – and it is - it must go towards building on the things that work, the things that respond to our changing needs.

Any change must be tested against the major reasons we need reform – our increasing burden of chronic disease and our ageing population.

Proposals should be moving us toward a joined-up, strengthened primary health care system built on team-based solutions.

We know that doctors are the stewards of community health resources. The clinical decisions we make can either be a cost or a saving to the health budget, depending on the individual situation, which is often about improving or saving a life.

There is now much greater transparency in our public hospitals, which means we can measure many more things, make comparisons, and devise ways to make things more efficient and affordable - all based on clinical insight.

This sort of decision-making is all about the best possible outcome for the patient, not the structure or the funding system, but one often follows the other.

To be successful, health reform must

involve empowering the health workers.

There are similar health problems all around the world, and the universal trend is greater involvement of clinicians in decision-making. The Francis Inquiry in the UK shows us what happens when they are not.

Self-analysis is routine in some specialties. The College of Surgeons is committed to excellence in clinical care, and all surgeons in operative practice are expected to participate in regular surgical audit, peer review and quality assurance activities. This leads to improved standards, better care, and better outcomes.

Cardio-thoracic surgeons at St Andrew's War Memorial Hospital have turned this into an art form, with peer review in place since 1985. Their monitoring has provided a rich source of data for near-real time feedback to detect problems and improve outcomes.

Clinical input and review can make all the difference. This is a practical reform and patients are the winners – along with the health budget.

We need clinicians to be able to influence governance of our Local Hospital Networks. We can and must apply the same principles to primary care through proper clinical influence over Medicare Locals, and with the strategic direction, design, and implementation of the PCEHR.

These may sound like small reforms, but they will make a big difference.

We look forward to working with the new Government to make this reform process a reality.

[TO COMMENT CLICK HERE](#)



Transparency: getting the cost-benefit balance right

BY AMA SECRETARY GENERAL ANNE TRIMMER

“The AMA submission attracted predictable headlines that doctors don’t want light to be shone on their relationships with pharmaceutical companies”

The AMA has responded to the transparency proposals under consideration as part of the review by Medicines Australia of its Code of Conduct.

The AMA submission attracted predictable headlines that doctors don’t want light to be shone on their relationships with pharmaceutical companies.

A closer reading of the AMA’s submission shows a very different position.

The AMA supports increased reporting measures where that reporting can inform a patient’s understanding of the relationships that his or her doctor has with pharmaceutical companies.

What the AMA does not support is a detailed reporting of ‘tea and biscuits’ or ‘coffee and muffins’ benefits, which would add considerable cost to the health system with no improved understanding of the relationships that might influence a doctor’s prescribing or recommending practices.

In its submission, the AMA specified that a successful reporting model would:

- provide information to enable patients to make well-informed decisions about their health care options, taking into account the context and nature of their doctor’s involvement with a company;
- not deter or constrain legitimate and ethical relationships as governed by industry and professional codes of conduct; and
- provide value to patients while balancing the red tape and resources impact on both companies and doctors.

It is useful to understand the origins of the US Physicians Payment Sunshine Act on which many proponents would like to base the Medicines Australia reporting requirements.

While now part of the Patient Protection

and Affordable Care Act, it was originally proposed by Senator Chuck Grassley (Republican, Iowa) and Senator Herb Kohl (Democrat, Wisconsin). The Senators pushed for a disclosure regime to address two ills they perceived in the US health care system:

- inappropriate prescribing or product use where the prescribing or use was influenced by the relationship between a health care practitioner and a pharmaceutical or medical device company; and
- unnecessary costs in the healthcare system attributable to expenditure on non-essential engagement between companies and health care practitioners.

When looked at in context, the types of arrangements that might be considered to influence a doctor’s actions are those where the doctor derives personal benefit, for example in the form of consulting fees, advisory board fees, royalties from co-development of a product, or sponsorship to attend an educational event.

These are the types of benefits that the AMA proposes should be disclosed so that patients can be fully informed of any relevant relationship.

However, to extend the reporting requirement to benefits such as coffee and muffins distracts from these more significant relationships, and adds considerable cost to the reporting system. That additional cost has to be measured against the perceived ‘ill’ that such disclosure is thought to address.

Ultimately, any additional cost incurred in reporting to minute levels of detail (and there are considerable costs in developing and incorporating these systems both for companies and doctors) results in additional costs in the health care system. And for no perceivable benefit to the patient.

[TO COMMENT CLICK HERE](#)



Health on the hill

Political news from the nation's capital

Dutton prepares to take scalpel to health jobs, agencies

Health Minister Peter Dutton has fuelled speculation that several Federal Government health programs and agencies will be axed or merged and dozens of jobs could go as part of a drive to achieve greater spending efficiencies in his portfolio.

In a sharp attack on what he described as “unsustainable” growth in the federal health bureaucracy under Labor, the incoming Minister put public servants on notice that funding priorities – and the jobs that go with them – would change.

“I want fewer spin doctors and more real doctors, and I want more money spent on operating theatres and not backroom operations,” Mr Dutton said.

The Minister said that although all 6500 employees of the Department of Health and Ageing (DoHA) were “working hard...I think some of those jobs will have to go”.

One of the first organisations caught up in the changes has been the Office of Aboriginal and Torres Strait Islander Health, whose functions have been brought within DoHA under the aegis of a new Indigenous Health Service Delivery Division.

While refusing to directly address concerns that organisations including the Australian National Preventive Health Agency (ANPHA), the National Health Performance Agency (NHPA) and the Australian Institute of Health and Welfare (AIHW) are in line for major spending cuts or even closure, Mr Dutton confirmed that the proliferation of health agencies and programs that occurred under the Labor was in the Coalition's sights.

“The only point I would make, without speculating further on some of the press that has been around, is to say that we want to make sure we get the most efficient spend possible for tax payer money, so that

we can get as much money as we can into those frontline services,” the Minister said on ABC Radio National late last month.

“Over the course of the last six years, numbers in terms of the Department [of Health and Ageing] and agencies increased by close the 30 per cent.

“Particularly in difficult economic times, we have to make decisions about, if we want to spend money on frontline services, we have got to say, ‘do we spend a dollar here or are we better off spending it on frontline services?’

“That’s the decision that I will ultimately have to make.”

While the Coalition does not appear to be planning any significant cutbacks to overall health spending – the expansion of hospital funding under Labor appears set to continue - Mr Dutton has indicated that the allocation of funds within the health budget will change.

“I want to make sure that of the 18 outside agencies that have been set up or are operating at the moment, that they are running as efficiently as possible,” he said.

The Labor Government established a string of agencies as part of its health reforms, including several to identify, measure and report on the delivery of medical services throughout the country, as well as to target health priorities such as reducing rates of obesity, drinking and smoking.

Mr Dutton said the information gathered and collated by several of these agencies was important in assessing and guiding health policy, but indicated that current arrangements were likely to change as he sought to free up funds to redirect to so-called frontline services.

Before the election the Coalition pledged a

review of the Medicare Local network, and roles of both the AIHW and the NHPA are also under scrutiny.

The two agencies between them have an annual budget of around \$40 million.

There is speculation that the NHPA, set up two years ago to provide uniform national statistics on the performance of hospitals and other health services, may be absorbed by the Health Department, while the AIHW may have its budget and remit substantially clipped.

But Mr Dutton was at pains to emphasise that the pursuit of spending efficiencies would not come at the expense of function.

He said there was “no doubt about the worth” of the information gathered by such organisations.

“I have said to my State colleagues that I want to be absolutely sure of the information we are collecting, both State and Federal, to make sure that we have reliable, consistent, up-to-date data sets so that we can have a comparison across State and Territory boundaries.

“[But] there is more than one body collecting data, and we have to make sure that we are doing it in the most efficient way possible.”

Speculation that ANPHA may be cut back or abolished has fuelled concerns that the Coalition Government may take a lighter approach to tobacco and alcohol taxation and regulation than Labor, which implemented the world's first plain tobacco packaging laws, and introduced a punitive excise on so-called alcopop drinks.

But Mr Dutton said his Government was keen to limit tobacco and alcohol-related harm, and would be guided by evidence about the most effective policies to adopt.

...CONTINUED ON PAGE 6



Health on the hill

Political news from the nation's capital

...CONTINUED FROM PAGE 5

"We are very keen to pursue evidence-based policies and ideas," he said, "but we don't think prohibition would work with regard to tobacco or alcohol".

He added that Labor's experience had shown that increasing the excise on alcohol as a way to curb drinking "did not work".

Adrian Rollins

[TO COMMENT CLICK HERE](#)

Review launched into e-health record scheme

The Abbott Government has ordered a review of the troubled shared electronic health record program amid concerns about poor take-up, cost overruns and implementation problems.

Health Minister Peter Dutton has ordered the review – the details of which are yet to be released – citing concerns that the Commonwealth so far has little to show for its \$1 billion investment in the Personally Controlled Electronic Health Record scheme.

"We all support an electronic health record," a spokeswoman for Mr Dutton told *The Australian* late last month. "However, we have grave concerns about the amount of money the previous Government spent on e-health for very little outcome to date.

"At a cost of around \$1 billion, we should have a lot more to show for it."

While more than 650,000 people have registered for a e-health record, the number of shared health summaries that have been created remains small, with many doctors and practices still putting technical and administrative processes in place, and ongoing concerns about the remuneration for practitioners who create shared health summaries.

The implementation of the PCEHR was also rocked in August when several clinical advisers to the National E-health Transition Authority (NEHTA), including former AMA President Mukesh Haikerwal, quit their positions, reportedly

because of the repeated failure of the Authority to take clinician concerns into account in designing and rolling out the e-health record system.

The AMA has backed the idea of a national electronic health record system, but has raised concerns about the design and implementation of the PCEHR, including a lack of coordination with and support for doctors and practices in installing and operating appropriate software and administrative arrangements, as well as adequate compensation for practitioners for the time taken to prepare and maintain patient e-health records.

AMA President Dr Hambleton has repeatedly called for the appointment of a clinical advisory group to guide implementation of the PCEHR and make it much more clinically useful.

Adrian Rollins

[TO COMMENT CLICK HERE](#)

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

Disclose drug company payments above \$500: AMA

The AMA has called for an interim \$500 threshold on the public disclosure of pharmaceutical company payments to individual practitioners.

In its submission to Medicines Australia (MA) on a proposed reporting model for industry payments, the Association urged that modest threshold limits be adopted to minimise the administrative burden on industry and practitioners while satisfying public interest in the disclosure of substantive payments.

There have been calls for the Australian pharmaceutical industry to emulate the mandatory Sunshine Act reporting model adopted in the United States, but in a letter accompanying the submission, AMA President Dr Steve Hambleton warned this would be a “seriously retrograde” step.

Instead, Dr Hambleton argued, MA should adopt a model that met legitimate demands for disclosure without imposing a punitive reporting burden on either doctors or industry.

He said the code should enable the public disclosure of substantive payments made to practitioners for a clearly defined set of services, rather than MA’s proposal to disclose all payments and benefits provided.

In its submission, the AMA recommended that all payments and benefits worth more than \$25 should be recorded, while the threshold for public disclosure should be set at \$500 or more.

It said the focus should be on four different types of payments: consulting fees, speaking fees, sitting fees (for sitting on company boards and the like), and sponsorships to attend events, including all registration fees paid, as well as travel and accommodation costs.

“Not only is it likely that the above payments will be of more interest to patients than ‘tea and biscuits’ benefits, but this approach would vastly decrease the administrative burden on both industry and practitioners,” Dr Hambleton said.

In its submission, the AMA urged MA to consider a number of refinements to its proposed code, including dropping the use of the Australian Health Practitioner Regulation Agency registration number to identify doctors (arguing that a name and address is sufficient information) and including a reporting field that would allow practitioners to identify the clinical context in which the payment was made.

The AMA said the MA should look at including clinical research payments in the code, and questioned the decision to exclude payments made as part of business to business trading arrangements.

It argued that the information practitioners are required to check

and verify should be limited to their name, practice address, and date, form and category of payment.

In addition, the AMA urged that users of the public report website be required to read and acknowledge a statement explaining that the listing of an individual doctor’s name did not imply any unethical or inappropriate behaviour, and that information should only be accessible by entering one practitioner’s name at a time.

Dr Hambleton recommended that the functioning of the proposed reporting model be evaluated after two to three years, including an assessment of who was using the database, what information they searched for and what benefit they derived from it.

“Public reporting should not continue if the costs of reporting outweigh the, as yet, unquantifiable benefits to the patient,” the AMA submission said.

Adrian Rollins

[TO COMMENT CLICK HERE](#)

RESTORE SIGHT FOR JUST \$25



We need to perform 12,000 operations each month

Three out of four people who are blind can have their sight saved or restored. In some developing countries the operation to overcome cataract blindness can take only 20 minutes and cost just \$25. Each month, our goal is to restore sight to 12,000 people. Donate now to help us continue Fred’s work.

DONATE NOW
1800 352 352
www.hollows.org.au



The Fred Hollows
Foundation

Increased role for pharmacists poor prescription for rural ills

Calls to allow pharmacists in country areas to issue prescriptions and administer vaccinations would condemn rural Australians to substandard care, the AMA has warned.

The Grattan Institute, a think tank, has proposed that pharmacists be given a greater role in providing care in rural communities as a way to improve access to GPs for more serious medical conditions and concerns.

But AMA President Dr Steve Hambleton said it was a flawed idea that would compromise the standard of care rather than improve access to primary health services.

“GPs are the cornerstone of primary care for Australians, no matter where they live,” Dr Hambleton said. “The key to improving access to primary care for rural Australians is to provide greater support for GPs, not undermine them or have alternative health practitioners take over their specialised role.”

He said that pharmacists already had a very important role to play in rural health, by being pharmacists.

Dr Hambleton said the AMA has been working with the Pharmaceutical Society of Australia in a plan to allow practices to employ pharmacists on site, so that they can work alongside GPs and practice nurses in a primary care team led by the GP.

“This is a much safer and more practical primary health care model to serve the growing needs of rural Australians”, he said.

According to the Grattan report, a shortage of GPs in many rural areas is imposing severe costs on individuals, doctors and the health system.

Author Dr Stephen Duckett said more than one million people were living in areas where there was a shortage of GPs, with barely half the GP services per person in very remote areas compared

with the major cities.

Dr Duckett said the shortage was forcing many patients in rural and remote areas to defer or even avoid trying to see a doctor, with serious health consequences.

“People in rural areas with low access to GPs are more likely to have serious health risks,” he said. “If they can’t get care it will cost them, and the taxpayer, much more in the long run.”

Dr Duckett said areas including Goulburn, Tamworth, Mount Isa, as well as the Northern Territory and most of Western Australia, were hit particularly hard by a shortage of GPs.

He suggested that pharmacists and physician assistants in under-served rural areas be allowed an expanded role in providing basic health services, freeing up GPs to handle more serious conditions and complaints.

“Pharmacists and physician assistants could take on some of the less complex tasks performed by GPs, without compromising quality and safety,” Dr Duckett said. “That would save money and free up GPs to do the more complex work they are trained for.”

But Dr Hambleton it was a poor solution that was potentially dangerous and would consign rural Australians to poorer quality care.

He said there could be a greater role played by physician assistants, but only under tightly controlled circumstances, and the extra training involved would divert resources away from training the next generation of GPs.

“The AMA is not opposed to the use of physician assistants who would work strictly under the direction and direct supervision of GPs, but the reality is that there will be no extra training capacity for any new health professional in Australia until at least 2025,” Dr Hambleton said,

adding that “the priority in medical training must remain with the medical students already in the training pipeline”.

“Providing prescriptions and vaccinations are key functions performed or directly supervised by GPs. It would be unwise to compromise the quality of health care by taking these functions away from general practice,” the AMA President said.

Rather than trying to get other health workers to take over some of the functions of GPs, Dr Hambleton said the AMA has proposed safer and more practical solutions to improve the access of rural Australians to GP services.

To achieve this, the AMA has called on the Abbott Government to provide a dedicated, quality training pathway, with the right skill mix to ensure GPs are adequately trained to work in rural areas, as well as more funding to support and encourage more generalist training.

To help address the imbalance in the distribution of GPs between rural and metropolitan areas, the AMA and the Rural Doctors Association of Australia have developed a Rural Rescue Package (<https://ama.com.au/node/4136>), which recommends financial incentives to ensure competitive remuneration for rural doctors.

In addition, the AMA has urged an extension of MBS video consultation items to include GP consultations for remote Indigenous patients, aged care residents, people with mobility problems and those who live some distance from the nearest GP.

The AMA has also urged the Government to replace the current flawed Australian Standard Geographical Classification and Districts of Workforce Shortage systems with a more comprehensive model that more accurately reflects the reality of on-the-ground workforce conditions.

Adrian Rollins

[TO COMMENT CLICK HERE](#)

Chiros told to take hands off kids until there's proof

Chiropractors should be banned from manipulating the skeletons of children until they can prove it helps instead of harms, AMA President Dr Steve Hambleton has said.

Speaking in the wake of disputed claims that the vertebrae of a four-month-old baby were fractured during chiropractic treatment, Dr Hambleton said there should be a stop to chiropractic procedures on children unless there is scientific evidence that they are beneficial.

“We know there are more and more chiropractors treating children for all sorts of things like infantile colic, like bed-wetting, like middle ear infections, all sorts of things for which it's simply biologically implausible that manipulation...or doing anything with the spine is going to make any difference,” the AMA President said. “You shouldn't be doing anything with a young person...without significant levels of quality evidence.”

The scope of chiropractic practice has come under increasing scrutiny amid concerns some practitioners are providing health advice and services well beyond their area of expertise.

In addition to claims that some chiropractors are seeking to treat children from a very young age - some as young as just a few months old - several have been linked to the activities of anti-vaccination groups.

Most recently, chiropractor Tim Robards, who appeared on *The Bachelor Australia* television show, was implicated in the promotion of anti-vaccination messages.

The Daily Telegraph reported that the Facebook page of the chiropractic clinic Mr Robards co-owns, Health Space Clinic, had a link to a discredited 2009 article claiming



the health risks posed by the Gardasil and Cervarix vaccines were far greater than the risk of cervical cancer itself.

A spokeswoman for Network Ten, which broadcasts *The Bachelor Australia*, told *The Daily Telegraph* that the Facebook page was “a professional website, it's related to his [Mr Robard's] business and not him personally. It's a link to a website, and it's not an endorsement”.

But the latest revelation adds to concerns that some chiropractors may be peddling anti-vaccination messages to their clients.

Earlier this year, the Chiropractic Board of Australia was moved to issue a directive to all practitioners to remove all anti-vaccination material from their websites and clinics “to protect public safety”.

The Board told *The Daily Telegraph* that it took “a very strong view” of practitioners who made unsubstantiated claims about treatment that were “not supported within an evidence-based context”.

Dr Hambleton said that while there was some evidence for the benefit of musculoskeletal treatments for adults,

there was no scientific support for the subluxation theory advanced by some chiropractors that correct spinal alignment boosts the immune system and obviates the need for vaccination.

He said there was a group of chiropractors who, appropriately, advocated that practice should be confined to those areas where there was scientifically demonstrated benefit.

“And then there's another group that talk about subluxation theory...[which is] simply biologically implausible - there's not a shred of credible evidence that backs up that theory,” Dr Hambleton said.

The AMA President said the Chiropractic Board should prevent chiropractors providing advice and treatments for which there was no scientific support, such as the manipulation of bones of young, particularly very young, children.

“If there's no evidence, [the Board] should stop chiropractors from acting in this area,” he said.

Adrian Rollins

[TO COMMENT CLICK HERE](#)

Poor air standards leaving communities breathless



Communities are being exposed to dangerously high levels of air pollution that are harming health and causing premature deaths, a senior AMA member has warned.

AMA Federal Councillor Dr Michael Gliksman told a conference on air quality that the nation's fragmented and outdated system for assessing and monitoring air pollution and enforcing clean air standards was failing the community and leaving many vulnerable to significant harm.

Addressing the Air Pollution Forum hosted by the Woolcock Institute in Sydney on 19 September, Dr Gliksman warned that increasing pollution from road transport and mining, combined with the growing effects of climate change, was smothering many communities in an increasingly toxic mix of airborne chemicals and particles that were harming health.

"It is very likely that these combined effects will have significant adverse effects on the morbidity and mortality of the Australian population," he said. "There is no known safe level of exposure to air pollutants, such as ozone or particulates, and exposure to levels below the current standard poses risks to human health."

In its submission to a recent Senate inquiry into air quality, the AMA identified major shortcomings in current pollution standards, as well as the effectiveness of systems to monitor and enforce those standards.

In the submission, the AMA warned that "thousands of Australians are dying prematurely or being hospitalised for asthma attacks and heart complaints because of lax standards and enforcement that

leave millions exposed to harmful levels of particulate matter, diesel fumes and other airborne pollutants".

In its findings, the Senate Community Affairs Reference Committee echoed the AMA's concerns and called for significant improvements in the nation's air quality monitoring arrangements as well as for mandatory health impact assessments for commercial and industrial developments.

Dr Gliksman said advances in understanding the health effects of air pollution had made improvements in pollution detection and enforcement imperative.

"There is considerable evidence documenting the substantial health impact of air pollution, which range from acute and chronic effects, reproductive and neuro-cognitive defects, through to premature mortality," he said. "The World Health Organisation's most recent appraisal of scientific evidence indicated that these effects are even more pronounced than was previously thought."

Dr Gliksman warned that this made the task of overhauling and upgrading surveillance and enforcement systems even more urgent.

"Various developments have called into question the effectiveness of current air quality management in Australia," he said. "Current air quality standards lag behind international standards. They have failed to keep pace with scientific evidence.

"Insufficient monitoring and poor compliance mechanisms, fragmentation between different sectors and tiers of government, and the lack of exposure targets are but some of the areas requiring review and reform."

Dr Gliksman said failings and gaps in current arrangements left individuals and communities vulnerable to harm.

"Major sources of hazardous air pollutants are not currently regulated. The current monitoring network needs to be strengthened and expanded [and] more effective enforcement mechanisms are also required," he said.

Dr Gliksman warned that governments and business could no longer neglect the issue.

"Local communities affected by air pollution are rising up in protest at what is happening to their lifestyle, their livelihood, and their health," he said. "These communities have a growing and meaningful voice, [and] the AMA and other health groups are adding public health evidence to that voice."

Adrian Rollins

[TO COMMENT CLICK HERE](#)

OCTOBER HEALTH EVENTS

The dates and events listed are major awareness days, conferences, weeks and months related to health. If you know of an upcoming national health event please email the details to ausmed@ama.com.au

Sun	Mon	Tue	Wed	Thur	Fri	Sat
		1 NSW Mental Health Month National Dyslexia Awareness Month National Lupus Awareness Month Breast Cancer Awareness Month	2	3 World MSA (Multiple System Atrophy) Awareness Day	4 National Amputee Awareness Week	5
6	7	8	9	10 World Mental Health Day	11 World Sight Day National Hat Day for Mental Health Research	12 World Arthritis Day
13 National Nutrition Week National Haemophilia Awareness Week & Red Cake Day	14 National Be Medicinewise Week National Veterans Health Week	15 International Pregnancy and Infant Lost Week Speech Pathology Australia Book of the Year Awards Ceremony 2013	16 Global Drug Safety Day National Anaesthesia Day	17	18	19 National Loud Shirt Day
20 National Herpes Day National Week of Deaf People World Osteoporosis Day National 'Wear What Matters' MedicAlert	21 National Sock it to Suicide Week	22 National Pink Ribbon Day	23 NSW Great Strides Walkathon	24 World Polio Day National Occupational Therapy Week	25	26 National Bandanna Day
27	28	29	30			



Don't let her drink dirty water

World Vision

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.

The good news is, problems like dirty water can be solved. You can help children access clean water through World Vision's Water Health Life program by providing practical and effective solutions.

From \$39 a month your support will help drill boreholes, protect water sources and provide health and hygiene training. You'll be helping communities to make long-term changes that ensure a clean water supply and basic sanitation.

Stop dirty water killing children, support Water Health Life:
visit worldvision.com.au or call 13 32 40.

Water Health Life

Basic Needs. Permanent Solutions

World Vision Australia is a Christian organisation pursuing freedom, justice, peace and opportunity for everyone in the world. ABN 28 004 778 081 Ref# 5199 C10215 A961 R27

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

Doctors' photos of patients a worry, *Sydney Morning Herald*, 13 September 2013

Doctors are using personal phones to take photographs of patient injuries. AMA President Dr Steve Hambleton said the Association was taking the issue extremely seriously, with three committees working to develop guidelines.

Ban considered as trial tests if vapour safer, *Sun Herald*, 15 September 2013

Australia could become the first major nation to outlaw smoking, with a trial about to test the viability of electronic cigarettes as a safer replacement for tobacco. Dr Hambleton said Australia was the global leader in tobacco control and should not let its guard down.

Why are we all getting fatter? Maybe, just maybe, it's because smart women can't cook, *Sunday Telegraph*, 15 September 2013

Bring back home-economics classes and make it a compulsory class. Dr Hambleton recently stated that Australians eat out too much, and there's a de-skilling of a generation. Everyone in schools should be taught how to prepare and cook food.

Sector calls for transparency and end to mistakes in PCEHR, *The Australian*, 17 September 2013

Medical experts have urged Tony Abbott to rectify the national e-health record system following significant mistakes and missed opportunities. Dr Hambleton said the AMA was not happy with uptake or processes of the PCEHR.

Drivers in fast lane to health dangers,

Adelaide Advertiser, 18 September 2013

Exhausted and overweight truck drivers are suffering heart attacks and blackouts at the wheel because of punishing deadlines. AMA Chair of General Practice Dr Brian Morton said taking health checks to the truckies at truck stops is a great idea.

Sick outlook for e-health, *Hobart Mercury*, 19 September 2013

Doctors want the new Government to pay them to spend the time uploading patient e-health records. AMA Vice President Professor Geoffrey Dobb said the Government needed to value the work of the health professionals setting up these records.

Doctors protect secrecy, *Herald Sun*, 27 September 2013

Doctors are resisting a push by drug companies to reveal all the payments they make to medical practitioners for speeches, consultancy work, overseas trips and meals. The AMA wants only payments greater than \$500 to be disclosed.

Call for age limit after chiropractor breaks baby's neck, *Sun Herald*, 29 September 2013

President of the Chiropractors' Association of Australia Laura Tassell said chiropractic treatment is as safe for children as it is for adults. But Dr Hambleton said the Chiropractic Board of Australia needed to either produce evidence supporting the safety and efficacy of chiropractic treatments for children or rule out paediatric care.

Principal's WiFi walkout, *Sunday Telegraph*, 29 September 2013

The long-time principal of an exclusive Sydney girls' school has quit due to health concerns over WiFi radiation. Dr

Hambleton said there was no known mechanism for WiFi to damage DNA.

Chemist plan to assist GPs, *Courier Mail*, 30 September 2013

Pharmacists would be able to administer vaccines and provide prescriptions under a plan to alleviate pressures on bush doctors. Dr Hambleton said pharmacists were not trained to vaccinate or prescribe medications.

Radio

Dr Steve Hambleton, SBS Ethnic Radio, 25 September 2013

AMA President Dr Steve Hambleton raised concerns that the Abbott Government's plan to transfer asylum seekers to an Australian overseas processing centre within 48 hours of arrival may not allow time for proper health assessments.

Dr Steve Hambleton, 4BC Brisbane, 27 September 2013

Dr Hambleton discussed a Bill calling for the exclusion of non-vaccinated children from Queensland childcare centres. He said there were concentrated pockets of non-vaccinated people in Queensland.

Dr Steve Hambleton, Radio Adelaide, 27 September 2013

Dr Hambleton discussed proposed euthanasia legislation. He said doctors have an obligation to provide palliative care, but not to end patients' lives.

Dr Steve Hambleton, 3AW Melbourne, 30 September 2013

Dr Hambleton said the AMA recommended against chiropractic treatment for babies. He said many claims made by chiropractors were biologically implausible.

[TO COMMENT CLICK HERE](#)

AMA in action

AMA President Dr Steve Hambleton has had a busy fortnight with public engagements and media appearances. He has discussed health checks for asylum seekers, serious health problems from bushfire smoke, and chiropractic treatment for children.

Dr Hambleton also flew to Sydney to attend the Australian Commission on Safety and Quality in Health Care (ACSQHC) Masterclass with National Health Service Chief Knowledge Officer Professor Sir Muir Gray. The topic of the session was “reducing unwarranted medical practice variation”. In his speech to the conference, Dr Hambleton talked of the strong drive among medical practitioners to improve clinical performance, and the opportunities that were available to achieve this within existing structures, as long as there was strong clinician engagement.

Dr Hambleton also attended the United General Practice Australia (UGPA) meeting on the 2 October 2013 at AMA House in Canberra, which discussed – among other issues – ways to improve access to GP services in rural areas.

[TO COMMENT CLICK HERE](#)



Dr Steve Hambleton, Dr Heather Buchan, and Sir Muir Gray



Sir Muir Gray conducts the Masterclass in Sydney



UGPA meeting members (l to r) Sean Rooney, Dr Steve Hambleton, Dr Sheilagh Cronin, Dr Liz Marles, Dr Patricia Baker, Dr Edward Vergara, Dr Rod Pearce

INFORMATION FOR MEMBERS

Can I prescribe ...?

Most doctors know what the rules are for prescribing medicines in Australia. Or do they?

AMA members frequently ask whether they are able to prescribe in certain circumstances. The most common questions are:

- Can I prescribe for myself?
- Can I prescribe for my family?
- Can I prescribe for someone who isn't directly my patient (a third party)?
- Can I backdate prescriptions?

It is understandable that doctors are uncertain, because there is no simple answer.

Prescribing in Australia is regulated by a range of laws.

For a medicine to be prescribed in Australia, the Therapeutic Goods Administration (TGA) must approve it for sale.

However, each State and Territory has its own laws regulating the prescription of medicines.

These laws determine who can prescribe, which medicines, in what circumstances, in what manner and for what purpose. In addition, specific conditions must be met to prescribe certain classes of medicines, such as some with Schedule 4 and Schedule 8 classifications.

These laws vary in each jurisdiction, so doctors must be careful they understand and comply with the laws in force where they practise.

A further layer of compliance is added for patients to receive a government subsidy under the Pharmaceutical Benefits Scheme (PBS) when they purchase prescribed medicines. Doctors must comply with requirements and restrictions under Commonwealth laws in order to prescribe under the PBS.

Finally, all doctors are bound by the Medical Board of Australia's code of practice – *Good Medical Practice* – as a condition of their registration to practise in Australia.

So can doctors self-prescribe, prescribe for family or for a third party?

Here's what the different laws say:

- Commonwealth, NSW, Queensland, Tasmanian and South Australian laws do not appear to prohibit self-prescribing, prescribing for family or for a third party.
- Doctors practising in Victoria cannot prescribe any S4 or S8 medicines for themselves or for a third party.
- In the Northern Territory, it is slightly more complicated. Doctors cannot self-prescribe S8 medicines or certain

restricted S4 medicines, and cannot prescribe for a third party unless the third party is the partner of a patient being treated for Chlamydia who is also likely to have Chlamydia.

- In the ACT, doctors are only prohibited from prescribing for themselves if they are still an intern, or the medicine is a restricted medicine.
- WA law simply prohibits prescribing for the purpose of self-administration.

Good Medical Practice cautions against prescribing for self, family, friends or "those you work with".

It recommends "seeking independent, objective advice when you need medical care, and being aware of the risks of self-diagnosis and self-treatment".

It also advises doctors to "avoid providing medical care to anyone with whom you have a close personal relationship ... because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient".

No State or Territory law appears to specifically prohibit backdating of prescriptions. Interestingly, neither does Commonwealth law. While the PBS website states that prescriptions must be not backdated, in fact neither the *National Health Act* nor the *National Health (Pharmaceutical Benefits) Regulations* provide any power to enforce this.

However, all prescribing-related laws require that the prescriber signs and dates prescriptions. It is likely that the intention, while not enforceable, is that the date is contemporary with the signature.

In summary, it is important that you understand the laws in force in the State or Territory in which you practise. Don't rely on hearsay (or this article), because laws change or can be misinterpreted without legal expertise.

If in doubt, check with the drugs and poisons unit in your State/Territory. The TGA maintains up-to-date contact details on its website at: www.tga.gov.au/industry/scheduling-st-contacts.htm.

Information about PBS prescribing rules is available at www.pbs.gov.au.

Good Medical Practice is available at: www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

The AMA's website also maintains a summary of prescribing rules information and links to other sources at <https://ama.com.au/node/12303> or you can go to the 'resources' tab on our homepage and look under 'FAQs'.

TO COMMENT CLICK HERE

Doubts over value of MD program

Critics have questioned the value of the University of Sydney's flagship Doctor of Medicine (MD) program, due to commence next year.

The program, accredited by the Australian Medical Council, will give postgraduate medical students opportunities to improve their research experience.

It is a four-year professional postgraduate entry course, which aims to ensure excellent clinical skills and preparedness for practice, give first-hand experience in research, and provide experience and awareness of health in an international setting.

In the first and second year, students will receive clinical training on campus and in their clinical schools.

In the final two years, however, training will be conducted in a variety of settings including hospitals in community, metropolitan, urban, and rural areas.

Topics covered in the curriculum will include basic and clinical

services, patient and doctor, population medicine, and personal and professional development.

But there are concerns that students will be lured into undertaking the course for little additional benefit compared with existing programs.

Even though the MD program will allow students to expand their research experience, there is scepticism that it is qualitatively different to existing MBBS programs.

Australian Medical Students' Association President Mr Ben Veness said he did not view the MD program as a worthwhile innovation, arguing that current MBBS programs offered a very positive and holistic university experience.

"It unfairly suggests the MBBS degrees do not have the same [clinical] quality as the MD, but the only difference is that the MD requires an extra level of research exposure," he said.

Sanja Novakovic

[TO COMMENT CLICK HERE](#)

Alcohol labels - few and far between

The answer to life's questions is rarely found at the bottom of a bottle – and neither is advice about safe drinking.

An audit by the Foundation for Alcohol Research and Education (FARE) has found that just 37 per cent of alcohol bottles carry warnings about the health effects of drinking, two years after the industry promised alcohol health warning labels would appear on all products by 2013.

The audit found that spirits and mixed drink products were the best at complying with the voluntary warning labels, with 43 per cent of products displaying the labels.

But, despite the relatively low rate of compliance, it is a substantial increase from a year ago, when only 16 per cent of products displayed the labels.

State and Federal Health Ministers have given the industry until the end of the year to voluntarily implement the labels.

In its audit, FARE found that, even where warning labels were applied, they were mostly small and unobtrusively placed - 86 per cent took up less than five per cent of

the label, and 93 per cent of all messages were placed on the back, bottom or side of the product.

AMA President Dr Steve Hambleton said that warning labels should be mandatory on all alcohol products, especially as a deterrent to teenage drinking and drinking while pregnant.

Dr Hambleton said Australia's binge-drinking culture was getting worse and every capital city had pockets where drunken violence occurs.

"Health warning labels on alcohol must contain strong, clear messages about the negative health effects of excessive or irresponsible drinking," Dr Hambleton said.

"The labels introduced voluntarily by the alcohol industry do not go far enough. They represent a soft approach on health labelling."

Dr Hambleton said that health warning labels were just part of an overall strategy to deter underage teenage drinkers.

"Steps must be taken to stop young teenagers from picking up the bottle or can in the first place," Dr Hambleton said.

Dr Hambleton also called for a ban on marketing and advertising of alcohol to teenagers, and expressed concerns about the use of social media by alcohol companies.

University of Western Sydney researchers tracked alcohol promotion on Twitter by seven global alcohol brands over six months and found that, although their Twitter following was relatively small, their promotions were widely retweeted to a much larger secondary audience, which possibly included those aged younger than 18 years.

While admitting that regulating social media was difficult, the researchers said lessons could be learnt from the successful combination of research, public pressure, political will and international cooperation that led the World Health Organisation ban tobacco promotion in 168 countries in 2003.

Kirsty Waterford

[TO COMMENT CLICK HERE](#)

INFORMATION FOR MEMBERS

AMA List of Medical Services and Fees - 1 November 2013

The 1 November 2013 edition of the AMA List of Medical Services and Fees will soon be available both in hard copy or electronic format.

Members listed as being in private practice or with rights of private practice should receive their hard copy no later than 31 October 2013. Salaried members who have ordered a hard copy should also receive their copy by 31 October 2013.

The AMA Fees List Online (<http://feeslist.ama.com.au/>) will be updated as at

1 November 2013. To access this part of the website, simply enter your username and password in the box provided on the screen. Members can view, print or download individual items or groups of items to suit their needs.

Electronic versions (PDF or CSV) of the AMA List will also be available for free download from the Members Only area of the AMA Website (www.ama.com.au/feeslist) from 22 October 2013.

A Fees Indexation Calculator is also available for members to calculate their own fee increase based on their individual cost profile.

To access this part of the website simply enter your username and password in the box on the 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 November 2013**.
- 4) Download either or both the **CSV** (for importing into practice software) and **PDF** (for viewing) versions of the AMA List.
- 5) For the Fees Indexation Calculator, select option **15. AMA Fees Indexation Calculator**.

Members who do not currently have a username and password should email their name, address and AMA member services number to memberservices@ama.com.au requesting a username and password.

If you do not receive your hard copy of the 1 November 2013 AMA List of Medical Services and Fees or would like one, please contact the AMA on **02 6270 5400**.

Handy pics may pitch the unwary into privacy minefield

Three AMA committees are working urgently to develop guidelines for doctors over the use of mobile phones and other devices to take photos of patients amid major privacy concerns regarding the practise.

A study has found that, in just one major Australian hospital, around half of all doctors and nurses took photos of patients, with about 20 per cent using their personal smart phones to take the images.

AMA President Dr Steve Hambleton said that while being able to quickly and easily take and transmit photos of patients was a great aid to diagnosis, treatment and medical training, doctors needed to also be aware of the serious privacy issues involved, and the need to take great care in how this was done.

The study, conducted by RMIT University researcher Kara Burns and published in *Australian Health Review*, found that while taking photos of patients was common, obtaining their consent was much less so, with 40 per cent admitting they did not always seek patient approval.

Ms Burns, a Darwin-based medical photographer, told *The Sydney Morning Herald* that the easy availability of camera phones was improving patient care, but also raising serious privacy concerns.

"Everybody you talk to that works in health care will have an experience of seeing a doctor pulling out a phone, or even being the patient who is being photographed," she said.

Ms Burns said most photos were intended to be included in a patient's record or for medical education purposes, but there was no clear accountability for how they were used.

Worryingly, she said, failure among doctors and other medical staff to comply with written consent guidelines when taking photos was "endemic".

Dr Hambleton said the AMA was taking the issue "extremely seriously", and three committees were working on guidelines to help doctors make the most of the benefits provided by smart phones and other devices without compromising patient privacy.

"These new technologies have been really great for helping patients," he told *The Sydney Morning Herald*. "For example, if a patient has a fracture that can be photographed and transferred to [other doctors], that makes the job of deciding who comes in and what sort of care is required, much more simple."

Dr Hambleton said that while doctors went to great lengths to ensure that patients could not be identified in images used for teaching or medical case reports, they may not be aware of other ways in which the images they took needed to be protected.

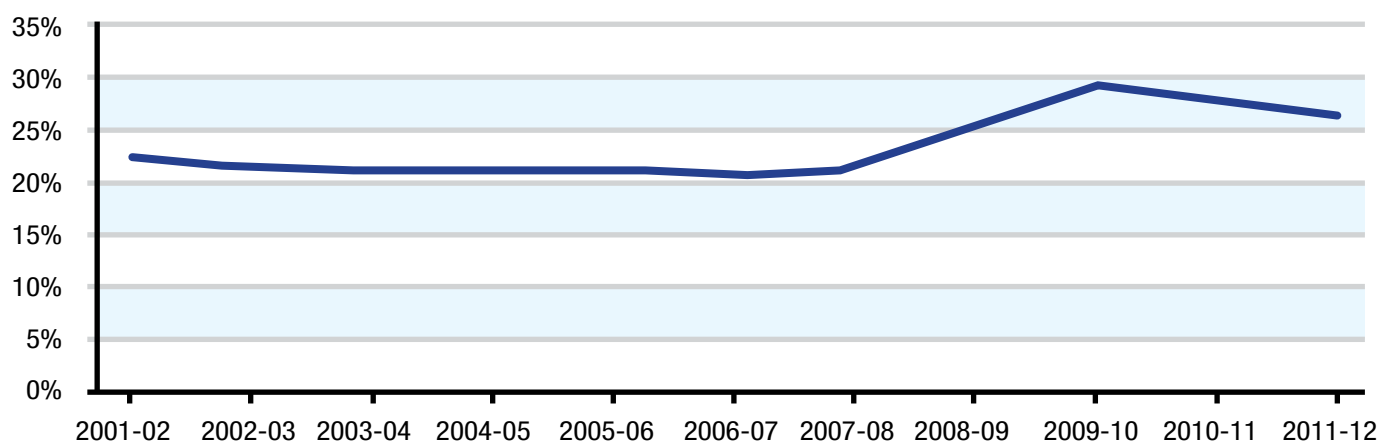
"Does it go straight to the patient's medical file, or does it stay on the phone, and does the phone have the right level of security?" he said. "Doctors need to be aware of the magnitude of the risk."

Adrian Rollins

[TO COMMENT CLICK HERE](#)

Medicines take biggest bite out of family health budget

Expenditure to revenue ratio



The ratio of health expenditure to tax revenue for the Australian Government, current prices, 2001-02 to 2011-12

Source: AIHW health expenditure database and ABS 2013d

Australians paid an average of \$1100 on out-of-pocket health expenses in 2011-12, with the major share being spent at pharmacies on medicines, medical aids and appliances.

Doctors, by contrast, held medical costs down, with patients forking out an average of just \$131 for medical services in 2011-12 – up just \$2 from the previous financial year – and accounting for less than 12 per cent of overall out-of-pocket spending on health care.

The figures were contained in a national snapshot of health expenditure compiled by the Australian Institute of Health and Welfare, which found that, overall, health is consuming a steadily increasing proportion of the nation's wealth.

In 2011-12, total health spending reached \$140.2 billion, a 7.6 per cent jump from the previous year, and accounted for 9.51 per cent of gross domestic product – up from 8.4 per cent a decade earlier, reflecting

the growth in demand for medical care from an ageing population, as well as the proliferation of increasingly effective but expensive drugs, equipment and treatments.

More telling for those with the task of managing the Federal Budget, the AIHW has for the first time reported on health spending as a proportion of tax revenue.

Its figures show that, in the seven years leading up the global financial crisis in late 2008, health spending as a proportion of Commonwealth tax revenue hovered between 21.4 and 22.4 per cent before jumping to almost 29 per cent in 2009-10 as the economic upheaval battered tax collections while leaving demand for health care untouched.

The ratio has eased lower since then, down by 0.6 of a percentage point to 26.4 per cent in 2011-12, but remains well above pre-GFC levels.

In a discomfiting outlook for the Government, there seems little prospect of a return to the speed of tax revenue growth experienced through the early to mid-2000s, suggesting that health expenditure is going to continue to consume a hefty share of taxes collected.

The report shows that spending on public hospitals grew by \$2.1 billion in real terms in 2011-12, with little shift in how the burden was shared between the Commonwealth and the states.

In an insight into where the burden of out-of-pocket health expenses for families lies, the AIHW report shows that more than 39 per cent of such spending was for medications (amounting to an average of \$358 per person), followed by 19 per cent for dental care, 11.9 per cent for medical services, 10.1 per cent for medical aids and appliances, and 7.8 per cent for other practitioner services.

Adrian Rollins

[TO COMMENT CLICK HERE](#)

Most elderly return home after hospital



Most older Australians who are admitted to hospital are able to return to their home after they are discharged, despite one third of all admissions to residential aged care being from hospital, a new report shows

An Australian Institute of Health and Welfare report also found that the reasons for entering hospital are different for older people living at home than for those living in aged care, with those in aged care twice as likely to be admitted to hospital after a fall.

The report, *Movement between hospital and residential aged care 2008-2009*, focuses on people aged 65 years and older, and includes the first analysis of the use of hospitals by people already in residential care.

AIHW spokesperson Dr Pamela Kinnear said that about 90 per cent of the 1.1 million hospitalisations a year for older Australians were for people who lived at home in the community. Nearly all others were for those living in residential aged care.

“On leaving hospital, 83 per cent of patients returned to their home in the community and 8 per cent were discharged back to their home in residential care,” Dr Kinnear said.

“Just over 4 per cent of patients were admitted into residential care or transition care when they left hospital. The remaining 5 per cent of hospitalisations ended with the patient’s death.”

Dr Kinnear said factors such as age and having dementia increased the likelihood of a person entering care after being discharged.

“People were more likely to be admitted into residential aged care than return to the community if they were in hospital for longer, were diagnosed with dementia or stroke, were older, had an unplanned hospital admission, or were in palliative care before being discharged,” she said.

Aged care residents entered hospital for different reasons than older people living in the community.

“Respiratory conditions were the leading

cause of admission for permanent aged care residents, while circulatory conditions were most common for people admitted from the community,” Dr Kinnear said.

Aged care residents were twice as likely as other older Australians to be admitted to hospital because of a fall (10 per cent versus 5 per cent).

There were just over 120,000 admissions into residential aged care nationally in 2008-09, including transfers between aged care facilities. Almost one-third of all these admissions were from hospital.

The report found that people who moved from living at home to living in permanent residential care via hospital had the longest stays in hospital, at an average of 28 days, compared with an overall average hospital stay of 6.1 days.

People who returned home on discharge tended to have the shortest stays. Death in hospital was generally preceded by a moderately short stay (a mean of 12 days).

Debra Vermeer

[TO COMMENT CLICK HERE](#)

Queensland Uni rocked by study scandal

Criminal investigators have been called in after the University of Queensland was forced to retract a major study on Parkinson's disease because of a lack of evidence.

In a scandal that has rocked the sandstone university, one of the Group of Eight institutions, the study, *Treatment of articulatory dysfunction in Parkinson's disease using repetitive transcranial magnetic stimulation*, - published in the *European Journal of Neurology* in 2011 - has been discredited.

In a statement, the University's Vice Chancellor Professor Peter Hoj said a preliminary investigation had found no data to support the study or its conclusions.

Professor Hoj said Queensland's Crime and Misconduct Commission (CMC) had been called in to investigate the matter, and the journal had agreed to retract the paper.

The lead author of the paper, renowned speech disorder expert Professor Bruce Murdoch, has resigned since the allegations first came to light.

In the paper, he and his fellow authors claimed to have developed a technique using a coil emitting magnetic impulses held over the head of patients to achieve significant improvements in speech impairment.

But an internal university investigation ordered by Professor Hoj failed to find any evidence that the study, including the use of the technique, had ever taken place.

In a statement, the UQ Vice Chancellor said that, "as a result of its investigation to date, UQ has asked the journal that published the paper to retract it on the grounds that no primary data can be located, and no evidence has been found that the study described in the article was conducted".

Underlining the seriousness of the scandal, Professor Hoj said the University had "informed the Crime and Misconduct Commission of the allegations, and will receive further advice from the CMC once it has received the inquiry panel's final report".

He said a \$20,000 grant from a non-government organisation, awarded for the study, had been returned "due to our concerns it had been allocated on the basis of information from the discredited paper."

Professor Hoj said having the paper retracted by the journal was an important step in ensuring the integrity of future scientific inquiry.

"By having the paper retracted, the University enables the global scientific community to learn that the research reported in the paper has no place in the body of scientific knowledge, and so cannot be used as a basis for further research," he said.

The editor of the journal, Professor Tony Schapira, told the *Brisbane Times* that, through his actions, Professor Murdoch had "let everyone down".

"We condemn the actions of scientists who seek to deceive the

scientific community," Professor Schapira, from University College London, said.

"The community expects, and should receive, the highest standards of honesty and ethical conduct."

He said the journal had numerous checks in place to ensure papers submitted for publication were legitimate, including peer review and author statements.

"But in the end we remain dependent upon the integrity of submitting authors," he said.

Adrian Rollins

[TO COMMENT CLICK HERE](#)

INFORMATION FOR MEMBERS

Guide for Practitioners: Notifications in the National Scheme

The Australian Health Practitioner Regulation Authority (AHPRA) has prepared a guide and a series of information sheets to explain to doctors what happens when it receives a notification about a practitioner from the Medical Board of Australia.

The publication, *A Guide for Practitioners: Notifications in the National Scheme*, and the information sheets can be viewed and downloaded at: <http://www.ahpra.gov.au/Notifications/Fact-sheets.aspx>

The guide for practitioners was written by AHPRA, in conjunction with the various national boards, to explain to health practitioners the complaints process.

AHPRA Chief Executive Officer Martin Fletcher said that the majority of health care practitioners were highly skilled and deeply committed to providing safe care, and acknowledged it could be very confronting for them to be the subject of a notification.

The guide describes what occurs when AHPRA receives a notification from the Medical Board.

This information will complement the direct correspondence that individual practitioners will receive if a notification is made about them.

The AMA first called for the development of the Guide in its submission to the Senate Finance and Public Administrative References Committee in April 2011.

The document sets out the notification process, including the time limits that apply.

It is intended to enable practitioners to better understand the process and what is required of them, as well as providing a means to verify that their matter is being handled in a manner consistent with AHPRA processes.

More waiting longer for elective surgery



Elective surgery waiting times are growing despite a substantial increase in admissions as pressure on the nation's public hospital system builds.

Figures compiled by the Australian Institute of Health and Welfare show that the length of time 90 per cent of patients have to wait for elective surgery has blown out in the past five years, from 219 days in 2008-09 to 265 days in 2012-13.

While the report showed that the proportion of patients forced to wait more than a year for treatment has remained steady at around 3 per cent, many still face long delays despite a breakthrough national deal 18 months ago to cut elective surgery waiting lists.

Those waiting for knee replacements and operations to repair broken noses have faced the longest delays, with a median waiting time of around 196 days in 2012-13.

Overall, ophthalmology (76 days), ear, nose and throat surgery (68 days) and

orthopaedic surgery (65 days) were the surgical specialties with the longest median waiting times, while cardio-thoracic surgery had the shortest – 17 days in 2012-13.

This meant that those awaiting coronary artery bypass graft procedures faced the shortest median waiting time of any elective surgery patient last financial year, just 16 days.

While many elective surgery patients continue to face lengthy delays in receiving treatment, the AIHW report showed there had been considerable growth in admissions for elective surgery in 2012-13, which were up 1.8 per cent from the previous financial year.

All up, 673,000 elective surgery patients were admitted during the 12 months to June this year – around 25 per cent for general surgery and about 15 per cent for orthopaedic procedures.

AMA President Dr Steve Hambleton said it was too early to tell if the deal brokered

by governments in late 2011 – the National Partnership Agreement on Improving Public Hospital Services – was working.

Under the deal, incentive payments worth up to \$800 million were on offer to State and Territory governments who achieved improvements in cutting elective surgery waiting times.

So far, of the various jurisdictions, only the Australian Capital Territory has achieved significant reduction in waiting times.

According to AIHW figures, while admissions have increased in four jurisdictions – NSW, Western Australia, the ACT and the Northern Territory, only the ACT has seen a marked decline in elective surgery waiting times, with the median dropping from 74 to 51 days between 2008-09 and 2012-13.

During the same period, NSW saw a climb in median waiting times, from 39 to 50 days.

According to the AIHW, median waiting time in most other states and territories were “fairly stable”.

Dr Hambleton said it was too soon to judge whether or not the 2011 deal had been a success.

“Hospitals are under pressure, they're doing the best they can,” the AMA President told ABC radio. “Patients are still going to be waiting for about the same length of time, some a little shorter, some a little longer.”

Dr Hambleton said that one aspect of the issue not covered by the Institute's report was the likelihood of any diminution in the blame game and bickering between the states and the Commonwealth over health funding and hospital performance.

Adrian Rollins

[TO COMMENT CLICK HERE](#)

Obamacare starts amid Republican fury

The Obama Administration's landmark health reforms have commenced operation in the face of fierce opposition from hardline Republican opponents.

In a stunning showdown, a determined core of Republican congressmen have forced a shutdown of much of the US Government and could yet threaten to derail the country's fragile economic recovery as they try to force the White House to agree to delay or dismantle much of the Affordable Care Act, also known as Obamacare.

But US President Barack Obama and House Democrats have so far resisted the intense pressure, and President Obama appears increasingly confident that it is the Republican opposition that will eventually splinter and collapse.

Late last week he ridiculed the public statements being made by some of the most vociferous opponents of Obamacare from within the Tea Party caucus of the Republican Party, and several moderate

Republicans have publicly lambasted hardliners within their own party for their actions in Congress.

"Just yesterday one House Republican said - I'm quoting here alright because I want to make sure people understand, I didn't make this up - one House Republican said, 'We're not going to be disrespected. We have to get something out of this and I don't know what that even is'. Think about that," President Obama said.

While thousands of federal public servants have been told not to report for work, and dozens of Government institutions have been shut down or put in caretaker mode, a key element of Obamacare came into operation last Tuesday (1 October) when state-based insurance exchanges opened for business.

The exchanges will enable 32 million Americans currently without any form of health cover to choose from a range of health insurance plans that will come into effect from 1 January next year.

(For more detail on Obamacare, see *Obamacare survives US Govt shutdown, so what is it exactly?*, p27).

The fierce opposition to the health reform is an aspect of the visceral fear and loathing many Americans feel toward the Obama Administration in general, and President Obama in particular.

The depth of feeling many express regarding President Obama has similarities with the fury some expressed toward Julia Gillard while she was Prime Minister.

As of late last week attempts to negotiate a settlement to the US political stalemate had got nowhere, stoking fears that, for the first time in its history, the US Government might have to default on its debt obligations, with potentially disastrous ramifications for the international economy.

Adrian Rollins

[TO COMMENT CLICK HERE](#)

INFORMATION FOR MEMBERS

Evaluation of the Practice Nurse Incentive Program

Call for general practices and Aboriginal health services to participate in an interview to inform the Evaluation

The Practice Nurse Incentive Program (PNIP) was introduced in January 2012 to support practice nurses and Aboriginal health workers working in general practices, Aboriginal medical services and Aboriginal community controlled health services to undertake an expanded and enhanced role in preventive health, chronic disease management and care coordination. It replaced a range of funding arrangements including Practice Incentive Program, Practice Nurse Incentive, and six of the Medicare Benefits Schedule practice nurse items.

The Department of Health and Ageing has contracted KBC Australia, in collaboration with Thinc Health, to undertake an evaluation of the PNIP.

As part of the evaluation, KBC will interview general practices and Aboriginal health services to identify the impact of the changed funding mechanism on the:

- role and function of practice nurses and GPs;
- the business model of practices; and
- the workforce mix within practices and Aboriginal health services.

Practice personnel to be interviewed

Key personnel to be interviewed could include the GP practice principal or medical director, and/or practice manager, CEO of Aboriginal health service, practice nurse manager or senior practice nurse.

Telephone interviews can be undertaken individually or in a group, dependent on the preference of the practice.

It is estimated that interviews will taken about one hour.

For inquiries, or to register your interest, please contact:

Monika Rickli at KBC Australia:
(02) 6361 4000
mrickli@kbconsult.com.au



Bulk billing hides true cost of care

BY DR BRIAN MORTON

“Unfortunately we GPs are our own worst enemy, as we willingly absorb the true cost of providing quality medical care”

One of the more enjoyable aspects of being a GP is supervising and training GP registrars in my practice. It is rewarding to see these future GPs develop their skills and confidence during their placement with me.

It worries me, however, when I meet registrars outside my practice who have been put off and demoralised by what they see as the churn of patients through the surgery stimulated by bulk-billing. Sweatshop and battery hen farm are some of the terms I have heard!

Like the GP registrars, I understand only too well the perverse effects of artificially low fees for standard consultations on the long-term viability of general practice in this country.

The present system largely provides no real price signal to patients of the cost of medical care. It encourages patients to make unnecessary visits to the surgery because their GP bulk bills. In this environment, a GP's time is wasted dealing with unnecessary presentations such as grazed knees or runny noses that could be managed at home with a little common sense.

At the same time, the inadequate rebate for a standard consultation encourages “six-minute medicine” in order to generate a high throughput of patients to pay salaries and rent and recoup the other rising costs of running a practice.

This means less time to manage patients with more complex issues and less time to deliver high-quality preventative care. Compressed consultations means unnecessary tests – more pathology and radiology investigations and increasing rates of referrals to higher-cost specialties.

The result is higher overall costs for the health system.

Inadequate rebates do not capture the true value of GP care offered to patients, and some practices have an over-dependence on chronic disease

management items for a reliable income stream. On that score, perhaps it is time to rethink the chronic disease management items, how they are being used, and who they are benefiting.

Certainly, we need to be able to streamline and improve GP-coordinated access for patient multidisciplinary care and other support services for those patients where there is a clinical need, and where it will improve the quality of life.

The overall result of the present system is a distortion of the marketplace and questionable viability for quality general practice.

Unfortunately we GPs are our own worst enemy, as we willingly absorb the true cost of providing quality medical care. Of course we all have a strong commitment to our patients, especially to bulk billing those who are disadvantaged.

Sadly, the profession is seen as a soft target by the Government – witness the decision in the last Federal budget to delay MBS indexation by eight months, effectively cutting MBS rebates in order to save \$664.4 million over four years. There was no consideration made of how the decision would affect patient access to care. The assumption is always that GPs will absorb the costs and continue to bulk bill. This is usually backed by a proud boast about the high rate of bulk billing.

I encourage GPs to set their fees based on their practice costs and workload. We must be remunerated fairly for our services to maintain the viability of our practices.

It is important for you to review your fees on a regular basis to ensure that they reflect the true costs of running your practice and the value of the service you provide. The AMA has several resources on its website (<https://ama.com.au/policy/doctors-fees>) to assist you to move to patient billing.

[TO COMMENT CLICK HERE](#)



Plenty of ways for new Government to cut waste

BY DR DAVID RIVETT

“On a positive note, we have in Peter Dutton a Health Minister who respects the medical profession, and Fiona Nash, his assistant in the Senate, is a fierce advocate for rural Australia”

Some statements from patients can certainly cause mirth.

I was recently conducting a pre-op check on an ageing patient with Alzheimer's when he volunteered that he had recently had shingles. I asked where he had it, and he replied, in some detail, that he “got it in the garden under a bush - I just ducked in to weed under a tree, and came out with shingles”. My concentration was gone. I had to leave the room for a minute to compose myself. Often our questions are open to misinterpretation and I guess I was the guilty party.

The political scene has certainly changed, with the Coalition assuming control of the House of Representatives. Any waste seems to be in their sights, as exemplified by the Prime Minister's decision to quarter himself in inexpensive digs while The Lodge is renovated. His deputy, Foreign Affairs Minister Julie Bishop, slashed her party's travel costs to New York. Leading by example such as this always inspires my respect.

I feel any waste in the provision of medical services will now be high on the agenda for cuts. So, wishing to be helpful, I will offer some suggestions:

First and foremost, end the subsidy through private health insurance of snake oil therapies with no scientific validity. All government /taxpayer subsidised care should be evidence-based.

Secondly, continue Mr Rudd's agenda of renegotiating pharmacy agreements so that the taxpayer meets no more than the true cost of PBS medicines to the pharmacist, plus a realistic dispensing fee.

Take this further and decree that pharmacies

accepting government monies for PBS prescribing will not market “alternative” or “natural” concoctions unless such have sound evidence of efficacy.

And should stable patients on meds such as statins and antihypertensives really have to front up monthly at the pharmacy for repeats on their 28 to 30 day supply of medications?

Thirdly, start a cost-benefit analysis of the multiple government and quasi-government bodies that regulate the provision of health care. Medicare Locals are already up for review, and the requirement for accreditation to access Commonwealth Practice/Service Incentive Payment schemes should also get a guernsey.

Multiple big budget taxpayer-funded bodies need similar and timely review. The National E-Health Transition Authority, Health Workforce Australia, and many subsections of the Department of Health and Ageing should be independently reviewed. Any savings should be directed toward service provision, not more grandiose enquiries and regulatory bodies.

Fourth, the Government should simplify the Enhanced Primary Care program, and the authority script red tape, which is wasting GP time.

On a positive note, we have in Peter Dutton a Health Minister who respects the medical profession, and Fiona Nash, his assistant in the Senate, is a fierce advocate for rural Australia.

I trust we are entering a new era where a sound foundation for a better healthcare system can be laid and the AMA can be truly involved in guiding positive change.

[TO COMMENT CLICK HERE](#)



New medical schools no panacea for rural health

BY AMSA PRESIDENT BEN VENESS

If the proponents of new medical schools voted Liberal or Nationals thinking a Coalition Government would help their chances, they miscalculated.

Our new Prime Minister ran on a ticket of fiscal responsibility. Our new Health Minister's policy is to increase resources at the front line and remove unnecessary bureaucracy.

Our new Education Minister has said he's obsessed with quality.

None of the proposed new medical schools – at Charles Sturt and La Trobe universities on the east coast, and Curtin University in the west – stack up against these objectives.

Fiscal responsibility demands respect for the taxpayer's dollar. Roughly one-third of taxpayers live in regional or remote Australia. They are getting a relatively raw health deal at the moment, with about 200 doctors per 100,000 head of population compared with 370 per 100,000 in the major cities. Same tax rate, half the doctors.

This isn't a new problem, and it is in fact why our Prime Minister oversaw a massive expansion in new medical schools the last time he was in Government. As Health Minister, Tony Abbott in 2005 spoke at the graduation ceremony for the first doctors to come out of Australia's first regional medical school, at James Cook University in Townsville. Since then, more new schools outside of major cities have opened. As of 2013, Australia has 18 medical schools and one-third of medical students participate in a rural clinical school program.

Among medical students, demand for rural clinical rotations is high, even at campuses like the University of Sydney.

When my cohort was offered the chance to spend up to a year in Broken

Hill, Lismore, Dubbo or Orange, the school had to run a ballot. The year after mine, bystanders live-tweeted the drama. Unfortunately, most of this rural excitement during the medical school years is killed off post graduation.

When the first 46 doctors from the University of New England's medical school started work this January, none of them was still in Armidale. This wasn't the students' fault: Armidale Hospital isn't accredited and resourced to train interns. (My hospital, Royal Prince Alfred, took 58 this year.)

Job opportunities in rural Australia are thin for junior doctors. The emergent issue with our medical workforce is not a lack of students, but a lack of training positions.

Australia has gone from graduating 1500 medical students a year to more than 3000, but not enough effort has gone into expanding workforce capacity.

More than 2000 applications were lodged this year for just 1200 places in the general practice training program. More than one in three junior doctors who wanted to serve Australia as a GP missed out.

So, what of the specious claim that another rural medical school is the panacea we've all been waiting for? Firstly, the Curtin proposal is in east Perth. It would be another urban medical school.

Secondly, there is no strong evidence to support an assertion that new rural medical schools would address the inequitable distribution of doctors. We don't yet know how to fix this internationally-shared problem. A 2009 Cochrane review on the topic concluded that there are "...no well-designed studies to say whether any of these strategies are effective or not."

All these new students need somewhere to train, and the proposed Murray Darling Medical School wants to use Bendigo Hospital. This hospital is already full of students from the University of Melbourne and Monash University. With doctors forced to supervise more students, patient services would decrease, teaching quality would be compromised, or both. Would a dilution of clinical teaching and supervision appeal to quality-obsessed Education Minister Christopher Pyne? To patients?

Medical graduates can't fix a rural workforce shortage if there aren't rural jobs to go to. Without an expanded rural training capacity, the new doctors would be forced to return to the cities for their internship and specialty training. There, they would likely settle down.

Rural communities deserve better than to be undersold in the veiled hope of improving a few universities' reputations.

Rejecting calls for new medical schools and investing in expanding rural training capacity would be fiscally responsible, deliver on the promise of redistributing funds to frontline services, avoid duplicating university bureaucracy, and maintain the quality of medical education.

In time, both quality and quantity would improve as more supervisors become available to train medical students at our 17 existing rural clinical schools.

Now is Prime Minister Abbott's chance to finish the job he started as Health Minister a decade ago.

Benjamin Veness is the president of the Australian Medical Students' Association. He is studying medicine and a Master of Public Health at The University of Sydney. Follow on Twitter @venessb and @yourAMSA

A version of this article first appeared in The Sydney Morning Herald on 30 September.

[TO COMMENT CLICK HERE](#)



Scrapping medicines authority system should top Govt's to-do list

BY PROFESSOR GEOFFREY DOOB

“The AMA urges the new Government to look at the PBS Authority Policy as one of its first deregulation projects”

A new Government and a new Health Minister provide an opportunity to fix the long-standing red tape burden imposed by unnecessary regulation of PBS medicines.

AMA members regularly raise with us the impact this regulation has on their practice and their patients. The biggest impact is the requirement to call the Authority Freecall Service for an administrative officer to decide if the medical practitioner can have the necessary authority to prescribe a certain PBS medicine. In 2008-09, 6.4 million calls were made to the Authority Freecall Service, of which only 2.8 per cent did not result in an authority being provided.

Obtaining an authority diverts the medical practitioner from patient care. Based on information about Freecall waiting times provided to the AMA by the former Minister for Human Services, Senator Kim Carr, in November 2012, an estimated 25,000 patient consultations are lost every month while medical practitioners are waiting to obtain authorities to prescribe medicines.

The Coalition's election policy document, *Boosting Productivity and Reducing Regulation*, states that “regulation should only be imposed where absolutely necessary and should not be the default position in dealing with public policy issues”. The Coalition has committed to a comprehensive review of legislation and regulations to repeal in its first term.

The AMA briefed the-then Shadow Health Minister Peter Dutton early this year about the PBS Authority Medicines policy and its negative impact on medical practitioners and their patients.

The AMA fully supports the objectives of the PBS to provide subsidised, cost-effective medicines to the Australian public. We understand that the Government needs to ensure taxpayers receive value for money, and that includes appropriate, quality prescribing by medical practitioners.

However, the AMA is still to see evidence that the PBS Authority Medicines policy is an effective or efficient way to achieve this.

Our view is that the authority system imposes an administrative burden on the vast majority of medical practitioners who do the right thing in order to potentially deter the few who may seek to prescribe outside the PBS requirements.

The Department of Human Services' (DHS) compliance program already identifies individual medical practitioners with prescribing habits different to their peers, and audits prescribing of PBS medicines to patients who do not meet the PBS conditions.

The National Prescribing Service's MedicineWise program is funded by the Government to improve the quality use of medicines. For example, it provides individual medical practitioners with information to compare their prescribing patterns with those of their peers, based on DHS data, and collects and analyses detailed information about how and why medicines are prescribed in medical practices, and whether prescribing aligns with recommended best practice. This information informs policy and clinical practice and shows the effectiveness of the PBS, particularly how new PBS medicines are used.

The DHS has other means than the authority system to track medicines prescribed and dispensed under the PBS, and allow detailed information on utilisation to be collected and analysed. This information can inform NPS activities and highlight risk areas to be audited by DHS.

The AMA urges the new Government to look at the PBS Authority Policy as one of its first deregulation projects. To assist, the AMA has provided a detailed submission (based on Therapeutics Committee advice) that proposes a staged approach to lifting the burden of the authority system.

[TO COMMENT CLICK HERE](#)



Practitioners should be alert to internet pitfalls for the young

BY CHOONG-SIEW YONG

“Not all online activity will pose harm, but it may be an avenue of inquiry when speaking with younger patients”

During the recent meeting of the AMA's Public Health and Child & Youth Health Committee, members considered children and young people's use of the internet. Today's children and young people are growing up with unprecedented internet access and reliance on social networking, and, while there are likely to be many benefits, there are also likely to be potential problems.

Concerns range from internet and gaming addiction to increased access and exposure to websites that promote unhealthy thinking and behaviours, such as websites that promote bullying, self-harm and eating disorders.

Last year, the AMA produced two resources on childhood bullying (one for doctors and another for consumers), both of which highlight the pervasive nature of cyber bullying. The longer term effects of cyber bullying may be more serious than other forms of bullying, with a potentially increased risk of suicidal thoughts and behaviours. Children and young people also report a reluctance to disclose that they are experiencing cyber bullying due to fear that they may be banned from, or have restricted access to, their mobile phones or computers.

There is also a wide range of internet content that is not appropriate for children and young people.

An emerging area of interest is the growth in websites that focus on self-harm and body image. 'Thinspo' or 'thinspiration' websites often include detailed information about dangerous eating and exercise habits, as well as advice on how to hide these behaviours. Most sites also include extensive

photo galleries of extremely thin fashion models and celebrities.

Many websites allow users to post material anonymously that may be appealing for those experiencing psychological distress. Excessive exposure to these websites may normalise harmful thinking patterns and behaviours.

There are also groups of children and young people who spend excessive amounts of time on the internet (including online gaming). While there was some debate about the inclusion of "internet use disorder" in the latest version of the Diagnostic and Statistical Manual of Mental Disorders, it is clear that this is another area that requires further research. Overseas experience shows that, left unattended, internet and gaming addictions can have very serious consequences.

While clinical guidance is emerging, it is important that medical practitioners with younger patients are aware of these issues.

Not all online activity will pose harm, but it may be an avenue of inquiry when speaking with younger patients.

There are a small number of organisations undertaking research and advocacy in this area in Australia, such as the Young and Well Cooperative Research Centre and the Network for Internet Investigation and Research Australia (NiRA). The NiRA website has information for both the public and health professionals (<http://www.niira.org.au>).

This is an area the Committee will continue to monitor.

[TO COMMENT CLICK HERE](#)



Obamacare survives US Govt shutdown, so what is it exactly?

BY DR LESLEY RUSSELL, SENIOR RESEARCH FELLOW, AUSTRALIAN PRIMARY HEALTHCARE RESEARCH INSTITUTE, AUSTRALIAN NATIONAL UNIVERSITY

This article first appeared in The Conversation on 30 September, 2013, and can be viewed at: <http://theconversation.com/explainer-what-is-obamacare-18642>

A political stalemate in the US Congress has forced the Federal Government into shutdown mode, but the policy at the heart of the impasse – the Affordable Care Act (known as Obamacare) – survived, and implementation began on 1 October. Dr Lesley Russell explains what Obamacare is, and how it works.

In March 2010, after much policy wrangling and expenditure of considerable political capital, President Obama signed into law the Affordable Care Act (known as Obamacare) – a bill to deliver the most sweeping health care reforms in the United States since Medicare and Medicaid were implemented in 1965.

Since then, the legislation has survived major challenges, including a Supreme Court judgement, 42 votes to repeal in the House of Representatives, and the Catholic Church contesting the requirement that insurance should cover contraception.

Implementation of Obamacare has been a complicated and protracted task but, despite opposition and controversy, this has proceeded surprisingly on track and on time.

The final, major phase of implementation began on 1 October, when the state-based insurance exchanges opened for business, enabling consumers to choose insurance that will begin on January 1, 2014. At that time, Medicaid expansions will also come into effect.

“Ultimately these provisions will see more than 32 million Americans who currently lack health insurance, covered. The newly-insured – who today look to the hospital emergency department for their care, or go without – will be less educated, more likely to be unemployed or poor, and more racially diverse than those who currently hold health insurance”

Ultimately these provisions will see more than 32 million Americans who currently lack health insurance, covered. The newly-insured – who today look to the hospital emergency department for their care, or go without – will be less educated, more likely to be unemployed or poor, and more racially diverse than those who currently hold health insurance.

For all its imperfections, Obamacare is a package of genuine reforms which make major advances in:

- developing new ways to deliver and fund health care services;
- requiring improvements in quality and safety;
- expanding the health workforce; and in
- implementing a whole-of-government approach to prevention and tackling health disparities.

When fully implemented, it will hold down health care costs, reduce the deficit by US\$109 billion over the next decade, increase jobs and productivity, and

provide affordable health insurance for millions of Americans.

So it's shocking that despite (or perhaps because of) the endless debates, pontificating, slogans, advertising, and campaigning, most Americans are no wiser today about what Obamacare means for them and the nation than they were four years ago.

A recent poll shows that 44 per cent of Americans think Obamacare is a bad idea. Confusion about what is in the law plays a role in the public's negative perceptions – 34 per cent said they don't understand the law very well, while just 35 per cent claimed to have some understanding of the law. A poll taken in April found that 40 per cent of Americans were unsure about whether the Affordable Care Act still existed.

Most Australians are bemused by the illogical fears of so many Americans about these reforms and the continuing ideological assault from the right. There is considerable irony in the implacable Republican opposition given that many provisions of the law originated in conservative policies.

...CONTINUED ON PAGE 28

Obamacare survives US Govt shutdown, so what is it exactly?

...CONTINUED FROM PAGE 27

The public's confusion is highlighted by the fact that, while very few Americans understand the full scope, impact and costs of the reforms, they do want the many benefits that have already been implemented to continue. These include:

- allowing children aged less than 26 years to stay on their parents' policies;
- lower drug costs for people on Medicare who are heavy users of prescription drugs;
- free preventive health services such as immunisations, mammograms and contraceptives; and
- a ban on lifetime limits on insurance payments.

Insurance companies cannot deny coverage to people with pre-existing conditions and, starting in 2014, insurers must accept all applicants. Medicare has started to reward hospitals for providing good (rather than lots of) care, and there is mounting evidence that the overall growth in health spending has slowed.

Although the law contains many provisions, its main goal is to expand health insurance cover. Beginning in 2014, every American will be required to have some form of health insurance. Essentially that's how the scheme funds the prohibition on insurers refusing coverage to those with pre-existing conditions. Of the 32 million newly-insured Americans, 32 per cent will gain coverage from Medicaid, 45 per cent from the individual exchanges, and 23 per cent from their employers.

For 60 per cent of these people, the cost

to them of their health insurance will be \$100 or less a month. From 2014, those with incomes of between 100 and 400 per cent of the federal poverty level will qualify for subsidies to purchase health insurance through the new state health exchanges, which will act as competitive markets for an array of approved insurance products. A different set of exchanges will cater to small businesses, which currently lack the marketplace clout to negotiate affordable health insurance for their employees.

Obamacare envisioned most states establishing and running their own insurance exchanges, and US\$1.8 billion has so far been provided to help with this task. States are required to establish websites to help consumers – including those with poor literacy and whose first language is not English – compare health plans, determine their eligibility for tax credits, and to provide assistance with enrolment.

However, 36 states, mostly Republican-led, are leaving the job entirely to the federal government. In an ironic upending of conservative philosophy, this will see the federal government play an increased role in health care.

The other major health care initiative designed to cover the uninsured – expanding Medicaid to include more low-income Americans (those with incomes up to 133 per cent of poverty) – is opposed by at least 20 Republican governors. This is despite the fact that the federal government would pay 100 per cent of the costs of this expansion from 2014 to 2016, and up to 90 per cent

thereafter – a deal which would see states save money because they would no longer be required to pick up the bill for uncompensated hospital care.

However some governors, even those with Tea Party bona fides such as Jan Brewer of Arizona, have read the tea leaves and chosen to go with the Act.

The Supreme Court ruling last year gave states the option of choosing not to participate in the Medicaid expansion. In states that don't commit to the expansion, people who are too poor to buy coverage in the exchanges, even with a federal subsidy, will be left without insurance. This could add up to as many as 11.5 million people, or half the people who could potentially be newly eligible for Medicaid.

There is evidence that insurer interest in the new insurance markets is robust – a good signal for competition, especially in those states where one insurer has dominated. The plans to be offered from next year are also more comprehensive than many bare-bones policies currently available to individuals. Data just released by the Government show that, on average, consumers will have a choice of 53 health plans, and the average premium costs are more than 16 per cent lower than previously projected.

The ability of the insurance exchanges to be ready for prime time on October 1 was critical to the lasting success of Obamacare. A failure to deliver would have fulfilled everyone's worst fears, but smooth operations mean real health care reform has finally arrived.

[TO COMMENT CLICK HERE](#)



Research

Immune response holds treatment clue for devastating diseases

Australian researchers have solved a molecular mystery that could open the way to finding potential treatments for currently untreatable diseases like Huntington's disease and Lou Gehrig's disease.

The University of Adelaide team has identified a likely molecular pathway that causes a certain group of diseases.

The group of about 20 diseases, which show overlapping symptoms that typically include nerve cell death, share a similar genetic mutation mechanism. But how this form of mutation causes these diseases has remained a mystery.

Professor Robert Richards, Head of Genetics in the University's School of Molecular and Biomedical Sciences, said that, despite the genes for some of these diseases having been identified about 20 years ago, scientists still haven't understood the underlying mechanisms that lead to people developing clinical symptoms.

"By uncovering the molecular pathway for these diseases, we now expect to be able to define targets for intervention, and so come up with potential therapies," Professor Roberts said.

"Ultimately, this will help sufferers to reduce the amount of nerve cell degeneration or slow its progression."

In an article published in *Frontiers in Molecular Neuroscience*, Professor Richards and colleagues put forward new evidence for the key role of RNA in the development of the disease.

RNA is a large molecular in the cell that

copies genetic code from the cell's DNA and translates it into the proteins that drive biological functions.

Professor Richards said people with these diseases all have expanded numbers of copies of particular sequences of the 'nucleotide bases' which make up DNA.

"In most cases people with these diseases have increased numbers of repeat sequences in their RNA," he said.

"The disease develops when people have too many copies of the repeat sequence. Above a certain threshold, the more copies they have, the earlier the disease develops and the more severe the symptoms.

"The current gap in knowledge is why having these expanded repeat sequences of genes in the RNA translates into actual symptoms."

Professor Richards said evidence points towards a dysfunctional RNA and a pivotal role of the body's immune system in the development of the disease.

"Rather than recognising the 'expanded repeat RNA' as its own RNA, we believe the 'expanded repeat RNA' is being seen as foreign, like the RNA in a virus, and this activates the innate immune system, resulting in loss of function and ultimately the death of the cell," he said.

The University of Adelaide team carried out their research on flies in the laboratory.

"This new understanding, once proven in each of the relevant human diseases, opens the way for potential treatments, and should give cause for hope to those with these devastating diseases," Professor Richards said.

Debra Vermeer

[TO COMMENT CLICK HERE](#)

Little gain from long-term pain relief

Researchers have found that codeine may produce a heightened sensitivity to pain if used for extended periods of time.

University of Adelaide researchers compared the impact and effects of codeine and morphine on patients, and found that codeine provided less pain relief than morphine, but left patients with a similar level of pain sensitivity.

Lead author and PhD student Jacinta Johnson said pain sensitivity can be a major issue for users of opioid drugs because the more you take, the more the drug can increase your sensitivity to pain, resulting in patients never quite getting the relief required.

"In the long term, it has the effect of worsening the problem rather than making it better," Ms Johnson said. "We think that this is a particular problem in headache patients, who seem more sensitive to this effect.

"Both codeine and morphine are opioids but codeine is a kind of 'Trojan horse' drug – 10 per cent of it is converted to morphine, which is how it helps to provide pain relief. However, despite not offering the same level of pain relief, we found that codeine increased pain sensitivity just as much as morphine."

Professor Paul Rolan, a headache specialist at the University of Adelaide, said codeine has been widely used as a pain relief for more than 100 years, but its effectiveness has not been tested in this way before.

"In the clinical setting, patients have complained that their headaches became worse after using regular codeine, not better," Professor Rolan said.

...CONTINUED ON PAGE 30



Research

...CONTINUED FROM PAGE 29

Professor Rolan said, while more research was needed, the laboratory findings suggested a potential problem for anyone suffering from chronic pain who needed ongoing medication.

“People who take codeine every now and then should have nothing to worry about, but heavy and ongoing codeine use could be detrimental for those patients who have chronic pain and headaches.

“This can be a very difficult issue for many people experiencing pain, and it creates difficulties for clinicians who are trying to find strategies to improve people’s pain.”

The research was presented at the 2013 International Headache Congress in the United States.

Kirsty Waterford

[TO COMMENT CLICK HERE](#)

Famine cheating diets put to the test



Australian researchers are looking to recruit 100 women to take part in a three-year study aimed at comparing the effects of fast versus slow weight loss on the ‘famine reaction’ – a biological response to dieting that is thought to be the reason why most diets fail.

Half of the women will be placed on a

low calorie ‘starvation diet’ followed by a period of weight maintenance over a 12 month period, while the other half will be on a more moderately restricted diet over 12 months.

The study is being led by Associate Professor Amanda Salis of Sydney University’s Boden Institute of Obesity, Nutrition, Exercise and Eating Disorders.

“We’re looking for 100 post-menopausal women who are willing to work with us for three years,” she said.

“And what we’re going to be asking these women to do is to find out and compare the effects of fast versus slow weight loss on the famine reaction.”

Associate Professor Salis told the recent Sydney University 21st Century Medicine Lecture Series that the famine reaction has been identified as the number one physical reason why most diets fail.

“Our bodies are not designed to cope with changes. And what happens when you start to lose weight is that your body sets off a physical reaction that I call a famine reaction, and this is what makes your life miserable when you’re on a diet,” she said.

The famine reaction is controlled by a part of the brain called the hypothalamus. One of the functions of the hypothalamus is to keep the level of body fat at a constant and optimum level.

Associate Professor Salis said that, in mice, it has been observed that when the animal is not getting enough to eat, there is an increase in the amount of the chemical neuropeptide Y in the brain.

She said her doctoral research showed that neuropeptide Y is one of the main ringleaders in instigating the famine reaction that makes every dieter’s life a challenge.

“When you first start a diet, losing weight is easy,” she said. “But after you’ve lost a certain amount of weight, your hypothalamus says ‘I don’t like this’, and that’s when it brings on these chemical changes that induce the famine reaction.”

Associate Professor Salis said the famine reaction does three main things: it makes you feel hungry for substantial, fattening food that will stop you from losing more fat, and preferably gain it back; it makes you feel lethargic, which is another mechanism the body uses to protect you from wasting away; and it drops the metabolic rate, causing your weight loss to plateau.

To investigate this, Associate Professor Salis, who said she had been overweight as a young adult, embarked on a conventional diet of eating less and moving more.

“But when I felt the famine reaction kick in, instead of trying to fight back, like all the diets tell you to do, I just went with the flow and said ‘why don’t I eat and deactivate that famine reaction?’”

“After a while of eating to satisfy that famine reaction, I no longer felt hungry and I could start dieting again and lose a bit more weight.”

All up, she lost 28 kg.

In the upcoming study, Associate Professor Salis will be looking at the role of ketones, which are produced naturally by the body when it is not getting enough carbohydrate to fuel the brain. Ketones are produced in higher quantities during very rapid weight loss.

She said studies have shown that people on very low calorie, or ‘starvation’ diets, don’t feel hunger, and it is thought that the elevated level of ketones that occurs when people are on a very fast weight loss diet may suppress appetite.

...CONTINUED ON PAGE 31



Research

...CONTINUED FROM PAGE 30

“During the trial, what we want to do is to compare head to head, for the first time, the famine reaction and the strength of the famine reaction during weight loss that’s achieved with a faster diet or a slower diet,” she said.

Debra Vermeer

[TO COMMENT CLICK HERE](#)

Millions unaware of ticking hypertension time bomb



Almost half of patients with hypertension are unaware they have the potentially life-threatening condition, an Australian-led international study has found.

The research, conducted in 17 countries and involving more than 153,000 people, showed that two thirds of those diagnosed with hypertension did not receive adequate care for their condition.

According to the study, published in the *Journal of the American Medical Association (JAMA)*, a majority of those who knew they had high blood pressure received drug treatment for hypertension. However, only a third of those had their hypertension under control.

There is a significant need for better diagnosis and treatment.

Senior author and Professor of Medicine at McMaster University, Dr Salim Yusuf,

said that drug treatments that work to control hypertension were well known.

Associate Professor Clara Chow, from The George Institute of Global Health, and the University of Sydney, agreed, and said treatments were generally inexpensive - but only about one third of patients were achieving their target blood pressure.

“The results are alarming,” Associate Professor Chow said.

Associate Professor Chow and her colleagues organised the study in three high-income countries: Canada, Sweden, and United Arab Emirates; 10 middle-income countries: Argentina, Brazil, Chile, Poland, Turkey, Malaysia, South Africa, China, Colombia, and Iran; and four low-income countries: Bangladesh, India, Pakistan, and Zimbabwe.

“Although Australia is not included in the study, it faces similar problems,” she said.

Another major issue with patients who are unaware of hypertension, is lack of symptoms. Patients tend to resist taking daily doses of medication if they do not see or feel any major symptoms.

“Australians should realise from this that hypertension is exceedingly common and nearly half of us are walking around with it, not knowing that our blood pressure is high.

“Australians should have regular annual checks,” Associate Professor Chow said.

Sanja Novakovic

[TO COMMENT CLICK HERE](#)

Psychosis switch points way to improved treatment

People with psychotic illnesses such as schizophrenia show similar brain changes to those of their immediate family members who present no signs of illness, new research shows.

These brain changes represent a marker of genetic risk of developing a psychotic illness and could open the way to developing new, more specific treatments.

The study, from researchers at Monash University, The University of Melbourne and the University of Cambridge, was published in the journal *JAMA Psychiatry*.

Lead researcher, Associate Professor Alex Fornito of Monash University, said the genetic markers could be targeted in the development of new treatments that may help to reduce the risk of developing psychotic illness.

“First-degree relatives of people with psychosis are at increased genetic risk of developing a psychotic illness,” Associate Professor Fornito said.

“We have found that people with psychosis and their unaffected first-degree relatives, who otherwise present no signs of illness, show similar brain changes when compared to healthy people.”

Associate Professor Fornito said even at the earliest signs of illness, patients showed altered activity in a specific brain circuit that links a region deep in the brain, called the striatum, with the prefrontal cortex.

This circuit plays an important role in attention, learning and memory.

“The fact that we see the same brain changes in this group, in the absence of any overt signs of illness, points to a neural biomarker of risk for psychosis,” he said.

“Patients who showed more severe changes in this circuit also showed more severe psychotic symptoms, providing a direct link between these brain changes and illness severity.”

...CONTINUED ON PAGE 32



Research

...CONTINUED FROM PAGE 31

The study examined 19 young people experiencing their first episode of psychotic illness and 25 of their unaffected parents or siblings. A group of 26 healthy, unrelated participants was also recruited to draw comparison. The researchers used MRI to map the activity of different brain systems.

The study also found a change in brain activity that was specific to patients experiencing psychosis, but not their relatives.

Associate Professor Fornito said this change may reflect a 'switch' that determines whether a person moves from an at-risk state to full-blown illness.

"We know that activity in brain circuits linking the striatum and prefrontal cortex are heavily influenced by the neurotransmitter dopamine, which is a major target for all medications currently used to treat psychosis," he said.

"The difficulty is that these drugs have rather diffuse effects on the brain, affecting many different systems. They also often have unpleasant side effects.

"Our findings point to a more specific treatment target. We are currently investigating whether we can selectively improve activity patterns in the affected brain circuits using non-invasive magnetic stimulation techniques.

"If successful, using these techniques in at-risk populations may help delay, minimise or prevent the impact of psychosis onset."

About three in every 100 people will experience a psychotic episode at some point in their life. Psychotic disorders have been estimated to cost the Australian economy more than \$2 billion each year.

Debra Vermeer

[TO COMMENT CLICK HERE](#)

Adult cells reprogrammed in stem cell breakthrough



Researchers have reprogrammed adult mouse cells inside living mice to behave like embryonic stem cells, in what scientists are claiming is a major breakthrough.

The technique, published in the journal *Nature*, allows researchers to reprogram cells in living mice without removing those cells from their natural environment. It is the first time this reprogramming of cells has been achieved outside of a petri dish in a laboratory.

Initial tests suggest that these cells are able to take on a wider variety of identities than those generated by earlier methods, meaning it could potentially be used to restore damaged cells or organs in the human body.

Associate Professor Andrew Laslett, the Research Group Leader of Stem Cells at Australia's CSIRO, said the ability to change multiple different cell types in a living mouse back into IPS cells (induced pluripotent stem cells), that can turn into any cell type in that mouse, or even into an entire new mouse, is unprecedented.

"This research provides a better understanding of the reprogramming

process in mice, and will enable further investigations into applications targeted at treating specific diseases and injuries," he told the Australian Science Media Centre (ASMC).

"The reprogramming method described is not suitable for use in humans, but its use for research in mice could ultimately provide information critical for the safe use of reprogramming technology in humans to address unmet healthcare needs."

The breakthrough is a long way from being able to be applied therapeutically to humans, but doctors still welcomed the research as a great leap forward in understanding.

Professor Rob Ramsay, Head of the Cancer Cell Biology Program at Melbourne's Peter MacCallum Cancer Centre and a member of the International Society for Stem Cell Research, said the technique brought great promise.

"These findings are a genuine leap forward in understanding the possibilities of reprogramming cells in many different organs in animals, bringing the promise of therapies that fundamentally alter the make-up of cells a little closer to clinical use," he told ASMC.

"The newly published research addresses the shortcomings of IPS cells, which do not have the same range of capacities as embryonic stem cells; a point of difference for stem cell researchers and a cause of ongoing debate for ethicists."

Professor Ramsay said the research team, led by Manuel Serrano at the Spanish National Cancer Research in Madrid, had built on the work of 2012 Nobel Prize winner Professor Shinya Yamanaka from Japan, and had been able to develop embryonic-like tumours in mice, in lots of different organs.

...CONTINUED ON PAGE 33



Research

...CONTINUED FROM PAGE 32

“Cells of these embryonic growths, teratomas, can make a vast variety of different cell types, such as muscle, bone and skin, indicating that cells from a range of organs can be ‘reprogrammed’ to revert to an embryonic state.

“Most importantly, these ‘in animal’ reprogrammed cells were more primitive than the IPS cells made using Professor Yamanaka’s test-tube method, heralding a new range of research techniques to study the development of many diseases, including cancer.”

Professor Ramsay said Australian scientists, who had been pioneers in stem cell research, would be likely to quickly incorporate these discoveries into their efforts to understand genetic-based diseases and develop new therapies.

Debra Vermeer

[TO COMMENT CLICK HERE](#)

Impulse to smoke can start early



Being impulsive, consuming alcohol regularly, and receiving poor grades in school may encourage teenagers to take up smoking, according to a new study.

University of Montreal researchers followed 1293 teens from the greater Montreal area that were part of the

Nicotine Dependence in Teens study that started in 1999. The teens were monitored from age 12 until they were aged 24.

The researchers found that the biggest three risk factors for the teens to start smoking were being impulsive, using alcohol regularly and getting poor grades.

The researchers found by age 22, 75 per cent of the participants had tried smoking, with 44 per cent starting before high school, 43 per cent starting during high school and 14 per cent starting after leaving high school.

Not all participants who tried a cigarette continued to smoke.

Lead researcher Professor Jennifer O’Laughlin speculated that one potential reason impulsiveness may play a role in smoking in young adulthood is because parents of impulsive children exercise tighter control when they are living with them at home, to protect their children from adopting behaviours that can lead to smoking, and that this protection may diminish over time.

The study was published in the *Journal of Adolescent Health*.

Meanwhile, a New Zealand study has found that one of the most effective ways to quit smoking is by using e-cigarettes.

The New Zealand researchers found that more people stopped smoking for at least six months with e-cigarettes than with nicotine patches.

E-cigarettes are battery-powered devices that simulate the effects of smoking by heating a nicotine liquid into vapour, which the user then inhales and exhales.

E-cigarettes are banned in Australia. However, research has shown one in 10 Australian smokers that were aware of the product has tried them.

The study split more than 650 participants who wanted to quit smoking into three groups, each of which received a 13-week supply of commercially available e-cigarettes (16mg nicotine), nicotine patches (21mg, one daily) or placebo e-cigarettes.

More than 7 per cent of participants in the e-cigarettes group quit, compared with 5.8 per cent of those using nicotine patches and 4.1 per cent using the placebo.

After six months, of those participants who had not quit, 57 per cent in the e-cigarette group had reduced their daily consumption of cigarettes by at least half, compared with 41 per cent of those using patches.

Lead author, Associate Professor Chris Bullen from the University of Auckland, said the results provided a benchmark for e-cigarette performance, but said larger trials were needed.

The study also suggested that e-cigarettes were comparable to nicotine patches in terms of safety, although the researchers did say long-term research was needed.

AMA President Dr Steve Hambleton told the *Sun Herald* that Australia was the global leader in tobacco control and should not let its guard down.

“Plain packaging is having a real impact now, as is the pricing strategy,” Dr Hambleton said. “The end for tobacco is coming.”

Dr Hambleton said nicotine replacement therapy was a positive measure in helping people quit, but said he was concerned that the unregulated e-cigarette industry could become a recruiting tool for the next generation of smokers.

Kirsty Waterford

[TO COMMENT CLICK HERE](#)



Members' Forum

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

In the last edition of *Australian Medicine*, AMA Chair of Doctors in Training Dr Will Milford raised concerns about the conduct of some Medical Colleges in providing training, not least the imposition of unheralded and unexplained changes to accreditation. One AMA member shares his concern.

Many thanks for your article highlighting the concerns of many doctors-in-training regarding the impositions of Colleges placed upon trainees whilst undertaking training. These costs and impositions are not just necessarily financial, and I concur that Colleges have been not well versed in informing trainees of proposed curriculum changes in a timely fashion. I remain pessimistic that calling upon Colleges to increase transparency of fee structures will lead to greater satisfaction among their trainees. Unfortunately, the problem with trying to engage the Colleges in 'improving transparency' in their selection processes, fee structures and assessment processes is that this in itself increases the costs within the bureaucracy – and pushes up training costs even further! If anything, it is the increasing red tape that trainees have to negotiate through their training that inevitably leads to increased costs being imposed upon us – both pre-vocational doctors trying to get into training programs, as well as trainees - by the Colleges. I also doubt that "increasing competition" will occur anytime soon to break the 'monopoly' that organisations such as RACS have in training, and many Colleges continue to extract fees from their graduates well into their consultant years. I hope I can be proven wrong, and look forward to hearing more from AMACDT on their proposals and lobbying efforts.

Submitted by Xavier Yu (not verified)

Artist and journalist Chips Mackinolty gave an insider's view of Aboriginal health in the Northern Territory. One reader shares his enthusiasm about the use of shared electronic health records in the Northern Territory.

Nice article Mr Mackinolty. This is some encouraging news. As a paediatric registrar working in Alice Springs Hospital, I wholeheartedly advocate the use of the shared electronic health record. It is golden when a patient who comes in from the bush has one of these. When you ask the parents about other active and past medical problems in their child, the verbal history is

"The Northern Territory for one is getting on with it. Life is better when people agree for the greater good."

often incomplete. This is no fault of their own and I am sure I would be the same if I had just been flown in with my sick child from Docker River (or anywhere else) at 2 o'clock in the morning. In a child with acute gastroenteritis and severe dehydration (common in our ward) - knowing what their weight was 3 weeks ago (when they were at the clinic getting their ears checked) is invaluable in their fluid management and treatment goals. Isn't it nice when different communities and clinics can all get along and agree to use the same computer system for sharing useful information? It seems just plain ol' common sense! The Northern Territory for one is getting on with it. Life is better when people agree for the greater good.

Submitted by John Gunn (not verified)

Late last year, the issue of doctors' Right of Private Practice (RoPP) in public hospitals came into the media, as the Queensland Auditor-General undertook a performance audit of RoPP arrangements in the Queensland public health system. One member shares his opinion.

I'd have to take issue with [the comments of many others regarding this topic]. Many public doctors I know of are not working to full capacity at all, generally working in overstuffed units for three days a week then working in private practice "in their own time" to further enhance their already inflated salary and many perks. This has been at the expense of genuine private practitioners who pay half their salaries to run their practices, employ staff and don't get the benefit of sick and study leave or subsidised superannuation. This enquiry is long overdue and it sickens me that AMA takes the stance that all doctors are virtuous, hard working and poorly remunerated. In my experience most public service doctors are not members of the AMA anyway.

Submitted by Hard pushed VMO (not verified)

[TO COMMENT CLICK HERE](#)

Tomich Hill Wines

BY DR MICHAEL RYAN



Tomich Hill Wines sits nestled on some 200 acres, between 300 and 400 metres above sea level, and has in one corner the significant river that is the Onkaparinga in the Adelaide Hills.

John Tomich is a well-known ear, nose and throat surgeon who grew up on a grape farm in New South Wales. The pull of the vine is deep in his blood, and this led he and his wife Vicki to purchase the vineyard.

He has two sons, Randal and Damian, that are up to their elbows in schist and soil with old mineralic laterite rock. The third son, Sam, is a chartered accountant and manages the financial side.

The cool climate nature of this site (five degrees Celsius cooler than Adelaide), combined with the soils, makes for fruit of restrained intensity and balanced acidity. John completed a Diploma in Oenology and is finishing the exclusive Masters of Wine degree from the United Kingdom, and I'm sure he realised many years ago that fruit bombs have their place, but the elegant wine leaves a deeper impression.

John and his family have a great wine philosophy: "Give back to the soil more than you take."

Supreme effort is taken with sustainable farming. Energy efficient machinery, wildlife corridors, water catchment facilities and carbon footprint minimisation strategies are all part of business.

Randal and Damien both had experience in broadacre farming, and Randal has developed soil management techniques which are used by his company Ag Soilworks – techniques now recognised and used in California.

Grapes grown include Shiraz, Cabernet Sauvignon, Pinot Noir, Sauvignon Blanc, Chardonnay, Riesling, Pinot Grigio and Gewurztraminer.

Having tried all species, I can honestly say that there is a sense of place with the fruit expression and quality. The winemaking techniques are faultless and, in the very competitive sparkling wine range, their cheerful and their high end Method Traditionale shines.

I am grateful that the Tomich family has chosen winemaking as an outlet for their creative passions; the products are inviting and outstanding. They are themselves grateful for their success, and the ability to provide sponsorships for organisations such as the Australian String Quartet and the Croatian Sports Centre - to name but two.

Having met John and Sam recently, I feasted upon their wine enthusiasm and dined out on their pouring generosity. It seems that John has the best of both worlds, with the wonderful collegiate atmosphere that exudes from medicine, and now the fellowship of the grape that goes with winemaking. Make sure you visit if in the Adelaide Hills region, and be prepared for great hospitality.

WINES TASTED

1. 2012 Tomich Hill Sauvignon Blanc

Light straw colour with a tinge of green. The nose is a lively Australian style with lemon, hints of gooseberry, but with distinctive floral and pea-like notes. Great on the palate, with broad quality fruit and a mid-palate finish of good crisp acid. Have with flash-fried calamari.

2. 2012 Tomich Hill Pinot Noir

A nice cherry red colour. For a young wine, there is a lot to like about the nose. Predominately in the red cherry fruit spectrum, notes of brooding complex fruit are emerging, hints of spice and mild stalkiness. The palate is seamless, with a gentle lingering tannin finish. This has been made well with 10 per cent whole bunch for that stinky, funky character and, amazingly, 30 per cent new French oak, that is nicely integrated. Duck rillettes with burnt orange sauce and rocket side salad.

3. 2010 Tomich Hill Shiraz

Dark crimson colour indicates its power. Cool climate features with red fruits and plummy notes, well supported by spicy brambly notes with hints of chocolate emerging. Again, a supple, restrained, elegant wine as the palate is well satisfied in all corners. Carpaccio beef through to venison pie. Will cellar seven or more years.

4. 2009 Tomich Hill Family Reserve Chardonnay

This is one of the best. Developing deep straw colour. The bouquet is typical of the new Australian Chardonnay, with initial notes of lemon, vanilla, almonds and then slight yeasty and oak notes. A luscious creamy palate with good acidity makes this a cracking food wine. Have with soft French Cheeses. Cellar for five to seven years.

[TO COMMENT CLICK HERE](#)



Income replacement – getting it right.

When you are looking to insure one of your most important assets - your income - it helps to find a policy that could help pay the bills if you can't work due to illness or injury.

OnePath Life, Smart Investor's Life Company of the year for the past four years, has developed ProSecure Income Replacement Plan exclusively for professionals. This protection is available to AMA members and can provide up to 75% of your monthly earnings (to a maximum of \$20,000 per month)¹. To find out more click [here](#) or call 1800 658 679.

ProSecure Income Replacement Plan is issued by OnePath Life Limited (ABN 33 009 657 176, AFSL 238341). You should consider the Product Disclosure Statement, available online at www.onepathprofessionalinsurance.com.au/AMA or by calling 1800 658 679 in deciding whether to acquire or continue holding this product.

¹ The monthly amount payable for the Total Disability Benefit is the lesser of (1) the monthly benefit that you choose to insure (to a maximum of \$20,000) and (2) 75% of the first \$20,000 per month of your pre-claim earnings plus 50% of the next \$10,000 per month of your 'pre-claim earnings' less 'other payments'. Please refer to the Glossary in the PDS for further information on 'pre-claim earnings' and 'other payments'. It is in your interest to not insure more than the maximum you can be paid. The monthly amount payable excludes business expenses.

Take control of your finances with WealthDirect!

The AMA is excited to offer members WealthDirect – a unique, online, financial and investment platform. AMA members are the first to have access to WealthDirect's investment management, reporting and transaction tool.

WealthDirect is designed to place you in control of your investments and financial future; you choose the services you want, the products you would like to invest in, and engage a financial adviser as and when you need assistance.

WealthDirect gives AMA members access to services including research, reporting, online trading and a DIY financial health-check.

To find out more, visit www.ama.com.au/node/8669





General Enquiries:
1300 133 655
Web:
www.ama.com.au/amex



General Enquiries:
1300 245 578
Web: www.ama.com.au/memberservices



General Enquiries:
1800 658 679
Web:
www.ama.com.au/onepath



General Enquiries:
1300 360 525
Web: www.ama.com.au/memberservices



Bookings:
13 30 39
Web: www.ama.com.au/memberservices-hertz



General Enquiries:
1300 133 655
Web: www.ama.com.au/powerbuy



General Enquiries:
1300 133 655
Web: www.ama.com.au/memberservices-qantas



General Enquiries:
300 133 655
Web: <http://www.ama.com.au/memberservices-vw>



General Enquiries:
1300 133 655
Web: <http://www.ama.com.au/node/5292>

GREAT MEMBER DEALS

Discounts off new Volkswagen and Skoda vehicles for AMA Members*

AMA members can access substantial discounts off the list price of new Volkswagen and Skoda vehicles. **A deal that could save you thousands!**

The discount is model dependant and does not include options and accessories. Please see your local VW dealership for further details on the discount structure.

To access this exclusive offer simply contact AMA Member Services on 1300 133 655 or email memberservices@ama.com.au.



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

Great Qantas Club Rates for AMA Members

AMA Member Rates (GST inclusive)

Joining Fee: \$230 - save \$140
1 Year Membership: \$372 - save \$113
2 Year Membership: \$660.30 - save \$214.69

Partner Rates(GST inclusive)

Partner Joining Fee: \$190
Partner 1 Year Membership Fee: \$320
Partner 2 Year Membership Fee: \$570

These special rates can be accessed by members.

If you have any questions about this offer please do not hesitate to contact AMA Member Services via email or phone on 1300 133 655. Call AMA Member Services on 1300 133 655 or email memberservices@ama.com.au



PowerBuy and the AMA have partnered to give Members savings on popular IT products and services. PowerBuy offers discounted deals on brands including Dell, Lenovo, HP, Fuji Xerox and NETGEAR.

For further details and to access PowerBuy's special offers for AMA Members, simply visit www.ama.com.au/powerbuy or phone AMA Member Services on 1300 133 655.