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Vote 1 Health

AMA puts health at centre of election agenda, pp4-5

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Getting the focus on health

BY AMA PRESIDENT DR STEVE HAMBLETON

"The AMA will do what it can to elevate health to its rightful place as a key issue at this election and at every election"

The local headlines are dominated by the PNG 'solution' for asylum seeker boats, election date speculation, opinion polls … and a baby boy born overseas.

But are these the issues that will affect the daily lives of Australian families for the next three years? I think not.

There seems to be a real disconnect between the issues promoted by our politicians to win votes and an election and the issues that research shows dominate kitchen table conversations across the nation.

In an Essential Media Research Report last month, voters indicated that the four most important issues that would influence their vote were, in order:

- management of the economy – 47 per cent;
- ensuring the quality of Australia's health system – 45 per cent;
- Australian jobs – 34 per cent; and
- ensuring a quality education for all children – 25 per cent.

These four issues have led the Essential Media research 'vote influencer' list in just about every report since the last election in 2010.

In a modern country like Australia, you would expect and hope that the Federal election would be fought on these issues.

It would be a source of great optimism if our political parties engaged in a battle of ideas and policies about the economic security, health, education, and employment of the Australian population.

These would seem to be the things that matter most for families as they go about daily life.

They want to be in meaningful and rewarding employment, have sufficient income to cover the cost of living and enjoy a comfortable lifestyle, and to be able to provide a good education and reliable health services for all family members.

Both the 2007 and 2010 Federal Elections provided strong battlegrounds on health policy.

The AMA will do what it can to elevate health to its rightful place as a key issue at this election and at every election.

Health reform must be resuscitated urgently or Australians will find it more and more difficult to get access to quality affordable health care – where and when they need it.

There are tough economic conditions nationally and internationally, but the next Government must invest the best it can in the health of the Australian people.

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

If new funding is limited, then it must go towards building on the things that work.

In the absence of plans from either side for major health reform, the AMA thinks the issues that will resonate most with voters will be public hospitals, access to and affordability of quality care from a doctor, and confidence that there will be enough medical professionals to serve the needs of the community.

We must build capacity in our public hospitals. Funding must be better targeted, patient-focused, and clinician-led. This will require unprecedented cooperation between the Federal and State governments.

The complete pipeline of medical training needs to be properly funded to ensure we have a medical workforce in sufficient numbers to meet future community need. This will involve some long-term vision and planning, not stopgap year-by-year solutions.

And planning is needed to allow primary care, led by general practice, to cope with the growing demands of chronic disease in the community.

In the current circumstances, we may not have the environment for significant new health funding, but we have an urgent need for some smarter thinking on how precious health dollars are allocated and spent. The funding must find its way to the patient.

Elections are about choices. The type of health system we want is one of those crucial choices.

TO COMMENT CLICK HERE

Health reform neglected at nation's peril

AMA President Dr Steve Hambleton has declared that far-sighted health reforms are urgently needed if the nation is to cope with the growing burden of chronic disease and a rapidly ageing population.

In a forceful statement ahead of the Federal election, Dr Hambleton urged voters to judge the major political parties on health – particularly how they proposed to address the need for long-term action to strengthen primary health care.

The AMA President told the National Press Club, in a televised speech on 17 July, that although the nation had excellent acute care services, there needed to be a "seismic shift" in the focus of health policy toward maintenance and prevention.

"Our current focus of getting people in and out of hospital fast is just not good enough," Dr Hambleton said. "It is far preferable to keep them from ever getting there with health maintenance and prevention programs. There is a bigger bang for the health buck in primary care."

Figures released earlier this month showed that heart attack survival rates have soared since the turn of the century, highlighting the effectiveness of Australia's acute care system.

"If you are going to get seriously unwell, Australia is a great place to do it. You will get world-class care," Dr Hambleton said. "Our health system is perfectly designed to get the results that it gets. The problem is, it was designed for a different set of problems [than those the country now faces]."

He said the focus needed to be on prevention and management.

"Let's not wait for the heart attack and the ambulance. Let's fix the lifestyle and prevent the heart attack instead."

In his speech, the AMA President said health was one of the central concerns of voters, and he released the AMA's *Key Health Issues for the Federal Election 2013* paper, setting out the challenges the major parties needed to address before the election.

Public health

To promote health and prevent illness, the AMA has called for measures including curbs on the marketing and sale of alcohol, energy drinks and heavily sweetened beverages to children and adolescents; tougher air quality standards; strict pollution monitoring of coal seam gas projects; and the adoption of the five-star food labelling system.

Affordability

The Federal Government has trumpeted figures showing bulk billing rates are at record high levels, but Dr Hambleton said this was "only part of the story", and warned that affordable access to health care was under pressure.

He said out-of-pocket expenses for Australian patients were the sixth highest in the developed world, accounting for 19.3 per cent of overall health spending, compared with 9.9 per cent in the United Kingdom and 11.6 per cent in the United States.

Dr Hambleton said that although discretionary purchases at chemists accounted for the biggest proportion of such spending, this could well change.

He told the National Press Club that recent Budget measures, including freezing Medicare rebates, imposing a $2000 cap on tax deductions for work-related self-education expenses, lifting the Extended Medicare Safety Net threshold, and axing tax deductions for out-of-pocket medical and health care gaps, would "wreak havoc" on affordable access to care.

"These changes shift the cost of medical services onto the chronically ill, the elderly, young families, accident and trauma victims – these are all people who need medical care," he said.

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Health reform neglected at nation's peril

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"People are spending large out-of-pocket costs, and that's not how the Medicare system was set up."

Medical training

The AMA President lamented the failure of all levels of government to adequately prepare for the swelling numbers of medical graduates.

There has been a 120 per cent increase in medical student numbers since 2000, and there are fears there will be a shortfall of more than 350 internship places for graduates this year – which will steadily increase in subsequent years - unless governments make a concerted effort to boost medical education and training.

While training opportunities for hundreds of medical graduates are under threat, Dr Hambleton said the health system retained its "unhealthy reliance" on international graduates to help plug holes in the health workforce.

The AMA President condemned the approach taken by some states, particularly Victoria and Western Australia, to give medical graduates from within the state or from overseas priority ahead of graduates from interstate when allocating internships.

"At the moment, we've got international graduates who are getting preference over Australian doctors in some states," he said. "We've actually got to stop the unhealthy reliance on international colleagues. We've got to actually train our own."

General practice

Dr Hambleton reiterated the AMA's call for the GP Super Clinics program, which he dubbed "an expensive failure", to be scrapped, and unspent funds to instead be directed to upgrade the infrastructure of existing practices.

In addition, he said, the establishment of many Medicare Locals had been handled poorly, and needed to include much better engagement with GPs.

The benefits of putting GPs at the centre of care were most apparent, the AMA President said, in the provision of services for patients with complex and chronic conditions.

Dr Hambleton said the Coordinated Veterans Care program established by the Department of Veterans Affairs, under which GPs were funded to provide comprehensive planned and coordinated care, should be a model for the provision of services more broadly.

Asylum seekers

In his speech, delivered two days before the Rudd Government announced a deal to send all boat-borne asylum seekers to Papua New Guinea for processing, Dr Hambleton put all sides of politics on notice regarding the need to improve oversight of care for detainees.

"This is a humanitarian issue," he told the National Press Club.

"Once we take responsibility for people seeking asylum in Australia, they should have access to an appropriate level of health care, whatever the detention arrangements or location in which they are placed.

"The next Government must establish a truly independent medical panel to oversee, and report regularly on, the health services that are available to asylum seekers in immigration detention facilities, both onshore and offshore."

Health reform and elections

Dr Hambleton challenged all sides of politics to broaden their horizons and develop far-sighted policies that would position the nation well to meet the challenges posed by rising chronic disease and an ageing population.

"Looking at an election cycle and saying 'I'm going to get something off the front page' is really not good enough anymore," he said. "We've got to think a decade out. It's a big challenge for politicians, but we've got to set these rules up as the AMA and as the people of Australia…to say, 'if you fit within these rules, it works now at this election and it will work for elections to come'."

Dr Hambleton said these rules were framed around the need for reforms to prepare the country to care for an older and chronically diseased population – and to minimise the incidence of the latter.

"Proposals should be moving us toward a joined-up, strengthened primary health care system built on team-based solutions," he said. "That is how the AMA will judge the competing health policies at this election – and that's how you should judge them, too."

To view the AMA's publication *Key Health Issues for the Federal Election 2013*, go to: https://ama.com.au/keyhealthissues

Adrian Rollins

TO COMMENT CLICK HERE

Cap will cost doctors $10,000 a year

Doctors face a $10,000 hit to their bank balance when the $2000 cap on tax deductions for education expenses comes into force next year.

A survey of more than 4200 AMA members has found that they spend, on average, $12,637 a year on work-related self-education expenses – far more than the median deduction of $905 cited by the Federal Government in justifying the cap.

The finding bears out the AMA's criticism that the tax change is poorly conceived and will unfairly hit the medical profession hard simply because it has relatively high continuing education costs.

The detailed and extensive survey, which required doctors to consult their taxation records in order to respond, showed that all practitioners incurred education expenses well in excess of the arbitrary $2000 cap, with some reporting expenditure more than eight times the proposed threshold.

According to the survey, Fellows spent on average $12,637 a year on self-education, vocational trainees (doctors in training) $11,369, and pre-vocational trainees $6549.

It also identified significant variation between specialities. Surgeons spent, on average, $16,578 a year on self-education, compared with $9744 for general practitioners.

AMA President Dr Steve Hambleton said the results gave the lie to Federal Government claims the cap would not affect doctors making legitimate claims for self-education expenses.

Dr Hambleton said the architects of the cap had shown a total lack of understanding of the reality of professional self-education for doctors.

He said Treasury had failed to conduct a sector-by-sector analysis of the probable affect of the tax change across the professions, and had not provided any credible justification for setting the cap at $2000.

Dr Hambleton warned that although the cap would hurt all doctors, the effect would be greatest on doctors in training, those working in remote areas, and surgeons.

"For example, one vocational trainee spent nearly $40,000 on self-education to gain essential and minimum qualifications to practise medicine, and this was purely on courses – no skiing holidays and no fancy hotels, as Treasury so wrongly asserts," he said.

In its response to Treasury's tax cap Discussion Paper, the AMA warned that doctors in training would be hit "very hard".

It said the average $11,369 they spent on self-education was almost exclusively in pursuit of basic qualifications needed to practise in their chosen specialty, and was at a time when their earnings were low.

As a result, education expenses were a very high proportion of income, and the cap would have "a perverse affect on career choice, encouraging junior doctors to practise in areas where they will get the greatest return, rather than where community need is greatest".

Adrian Rollins

TO COMMENT CLICK HERE

Treasury flunks tax cap case

"Our improved health outcomes are a result of maintaining a highly motivated, committed and trained workforce. The Government's decision attacks and erodes the very strength of the health system, its medical workforce"

Treasury's justification for the $2000 tax deduction cap for self-education expenses is poorly conceived, riddled with inequities and inconsistencies that contradict basic principles of tax system, lacks intellectual rigour, and includes little quantitative analysis, according to a damning assessment by the AMA.

The AMA has roundly condemned the proposed cap, outlined in a Discussion Paper released by Treasury for public comment, as a tax on learning developed with little grasp of its long-term implications for the quality of health care, warning it could lead to "misdiagnosis or, in the most extreme situation, death".

In a strongly worded assessment that reflects badly on the quality of Treasury policy advice, the AMA said the cap proposal was poorly conceived and riddled with inequities and inconsistencies that contradicted basic principles of the tax system, while the Discussion Paper meant to explain it lacked intellectual rigour, included little quantitative analysis, and was riddled with unsubstantiated and contradictory assertions.

More than 20,000 doctors and other professionals outraged by the tax change have signed up to the Scrap the Cap campaign, and the AMA President Dr Steve Hambleton and other officials have met with senior members of the Government and the Coalition Opposition to express the profession's strong opposition to the proposal.

In his nationally-televised speech to the National Press Club on 17 July, Dr Hambleton was forthright in his condemnation of the measure, which is due to come into effect on 1 July 2014 with Liberal Party support.

"This cap is dumb policy," he said. "It is at odds with the Government's stated commitment to education. If this measure is not scrapped, many professionals – not just doctors – will be less skilled in the future."

The unheralded cap was sprung on an unsuspecting community in April as part of a package of measures to help pay for changes to the nation's schooling system.

In making its case for the controversial measure, the Government argued it was intended to hit rorters claiming tax deductions for first-class travel and luxury hotels, and would not affect those making claims for legitimate self-education expenses.

But, in its submission, the AMA said the misconceived policy would in fact seriously undermine vital supports for continuing education across the professions, particularly medicine, badly hampering efforts to upgrade skills and keep the quality of care at world-class standard.

"The Discussion Paper makes no attempt to analyse the impact of the measure on the provision of medical services," the AMA submission said. "It makes no allowance for the fact that year-on-year improvements in health outcomes are based on a lifelong commitment to skills and knowledge improvement through compulsory and self-motivated learning experiences."

As an example of the benefits of continuing professional education, the AMA cited figures showing that the heart attack death rate has shrunk to almost a fifth of its size 40 years ago, while the perinatal death rate has halved in the last 20 years.

"Our improved health outcomes are a result of maintaining a highly motivated, committed and trained workforce. The Government's decision attacks and erodes the very strength of the health system, its medical workforce," the submission said.

No evidence

The AMA has accused Treasury of providing no evidence to justify the cap or robust reasoning to set the threshold at $2000.

According to the Discussion Paper, current tax arrangements allow some to "enjoy significant private benefits", and the median tax deduction claimed for self-education expenses was $905 in 2010-11.

But the AMA said that on both counts Treasury's reasoning was seriously flawed.

At the very beginning of the Discussion Paper, Treasury acknowledged that the tax deduction for self-education expenses was in recognition of the fact that "people with the same level of income may incur very different costs in earning that income".

But the AMA said that, by proposing a crude $2000 cap, Treasury had "completely trash[ed]" this principle.

The assertion that those claiming the tax deduction were receiving a significant private benefit was "complete nonsense", the Association said.

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Treasury flunks tax cap case

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"The cap does not prevent people claiming deductions for costs which involve a significant private benefit. It simply discriminates against any area of economic activity which has relatively high costs of continuing education," the AMA said, decrying the lack of detailed analysis by Treasury of claims currently made, and what effect the cap would have.

"It is very disappointing that a Discussion Paper produced by one of Australia's premier economic policy bodies contains so little quantitative analysis," it said. "There is no quantitative basis to support the contention that there is a significant private benefit for medical practitioners… there is no quantitative basis for analysing the different claiming patterns between professions…[and] there is no quantitative basis for selecting the cut-off at $2000.

"Given the usual Treasury approach to such issues, we can either assume that providing real data would not support the approach adopted and would give ammunition to its opponents, or that the Government doesn't have the data. The AMA suspects a bit of both."

Doctors to be hit hard

Not only does the cap appear to have been arbitrarily set, but the AMA has highlighted how inequitable it will be when it comes into operation next July.

A survey of 4200 doctors found that they spend, on average, $12,637 a year on work-related self-education expenses (for more detail, see *Cap will cost doctors $10,000 a year*, p6), but the AMA said there was no recognition of this in the arbitrary cap set by the Government.

It said the cap failed to achieve equity between those professions with high continuing education costs and those where they were lower, between specialties within a profession that face differing expenses, between employed and self-employed professionals, and between those working in the city and the country.

In all, the AMA said, the cap "smashes a fundamental principle of tax law that a deduction is allowed for the costs incurred in producing income".

"Without any justification or evidence to contradict this principle, it is junked and all individuals are able to claim only $2000, regardless of the costs incurred," the submission said.

Peak universities organisation Universities Australia warned the policy could cause a 30 per cent plunge in post graduate enrolments in the next four years, undermining the nation's competitiveness and productivity.

It said modelling showed the cap would drive an increase of up to 54 per cent in the cost of post graduate courses, deterring around 30,000 potential students from enrolling and causing a 0.4 percentage point fall in national productivity – worth around $2.8 billion.

Adrian Rollins

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

Coalition joins fight against tax cap

A senior Coalition frontbencher has called for the Federal Government's $2000 cap on tax deductions for self-education expenses to the be scrapped, undermining previous bipartisan support for the measure.

Shadow Education Minister Christopher Pyne demanded the Rudd Government dump the measure following a meeting with AMA President Dr Steve Hambleton and representative from 15 other professional groups who are members of the Scrap the Cap alliance.

"The Rudd Government needs to scrap the cap because it was a bad policy decision adversely affecting hundreds of thousands of people," Mr Pyne said. "Labor's changes mean teachers, nurses and others at the coalface in areas like health and education will struggle to afford the often necessary education courses in their profession required to maintain the accreditation and skills.

"I am calling on the Government to scrap the cap. It was their mistake and they need to outline their plan to fix it."

Mr Pyne's call is the second public indication that the Coalition is backing away from its previous position accepting the cap.

In a column in *The Australian Financial Review* two days earlier, Liberal MP Kelly O'Dwyer condemned the cap as a "regrettable attack on excellence".

But uncertainty remains about whether an Abbott Government would reverse the tax change, after a spokesman for Shadow Treasurer Joe Hockey said that – despite Mr Pyne's call – the Coalition remained committed to keeping all the savings introduced by Labor in order to shrink the budget deficit.

Nevertheless, Dr Hambleton said that, through his declaration, Mr Pyne had shown the Coalition's strong commitment to education and medical excellence.

"The AMA is pleased that Shadow Minister Pyne and the Coalition have recognised the harm that would be caused by the cap, and have now joined the growing chorus to scrap it," he said.

Dr Hambleton said the AMA and other organisations representing more than 1.6 million professionals had been lobbying the Government for months to give a public guarantee that expenses incurred in the course of genuine professional development would be exempt from the cap.

"We have been asking for a simple explanation from the Government that it did not intend to send medical education in Australia back to the Dark Ages," he said. "The new cap is a tithe on training, a levy on learning and an excise on excellence."

Adrian Rollins

TO COMMENT CLICK HERE

Scamming scammers and the dastardly scams they peddle

The AMA has become alarmed that a growing number of scammers touting directory listings and other bogus commercial arrangements are targeting medical practices.

In recent weeks *Australian Medicine* has identified several incidents in which practices have been bombarded by increasingly aggressive demands for payment amounting to several thousands of dollars for advertising and other services that they have neither sought nor received.

To help members identify and deal with scammers, legal experts at the AMA have prepared the following advice.

What is a scam?

A scam is a scheme designed to obtain money, or something else of value such as your identity or financial details, by way of some trick or fraud. Some can be minor, involving relatively small sums of money. Others can amount to major fraud with devastating consequences.

These may include:

- telemarketing scams, where scammers trick you into believing that an order has already been authorised, and all they need for confirmation is a signature;
- being billed for listings on websites that are almost always worthless. They may start with a 'complimentary' listing, then try to lure you into an advanced listing' (at inflated cost). This is one of the most common forms of scam;
- firms which offer professional services, such as accounting, and promise a 'free consultation', only to then send a bill for many hundreds of dollars, with nothing in writing to protect you from their claim;
- being billed for unwanted 'financial services', in the form of worthless, unsolicited printed material delivered to your business with a clause saying that if you don't cancel by a particular time, you have committed to purchase for a year or more; and
- internet and 'phishing' scams

This is not an exhaustive list. There are many scams out there. NSW Fair Trading has a helpful list on its website: http://www.fairtrading.nsw.gov.au/Businesses/Scams/Business_scams.html

How do scammers operate?

Scammers know when to be very friendly and charming, then turn aggressive to intimidate you into paying.

They know how to make it look like their paperwork is above board.

Frequently, if you don't pay, they will threaten legal proceedings - although in reality most won't proceed to court as they don't want to be exposed.

Often you may receive letters from a 'collection agency' (debt collector).

Also, scammers frequently lie about what has been said on the phone, to discredit or trick you or your staff.

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Scamming scammers and the dastardly scams they peddle

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"A full legal challenge can cost a lot of money – usually much more then you have paid out, so may not be cost effective"

Things to watch out for:

- people who 'cold call', making contact with you out of the blue to sell you something. This form of contact is particularly risky;
- people who try to pressure you into signing now – using lines such as 'this offer is only available today'. High pressure selling may indicate a scam;
- people who insist that someone in your practice has previously authorised a particular purchase. This is a classic scam;
- companies based overseas with no local address or agent, or an Australian businesses with no street address. This is often a sign that a business does not want to be traced;
- businesses which try to make out that you have 'won' something or have been 'chosen'; and
- people who tell you that you should sign a document, but 'it isn't binding'. If anyone wants you to sign something, it is usually intended to be binding.

How can I protect myself from scams:

- scammers usually want your signature on a piece of paper. Do not be rushed into signing anything;
- do not give your credit card or bank account details to any person unless you are absolutely sure they are legitimate;
- train your staff to recognise problems and potential scams. Scammers often target junior staff;
- make sure you have procedures regarding who can sign for purchases or any document on behalf of the practice;
- have salespeople put everything to you in writing. If they are legitimate they will have no problem setting out their proposition in an email;
- you may find it helpful to refuse cold calls, just like you can refuse junk mail. Of course, make sure you are not hanging up on patients;
- return any unsolicited goods unopened, to the sender. Note the time and date of doing so. Take a photograph of the goods;
- check a company's ABN or ACN on the ASIC website. This is not a guarantee of legitimacy, but it means a company is registered in Australia and may at least be traceable;
- check with other practices or colleagues in your area to see if they have dealt with the company in question, and what their experience has been;
- check sites such as 'Scamwatch' http://www.scamwatch.gov.au and 'Moneysmart': https://www.moneysmart.gov.au/scams/avoiding-scams which provide information on scams; and
- check terms and conditions of any agreement very carefully. Some will say that 'terms and conditions had been previously sent', when this is not the case.

What should I do if I think I have been scammed?

- Report it to the Fair Trading authority in your state or the Australian Competition and Consumer Commission (ACCC). Consumer protection agencies can put together a case where there is sufficient evidence and occasionally get a significant legal victory against a scammer;
- put a stop on any payments from your bank account or credit card;
- let others know about it, including your staff;
- mostly scams do not attract the attention of the police. It is agencies such as the ACCC and offices of Fair Trading that deal with scams. But if it is particularly serious and involves serious fraud or other criminal activity such as threats, you should report it to the police;
- cease communicating with the scammer;
- contact your local AMA; and
- you may need to seek private legal advice.

The Australian Consumer Law can protect you from certain types of unscrupulous dealings, but once you have paid up, it can be very difficult to get your money back.

A full legal challenge can cost a lot of money – usually much more then you have paid out, so may not be cost effective.

Remember, you have to remain vigilant about scams. Scammers are thinking up new and creative ways every day to get money out of you.

The AMA is not suggesting that every company that approaches a medical practice is acting unethically or unlawfully. There are many legitimate suppliers in the commercial world who act honestly and ethically.

We are, however, saying that you should take a moment to educate yourself and your staff to spot a potential scam and avoid it.

TO COMMENT CLICK HERE

Short-term Medicare savings come at hefty cost

The country will pay a heavy price for policies that have devalued Medicare rebates, forcing up patient out-of-pocket expenses and deterring an increasing number of people from seeking the treatment they need, AMA President Dr Steve Hambleton has warned.

Delivering a key message of AMA Family Doctor Week 2013, Dr Hambleton told the National Press Club on 17 July that increasing barriers to access to primary care would come at a hefty cost in ill health and expensive treatment "down the track".

In a video launched to mark Family Doctor Week (to view, go to: https://ama.com.au/video/family-doctors-your -medical-home), Dr Hambleton said Medicare rebates had not kept pace with rises in the cost of providing care, leaving doctors and their patients increasingly out-of-pocket.

In the May Budget, the Federal Government froze Medicare rebates, which were due to go up in November, until July 2014 , saving it $664 million but further devaluing the fees paid by the Government to doctors.

When Medicare was introduced in 1984-85, its rebates covered 90.3 per cent of medical fees but, even before the freeze, this had slipped to just 78.5 per cent.

Over the period, Medicare benefits had grown 676 per cent, but patient-funded gaps had soared up 1876 per cent.

Combined with other changes in the Budget, including a sharp rise in the Medicare Safety Net threshold to $2000 and the phasing out of the medical expenses tax offset, the AMA estimates this will add a massive $2.4 billion to patient gaps in the next four years.

"The Government is simply shifting costs to patients," Dr Hambleton said. "Families will have to pay more each time they visit their family doctor."

The Federal Government has trumpeted a record-high bulk billing rate of 82.5 per cent as evidence that health care remains affordable, but Dr Hambleton said this figure masked the increased cost burden being shifted onto doctors and patients.

A recent report by the National Health Performance Authority found that around 12 per cent of people avoided or delayed seeing a doctor because of cost, and about 15 per cent in some areas reported they could not afford to have prescriptions filled.

Dr Hambleton warned such affordability concerns would come at a significant future cost.

"If we prevent access, or if access is not freed up at the beginning of the process, it's going to cost a whole lot more down the track," he said. "We need to make sure people can afford to see their family doctor."

The AMA President said Australian patients faced the sixth highest out-of-pocket costs in the developed world, and the patient's share of health spending had reached close to 20 per cent – far higher than in the United Kingdom (9.9 per cent) and the United States (11.6 per cent).

He said that "proper and realistic" indexation of Medicare rebates was urgently needed.

Adrian Rollins

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INFORMATION FOR MEMBERS

Guide for Practitioners: Notifications in the National Scheme

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

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

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

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

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

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

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

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

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

Doctors kept hanging on the telephone

Doctors are being forced to waste hours every week that could be spent with patients, waiting for government bureaucrats to answer phone calls under the Federal Government's cumbersome prescription authorisation rules.

An AMA survey has found that around 17 per cent of family doctors seeking permission to prescribe certain medicines have to wait 10 or more minutes a day to get through to a Department of Human Services clerk, while 3 per cent reported having to wait half an hour or more every day.

Overall, it is estimated that the time spent by doctors on the phone waiting for authority prescription approval is equivalent to more than 25,000 consultations a month.

The system was set up to control the use of certain types of dangerous or addictive medications but, following evidence that it was overly burdensome and prescriptive, the list was trimmed from 450 to 200 items in 2007.

But the AMA said that, even in its more streamlined form, the PBS Authority system created significant extra work for doctors with no demonstrable benefit to patients, and should be scrapped.

Drugs for cancer treatment, palliative care and pain management are among more than 100 medicines on the Pharmaceutical Benefits Scheme (PBS) that require medical practitioners to obtain authority from the Department of Human Services to prescribe them.

Under the system, doctors phone the Authority Freecall service, where an administrative officer decides if they can have the necessary authority.

But the evidence shows that it has little effect on prescribing behaviour.

In 2008-09, 6.4 million calls were made to the Authority Freecall Service, of which only 2.8 per cent did not result in an authority being provided.

A Department of Health and Ageing review in 2009 showed that "'there were no substantial changes relative to historical growth trends observed in either total script volume or total PBS outlays" from moving PBS authority medicines to streamlined arrangements.

In its 2009 review of the regulatory burden on business, the Productivity Commission recommended that the system be axed, and AMA President Dr Steve Hambleton said it was time for Government to act on this advice.

"There is no justification, on clinical or economic grounds, for this red tape," Dr Hambleton said. "Time spent by family doctors waiting on a phone line is time stolen from patient care."

He said the Government could easily make a significant improvement in the productivity and efficiency of the medical workforce by axing the system.

Adrian Rollins

TO COMMENT CLICK HERE

Top specialists join AMA Federal Council

A prominent anaesthetist and a leading ophthalmologist have joined the AMA Federal Council to fill vacancies created by the elevation of Dr Liz Feeney and Dr Iain Dunlop to the Executive Council.

Immediate past President of the Australian Society of Anaesthetists Dr Andrew Mulcahy, whose practice is based in Hobart, has been elected unopposed as the Anaesthetist Craft Group nominee on the Federal Council, replacing Dr Feeney.

Dr Mulcahy has more than 20 years experience as an anaesthetist, including as a Visiting Medical Officer at Royal Hobart Hospital, and currently works at all private hospitals in Hobart. He is also a member of the Medical Board of Tasmania.

Queensland-born ophthalmologist Dr Brad Horsburgh has been in private practice in Brisbane since 1995, and has been a Visiting Ophthalmologist at the Royal Brisbane Hospital since 2001.

Dr Horsburgh was appointed to the Queensland ophthalmology training program in 1991, and went on to complete Senior Registrar training through the Western England ophthalmology training program in 1994-95.

He is the current Chairman of the Queensland branch of the Royal Australian and New Zealand College of Ophthalmologists, and was elected unopposed to fill the vacancy left by Dr Dunlop.

Adrian Rollins

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Govt told: support GPs to make a difference

The Federal Government could boost the quality of life for patients with chronic and complex conditions and save tens millions of dollars by better support for family doctors, according to the AMA.

In a major pitch for improvements in the way the nation cares for people – many of them elderly – suffering chronic and complex disease, the AMA has called on the Commonwealth to introduce arrangements that would allow GPs to spend more time with such patients and enable them to plan and coordinate care.

In his pre-election speech to the National Press Club on 17 July, AMA President Dr Steve Hambleton said there had been a dramatic increase in the number of older patients with chronic and complex conditions that GPs were being called upon to treat.

Dr Hambleton said many patients had significant co-morbidities, and general practitioners were increasingly managing people multiple conditions including hypertension, depression, diabetes, brain and heart attacks, arthritis, asthma and oesophageal disease.

He said such work had become a key part of general practice, comprising more than a third of all problems managed and, with better support from Government, GPs could make a real difference to rates of hospitalisation and the quality of life for those with chronic and complex conditions.

"Chronic disease must be well managed and coordinated to reduce its effect on patients' health and wellbeing," Dr Hambleton said. "Family doctors are highly trained general health specialists, and are in the best position to ensure patients with complex and chronic diseases get the care they need."

There is an accumulation of evidence showing GP-coordinated care can deliver significant improvements.

Coordinated care trials in Queensland in 2008, for example, demonstrated that coordinated care reduced hospital admissions by up to 25 per cent, sliced 26 per cent off inpatient costs, helped lower rates of depression among patients, and improved their quality of life. The trial demonstrated that when all Medicare, prescription and hospitalisation expenses were included, the cost of providing care could be cut by 8 per cent.

Dr Hambleton urged the Government to apply the Department of Veterans Affairs' Coordinated Veterans Care model to the broader community.

"It provides additional funding support to GPs to provide comprehensive planned and coordinated care to eligible veterans with the support of a practice or community nurse," the AMA President said. "We need a broad coordinated care program to tackle chronic and complex disease based on this model."

Adrian Rollins

TO COMMENT CLICK HERE

Politicians heap praise on family doctors, but not funds

Federal and State politicians have lauded the central role played by family doctors in ensuring Australians receive world class health care, but have held back on commitments to increase support for GPs.

Federal Health Minister Tanya Plibersek and her Victorian counterpart David Davis used the occasion of AMA Family Doctor Week 2013 to praise the service provided by the nation's general practitioners.

Ms Plibersek said GPs were the backbone of the universal health system.

"The family doctor is a great institution," the Minister said. "[They are] a trusted source of advice and care, often beyond the clinical. It is their genuine, enduring, and intimate relationship with patients that helps make their clinical impact so powerful."

Ms Plibersek said the Government was "shifting the centre of gravity" of the health system toward primary care in recognition of the vital work GPs performed in caring for their patients, including pre-empting their health needs through preventive care and managing the care of those with complex and chronic conditions.

"We need a health system that, where possible, helps keep people well and out of hospital," she said. "That's why our Government is shifting the centre of gravity in our health system towards primary care – with general practitioners at the very heart."

But Mr Davis criticised Commonwealth policies that he said hampered the work of GPs.

He threw his support behind AMA calls for increased support for GPs to prevent and treat chronic illness and for unspent funds from the $600 million GP Super Clinics program to be directed to investment in upgrades for existing medical practices.

"Supporting existing practices to improve their facilities, expand services, and provide opportunities for teaching and training helps more patients than concentrating the investment in a small number of locations," Mr Davis said. "Better access to GPs helps patients with chronic conditions avoid hospital and aged care facilities."

Adrian Rollins

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Cooperation vital to close health gap

"...there has to be a solid requirement that all governments work together in genuine partnership, and with the guidance of Indigenous health leaders and communities"

The AMA has urged the Federal, State and Territory government to put partisanship to one side and begin to work together on plans to boost Aboriginal and Torres Strait Islander health.

AMA President Dr Steve Hambleton welcomed the long-awaited launch last week of the Commonwealth's National Aboriginal and Torres Strait Islander Health Plan as an important first step in developing a coordinated approach to dramatically improve Indigenous health in the next 10 years.

The Plan, developed in partnership with Aboriginal and Torres Strait Islander people, calls for a greater focus on child health and development and the social determinants of illness and disease as part of efforts to close the gap and establish health equality by 2031.

Indigenous Health Minister Warren Snowdon said that the Government was determined, with the support of peak Indigenous groups including the National Aboriginal Community Controlled Health Organisation, to take a broader approach to Indigenous health to encompass developmental and social issues including violence and alcohol abuse as well as stamping out racism and inequality in the health system.

"In this plan we signal the need to expand our focus on children's health to broader issues in child development," Mr Snowdon said. "We have much more work to do in developing robust research and data systems. I am also resolved that we will tackle the difficult and distressing issues of violence, abuse and self harm."

Shadow Indigenous Health Minister Andrew Laming said the Plan was an essentially empty statement short on detail, and accused the Government of springing the announcement on Indigenous health groups.

"The plan…contains little detail," Dr Laming told *The Australian*. "[It] appears to be yet another exercise in political spin, lacking any substance, and fails to say how we are going to get there."

But Mr Snowdon said the plan, developed following a series of 17 consultations held with Aboriginal and Torres Strait Islander communities and the receipt of more than 140 written submissions, would provide guidance for State and Territory governments about what the Commonwealth saw as priorities, and make sure they were taken into account in future intergovernmental agreements to improve Indigenous health.

The Minister used the announcement to intensify the pressure on the states and territories yet to commit to a new five-year National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes after the first deal expired last month.

So far, only the Commonwealth and Victoria have committed to a new five-year agreement, while Western Australia has pledged funds for just one year.

Dr Hambleton said a renewed agreement was vital, not only to ensure recent improvements in Indigenous health were sustained and built upon, but also to shepherd through the changes outlined in the Federal Government's Health Plan.

The AMA President said that, now the Plan had been released, there needed to be detailed and comprehensive commitments from all those involved - governments and medical and community groups – to ensure it was implemented.

Dr Hambleton said clear and measurable targets should be developed, as well as plans for how they were to be met.

He said this needed to be underpinned by appropriate funding and strategies to ensure the necessary workforce was available.

Underlying it all, he said, there had to be a solid requirement that all governments work together in genuine partnership, and with the guidance of Indigenous health leaders and communities.

"A National Implementation Plan is not truly national unless it has all the states and territories on board in a spirit of cooperation with the Commonwealth," the AMA President said.

Adrian Rollins

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No place for GP shortage

The AMA has called for an urgent boost to general practice training if there is to be sufficient family doctors to meet future health needs.

The Association said decisive action was needed to increase the combined annual intake of the Australian GP Training program and the Prevocational General Practice Placement Program from the current level of around 1200 places to at least 1500 places by 2016 and 1700 places by 2019.

AMA President Dr Steve Hambleton warned that, without such a lift in the training effort, patients would face increasing waiting times to see their family doctor, undermining efforts to prevent illness and keep people out of hospitals.

"Family doctors are cost effective and keep the population as healthy as possible through preventive care and early interventions, reducing the burden on hospitals," Dr Hambleton said. "If you want to keep waiting times down and ensure there is a GP in every community, invest in training."

The AMA made its call following the recent release of a report by Health Workforce Australia predicting the national shortage of GPs will surge to 614 positions by 2018 unless there was a lift in training.

Highlighting the country's dependence on doctors from overseas to help plug workforce gaps, the HWA report showed that if the intake of GPs from offshore was cut, the shortage would blow out to more than 2000 places in the next five years.

The most recent Medical Workforce 2011 report released by the Australian Institute of Health and Welfare (AIHW) showed a decline in the supply of GPs despite recent increases to GP vocational training, whereas other specialty areas demonstrated overall growth. Further, the report confirms the maldistribution of the Australian general practice workforce with an ongoing shortage of GPs in outer metropolitan, rural and remote Australia.

HWA said demand for GPs was likely to grow at 3.2 per cent a year, and said the uneven distribution of family doctors around the country was "a significant concern".

"Of all the specialty workforces, general practice is the most integral in providing primary care to the community," it said. "The GP workforce needs to be closely aligned to where people live."

It found that, whereas major cities had 124 GPs for every 100,000 people, in outer regional areas this ratio dropped to 99 GPs per 100,000, and 106 per 100,000 in inner regional areas.

In a joint statement earlier this year, GP representative groups including the AMA noted that medical undergraduate training places were originally increased to redress the rural and outer metropolitan community's access to general practice services.

"However, United General Practice Australia believes decisive action by the Government is needed to increase GP training numbers, to ensure that Australia attains a balance between the general practice and specialist workforces," the statement said.

Dr Hambleton said any lift in the training intake needed to be supported by improved support for practitioners who provide instruction and supervision.

He said the Practice Incentive Payment for teaching medical students should be raised to $200 for each teaching session, to better reflect the costs incurred by GPs in providing instruction.

"Family doctors need access to infrastructure, teaching tools and resources, and need to be supported to improve their teaching skills," he said. "Supporting our current GPs to teach the next generation of family doctors is vital to meet future community health needs."

Adrian Rollins

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INFORMATION FOR MEMBERS

PBAC nominations invited

AMA members are invited to nominate to a specialist position on the Pharmaceutical Benefits Advisory Committee (PBAC).

This is a challenging and stimulating position that provides the opportunity to contribute directly to pharmaceutical benefits policy in Australia.

PBAC is an independent expert committee that advises the Minister for Health on medicines in relation to the Pharmaceutical Benefits Scheme. PBAC is required to consider the clinical effectiveness, safety and cost effectiveness of a medication compared with existing therapies. Members must be able to interpret the comparative outcomes of therapy involving a drug and appraise evidence.

The AMA has been asked to nominate a range of potential candidates, particularly those with expertise in epidemiology. The AMA's Federal Executive Council will assess nominations prior to forwarding them to the Minister for potential appointment.

PBAC meets for three, three/four-day meetings a year and may hold up to three additional one-day meetings. PBAC members currently receive an annual salary of $36,750 and all travel costs are reimbursed. Appointments are for four years.

Further information about PBAC can be found on the DoHA website at www.health.gov.au.

To nominate, please forward a curriculum vitae no longer than 2 pages (Click here [https://ama.com.au/system/files/sample_cv.pdf] for an example) to cmoylan@ama.com.au **by Tuesday, 20 August 2013**. If you have any questions, please contact Georgia Morris on 02 6270 5466.

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

Changes put glaucoma patients at risk, *Sydney Morning Herald*, 13 July 2013

The AMA said people with common eye diseases risk devastating consequences if doctors lose control of treatment and diagnosis.

Health panel for detention centres:AMA, *Ninemsn News*, 17uly 2013

AMA President Dr Steve Hambleton said the health of asylum seekers was a humanitarian issue and should not be caught up in politics.

GP visit a $100 headache, *Adelaide Advertiser*, 17 July 2013

The cost of a visit to the doctor and a prescription medicine is now $100 as the value of Medicare rebate erodes. AMA President Dr Steve Hambleton said inadequate MBS indexation and the freeze on MBS indexation means the Government is shifting costs to patients.

AMA lashes government over refugees, *The Australian Financial Review*, 18 July 2013

In a speech at the National Press Club, AMA President Dr Steve Hambleton criticised the government's inability to oversee the health of asylum seekers kept offshore and called for an independent medical panel to report on health services available in immigration detention centres.

Health push looks to prevention, *The Australian*, 18 July 2013

The Government will be encouraging Australians to commit to a regular GP or medical clinic in a plan to move away from public hospitals. AMA President Dr Steve Hambleton said the parties' health policies should be judged on whether they are a genuine health reform or politically opportunistic short-term changes.

Call to put phone down on script authority line, *6 Minutes*, 19 July 2013

The AMA has renewed its call to dump PBS authority scripts. AMA President Dr Steve Hambleton said waiting for a Department of Human Services bureaucrat to answer the phone was just a waste of time for what ended up being unnecessary red tape.

Seniors facing stop sign, *Sunday Herald Sun*, 21 July 2013

Victoria is the only state without compulsory restrictions for older drivers. AMA President Dr Steve Hambleton said the biggest concerns were with elderly drivers whose vision was impaired and who lacked the strength and coordination to control their vehicles.

Radio

Dr Steve Hambleton, 666 ABC Canberra, 15 July 2013

AMA President Dr Steve Hambleton discussed a scam targeting health services around the country and said he wants to alert his members so they can avoid false charges.

Dr John Davis – AMA, 936 ABC Hobart, 16 July 2013

AMA Tasmania President Dr John Davis discussed the Australian Medical Association's Family Doctor Week.

AMA, 2SM Sydney, 17 July 2013

The AMA has called on the Government to properly index the Medicare rebate to reflect the true cost of medical care.

Dr Steve Hambleton, 5AA Adelaide, 17 July 2013

AMA President Dr Steve Hambleton said the Medicare rebate has not been indexed to the rising cost of living and wages so more costs are being shifted on to patients.

AMA, 2SM Sydney, 17 July 2013

The AMA has called on the Government to properly index the Medicare rebate to reflect the true cost of medical care.

Dr Steve Hambleton, Triple J, 17 July 2013

AMA President Dr Steve Hambleton commented on reports that students are using the drug Modafinil around exam time. Dr Hambleton said there are side-effects from using the medication.

Dr Steve Hambleton, ABC NewsRadio, 17 July 2013

Dr Hambleton discussed the health of asylum seekers.

Dr Steve Hambleton, 2CC, 18 July 2013

AMA President Dr Steve Hambleton discussed his address to the National Press Club. In reference to asylum seekers, he said when Australia takes responsibility for any group of people it is important to provide them with adequate care.

...CONTINUED ON PAGE 20

AMA in action

AMA President Dr Steve Hambleton delivered a major speech to the National Press Club on 17 July in which he put health at the centre of the agenda for the forthcoming Federal election. The speech was broadcast live by ABC television, and was attended by journalist from national media outlets as well as representatives from key national lobby groups. In his address, Dr Hambleton called for national attention on preventive health care, medical service affordability, the damaging affects of the $2000 cap on tax deductions for self-education expenses, continuing improvements in Aboriginal and Torres Straight Islander health, tighter controls on alcohol marketing and the sale of energy drinks, greater support for doctors providing care for chronic conditions, investment in GP practice infrastructure, direct clinician involvement in the design and implementation of electronic health records, scrapping the PBS authority prescriptions system and independent medical oversight of asylum seeker health care. Dr Hambleton used his speech to launched the AMA's Key Health Issues For the Federal Election 2013 publication, which sets out the top health issues that the AMA wants to see addressed by all political parties in the lead-up to the Federal election, and beyond. The publication can be viewed at: https://ama.com.au/keyhealthissues. Following his address, which was chaired by National Press Club President Laurie Wilson, Dr Hambleton fielded questions from leading health journalists. AMA Victoria President Dr Stephen Parnis, AMA NSW President Dr Brian Owler, AMA Treasurer Dr Elizabeth Feeney, AMA past president Dr Mukesh Haikerwal, and AMA Council of GP Chair Dr Brian Morton were among those who attended Dr Hambleton's address. Dr Hambleton represented the AMA at a meeting with Shadow Education Minister Christopher Pyne in Adelaide on 25 July to discuss the $2000 tax cap on self-education expenses. The meeting, which was also attended by several delegates from the #Scrap the Cap alliance, was told the Coalition supported the call for the cap to be axed.

TO COMMENT CLICK HERE

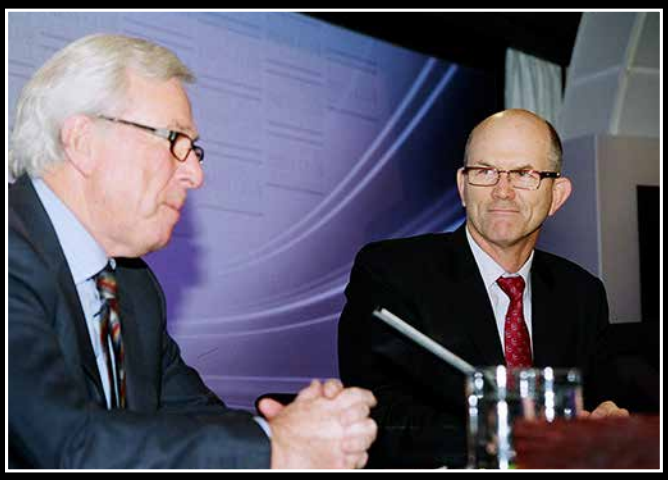
Dr Hambleton's address at the National Press Club

Dr Hambleton answering questions at the National Press Club

AMA President Dr Steve Hambleton (r), with Shadow Education Minister Christopher Pyne and AMA SA President Dr Patricia Montanaro following the Scrap the Cap meeting in Adelaide on 25 July

AMA President Dr Steve Hambleton presents Shadow Education Minister Cristopher Pyne with the AMA's 'Vote 1 Health' cap

Dr Hambleton with Dr Stephen Parnis and AMA Treasurer Dr Elizabeth Feeney



Laurie Wilson with Dr Steve Hambleton at the National Press Club

Regulation comes at higher cost

Medical practitioners have been hit with a hike in registration fees, and Queensland doctors may come off the worst.

The Medical Board of Australia (MBA) has lifted its registration fee for the period 1 October 2013 to 30 September 2014 to $695 – a rise roughly in line with the annual 2.5 per cent increase in the consumer price index.

Board Chair Dr Joanna Flynn said that limiting the increase to the rate of the CPI demonstrated the regulator's commitment to prudent financial management.

"The Medical Board has set the fee at a level that enables it to meet its regulatory responsibilities…while striving to be the effective and efficient regulator everyone has a right to expect," Dr Flynn said.

The fee hike came as Dr Flynn reported an increase in the number of complaints being dealt with by the Board.

While the MBA is yet to divulge details of the rise in complaints, Dr Flynn said handling them was a significant cost for the regulator.

"The number and complexity of these cases is never going to be entirely predictable," she said. "Managing notifications is a major cost for the National Board, and we will continue to keep fee levels under close review to balance both prudent financial management and effective notifications management."

Adding to the complexity, the Queensland Government has made a stunning intervention into the system regulating doctors, dismissing the Queensland Board of the Medical Board of Australia and announcing plans to appoint a Health Ombudsman to receive and act on complaints against practitioners (see *State of confusion,* p32).

Dr Flynn said the intervention was a worrying development that carried the risk of uneven and inconsistent standards across the country, and would also leave Queensland practitioners out of pocket.

"The Board is concerned that the changes in Queensland carry the risks of fragmentation of the National Scheme and variation in standards for practitioners in different states," she said. "Whatever the arrangements, the system for dealing with serious complaints must be accountable and effective and build public confidence in the integrity of the health system and health professionals. This is a big ask."

The MBA Chair added that the arrangements set in place by the Queensland Government not only posed a threat to national consistency of standards, but would add to the financial burden on doctors.

"The complaints function of the Health Ombudsman in relation to registered health practitioners would be funded through registration fees from Queensland practitioners. This may result in increased registration fees for Queensland practitioners," she warned.

Adrian Rollins

TO COMMENT CLICK HERE

AMA IN THE NEWS

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TV

AMA, ABC1 Sydney, 15 July 2013

Report on the mistreatment of elderly people in many Australian nursing homes. The AMA said there are not enough doctors to visit residents.

Dr Steve Hambleton, ABC1 Sydney, 17 July 2013

AMA President Dr Steve Hambleton discussed the key health issues for the Federal election. He said polls indicated voters are focused on the economy, health and education.

Dr Steve Hambleton, ABC News 24, 17 July 2013

AMA President Dr Steve Hambleton called for monitoring of the health of asylum seekers in detention. He said the Commonwealth Ombudsman and Australian Human Rights Commissioner do inspections but their understanding does not extend to health.

Dr Steve Hambleton, ABC1 Canberra, 17 July 2013

Refugee claims are set to be processed at the Manus Island detention centre for the first time. AMA President Dr Steve Hambleton said more needs to be done to address the health of asylum seekers.

Dr Steve Hambleton, SBS Sydney, 17 July 2013

Less than 24 hours after the deaths of four asylum seekers, another nearby boat was reported to be in distress. AMA President Dr Steve Hambleton called for an independent panel to investigate and monitor asylum seeker health.

Dr Steve Hambleton, Channel 10 Brisbane, 22 July 2013

AMA President Dr Steve Hambleton said health was one of the issues voters should be concerned about.

TO COMMENT CLICK HERE

INFORMATION FOR MEMBERS

Can I prescribe ...?

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

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

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

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

Prescribing in Australia is regulated by a range of laws.

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

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

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

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

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

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

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

Here's what the different laws say:

- Commonwealth, NSW, Queensland, Tasmanian and South Australian laws do not appear to prohibit self-prescribing, prescribing for family or for a third party.
- Doctors practising in Victoria cannot prescribe any S4 or S8 medicines for themselves or for a third party.
- In the Northern Territory, it is slightly more complicated. Doctors cannot self-prescribe S8 medicines or certain restricted S4 medicines, and cannot prescribe for a third party unless the third party is the partner of a patient being treated for Chlamydia who is also likely to have Chlamydia.
- In the ACT, doctors are only prohibited from prescribing for themselves if they are still an intern, or the medicine is a restricted medicine.
- WA law simply prohibits prescribing for the purpose of self-administration.

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

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

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

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

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

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

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

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

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

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

TO COMMENT CLICK HERE

No automatic ban for unsafe medicines

The medicines watchdog has admitted that pharmaceuticals and medical devices proven to be unsafe may still be sold on the market.

Unveiling a new early warning system to alert doctors and patients to potential safety concerns regarding some treatments, the Therapeutic Goods Administration said that withdrawing regulatory approval was only one of the options for dealing with unsafe drugs and devices.

"The TGA has to consider the balance between the benefits offered by a therapeutic product and the potential risks associated with its use for the population as a whole (or individual patient groups where the risks may be higher) before it makes a decision on an appropriate response," the watchdog said.

While the regulator said it may withdraw or suspend approval for products deemed to be dangerous, other options included warnings to doctors and consumers, changes to product information, tightening conditions for use, demanding an investigation by the manufacturer or recalling the product.

"In some cases, no action may be recommended, and the TGA will continue to monitor the safety concern," it said.

The watchdog made the revelation as it announced the introduction of an early warning system to alert doctors and consumers to potential safety concerns about pharmaceuticals and medical devices.

Under the two-stage system of alerts, health workers and patients will be notified as soon as concerns are raised about the safety of a treatment, with follow-up warnings where evidence shows it could cause harm.

In an advance on previous arrangements, the Trans-Tasman Early Warning System, jointly developed by medicines safety regulators in Australia and New Zealand, intends to alert both doctors and consumers when there may be a problem with a medicine or device.

In the first stage, the TGA will issue what it calls "monitoring communications", drawing attention to potential safety concerns that are yet to be investigated or substantiated.

This is followed up with an alert if a demonstrable link between the treatment and safety concerns is established.

In its advice to health professionals, the TGA was at pains to point out that announcements issued through the early warning system were to keep doctors and patients informed, and did not necessarily imply that a particular treatment was unsafe.

"Monitoring communications highlight potential safety concerns identified, but not yet fully investigated by the TGA, and are intended to encourage further reporting and research," the watchdog said. "Patients should not have their treatment changed because of a monitoring communication."

Similarly, even when investigations justify safety concerns about a medicine or device, this did not necessarily mean that its use should immediately cease.

"Even though an alert has been issued, it does not necessarily mean that a medicine or medical device is considered to be unsafe," the TGA said. "Health professionals should use clinical judgement in applying this information to individual patients.

"As always, the balance of benefits and risks of a medicine or medical device should be discussed with the patient before starting or continuing treatment."

The system has been under development for the past two years, and began operating early this month.

Adrian Rollins

TO COMMENT CLICK HERE

New research facility for brain diseases

A $54 million purpose-built brain research facility has opened in Sydney on the Prince of Wales Hospital Campus.

Leading medical research institution, Neuroscience Research Australia (NueRA), has developed the new facility, housed in the Margarete Ainsworth Building, as a centre for research on diseases that affect the brain and nervous system.

The building was named after Mrs Ainsworth, philanthropist, businesswoman and wife of gaming mogul Len Ainsworth, after she donated $10 million to the project – one of the largest such donations on record.

"I feel one must help where one can," Mrs Ainsworth said. "I have always supported [research into] mental illness, as it is so terribly devastating to families."

Although Mrs Ainsworth's donation was substantial, it only covered a fraction of the cost of the new facility, and both the Federal and NSW governments, along with other organisations and philanthropists, contributed significant funds.

Five levels of the building are either entirely or partially completed, but the remaining two levels stand empty awaiting additional funding.

The first stage of the project has included two floors of wet labs, two floors of dry labs, an MRI scanner that will be used for clinical and research use, a 150-seat seminar room, large office areas and staff facilities.

Once the first stage is complete, NeuRa is hoping to develop their facility further by incorporating a state-of-the-art sleep lab.

The goal is to increase Australia's ability to achieve world-class research of diseases affecting the brain and nervous system.

NueRa has also received donations from the Federal and State Governments.

Sanja Novakovic

TO COMMENT CLICK HERE

Massive diabetes bill underlines need to improve prevention, chronic care

The nation's health bill for treating diabetes has virtually doubled and is growing rapidly as the incidence of the disease escalates.

In a finding that lends urgency to efforts to bring down the prevalence of type 2 diabetes, the Australian Institute of Health and Welfare (AIHW) found that between 2000-01 and 2008-09 health care spending on diabetes surged from $811 million to $1507 million, driven by an increase in patients as well as improvements in treatment and access to care.

According to the Institute, the 86 per cent increase in diabetes-related expenditure substantially outstripped the 60 per cent increase in spending on all diseases over the same period, and diabetes' share of total disease expenditure rose from 2 to 2.3 per cent.

The results underline fears that diabetes will become an enormous drag on the health system unless efforts to prevent type 2 diabetes developing are stepped up.

The prevalence of the disease increases as populations get older and fatter, and studies suggest it will become a huge financial burden if current health and lifestyle trends continue.

Around 85 per cent of diabetics have the type 2 version and, of these, 77 per cent are aged 55 years or older.

In its report, the Institute cited estimates that the number of people with type 2 diabetes (officially estimated at 986,900 people in 2011-12) will double by the middle of the century, and the associated health bill will increase two-and-a-half times, solely as a result of ageing.

If current growth in the rates of obesity and inactivity is sustained, researchers warn the diabetes health bill could increase four-fold.

In a sobering codicil to its report, the Institute admitted its figures were likely underestimates of the true extent of health spending on diabetes because of limitations in the data and methods used in collecting it.

Underlining AMA concerns about shortcomings in the health system regarding the treatment of chronic conditions, the AIHW report showed that the major chunk of spending on diabetes was for hospital care.

In all, $647 million (42 per cent of overall diabetes expenditure) in 2008-09 was for hospital admitted patient services, compared with $498 million (33.1 per cent) on medications and $362 million (24 per cent) on out-of-hospital medical expenses.

Highlighting how costly periods of hospitalisation are, and the enormous savings to be made by helping patients manage their condition and minimising hospital visits, the Institute said each hospital admission cost an average of $7600, compared with an average of $42 per service for out-of-hospital care and an average of $47 for each prescription of blood glucose-lowering medication.

Disturbingly for governments and hospitals trying to manage tight budgets, the signs are that hospital episodes for diabetes patients are increasing.

The fastest-growing area of spending on diabetes care between 2000-01 and 2008-09 was for hospital care, up 116 per cent, the vast majority (84 per cent) involving patients with type 2 diabetes.

The AMA has called for significant improvements in arrangements to help GPs manage and coordinate treatment for patients suffering chronic disease.

AMA President Dr Steve Hambleton told the National Press Club earlier this month that GPs are increasingly treating older patients presenting with two or more complex chronic conditions simultaneously, including diabetes, hypertension, cholesterol-related disorders, depression, anxiety, arthritis and asthma.

Dr Hambleton said the Department of Veterans Affairs' Coordinated Veterans Care program, which provided additional support for GPs to comprehensively plan and coordinate veteran care with the support of practice or community nurses, should be the model for a broader program across the health sector.

Adrian Rollins

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Young most likely to be held in solitary

Children and adolescents in public mental health care are more likely to be held in solitary confinement than adults, government figures show.

Children and young people were being held in seclusion – defined as being confined alone in a room or area where free exit was blocked – at the rate of 20.9 per 1000 bed days in public mental health services in 2011-12, according to figures compiled by the Australian Institute of Health and Welfare.

The comparable rate among patients in general mental health services was 11.9 per 1000 bed days.

The nationwide figures, produced for the first time, show that overall progress is being made in reducing the incidence of seclusion, which was one of the mental health care priorities set by the nation's health ministers last decade.

At a meeting in 2005, the health ministers resolved that there should be less use made of seclusion as part of a plan to reduce harm in mental health.

As one of the core principles guiding the planning and delivery of care, the ministers resolved that "mental health consumers have the right to receive care in the least restrictive environment, and with the least restrictive or intrusive treatment, that is appropriate to their health needs and their immediate circumstances".

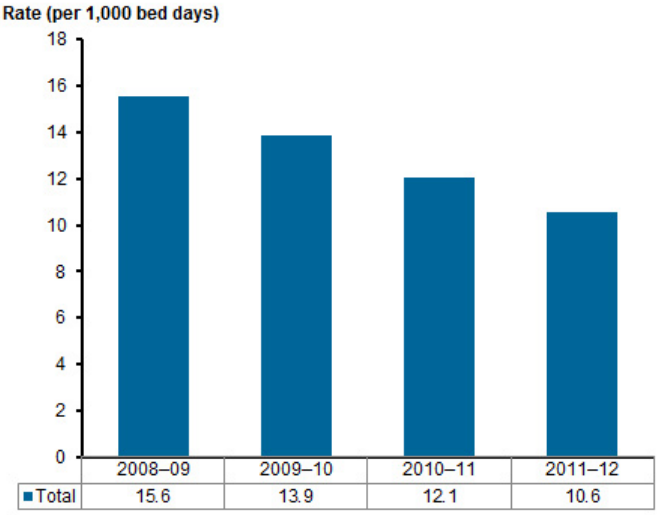
The figures compiled by the Institute show that, across all public mental health services, progress has been in this aspect of providing safer care.

Rates of solitary confinement have been cut by around a third, down from a rate of 15.6 events per 1000 beds in 2008-09 to 10.6 in 2011-12.

Among those in general mental health care units, the rate fell from 16.7 to 11.9 between 2008-09 and 2011-12, while among older patients it dropped from 5.1 to 1.6, and in forensic units it edged marginally lower from 11.1 to 10.2.

But among children and adolescents, it actually increased, from 19 to 20.9.

A national breakdown of the figures in 2011-12 showed that patients in the Northern Territory were the most likely to be held in seclusion, with a rate per 1000 bed days of 25.7.



At the other end of the scale, the rate in the ACT was just 1.3, followed by Western Australia with 4.7.

In NSW the rate was 9.8, in Victoria 13.3, in Queensland 13.1 and South Australia 10.1.

Associate Professor John Allan, Chair of the Australian Health Ministers' Advisory Council's Safety and Quality Partnership Standing Committee, told the *Hobart Mercury* that seclusion was traditionally used for patients whose behaviour posed a risk of harm to themselves or others, and could have traumatic consequences.

Seclusion does not stop the behaviour, [and] patients feel they have been let down and suffer a loss of confidence," Associate Professor Allan said.

Acting Tasmanian Chief Psychiatrist Professor Ken Kirby said seclusion was only used in relatively rare circumstances.

"It is usually a last resort, and is preceded by care plans which identify trigger points and the use of de-escalation techniques – an area in which staff receive extensive training," Professor Kirby told the *Hobart Mercury*.

Adrian Rollins

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Health on the hill

Political news from the nation's capital

Test results loaded on shaky e-health foundations

The Federal Government is pushing ahead with the roll-out of extra functions for electronic health records despite concerns that it is yet to get the system's fundamental design right.

In the face of calls from the AMA for it to focus on refining the basic functions of the Personally Controlled Electronic Health Record to improve its clinical usefulness, the Government has announced the allocation of $8 million to enable patients to upload pathology and diagnostic imaging test results to their shared health summaries.

Announcing the move – which has been a long-standing element in the rollout of the e-health record system - Health Minister Tanya Plibersek said it was the "landmark next step" in the evolution of the PCEHR.

"We expect both doctors and patients will find the new functionality useful, as it will reduce the need for them to chase down results or duplicate tests," Ms Plibersek said. "In an emergency, having this kind of information on a patient's e-health record could save lives."

The AMA said that although pathology and diagnostic imaging test results were important inclusions in electronic health records, the Government was yet to address fundamental problems in the design of the PCEHR that undermine its clinical usefulness.

The Association has consistently raised concerns that, as currently framed, the PECHR allows patients to remove or restrict access to information, meaning treating doctors cannot rely on it as a comprehensive and accurate source.

The AMA has called for the establishment of a clinical advisory group to review the system's design and recommend changes to make it a much more useful and valuable resource for doctors and their patients.

AMA President Dr Steve Hambleton said such a review and overhaul was urgently needed, before any more resources were poured into developing and adding new features to a record that will not be used by clinicians when treating patients.

Dr Hambleton told the National Press Club on 17 July that the AMA was a "strong supporter" of the concept of a shared electronic health record, and the inclusion of critical information like pathology and diagnostic imaging test results was fundamental if they were to be clinically useful.

"The roll-out of the PCEHR has been slow and patchy across the country," Dr Hambleton said. "The AMA is not surprised. The design means that its use is limited for doctors in terms of accessibility, content, accuracy and the comprehensiveness of information."

But Ms Plibersek rejected criticisms of the system, including the rate of take up by doctors and patients.

The Minister told the Health Informatics Conference in Adelaide on 17 July that around 520,000 patients had registered for a PCEHR, as had nearly 5000 GP practices, hospitals and other health organisations, while more than 16 million health documents – mostly Medicare Benefits Schedule billing information - had been uploaded to the system.

"We've built the e-health superhighway, and I'm proud to say we've had a lot of drivers join it already," she said.

But Dr Hambleton said that the addition of MBS billing information to the health record was, of itself, not very useful for doctors in making decisions about the treatment of their patients.

He said that simply seeing that a patient had received a Medicare rebate for a colonoscopy was not particularly informative, and that what a doctor needed to know was the result of that procedure.

"We need to direct efforts towards the adoption of the PCEHR by all medical practitioners, now that there has been good sign up by general practices," Dr Hambleton said. "As the AMA has consistently said, there is very little need for general practice to 'e-health with itself'. Essential clinical information needs to be shared between general practitioners and all other medical specialists.

"As the PCEHR has rolled out and clinical practice software has become more integrated, we are seeing significant constraints on the clinical usefulness and usability of the health record, flowing from its design," the AMA President said.

"We need to make the system easier to use, to get all medical practitioners using the current system in a meaningful way.

"To do this, they will need to be confident that the PCEHR will have the information they need, that it is reliable, and that they can get access to it."

Dr Hambleton said this should be the focus of the design and implementation of the pathology and diagnostic imaging information that will be added to the electronic health record.

Adrian Rollins

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Health on the hill

Political news from the nation's capital

Plain packs may cause smoker second thoughts

Plain cigarette packs may be encouraging smokers to think about quitting, according to the first study into the effects of Australia's world-first plain packaging legislation.

Smokers of cigarettes from plain packages were almost twice as likely to have considered quitting their habit as those smoking branded products, research published in the *BMJ* last week (can be viewed at: http://www.bmj.com/content/347/bmj.f4665) found.

Based on interviews with 536 smokers – 72 per cent of whom were smoking plain packaged products – the study gives the first indications about the effectiveness of plain packaging as a way of encouraging people to give up the habit.

In a sign of the influence of the so-called halo effect, researchers found that those smoking from plain packages tended to find their cigarettes less satisfying than branded pack smokers, and rated quitting as a higher priority.

Health Minister Tanya Plibersek seized on the results of the study, which was commissioned by Quit Victoria, as evidence that the Government's reform was putting people off smoking.

"The new research shows plain packaged cigarettes with larger health warnings increases smokers' urgency to quit, and makes smoking less appealing," Ms Plibersek said. "We've had feedback from smokers saying their cigarettes taste worse since the Government has required packaging to be plain."

Under laws that came into effect last December, all tobacco products must be sold in plain packaging carrying large and graphic health warnings.

Two countries are considering introducing similar legislation, but the British Government has controversially dropped similar plans (see *Claims of undue influence cloud UK backflip on plain packaging* on p41), citing a lack of evidence as to the effectiveness of the measure.

But although the study, conducted last November and December as the plain packaging laws were being implemented, suggests smokers of cigarettes from plain packs are more likely to considering giving up, there is as yet no evidence that the change has led people to quit.

Nor, the authors admitted, were they able to "tease apart" whether it was the plain packaging itself, or larger health warnings, that may be influencing the perceptions of smokers.

As pointed out by the *Crikey* web news service last week, the study's results also shed no light on whether plain packaging has been successful in one of its key goals, deterring children and adolescents from taking up smoking.

And, underlining the need for caution when assessing the effectiveness of plain packaging, the study found there were "no significant differences in the proportion of plain and branded pack smokers who thought frequently about the harms of smoking or thought smoking harms had been exaggerated".

Adrian Rollins

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No mister or missus at Medicare

Patients will no longer have to identify themselves as male or female when making a claim through Medicare, under changes announced by the Federal Government.

Moving to end what it said was gender discrimination in the universal health system, the Government has ordered that all references to males or females in the description of 6000 medical procedures and clinical services be removed from the Medicare system.

Health Minister Tanya Plibersek and Human Services Minister Jan McLucas said the identification of gender was particularly problematic for some members of the community, and the changes would bring Medicare into line with the Government's recently released *Guidelines on the Recognition of Sex and Gender.*

"At the moment, there are some Medicare services described as being for a man or a woman," the ministers said. "This has caused discrimination against gender diverse Australians who have had to have unnecessary discussions about their gender identity in order to get access to a Medicare service, or to claim a rebate."

Ms Plibersek and Ms McLucas cited as an example the fact that Medicare

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Health on the hill

Political news from the nation's capital

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descriptions for some procedures involving the uterus were couched in terms of the 'female' or 'woman', whereas there were some people who had a uterus but considered their gender to be male.

The ministers said all references to gender would be removed from Medicare, though they admitted that achieving this would not always be straightforward.

"We are able to remove references to gender in Medicare by doing things like describing a medical procedure in more detail, or using anatomical language instead," Ms Plibersek said. "These changes will make a big difference to intersex Australians, who may not wish to identify as any gender."

To fully implement the reform, changes will also be made to Medicare claims and processing functions.

The Government said the changes were being made in consultation with members of the intersex and gender diverse communities, as well as medical experts.

Adrian Rollins

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Senators duck and weave doping calls

A Senate inquiry has recommended that any move to regulate sports scientists be delayed until investigations into the use of performance enhancing drugs are concluded.

In a result that has dismayed those pushing for the urgent introduction of accreditation standards and codes of conduct for sports scientists, the Senate's Rural and Regional Affairs and Transport References Committee has

advised the Government should refrain from "detailed consideration" of any new regulations until the Australian Sports Anti-Doping Authority and the Australian Crime Commission have completed their inquiries.

Early this year the ACC aired allegations that criminal gangs were involved in the supply and distribution of performance enhancing drugs to professional sports clubs, and ASADA launched an investigation into claims that players at AFL club Essendon and NRL side Cronulla had been administered performance enhancing drugs in breach of World Anti-Doping Authority rules.

The allegations have brought the role of sports scientists in professional sports clubs into focus, amid claims that in some cases they devised and operated player supplement programs without supervision from qualified medical staff.

Greens Senator Richard Di Natale, who called for the Senate inquiry, condemned the failure of the major parties – which control a majority on the Committee – to support calls for the regulation of sports scientists.

"The clear consensus during the inquiry from major sporting bodies and health care professionals was that accreditation of sports scientists is essential," Senator Di Natale said.

"Sporting clubs need to be confident that the people they employ and trust to care for their athletes have the appropriate skills, qualifications and experience – and only accreditation can provide that assurance," he said.

The Greens Senator accused the major parties of a "dreadful act of cowardice" by refusing to back the accreditation call.

"The fact that some politicians were criticised for overreacting when the doping scandal first broke has caused the old parties to go to ground when action is sorely needed," he said.

"[They] haven't committed to any reforms that would help protect the next generation of athletes from any cowboy who decides to call himself a sports scientist and start offering athletes injections or dangerous drugs."

While baulking at accreditation, the Committee recommended the Government consider developing a statement of ethics that would apply to all sports and all players and officials.

It also suggested that all sports science courses should include topics on ethics and duty of care, and that all athletes taking part in professional or high-performance programs be given training in ethics, integrity and their rights and responsibilities regarding their long-term health and welfare.

Adrian Rollins

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Your AMA Federal Council at work

What AMA Federal Councillors and other AMA Members have been doing to advance your interests in the past month

Name	Position on council	Activity/Meeting	Date
Dr Beverley Rowbotham	Pathologist Craft Group nominee	Medical Board of Australia CPD audit working party	20/6/2013
		Australian Association of Pathology Practices (AAPP) consultation on MBS funding proposals for pathology services	9/7/2013
Dr Brian Morton	General Practitioner Craft Group nominee	GP Roundtable	25/06/2013
Dr Cathy Hutton	AMA member	Diabetes Advisory Group	26/06/2013
Dr Anne Wilson	AMA member	Mental Health Nurse Incentive Program Expert Reference Group	26/07/2013
Dr Steve Hambleton	AMA President	Australian Commission on Safety and Quality in Health Care (ACSQHC) Medical practice variation project update	16/7/2013
		PCEHR Peak Consultation and Communications Group	18/7/2013
Dr Elizabeth Feeney	AMA Treasurer	Anti-microbial resistance meeting with Australian Veterinary Association, Chief Veterinary Officer, Chief Medical Officer17	17/7/2013
Dr Iain Dunlop	AMA Chairman of Council	Health Technology Assessment Consultative Committee	24/7/2013
Dr Chris Moy	AMA member	NeHTA Clinical Usability Program Steering Group	24/7/2013

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GPs in tight spot as Medicare gap widens

BY **DR BRIAN MORTON**

"The AMA knows the importance of keeping general practice viable. GPs are the cornerstone of the health care system"

How much longer can the Australian Government continue to erode the value of Medicare rebates before there is a reaction in the marketplace?

Medicare rebates have never covered all the costs of medical services. However, in 1984-85, they covered 90.3 per cent of medical fees. Today there is a glaring gap, with rebates covering only 78.5 per cent of medical fees.

Since 1985, annual indexation of the Medicare Benefits Schedule (MBS) has been below the market indices that have a direct impact on the cost of providing medical services – the labour price index and the consumer price index. This has resulted in a 40 per cent decline in the real value of Medicare fees, to which Medicare rebates are aligned.

With costs rising and the rate of indexation not keeping pace, more and more patients have seen their out-of-pocket expenses increase.

Between 1984-85 and 2011-12, aggregate Medicare gaps grew on average by 11.7 per cent a year. This makes patient out-of-pocket expenses the fastest growing area of expenditure in health. They are now a material element in cost-of-living pressures on households.

Recent Budget measures are set to further add to patients' pain and the pressures on family doctors.

Three of these in particular seriously erode the value of Medicare and shift more of the cost for medical care on to patients: freezing the Medicare rebate until mid-2014, increasing the Extended Medicare Safety Net general threshold, and abolishing the medical expenses tax offset.

All of this puts GPs in an unenviable position.

The Government brags about record bulk billing rates, which only inflates patient expectations for discounted medical services.

Medical practices, while in the business of care and compassion, are businesses nevertheless. The fees they charge must cover all the practice costs – the wages for reception staff, the nurses, accounting fees, rent, electricity, insurance, continuing professional education, and government red tape, among other things. This is something Health Minister Tanya Plibersek conveniently overlooks when she talks about GP earnings.

The AMA knows the importance of keeping general practice viable. GPs are the cornerstone of the health care system.

The AMA assists GPs with advice when setting up their practices, provides tools to help in setting fees, keeps GPs informed about the effect on their business of government policy, and advocates on their behalf to ensure GPs can continue to provide comprehensive care to the Australian people. For more detail, have a look at the AMA's *Key Health Issues for the Federal Election 2013* (to view, visit http://ama.com.au/keyhealthissues) and make regular visits to the AMA website and the General Practice Landing Page.

Governments are compelled by the will of the people, eventually.

I therefore encourage you to download the AMA's latest Gaps Poster highlighting the devaluation of Medicare from (http://ama.com.au/ama-gaps-poster) and display it in your practice so your patients understand why there is a gap and why it is growing.

The more technically-minded may wish to include the *AMA Family Doctors – Your Medical Home* video in your waiting room video presentations.

We must make GP issues an election issue, even though it is an uphill struggle in the present political environment.

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Time for new priorities in safe hours campaign?

BY **CHAIR DR WILL MILFORD**

Since the AMA embarked upon its safe working hours campaign in 2001, the medical training environment has evolved dramatically.

Rapid growth in prevocational and vocational training numbers has created a surplus of junior doctors in many hospitals and specialties, industrial agreements have been strengthened - particularly in regards to un-rostered overtime - and the political push for efficiency dividends has seen hospitals act to cut excessive expenditure.

It is in this context that last year's AMA Safe Hours Audit recorded significant reductions in the number of doctors working in high fatigue risk categories. Since 2001, there has been a 16 per cent fall in the number of doctors doing shifts that exceed 14 hours per day, have no meal breaks, or have a break between shifts of less than 10 hours.

However, extremes are still prevalent, with some doctors reporting shifts of 43 hours duration or working weeks of greater than 120 hours.

Recent international developments have reflected a changing focus in fatigue management, with increasing concern for the potential adverse effects of safe hours regulations on medical training and the apparent lack of effect on patient safety.

In the United States, an 80-hour work week limit for all residents was introduced in 2003 and a 16-hour shift length restriction for interns was introduced in 2011. Subsequent reports indicate that the changes to intern shift length have resulted in an improvement of quality of life for interns, but have also increased handover frequency and upped the workload for senior residents. Perceptions of patient safety, fatigue and the balance of service and education have remained unchanged. More recently, evidence has also been published that these regulations have resulted in a reduction in intern operative exposure.

Opposition to the duty hour regulations has been obvious throughout the medical literature, with unproven assumptions about the effect of fatigue, the inflexibility of the current regulations and the lack of evaluation, all cited as major flaws to the US approach to doctor fatigue.

Across the border in Canada, a different approach has been taken. In June this year, a report on this issue was published by the National Steering Committee on Resident Duty Hours.

The report confirmed a lack of clarity regarding the relationship between fatigue and patient safety, and reflected the concerns that this relationship is more complex than simple policy directives such as duty hour restrictions may infer.

Other conclusions included the lack of any clear evidence that resident duty hour regulations have had either a positive or negative affect on academic performance - although there were findings that educational outcomes in surgery were probably adversely affected.

The report's recommendations were wide-ranging and high-level, and moved away from a regulatory response, concluding that accreditation could be the appropriate lever to enforce appropriate fatigue risk management activities.

Australia's non-regulatory approach, using the AMA's National Code of Practice, seems justified after considering the international evidence.

Not only has the approach seen a shift in workplace practice, with fewer doctors working in high fatigue risk categories, but it has not generated the concerns regarding a negative impact upon training that exist within the regulatory system in the US.

The impact of other factors on the Australian environment cannot be understated.

While the Code of Practice has produced improvements, increasing numbers of medical staff and the reluctance of health jurisdictions to pay overtime must also be credited with producing improvements in doctor fatigue.

Similarly, if the Safe Hours campaign is to be condemned for a perceived negative impact on medical training, than so must these other significant factors.

As the evidence regarding doctor fatigue and patient safety matures, it is clear that the problem is multifaceted and will require complex solutions beyond a simple restriction on working hours. Possible risks, such as a detrimental effect on training, need to be measured, considered and mitigated.

Patient safety should always remain the paramount priority, and maintaining this while maximising training opportunities should be the goal of future campaigns to reduce doctor fatigue.

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Improving the health of Aboriginal and Torres Strait Islander children – will Australia make the grade?

BY DR STEVE HAMBLETON

"... there are no quick fixes to address these health inequalities. But the AMA believes that a good place in the life-course to end the cycle of vulnerability is to make an investment in childhood"

One issue that has not had much attention so far in the lead up to the 2013 Federal election is the place of Aboriginal and Torres Strait Islander health.

Tony Abbott has indicated he will make this a priority by having this policy area run from the Prime Minister's Office. Kevin Rudd has yet to elaborate on the priority he would give Aboriginal and Torres Strait Islander health issues.

The AMA has made no secret of its view that the health of Aboriginal and Torres Strait Islander peoples is a national priority that requires a long-term intergenerational commitment across all levels of government.

The entrenched disadvantage and adversity in many Aboriginal and Torres Strait Islander communities over many years has resulted in persistent and life-long health problems that require targeted, coordinated and well-resourced efforts to address. There are no overnight solutions.

The AMA believes that it makes sense to focus on improving the health of Aboriginal and Torres Strait Islander children, the next generation. We know from the evidence that sustained investment in healthy early years is one of the keys to breaking the cycle of ill-health and premature death.

In its 2008 Aboriginal and Torres Strait Islander Health Report Card, the AMA made a range of recommendations about how this investment could best be made.

Among other things, the AMA recommended the establishment of a national network of Aboriginal community-controlled services specifically for mothers and children, and a national audit of the living environment conditions in Indigenous communities.

We also called for significant reductions in the rate of premature birth and low birth weight, and for at least 70 per cent of Aboriginal and Torres Strait Islander children to have a child health assessment by age two, including hearing checks.

We also recommended that Aboriginal and Torres Strait Islander families have ready access to affordable nutritious food.

Australia has made some early progress in addressing some of these areas, including lowering the infant mortality rate, and establishing child and maternal services. However, there is a long way yet to go. The most recent data shows, for example, that:

- 12 per cent of babies born to Aboriginal and Torres Strait Islander mothers were of low birth-weight, compared with 6 per cent for other mothers;
- Aboriginal and Torres Strait Islander mothers are twice as likely to die in childbirth than other mothers;
- Aboriginal and Torres Strait Islander babies and children are more likely to die through infection or injury than other children;
- Aboriginal and Torres Strait Islander children are almost eight times more likely than other children to be the subject of substantiated child abuse and neglect; and
- Aboriginal and Torres Strait Islander children are twice as likely to be developmentally vulnerable than other children.

As well as this, because of parental and population age profile and family size, non-Indigenous Australian children have three times as many adults available to help with their child rearing, development and education than Aboriginal and Torres Strait Islander children.

These are just some examples of how more work needs to be done.

As I said, there are no quick fixes to address these health inequalities.

But the AMA believes that a good place in the life-course to end the cycle of vulnerability is to make an investment in childhood.

The AMA will continue to monitor these health inequalities and to urge governments to make the long-term investment that is needed, whichever party comes into power.

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State of confusion

BY **DR STEPHEN PARNIS**

"The harm to a doctor's reputation and wellbeing in these circumstances is obvious and profound, even if that doctor were subsequently found to have done no wrong"

Since 2010, all health practitioners in Australia have been legally required to register with the Australian Health Practitioner Regulation Agency (AHPRA).

Each health profession is represented by a National Board, whose legislated role is to protect the public and administer the registration of practitioners and students.

Until only a few months ago, all states and territories had their own local boards.

However, the members of the Queensland Board of the Medical Board of Australia (MBA) were recently compelled to resign or were dismissed by the Queensland Minister for Health. This leaves doctors in Queensland in a state of confusion and uncertainty.

As a consequence of this action, the MBA announced special arrangements to manage the work of the Queensland Board of the MBA, such that registrations are being handled by a Queensland Registration Committee, made up of Board and Committee members from New South Wales.

The MBA has also temporarily delegated powers to deal with notifications about practitioners' conduct and performance to the Queensland Medical Interim Notifications Group (QMING).

Notifications, or complaints, are a serious matter for salaried doctors everywhere. If a complaint progresses to formal hearings, the implications for the doctors involved are profound. Proven allegations may result in sanctions, restrictions on ability to practise medicine, suspension or even cancellation of registration, and permanent reputational harm.

The AMA has always supported a functional, efficient system for registering medical practitioners, and a fair, transparent system for handling complaints. We have engaged with AHPRA since its establishment to highlight the essential nature of these principles.

In addition to dismissing its Medical Board, the Queensland Government has announced a proposal for a Health Ombudsman to receive and act on complaints, and to oversee the performance of AHPRA and the national boards in their health, conduct and performance roles within the State.

The Queensland Health Ombudsman would also replace the Health Quality and Complaints Commissioner (HQCC), to become the single entry point for all complaints.

AMA Queensland and the Federal AMA have recently made submissions to the Queensland Parliament in relation to the Health Ombudsman Bill 2013. Both entities have serious concerns with a number of aspects of the Queensland Government model.

Firstly, it is essential that any complaints handling system is independent of Government, but there are several provisions in the Bill that compromise the independence of the Ombudsman, AHPRA and the national boards from Government. The Federal AMA believes this significantly compromises the overall integrity of the health complaints system in Queensland.

There are provisions that would empower the Ombudsman to suspend or place conditions on a health practitioner's registration in certain circumstances, prior to any formal finding of professional misconduct.

There is the potential to 'name and shame' doctors under investigation, as the Ombudsman may publish information about action that has been taken about a practitioner. This raises serious concerns about procedural fairness and a doctor's right to a presumption of innocence.

The harm to a doctor's reputation and wellbeing in these circumstances is obvious and profound, even if that doctor were subsequently found to have done no wrong.

We are also concerned about funding issues. The Federal AMA remains unconvinced that the Health Ombudsman will be sufficiently resourced to fulfill all of its proposed functions. There is a real possibility that medical registration fees in Queensland will rapidly rise, which the AMA would vigorously oppose.

The AMA urges the Queensland Government to rethink many aspects of its proposed model for medical registration and the handling of notifications in that state. It is a radical departure from processes that are used in the rest of the country, and threatens the basic rights of doctors to fair, independent judgment.

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Declining poverty is good for our health

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

Poverty can be both relative (in Australia) and absolute (in parts of Africa and India). The level of income below which poverty is declared varies, from $US1.25 a day in the world's 15 poorest countries, according to *The Economist* (1 June, 2013), to $US63 a day for a family of four in America.

Apart from the compelling concern poverty stimulates in us for the 1.2 billion people who live on less than $US1.25 a day, there is the matter of their health that should make us as health professionals think seriously.

All is not gloom.

Take heart from the progress that has been made this century in lifting people from poverty and in improving maternal and child survival.

To quote *The Economist* again, the principal aim of the Millennium Development Goals (MDGs), developed by the United Nations in September 2000 – to halve the 1990 level of extreme global poverty by 2015 – was "achieved five years early".

The MDGs raise an important point. Workable goals are always built on a platform of feasibility. There is no wisdom, even when defining stretch goals, in aspiring to an unattainable level. With poverty, the goals have been realistic. The outcome was foreseeable when the MDGs were set.

Not that the MDGs can claim all the credit. China has been at the forefront of extreme poverty reduction and, more or less independently of the MDGs, has contributed hugely to global progress.

Also remember that the success the world has had in alleviating extreme poverty does not, of course, mean that those rescued from it now enjoy stylish middle-class accommodation, access to vital health services or to education.

Crossing the poverty line is but the first step in community development for many nations, and subsequent steps may be more difficult and complex. That is no reason not to plan to take them, but we should be ready for the hard yards involved.

The MDGs are due to expire in 2015. The United Nations and its agencies, including the World Health Organisation, are considering how the development agenda should be expressed for the next decade and beyond.

Sustainability is a major preoccupation now, alongside poverty, and goal-makers ponder the significance that climate change and capricious global financial systems will have for the health of the world.

The effects of economic growth, including poverty reduction, occur almost independently of the political configuration of the country.

If the rates of economic growth seen currently in developing countries were to continue, *The Economist* projects they could cut extreme poverty from 16 per cent to 3 per cent by 2030.

Whether the better off nations will allow such growth to continue, given their own economic difficulties, is a serious question.

Economically-challenged countries that are well off close doors to remain safe, decreasing vital trade with less-developed nations.

Whatever trajectory economic development follows, we, as health-interested people, can say that - at least in regard to the reduction of poverty - it is good for people's health.

Beside economic growth, *The Economist* draws attention to the extent to which income distribution is important for poverty reduction.

In countries where there are severe inequalities in income, poverty reduction is much diminished, as economic growth feeds the rich.

'Trickle-down' effects are not a major force in poverty reduction. Policies that achieve income redistribution in favour of the poor, either directly or through social services, contribute about one-third to poverty reduction.

While the falling rates of extreme poverty are a cause for celebration, now is not the time for disengaging from serious debate about global health and the role that poverty plays. The agenda is changing.

As cities flourish and poverty rates fall, think of the world's largest migratory wave in history which is bearing hundreds of millions of people from the country to cities in search of prosperity, and what that means for child-bearing and care, for diet, for exercise and myriad health effects, including cardiovascular disease. Consider what it means for environmental sustainability.

Serious thought and debate about poverty, poverty reduction and the future of global health are essential.

TO COMMENT CLICK HERE

Members' Forum

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

President of the Australian Medical Student Association Mr Benjamin Veness shared his experiences with stress among medical students, prompting some readers to share their own stories and suggest possible solutions.

My son is presently taking a year off his medical studies midway through a four-year course. After doing engineering, then Graduate Medical School Admission Test (GAMSAT), then two years of medicine, he has lost his enthusiasm and motivation, and is trying to find it again while travelling for a year. He seemed fine till midway through his second year. Being male, he doesn't verbalise his emotions very well and I personally was very worried by his withdrawal and what I would call depression. I did try to contact the medical school but was thwarted by privacy issues and the difficulty of doing anything online unless you have a student number! I wonder how many other potentially excellent doctors are lost because they withdraw from the course due to the crushing workload in the first two years and all the others stresses of learning the ropes of medicine. It is great career and I have enjoyed mine immensely. I hope my son will return to medicine.

by Dr Gail (not verified)

Thanks for sharing the experience of your son and hope that he finds a suitable way through how he currently feels. I would think that medical schools/universities have mentoring and support networks so that not only peer but supervisor support and guidance are readily available. Similarly, [I] would expect that *beyondblue* and similar groups would have a good presence.

by Peter Thompson (not verified)

The Federal Government is coming under mounting pressure to dump its controversial $2000 cap on tax deductions for self-education expenses amid a groundswell of opposition from organisations representing more than 1.6 million doctors, nurses, engineers, lawyers, accountants and other professionals. One reader shares his view.

I trust, as a matter of equality, that all taxpayer-funded education trips for politicians will be capped at $2000.

by Edward Heffernan (not verified)

Ophthalmologists have launched legal action against medical practice regulators in an escalation of a row over the role and responsibilities of optometrists. This idea has sparked concerns from some our readers.

This is very similar to the proposal some years ago for psychologists to be able to prescribe psychoactive medications. It is a very worrying [development].

by Peter Binns (not verified)

It is very concerning. Especially when they start to administer topical Beta-blockers to elderly patients prone to bradyarrythmias.

by Eye Doctor (not verified)

The Federal Government has sharpened its pitch to the primary health sector ahead of the Federal election, boosting funding for research and outlining plans to shift it to the centre of national health policy. Members voiced their opinion on what is needed for better primary health care.

Contrary to [Health Minister] Tanya [Plibersek]'s assertion, Medicare Locals are not the newest front-line in GP medicine. They are blood-sucking parasites that drain money away from genuine coalface general practice and contribute only to the welfare of the bloated mandarins who run them. They are also contributing to the Government's grasp on the GPs' throats - where have the after hours and psychiatric care funds gone? The future of general practice depends on the destruction of this blight on the profession.

by Pat Gibney (not verified)

The future of efficient, effective and accessible patient-centred primary health care is a very well integrated primary health care team led by GPs and practice nurses, with a well coordinated buy-in from the allied health professions. Medicare Locals are proving around Australia that they can drive the required coordination of all primary health professionals. This process also involves the evolution of the electronic medical record, which feeds out to a patient's relevant multidisciplinary health team. It doesn't happen overnight, it is not without some mistakes, but in the end it will result in getting closer to world best practice in primary health care. Some health professionals choose to lead to a new future by hard work, some follow and some just sit and complain. As chair of Barwon Medicare Local, I know Medicare Locals have chosen a strong leadership role.

by Dr Tim Denton (not verified)

Rules forcing doctors to get permission from public servants before prescribing medicines is outdated and needs to be scrapped, according to the AMA. One reader expresses the need for a better tracking system for prescribed medication.

I think a free-for-all system will increase the cost to taxpayers and increase iatrogenic opioid issues. The last 20 years has seen Australia become the drug capital of south-east Asia, with a large number of patients misusing S8 drugs. This has resulted in a strong element of criminality, whereby many patients sell their opioids. If AMA is proposing getting rid of the PBS Authority, they need to have a good back up plan to track doctor shopping and over-prescribing of dangerous medication. The halt system is inundated with self-inflicted illnesses through misuse of prescribed medication. So please, have a better system of tracking prescribed medication, as the alternative would see more tax rises to pay for more bad decisions.

by Anonymous (not verified)

TO COMMENT CLICK HERE

Research

Men's Health

An obese grandfather could heighten the risk of unhealthy weight gain in both his children and grandchildren in a disturbing insight into the long-lasting affects of poor nutrition and lifestyle.

Researchers from the University of Adelaide's Robinson Institute have found that molecular signals in sperm of obese fathers can lead to obesity and diabetes-like symptoms in two generations of offspring, even if the offspring eat a healthy diet.

The researchers examined two groups of mice, one fed a high fat diet for ten weeks and the other kept on a control diet. Both groups were mated with mice on a control diet.

Researchers found the offspring of the mice whose fathers were on the high fat diet were 21 per cent more likely to become obese.

Lead researcher Dr Tod Fullston said the father's diet changed the molecular makeup of their sperm, which in turn may have programmed the embryo for obesity or metabolic disease later in life.

"For female offspring, there is [also] an increased risk of becoming overweight or obese. What we've also found is that there is an increased chance of both male and female offspring [of an obese father] developing metabolic diseases similar to type 2 diabetes.

"This is the first report of both male and female offspring inheriting a metabolic disease due to their father's obesity.

"It's been known for some time that the health of a mother before, during and after pregnancy can impact on her child's health, but the father's health during this period is often overlooked.

"If our laboratory studies are translatable to humans, this could be a new and as yet unexplored intervention window into the epidemic of childhood obesity."

The research was published in the *FASEB* journal.

University of Adelaide researchers have also found that men who get up more than once a night to pee could be suffering from a range of health conditions.

Professor Gary Wittert, Director of the Freemasons Foundation for Men's Health, said the need to urinate at night is a problem with urine storage, and this disrupts sleep. He said it is an indication of, and can also exacerbate, other health conditions.

"Nocturia, combined with the sensation of not being able to hold on (urgency), or frequent urination, suggest the presence of overactive bladder syndrome," Professor Wittert said. "We are now beginning to understand the broader relevance of this in relation to other health problems."

One on five Australian men aged 40 years or older, and a third of men aged 70 years and older, have overactive bladder syndrome.

Researchers examined lifestyle, metabolic and physical factors associated with the progression or improvement of lower urinary tract symptoms.

Researchers found that men with a higher level of physical activity were found to reduce or eradicate lower urinary tract symptoms more quickly than men who were less active.

Men who were widowed, had higher plasma estradiol and had depression were more likely to suffer an increase in the severity of their condition, but the symptoms reduced dramatically when these issues were addressed.

Lead researcher Dr Sean Marin said the presence of lower urinary tract symptoms, although commonly thought to relate to the prostate, may have more to do with factors outside the bladder and prostate.

"These urinary problems are associated with other conditions, such as sleep apnoea, depression or anxiety and obesity, and many of these problems are treatable or modifiable," Dr Martin said.

"As we've seen in our study, men can overcome their urinary problems if the underlying issues are correctly managed."

Professor Wittert said nocturia and overactive bladder syndrome are also risk factors for type 2 diabetes and cardiovascular disease.

"Often when a man presents to his GP about urinary problems, the first assumption is that it's all because of the prostate. However, our message is: men who are suffering from any of these water-works problems are also likely to be suffering from a range of other health problems that should be looked for and managed.

"In this way, men have a greater chance of reversing their bladder problems and potentially preventing more serious disease."

The research was published in *The Journal of Urology*.

Kirsty Waterford

TO COMMENT CLICK HERE

Research

Dementia's march may be faltering

Alzheimer's disease may in future blight far fewer lives than had been feared following signs that the incidence of the debilitating and deadly condition may be receding.

In a promising development for individuals and health authorities, new research suggests the prevalence of dementia in the United Kingdom has decreased in the past two decades – contradicting assumptions that the condition is on the rise.

The study found that people born in the latter part of the twentieth century had a lower risk of developing dementia than those born earlier in the century, hinting that the recent rise in Alzheimer's disease – an underlying cause of dementia – may not be inexorable.

The findings were based on interviews with more than 7500 people aged 65 years and older, and researchers compared the results with those from a similar study conducted between 1989 and 1994 in the same locations.

The researchers found only 6.5 per cent of those interviewed between 2008 and 2011 showed symptoms of dementia, compared with 8 per cent among those interviewed between 1989 and 1994.

The study also found women were more likely to develop dementia than men, with 8 per cent of women estimated to have the disease compared to only 4.9 per cent of men.

The research was published in *The Lancet*.

The *New York Times* also recently reported that a study conducted in Denmark in 2010 found people in their nineties who were given a standard test of mental ability scored substantially better than people who had reached their nineties a decade earlier.

Alzheimers Australia Chief Executive Officer Glenn Rees said that, while a reduction in the prevalence of dementia in the UK is welcome news, it highlighted the need for better data on its incidence in Australia.

"We know that the estimates do change. The projection for the number of people with dementia in 2050 recently was scaled back from over a million to 900,000," Mr Rees said.

Currently, there are more than 320,000 Australians living with the condition, and this number is expected to rise to around 400,000 within the next 10 years.

Each week, 1700 new cases of dementia in Australia are diagnosed, and it is the third leading cause of death in Australia.

While researchers offshore are finding signs Alzheimer's may be on the slide, Melbourne scientists are helping unravel the links between a person's brain chemistry, their genes and the risk of developing the disease.

Their research, recently presented at the Alzheimer's Association International Conference in Boston, has shed new light on the highest risk group for Alzheimer's disease.

The research examined the interplay between two known Alzheimer's disease (AD) risk factors – amyloid plaques in the brain and the common gene variation, BDNF Val66Met.

Lead researcher Professor Paul Maruff, Chief Science Officer at Melbourne-based cognition testing company Cogstate, said the study confirmed that both elevated brain amyloid and the common gene variation are risk factors for AD.

"The presence of both [elevated brain amyloid and the common gene variation] signal those at highest risk, and patients in whom cognitive deterioration was more rapid," Professor Maruff said.

"This is important because it can help to identify those with the most to gain from early drug [treatment] and perhaps even behavioural intervention designed to prevent AD."

Interestingly, Professor Maruff and his colleagues found older patients diagnosed with mild cognitive impairment, but who had normal brain amyloid levels, did not show a decline in memory over time, suggesting their cognitive impairment may have been due to other, more readily treatable, causes such as depression or stress.

The researchers also found that healthy older people with abnormally high brain amyloid levels and who also carry the common gene, suffered more rapid declines in memory and other aspects of cognition than those without the gene variant.

Australian of the Year and Alzheimer's Australia National President Ita Buttrose has called on both sides of politics to outline their plans to address the impending dementia epidemic.

"There is a need for political leadership to tackle the stigma and social isolation associated with dementia by engaging people with dementia in our communities and ensuring they have access to the everyday services we all enjoy," Ms Buttrose said.

Kirsty Waterford

TO COMMENT CLICK HERE

Research

Heart attack survivors missing the beat

Many heart attack survivors underestimate their risk of having a future heart attack and fail to follow their GP's advice or attend rehabilitation, according to a new report.

The study found around 40 per cent of heart attack survivors admitted to not following their GPs instructions to improve their heart heath.

One in three (34 per cent) reported that they occasionally forgot to take their prescribed medication, and only 54 per cent of men and 39 per cent of women attended cardiac rehabilitation after their heart attack.

Those who did attend rehabilitation were found to have an increased understanding of their illness and were more concerned about having a repeat event.

Carers were found to be more deeply affected by the heart attack of their loved one than the survivors themselves, were burdened by greater concern about the attack and were worried when survivors did not take responsibility for their future heart health.

One in ten heart attack survivors reported being current smokers and 93 per cent felt their cholesterol was under control, despite one third (35 per cent) of survivors having total cholesterol levels above the recommended treatment targets.

The majority of survivors believed lifestyle changes were important to maintain good health, but 83 per cent of women and 73 per cent of men reported this as a challenge. The majority, 58 per cent, did not adhere to a healthy diet and only 32 per cent exercised regularly.

The report, by Baker IDI, was based on data from more than 1000 people – 536 of whom had survived a heart attack following hospitalisation, and 511 who cared for a survivor.

Lead researcher Professor Simon Stewart from Baker IDI said the study served as a major wake up call to Australians living with coronary heart disease, and highlighted the need for more effective prevention and support programs for heart attack survivors.

"The findings suggest that heart attack survivors are failing to make the necessary lifestyle changes to mitigate their risk of a repeat heart attack," Professor Stewart said.

"Nearly one in four people who are fortunate to survive a heart attack will go on to have another episode or require medical intervention. Within a year, one in 11 of these people will die. But, despite the odds, many of the survivors we surveyed weren't following optimal care strategies.

"I think we need to place greater emphasis on patient education, supported by innovative strategies such as telephone support and in-home care."

Commenting on the report, The Heart Foundation's National Director of Cardiovacsular Heath Dr Rob Grenfell said the findings highlighted the worrying fact that most people who survived a heart attack thought that they were 'fixed' following discharge from hospital.

"Our hospitals are well equipped to treat heart attacks, and currently Australians have the best chance of surviving their heart attack then ever before, with deaths from heart attack declining by 39 per cent over the last two decades," Dr Grenfell said. "However, as a patient leaves hospital, our health system does not appear to adequately provide ongoing care and support. There is a limited connection between services, and essential lifestyle programs are disjointed or, frankly, unsupported."

Kirsty Waterford

TO COMMENT CLICK HERE

A pill a day could keep heart attack at bay

A simple daily dose of cholesterol-lowering medication could protect tens of thousands of men from heart attacks and strokes and save governments millions of dollars in health expenses, according to British research.

In a result that lends support to calls for expanded use of statins, a West Scotland study has found that taking the cholesterol-lowering medication pravastatin (40 milligrams) each day for five years cuts the risk of "cardiovascular events" over a 15-year period, adding to quality of life, reducing hospitalisation rates and delivering substantial health savings.

The findings were based on the results of a randomised trial involving 6595 men aged between 45 and 54 years who had

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Research

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hypercholesterolaemia but without a history of myocardial infarction.

It found that for every 1000 who took a daily 40 milligram dose of pravastatin for five years, there were 163 fewer hospital admissions over 15 years due to cardiovascular problems including myocardial infarction, stroke, heart failure, coronary revascularisation and angiography.

The researchers said that, in all, the treatment prevented 1836 days of hospitalisation over 15 years for every 1000 men taking the statin, at a net saving to the health system (taking into account the cost of the medicine) of $1.3 million.

The study's authors said there was no evidence of any increase in non-cardiovascular admissions or associated costs among those taking pravastatin.

The significance of the findings has been thrown into stark relief by recent debates about the effectiveness of statins as a preventive treatment.

"Our analyses suggest that statins are even more cost-effective in primary prevention than had previously been suspected," the authors said. "These effects, seen across a range of underlying cardiovascular risks, suggest that treatment of even lower-risk individuals would still be economically efficient and deliver significant public health benefits. Our results add to and support a recent call for expanded use of statins."

But they added the proviso that there was potentially an increased risk of developing diabetes among patients using statins for more than five years.

Adrian Rollins

TO COMMENT CLICK HERE

Life-threatening reactions prompt tick alert

Common ticks cause life-threatening reactions in dozens of patients every year, the largest ever study of Australian tick bites has found.

Researchers from three Sydney hospitals – Hornsby, Concord and Mona Vale – found that 34 patients suffered anaphylaxis – an acute life-threatening allergic reaction – after being bitten by ticks, most commonly the paralysis tick *Ixodes holocyclus*, which is endemic along the nation's eastern seaboard.

The findings were based on an examination of emergency presentations of patients with tick bite at Mona Vale Hospital

between January 2007 and December 2008.

The study, led by Dr Tristan Rappo of Hornsby Hospital, identified more than 500 cases of tick bite cases at Mona Vale Hospital over the two-year period, 6 per cent of which involved anaphylaxis.

Dr Rappo said tick bite anaphylaxis has been rarely reported in Australia, and the first formal notification was not made until the 1960s.

Of those found in the study to be suffering anaphylaxis, the vast majority (94 per cent) showed symptoms on their skin, and more than a third (13 out of 34 cases) had a history of allergies or previous anaphylaxis.

The most common sites of tick bites were the head and neck (57 per cent) and trunk (20 per cent).

Dr Rappo said ticks were common in Australia – there are about 70 species – meaning health workers needed to be aware of the symptoms they could cause.

"The variations in the presenting symptoms and signs, as well as in management, highlights the need for increased awareness and guidelines for tick bite management in tick-endemic areas," he said.

The study was published in *Emergency Medicine Australasia*.

Adrian Rollins

TO COMMENT CLICK HERE

Glaxo execs held in Chinese bribery scandal

"While we don't expect them to set a moral example, we expect them to obey the law"

Chinese authorities are looking into the operations of a number of multinational drug companies after four senior GlaxoSmithKline executives were detained amid allegations of widespread bribery and corruption.

Head of the Economic Crimes Investigation Unit at China's Ministry of Public Security, Gao Feng, told *The Guardian* that "some clues" of illegal money transfers involving several pharmaceutical giants had come to light during a six-year investigation into the activities of executives from GSK's Chinese subsidiary.

In a rare public briefing for national and international media, Mr Gao revealed that investigations had found almost $540 million in bribes and deals was funnelled out to doctors and lawyers through a network of more than 700 travel agencies and middle men.

"We found that bribery is a core part of the activities of the company," Mr Gao said. "To boost their share price and sales, the company performed illegal actions."

According to reports in Chinese newspapers, cited by *The Guardian*, travel agencies working for GSK would create bogus meetings that ostensibly required travel, and would use the money provided to bribe doctors to prescribe GSK drugs.

Each doctor was given a credit card by GSK, and kickbacks were transferred to the card the day after drugs were prescribed.

In return, it is alleged, travel agencies bribed GSK executives with cash and sexual favours.

Such corruption is not unusual in the Chinese health system, *The Guardian* said. Hospitals frequently use drug sales to make up for shortfalls in government funding, and doctors supplement their modest income with kickbacks from drug companies and patients.

The head of GSK's Chinese operations, British national Mark Reilly, left China on 27 June, but GSK said it would cooperate fully with Chinese authorities in their investigations.

In a statement released on 15 July, the British-based company said it was "deeply concerned and disappointed by these serious allegations of fraudulent behaviour and ethical misconduct by certain individuals at the company and third-party agencies".

The company said such behaviour, if proved, would be a clear breach of its procedures, values and standards.

"GSK has zero tolerance for any behaviour of this nature," the company said. "GSK shares the desire of the Chinese authorities to root out corruption. These allegations are shameful and we regret this has occurred. We will cooperate fully with the Chinese authorities in the investigation."

The pharmaceutical giant said it had already acted on the allegations.

"We are reviewing all third party agency relationships. We have put an immediate stop on the use of travel agencies that have been identified so far in this investigation and we are conducting a thorough review of all historic transactions related to travel agency use," the company said.

The scandal has erupted as the operations of drug companies are coming under increasing scrutiny in many parts of the world.

In the United States, the Physician Payment Sunshine Act introduced as part of the Obama Administration's health reform package requires company to disclose payments made to individual physicians, and a similar regime is being developed by the Australian medicines industry, in consultation with groups including the AMA.

AMA President Dr Steve Hambleton said that while the AMA supports increased transparency surrounding the relationship between pharmaceutical firms and doctors, the disclosure of payments to individual practitioners had to be handled sensitively to ensure the public was well informed.

The activities of foreign drug companies has already come under scrutiny in China over concerns about market position and pricing, and earlier this month Nestle, Abbot and Mead Johnson agreed to cut the cost of their infant formula by up to 20 per cent after the Chinese Government announced an inquiry into formula pricing.

Mr Gao put multinational pharmaceutical firms on notice that their activities were being closely monitored by Chinese authorities.

"I need to remind foreign pharmaceutical companies that, because they occupy a leading position in the industry and reap huge amounts of commercial profits, they should also bear a great responsibility to society and the public," the official told *The Guardian*. "While we don't expect them to set a moral example, we expect them to obey the law."

Adrian Rollins

TO COMMENT CLICK HERE

Mystery killer takes heavy annual toll of the young

Health experts are struggling to identify an encephalitis-style infection that has killed thousands of children in impoverished areas of northern India in the past two decades.

According to the *New York Times*, Indian doctors have joined forces with specialists from the US Centers for Disease Control and Prevention to track down the cause of the mystery illness that can strike down young children in a matter of hours, causing severe dehydration, convulsions and – in about a third of all cases – death.

The unidentified disease – first publicly noted in 1995 when an outbreak left 300 children dead and a further 700 seriously ill – appears every northern spring and summer, killing dozens, if not hundreds of children at a time, and striking fear into anxious parents.

This year, more than 70 deaths have been attributed to the disease in just one northern India state alone – Bihar – and authorities expect many more cases are going unreported.

The illness has been provisionally dubbed acute encephalitis syndrome, but tests for known causes of brain swelling such as meningitis and Japanese encephalitis have come back negative, according to the *New York Times*.

Senior Indian health officials admit they are in the dark about what the disease is, and how it is caused.

"This outbreak happens every year, and we have not been able to identify the cause, or link even a single factor responsible," the Director of the National Centre for Disease Control in India, Dr L.S. Chauhan told the *New York Times*.

In an effort to lift the veil of mystery surrounding the disease, Dr Chauhan – with assistance from the US CDC – is training seven physicians to help try and track down the infection.

Working at the epicentre of the outbreak in the Muzaffarpur region, the team is investigating a wide range of potential causes and sources including viruses, bacteria, water contamination, pesticides, rats, bats, mosquitoes, sand flies and even alcoholic tree sap.

Australian virologist Dr Ian Mackay said in his blog *Virology Down Under* (http://www.uq.edu.au/vdu/) that it was hard to understand why it had taken so long for international collaborative efforts to identify the disease to get underway.

Dr Mackay said that, from available information, it was difficult to ascertain exactly what the Indian researchers were testing for, and what sort of facilities they had to conduct their tests.

"There are many infectious potential causes of such disease, and many, many potential sources for acquiring such pathogens, which includes a wide range of viruses," he said. "Some of these viral culprits have only recently been discovered - the picornaviruses - klassevirus, parechovirus cosavirus and the Saffold viruses - among many better-known viruses."

Adrian Rollins

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INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

From graduates preparing their first resume to experienced doctors seeking to carve out a new career path in the Commonwealth public service, the AMA Careers Advisory Service has been on hand to provide practical advice and information.

Since the Service was launched in September, AMA Careers Consultant, Kathryn Morgan, has handled dozens of inquiries from members looking for help and advice on advancing their careers, both within medicine and beyond.

The Careers website, which is at: http://careers.ama.com.au/, gives members access to both general and specific careers advice and information. In addition to direct links to external websites and specific sources of information, the Service also offers practical advice for medical professionals as their medical careers advance.

The Careers Service provides information and support relevant to all stages of an individual's career, from medical students looking for assistance preparing internship applications - particularly writing resumes and covering letters - through to doctors in training who want to brush up their interview skills to give them a competitive edge at all-important medical college interviews.

But the Service is not only there for those in the early stages of their medical careers. It has also helped qualified medical professionals looking to apply their skills and expertise in jobs beyond medical practice. Among these have been those looking for non-clinical roles in Commonwealth and State public services that take advantage of their skills and experience.

The Service is constantly updating content on its website, including listings of career-related events being staged across the country, and uses feedback from members to help add and develop resources.

Members are encouraged to visit the website, if they haven't done so already, and we welcome feedback, which can be submitted via the online feedback form on the website.

There will be further updates on developments in the Careers Service in coming months as we develop more ways to assist members along their medical career path.

If you or your colleagues would like to convene a skills workshop facilitated by Kathryn, please contact her at:

Phone: (02) 6270 5410
1300 884 196 (toll free)

Email: careers@ama.com.au

Claims of undue influence cloud UK backflip on plain packaging

British Prime Minister David Cameron has come under intense pressure over his relationship with Conservative Party election strategist Lynton Crosby following his Government's decision to abandon plans to introduce plain tobacco packaging and a minimum unit price for alcohol.

Mr Cameron was besieged in Parliament by questions about the role played by Mr Crosby – whose clients include tobacco giant Philip Morris and a drinks industry body campaigning against alcohol minimum pricing in Australia – in convincing the Government to drop the policy proposals.

As reported in *Australian Medicine* (https://ama.com.au/ausmed/british-government-dumps-plain-packaging-push) in May, Mr Cameron ordered that a reference to plain packaging laws be pulled from the speech delivered by Queen Elizabeth to Parliament, in which she set out the Government's legislative agenda.

Then his Government formally abandoned plans to set a minimum unit price for alcohol, even though Mr Cameron had previously backed the idea as a way to curb binge drinking.

In Parliament, and later in a media conference, the UK Prime Minister vigorously denied suggestions either decision had been influenced by Mr Crosby, who began advising the Conservative Party in the lead-up to the UK General Election in 2005 after overseeing four federal election campaign victories for the John Howard-led Liberal Party in Australia.

"He [Mr Crosby] has never lobbied me on anything," Mr Cameron told the House of Commons, and later said at a media conference that "this is a complete red herring which is raised by the Labour Party because it is in political trouble…[over] its relationship with unions".

The British PM said the decision to drop plain packaging legislation was taken in consultation with Health Secretary Jeremy Hunt "for the very simple reason that there is not yet sufficient evidence for it, and there's considerable legal uncertainty about it".

But a study published in the *BMJ* last week suggests plain packaging may be effective in encouraging smokers to consider giving up the habit (see *Plain packs may cause smoker second thoughts,* p26).

Last December Australia became the first country in the world to introduce plain packaging laws after defeating a High Court challenge mounted by the major tobacco companies.

Adrian Rollins

TO COMMENT CLICK HERE

Millions die from pollution

More than two million people die every year because of foul and polluted air, according to a United States study.

Researchers at the University of North Carolina have released estimates that up to 3.5 million people die annually from the effects of air pollution, mostly ozone and fine particulate matter.

Study co-author Dr Jason West told *United Press International* said the study showed that "outdoor air pollution [is] among the most important environmental risk factors for health".

"Many of these deaths are estimated to occur in East Asia and South Asia, where population is high and pollution is severe."

Diplomatic tensions between Singapore and Indonesia escalated earlier this month when a dense cloud of smoke from burning Sumatran peat land – being cleared for palm oil plantations – smothered the island nation in a chocking blanket of smog.

And early this year much of Beijing was brought to a virtual standstill when levels of air pollution reached extreme levels, underlining concerns that the Chinese and other Asian people are paying a heavy price in health for the rapid economic development of their countries.

The University of North Carolina researchers modelled concentrations from an ensemble of chemistry–climate models to estimate the global burden of outdoor air pollution on present-day premature human mortality.

"Using simulated concentrations for 2000 and 1850 and concentration–response functions (CRFs), we estimate that, at present, 470,000 premature respiratory deaths are associated globally and annually with anthropogenic ozone, and 2.1 million (and up to 3 million) deaths with anthropogenic [fine particulate matter-related cardiopulmonary diseases (93 per cent) and lung cancer (7 per cent)," the study said.

The AMA has called for tighter regulation and monitoring of air pollution, particularly fine particulate matter, in Australia.

Adrian Rollins

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INFORMATION FOR MEMBERS

Doctor health under examination

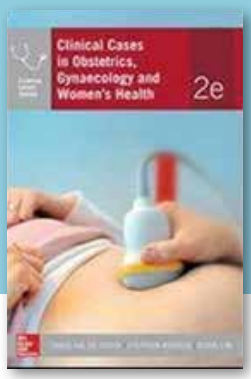
The wellbeing of health professionals themselves will be the focus of a conference to be held in October.

The Health Professionals' Health Conference 2013, under the title the *Caring for You, Caring for Others*, will bring together local and international experts to discuss all aspects of the health of doctors and other medical professionals, including physical and mental wellbeing, mandatory reporting, managing conflict, ageing and "compassion fatigue".

The Conference is being held at the Sofitel Brisbane from 3 to 5 October.

For more details and to register, visit: www.hphc2013.com.au

BOOK REVIEW



Clinical cases in obstetrics, gynaecology and women's health

By Caroline De Costa, Stephen Robson and Boon Lim

McGraw Hill Education, RRP $55, pp316. ISBN 978-1-7430-77-2
Reviewed by Gino Pecoraro*

Clinical cases in Obstetrics, Gynaecology and Women's Health is a handy A5-sized pocket textbook suitable for medical students, general practitioners and early year obstetrics and gynaecology registrars.

This easy-to-read and portable primer of women's health is filled with simple, frequently unwritten information like positioning of patients when examination is difficult, as well as guidelines for the diagnosis and management of common issues like gestational diabetes.

Scattered throughout the text are reminders that patients are more than just clinical problems. Embedded in any treatment plan is recognition and acknowledgement of associated emotional and social needs.

Part one concentrates on the vital background information on how to take an effective and complete obstetric and gynaecological history, as well as what is involved with a gynaecological examination in an adult.

Each section starts with a life-like clinical scenario. It may be a patient asking for advice, someone presenting with specific symptoms or the reader being faced with a clinical emergency.

These scenarios are representative of the full scope of women's health practice, including management in pregnancy and labour, fertility issues and gynaecological problems later in life.

From acne, unexpected pregnancy, questions around safe sex and amenorrhoea through to twin pregnancy, placental abruption, pain relief in labour and elective Caesarean section - most frequently encountered subjects are covered.

There's also a case covering prolapse and urinary incontinence.

This problem-based learning approach is a continuation of methods used in modern medical education, and should feel familiar and comfortable to the junior doctors the book is aimed at.

Using a series of patient questions to stimulate thought, the reader is guided through history, examination, investigation and treatment.

Interspersed throughout the text are important pieces of theoretical knowledge explaining why a particular course of investigation or treatment is required.

In some cases, prompts to remind the reader to ask for important collateral history are included and help ensure all avenues of the potential case are explored and dealt with.

Tables, illustrations and photographs are presented where appropriate to consolidate important factual information and illustrate important surgical techniques such as repair of episiotomy.

By working through each case in a logical fashion, the reader is encouraged to be an active participant in the care of the patient rather than reading lists of differential diagnoses, investigations and treatment.

Where multiple options are available, they are expanded upon and reasons for choosing one over another offered.

At the end of each clinical scenario, a section entitled "clinical pearls" provides a summary of important learning points around the topic.

These pearls include information such as incidence rates of common problems, brief targeted discussions of pathophysiology and sensible advice on treatment options.

For potentially life-threatening scenarios like primary postpartum haemorrhage, easy to follow flowcharts detailing investigation and treatment (including asking for help) provide a one-stop reminder for junior staff members in a stressful situation.

Doses for frequently used drugs, especially in emergency situations, are not always given throughout the text and I would recommend this be considered as an addition in future editions to make the textbook truly all-inclusive and self-sufficient for junior medical staff.

All in all, this book provides an excellent summary and easily portable resource for any medical student or junior doctor to use during a women's health term.

Information is provided in an easy-to-read and rapidly accessible format, with practical advice from the authors that clearly reflects their extensive real-life clinical experience in the field.

** Dr Pecoraro is a Brisbane-based obstetrician and gynaecologist, a past President of AMA Queensland, and represents the Obstetrician and Gynaecologist Craft Group on the AMA Federal Council*

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Public transport - just the ticket

BY **DR CLIVE FRASER**

After writing this column for the past 10 years I can report that the email feedback that I receive is polarised.

Firstly, I receive many requests to review high-performance eco-unfriendly vehicles.

German cars, V8s - anything that goes fast - and who cares how much fuel it uses to get there?

I equally receive requests from green doctors to review relatively environmentally-friendly cars.

Hybrids, electric cars, anything that goes a long way without producing too much CO2.

In deference to the second group I thought that this month I'd take a different look at how to get from A to B.

That is, no car review this time, but a peek at the public transport system.

To set the bench-mark as high as possible, I road-tested the public transport system in Hong Kong to see what might lie ahead for all of us in a world without cars.

My journey started at the airport where I bought an Octopus Card for $300 Hong Kong dollars (about $A42).

This included an each-way trip on the Airport Express to the city and unlimited MTR (train and bus travel) for three days.

Oh, and as an added bonus, the Airport Express part of the journey also includes free transfers to and from your hotel on a local bus.

Once purchased, the Octopus Card can be topped up for travel on other transport, such as trams and ferries.

And the same card can be also used to pay for small value items at hundreds of locations, and can even be used in some taxis.

The Octopus Card is so smart that it only needs to be in the vicinity of the reader, and doesn't even have to leave your wallet or purse to be read.

Public transport in Hong Kong is unbelievably cheap, with a scenic bus trip across the island to Stanley only costing $A1.10, and travelling the whole 13 kilometres of historic tramways costs only 32 cents.

The Star Ferry to Kowloon across the harbour only costs 35 cents each way, and the views of the sky-line and the laser light show are free.

When using public transport in Hong Kong there are some idiosyncrasies to master, such as on buses you pay on the way in and on trams you pay on the way out.

While all the signs are bilingual, there is still room for confusion as there are two stations on the train network with what seems like the same name (Wan Chai and Chai Wan).

In providing what is arguably the best public transport system in the world, it does help that Hong Kong is still the most densely populated city on earth.

There are twice as many skyscrapers in Hong Kong as there are in New York.

Hong Kong also boasts more Rolls Royces per capita than anywhere else but, apart from the trip to Stanley, there isn't really anywhere to drive to.

For those that like walking, Hong Kong also boasts the longest escalator system in the world.

At 800 metres, it takes locals down-hill from Soho in the morning, and at 10.15am it reverses its direction to take them home.

Hong Kong is a great city, and like all great cities you don't need a car to get around.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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