AUSTRALIAN
Medicine
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Health reform - needed the world over

BY AMA PRESIDENT DR STEVE HAMBLETON

Early this year, *Australian Medicine* readers will be aware, I attended the Chinese Medical Association's annual meeting.

One of the lasting messages from that gathering was the need to build a better primary care workforce in China to tackle the growing epidemic of non-communicable diseases.

China is intent on training more than 200,000 new specialist general practitioners by 2020 – and they are probably the only country on earth who could do it!

I have just presented a paper on health reform at the first in a series of three focused annual conferences aimed at transformational change in Canadian healthcare, and in the last few days I attended the American Medical Association's House of Delegates, who also recognise the need for health reform.

All of these countries realise that their health systems are designed for acute care. They were set up well to deal with acute problems.

We know in Australia that a well-trained specialist general practitioner can deal with 90 per cent of the problems that they face.

We have secondary and tertiary specialists who can be called in to get to the root of the problem.

Each of these countries is facing an ageing population, we are all experiencing an explosion in medical knowledge, accompanied by an increased ability to do more and more for our patients.

And we are all facing financial pressures arising from that very ability.

We all are seeing our patients, on average, getting larger and larger, resulting in more and more chronic conditions such as diabetes, heart disease, renal failure, hypertension, coronary artery disease, heart failure and osteoarthritic joints that need replacing.

Treating this new population with multiple co-morbidities is what is driving up our health care costs.

The US is losing the cost race and is currently spending 18 per cent of its gross domestic product (GDP) on health, with another 30 million people about to be added to the bill through Obamacare. Canada is spending 12 per cent of its GDP on health, with worse outcomes than Australia which - as we know - spends 9.3 per cent.

The Canadians at the conference noted that despite the fact that they could currently afford this spend they could not afford the future trajectory.

We all need a major reorganisation of our health systems to shift the focus to community-based, medically-led teams to manage chronic medical conditions. This will focus our increasingly limited resources on the inexpensive end of health care to delay hospitalisation or, in some cases, avoid it altogether.

Electronic medical records and electronic sharing of information is seen as way to enable community and team-based health care to operate efficiently.

Accurate sharing of information should also close the information gap between community, residential and inpatient care.

Australia is one step ahead of both Canada and the USA, now that we have settled on a communication standard for the transfer of information between software packages and different parts of the health system. They were quite surprised by the fact that despite more than 99 per cent of our general practitioners use electronic medical records, none of them can as yet talk to each other.

In Canada it has been impossible to date for the country to agree on a common 'rail gauge' for e-health, because most of the health care decisions are made at the provincial level. In the US, the House of Delegates of the AMA also recognised this, and voted to compel the software houses to facilitate interoperability.

On the same theme, at its Annual Representative meeting the British Medical Association passed a motion to facilitate the secure transfer of handover data between health care professionals, particularly between primary and secondary care colleagues.

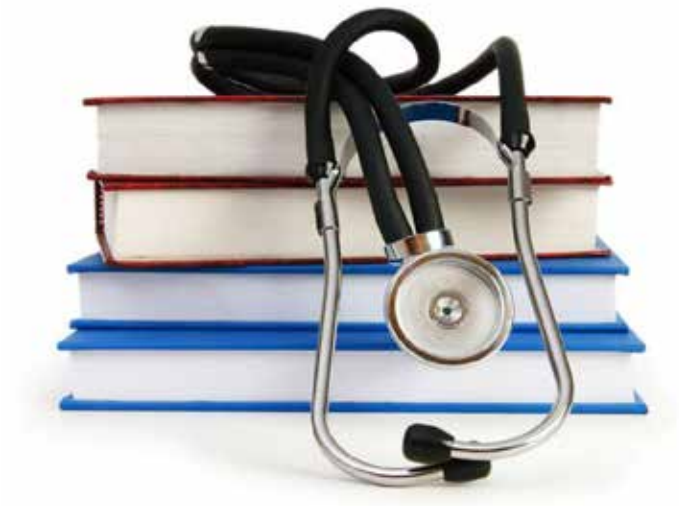
In my talk in Canada, I also pointed out that Medicare in Australia had already begun the process of providing rebates for a structured approach to chronic disease management, with the Australian Medical Association and the Coordinated Veterans' Care Program taking this one step further with longitudinal interactive approaches to chronic disease management.

Finally, medical associations internationally all share the view that only doctors can safely provide medical care, and that to avoid rising costs and fragmentation of health care, non-medical health care providers must work in medically-led health care teams.

Moves by pharmacists, optometrists, nurse practitioners and others to work outside of their scope of practice are happening worldwide, and all our international colleagues agree this should be vigorously resisted.

TO COMMENT CLICK HERE

Anti-tax cap campaign stepped up



The AMA has acted quickly to pressure freshly installed Prime Minister Kevin Rudd to ditch the Government's controversial $2000 cap on tax deductions for work-related self-education expenses as the campaign against the measure intensifies.

Thousands of doctors outraged by the move have visited the Scrap the Cap website (www.scapthecap.com.au) and, as at 28 June, more than 5200 had signed a petition demanding that the tax change be dumped.

Hours after Mr Rudd was sworn in to replace Julia Gillard as Prime Minister, AMA Vice President Professor Geoffrey Dobb called on him to overturn the tax deduction cap.

In a public statement, Professor Dobb said the measure was poorly conceived, and would undermine the ability of doctors to undertake the training needed to acquire knowledge and skills and keep them up-to-date.

"The cap is bad policy," he said. "It is anti-education and stifles excellence."

The AMA is seeking urgent talks with Mr Rudd and Health Minister Tanya Plibersek, as well as Opposition Leader Tony Abbott and Shadow Health Minister Peter Dutton, to convince both major parties to dump their support for the tax cap – due to come into effect from 1 July next year - ahead of the Federal election.

AMA President Dr Steve Hambleton has written to AMA members urging them to get involved in the campaign to have the tax change dumped, including signing the petition, providing an account of how the cap would affect them.

In a determined push to bring the issue home for every federal Member of Parliament before the Federal election, the AMA has also launched a dedicated campaign website – doctors4health.com.au – enabling doctors to directly email their local MPs highlighting their objections to the tax change.

The AMA's campaign has the backing of the nation's peak general practice representative group United General Practice Australia, which condemned the measure as an ill-considered tax on learning.

"The tax on learning is a contradiction," UGPA said in a statement released late last week. "The government seeks to have a well-trained medical workforce, but at the same time discourages medical practitioners from enhancing and maintaining their skills to provide high quality patient services."

An AMA survey has highlighted the devastating impact the $2000 cap is likely to have.

Of almost 600 doctors polled, 79 per cent reported spending more than $5000 a year on self-education expenses.

Dr Hambleton said the result underlined how poorly conceived the policy had been.

In a Discussion Paper released at the end of May, the Government indicated that the full gamut of education-related expenses would count toward the $2000 cap, including tuition and registration fees, textbooks, journals, computers, student union fees, accommodation, running expenses and travel.

"If membership of a professional association includes an educational component - and many do - this cost will also be included in the cap, which makes the reform even worse than originally thought," Dr Hambleton said. "It will take no time at all for doctors and other professionals to reach the $2000 cap."

The only deductions for expenses not included in the cap would be the non-CPD component of professional membership fees, overtime meal expenses, travel costs not related to education activities, home office expenses, professional indemnity and income protection insurance and clothing and uniform expenses.

The Government has put up for consultation whether there should be a $250 no-claim threshold, which for many would effectively mean the cap was $1750.

More than 4500 doctors responded to the AMA's initial survey on the issue, with 98 per cent expressing their strong objection to the change, and Dr Hambleton urged doctors to maintain their rage.

"All politicians need to hear your stories, and they need to feel your anger," he said.

"The strength of our membership can and will make a difference."

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Medicare Locals told: dump flawed contracts

Medicare Locals have been put on notice to use an improved contract for GP after hours services after serious flaws were discovered in the terms that several offered to practices.

The Australian Medicare Local Alliance (AMLA) has issued a revised template contract for GP after hours services after the AMA successfully lobbied the Department of Health and Ageing to change contracting guidelines for Medicare Locals.

Many doctors had strongly resisted pressure to sign after hours service contracts amid concern that some Medicare Locals were trying to impose overly onerous conditions that would have added significantly to the costs and administrative burden on GP practices.

Under Government reforms, from today Medicare Locals will have responsibility for organising after hours GP services.

AMA Vice President, Professor Geoffrey Dobb, said the revised contract prepared by AMLA – with expert legal input from the AMA – should immediately replace the flawed deals offered by some Medicare Locals.

"This is a victory for common sense," Professor Dobb said. "In their original form, many of the contracts that were issued dramatically increased red tape and compliance costs, even though the funding being provided to practices to support after hours care was unchanged in comparison to former arrangements."

Professor Dobb urged Medicare Locals nationwide to quickly adopt the new contract template, and advised general practitioners to be wary of signing any contract for after hours services that sought to impose more onerous conditions than offered by the template document.

"The AMA has worked with AMLA in the development of a more sensible and balanced contract which is a vast improvement on the contracts previously issued by a number of Medicare Locals," he said.

"We call on all Medicare Locals to use the new template, which will better support access to GP after hours care for patients without the unnecessary overheads and administrative burdens."

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Doctors leave modest hospitality bill

Drug companies have spent an average of just $36 on hospitality for doctors attending conferences, workshops and other events hosted by them.

In a result that belies claims medical practitioners are being showered by pharmaceutical firms with lavish meals, drinks and luxury accommodation, figures provided by peak industry body Medicines Australia show that, while more than $28 million was spent staging 13,290 conferences and workshops in the six months to March this year, the average expenditure for each attendee was just $36.15.

As scrutiny of the relationship between drug companies and practitioners intensifies, the Medicines Australia reports shows that the events it organised provided more than 27,000 hours of education at an average cost $75.40 per person.

In addition to staging events, pharmaceutical companies paid doctors honoraria and travel expenses for sitting on advisory boards.

The Medicines Australia report shows that between January and March this year doctors attended 49 advisory boards on 376 occasions, at an average cost of $2531.55 per person.

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Australian Nurses Federation told to butt out

The AMA has successfully thwarted a bid by the Australian Nurses Federation to insert itself into pay negotiations between practice nurses and their employers.

In a significant decision, the Fair Work Commission rejected the Federation's claim that practice nurses were low paid, and found that its bid to bargain on behalf of nurses at 682 medical practices – mostly in Victoria, New South Wales and Tasmania - could force up wages without any additional public benefit.

In mid-2011 the ANF announced plans to negotiate a collective enterprise agreement for practice nurses covering about 900 practices nationwide, asking Fair Work Australia (FWA) to grant it a low-paid authorisation, allowing for a pay determination if no agreement was reached with employers.

But, in fighting the case, the Federal AMA, together with AMA Victoria and AMA Tasmania, gathered evidence showing that practice nurses were not low paid and bargained extensively with employers, and warned that collective pay negotiations with the ANF would undermine existing collaborative and flexible work arrangements, and could lead to job cuts and hiring freezes.

The Commission accepted evidence from the AMA that practice nurses were generally paid about 20 per cent above the award rate, so could not be considered low-paid.

Lawyers representing the AMA also successfully argued that pay rates for nurses in public hospitals should not be automatically extended to private practice because of differences in working environment and duties, and added that it was wrong to treat all private practices as the same, given the great breadth and variety in where they were located and what they did.

The AMA's arguments were supported by witness statements from a significant number of doctors and practice managers worried about how the ANF claim might affect their ability to operate.

Chair of the AMA Council of General Practice Dr Brian Morton said the Commission's decision was a significant victory for medical practices and those who worked in them.

"In rejecting the ANF application, the FWC concluded that most practice nurses were not low paid, and that the case for the authorisation was not strong," Dr Morton said.

"It found several important factors indicated that multi-employer bargaining may be undesirable or less appropriate than genuine enterprise-based bargaining and, on that basis, it was not in the public interest to make the authorisation."

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OK Kevin, now its time for health

The AMA has urged the major political parties to sharpen the policy focus on health now that Labor's long-running leadership woes have been resolved.

Responding to the decision of Labor's parliamentary caucus to reinstate Kevin Rudd as leader almost three years to the day after dumping him in favour of Julia Gillard, the AMA said it was now time to turn attention to urgent health issues.

Hopes have been raised that poorly conceived measures such as the controversial $2000 cap on tax deductions for work-related self-education expenses might be discarded after Mr Rudd indicated on his return to the prime ministership that he would review Government policies.

On Friday, Mr Rudd reaffirmed his Government's commitment to the Gonski education reforms, but he has yet to make public comment on health reform, which was a centrepiece of his first term in office.

In an early pitch for fresh approach to pressing health issues, AMA Vice President Professor Geoffrey Dobb last Thursday asked Mr Rudd to not only dump the tax deduction cap, but challenged both major political parties to outline plans for a long-term solution to looming bottlenecks in medical training, upgrade support for general practice, increase public hospital capacity and vastly improve health services to immigration centre detainees – particularly children.

"The AMA looks forward to a real debate between the major parties in the lead-up to the election, showing how they will tackle these and other pressing issues that are vital to ensuring Australians continue to receive high quality health care," Professor Dobb said.

Late last week it was still unclear whether Tanya Plibersek would remain as Health Minister, though Mr Rudd has so far shown little inclination to dump frontbenchers who have not already resigned of their own accord.

Several Cabinet ministers quit in the wake of Ms Gillard's party room loss, including Treasurer Wayne Swan, Trade Minister Craig Emerson, School Education Minister Peter Garrett, Communications Minister Stephen Conroy and Agriculture Minister Joe Ludwig.

Mr Rudd is expected to reveal the composition of his ministry today.

Several major health programs and policy changes initiated by Mr Rudd in his first term are still being rolled out or bedded down.

Among them is the much-maligned GP Super Clinics program, which was the subject of a damning report from the Auditor-General last month.

The scheme has been dogged by cost overruns and lengthy delays, and the AMA has urged the Government to halt any further expenditure and instead divert unspent funds to the far more effective program to upgrade general practice infrastructure.

Mr Rudd also oversaw the introduction of Medicare Locals, and an ambitious program of reforms to the funding of public hospitals.

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Toxic cocktails in AMA's sights

Night clubs and bars should be banned from selling potent cocktails of energy drinks mixed with spirits and alcohol sponsorship of sport should be phased out as part of efforts to reduce the huge personal and social toll caused by unhealthy drinking, according to the AMA.

Emergency physician and AMA Victoria President Dr Stephen Parnis told a National Alliance for Action on Alcohol forum at Parliament House that young lives were being blighted every day by the effects of alcohol, and action like prohibiting licensed venues from selling alcohol and energy drink mixes was urgently needed.

Dr Parnis told the forum that more than 70 per cent of teenagers between 14 and 19 years of age had consumed alcohol in the previous year – and more than a quarter regularly drank amounts that put their health at risk.

Around 15 per cent of all deaths among 15 to 24-year-olds were due to risky drinking, he said.

The forum also heard from West Australian Police Commissioner Karl O'Callahgan, who launched a broadside at the nation's drinking culture and the failure of politicians to take meaningful action to curb alcohol-related harm.

"Binge drinking and alcohol-fuelled violence has reached epidemic proportions, and the time for band-aid solutions is well past," Mr O'Callahgan said. "The WA police cannot arrest their way out of this problem and nor can any police force in the nation. Governments need to stop treating the symptoms and commit to treating the cause."

Dr Parnis said evidence of the extent of harm caused by alcohol was in, and it was now time for action.

"The medical profession believes that this debate is over," he said. "The question is not what should be done, but will decision makers take the action the evidence compels them to take."

While the AMA has not backed a lift in the legal drinking age to 21 years, Dr Parnis detailed a seven key measures the Association believes should immediately be adopted to help reduce the harm alcohol causes.

A principal recommendation from the AMA was to end anomalies in the tax regime that saw full-strength wine taxed at a quarter of the rate of mid-strength beer, and instead impose an excise based on the percentage volume of alcohol a drink contains.

"It is not a difficult concept," Dr Parnis told the forum. "Putting tax at a higher rate will push prices higher and, hopefully, restrict availability. [Taxes] should be set at a level that sustains high prices, so that the price signal reflects the substantial social costs of alcohol consumption."

The AMA has also demanded that the marketing of alcohol to children and adolescents, in all its forms, be prohibited.

Dr Parnis said alcohol brands were appearing on skateboards, children's clothes and other products used and worn by young people, and were heavily promoted through sport and social media.

"The AMA believes that a phased reduction and, ultimately, elimination of alcohol sponsorships for sporting events must be on the table."

Other proposed measures include tightening licensing regulations to take into account opening hours and the density of liquor outlets in a given area, prominent health warnings on alcohol packaging, mass media campaigns on the health risks of drinking, diversion programs for people who get into trouble for alcohol-related offences and greater support for the treatment of alcohol dependence.

Dr Parnis said experience showed the alcohol industry could not be relied upon to promote its products responsibly, and governments needed to act to protect children and adolescents from such marketing.

"We do not buy for one minute the alcohol industry's statements that its marketing is targeted at adults," he said. "They want people to drink as early as they can [in life]: 'Let's get them hooked; let's get them to drink as much as they can'.

"The voluntary system of regulation [DrinkWise] is an absolute sham, and until we have meaningful, government-imposed regulation of alcohol advertising that is backed up by serious sanctions, we will not see progress in this area."

The Alliance, of which the AMA is a member, has launched an election manifesto that calls for a national strategy to cut adult alcohol consumption by 10 per cent within 15 years.

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AMA IN THE NEWS

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

Print/Online

Work fit for GPs treated as emergency, *West Australian,* 17 June 2013

AMA Vice President Professor Geoffrey Dobb said there was a higher percentage of GP type injuries at emergency departments in remote areas where patients might not have access to a GP.

Be prepared to pay extra, *Daily Telegraph*, 19 June 2013

Government health spending increased an extra 5 per cent from last year, but the AMA estimates that inflation in the health system is at about 7 per cent, and the additional funding will not meet the needs of the health sector.

Spirited debate, *Adelaide Advertiser,* 19 June 2013

The AMA said alcohol consumption during the first trimester could be risky for the foetus. Past President Dr Andrew Pesce said it was women who drink less often and in lesser amounts who should be monitored for their alcohol intake.

Tax cap a barrier to extra study, *Adelaide Advertiser,* 26 June 2013

AMA President Dr Steve Hambleton said the $2000 limit on how much people could claim on tax for work-related study expenses would undermine education and quality health care.

Radio

Dr Brian Morton, 666 ABC Canberra, 20 June 2013

Dr Brian Morton discussed widespread hand, foot and mouth disease. A strain of the disease has caused several deaths in NSW.

Professor Geoffrey Dobb, 5AA Adelaide, 22 June 2013

AMA Vice President Professor Geoffrey Dobb accused the Gillard Government of wasting obscene amounts of money on the $600 million GP Super Clinics program, with many clinics built in areas where they were not needed and others being put in marginal electorates.

Television

Dr Hambleton, ABC News 24 Sydney, 17 June 2013

Hard-core gym junkies outnumber heroin and amphetamine users, and are introducing steroids into their daily routine. The AMA is concerned that younger people are turning to steroid use.

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INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

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AMA in action

Immediate past AMA president Dr Andrew Pesce and AMA Victoria President Dr Stephen Parnis were part of a network of supporters of improved disability care and services who descended on Melbourne's Etihad Stadium on 16 March for the Collingwood versus Western Bulldogs AFL match. During the match, which was dedicated to the promotion of inclusion and equality for people with a disability, Dr Pesce and Dr Parnis mingled with other people who were driving forces behind the National Disability Insurance Scheme and the creation of DisabilityCare Australia, including Minister for Employment and Workplace Relations Bill Shorten and financier Bruce Bonahady. Dr Parnis also represented the AMA in Canberra at a forum organised by the National Alliance for Action on Alcohol, *Healthier families, safer communities: New directions to reduce alcohol related harm*. Dr Parnis was among several speakers who highlighted the enormous harm caused by alcohol, and called for Government action to increase alcohol taxes and ban the marketing of alcoholic drinks to children and adolescents. As the Federal election draws near, the AMA Council of General Practice held a two-day meeting to discuss a number of key health issues, including the $2000 cap on tax deductions for work-related self-education expenses, and GP training.

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Dr Parnis addressing the NAAA Healthier families safer communities New directions to reduce alcohol related harm event

Dr Pesce with Minister for Employment and Workplace Relations Bill Shorten

Former AMA President Dr Andrew Pesce (l) with inaugural DisabilityCare Australia Board Chair Bruce Bonyhady and AMA Victoria President Dr Steve Parnis (r)

Medical training fears as demand swells

The capacity of the medical training system is being stretched as the tidal wave of students that swept into the nation's medical schools in recent years is beginning to swamp postgraduate places.

Figures compiled by the Medical Training Review Panel show that demand for second year postgraduate places has surged, jumping 23 per cent last year to reach 3101 places in 2012 – a doubling of the number in just eight years.

In a sobering warning for educators scrambling to cater for the sharp increase in demand, the Panel said the figure was likely to be an underestimate, with "unknown numbers" of doctors likely to have been recruited by health services.

The result has underlined concerns by the AMA that government have prepared poorly for the surge in medical trainees in the past 10 years, leaving many aspiring doctors at risk of missing out on vital training places and potentially wasting millions of dollars spent on educating medical graduates.

Data prepared by the Panel shows the effectiveness of efforts last decade to boost medical student numbers as a way to help address looming shortages in the medical workforce.

Last year there were 16,868 medical students – almost 120 per cent more than the number studying in 2000.

This growth has been driven by a 100 per cent increase in the number commencing medical school (3686 in 2012), while the number of domestic students who graduate rose by virtually the same percentage between 1999 and 2011.

The AMA fears a repeat of last year's chaotic situation in which dozens of medical graduates were left in limbo for months as Commonwealth, State and Territory governments wrangled over who should pay for extra intern places.

The Panel predicts there will be 3556 medical graduates seeking internships this year, while indications are that just 3201 internships will be on offer.

AMA President Dr Steve Hambleton and Chair of the AMA Council of Doctors in Training Dr Will Milford have been vocal critics of the haphazard and patchwork approach that has so far been adopted by the nation's government to the issue.

In a column in *Australian Medicine* today (to view, click here), Dr Milford has bemoaned the parochial response of State and Territory governments, which are making only half-hearted contributions to efforts to develop a national intern application system.

At the other end of the training pipeline, the number of practitioners becoming college fellows has swelled dramatically.

There were 2629 new fellows admitted across the specialties in 2011 – a 133 per cent jump from the 1126 that joined in 2000.

Of these, around 40 per cent were women and a quarter were overseas trained.

General practice continued to be the most common specialty, accounting for almost 41 per cent of fellows, followed by adult medicine (14 per cent), anaesthesia (8.5 per cent), surgery (8 per cent) and psychiatry (5 per cent).

But the sharpest growth has been in paediatrics, where the number of new fellows soared almost 120 per cent between 2007 and 2011, while radiation oncology (83 per cent) and psychiatry (82 per cent) also grew strongly over the period.

While the nation is grappling with how to provide training opportunities for medical graduates, data compiled by the Panel shows the country is still relying heavily on overseas trained medical practitioners to help plug holes in the medical workforce.

In 2011-12 visas were granted to 3560 practitioners from overseas, 40 per cent of whom were from the United Kingdom and Ireland, while 9 per cent came from India, 8.4 per cent from Malaysia, 5 per cent Sri Lanka, and 3 per cent from each of Pakistan, the Philippines and Singapore.

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Drug company transparency rules far from clear

Pharmaceutical company payments to doctors of as little as $10 may be disclosed under model reporting guidelines prepared by the medicines industry.

Payments made by drug firms to individual practitioners could be publicly itemised and disclosed from mid-2016, according to draft proposals released by Medicines Australia (MA) earlier this month.

But the model guidelines, which are up for consultation and discussion during the next 12 months, are contentious.

The AMA, along with several other medical groups including the Royal Australian College of General Practitioners and the Royal Australasian College of Surgeons, have participated in a Transparency Working Group convened by Medicines Australia to thrash out ways to increase transparency surrounding payments made by pharmaceutical companies to individual doctors.

However, the MA reporting model is but one possible reporting structure, and does not reflect a consensus view within the Working Group.

While the AMA has supported moves to improve the transparency of relationships between the medicines industry and doctors, it is concerned that any information that is publicly disclosed is fair and helps inform patients in making decisions about their health care.

AMA President Dr Steve Hambleton has highlighted the importance of doctors being able to attend conferences and workshops to learn of the latest advances in medicines, particularly where they are able to interrogate manufacturers about evidence and efficacy.

Under the model guidelines, companies which made payments or other "transfers of value" would be obliged to record and disclose the name and location of the doctor involved, their registration number, the size, date and form of payments, and what they were for.

Medicines Australia has suggested two alternate thresholds for the disclosure of payments - $25 or $10, but the latter only if the aggregate reaches more than $100 in a calendar year.

The proposed code would be intended to include cash payments, in-kind items or services, or stocks, options or other ownership interests, and could be for consultation work, speaking engagements, honoraria, travel expenses, market research, education costs, royalties or license fees, grants or a charitable contribution.

Payments would be exempt from disclosure where they were made to cover the costs of attending a continuing professional development program which was accredited, and where the drug company was not involved in selecting those who would attend, nor any direct payments to them.

"Engagement with doctors is important and legitimate because patients want to be sure that their doctors know how to use the medicines they're being prescribed"

The impetus for increased transparency in the relationships between doctors and pharmaceutical companies has come largely from overseas, particularly the United States, where laws requiring the disclosure of drug company payments to individual doctors have come into force.

Medicines Australia Chief Executive Dr Brendan Shaw said the proposed transparency model was "similar" to the US Physicians Payments Sunshine Act.

Dr Shaw said his industry was keen to improve the transparency of the industry-doctor relationship.

"Medicines Australia members overwhelmingly support greater transparency so that the nature of their relationships with doctors is open to greater scrutiny," he said. "Engagement with doctors is important and legitimate because patients want to be sure that their doctors know how to use the medicines they're being prescribed."

Consultations about the model will conducted over the next 12 months, and will be completed in time for Medicines Australia to submit its next industry Code of Conduct to the Australian Competition and Consumer Commission for approval by the end of 2014.

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Advanced Paediatric
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APLS PAC 2013 Conference – Preliminary Program Available

Program details are now available for Australia's dedicated Paediatric Acute Care Conference, coming to Noosa in October.

PAC 2013 is the fifth annual conference from Advanced Paediatric Life Support Australia, now established as the leading acute paediatrics conference in the region.

Following previous events in Coolum, Canberra and Melbourne, PAC 2013 will take place at the beautiful Sheraton Noosa Resort and Spa between Fri 25-Sun 27 October.

With expert international speakers to be announced and ample opportunities for networking and relaxing, PAC 2013 will be a highlight on the paediatrics calendar.

Delegate fees start at $275 for APLS members and $650 for non-members. Registration is open now.

You can find out more about APLS PAC 2013 and APLS Australia at www.apls.org.au

Cancer verdict in the mail

People turning 60 years today will be among the first to be eligible for a free bowel cancer test under a $16 million expansion of the nationwide screening program.

From today, people who have recently turned 60 years will be among 5.4 million Australians in the next four years offered the chance for a free bowel cancer test.

Health Minister Tanya Plibersek said the initiative was a significant advance in the detection and treatment of one of the nation's most common cancers, which kills around 80 people a week.

Until today free bowel cancer screening tests were only available for those who have turned 50, 55 and 65 years, and Ms Plibersek said the program's expansion to include 60-year-olds was an important development, and urged people to take the opportunity.

"While bowel cancer is very common, it can also be successfully treated if it is detected early enough," she said. "I urge everyone who is invited to participate, to take up the offer straight away and not put it off. It could save your life."

People contacted by the Government can request a bowel cancer screening kit, which is sent in the mail and can be used in the privacy of their own home.

The kit includes a faecal occult blood test, which can be posted by return mail, and the results are sent directly back to the patient and their nominated doctor.

The screening program will undergo a further expansion on 1 July 2015, when 70-years-olds will be included for the first time.

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Patients delay care as Medicare rebates frozen

The Federal Government's decision to freeze Medicare rebates has been put under the spotlight by findings that many patients are delaying seeing a doctor because of cost concerns.

In some areas up to 13 per cent of adults with a long-term health condition put off seeing a GP because of out-of-pocket costs, according to a National Health Performance Authority (NHPA) report, underlining warnings from the AMA that holding Medicare rebates down until mid-2014 could come at the cost of patient health.

The delay, announced in the Federal Budget, is expected to save the Government $664 million, but AMA President Dr Steve Hambleton said at the time that it was likely to lead to a drop in bulk billing rates as GPs were forced to impose out-of-pocket charges to help cover practice costs.

The bulk billing rate reached a record high of 82.4 per cent in the March quarter, and there is evidence that patients are more likely to seek treatment when they do not face additional costs.

A NHPA breakdown of patient health and access to care by Medicare Local region found a strong association between bulk billing rates and use of GPs.

By contrast, the NHPA found there was no particular correlation between how ill a patient reported themselves to be, and their likelihood of seeking treatment.

AMA President Dr Steve Hambleton said the study indicated a worrying trend among some patients to seek treatment according to ability to pay rather than medical need.

"The report confirms that our GPs and specialists have worked hard to be accessible and to maintain affordability of health care, with no additional assistance from Government," Dr Hambleton said. "This will become increasingly difficult given the Government's failure to adequately index Medicare rebates, including its Budget decision to delay indexation until July 2014."

The AMA President said it seemed perverse, given the findings of the NHPA report, that the Government had pushed ahead with its decision to freeze Medicare rebates, which would only add to pressure on the affordability of medical services.

NHPA Chief Executive Diane Watson said the report showed there was no particular correlation between health and the likelihood of seeing a practitioner.

"The local populations in parts of the country where people have the poorest health were no more likely to have seen a doctor or dentist in the past year," Dr Watson said.

The study underlined the wide variety and complexity of the health landscape nationwide, with no Medicare Local area performing consistently well or poorly across a range of health measures.

The report was accompanied by the launch of the My Healthy Communities website (www.myhealthycommunities.gov.au), which enables comparisons between the performance of the nation's 61 Medicare Local regions across a variety of health measures, including visits to GPs, out-of-pocket expenses, hospital admissions, specialist waiting times, bulk billing rates and prescription medicine costs.

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Your AMA Federal Council at work

Name	Position on council	Activity/Meeting	Date
Dr Steve Hambleton	President	Australian Commission on Safety and Quality in Health Care Clinical Care Standards Advisory Committee	29/5/2013
		Canadian Medical Association	13/6/2013
Dr Brian Morton	General Practitioners craft group nominee	Chief Medical Officer -MERS-CoV (Middle East respiratory syndrome)	1/6/2013
		Department of Health and Ageing - GP MRI	5/6/2013
		Pandemic planning update Chief Medical Officer	6/6/2013
		Medibank Health Solutions	13/6/2013
Dr David Rowed	AMA member	Standards Australia IT-014 Health Informatics 2013-2014 Planning Workshop	3/6/2013
Prof Geoffrey Dobb	Vice President	National Health Performance Authority Healthcare Efficiency Advisory Committee	5/6/2013
		Independent Hospital Pricing Authority Stakeholder Advisory Committee	17/6/2013
Dr Peter Ford	AMA member	National Aged Care Alliance - Aged Care Gateway Advisory Group	6/6/2013
Prof Mark Khangure	Radiologists craft group nominee	Medical Services Advisory Committee Review Consultation Committee for Cardiac services for implantable electronic devices	25/6/2013
Dr Gino Pecoraro	Obstetricians and Gynaecologists craft group nominee	TGA Codes of Conduct Advisory Group	21/6/2013

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Ophthalmologists cop black eye from competition czar

The competition watchdog has delivered a major rebuff to the nation's ophthalmologists, denying those who work in shared practices permission to collectively set fees.

Just three months after giving the green light for GPs working in the same practice to collectively set patient charges, the Australian Competition and Consumer Commission has knocked back a similar request from the Australian Society of Ophthalmologists (ASO).

In a draft decision with clear implications for specialties where practitioners are in heavy demand, Commission Deputy Chair Dr Michael Schaper indicated that, in coming to its determination, the watchdog had paid close attention to the dynamics of the market for ophthalmologist services.

Dr Schaper said particular note had been made of the fact that the majority of the nation's 812 practicing ophthalmologists worked in shared practices.

"The ACCC is concerned that, if most ophthalmologists could agree with other members of their practices on prices for services, it may result in higher prices for patients," he said. "This is particularly concerning in an environment of high demand and long waiting times for these services."

Currently, each ophthalmologist sets their own fees, in competition with those in their area - including in their practice.

The watchdog said the reason GPs had been given permission for joint practice fee setting where ophthalmologists had not was the relative scarcity of the latter, with only "a small number in any given area within Australia…unlike the larger number of GPs".

Although it is only a draft decision, the wording of the ACCC's announcement appears to offer the ASO little encouragement of a change of view before the final determination is issued.

"The ACCC's preliminary view is that the public benefits are not likely to outweigh the detriments from the proposed arrangements," the statement said. "The ACCC may grant an authorisation when it is satisfied that the public benefit… outweighs any public detriment."

AR Abbott backs medical research

The Coalition has pledged to streamline grants for medical research and shield the National Health and Medical Research Council from budget cuts as it begins to roll out policy ahead of the 14 September election.

Drawing on the findings of the McKeon Review into the nation's health and medical research system, the Opposition has promised to overhaul the way in which research projects are assessed and funded and make it easier to conduct clinical trials.

The policy, unveiled by Opposition leader Tony Abbott and Shadow Health Minister Peter Dutton on 24 June, calls for the simplification of the research grant application and assessment process, and a transition in the term of NHMRC grants from three to five years.

To improve the nation's attractiveness as a destination to host clinical trials, the Coalition also plans to "move swiftly towards a nationally consistent approach" to the way trials are conducted and overseen, if elected.

Mr Abbott said the changes were much needed if Australia was to remain a world leader in medical research.

"Investing and supporting medical research is one of the best long-term investments in health that a government can make," Mr Abbott said. "The Coalition has listened to our medical researchers, who have said that existing guidelines and processes are cumbersome, costly and inefficient."

The McKeon Review found that NHMRC grant applications were complex and time consuming to make, with estimates that researchers spent up to a quarter of their time applying for or reviewing grants.

"This is not the most productive use of our best and brightest minds," the Coalition policy said. "Our researchers want to be in the clinic and the lab, working for the betterment of patients and the health system, not trawling through mountains of unnecessary paperwork."

According to the Opposition, supporting medical research is part of a broader strategy to ensure the nation maintains a diverse economic base.

Prior to the policy's launch, Mr Dutton was forced to defend the Coalition's position on health.

Challenged over his admission to The Australian Financial Review last month that health was a lower campaign priority for the Coalition than asylum seekers or the cost of living, the Shadow Health Minister told ABC television the Opposition would have a "cracker" of a health platform.

He said the health policy had been developed following extensive consultation and was "ready to go", but added it would be released at a time of the Coalition's choosing.

"We will have a cracker of a policy," Mr Dutton said. "We've got a lot that we will announce, at an appropriate time. We'll make our announcements at a time that suits us."

But he has been regularly taunted by Health Minister Tanya Plibersek, who said he has barely asked her a question on health in Parliament.

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Vaccination deniers told to disband

The Senate has taken the rare step of urging an anti-vaccination group to disband, condemning its "harmful and unscientific" scare campaign that is helping undermine national immunisation rates.

All the major political parties last week threw their weight before an Australian Greens motion calling for the controversial Australian Vaccination Network to cease operations.

Greens Senator Dr Richard Di Natale said that, through unanimous support for the motion, the Senate was sending a clear message to the embattled group that they should "pack up and go home".

Senator Di Natale said the AVN – which is fighting a rearguard action in NSW courts against State Government moves to force it to change its name – had been irresponsibly peddling misinformation around vaccines.

"I have had people contact me who have lost children to diseases that have a safe and effective vaccine," he said. "Well-meaning parents are being fed dangerous misinformation which undermines their faith in the safety of vaccines. This has to stop."

Governments have been galvinised into action following evidence that vaccination rates in pockets of the community – including in well-to-do areas of eastern Sydney – have dipped well below 90 per cent among older children, creating conditions conducive to a sustained outbreak of serious diseases such as measles.

This is despite overwhelming scientific evidence of the efficacy of vaccination.

Eminent immunologist Professor Christopher Parish of the John Curtin School of Medical Research said last week that vaccinations had proven to be a "remarkably effective way" of protecting people against infections.

Professor Parish cited long-term population health data from the United States showing that between the pre-World War Two period and 1996 there had been near 100 per cent declines in the incidence of major diseases including diphtheria, measles, rubella, pertussis and polio because of the advent of vaccines.

A meeting of the country's health ministers last month discussed a number of proposals to boost child immunisation rates, including a requirement that parents show proof of immunisation status before enrolment in schools or child care, education campaigns and the referral of children not fully immunised to GPs for catch-up vaccinations.

This follows the introduction in New South Wales in May of significant new laws under which parents or guardians trying to enrol children in childcare will be required to provide evidence that their child has been fully vaccinated, is on a recognised vaccination catch-up schedule, or has a doctor-approved exemption on personal, philosophical, medical or religious grounds.

And, under tough new rules that come into effect from today, parents will only be eligible for a child care rebate where their child has been fully immunised, or has an exemption on religious grounds (as a practising member of the Church of Christ, Scientist) or because of exceptional circumstances.

Parents have been warned to check their child's immunisation status, with new rules coming into effect from today requiring that they have received an additional two meningitis vaccines – meningococcal C and pneumococcal – before they can be considered fully immunised and qualify for government benefits.

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Anti-vax parents told: don't pay

Parents seeking a "conscientious objector" exemption to their child's vaccination are being urged to refuse to pay doctors who decline to back their claim.

In a sign of the level of resistance being mounted by some against vaccination, *Australian Medicine* has seen a copy of a letter being circulated among anti-vax parents giving them detailed instructions on how to go about claiming 'conscientious objector' status.

It tells parents to document the names of any receptionists spoken to when making an appointment, not to make any payment before seeing the doctor, and not to take any children.

Instead, parents are advised, ask any doctor who refuses to sign a conscientious objector form to provide copies of scientific evidence demonstrating the link between raised antibody levels and immunity, and studies comparing the health of vaccinated and unvaccinated children.

Parents are advised that if the doctor treats them with "disrespect", they can report them for their conduct and, if they do not sign the conscientious objector form, refuse to pay.

"If you do not get the form signed, do not pay for the consultation, as you did not get what you went for," the letter advises.

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Health on the hill

Political news from the nation's capital

Super Clinics: little to show for $420 million

The Federal Government is under mounting pressure to scrap its flawed GP Super Clinics program after the Commonwealth Auditor-General confirmed the scheme was badly designed and delivered poor value for money.

In a damning assessment, the Auditor-General found that although almost $420 million had so far been spent on to the $600 million program, only three of the 36 clinics promised in 2007 were completed on time, with seven still not operational, while just one of the 28 announced in 2010 was fully functional.

The Australian National Audit Office (ANAO) report showed that not only had there been serious delays in commissioning many of the clinics; several had swallowed enormous sums of money for little demonstrable public benefit.

It found that spending on individual clinics ranged between $1 million and $15 million.

In the most egregious examples of expenditure, $25 million ($12.5 million from the Commonwealth, matched by the South Australian Government) has been spent on each of two South Australian GP Super Clinics – one in Modbury, the other in Noarlunga – for a complement of 2.2 and 2.5 full-time equivalent GPs, respectively.

Echoing long-held concerns by the AMA that the program was poorly conceived and was a bad use of scarce health funds, the Auditor-General found that in setting up the clinics, there had been little attempt to assess the level of local need and what affect it might have on existing medical services.

"While…program guidelines required applications to address the extent to which a proposed clinic could impact on existing health services, this issue was not explicitly or substantively considered in the overall assessment," the ANAO report said, noting one instance where the main patient access to an existing GP practice was funnelled through the waiting room of a Super Clinic.

In addition, attempts to assess value for money and benchmark performance were inadequate.

"Consideration of value for money was hampered by a lack of clear and specific guidance to assessment panels on assessing the value for money of physical infrastructure, resulting in a lack of clarity and consistency in how the concept was applied in the assessment and selection process," the Audit report found.

Adding to suspicions that decisions over where to put many GP Super Clinics had been compromised by political considerations, the ANAO found that 54.8 per cent were located in marginal electorates, and devoured a disproportionate share of funding (65.7 per cent).

However, the Auditor-General pointed out that of the clinics in marginal electorates, 82 per cent from the first round were in areas of designated medical workforce shortage, as were 57 per cent of those announced in the second round.

Overall, according to the Auditor-General, there were occasions during the first round of the program when the Department of Health and Ageing's "risk management approach in the awarding of grants, and subsequently managing risks in the early stages of clinic roll-out, lacked rigour".

AMA Vice President, Professor Geoffrey Dobb, said the audit findings were damning, and the Government should immediately halt spending on the program and divert unspent funds to the far-more effective program to upgrade general practices.

"The report shows that the program has been very poor value for money," Professor Dobb said. "That money would have been much better spent on the Primary Care Infrastructure Grants program, which the Auditor-General last year found to be delivering excellent results."

Under the Primary Care Infrastructure Grants program, $117 million has been allocated over four years to upgrade 425 GP facilities.

Professor Dobb said it was time for the Government to stop throwing good money after bad.

"Obscene sums have been spent on these clinics for very little demonstrable benefit," he said.

"It is time to put a stop to the waste and direct the funds that can be salvaged to where they will do the most good."

Shadow Health Minister Peter Dutton told the 2013 AMA National Conference that the Super Clinics program was flawed and the money could have been much better spent.

But Mr Dutton held back from repeating the pledge he made before the 2010 election to scrap the scheme.

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Health on the hill

Political news from the nation's capital

DisabilityCare kicks off

Senior AMA members have met with the inaugural Chair of the DisabilityCare Australia Board, Bruce Bonyhady.

Former AMA President Dr Andrew Pesce and AMA Victoria President Dr Stephen Parnis met with Mr Bonyhady at an Australian Football League match dedicated to promoting inclusion and equality for people with a disability last month.

Law firm Slater & Gordon sponsored the 16 June match between Collingwood and the Western Bulldogs at Melbourne's Etihad Stadium, and there are plans to make it an annual event celebrating people with a disability and highlighting the importance of inclusion and respect.

The event was part of the lead-up to the introduction of the landmark DisabilityCare scheme, which comes into operation from today.

As part of preparations, the Federal Government last month announced the appointment of Mr Bonyhady – a father of two sons with a disability – to head the organisation.

The announcement came just days after Dr Pesce and Dr Parnis met with Mr Bonyhady.

Dr Pesce has been one of the driving forces behind the creation of a national system to provide on-going support for people with disabilities and their carers.

For the past decade he has worked as a passionate advocate of the need for a national disability insurance scheme, and he collaborated closely with Mr Bonyhady to put it in place – both served on the Independent Panel that advised the Government and the Productivity Commission during the Inquiry into Disability Care and Support.

Mr Bonyhady has held a number of senior positions in the funds management and insurance industry, both in Australia and internationally, and is the current President of Philanthropy Australia.

In a statement announcing his appointment, Minister for Disability Reform Jenny Macklin said Mr Bonyhady would bring a wealth of experience to the DisabilityCare Board, which will "set the strategic direction of DisabilityCare Australia and play an important role in safeguarding its financial sustainability, including by commissioning and considering actuarial advice on its decisions".

Other members of the Board include Dr Rhonda Galbally, Queensland Treasury Corporations Chair Sir Leo Hielscher, Aspen Medical Managing Director Glenn Keys, Catholic Health Australia Chief Executive Officer Martin Laverty, former Optia Incorporated Chief Executive Geraldine Harwood and Productivity Commission Associate Commissioner John Walsh.

In addition to her role on the DisabilityCare Board, Dr Galbally has also been appointed as the Principal Member of the Independent Advisory Council, created to ensure the Board has a ready source of advice from the perspective of people with a disability, Ms Macklin said.

The Minister said the 13-member Council comprised a mix of people with a disability, carers, and those involved in providing disability services.

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Health on the hill

Political news from the nation's capital

Abbott backs medical research

The Coalition has pledged to streamline grants for medical research and shield the National Health and Medical Research Council from budget cuts as it begins to roll out policy ahead of the Federal election.

Drawing on the findings of the McKeon Review into the nation's health and medical research system, the Opposition has promised to overhaul the way in which research projects are assessed and funded and make it easier to conduct clinical trials.

The policy, unveiled by Opposition leader Tony Abbott and Shadow Health Minister Peter Dutton on 24 June, calls for the simplification of the research grant application and assessment process, and a transition in the term of NHMRC grants from three to five years.

The Opposition has also embraced a McKeon Review recommendation that a "triage" system be established to winnow out uncompetitive grant applications at an early stage in the assessment process.

To improve the nation's attractiveness as a destination to host clinical trials, the Coalition also plans to "move swiftly towards a nationally consistent approach" to the way trials are conducted and overseen, if elected.

Mr Abbott said the changes were much needed if Australia was to remain a world leader in medical research.

"Investing and supporting medical research is one of the best long-term investments in health that a government can make," Mr Abbott said. "The Coalition has listened to our medical researchers, who have said that existing guidelines and processes are cumbersome, costly and inefficient."

The McKeon Review found that NHMRC grant applications were complex and time consuming to make, with estimates that researchers spent up to a quarter of their time applying for or reviewing grants.

"This is not the most productive use of our best and brightest minds," the Coalition policy said. "Our researchers want to be in the clinic and the lab, working for the betterment of patients and the health system, not trawling through mountains of unnecessary paperwork."

Universities Australia said the Coalition's pledge to protect medical research funding was welcome, but called for the commitment to be extended to include non-medical research as well.

It warned the Opposition's policy risked creating a two-tier research sector.

Meanwhile, the Australian Research Committee has embarked on the most comprehensive analysis of the nation's research capacity every undertaken, with effective delivery of health care nominated as one of 15 research priorities.

According to the Opposition, supporting medical research is part of a broader strategy to ensure the nation maintains a diverse economic base.

Prior to the policy's launch, Mr Dutton was forced to defend the Coalition's position on health.

Challenged over his admission to *The Australian Financial Review* last month that health was a lower campaign priority for the Coalition than asylum seekers or the cost of living, the Shadow Health Minister told ABC television the Opposition would have a "cracker" of a health platform.

He said the health policy had been developed following extensive consultation and was "ready to go", but added it would be released at a time of the Coalition's choosing.

"We will have a cracker of a policy," Mr Dutton said. "We've got a lot that we will announce, at an appropriate time. We'll make our announcements at a time that suits us."

But he has been regularly taunted by Health Minister Tanya Plibersek, who said he has barely asked her a question on health in Parliament.

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MPs pricked into action on dangerous cuts

The work safety watchdog will review arrangements nationwide to protect doctors, nurses and other health workers from injuries caused by needles, scalpels or other sharp objects under legislation proposed in Federal Parliament.

General practitioner and retiring Liberal MP Dr Mal Washer has received bipartisan support for a Private Members Bill calling for national action to reduce the incidence of needle-stick and scalpel injuries among health workers.

Under the proposal, Safe Work Australia will be directed to review Federal, State and Territory rules and guidelines regarding the protection of health workers from needle-stick and sharps injuries.

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Dr Washer said it was likely that there were more than 30,000 injuries to health workers caused by needles, scalpels and other sharp medical equipment each year, exposing thousands of workers to the risk of serious infection and causing great psychological trauma and significant workplace costs.

The West Australian MP told Parliament last week that doctors, nurses and other health workers were at risk of exposure to three serious blood-borne viruses including hepatitis B, hepatitis C and HIV during the course of their daily work, as well as a host of other pathogens including diphtheria, herpes, tuberculosis, syphilis and malaria.

Dr Washer said there were 18,500 instances of worker exposure to blood and body substances in hospitals in 2005, and research had shown that between 30 and 80 per cent of sharps injuries were not reported, making likely exposure much higher.

But he said that training health staff in how to work safely, combined with the use of safety-engineered medical devices, radically cut rates of stick and sharps injuries by up to 90 per cent or more.

Dr Washer said it was time for action.

"Australia has yet to adopt a nationally consistent approach to the use of safety-engineered medical devices in health care settings, through either prescriptive legislation or policy, despite the high rates of needle-stick, scalpel cuts and other sharps injuries," he told Parliament. "The development of a staff safety culture is a prerequisite for developing a strong patient safety culture. The most direct route to preventing percutaneous injuries is to make injurious devices safer to handle."

Government Whip Graeme Perrett said the Government backed Dr Washer's motion and had proposed amendments – accepted by the Liberal MP – to "make sure that State and Territory representatives are actively involved in the process of reviewing the existing code of practice for needle-stick injuries, so that we address all of the health and safety risks of biohazards broadly".

Chair of the Alliance for Sharps Safety and Needle-stick Prevention in Health Care Anne Trimmer said it was "about time" the issue was considered by Parliament.

"Overseas, this has long been recognised as a foreseeable and preventable hazard for health care workers," Ms Trimmer said. "The USA and Europe have had legislation in place to address the issue for…years."

According to research by the Medical Technology Association of Australia, introducing safety-engineered medical devices into health workplaces could, combined with guidelines and training, reduce injuries by more than 90 per cent, and save hospitals around $18.6 million a year.

Ms Trimmer said Australia lagged behind many parts of Canada, Europe, the United States and the United Kingdom, where the use of safety-engineered medical devices was mandatory.

She said that, under national workplace safety laws, employers were obliged to eliminate workplace hazards or, where this was not practicable, to minimise them as much as possible.

Ms Trimmer said that, in keeping with this, regulations should require the use of safety-engineered medical devices, accompanied by appropriate training and guidelines.

She said that, in addition, there should be systems put in place to report incidents of sharps or needle-stick injuries, and arrangements such as hot lines to encourage injured workers to report incidents and receive advice and support.

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Reluctant states risk squandering gains

The Federal Government has warned that recent successes in closing the health gap between Indigenous Australians and the rest of the community are being put at risk by the refusal of several State and Territory government to sign up to a new funding deal.

The first $1.6 billion, five-year COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes expired on 30 June, and as at late last week only the Commonwealth and Victoria had committed to a new five-year deal.

Indigenous Health Minister Warren Snowdon told The Australian he was deeply concerned by the failure to finalise a new round of funding.

So far only the Commonwealth and Victoria have pledged funding for a renewed agreement.

In the May Budget, the Federal Government allocated $777 million over three years to Closing the Gap initiatives, while *The Australian* reported Victoria will contribute $61.7 million over four years.

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Of the other states and territories, only Western Australia has pledged a contribution, offering just $31 million for a 12-month extension of the agreement.

The AMA has repeatedly called for all governments to step up and recommit to a further five-year agreement, warning that a failure to do so could undermine progress that had been made.

There have been promising early signs of success.

The COAG Reform Council reported that the gap between Indigenous and non-Indigenous child death rates had shrunk from 139 deaths per 100,000 to 109.9 per 100,000 between 1998 and 2011, 91 per cent of Indigenous children were enrolled in preschool in 2011 and, in the same year, the proportion attaining year 12 or its equivalent was almost 54 per cent – a 7 percentage point increase in five years.

AMA President Dr Stave Hambleton said this was heartening evidence of progress, and governments should not squander it by faltering in their effort.

"We need to keep this momentum going and build on it, but it can only happen with long-term funding and political commitment from all our governments," Dr Hambleton said.

The Reform Council indicated that much more needed to be done.

It found that although there was some improvement in the reading ability of Indigenous children between 2008 and last year, they fell behind in numeracy compared with the rest of the population.

In addition, the Council reported that there was little evidence of progress in reducing Indigenous death rates, with Aboriginal and Torres Strait Islander peoples continuing to die at around twice the rate as the rest of the community.

And employment prospects for Indigenous continued to lag well behind those of the broader population, with only NSW reporting progress in narrowing the employment gap between 2006 and 2011.

Dr Hambleton said the report showed that progress can be made "with the right support and commitment", and much more needed to be done.

"We urge the remaining governments to make a funding commitment that is at least the same as the current partnership agreement," he said.

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Rise of superbugs needs strong action

A Senate Committee has called for the establishment of a national organisation to help combat superbugs and monitor antibiotic use amid fears that antimicrobial resistance could soon render minor infections untreatable and make routine operations potentially deadly.

In an alarming assessment, the Finance and Public Administration References Committee has released a report warning that antimicrobial resistance is spreading rapidly worldwide, including in Australia, severely compromising the ability to treat many basic ailments.

The report, which drew on evidence from 38 submissions, including from infectious disease experts, warned that resistant infections were no longer confined to hospitals, and were increasingly being acquired in the community.

The Committee cited evidence from the President of the Australian Society for Antimicrobials (ASA), Associate Professor Thomas Gottlieb, that multiresistant infections were now a daily reality for many specialists.

"What I and a lot of our members have seen in the last decade is that the issue of untreatable infections is no longer an abstract notion; it is now a reality," Associate Professor Gottlieb told the inquiry. "It is a day-to-day issue for specialists in many practices. We are seeing them now in individual patients, many of whom will die of their infections – not through inadequate medical care but through unavailability of antibiotics."

Infectious diseases physician Professor Lindsay Grayson said resistance rates for urinary tract infections had risen from 5 to 20 per cent in a five-year period.

The ASA warned that resistance to last-line antibiotics was now common among many pathogens found in Australian hospitals, including carbapenems, fluoroquinolones and glycopeptides.

The Committee said urgent action was needed to stem, or at least control, the rise of antimicrobial resistance.

It called for the Commonwealth to establish an independent body to develop a national strategy to combat antimicrobial resistance and to rigorously monitor and report on antibiotic use in humans and animals.

The Committee said the current voluntary regime for reporting sales of antimicrobials be made mandatory, and recommended that Australian Pesticides and Veterinary Medicines Authority publish annual reports on antibiotic use on animals.

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The use of antibiotics in medical practice may also come under increased scrutiny.

The Committee wants the Australian Commission on Safety and Quality in Health Care to tighten access to antimicrobials in health services, and has recommended that the Department of Health and Ageing developed "additional mechanisms to improve antibiotic stewardship in general practice."

The Senate inquiry grew out of frustration with a perceived lack of action on key findings of the 1999 Joint Expert Technical Advisory Committee on Antibiotic Resistance, which originally raised the alarm about the rise of antibiotic resistance in the community.

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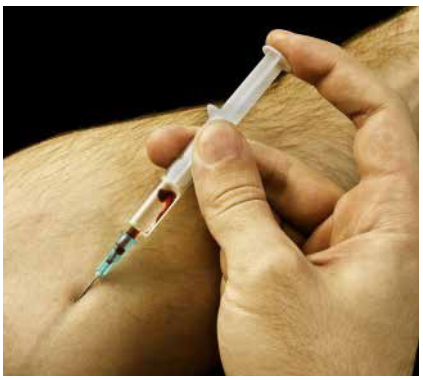
Anti-doping investigators get power upgrade



The nation's anti-doping watchdog has been awarded substantial new powers to investigate the use of performance enhancing drugs in sport.

Parliament has passed legislation that will give the Australian Sports Anti-Doping Authority the power to compel athletes, support personnel or other witnesses to attend interviews with ASADA investigators and provide documents and other information.

But the Government has had to curb some of the powers it initially planned to bestow on the authority following widespread concerns that they compromised the rights of athletes and others, including the right against self-incrimination.

Labor's Deputy Leader in the Senate, Senator Jacinta Collins, said the amended legislation would give ASADA the power, "subject to appropriate protections", to compel people to attend interviews and produce information or documents relevant to any inquiry the Authority is conducting.

This includes giving the ASADA Chief Executive Officer the authority to issue a disclosure notice requiring people to attend interviews or provide information.

"Importantly, a disclosure notice can go to anyone; not just athletes or their support personnel," Senator Collins said. "This recognises that people outside the jurisdiction of Australia's anti-doping regime may have information that would assist ASADA to identify and sanction those who commit anti-doping rule violations."

Under the new laws, people who refuse to comply with a disclosure notice are liable for a $5100 fine.

The Opposition and the Greens both supported the amended legislation after earlier raising objections to the sweeping extent of powers initially proposed.

ASADA is currently undertaking investigations into allegations of doping in several sports, most prominently the Australian Football League and the National Rugby League.

Jobe Watson, who is captain of the Essendon Football Club – which is at the centre of the ASADA probe into the AFL – last week sensationally admitted to taking a banned anti-obesity drug last year.

Mr Watson's admission undercuts Essendon's long-standing position that it had done no wrong, and has intensified the focus on the role of sports scientists in sports clubs.

So far, most attention in Essendon and the Cronulla Sharks NRL club have centred on the activities of sports scientist Stephen Dank, who oversaw supplement regimes at both clubs.

In particular, concerns have been raised that sports scientists at some clubs have been able to work without supervision from club medical staff.

A Senate inquiry into the practice of sports scientists has received a number of submissions calling for a system of accreditation for sports scientists, to bring them into line with other professions where practitioners have to meet minimum standards.

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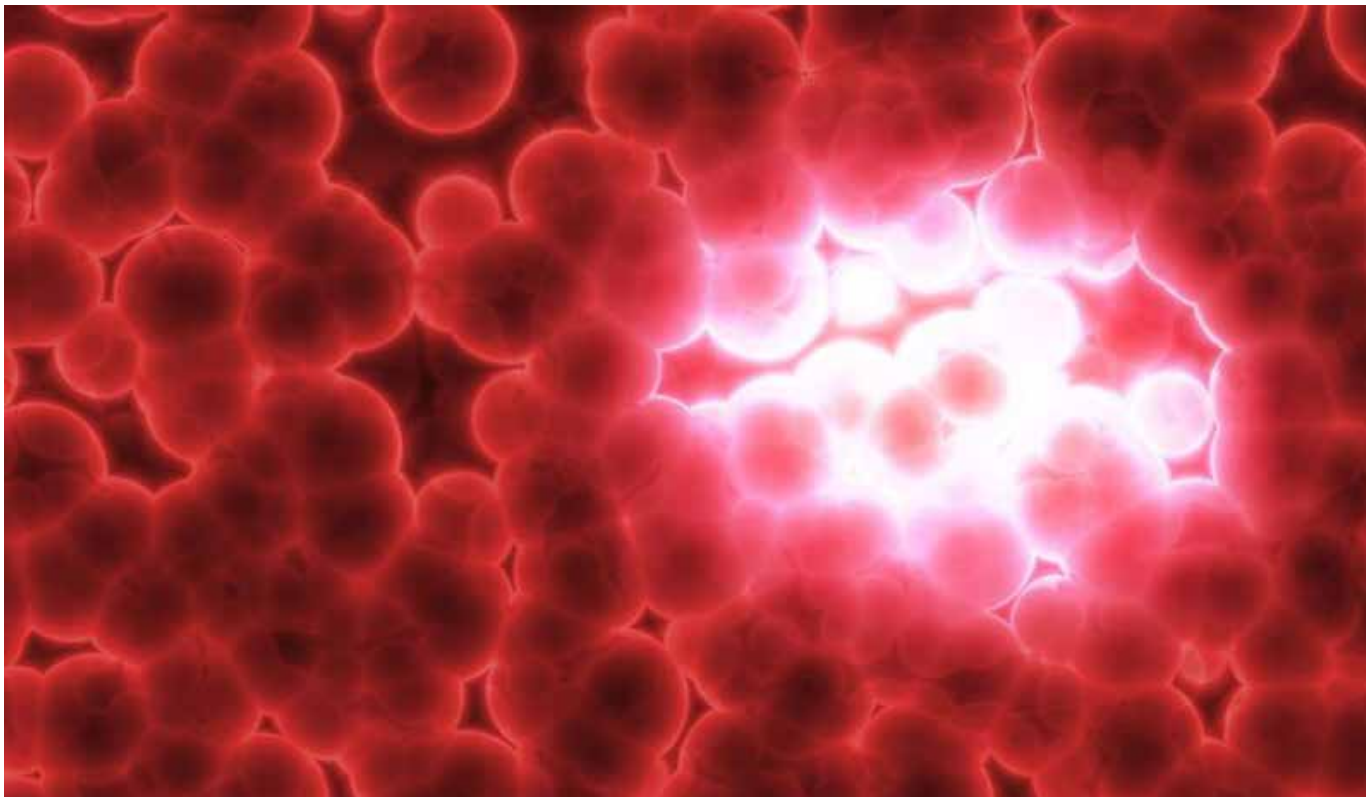
A cure for cancer?



Is a vaccine against cancer – one of the most sought after breakthroughs in medical research – possible?

One of the world's foremost researchers in immuno-regulation, Professor Christopher Parish, thinks the answer is probably yes.

But it won't be easy.

In a keynote address at The Australian National University's John Curtin School of Medical Research, where he is Director, Professor Parish has highlighted a promising line of inquiry that he thinks may lead to a universal cancer immunotherapy.

There have already been successes in developing vaccines for diseases that can lead to cancer, such as for hepatitis B and the Australian discovery of a vaccine for the human papillomavirus.

But Professor Parish said there were still no vaccines for many other cancer-causing infections, such as the hepatitis C virus, helicobacter pylori bacteria, flat worms and liver fluke.

And, he pointed out, pathogens only caused about 25 per cent of cancers, meaning other approaches were needed to tackle the majority of forms of the disease.

Professor Parish said the path taken by some has been to try and develop prophylactic vaccines for cancer to try and prevent the disease developing.

He said one of the most promising lines of research in this area has centred around developing a vaccine targeting mucin 1 (MUC1), which is a protein produced in high quantities by cancer tumours.

Researchers have found that people with antibodies against MUC1 have a reduced chance of developing bowel cancer.

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A cure for cancer?

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"... the big issue researchers have faced is the ability of tumour cells to rapidly mutate, quickly making specific antibodies redundant"

The problem, Professor Parish said, was that to properly test the vaccine would involve a trial of around 15 years – a time span far too long for commercial developers.

Another avenue of inquiry is to develop immunotherapeutic vaccines that switch on the immune response to cancer in patients who have already developed the disease.

An early example of this was the use of American physician Dr William Coley of the mycobacteria *Bacillus Calmette-Guérin* to treat cancer in the late 1800s. About 10 per cent of patients with stage four cancer deliberately infected with a variant of BCG experienced remission, though the toxic formulation produced serious side effects. Nonetheless, a version of the therapy is still used to treat early stage bladder cancer.

The problem, Professor Parish said, was that BCG was not antigen-specific, and it remained unclear how it worked.

The development of prophylactic vaccines for cancer has centred in recent times on stimulating lymphocytes to produce antibodies to specific cancerous antigens.

Here, the big issue researchers have faced is the ability of tumour cells to rapidly mutate, quickly making specific antibodies redundant.

Current immunotherapies include BCG, anti-CTLA-4 antibodies that encourage T-cells to proliferate, and dendritic cell-based vaccines.

Professor Parish said that although anti-CTLA-4 treatments had achieved a 10 per cent improvement in five-year patient survival rates, they involved serious side effects in the intestines, making patients very ill.

Dendritic cell-based techniques such as Provenge involve a complex and costly process (around $90,000 per treatment) tailoring the vaccine to each individual patient, and have been seen to hold much promise.

But Professor Parish said results to date have been "very disappointing".

A large trial found that it resulted in just a four to 12-month prolongation of life in patients with stage four prostate cancer, and the five-year survival rate was unchanged.

Another approach has been to use liposomes (which act like a molecular glue) to better target dendritic cells to cancer tumours.

One of these treatments, Lipovaxin, is being tested in a small scale clinical trial at Royal Adelaide Hospital, with early results suggesting it has some efficacy with no side effects.

But Professor Parish was more enthusiastic about another approach which has moved away from the idea of targeting specific antigens.

He said the standard prophylactic approach had hit multiple problems, including the difficulty of identifying the antigen early enough, the ability of tumour cells to rapidly mutate, and problems of auto-immunity.

"As researchers, we have been too obsessed with antigen-specific immune response," Professor Parish said.

Another approach altogether was to induce an innate immune response in patients that tumour cells cannot evade.

For this, neutrophil extracellular traps (NETs) are critical.

NETs are highly toxic nets thrown out by so-called suicide cells which race to the site of infections, and they very effectively trap and kill all cells caught in them.

The problem in the past has been that they are as toxic for self cells as they are for invaders, and have been linked to serious effects such as septic shock, stroke, and cerebral malaria.

But Professor Parish said "very encouraging" work was underway to harness NETs to target tumour cells.

Because they were not antigen specific, he said, it was very difficult for tumour cells to evade them.

However, those hoping for a miracle cancer cure any time soon are likely to be disappointed.

Promising as such research was, Professor Parish said the development of immunotherapy cancer vaccines was still in its infancy.

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Members' Forum

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

Medical groups have condemned controversial proposals for the establishment of two new medical schools as irresponsible given unresolved concerns about a looming shortage of internships in coming years. Members agreed and voiced possible solutions to the rural workforce crisis.

Junior doctors cannot operate on their own. Therefore, in a rural setting, there are very few positions for junior doctors. The reason there are fewer doctors rurally is not because doctors are snobs, or city slickers or because we need more medical schools, but because the government has not provided suitable positions. A new graduate cannot just turn up and begin practicing. It is illegal for good reason - they are not experienced enough to deal with the huge variety and seriousness of conditions that arrive at rural hospitals.

If the government wants more rural doctors it needs to start with more jobs to be filled rurally.

Creating medical schools rurally is useless/unethical if there isn't a real plan to increase the capacity of rural teaching hospitals. Failing that, the new swathes of students will simply have to apply elsewhere if they are to ever complete their training. And many will not find one [a training position]. They may (rarely) be able to move overseas. But for locally trained Australians, without that position they are not a fully qualified doctor. The question that needs to be asked is why don't senior doctors move rurally? If you can solve that, you can start producing more juniors.

by R (not verified)

The AMA slammed the Optometry Board of Australia over new rules that give optometrists the green light to treat glaucoma and other serious eye conditions without consulting ophthalmologists. AMA members agreed.

The Optometry Board is composed of optometrists and community members - do we really expect balanced opinions?

Why is this Board allowed to determine the scope of optometry practice?

Patrick Hanrahan (not verified)

The Federal Government has committed to organising a summit on collaboration between doctors and midwives following AMA concerns about current proposals for collaborative care. Several readers disagreed with the AMA's position, and expressed support for independent midwives.

What is the problem with enabling independent midwives? They are common in the UK, regulated by the same governing body as National Health Service practitioners, legally required to work to current Rules and Codes of Practice, and accountable for their practise. Twice referred to in this article as "undesirable".

by Sally French (not verified)

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Doctors in No Man's Land

BY **DR BRIAN MORTON**

"We need to continue our vigilance to ensure that new inclusions to the Vocational Register are also granted, upon application to the Medical Board, recognition in the specialty of general practice"

The AMA has consistently argued that non-Vocationally Registered (VR) GPs should be recognised for their considerable experience in both general practice and other areas of medicine, and continues to opportunistically press the case for a final round of grandfathering, a lifting of the A2 rebate, and its ongoing indexation.

As a member of the General Practice Recognition Eligibility Committee (GPREC), I am constantly reminded of the plight of those GPs who missed out being grandfathered to the Vocational Register.

In many ways, these GPs are in no man's land.

Non-VR GPs or Other Medical Practitioners (as they are referred to in the Medicare Benefits Schedule) are eligible only to claim A2 Professional Attendance MBS items, unless they are participating in one of the Government's workforce programs under which they can access A1 rebates.

These are programs such as the Rural Other Medical Practitioners (ROMPs) Program, the MedicarePlus or Other Medical Practitioners (MOMPs) Program, the After Hours Other Medical Practitioners (AHOMPs) Program, the Outer Metropolitan Other Medical Practitioners (OMOMPs) Program or the Temporary Resident Other Medical Practitioners (TROMPs) Program.

From the outset, the Vocational Register effectively created two classes of GPs.

The A2 rebates were initially set at 93 per cent of the A1 rebates, and have remained frozen in time – they have never been eligible for annual indexation, meaning they have been steadily declining in value against the A1 rebate.

The low rebates not only affect non-VR GPs. Their patients get a lower rebate, and potentially face higher out of pocket expenses.

It is hard to find employment. Check the GP wanted advertisements - most want VR GPs.

If they sub-specialise in order to keep their practice viable, this can affect eligibility for recognition under alternate pathways to Fellowship of the RACGP.

There are varying reasons why some medical practitioners did not make the VR.

The hardest luck cases are those who had been issued 'certificates of eligibility' before 1996, which would enable them to be placed on the Vocational Register once they were predominantly in general practice.

However, a change in legislation in 1996 rendered these certificates not worth the paper they were written on.

Those who were overseas furthering their education, or doing humanitarian work, or off work while they cared for sick family members or having their children, were caught out by the legislative changes - potentially excluded forever from the Vocational Register.

GPREC was established to assess the eligibility of a number of medical practitioners who had applied for inclusion on the Vocational Register.

Those not assessed as eligible have the right of appeal, with appeals being considered by the General Practice Recognition Appeal Committee (GPRAC).

Once all the outstanding applications and appeals have been assessed and finalised, the legislative amendment effectively removing the provisions for the Vocational Register will then be proclaimed, and it will cease to exist.

Other than through special workforce programs, non-Vocationally Registered GPs can only access A1 rebates by becoming a Fellow of the RACGP or the Australian College of Rural and Remote Medicine.

Those already in general practice can have their education and experience assessed and recognised via the General Practice Experience (Practice Eligible) Pathway. They can either sit the College exam once assessed as eligible, or go through a Practice Based Assessment.

We need to continue our vigilance to ensure that new inclusions to the Vocational Register are also granted, upon application to the Medical Board, recognition in the specialty of general practice.

We do not want to see another situation where eligible GPs are left stranded in no man's land.

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Catastrophise (*verb*): to make a situation seem worse than it actually is

BY **CHAIR DR WILL MILFORD**

One day last week, while Australia's media was preoccupied with Labor leadership tensions, gender cards and disgraced menus, the 16th report of the Medical Training Review Panel was quietly tabled in Parliament (to view, click here - http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-16-toc).

There are those who may agree with the aforementioned media bias, but for medical workforce buffs - and those whose careers hang on the whim of health bureaucrats - it signifies the release of crucial information regarding the current workforce environment.

The panel aspires to provide a comprehensive picture of medical education and training and, for the most part, it succeeds.

The report, presenting data from 2012, delivers a vision of a medical training sector rapidly approaching capacity.

With the much referred-to 'intern tsunami' almost at its peak, focus is shifting further down the training pipeline to prevocational and vocational training.

Vocational training has undergone a massive expansion, with two and half times the number of vocational trainees in training now as there were in 2000. Correspondingly, the number of new college fellows has also doubled, and this will accelerate further given the volume of vocational trainees currently in training.

Similar trends are apparent in prevocational training. The number of interns has increased by 8.3 per cent since 2011, and is up 92.7 per cent from 2004. The number of post-graduate Year Two trainees has risen by 23 per cent in the past two years, although it is in this area - and in the later prevocational years - that the data becomes increasingly inaccurate and prone to methodological error.

The number of medical students reached 16,868 in 2012, more than double the number in 2000, and graduate numbers are up two fold from 1999.

The trends differ between domestic and international graduating students. The number of domestic graduates increased by 99.6 per cent between 1999 and 2011, while the number of international graduates has more than trebled over the same period, rising by 217.4 per cent, with a corresponding increase in the proportion of total graduates who are from overseas, to a peak of 19.5 per cent in 2009.

Of more relevance, the report documented the growth in medical graduates. Their number jumped by 8.5 per cent between 2010 and 2011, and by 11.9 per cent between 2011 and last year. Further strong growth is predicted this year and next, before tapering off to a more modest pace of annual growth thereafter.

Translating this into something meaningful for today's graduates is problematic, as only one side of the workforce equation is demonstrated.

The report predicts that 3556 medical students will graduate and be eligible for an internship this year.

Preliminary indications are that there will be a shortfall of between 200 and 300 places, with only 3201 internships to be delivered by the states and territories in 2014. With the 2006 COAG agreement that all graduates occupying Commonwealth Supported Places (CSP) remaining in place, the exact shortfall will depend upon the number of international student graduates seeking an internship in Australia rather than continuing their careers offshore.

As yet there is no indication of the magnitude of the shortfall in other prevocational or vocational training positions, although there are preliminary suggestions that vocational training programs are experiencing unprecedented application numbers this year.

So is this a catastrophe? Has the AMA and AMSA catastrophised the intern crisis or training crisis?

Critics would argue yes, and point out that last year only 22 of the federally supported intern posts were taken up, ignoring more plausible explanations including the lateness of the offers, the return of service obligation and the novel settings in which they were offered.

Instead, should it be argued that the states and territories are guilty of catastrophication?

Discussions surrounding the numbers of graduating medical students - and the likely quantum of intern posts - are shrouded in secrecy.

It is disappointing that State and Territory health departments remain so busy guarding the budgetary bottom line that they remain blind to the opportunities that this glut of junior doctors brings - blind to the opportunity to provide an Australian trained medical workforce for their communities; blind to the opportunity to stop the 'brain drain' from low income nations.

Rather, State and Territory health departments catastrophise.

How terrible it is that, now we are educating the numbers of doctors that the community requires, this dilemma is universally portrayed as a catastrophe rather than the fantastic opportunity it truly represents.

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

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Is this the transparency we need?

BY **DR STEVE HAMBLETON**

One of the key policies developed by the Economics and Workforce Committee in the lead-up to national health reform was the need for transparency in health system performance and public hospital funding.

On 20 June 2013 the National Health Performance Authority (NHPA) released its report: *Healthy Communities: Australians' experience with access to health care in 2011-12.*

This report specifically focuses on the health status of populations living in Medicare Local catchments, and the relationship between the health status, service use and experiences with care across those populations in the context of GP, dental and specialist services, waiting times, and cost barriers.

It uses the percentage of adults who self-reported having a long-term health condition (in the Government's patient experience survey for 2011-12) as a measure of health status. While this may be useful data, it is not the same as a standardized, objective measure of health status.

Despite the sophisticated analysis and reporting by peer groups of Medicare Locals, the report doesn't tell us very much about the relationship between 'health status' and use of services.

However, the survey data showed that, in 2011-12, patients were generally fairly happy with their doctors, whether GP or specialist, in terms of usage of health care services and waiting time for services.

They also showed that reported cost barriers were highest for seeing a dental professional (ranging from 11 to 34 per cent), with barriers for getting a script filled, or for seeing a GP or a specialist, being two to three times less (for example, patients who reported waiting time to see a GP as a barrier to treatment ranged from 1 to 13 per cent).

The report doesn't tell us about the achievements of Medicare Locals.

Not only do the data it reports pre-date many Medicare Locals, but also, as NHPA states, its findings "do not reflect on the performance of Medicare locals as organizations".

NHPA states it will publish future reports on the comparable performance of health care organisations to stimulate improvements in the health system, increase transparency and accountability and inform consumers.

Medicare Locals do not have a monopoly on these issues. Nor does this report assist with their accountability for performance against these issues.

Clearly, there is a place for this sort of detailed analysis and reporting of performance.

But does it tell us how well the system is performing, what Medicare Locals have achieved or plan to achieve, and whether national health reform has delivered a better health system?

Is this the sort of transparency we need?

Since December last year, NHPA has released three Healthy Community updates and two hospital performance reports. In addition, there is steady stream of health and hospital statistical reports from the Australian Institute of Health and Welfare, hospital pricing reports, frameworks and work programs from the Independent Hospital Pricing Authority, and performance reports from the COAG Reform Council. These reports are recycling the same data.

For all this reporting, we appear to be none the wiser about:

- the actual funding provided to hospitals (even under Activity Based Funding, only the Commonwealth's share of hospital funding must be reported); or
- the service plans of all 136 local hospital networks (there is no central repository for these, with only some available on individual LHN websites); or
- the local needs analyses made by Medicare Locals.

The information we now have, courtesy of the National Health Reform Agreement, covers many aspects of performance, some in great detail.

What it doesn't tell us is whether the system as a whole is performing, how well it is or isn't performing, and the performance benchmarks that we can hold organisations clearly accountable against.

It's time to focus on clearly defined measures of system capacity, quantity and timeliness of service delivery, and the efficiency and quality of patient care.

We seem to be measuring many aspects of the system in more and more sophisticated ways, but missing out on the big picture: have we got sufficient capacity across our primary and acute sectors to deliver the care we need now and into the future?

The Committee will review the usefulness of these performance reports and analyse the degree to which they indicate progress or otherwise in our 'post health reform' system.

AMA Vice President Professor Geoffrey Dobb contributed to this column

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A year of achievement in public, child and youth health

BY **PROFESSOR GEOFFREY DOBB**

As I kick off another year as Chair of the Public Health and Child & Youth Health Committee, I thought it might be worthwhile reminding readers of this column about some of the important public health activities the AMA has been engaged in over the last 12 months.

Alcohol marketing has been a prominent issue for the AMA and the broader community. Last year the PHCYH Committee oversaw the development of the major research monograph, *Alcohol Marketing and Young People – Time for a new policy agenda*.

The publication was launched during the National Summit on Alcohol Marketing to Young People, which was held at Parliament House and attended by a range of parliamentarians and representatives from more than 20 health organisations and NGOs. A joint communiqué was issued following the Summit, calling for a parliamentary inquiry into the issue.

The AMA followed up the summit by organising a presentation by UK alcohol policy expert Professor Sir Ian Gilmore. In his very informative presentation, held at Parliament House, Sir Ian gave an analysis of alcohol policy reforms in the UK, and what lessons could be drawn from this for Australia.

To help minimise the harm caused by drinking, AMA called for alcohol pricing reform in its submission for the 2013-14 Federal Budget.

The AMA has also been engaged as a key member of the Front of Pack Food Labelling Project Committee, which has been Chaired by the Secretary of the Department of Health Jane Halton.

The star-based rating approach developed by the Committee ranks foods according to their fat, salt and sugar content, and was adopted by the nation's health ministers at a meeting last month.

This was a gratifying achievement for the AMA, which has long advocated the need to improve food labelling in order to help consumers understand more about their food choices (including likely effects on body weight).

> "All going well, this new voluntary food labelling approach will be rolled out next year"

All going well, this new voluntary food labelling approach will be rolled out next year. In addition, the PHCYH Committee sponsored submissions on revised dietary guidelines and clinical guidelines for the management of overweight and obesity.

The AMA has increased its advocacy around prisoner health.

Last year, the Committee oversaw the revision of the AMA's Position Statement on Health and the Criminal Justice System.

In August, I launched the Position Statement at the Public Health Association of Australia's Justice Health Symposium, where it was well received. The new statement incorporates a focus on the importance of appropriate 'through care'.

Building on a successful policy session on climate change at the 2012 AMA National Conference, the AMA has worked to increase awareness of the health effects of climate change.

A detailed submission was provided to the Senate Committee inquiring into recent trends regarding extreme weather events, and the nation's preparedness for them.

In the submission, the AMA called for a national strategy to ensure that health services could be rapidly mobilised during such events. The AMA also made a submission to a Senate inquiry into the implications of air quality for health.

In the submission, the AMA argued that policy and regulatory responses to clean air issues must be strengthened.

Another environmental issue with serious health implications is the development of coal seam gas mining. As outlined in my previous column, it is an issue the AMA will continue to monitor.

Given the topical nature of some of these issues, Committee meetings often involve robust discussions about how the AMA should advance its position.

Committee members have been lucky enough to hear from a number of excellent guest speakers to help inform their deliberations, including Louise Sylvan, Chief Executive Officer of the Australian National Health Prevention Agency; Andrew Cummings, Executive Director of the Australian Youth Affairs Coalition; Jules Kim, Deputy Chief Executive Officer of the Scarlet Alliance; Professor Helen Keleher, a recognised expert in women's health; and Professor Michael Levy, Director of Justice Health in the ACT.

With the upcoming Federal Election, 2013 is shaping up to be an equally productive year for both the AMA and members of the AMA's Public Health and Child & Youth Health Committee.

I look forward to informing members on the ongoing productive work of this Committee.

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Towards the federal election

BY **PROFESSOR STEPHEN LEEDER & ASSOCIATE PROFESSOR JIM GILLESPIE**

It seems unlikely that in the run-up to forthcoming federal election that health policy, or indeed any policy, will receive much attention.

The lines are drawn, the battle declared and the weapons – innuendo, insult, and necktie colour – are basic and bloody. We deserve better, and nowhere is the need more pressing than in relation to health care.

When Labour came to power, a vigorous and extensive reform program was put in place, the elements of which included a massive injection of capital from the Federal Government through the National Health and Hospitals Reform Commission, the development of an extensive preventive agenda, the formation of Medicare Locals (organisations that bring general practice and other community services into new conjunction), and the establishment of regional hospital networks with governing boards. State governments, especially, NSW, have responded to the federal stimulus, matching it and undertaking one of the largest reforms and reorganisations for decades.

That all of these changes have proceeded smoothly, although not without serious cost and disruption, is strong evidence of the commitment of those involved in health service provision to strive for better things.

Research has been reassessed and strengthened in NSW and federally. Implementation has not been uniform, but where the reforms have worked well, budgetary control has been achieved, clinicians have been refranchised in the chain of decisions, patients and carers have been brought closer to the services, and quality - as far as we can judge (not far) - has improved.

New lines of communication, often based on information technology, are opening in many places between hospitals and the community-based practitioners in the Medicare Locals, especially in the coordinated care of those many people who have complex illnesses that continue over years.

So much for the good news.

There seems to be complacency within the Government that they have achieved their goals, and reluctance from the Opposition to stir any attention in a policy space which has not been kind to them in the past.

In the remaining weeks before the federal election there are three major health policy challenges that it would be wonderful to hear addressed by those who now seek our vote. All are within our grasp to manage.

Firstly, the costs of health care rise each year at a rate in excess of economic growth. As a country with an explicit commitment to provide all necessary care to all who need it, without financial impediment, this requires either a shift in public policy to move these costs back to a patient's hip pocket, or a debate about how these costs could be limited.

Our experience of fiscal restraint in health care has not been encouraging. A slow squeeze, through 'efficiency dividends', cuts in payments to the states or freezes in Medicare rebates - especially in general practice - have provided the easiest options: short term budgetary gains where the consequences take time to appear and blame can be shifted to others.

Either way, the erosion of Medicare's universality that is exemplified in prohibitive co-payments for specialist services in the community, or the inaccessibility of outpatient services in many hospitals, should be addressed.

We either say that Medicare is over, or we fund it adequately and describe its purpose with fresh clarity. Policy shift by stealth hardly befits a democracy. There is a debate with several elements to be had about how we control the costs and pay for health care.

Secondly, it would be good to hear from the political contestants (or, more likely, it would be good if the winner considered in the next term) how we should manage the growing demand of people with chronic problems who require combined care from many services, private and public. Improved models of funding and care are unlikely to result in budgetary savings – the need is too large and growing. However, it would prepare the system to manage it largest future challenge.

Thirdly, there surely should be a national approach to building in our nation a capacity for intelligent conversation in the community about health and health care. True, shroud-waving clinicians moaning on TV about a pet under funded service set the cause back. They should know better. But unless the community is led (note the word) into an understanding of health and health care, we disenfranchise a major voice, which instead chatters on about waiting lists and hospital bed numbers. We can do better than this. But a story needs to be constructed and told about health care by our leaders.

Were these matters taken seriously, we would have a policy debate worthy of the name, and worthy of the basically sound health service (warts and all) that Australia has built in the past century.

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Research

Infant formulas linked to eczema reduction

Hypoallergenic infant formulas may help lower the long-term risk of allergies in children who are genetically vulnerable to them, a new study suggests.

The products, known as hydrolysed infant formulas, are designed to lower the probability of the allergic responses some infants have to standard formula.

Hydrolysed infant formulae contain cow milk proteins, but they are broken down to be less allergenic than the whole proteins found in regular formula.

Studies have shown that, compared with regular formulae, hydrolysed formulae appear to lower the risk of eczema and dermatitis in infancy and early childhood, though breast milk is still considered the best nutrition for infants, and has been shown to lower the risk of allergies.

In 2008, research using the German Infant Nutritional Intervention (GINI) study, funded by the German Government, found that if hydrolysed infant formula was received in the first four months of life it had a long-lasting preventative effect on atopic eczema in high-risk children. The research tracked more than 2200 children until the age of six.

Children are considered high-risk if they have a parent or sibling with a history of allergic disease. It is estimated that 50 per cent of Australian infants are considered high risk.

Researchers have since expanded the scope of study to track the same children as in the original study, but this time through to the age of 10.

They found that hydrolysed infant formula continues to have a preventive effect on the cumulative incidence of allergic disease, without rebound.

At birth, children were randomly assigned to receive one of four blinded formulae as a breast milk substitute for the first four months. The four formulas were: partially hydrolysed whey formula, extensively hydrolysed whey formula, extensively hydrolysed casein formula or standard cow's milk formula.

The research found that partially hydrolysed whey formula and extensively hydrolysed casein formula had a significant effect in reducing the likelihood of developing atopic eczema and dermatitis, up to 29 per cent, compared with high risk children consuming cow milk formula.

Extensively hydrolysed whey formula showed no significant risk reduction. There was no preventative effect on asthma or allergic rhinitis.

The research concluded, "[our] results support the present recommendation to use certain cow's milk protein hydrolysate infant formulas in high-risk infants to reduce the risk of atopic eczema, but not for respiratory allergies".

The research was published in the June edition of *Journal of Allergy and Clinical Immunology*.

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Iodine in bread not enough

Iodised salt used in bread is not enough to provide healthy levels of iodine for pregnant women and their unborn children, according to new research.

The University of Adelaide study followed almost 200 South Australian women throughout their pregnancy and six months after giving birth.

In 2009, Australian bread producers added iodine to bread in order to help provide a boost to iodine levels in Australia.

Lead author, Associate Professor Vicki Clifton, said that despite the inclusion of iodised salt in bread, women who were not taking an iodine supplement during pregnancy were still suffering from iodine deficiency.

"Those women who were taking a supplement in addition to eating bread with iodised salt were receiving healthy levels of iodine, well within World Health Organisation guidelines," Associate Professor Clifton said.

"Iodine is an essential element which is important for human brain development and thyroid function."

The research was published in *Nutrition Journal*.

KW

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Research

Ethnicity a predictor of obesity in children

New research has found that children who speak English as a second language and are from Middle Eastern or Asian families, are more likely to be overweight or obese and have lower levels of physical fitness.

A University of Sydney study of NSW primary school children found ethnicity was a significant predictor of obesity, physical activity and cardiovascular fitness.

Researchers analysed data from about 5000 primary school children and found about 35 percent of Middle Eastern and 28 per cent of Asian children were overweight or obese, compared with 22 per cent of children from English-speaking backgrounds.

The research found Middle Eastern boys from low socio-economic backgrounds were twice as likely to be obese as English-speaking boys, and three times as likely to have low cardiorespiratory fitness. Similar results were observed for Middle Eastern girls and Asian boys but, interestingly, not Asian girls.

The study suggested several behaviours, such as skipping breakfast, drinking too much soft drink, being rewarded with sweets, and regularly eating energy dense, nutrient poor foods were contributing to the increased risk of developing weight problems.

Lead author Dr Debra Hector said the research indicated governments should consider public health campaigns specifically targeted at Middle Eastern and Asian families.

"Our results indicate the need for obesity prevention initiatives to target children and their families from Middle Eastern and Asian backgrounds who live in low socio-economic areas," Dr Hector said

"They need to reach, and be culturally appropriate for, children who are most at risk."

The research was published in the *Journal of Paediatrics and Child Health*.

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Australian clinicians leading iron deficiency research

People with iron deficiency are at increased risk of chronic illness, heart failure, poor foetal development and reduced cognitive function and depression, a pioneering clinical study involving Australian researchers shows.

Research centres in Adelaide and Hobart are part of a world-first international clinical study looking at the treatment of iron deficiency and iron deficiency anaemia in pregnancy.

Lead researcher Dr Bernard Froessler from the University of Adelaide said that iron deficiency has become increasingly common among pregnant women in recent years.

"There is plenty of evidence showing iron deficiency and iron deficiency anaemia has a very negative impact on a woman and her developing foetus, with a higher risk of mothers needing a blood transfusion during birth, premature birth, babies born smaller and often underdeveloped, as well as [implications for] the future development of the child," Dr Froessler said.

"We are hoping that by treating iron deficiency in the mother, we can benefit both her and the child."

Professor Andrew Sindone and his team from Concord Hospital are investigating the link between iron deficiency and heart failure as part of the Effect of Ferric Carboxymaltose on Exercise Capacity in Patients With Iron Deficiency and Chronic Heart Failure (EFFECT-HF) study.

Professor Sindone said the relationship between iron deficiency and heart failure was significant.

"We don't understand whether iron deficiency is a marker of heart failure patients or causing the problem, but we have found it increases patient mortality rates and decreases their quality of life," Professor Sindone said.

Up to one in four Australian women and one in six Australian men are iron deficient, according to Associate Professor Al Khalafallah from Launceston Hospital. He said iron deficiency and iron anaemia were widespread and underdiagnosed in Australia.

"This condition is costing Australians and our economy millions of dollars each year, including in lost productivity, decreased educational performance, prolonged stays in hospital after surgery, increased morbidity and potential mortality," Associate Professor Khalafallah said.

"We know that correcting iron deficiency alone can be very beneficial and, with new treatments available, particularly intravenous iron, this is having a huge effect on how iron deficiency is being treated in chronically ill patients, for elective surgery and in pregnancy."

KW

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JULY 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	2	3	4	5	6
7 ASK Y (Against the Silent Killer of the Young) - Worldwide	8	9	10	11	12	13
14 MDS (Myelodysplastic Syndrome) Day – Nationwide National Diabetes Week Wee Week 2013	15	16	17	18	19	20
21	22 Fragile X Awareness Day National Pain Week	23	24	25	26 Stress Down Day Nationwide	27
28 World Hepatitis Day	29	30 Cerebral Palsy Awareness Week				

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

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WHO ramps up HIV action

The number of people eligible for HIV therapies has dramatically expanded following the release of updated treatment guidelines by the World Health Organisation.

In a move hailed by medical organisations as a major advance in tackling the disease and preventing its spread, the WHO has brought forwarded the recommended window to begin anti-retroviral therapy, upgraded protocols to prevent transmission between mother and child, and urged more frequent monitoring of those undergoing treatment.

Despite medical advances, HIV/AIDS remains a major global scourge, claiming hundreds of thousands of lives every year.

In its recent snapshot of world health, the WHO reported around 34 million people are currently living with HIV – 70 per cent of them in sub-Saharan Africa – and there were 2.5 million new cases in 2011.

But, while the problem remains huge, there is mounting evidence that progress is being made in treating the disease.

In 2011, 1.7 million died from the condition – almost 25 per cent less than in 2005 – and the number of people with access to antiretroviral therapy is growing, reaching eight million people in low and middle income countries.

Medical humanitarian organisation Medicins Sans Frontieres said the revised WHO guidelines would help ensure people with HIV got the treatment they needed earlier than ever before, and improve management of the condition.

"Early HIV treatment makes a major difference – it keeps people healthier and also helps prevent the virus from spreading," MSF President Dr Unni Karunakara said.

The humanitarian organisation said the move to viral load monitoring of those on anti-retrovirals was just as significant.

"There's no greater motivating factor for people to stick to their HIV treatment than knowing the virus is undetectable in the blood," said MSF's Medical Coordinator in South Africa Dr Gilles van Cutsem. "Viral load testing is the optimal way of maintaining people on first-line treatment, and knowing when to switch them to second-line drugs, so it's high time it's made available in countries with a heavy burden of the disease."

Dr Karunakara said the WHO's new guidelines, released on 30 June, were ambitious but feasible, and he urged strong international support to see that they were followed.

"In places like the Central African Republic, the Democratic Republic of Congo, Guinea and Myanmar, it's like the clock stopped over 10 years ago," Dr van Cutsem said, "with shamefully high numbers of people dying because they cannot obtain treatment."

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Rich country health spending stalls

The world's richest countries have continued to put a clamp on health spending as government struggle with mountainous debts tied to the global financial crisis.

Public and preventive health programs and out-patient services have borne the brunt of government austerity measures as spending on health stagnated in 2011 for a second consecutive year, an analysis by the Organisation for Economic Cooperation and Development has shown.

In an unprecedented development in the post-war era, government funding for health stalled in 2010, and OECD researchers David Morgan and Roberto Astolfi said evidence indicated that it continued to flat-line the following year.

"Since the onset of the economic crisis in 2008, health spending has stalled in many OECD countries after many years of continuous growth.

"For the first time since records began in 1960, health spending growth in real terms was, on average, zero in the OECD area…and preliminary estimates for 2011 for a limited number of countries suggest that the slowdown continued," the researchers said.

Government austerity will have had a particularly pronounced effect on the health sector, given that public funding accounts for, on average, 75 per cent of total spending on health across the OECD.

The researchers found that although cuts to government health spending had been across the board, some key areas were hit particularly hard.

Public and preventive health programs were hit with the greatest average cuts in funding, but budget cuts to out-patients services have made the biggest overall contribution to reducing health spending.

...CONTINUED ON PAGE 35

Obesity elevated to disease status

Obesity has been formally recognised as a disease by the American Medical Association in a move seen to have significant implications for the way the condition is treated.

As the waistlines of developed country populations continue to swell, the AMA moved on 18 June to stop framing obesity as a public health issue and instead treat it as a disease.

Health experts hailed the decision as an important step in helping tackle obesity and the health risk associated with being overwight.

"The American Medical Association's recognition that obesity is a disease carries a lot of clout," Dr Samuel Klein, director of the Center for Human Nutrition at Washington University School of Medicine in St. Louis, told *USA Today*. "The most important aspect of the AMA decision is that the AMA is a respected representative of American medicine. Their opinion can influence policy makers who are in a position to do more to support interventions and research to prevent and treat obesity."

According to some estimates, more than 40 per cent of American adults will be obese by 2030.

AMA Board member Dr Patrice Harris, said that "recognising obesity as a disease will help change the way the medical community tackles this complex issue that affects approximately one in three Americans."

The move to recognise obesity as a disease was accompanied by policies to ban the marketing of high stimulant and caffeine-rich drinks to adolescents, and to recognise the risks of prolonged sitting.

On the same day, the Association elected an internal medicine and infectious diseases specialist as its head.

Kentucky-based Dr Ardis Dee Hoven was installed as AMA President after being part of the Association's leadership group for the past eight years.

Dr Hoven, who has worked at the University of Kentucky's Bluegrass Care Clinic treating infectious diseases such as HIV/AIDS, is assuming the position at a difficult time for the American medical profession as it tries to navigate the implementation of Obamacare and changes brought about by steep cuts to Federal Government spending.

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Rich country health spending stalls

...CONTINUED FROM PAGE 34

According to the OECD study, most of the cutbacks have been achieved through a combination of holding back spending, reducing patient entitlements, rationing health services and tightening controls on wages, pharmaceutical prices and administrative costs.

While such measures may be effective in the short-term in helping contain health budgets and reduce the financial liabilities of heavily indebted governments, there are concerns that they may come at the expense of poorer population health and higher medical costs in the longer-term.

It can be hard to gauge the immediate effectiveness of public health campaigns, screening programs and vaccination campaigns, but the contribution they make to improved population health is considered to make a significant contribution to holding back future health spending.

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Europeans told: breathing, drinking a health hazard

The life expectancy of Europeans is being cut short by almost a year because of air pollution, while water contamination may be driving down sperm counts and impairing brain development, a comprehensive report on the region's environment has found.

The European Environment Agency and the European Commission's in-house science service, the Joint Research Centre, estimate that air pollution in Europe has become so bad that it is reducing average life expectancy by eight and a half months.

In a study released in late May, the agencies reported that up to 95 per cent of those living in European cities were exposed to levels of fine particulate matter in excess of World Health Organisation guidelines.

They found that air pollution in the region was contributing to cancer, heart disease, bronchitis and asthma – and these effects were being amplified by other environmental factors including water contamination, noise pollution and a lack of green spaces.

The agencies noted growing concern about the presence of chemicals in human water supplies – particularly possible effects on hormones.

"Global sales of products from the chemicals sector doubled between 2000 and 2009," the *Environment and human health report* said, adding that water treatment was failing to fully remove many residues of pharmaceuticals and substances that interfere with the endocrine system.

"There is growing concern about endocrine disrupting chemicals, which affect the hormone system," the study said. "Effects are not yet fully understood, but the chemicals may contribute to declining sperm count, genital malformation, impaired neural development, obesity and cancer."

The agencies warned that noise was an important source of stress and harm, affecting cognitive development, sleep and the development of cardiovascular disease.

But they were equivocal about other environmental pollutants such as electronic emissions and the presence of nanoparticles in food containers, clothes, creams, ointments and other consumer goods.

The agencies said there was "no conclusive scientific evidence" of a link between devices that emit electromagnetic fields, such as mobile phones, and cancer.

Similarly, they said little was known about the effect of nanomaterials in the human body, and there was yet to be "adequate assessment of potential risks".

The report's authors said research needed to take a more holistic approach to the accumulation of hazards to human health in the environment, rather than assessing the risk posed by each vector individually.

"People are usually exposed to multiple environmental factors throughout their lives, and more research is needed to understand the impacts," they said. "Science needs to move away from focusing on individual hazards and look instead at the complex, combined effects environmental and lifestyle factors are having on our health."

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China's wealth pays off in health

Children born in China can now expect to live longer than those born in most of eastern Europe, underlining the profound improvements in health that can accompany burgeoning prosperity.

A comprehensive World Health Organisation snapshot of global health trends has highlighted the big health gains to be made from economic development, showing that life expectancy at birth in China jumped more than 10 per cent between 1990 and 2011 to reach 76 years – outstripping the median gain among all countries of 7 per cent.

The WHO figures, published in *World Health Statistics 2013*, show enormous strides have been made in improving infant health in China in the past two decades.

Between 1990 and 2011 China's neonatal mortality rate per 1000 live births plunged from 23 to 9, the probability of a child dying in their first year plummeted from 39 to 13 per 1000 live births and the under-five mortality rate fell more than two-thirds from 49 to 15.

The results have contributed to worldwide improvement in infant survival rates – child mortality fell by an average 2.5 per cent a year between 1990 and 2011, and the number of child deaths virtually halved from 12 million to less than seven million over the same period.

But, despite the gains, the WHO has warned that the goal to cut the 1990 child mortality by two-thirds by 2015 will be missed, with millions of children continuing to die each year from easily preventable or treatable causes.

According to the WHO report, which provides key health indicator data from 194 countries, pneumonia was the biggest killer of children younger than five years in 2010, accounting for 14 per cent of all deaths, followed by complications associated with pre-term birth (around one million deaths), diarrhoea (10 per cent of deaths, malaria (7 per cent), HIV/AIDS (2 per cent) and measles (1 per cent).

The WHO figures make clear that, worldwide, malaria remains a major problem.

Almost 24 million people contracted the disease in 2011 – including more than 20 million in sub-Saharan Africa, and two million in south-east Asia.

Tuberculosis also exacts a heavy toll, infecting almost 5.8 million deaths in 2011 – mainly in south-east Asia, Africa and the western Pacific.

While such infectious diseases are relatively uncommon in high-income countries, their citizens are nonetheless caught up in the diabetes tidal wave sweeping the world – almost 10 per cent of all adults suffer from the condition, which is particularly prevalent in the eastern Mediterranean and the Americas.

When it comes to getting access to care, the WHO data suggest Australians are far better served than most.

They show that in Australia there were 38.5 doctors and almost 96 nurses and midwives for every 10,000 people, which compares favourably with the global average of just 14 physicians and 29 nurses.

Even among well-off countries, Australia appears particularly well served: the average among high-income nations is 27 doctors and 72 nurses per 10,000 people.

Less flattering are comparisons of the provision of hospital beds.

In Australia, there are 39 beds per 10,000 people, above the global average of 30 per 10,000, but well below the wealthy country average of 56 beds per 10,000.

For more details, the WHO report can be viewed at:

http://www.who.int/gho/publications/world_health_statistics/2013/en/

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Is my car haunted?

BY **DR CLIVE FRASER**

Having worked in the field of psychiatry for nearly 30 years, I'd be the first person to admit that I have met some interesting people in my time.

For the most part, I'm humbled that most of my patients are just like you and I.

They have all the strengths and frailties that make us human.

And while many people have confided some very personal details, I'm yet to meet someone who has told me that they've actually seen a ghost.

While this may simply be an aberration in my history taking, as I ask no screening questions on this topic, I am quite surprised that there have been no apparitions - particularly among those unfortunate individuals who have the severest of mental ailments.

Throughout recorded history, and in most cultures, there is a common element that sightings of - if not belief in the presence of - ghosts is almost universally described.

As a paid-up member of the Skeptics Society, I can assure you that I hold no belief in water divining or homeopathy, but I do know that millions of people around the world do believe in these things.

As a scientist, I can immediately explain this as relating to the power of the placebo.

So if millions of completely sane individuals can believe that a solution containing not even one atom of a substance may relieve them of their ailment, why can't I for a brief moment believe in ghosts?

My evidence for my car being haunted stems from the fact that, annoyingly and intermittently, my reversing sensors have started detecting something behind my vehicle.

This only began when my car was two years old.

After replacing the aforementioned sensors multiple times, the problem has persisted, with my dealership finally suggesting that my factory-fitted tow-bar was the problem.

But I'm still unable to understand how my tow-bar eluded detection for a whole two years and, according to Google, I'm the only owner on this planet with this problem.

Could it be a ghost?

Why not?

Some 'facts' about ghosts

What is the mass of a ghost?

Most ghosts are the same size as an ordinary human equivalent. The average human has a volume of 70 litres. As ghosts 'float' in the air, their mass would be 1.2 kilograms per cubic metre, which means the average ghost weighs 84 grams.

What do ghosts wear?

Clothes silly, just like the rest of us!

Why don't ghosts have feet?

A good question, which I can answer in a future motoring column if enough doctors need to know.

PS:

While not acknowledging that my car may be haunted, the manufacturer of my vehicle has now found a 'gremlin' in my gearbox, and will be replacing 30,000 units in Australia to eradicate the pesky problem.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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Cellar dwellers

BY **DR MICHAEL RYAN**

Having a cellar is a one of life's luxuries

What your cellar looks like can be as variable as the weather, from under the bed (which at least provides easy access) to custom built rooms that suggest you might be compensating for something else, like buying an old E-type Jaguar.

The reason to be particular about wine storage is that each bottle of wine is a living thing and needs its own version of homeostasis (a bit of 2nd year physiology comes flying back here).

Generally wine that is made to last will always cellar well and reward your patience with more complex characteristics.

It also allows wines bought for that special event or long-awaited anniversary to shine and highlight that treasure trove of great memories. Yes, I believe some people even buy divorce wines - although it is usually with the other party's money.

In general, reds will last longer than whites because they are infused with more natural preservatives from the tannins released from the red grape skins, as well as their higher alcohol content. White wines usually have greater acidity, which can be surprisingly effective in helping whites live on.

Temperature is the single most influential variable in cellaring wine. Anything above 22 degrees Celsius or below freezing will kill off this evolving living thing.

Most experts feel that between 13 and 14 degrees Celsius is appropriate for long, slow maturation. Heat tends to speed up reactions and can make wines mature more quickly, but go too high above 22 degrees Celsius and the wine can literally be stewed.

Another factor is temperature consistency. You don't want more than 0.5 degrees Celsius variation over a 24 hour period, as rapid heating and cooling makes the cork move like a piston, allowing in more oxygen, which speeds up the oxidation process. In a warm climate like Queensland, it is acceptable to have a cool place that is 16 degrees Celsius in winter and 22 degrees Celsius in summer, as changes in temperature are gradual.

Relative humidity is relatively important - and this isn't some bad Tasmanian joke. Corks dry out and let more oxygen in if stored below 70 per cent humidity. Some place bowls of water in their cellar to aid humidity. A lot of these issues are negated by the use of screw caps, but try selling that to a rabid Burgundian wine maker.

Excess light can imply heat, which is not desirable. But UV radiation itself contributes to spoiling.

Vibration is probably the least of your worries, but it isn't good form to toss your bottles around. The other fallacy is turning your bottles. This came from the turning of champagne bottles, and doesn't apply to still wine.

So you can buy yourself a maximum/minimum temperature hydrometer and monitor the cupboard under the stairwell, or you can turn a bit of unused space around the house into a cellar with a wine air conditioning unit.

Fridges designed for wine storage are great and look smart.

I also use my old examination couch at work, with every draw and cupboard filled with wine. I can comfortably cellar about 80 plus bottles that Mrs Plonk doesn't know about.

This month, Dr Plonk has selected the following from his shelves for a tasting:

Champagne - Fleury Organic Champagne NV

This is a Blanc de Blanc, which means 100 per cent Chardonnay. The nose has a wonderful lemon influence, with subtle yeasty, nutty characteristics. Maybe a hint of ginger spice. The palate is crisp with a finishing soft mouth feel.

White - 2010 Greystone Sand Drift Pinot Gris Waipara Valley NZ

There are pink hues in the colour, with a nose of white peach and honeyed almonds. The palate is generous, with enough acidity to balance the sweetness.

Red - 2008 Stella Bella Margaret River Shiraz

This has an intense bright purple colour, with a blackcurrant and black pepper nose. Secondary notes of olives and cedar waft in. The wine flows effortlessly, and has fine balanced tannins.

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