

A U S T R A L I A N

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Hospital vital signs slipping

Patients, staff pay as Govt shirks health bill, p6

INSIDE

- 7** Culture clubbed: move to stamp out harassment
- 8** Drs face challenge to prove their worth
- 10** Nation stocks up for flu season
- 11** Ten commandments to cut doctor red tape
- 29** The forgotten Anzac invasion
- 31** Patients could get caught in metadata net

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AMA LEADERSHIP TEAM



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In this issue

National news 6-16

Health on the Hill 30-32

Features

PHARMACY UNDER FIRE 26-28

THE FORGOTTEN ANZAC INVASION 29

Columns

- 3 PRESIDENT'S MESSAGE
- 4 VICE PRESIDENT'S MESSAGE
- 5 SECRETARY GENERAL'S REPORT
- 17 GENERAL PRACTICE
- 18 PUBLIC HEALTH OPINION
- 19 MEDICAL WORKFORCE
- 20 RURAL HEALTH
- 21 DOCTORS IN TRAINING
- 22 AMSA
- 23 ETHICS AND MEDICO LEGAL
- 24 INDIGENOUS HEALTH
- 25 MEDICAL PRACTICE
- 33 WINE
- 34 MOTORING
- 35 MEMBER SERVICES



Report Card puts the spotlight on public hospital funding

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

“Without sufficient funding to increase capacity, public hospitals will never meet the targets set by governments, and patients will wait longer for treatment”

One of the AMA's major advocacy roles is to fight for proper funding for the nation's public hospitals, and our primary campaigning tool is the annual *AMA Public Hospital Report Card*.

The Report Card sends a strong message to all Australian governments that public hospitals are a major pillar of the health system, and they must be supported with proper funding, resources, and staff to build capacity and meet growing demand.

The Report Card presents data published by the Commonwealth, year on year. Its purpose is to enable an assessment of the performance of our public hospitals and their capacity to meet the community's need for hospital services.

The Commonwealth is currently withdrawing from its commitment to sustainable public hospital funding, and its commitment to meet an equal share of growth in public hospital costs.

In its 2014-15 Budget, the Commonwealth announced that, from July 2017, it will strictly limit its future contribution to public hospital costs, with future funding growth restricted to the cost of indexation and population growth.

This will fall well short of the funding needed to position public hospitals to meet the increasing demand for services. The changes mean that State and Territory governments will have greater responsibility for funding public hospital services.

In the shorter term, the Commonwealth has reduced hospital funding to the States and Territories by \$1.8 billion up to 2017-18 by withdrawing the funding guarantees made in the National Health Reform Agreement.

In its Budget update released on 15 December 2014, the Government announced a further reduction in funding for public hospitals of \$941 million over four years. The Government claimed this reduction was simply the result of the method for hospital financing put in place by the previous government.

The Government appears to be picking and choosing which elements of existing health financing arrangements they will observe, depending where the cost falls.

The Government has justified its extreme health savings measures on the basis that Australia's health spending is unsustainable. But Australia's health financing arrangements are not in crisis.

In 2012-13, Australia had the lowest growth (1.5 per cent) in total health expenditure since the Government began reporting it in the mid-1980s. Without any specific government measures, there was negative growth (minus 2.2 per cent) in Commonwealth funding of public hospitals in 2012-13, and only 1.9 per cent growth in 2011-12. Our health sector is doing more than its share to ensure health expenditure is sustainable.

Australia's expenditure on health has been stable as a share of GDP, growing only one per cent over the last 10 years. Health expenditure does not demand radical changes to existing services.

If it proceeds with its savings measures, the Commonwealth will lock in hospital funding and capacity at the inadequate levels demonstrated by current performance.

Without sufficient funding to increase capacity, public hospitals will never meet the targets set by governments, and patients will wait longer for treatment.

Commonwealth funding for public hospitals is now at a low base, and the Commonwealth's current approach will keep it there.

At the same time, the Commonwealth Government has embarked on a debate on roles and responsibilities in health as part of the Reform of the Federation. At this point, what this debate will actually mean for future public hospital funding is unknown.

Clearly, what it should mean is agreement by the Federation on sufficient and guaranteed funding for public hospitals to meet the needs of the Australian community.

The AMA will remain vigilant to make sure our governments do not neglect their responsibility to provide the community with quality public hospital services.



Australians need to get physical

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Physical inactivity is an increasing problem in our nation.

Currently, between 60 and 70 per cent of Australians are either sedentary or have unacceptably low levels of physical activity. These lifestyle habits make an enormous contribution to the burden of disease in Australia and around the world.

As an emergency physician, I regularly encounter many of the damaging health effects of physical inactivity in the patients I treat

A lack of physical activity has been identified as the fourth most significant risk factor for global mortality. It is estimated to be the main cause of up to a quarter of the worldwide burden of breast and colon cancer, 27 per cent of diabetes, and 30 per cent of the ischemic heart disease.

As an emergency physician, I regularly encounter many of the damaging health effects of physical inactivity in the patients I treat. Recent examples include a 35-year-old man who was suffering a heart attack, a woman of similar age with uncontrolled type 2 diabetes, and several patients with serious injuries related to falls after prolonged immobility.

It is often the case that people consider exercise in the context of achieving weight loss. But the benefits of physical activity extend much, much further.

Regular physical activity is known to reduce the risk of common and serious pathologies such as cardiovascular disease and stroke, type 2 diabetes, hypertension, some cancers and osteoporosis.

Just walking for half an hour a day, five days a week, may prolong life expectancy by up to three years.

I myself have benefitted tremendously from regular exercise. More than 10 years ago I started a new job and wasn't allocated a car space. After much initial angst, I started riding a bicycle

the three kilometre journey. Cycling is now my principal means of transport, and I am much fitter and healthier for the change.

Physical activity doesn't just provide physical benefits. Good evidence has demonstrated its positive effect on mental health.

It can improve both short and long-term psychological wellbeing by reducing stress, anxiety and depression, and there is also evidence to suggest that physical activity may be useful in the treatment of mild to moderate depression.

There is much that individuals can do to improve their activity levels. But they can't do it all. It is not simply a matter of motivation and willpower.

There are key issues, often beyond the control of individuals, that must be considered at community, corporate, and government levels. Affordability issues and a lack of access to necessary infrastructure, can, and do, prevent many people from taking part in adequate physical activity.

There must be appropriate opportunities for people at all stages of life to engage in physical activity.

From health care settings to schools and workplaces, we need to systematically increase physical activity. In urban planning and architecture, roads, public transport and open public spaces, there is much to do in building a strategy for an active and healthy society.

It has been estimated that increasing participation in physical activity by just 10 per cent would save \$258 million, with 37 per cent of those savings in the health sector alone.

Within our own profession, let's emphasise the benefits of exercise and increased physical activity. They are important tools in the quest for resilience and improved mental health, given the demanding lives we lead as doctors.

In an address I recently gave to health sector leaders and MPs at Parliament House, I announced the AMA would work to realise an important step in achieving these goals - the active involvement and support of the Federal Government in developing a National Physical Activity Strategy. The old adage still applies - use it, or lose it.



Improving public health is core AMA business

BY AMA SECRETARY GENERAL ANNE TRIMMER

“Public health advocacy is a core AMA activity. Public health campaigns will be a feature of that advocacy over coming years”

The AMA has as one of its two principal objectives promoting patient wellbeing, which includes advocating health policies that benefit the community. This is reflected in the AMA's mission statement, *Leading Australia's Doctors – Promoting Australia's Health*.

At its most recent meeting, the AMA Federal Council had before it an audit of the AMA's Position Statements on public health issues. These are wide-ranging, covering topics as diverse as child abuse, obesity and tobacco smoking.

Federal Council endorsed a program under which the Position Statements are reviewed and updated with current research before re-publication.

In some cases, older Position Statements have taken on new relevance, such as the 2008 Position Statement on methamphetamines. With the current 'ice epidemic' attracting the attention of politicians and health workers alike, it has become more pressing for the AMA to review its Position Statement to ensure its relevance in 2015. This work is underway.

In addition to reviewing the Position Statements, Federal Council has agreed to a series of public health campaigns to be conducted during the year.

Some reflect ongoing work, such as driving the outcomes from the National Alcohol Summit convened by the AMA in October last year.

The central strategy agreed to by the Summit is for the Federal Government to provide national leadership to address the excessive use of alcohol and minimize alcohol-related harms.

Other campaigns take the AMA into newer areas of public health advocacy, such as a project being undertaken jointly by the AMA

and the Australian Institute of Sport to provide resources for GPs, coaches and parents to identify and manage concussion acquired during sport.

In another initiative, a working group of doctors from around the country has been convened to develop ways to reduce the incidence and risk of road trauma. An early priority is to expand the reach of the NSW Government's *Don't Rush* campaign to other jurisdictions, and to investigate the increasing rates of drug driving.

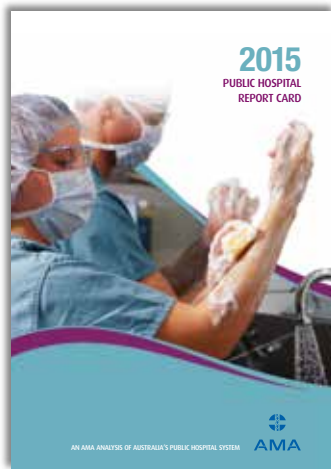
A major activity in 2015 is a campaign to increase public awareness of the benefits of tackling physical inactivity – by getting moving. Areas of focus include supporting doctors to take the opportunity, when consulting with their patients, to advise them of the potential health benefits of getting physically active. There will be a series of tools and resources developed for use by doctors, as well as a major event later in 2015.

The role of national medical associations in addressing the social determinants of health was the theme of a symposium held last month in London, jointly convened by the British Medical Association and Canadian Medical Association.

The contributions made by the associations are diverse. For example, the Canadian Medical Association holds public online forums to engage with the community on public health issues. The Swedish Medical Association has published a guide on physical activity in the prevention and treatment of disease.

In Toronto, a poverty assessment tool has been developed for use in GP practices and an income security health promoter has been engaged as a member of the primary health care team to assist GPs to better support their patients.

Public health advocacy is a core AMA activity. Public health campaigns will be a feature of that advocacy over coming years.



Patients face longer waits as hospital cuts bite

Patients face increasingly lengthy waits for hospital care as the Federal Government squeezes funding despite rising demand, the AMA has warned.

The AMA's annual *Public Hospital Report Card* has found that despite the best efforts of doctors and other health professionals, who are working increasingly efficiently and effectively, hospitals are struggling to meet the needs of an expanding and ageing population.

In a clear sign of a system under stress, the national median waiting time for elective surgery has remained stuck at historically high levels.

For the fourth year in a row, patients waited an average of 36 days for elective surgery in 2013-14, almost 10 days longer than they were a decade earlier.

Meanwhile, less than 80 per cent of category 2 patients were admitted within the clinically recommended time of 90 days last financial year, well short of the national target.

And the Report said the actual situation was even worse than the data suggests.

The AMA said official figures disguised the true length of delays that elective surgery patients faced because they only started to count waiting time from when the patient saw their specialist, rather than from the time of referral by their GP.

"This means that the publicly available elective surgery waiting list data actually understate the real time people wait for surgery," the Report said. "Some people wait longer for assessment by a specialist than they do for surgery."

Much of this is due to an inadequate number of beds and the staff to serve them.

The AMA's analysis has found that hospitals have proportionately far fewer beds than they did 20 years ago, contributing to lengthy waits in emergency departments and for elective surgery.

The number of beds per 1000 people fell to just 2.57 per cent in 2012-13, down from 2.62 the previous years and shows no sign of improving.

Among those most likely to need hospital care, the picture is just as bleak. The number of beds for every 1000 Australians aged 65 years and older has reached a record low of 17.5, a massive 56 per cent decline since the early 1990s.

"Public hospital capacity is not keeping pace with population growth, and is not increasing to meet the growing demand for services," the report said.

AMA President Associate Professor Brian Owler said the results showed that, even before the latest massive Federal Government funding cuts bite, public hospital performance was already being hit by inadequate resources.

In last year's Budget, the Government announced measures that will rip \$20 billion out of hospital funding in coming years, including the renunciation of spending guarantees and cut in funding indexation to the inflation rate plus population growth. These cuts were compounded late last year by a further \$941 million reduction in spending over the next four years.

A/Professor Owler warned the funding cutbacks would entrench sub-par hospital performance.

"If it proceeds with its savings measures, the Commonwealth will lock in hospital funding and capacity at the inadequate levels demonstrated by current performance," the AMA President said. "Without sufficient funding to increase capacity, public hospitals will never meet the targets set by governments, and patients will wait longer for treatment."

The Government has argued budget cuts are necessary because health spending is growing unsustainably.

But A/Professor Owler said total health expenditure actual shrunk in 2012-13, and Commonwealth support was now "well short of [what is needed] to position public hospitals to meet increasing demand".

The *AMA Public Hospital Report Card 2015* can be viewed at the AMA website: ama.com.au

ADRIAN ROLLINS



Culture clubbed: moves begin to stamp out harassment

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLTER

The AMA early this month convened a high level Roundtable meeting in Canberra to confront the issue of sexual harassment within the medical profession.

More than 40 medical profession leaders – including the Presidents and/or senior representatives of the Medical Colleges, trainee representatives, and medical students – attended the meeting.

The Sex Discrimination Commissioner, Elizabeth Broderick, and Susan Pearce, the Acting CEO of the NSW Health Education and Training Institute, addressed the meeting and participated in proceedings.

Having resolved to confront the scourge of sexual harassment, it is fair to say that the profession is learning. This first meeting was about continuing that learning process and setting an agenda of work for the profession over the coming months.

We know that sexual harassment is under-reported, but we also know that it exists and must be acted upon. A number of projects have already commenced to seek opinion and provide an opportunity for members of the profession to speak up.

It is clear that we need to review the processes for making a complaint about sexual harassment and the process that follows.

We applaud the Royal Australasian College of Surgeons for convening an independent expert panel to review their processes. There is no doubt that this will also inform other Colleges and organisations. We all eagerly await the recommendations of the expert panel.

For trainees, there is convergence of the roles and responsibilities of Colleges and employers, such as State Health Departments. We need to ensure better coordination between these groups. We must make the complaints process clear and accessible to trainees.

Many people have concerns about the safety of accessing these processes. Apart from the stigma and shame that those making the complaint may feel, there is concern about the repercussions that may follow such a complaint. This must change.

We need safe environments that all members of the profession can access to discuss their concerns about the behavior of colleagues, and be able to voice complaints without fear of recrimination. This needs to be followed by action, with due process, and protection of the complainant.

The Roundtable spent time yesterday discussing the need for cultural change. There is no doubt that education about bullying and harassment is important, particularly in the early years of medical education. Here there is a role for universities and our educators.

The soon-to-retire Chief of Army, General David Morrison, recently said: “The standard of behavior you walk past is the standard that you accept”. Immediate and effective cultural change must start from the top.

Organisations such as the AMA and the Medical Colleges have a key role to play. At the coalface, whether it be in the operating room or the clinic, we need to make sure that we have leaders that set the tone and call out bad behavior when we see it.

Yesterday’s meeting was just the start of the process of cultural change and strong action against harassment in all its forms within our profession.

We have an agenda, and we have commitment to bring about change. We will work diligently to enhance our profession and protect all of the individuals who make such valuable contributions to the profession and to our patients. And we will report regularly on developments.

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Plans to put doctors to the test

Doctors could face more regular and stringent aptitude tests as part of proposals being considered by the medical profession regulator to make sure patients are shielded from sub-standard care.

The Medical Board of Australia has commissioned an international review of arrangements used by countries to ensure medical practitioners provide safe and ethical care throughout their professional career.

The review is the latest step in the Board's plan to address concerns that the current regime may not be rigorous enough.

“Proposals to introduce a revalidation scheme in Australia are controversial, with concerns it will impose a regulatory burden on the medical profession out of all proportion to the scale of the problem”

While Australian doctors must meet registration standards and participate in continuing professional development activities, the Board has pointed to the results of Canadian research to suggest that the performance of more than 1350 currently registered Australian practitioners might be unsatisfactory.

“We started a conversation about revalidation in Australia in 2012 as part of our commitment to making sure doctors... maintain the skills to provide safe and ethical care to patients throughout their working lives,” Medical Board Chair Dr Joanna Flynn said. “Commissioning this research will help make sure that the decisions the Board makes in future about revalidation are effective, evidence-based and practical.”

Proposals to introduce a revalidation scheme in Australia are controversial, with concerns it will impose a regulatory burden on the medical profession out of all proportion to the scale of the problem.

Dr Flynn told the AMA National Conference in 2013 that of 95,000 registered practitioners in Australia, less than 5000 were the subject of complaints each year, and only a small number of these were upheld and resulted in regulatory action. The Conference was told that just 3 per cent of doctors were the source of 49 per cent of complaints.

But she said the complaints system by itself was not sufficient to provide assurance that all practising doctors were competent, citing examples where doctors continued to work despite being the subject of multiple complaints.

Dr Flynn told the conference that to maintain the trust of the public, the medical profession had to accept the need for a system that verified the competence of practitioners.

“We will need to do something beyond what we are currently doing,” Dr Flynn said, adding that claims that CPD programs provided sufficient assurance were unconvincing.

“Can you assure me that everyone who has done your CPD program is actually competent and practising at a reasonable standard?” she asked. “My sense is that, for most CPD programs, they don't do that, or at least, not to a high enough level of certainty.”

The regulator said the Medical Board did not have any preconceived ideas about what an Australian revalidation system would look like.

In 2012, Dr Flynn said many countries had begun to undertake more formal cyclical processes of revalidation for doctors, and the Board needed to consider if current arrangements were sufficient or “do we need to take on the bigger challenge and... devise an evidence-based, multifaceted, valid and cost-efficient way to ensure that every registered practitioner demonstrates that they continue to be able to meet the standards that both the profession and the community expect? It is time to begin that conversation.”

The Board has commissioned the Collaboration for the Advancement of Medical Education, Research and Assessment at Plymouth University Peninsula Schools of Medicine and Dentistry to conduct the research.

In particular, it has asked the researchers to assess evidence about the effectiveness of revalidation regimes in countries similar to Australia, identify best practise and any gaps in knowledge, and propose a range of models for possible adoption.

The Board is due to receive and consider the study in the second half of the year.

See also: *'The validation of doctors, or how to spot the bad apples'* pp30-31

ADRIAN ROLLINS

Ban insurance policies that leave patients stranded: AMA



Patients are being forced into last-minute cancellations of vital surgery to repair eyesight, fix dodgy knees and hips and reconstruct hands, faces and chests ravaged by cancer because of unexpected gaps in their private health cover.

The AMA has called for private health insurance policies that exclude basic and common procedures to be banned, after a survey of AMA members found insurance companies are increasingly marketing policies with exclusions and caveats that patients do not fully understand, and which are forcing them to forego common procedures like cataract surgery, hip and knee joint operations and reconstructive breast, face and hand surgery.

In a submission to the Australian Competition and Consumer Commission on the private health insurance industry, the AMA said health funds were engaging in sharp practices that left consumers confused and unaware of major gaps and shortfalls in their cover.

“There is a significant disconnect between most consumers’ understanding of the services and rebates they are entitled to under their private health insurance policy and the reality of what their product provides,” the submission said.

It complained that insurers presented their products in a poor and confusing manner, and often they were explained incorrectly by frontline staff.

“The combined effect means that consumers have limited ability to ‘shop around’ and compare products, and to fully understand the products they have purchased,” the AMA said. “It is usually only at the time when people need to have medical treatment in

a hospital that they first comprehend that their insurance policy is deficient.”

The number of policies being sold with exclusions and minimum benefits has accelerated as premiums have increased. A decade ago, just a third of policies had restrictions, exclusions or higher excess, but they account for around a half of all policies held now.

The Australian cited Private Healthcare Australia figures showing more than 985,000 policies were downgraded between February 2012 and December 2014, and the number is expected to surge higher following the latest average 6.2 per cent premium increase that came into effect on 1 April.

In its submission, the AMA said many practitioners were concerned that insurers were deliberately allowing people to take out health policies unlikely to suit their health needs, such as selling cover that excludes psychiatric care to patients with a chronic psychiatric condition.

In addition, firms are marketing changes to policies without fully explaining the consequences for consumers.

One doctor surveyed by the AMA reported that, “I’ve had patients who were told their premiums would not rise this year, but did not understand this had only happened because they had been shifted to a policy with exclusions. The detail was in the fine print”.

Insurers faced particular condemnation for marketing ‘public hospital only’ policies, which the AMA said were of no value to consumers, and called for them to be withdrawn from the market.

The AMA reserved special condemnation for the pre-approval processes used by private health funds to try to dodge their obligations.

Under the Private Health Insurance Act 2007, private funds are required to pay benefits for hospital treatment for which a Medicare rebate is payable.

But AMA reported that some insurers were adopting a virtually default position of refusing to pay a claim, forcing patients to complain and challenge the decision.

The AMA has called for policies that exclude common procedures, or provide cover only for treatment in public hospitals, to be banned.

ADRIAN ROLLINS

New strains force late start for flu vaccination program

Doctors and patients will for the first time have access to single-dose vaccines covering the four most common flu viruses amid concerns a mutated strain that wreaked havoc in the northern hemisphere could take hold in Australia.

The Therapeutic Goods Administration has approved nine vaccines, including, for the first time, three quadrivalent formulations, as preparations advance for the roll-out of National Seasonal Influenza Immunisation Program from 20 April.

The TGA said the vaccines approved for the program provided coverage for two new strains following expert advice about the prevalence of different types of infections in the last 12 months.

The World Health Organisation and the Australian Influenza Vaccine Committee have recommended that vaccines this year cover one existing and two new strains – the California H1N1-like virus that has been in circulation since 2010, the Switzerland H3N2-like virus and the Phuket 2013-like virus.

In addition, the quadrivalent vaccines, FluQuadri, FluQuadri Junior, and Fluarix Tetra, will cover the Brisbane 2008-like virus.

Drug company Sanofi Pasteur, which manufactures two of the quadrivalent vaccines, said they were well tolerated and provided additional protection because they covered both B strains of the influenza virus as well as the two A strains – compared with trivalent vaccines that covered both A strains but only one B strain.

The national immunisation program, which usually commences in March, had been held back a month as manufacturers have scrambled to produce sufficient stocks of the vaccines.

“The double-strain change has resulted in manufacturing delays due to the time it takes to develop, test and distribute the reagents needed to make the vaccine,” a Health Department spokesperson said. “The commencement of the program is being delayed to ensure sufficient supplies of influenza vaccine are available from at least two suppliers in order to mitigate the risk of administration of bioCSL’s Fluvax to children under five years of age.”

The AMA and other health groups expressed alarm last year over revelations that 43 infants and toddlers were injected with Fluvax in 2013 despite warnings it could trigger fever and convulsions.

The TGA has repeated its advice that Fluvax is not registered for use on children younger than five years, and that it should only be used on children between five and nine years following “careful consideration of potential benefits and risks in the individual child”.

Fluvax will be supplied with prominent warning signs and labels to remind practitioners that it should not be administered to young children.

In a stroke of good fortune, the delay in the vaccination program

has coincided with a relatively quiet start to the flu season, with reports that influenza activity has so far been weaker than that experienced at the same time last year.

The Health Department and the TGA said that, despite the delay, they do not expect any flu vaccine shortages, and the Government has committed \$4.5 million over the next five years to provide free flu vaccination for Indigenous children aged between six months and five years.

The Government has also renewed the contract of the Australian Sentinel Practices Research Network, based at the University of Adelaide, to undertake national surveillance of flu-like illnesses.

The network, which has been operating for more than a decade, collates information from more than 200 GPs and medical practices across the nation to provide health authorities with an early warning of developing outbreaks. Its information is used in conjunction with data from hospitals.

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Ten commandments to cutting red tape



The AMA has declared war on unnecessary bureaucratic red tape, issuing guidelines for the design of medical forms and reports that gather critical information in a way that minimises the burden on doctors.

In the course of their daily practise, medical practitioners are required to fill out multiple forms for Government departments including Centrelink, the Department of Veterans' Affairs and State and Territory WorkCover authorities, with research showing GPs spent an average of 4.6 hours a week on red tape in 2011 - valuable time that the AMA said could otherwise be spent with patients.

The AMA said that although much of the data provided was vital in helping determine patient entitlements, and could have serious consequences for the effective provision of medical services, often forms also asked for details that were repetitive, extraneous or unnecessarily intrusive in nature, and could be dropped or amended without affecting the quality of information provided.

"We understand that organisations depend heavily upon the accurate completion of medical forms to determine patient entitlements," AMA Vice President Dr Stephen Parnis said. "Unfortunately, many fail to appreciate the real time implications for doctors having to complete these forms. The key is to focus on obtaining necessary information that is easily accessible, and which does not require doctors and medical practices spending excessive time filling in forms."

"Doctors prefer spending time on patient care, not bureaucracy," Dr Parnis said.

The AMA has set out 10 standards that it is asking Government departments and other organisations to take into account when designing medical forms.

These include ensuring that doctors are asked to supply only essential information, that patient privacy is protected as much as possible, and that the forms be available in an electronic format compatible with, and available through, existing medical practice software.

In addition, the AMA said forms must carry clear notification that doctors can charge a reasonable fee for their services.

The Association said that in designing forms, government departments and other organisations often failed to take into account the implications for doctors, and suggested that forms be field tested under the supervision of a representative of the AMA or other medical organisation prior to their release.

"The AMA believes that medical forms can be designed in a way that captures the necessary information in a more simple and concise way," Dr Parnis said. "Our Guide can help organisations design forms that do not impose unnecessary red tape and compliance costs on busy doctors."

ADRIAN ROLLINS

AMA Guide to 10 minimum standards for medical forms

1. The form is available in an electronic format that is compatible with existing electronic general practice medical records software.
2. Forms are distributed through medical software vendors. Access to forms does not require web surfing during consultations, nor form-filling online.
3. The form has a clear notation that states that medical practitioners may charge a reasonable fee for their services and whether the services are eligible for rebate by Medicare or other insurers.
4. Demographic and medical data can be selected to automatically populate the electronic form with adequate space being provided for comments.
5. Only information essential for the purpose is requested and must not unnecessarily intrude upon patient privacy.
6. Forms do not require the doctor to supply information when a patient can reasonably provide this in their own right.
7. A copy is saved in the patient electronic medical file for future reference.
8. Data file storage size is kept to a minimum.
9. Prior to their release, forms are field tested under the auspices of a recognised medical representative organisation such as the AMA and the RACGP, in association with the MSIA (Medical Software Industry Association).
10. Consideration should be given to future compliance with encrypted electronics transmission capability, in line with new technologies being introduced into general practice.

Plain packaging objections up in smoke



Tobacco plain packaging is working to encourage smokers to kick their habit and dissuade young people from taking it up, according to the most comprehensive evaluation of the reform yet undertaken.

Just days after Britain and Ireland followed Australia's lead by passing laws requiring that tobacco products be sold in plain packaging emblazoned with large health warnings, a *British Medical Journal* analysis of 14 peer-reviewed studies concluded that the public health measure was "delivering on its hypothetical promise".

"The evidence suggests that plain packaging is severely restricting the ability of the pack to communicate and create appeal with young people and adults," paper's authors, Professor Gerard Hastings and Dr Crawford Moodie, both of the University of Stirling, said.

Not only was plain packaging effective in reducing the appeal of tobacco products, the authors said a cross-sectional tracking survey of smokers showed plain packaging caused them to think more about quitting the deadly habit.

"Plain packaging in Australia has been a casebook example of effective tobacco control – a policy measure driven by evidence, carefully designed and implemented, and now rigorously assessed," Professor Hastings and Dr Moodie wrote. "Plain packaging is beginning to deliver on its promise."

Professor Melanie Wakefield, a Principal Research Fellow of the National Health and Medical Research Council, led the evaluation published in the *BMJ*, and said its findings "should give confidence to countries considering plain packaging that plain packs not only reduce [the] appeal of tobacco products and increase the effectiveness of health warnings, but also diminish

the tobacco industry's ability to use packs to mislead consumers about the harms of smoking".

The industry, which has been fighting a bitter battle to have the Australian legislation overturned ever since its introduction in 2012, dismissed the *BMJ* analysis, and reiterated its claims that plain packaging laws have simply forced smokers onto cheaper cigarettes and fuelled trade in illicit tobacco products.

Philip Morris Limited Director Corporate Affairs Chris Argent claimed tobacco excise increases were largely responsible for any changing in smoking habits.

"The fact is that smoking rates in Australia have been declining steadily since 1991, and there has been no significant deviation in that trend since plain packaging was implemented," Mr Argent said.

Professor Hastings and Dr Moodie admitted that, because plain packaging was introduced as part of a wider package of measures including larger health warnings, mass media campaign and tax increases, it was hard to separate out the effects of each measure.

But they said the picture that had emerged from the 14 studies included in the evaluation suggested the policy was working and, just as significantly, that industry warnings of a surge of trade in cheap and illegal cigarettes were unfounded.

The researchers, both experts in marketing, added that the laws were important in the context of imminent major advances in the use of packaging to promote products.

Technological developments are underway which promise to turn packets into multi-sensory billboards for products, including playing music, pre-recorded messages and other noises, emitting scents and glowing in the dark.

Professor Hastings and Dr Moodie said conductive inks were also being used that allow for cheap electronic circuits to be incorporated into cardboard, with the potential for cigarette packs to carry moving images, or to be capable of communicating with consumers through their mobile phones, smart watches and glasses or other devices.

"Whatever direction these innovations take, it is clear that the marketing power of the pack is only going to increase. So governments which do not act on plain packaging today will have a bigger problem to tackle tomorrow," they said.

The *BMJ* study "Death of a salesman" can be viewed at: http://tobaccocontrol.bmj.com/content/24/Suppl_2/ii1.full

ADRIAN ROLLINS

Cosmetic patients could face wait before going under knife



Patients who want face lifts, breast implants, liposuction, botox injections and other cosmetic procedures will face a mandatory cooling off period under guidelines being considered by the medical profession watchdog.

Horror stories of botched operations, life-threatening post-operative infections and unexpected complications have sparked concern about the level of accountability and consumer protection in the burgeoning cosmetic surgery industry, estimated to be worth around \$1 billion a year.

The Medical Board of Australia, which regulates the medical profession, has released draft proposals to improve public safety, including a seven-day cooling off period for adults, a three-month cooling off period and mandatory psychological assessment for patients younger than 18 years, explicit treating practitioner responsibility for post-operative care, and mandatory face-to-face consultations before the prescription of botox and other schedule 4 cosmetic substances.

Medical Board Chair Dr Joanna Flynn said the proposals, which are open for public comment, have been drafted in acknowledgement that cosmetic surgery differs from other medical procedures because it is entirely elective, is usually initiated by the patient, is undertaken to improve appearance rather than address a medical need, is performed outside the public hospital system, and usually paid for directly by the patient.

Its move is in response to a report from the Australian Health Ministers' Advisory Council, which warned that consumers were taking an increasingly casual attitude to cosmetic surgery despite the fact that it was a significant intervention that carried risks and complications.

"If the cosmetic procedure is performed by a medical

practitioner without the appropriate training, or in a facility that does not have the appropriate staff or equipment, or the post-operative care is inadequate, the outcome can be far more devastating than unmet expectations," the Board warned. "The outcome may be a serious complication resulting in disfigurement or death."

Concerns about the standard of care have been underlined by recent inquests in Victoria and South Australia which found that two young women died of complications arising from liposuction surgery following inadequate post-operative care.

In addition, state regulators have received numerous complaints about problems including bleeding, pain and infection through to scarring, nerve damage, gross deformity and psychological distress.

Even where cosmetic procedures were carried out skilfully and safely, the nature of the undertaking made it more prone to patient dissatisfaction than many other specialties, according to a report from the-then Health Quality and Complaints Commission in Queensland.

The Commission reported that plastic surgeons were twice as likely to be embroiled in disputes about informed consent as any other specialty, and speculated that this might be due to the "elective nature of cosmetic procedures and the costs associated [which] may contribute to higher patient expectations and lower tolerance for poor outcomes".

The Medical Board said the fact that patients could directly request cosmetic surgery rather than seek a referral from a GP meant they missed out on an important source of advice on possible risks and benefits, as well as alternatives.

The Board said that informed consent was a critical step before a patient decided to proceed with cosmetic surgery, underlining the need for a cooling off period.

While noting that the Australian Society of Plastic Surgeons has specified a minimum 10-day cooling off period for cosmetic procedures in its code of conduct, the Board bemoaned the lack of a consistent nationwide guide for consumers or practitioners.

It said complaints data supported the view that some consumers went ahead without fully appreciating the risks involved, suggesting informed consent processes in these instances were inadequate or poorly done.

The Board's discussion paper can be viewed at <http://www.medicalboard.gov.au/News/Current-Consultations.aspx>

The closing date for submissions is 29 May, 2015.

ADRIAN ROLLINS



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

Make vaccination law, *The Sunday Telegraph*, 22 March 2015

The Sunday Telegraph has launched a national campaign for pregnant women to get free whooping cough boosters in the third trimester. AMA President A/Professor Brian Owler called on the Federal Health Minister Sussan Ley to fund the boosters.

Doctors to anti-vaxxers: you're endangering kids, *The News Daily*, 24 March 2015

AMA Vice President Dr Stephen Parnis told The News Daily that anti-vaccination campaigners were rejecting the weight of scientific evidence that vaccination was safe and effective and saved lives.

Misogyny in medicine: don't put up with it, *The Age*, 25 March 2015

AMA President A/Professor Brian Owler said he was proud of Australia's medical profession and admitted it was "challenging" to hear assertions that members of the profession acted in unacceptable ways, particularly when it came to sexual harassment.

Medics to fix 'fear' culture, *The Daily Telegraph*, 4 April 2015

A change in the way doctors and nurses report abuse is needed to buck the scourge of sexual harassment and protect whistleblowers within the medical industry, according to critics. AMA President A/Professor Brian Owler said the AMA was committed to bringing about cultural change within the profession.

\$8.40 more to see doctor, *The Herald Sun*, 7 April 2015

Patients could be paying up to \$8.40 more for a visit to the doctor by 2018 – more than they would have paid under the GP co-payment. AMA President A/Professor Brian Owler said the Federal Government extended freeze on Medicare rebate indexation meant fewer patients in future would be offered bulk billing.

Religious belief saw mum and baby die, *The Daily Telegraph*, 8 April 2015

The AMA has defended doctors at a top Sydney Hospital forced to let a heavily pregnant woman and her unborn child die after the mother refused a blood transfusion because she was a Jehovah's Witness. AMA Vice President Dr Stephen Parnis said doctors could not force a patient to accept treatment, even if they were pregnant.

RADIO

A/Professor Brian Owler, 4bc Brisbane, 31 March 2015

AMA President A/Professor Brian Owler talked about the Federal Government changing aviation rules to require two people in an aeroplane cockpit at all times. A/Professor Owler said the AMA was not sold on the idea that doctors treating pilots should be forced to breach doctor-patient confidentiality if they think a pilot is unfit to fly.

A/Professor Brian Owler, 774 ABC Melbourne, 7 April 2015

AMA President A/Professor Brian Owler talked about the Government's plan to freeze the amount received by doctors in rebates. A/Professor Owler suggested that many doctors will have no choice but to pass the increased cost onto patients.

Dr Stephen Parnis, 2GB Sydney, 7 April 2015

AMA Vice President Dr Stephen Parnis discussed the case of a pregnant Jehovah's Witness woman who refused a blood transfusion, resulting in the death of herself and her baby. Dr Parnis said doctors must respect a patient's wishes and beliefs, no matter how vexing the circumstances.

Dr Brian Morton, SBS Ethnic Radio, 8 April 2015

AMA Chair of General Practice Dr Brian Morton discussed evidence of an increase in the number of parents choosing not to immunise their children. Dr Morton said some parents believe it places too much strain on a young child's immune system, but actually the opposite is true.

TELEVISION

A/Professor Brian Owler, Channel 9, 17 March 2015

AMA President A/Professor Brian Owler discussed suggestions teenagers undergo a psychological assessment before cosmetic surgery. A/Professor Owler said cosmetic surgery was the source of a number of complaints.

Dr Brian Morton, ABC Sydney, 1 April 2015

AMA Chair of General Practice Dr Brian Morton talked about rising private health insurance premiums and the industry's pitch for contracts in the Government's new primary health networks. Dr Morton said the AMA would be worried if a private insurer controlled a primary health network.



AMA in action

From workplace sexual harassment to the social determinants of health and the benefits of being physically active, the AMA has been active on many fronts in recent weeks advancing the interests of patients and the medical profession.

Alarmed by reports of sexual harassment in the medical profession, AMA President Associate Professor Brian Owler on 1 April convened a Roundtable, attended by more than 40 representatives of medical colleges and other professional groups, on how to stamp it out. Days earlier he had addressed an international conference on the social determinants of health in London, where he talked about Australia's challenges in

closing the health gap between Indigenous and non-Indigenous Australians. This was the centrepiece of discussions for the AMA's Indigenous Health Taskforce last month. Around the same time, AMA leaders from across the country converged on Canberra for the AMA Federal Council meeting which discussed public health initiatives – an issue pursued by Vice President Stephen Parnis when he helped promote the Heart Foundation's campaign to encourage Australians to get more physically active.

ADRIAN ROLLINS



AMA President Associate Professor Brian Owler (L) meets with other members of the AMA Board at AMA House, Canberra on 20 March



AMA Vice President Dr Stephen Parnis helps promote the Heart Foundation's Get Active with Assistant Health Minister Fiona Nash, Shadow Health Minister Catherine King and Green's Senator Dr Richard Di Natale



AMA President Associate Professor Brian Owler, Vice President Dr Stephen Parnis and Secretary General Anne Trimmer among those attending the AMA Sexual Harassment Roundtable at AMA House, Canberra on 1 April



(L to R) Australian Sex Discrimination Commissioner Elizabeth Roderick, Sexual Harassment Policy consultant Avril Henry, AMA President Associate Professor Brian Owler and Dr Diana Semmonds, Board Director, Royal Australia and New Zealand College of Ophthalmologists at the AMA Sexual Harassment Roundtable.



AMA President Associate Professor Brian Owler meets with representatives of Pathology Australia last month



AMA Indigenous Health Taskforce discusses issues around Closing the Gap in March



AMA President Associate Professor Brian Owler addresses the joint British Medical Association - Canadian Medical Association Symposium on the Social Determinants of Health, London



AMA State Presidents (L to R): Dr Tim Greenaway (TAS), Dr Tony Bartoni (VIC), Dr Patricia Montenegro (SA), Associate Professor Rob Parker (NT), Dr Michael Gannon (WA) and Dr Saxon Smith (NSW) at last month's AMA Federal Council meeting



AMA Council of Doctors in Training Chair Dr Danika Thient and AMSA President James Lawler at the start of last month's AMA Federal Council meeting



Vaccinations - protecting the vulnerable

BY DR BRIAN MORTON

“It constantly confounds and frustrates me when I hear of children and adults contracting and occasionally dying from a preventable disease”

The 2015 seasonal influenza vaccination program begins this week.

The program, which is usually launched in mid-March, was delayed because of the need for a double-strain change from last year's vaccine. The delay ensured there will be sufficient supplies available.

In all, the TGA has registered nine vaccines, which should help mitigate the risk of bioCSL's Fluvax® being administered to children younger than five years, though GPs and other vaccine administrators will still need to be vigilant on this score. In addition, bioCSL's Fluvax® is not recommended for use in children aged five to nine years.

This year, the National Immunisation Program has been expanded to include Aboriginal and Torres Strait Islander children aged six months to younger than five years, which will help to protect one of our most vulnerable population groups. These children are five times more likely to die from influenza, and much more likely to be hospitalised with influenza, than non-Indigenous children.

It constantly confounds and frustrates me when I hear of children and adults contracting and occasionally dying from a preventable disease. I fear far too many people these days rely too heavily on herd immunity, rather than taking action to protect themselves and their children by being vaccinated.

Only last month, we had the tragic death of 32-day-old baby Riley Hughes in Western Australia from whooping cough. Being too young to be vaccinated, babies such as

Riley rely on a responsible community to keep them safe. Unfortunately, the complacency we continue to see in some parts of the community regarding immunisation increases the risk of people catching and transmitting preventable killer diseases.

The Australian Immunisation Handbook advises that providing the pertussis vaccine to pregnant women in their third trimester achieves a timelier and higher antibody response in both mother and infant after birth, than if provided post-partum or pre-conception. This seems like a good investment in preventive medicine and our future.

A number of State governments have responded by committing to providing pregnant women with the pertussis vaccine, but perhaps it is time for the Federal Government to ensure its availability through the National Immunisation Program. States have provided the vaccine before, but it is often subject to available funding.

As GPs, not only should we be advising our pregnant patients about the benefits of being vaccinated, but we should also be emphasising the need for those family members who will be directly in contact with the baby in its first six months of life to be vaccinated.

GPs, as the primary health care provider, should be proactive when it comes to vaccination. Don't leave it to the pharmacy down the road. Utilising practice recall systems to remind patients they have a vaccination due, or checking on their vaccination status when you haven't seen them for a while, helps ensure you are their access point for vaccination.



Limiting the availability of essential medicines for all

BY PROFESSOR STEPHEN LEEDER, EMERITUS PROFESSOR
PUBLIC HEALTH, UNIVERSITY OF SYDNEY
EDITOR-IN-CHIEF, *MEDICAL JOURNAL OF AUSTRALIA*

On the ABC Health Report on November 26, 2012, Dr Norman Swan commented that “Australia is the third most expensive country in the world for pharmaceuticals, and we pay up to 40 per cent more for generics than the UK, which amounts to an annual excess of between \$1.5 billion and \$3 billion of taxpayer’s money”. He based his claims on a study by Philip Clarke, a professor of health economics at the University of Melbourne. Professor Clarke has published related papers in the *Medical Journal of Australia*.

Inevitably, such huge amounts of money in the drug industry come with swirling clouds of politics, and brave is the person who would tackle the vested interests that sustain these distortions in therapeutic drug supply in Australia

Although up until 10 to 15 years ago, Professor Clarke said, Australia had a reputation for having “just about the world’s cheapest pharmaceuticals, apart from New Zealand”, a lot of blockbuster drugs have come off patent. This means that generic drugs that have similar action to the patented blockbusters are being used more commonly internationally. But Australia has not kept pace.

Professor Clarke cited the case of atorvastatin or Lipitor. In the 15 years up to 2012, the Australian Government, he said, had spent \$15 billion on this drug alone. The professor spoke of an agreement struck in Australia with the pharmaceutical industry that dropped the price by 15 per cent when it came off patent. This compares with a reduction in price of about 95 per cent in New Zealand, Sweden and the UK. The comparative over-charging at several levels clearly places restrictions on what other pharmaceuticals can be subsidised from the public purse.

On the show, Dr Swan and Professor Clarke went on to discuss how, “if you could make savings on generics, it opens up funds to

potentially purchase new cost-effective drugs and to list them more quickly”. With many brilliant new drugs now available, the need to use money wisely in purchasing pharmaceuticals is intense.

Inevitably, such huge amounts of money in the drug industry come with swirling clouds of politics, and brave is the person who would tackle the vested interests that sustain these distortions in therapeutic drug supply in Australia.

Meanwhile, the Government engages in hand-wringing about the “unsustainable” costs of health care. Government responses, including demanding price disclosure, are a step towards removing this waste, but much remains to be done.

The pricing of pharmaceuticals is also caught up in the Trans-Pacific Partnership Agreement (TPPA) that seeks to harmonise trade among countries including Australia, the US, Canada, Peru, Singapore, New Zealand and more.

The terms of the agreement remain secret but, as Anne-Marie Thow from the Menzies Centre for Health Policy at the University of Sydney and her colleagues commented in a recent MJA paper on the agreement, concerns include the adoption of intellectual property rules in the TPPA that “prolong monopolies over new medicines and delay the availability of cheaper generics”.

I wrote recently in MJAInSight an article concerning the fact, as expounded in a paper in *The New England Journal of Medicine*, that insulin, although nearly 100 years old, remains available only in patented form. Clever derivatives and slight tinkering are patented, and no cheap generic form is available. With so many people with diabetes in low-income and middle-income countries in need of insulin, lives that could be saved with cheap insulin are lost - a tragedy especially for diabetic children.

Considerable political courage is needed to manage the drive towards huge profits in the several sectors and industries associated with the production and sale of pharmaceuticals.

The drive is in no way unique and can be found wherever business operates.

But the unwillingness to tackle it, whether in relation to the cost of generics or the machinations of the TPPA, does a Government no credit, especially if it then seeks easy, inequitable ways of fixing its budget. Co-payments on bulk-billed patients come to mind, along with the word ‘feeble’.



Specialist unemployment: time to be worried?

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Consultants working for free to maintain their recency of practice. New Fellows accepting positions with reduced conditions to get their foot in the door. Others prompted to work part time or as locums. Young Fellows choosing to do more sub-specialty training because they cannot find work in their chosen field.

Apocryphal stories maybe, but there is genuine concern in the profession that some specialists are experiencing underemployment or even unemployment.

“Exit block” from training – where recently graduated Fellows stay in training positions that would otherwise be filled by specialist trainees because the consultant jobs aren’t there – is a knock-on effect from this scenario.

We should be worried about shrinking employment opportunities for new Fellows and exit block for specialist trainees.

Among other things, it would mean that some specialists are struggling to get the workload they need to keep their skills fresh. Nor would trainees be getting access to the positions that provide the clinical cases they require to complete their specialist training. It would ultimately mean that Australia is squandering its considerable investment in the medical workforce over the past decade.

So are we really seeing the early signs of an oversupply of specialists, or is the issue a poorly distributed workforce?

Unfortunately, there is no hard data, but anecdotal reports of underemployment and unemployment in some specialties are emerging.

A specialty that might be affected is anaesthesia, where there is increasing concern that an oversupply of anaesthetists is looming. There is a range of possible reasons for this situation, including the large numbers of anaesthesia trainees employed by public hospitals; fewer opportunities for consultants in the public system; fewer private sector opportunities in major metropolitan areas; difficulties in getting credentialing at private hospitals; and senior specialists delaying their retirement.

I met with the Australian and New Zealand College of Anaesthetists and the Australian Society of Anaesthetists in

January to discuss the state of the anaesthesia workforce.

Surveys of new Fellows run by both organisations showed that some had experienced unemployment and underemployment after gaining Fellowship, and were concerned about future career prospects.

I understand that the situation in anaesthesia could be emerging in some other specialties as well.

The outcome of the meeting was a joint submission to the National Medical Training Advisory Network (NMTAN) asking it to include the anaesthetist workforce in its modelling program as a matter of urgency. Pleasingly, it has told us that this is indeed a priority for the network.

The AMA is being proactive in getting an understanding of the scale of specialist unemployment across the specialties. The Medical Workforce Committee is taking the lead, working closely with our doctors in training.

We need to get this right and find out whether an oversupply of specialists is building, or whether the problem is one of distribution.

Both scenarios would have obvious, and very different, implications for developing and coordinating the future medical workforce.

Separate to the joint submission on the anaesthetist workforce, the AMA has asked NMTAN to undertake the data collection needed to determine what’s happening across all specialties, and identify the measures needed to ensure that, subject to community demand for medical services, there will be sufficient jobs for doctors when they finish their training.

I’m hopeful that NMTAN is taking the issue seriously.

In the meantime, we are liaising with the Colleges on how their new Fellows are faring.

While we don’t want to generate unnecessary angst among trainees on their job prospects, it is important that they have a clear idea of future workforce scenarios when they make their career choices.



Great news for rural and regional representation on AMA Federal Council

BY DR DAVID RIVETT

For 10 years, the interests of rural doctors have been represented at the AMA through a committee whose members have been drawn from all the states and both the Council of Doctors in Training and the Australian Medical Students Association. However, this exists at the whim of the Federal President. It's Chair has observer status at both AMA Council of General Practice and Federal Council meetings.

The proposed changes endorsed unanimously by Federal Council at its March meeting, and approved by the Board of AMA, will see rural doctors recognised as a special interest group with a voting seat at the table of Federal Council, and certainty of continuation as a newly established Council of Rural Doctors within the AMA. Both these changes will strengthen rural representation.

Additionally there will be an entitlement to a minimum of two votes at National Conference. Additional votes will depend on member numbers.

I strongly applaud these changes, and ask all rural and regional doctors, be they specialists, GPs or trainees, to support the recognition of rural doctors as a special interest group.

There will be a transition process to identify doctors who meet the criteria of a doctor in rural practice, most likely based on postcode of practice. Individual members will have an opportunity to determine if their vote, for Federal Council purposes, is by membership of the Rural Doctors Special Interest Group, or based on their Specialty Group membership (which is the craft group). Either way, a member will have access to information relevant to their membership of both groups.

To drive the development of rural doctor interests further, we need enthusiastic State representatives to the new Council of

Rural Doctors, and candidates for election to Federal Council as the Chair of the new rural doctors' special interest group. The latter process will take a little while to put in place.

This change is extremely timely, as it is now widely recognised that workforce numbers are no longer inadequate in Australia, but rather that workforce distribution is the number one problem crying out for a solution.

The AMA has proposed robust solutions for the rural workforce crisis which involve enhancing the provision of quality rural training, (not just for GPs but across the profession), enabling excellence in the provision of care, ensuring liveable workplace rosters, spousal preferential employment and enhanced financial rewards for both working in rural and remote areas and for providing on-call services in these areas.

Compulsion is not a solution.

Rather, there must be attractive work conditions that enable both high quality care provision and a great lifestyle.

We believe doctors will then look more keenly at work outside the urban boundaries. As I have said repeatedly to Government, make the conditions right and the numbers will follow.

The current Federal Health Minister Sussan Ley and Assistant Health Minister Fiona Nash both have rural backgrounds, so the opportunity is ripe to push for changes.

However, we also have a Treasurer hell-bent on slashing and cutting resources for even the most worthwhile of structural changes, so I can only wish all power to both ministers in enlightening our Federal Treasurer.

INFORMATION FOR MEMBERS

Global Conference on One Health

Medical practitioners and veterinarians are being brought together at an international conference intended to foster greater collaboration between the professions.

The World Medical Association and the World Veterinary Association have jointly organised the Global Conference on One Health to be held in Madrid on 21 and 22 May.

The WMA said the conference aimed to bring together veterinarians, physicians, students, public health officials, non-government organisations

and other participants to strengthen links and communications between the professions in order to "improve the different aspects of health and welfare of humans, animals and the environment.

The conference will include sessions on zoonotic diseases, antimicrobial resistance, natural disaster managements and human and animal exposure to environmental hazards.

Conference details can be viewed at: <http://www.wma.net/en/50events/20otherevents/80onehealth/index.html>

GP training - into the great unknown

BY DR DANIELLE MCMULLEN, A GP REGISTRAR, CHAIR AMA NSW DIT COMMITTEE, AND AMA CDT REPRESENTATIVE ON AMA COUNCIL OF GENERAL PRACTICE.

Last week thousands of hopeful GP registrars, the future of our GP workforce, were asked to apply for the Australian General Practice Training Program. But, as it stands today, they are applying to an unknown beast. These doctors must surely feel like they are bravely stepping into a dense fog.

In its 2014-15 Budget, the Commonwealth systematically dismantled the program that has trained many of our highly qualified GPs since 2001.

For more than a decade General Practice Education and Training (GPET) coordinated and oversaw general practice training delivered across the country by regional training providers (RTPs).

While controversial at the outset, GPET then flourished in a growing and increasingly complex environment – it allowed registrars a single point of application and entry, with the flexibility to choose a training pathway towards fellowship of the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM).

At the end of 2014, GPET was quietly rolled into the Department of Health, and in December 2015 the current RTPs will cease to exist. The change is worrying enough (after all, doctors can be creatures of habit), but what is most alarming is that nearly 12 months after the Budget announcement of these changes, we are no clearer on the details of what training will look like in 2016.

At time of writing, the new training organisations remain nameless, shapeless, faceless - we understand there will be fewer of them, but we don't know how many, where they will be or who they will be.

The tender process for new training organisations has not yet begun, much less been completed.

In addition to the significant changes to vocational training, the 2014-15 Budget also scrapped the Prevocational General Practice Placements Program, which was the only avenue for prevocational doctors in their intern or Postgraduate Year Two year to experience the general practice environment. This gaping hole in the general practice workforce pipeline will result in fewer numbers of interested GP trainees, and throw general practice back to an option of last resort.

We run a real risk of setting GP training back 15 years, to before GPET, when GP training was fragmented, less attractive to junior doctors and we were facing a significant shortage of quality GPs, especially in rural and remote Australia.

“General practice is an incredible career offering variety, flexibility and fantastic medicine. We need to sing its praises, protect its future, and safeguard its quality. The time for that is now”

At best, we will suffer one or two years of chaos. At worst, the flow on effects of this upheaval will be felt for years to come.

Excellent clinical supervisors, those GPs welcoming registrars into their practices, will forever form the cornerstone of quality general practice training. But they need to be supported by high quality training organisations. And registrars deserve a well-organised, well-supported training environment.

A change is coming – that is for certain. And time is running short but it's not out yet.

We need urgent clarity and real consultation to plan well and shape the future of general practice training in Australia.

The AMA supports RACGP and ACCRM taking back control of general practice training. The Department of Health should not be the new GPET - the Colleges are best placed to train the specialist GPs of our future. But even they are being kept in the dark.

General practice is an incredible career offering variety, flexibility and fantastic medicine. We need to sing its praises, protect its future, and safeguard its quality. The time for that is now.

Dr McMullen will chair the “General practice training – the future is in our hands” policy session at the AMA National Conference in Brisbane on Saturday 30 May at 2:15pm.

Sexual Harassment:

why boys need to become men

BY MATTHEW LENNON*

Prevention: to eliminate the cause of complication at its origin. This is the primary aim of medical practice, the secondary measure being symptomatic treatment. Safe and effective reporting systems address the presence of sexual harassment, but it is at a deeper cultural level where prevention may be achieved.

Dr Gabrielle McMullen sparked debate last month when she spoke about sexual harassment in the profession and the failings of professional bodies.

“In ‘the boys’ culture, successful sexual endeavours are met with a quiet laugh or congratulatory pat; your status is elevated and self-esteem balloons. You are told that your sexual successes are the measure of a man”

Her advice to junior doctors “to accept sexual advances” has been rejected by both the AMA and AMSA, but the outcry she sparked has catalysed the conversation on reporting structures within the medical field.

Medicine is strictly hierarchical, and each member of the hierarchy assesses those below them.

The power granted by the hierarchy provides opportunities for the exploitation and bullying of more junior colleagues. Moreover, in the cases of such misconduct, every incident of reporting carries an intrinsic career risk.

Dealing with these inherent reporting problems is one step to addressing sexual harassment.

However, at a more fundamental level, at a preventive level, lies the issue of culture, in particular a culture of the sexualisation and objectification of women - a “boys” culture.

For any human behaviour, it is the dominant culture that informs an individual’s more basic instincts, allowing them discern right and wrong.

In “the boys” culture, successful sexual endeavours are met with a quiet laugh or congratulatory pat; your status is elevated and self-esteem balloons. You are told that your sexual successes are the measure of a man.

It is precisely this sort of validation that perpetuates workplace sexual harassment.

The egocentric desire for personal gratification and group approval means that women, rather than being considered human persons to respect, are reduced to mere means to a personal ends.

Whereas “boys” are motivated by self-interest and gratification, men are driven by principle.

This is why we need “the boys” culture to become “the men” culture - a culture in which it is the duty of every man to recognise the dignity of every woman; in which harassing women into sexual situations is not met with congratulations, but rather vociferous castigation.

In the public discourse on this issue, the voice of men has been quiet. This needs to change.

Late last year, a video of a speech Emma Watson delivered to the UN went viral.

She launched the “HeforShe” campaign in which she called for men to stand up and speak out for gender equality, pointing out that gender stereotypes pigeon-hole men as much as they do women.

The 2013 Male Champions for Change initiative, in which 21 leading Australian CEOs spoke out for women in the workplace, was an important instance of male voices speaking clearly on the issue, for there is no-one who could better change the behaviours of men than men themselves.

If we want to ameliorate and rectify wrongs we need effective and accessible reporting systems.

But if we genuinely want to have equity in the medical profession we need a change in our culture.

We need our boys to become men.

** Matthew Lennon is a medical student from the University of New South Wales, and is Policy Officer for AMSA for 2015. Follow on Twitter @mattjlennon.*



Why saying no to the death penalty is the ethical thing to do

BY DR MICHAEL GANNON

The harrowing circumstances of Australians Myuran Sukumaran and Andrew Chan, the death row inmates facing the very real possibility of execution by firing squad in Indonesia for drug trafficking, has forced many of us to consider our own morals and beliefs regarding the death penalty.

To one extent or another, the views of our individual members would reflect those of the broader Australian community, ranging from outright opposition under any circumstance, to acceptance and even support for the death penalty for certain crimes.

There are many factors that influence our individual opinions, including our upbringing, religious and cultural influences, and personal experiences. Our individual views are neither right nor wrong, they are simply our personal opinions, based on our own individual beliefs and values.

“The AMA advocates that, as members of the medical profession, we cannot condone the use of capital punishment”

While each and every one of us has a personal view on the death penalty, as doctors we are ethically obliged to provide care to those who commit crimes, as well as those who are victims of crime. It is our ethic to treat everyone equally with respect and dignity, without judgement.

It is with this ethic in mind that the AMA recently adopted a formal position opposing the death penalty. While we have a longstanding policy that doctors should not be involved in capital punishment in any way, and that to do so is in direct conflict with a doctor's duty to serve humanity, we did not have a formal position on the broader, social issue of the death penalty itself (irrespective of the involvement of medical practitioners).

The AMA advocates that, as members of the medical profession, we cannot condone the use of capital punishment.

With the support of the Federal Council, AMA President Associate Professor Brian Owler earlier this year wrote to the Indonesian Ambassador in Australia, Nadjib Riphath Kesoema, requesting clemency for the two Australians on the grounds that respect for human life is a fundamental tenet of the medical profession.

While acknowledging the terrible toll that illicit drugs inflict on society, the President stated the AMA's opposition to the death penalty for any person, regardless of how heinous the crime - including involvement in the pernicious illegal drug trade.

The AMA has taken great care to advocate our position in a way that demonstrates humility and respect for Indonesian sovereignty. We consulted with the Foreign Minister's Office to ensure that our advocacy would not interfere with the Australian Government's diplomatic efforts on behalf of Mr Sukumaran and Mr Chan.

On their advice, A/Professor Owler wrote to the Ambassador in Canberra rather than directly to Indonesian President Joko Widodo, which may have been considered disrespectful. The AMA President also wrote to the President of the Indonesian Medical Association, Dr Zaenal Abidin, to inform him of the AMA's position.

We have gone to great lengths to consider different cultural mores. We understand the scale of Indonesia's drug problem. We see the misery of this disgusting trade on our own streets each day. We see how it destroys the lives of so many people - the addicts themselves, their families, and the other victims of their crimes. Those involved in this destructive trade deserve punishment.

However, we sincerely hope that the efforts of the Australian Government, and the collective advocacy of organisations and individuals around the world, will persuade the Indonesian President to grant clemency to Myuran Sukumaran and Andrew Chan, and commute their death penalties to a lesser sentence.

We thank those members and others who have asked the AMA to speak out on this important ethical issue.



The AMA a persistent and powerful voice on Indigenous health

BY PROFESSOR IAN RING, PROFESSORIAL FELLOW AT THE AUSTRALIAN HEALTH SERVICES RESEARCH INSTITUTE, UNIVERSITY OF WOLLONGONG. PROFESSOR RING HAS WORKED WITH THE AMA ON INDIGENOUS HEALTH ISSUES FOR MORE THAN 20 YEARS.

Nothing exemplifies quite so clearly the AMA's concern with issues far broader than simply representing the interests of doctors as does its role in Aboriginal health.

That interest is broad in scope, genuine and effective, and dates at least from Dr Brendan Nelson's term as AMA President in the mid-1990s.

Almost every President since has shared Dr Nelson's deep, personal and organisational concern and involvement in Aboriginal health, and that involvement is the specific reason I, and no doubt others, joined the AMA many years ago.

That involvement has taken a variety of forms - lobbying, promoting public awareness through the media, preparing and disseminating annual Report Cards on a wide variety of relevant topics, and active engagement with Indigenous organisations and leaders.

Promoting public awareness of issues regarding Aboriginal health has been central to the AMA's role and purpose, and has taken many forms.

For example, Keith Woollard and I travelled to New Zealand during his term as President (1996-98), notionally to learn more about international experience in improving Indigenous health, but with a secondary aim of drawing the attention of the Australian media. Both aims were achieved. There was substantial Australian press coverage and, equally, we learnt a lot about the linkage of health services with community, cultural, social and economic programs.

Lobbying has taken many forms.

During the late 1990s, when the lack of progress in Aboriginal and Torres Strait Islander health was seen as an international disgrace and symptomatic of a national failure to come to grips with the issues concerning Australia's Indigenous peoples, the AMA arranged to bring together political, public service and health leaders in an effort to bring about a more effective focus on Indigenous health.

It organised meetings with the-then Prime Minister John Howard and several of his ministers, including Senator Amanda Vanstone, Michael Wooldridge, Tony Abbott and John

Herron and Commonwealth Department secretaries. It also met with Aboriginal leaders and organisations, notably the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Australian Indigenous Doctors Association (AIDA) and other leaders of the medical profession.

Under the leadership of the current President Associate Professor Brian Owler, the AMA is an active participant in the Close the Gap campaign and lobbies effectively on matters of key importance to Indigenous health, such as patient co-payments

The AMA's role became more institutionalised during Dr Kerryn Phelp's term with the formation of the AMA Indigenous Taskforce, whose membership was drawn from NACCHO, AIDA, the Indigenous branch of RACGP, Aboriginal health leaders, AMSA, AMA council members and other AMA members with an active involvement in Aboriginal health.

Since its inception, the Taskforce has produced annual Indigenous Health Report Cards highlighting issues including infant health, inequality, incarceration, low birth weight, workforce requirements and Indigenous primary health care.

Under the leadership of the current President Associate Professor Brian Owler, the AMA is an active participant in the Close the Gap campaign and lobbies effectively on matters of key importance to Indigenous health, such as patient co-payments.

This is in keeping with the AMA's well-established role as a persistent, sustained and powerful voice on Indigenous health for at least the past two decades.

During that time, much has changed for the better, particularly as a result of the Close the Gap campaign – although recent cutbacks to funding are a significant concern.

For the future, the development of the Implementation Plan for the National Aboriginal and Torres Strait Island Health Plan will be a priority, including ensuring that it is guided by the voice of Aboriginal people and effectively addresses issues of culture and racism, as well as the practical issues of service models, building service capacity and ensuring an adequate workforce and funding.



AHPRA Prescribing Working Group

BY ASSOCIATE PROFESSOR ROBYN LANGHAM, CHAIR, MEDICAL PRACTICE COMMITTEE

AHPRA and the Chairs of the National Boards have convened a Prescribing Working Group (PWG) with the aim of developing a governance framework to support the development and review of National Boards' regulatory policy for prescribing scheduled medicines.

I represent the AMA on the PWG.

The AMA welcomes the establishment of the PWG.

In our view, the Intergovernmental Agreement and the Health Practitioner Regulation National Law Act 2009 have not delivered adequate safeguards for determining the competencies for prescribing rights.

This has been demonstrated by the fact three health professions in recent years - optometry, nursing and midwifery, and pharmacy - are taking different approaches to expand their scopes of practice with respect to prescribing.

More recently, the Physiotherapy Board applied to the Australian Health Workforce Ministerial Council for approval to endorse the registration of physiotherapists for scheduled medicines under the National Law, before the Board had worked through the process of ensuring appropriate accreditation standards and programs of study for prescribing practice were available.

The approaches adopted by these Boards have not conformed with the frameworks set out in the National Prescribing Service (NPS) *Competencies Required to Prescribe Medicines*, which establishes the competencies that health professionals need in order to safely, appropriately and effectively prescribe, or in Health Workforce Australia's *Health Professionals Prescribing Pathway* (HPPP), which provides a structure for health professional National Boards and Accreditation Councils to make their education requirements, competency standards and assessment processes nationally consistent.

There is no high level evidence that independent non-medical prescribing is safe for patients or cost effective for the health system.

The current process of Ministerial sign-off on ad hoc approaches to non-medical prescribing that do not involve first establishing

the education and training standards, practitioner competencies, and accredited education and training courses, is not sufficient to safeguard patient safety or the quality use of medicines.

For the work of the PWG to be effective, there needs to be a mechanism for establishing a rigorous governance framework that requires the Boards to work together to ensure consistent standards of education and training, and of practice, underpinning prescribing rights. This would provide the community with the necessary assurance that new prescribing rights are adopted safely, in accordance with the NPS and HPPP frameworks.

“The evidence base for safety and cost-effectiveness is unlikely to increase without arrangements by the professions or their Boards to evaluate and review the expanded scopes of prescribing practice they adopt”

Importantly, the process of expanding scope of practice to prescribing scheduled medicines needs to be supported by a robust review mechanism that validates regulatory policy compliance and rationalises cost effectiveness.

The evidence base for safety and cost-effectiveness is unlikely to increase without arrangements by the professions or their Boards to evaluate and review the expanded scopes of prescribing practice they adopt.

The AMA will continue its strong advocacy for robust regulatory oversight for safe practitioner prescribing practice.

The PWG meets quarterly by teleconference, and the next meeting is scheduled for 7 May.

Pharmacy under fire



Multi-billion dollar pharmacy deal falls foul of audit

Negotiations on a fresh multi-billion dollar funding deal for the nation's pharmacies have been overshadowed by revelations of spiralling taxpayer handouts, cost overruns and inadequate government oversight.

An investigation by the Commonwealth Auditor-General has found significant shortcomings in the operation of the current \$15.4 billion Community Pharmacy Agreement, under which the Federal Government has paid out \$13.8 billion to chemists to dispense medicines through the Pharmaceutical Benefits Scheme.

In a scathing assessment of the administration of the Agreement, the Auditor-General found a \$200 million shortfall in expected savings, a \$300 million blow-out in pharmacist incentive payments, and the diversion and re-allocation of more than \$13 million of funding without ministerial approval.

"The Department of Health's administration of the Fifth Community Pharmacy Agreement has been mixed, and there is a limited basis for assessing the extent to which [it] has met its key objectives, including the achievement of \$1 billion in expected savings," the report said. "A number of key government negotiating objectives for the 5CPA were only partially realised, and there have been shortcomings in key aspects of Health's administration at the development, negotiation and implementation phases."

Health Minister Sussan Ley, who is set to begin negotiations with the Pharmacy Guild of Australia on the next five-year Community Pharmacy Agreement, said the findings were deeply concerning.

Ms Ley said the Auditor's revelations raised serious questions not only about the Health Department's administration of the

agreement, but also negotiation of the current agreement by the previous Labor Government, which signed off on it in 2010.

The Auditor-General's report has come at a highly sensitive time for the industry, which is not only negotiating a new Community Pharmacy Agreement but is also pushing hard to expand the range of services pharmacists are allowed to provide, including flu vaccinations and health checks.

The Pharmacy Guild earlier this year launched a multi-million dollar advertising campaign in an effort to boost the public standing of pharmacists.

But the message risks being undermined by revelations that chemists add up to eight different charges and mark-ups to the cost of a prescription, including dispensing, dangerous drug and container fees. News Limited has reported that these accumulated charges can inflate the price of a box of 112 aspirin from \$1.10 at the wholesaler to \$13.31.

The Guild's image risks being further tarnished by findings that \$5.8 million provided to it by the Commonwealth to fund professional development programs has instead been diverted into financing a "communications strategy" without ministerial approval, and that most of the \$7.3 million given by the Government to encourage electronic prescribing has been used for other purposes.

The embattled industry has lashed out at critics, vehemently rejecting what it said were attempts to portray pharmacies as "millionaire factories", instead insisting that many are instead under significant financial pressure.

"It is offensive and unacceptable that this false impression of profiteering should be put about at a time when the Guild is negotiating a new five-year Community Pharmacy Agreement with the Government to ensure local pharmacies remain viable," the Guild said. "Community pharmacies are under stress, and this kind of vicious, prejudiced and ill-informed journalism is reprehensible."

The Health Department has accepted Audit Office recommendations to improve its administration of Community



Pharmacy under fire

Pharmacy Agreements, including more stringent account keeping and documentation standards.

But the Guild said the Auditor-General had not made “any adverse findings” regarding its role in administering the agreement.

ADRIAN ROLLINS

Pharmacies could feel hot breath of competition

The AMA has argued patients will be the winners if proposals to abolish arcane rules stifling competition in the pharmacy sector are adopted.

Chair of the AMA Council of General Practice Dr Brian Morton said recommendations from the Government’s Competition Policy Review to remove restrictions on the ownership and location of pharmacies would improve patient access to medicines.

The Review, chaired by prominent economist Professor Ian Harper, found that rules that prevent new pharmacies opening within 1.5 kilometres of an existing outlet and require that only pharmacists can own a chemist shop did nothing to enhance access to medicines or improve the quality of advice to consumers.

“Current restrictions on ownership and location of pharmacies are not needed to ensure the quality of advice and care provided to patients,” the Review concluded. “Such restrictions limit the ability of consumers to choose where to obtain pharmacy products and services, and the ability of providers to meet consumers’ preferences.”

The Pharmacy Guild of Australia has rejected the assessment, arguing that current arrangements have served patients and the community well.

“We believe that pharmacies should be owned by small business people trained in universities, trained in the art of pharmacy, and we don’t think that they deserve to be in huge supermarkets that don’t have your health care as number one priority,” Guild President George Tambassis said.

But Professor Harper said industry opposition to allowing supermarkets to provide pharmacy services had been undermined by the fact that a Queensland pharmacy that incorporates an IGA outlet recently received an industry award.

He told ABC Radio that “the pharmacy industry has no difficulty with supermarkets being inside pharmacies. They’ve

just awarded a prize for a pharmacist in Queensland who’s allowed IGA Express to open up a business inside the pharmacy. That doesn’t seem to be the issue.”

Professor Harper said rules on location and ownership did not apply to medical practices or private hospitals, and “we see no reason why they should apply to pharmacies either”.

He said there was no intention to change the authority to dispense medicine, which would always remain the prerogative of “licensed professionals”.

But the Review said current anti-competitive rules did nothing to improve access to medicines, particularly for people living in remote and rural areas.

It said Government could use community service obligations and tenders for the provision of pharmacy services in under-served areas to ensure rural patients had access to prescription drugs, noting that the “supply of medicines in remote areas is already partly conducted through channels other than retail pharmacies, including through Aboriginal health services. That is unlikely to change, even if the current pharmacy location and ownership rules are reformed”.

ADRIAN ROLLINS

Who gets the pharmacy billions

Almost one in five community pharmacies raked in more than \$1 million from taxpayers in dispensing fees, incentive payments and other entitlements last financial year, a Commonwealth Auditor-General report has shown.

In a rare glimpse into the public funding arrangements for retail chemists under the multi-billion dollar Community Pharmacy Agreement, the Auditor-General found that 941 of the nation’s 5371 retail pharmacies received more than \$1 million in Government payments in 2013-14, while a further 500 received between \$800,000 and a \$1 million.

On average, pharmacies received \$12 from the Government for every prescription they filled in 2013-14.

In all, the Auditor-General found that of the \$15.4 billion going to pharmacies under the current Community Pharmacy Agreement, \$11.6 billion comes from the Commonwealth in remuneration payments, \$2.2 billion comes from the pockets of patients in direct co-payments, \$950 million is disbursed from a Government fund for medicine wholesalers and \$663 million is provided for professional development programs.



Pharmacy under fire

... from p27

Worryingly, given the scale of the largesse, the Auditor-General found significant flaws in the Health Department's administration of the scheme, including an inability to accurately track medicine costs and pharmacy remuneration.

The Auditor-General sought to fill this gap by using Department of Human Services data to calculate the value of Pharmaceutical Benefit Scheme and Repatriation Schedule of Pharmaceutical Benefit prescriptions.

It found that, for 2013-14, the "actual cost of prescriptions was \$459 million higher than the sum of the cost components as derived by Health".

"Health has been unable to identify actual expenditure on the components of pharmacy remuneration for a growing number of prescriptions subsidised by the Australian Government," the Auditor-General said.

Among the findings, the Auditor-General reported that the Premium Free Dispensing Incentive, introduced to encourage greater uptake of generic medicines by compensating pharmacists for dispensing drugs that do not have the premium of branded medicines, is being claimed regardless of whether or not a substitute was provided. The incentive, worth \$1.50 per prescription, is automatically paid on 4500 (83 per cent) of PBS branded items.

These and other findings have fuelled accusations that tight restrictions on pharmacy ownership and location have undermined competition in the industry and created outsized profits for a select few at enormous cost to patients and taxpayers, with some calling for an inquiry into the sector.

Under current laws, pharmacies must be owned by a licensed pharmacist, and new pharmacies are not allowed to open within 1.5 kilometres of an existing outlet. The rules have effectively blocked other retailers, particularly the major supermarket chains, from entering the industry.

Pharmacy ownership is tightly held – of around 27,000 registered pharmacists, fewer than 4000 own stores.

But the Pharmacy Guild of Australia has vehemently rejected what it said were attempts to portray pharmacies as "millionaire factories", instead insisting that many are instead under significant financial pressure.

"It is offensive and unacceptable that this false impression of profiteering should be put about at a time when the Guild is negotiating a new five-year Community Pharmacy Agreement with the Government to ensure local pharmacies remain viable," the Guild said. "Community pharmacies are under stress, and this kind of vicious, prejudiced and ill-informed journalism is reprehensible."

ADRIAN ROLLINS

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



Notice of Annual General Meeting

Notice is hereby given that the Fifty-Fourth Annual General Meeting of members of Australian Medical Association Limited will

be held at 4.10pm on Friday 29 May 2015 at the Brisbane Hilton Grand Ballroom, 190 Elizabeth Street, Brisbane QLD 4001.

Business:

1. To receive the Minutes of the Fifty-Third Annual General Meeting held in Canberra on Friday 23 May 2014.
2. To receive and consider the Annual Report of Australian Medical Association Limited for the year ended 31 December 2014.
3. To receive the audited Financial Reports for Australian Medical Association Limited and its controlled entities for the year ended 31 December 2014.
4. To appoint auditors for Australian Medical Association Limited and its controlled entities.
5. To consider and if thought fit adopt as a special resolution, the following motion:
That the Constitution of the Company be amended by deleting existing paragraph 17.6(c) and that the paragraph in clause 17.6 immediately following existing paragraph 17.6(c) be numbered as paragraph 17.6(c).
6. To transact any other business which may properly be transacted by an Annual General Meeting.

A member eligible to vote at the Annual General Meeting may appoint a proxy in accordance with Clause 15 of the Company's Constitution. A proxy need not be a member of Australian Medical Association Limited (section 249L Corporations Act). To be effective the proxy form must be received, as stated below, not less than 48 hours before the time for holding the Annual General Meeting.

Proxies must be received by Australian Medical Association Limited as follows:

By mail:

Secretary General (Company Secretary)
Australian Medical Association Limited
AMA House, 42 Macquarie Street,
Barton ACT 2600

OR

PO Box 6090, Kingston ACT 2601

OR

Email: agm@ama.com.au, Facsimile: (02) 6270 5499

A proxy form can be accessed at <https://ama.com.au/proxy>

Ms Anne Trimmer

Secretary General
20 March 2015

When the ANZACS landed on Malta



Australia Hall Pembroke, Malta as it is today



AMA Vice President Dr Stephen Parnis with the Australian High Commissioner to Malta Jane Lambert

As Australia prepares to mark the centenary of the Gallipoli campaign, a chance encounter by AMA Vice President Dr Stephen Parnis has sparked efforts on the other side of the world to preserve the remnants of a little-known chapter in the ANZAC story.

Strategically positioned between the tip of Italy and the north coast of Africa, Malta is no stranger to conflict. At various times it has been fought over by the Phoenicians, Carthaginians, Romans, Ottomans, French, Germans and British.

But AMA Vice President Dr Stephen Parnis was nevertheless surprised when he saw the Australian coat of arms engraved on the façade of an imposing sandstone building on the outskirts of Pembroke on the island's north coast during a visit in August last year.

"I was in the car heading to my cousin's place when I saw it," Dr Parnis told *Australian Medicine*. "I knew wounded Australian soldiers had been brought to the island for treatment, but I had never heard of the building."

The structure, called Australia Hall, was erected in November 1915 using donation from the Australian public.

It served as a much-needed centre for entertainment and recreation for convalescing troops who arrived on the island in their thousands as the deadly toll of the Dardanelles campaign and other conflicts in the eastern Mediterranean mounted.

In May 1915 alone, 4000 wounded ANZACs from Gallipoli were transported to Malta, and by the end of World War One 58,000 had crossed its shores – including around 200 who never left and are buried on Malta.

Remarkably, the two-storey Hall survived the Second World War unscathed despite the fact that during the conflict Malta was the target of a sustained German and Italian bombing campaign that made it one of the most heavily bombed places on earth.

But the ensuing decades were less kind, and the building now sits – roofless, gutted and unused - on prime land.

His interest piqued by his chance discovery, Dr Parnis got in

touch with former AMA President and Australian War Memorial Director Dr Brendan Nelson to see what might be done to preserve the building.

Within days he received a call from the Australian High Commissioner to Malta Jane Lambert, who has since become closely involved in efforts to protect Australia Hall, including regular contact with its private owner.

Given the building's dilapidated state, any restoration work would not only require the co-operation of the current owner, but would likely cost several millions of dollars – money yet to be forthcoming from the Australian Government.

But Dr Parnis praised the efforts of Ms Lambert and was hopeful that Australia Hall will be preserved and restored.

"The High Commissioner has been in constant contact with the person who owns it and brought to their attention the significance of this building to Australia, so that when restoration occurs it will be sensitive to Australian history and sensibilities," he said.

Planning requirements and delays have meant there is unlikely to be an announcement about the Hall's restoration on Anzac Day, but there are hopes plans will be completed in time to be revealed on the occasion of its anniversary in November this year.

For Dr Parnis, restoring the building to something approaching its former glory would be a way to ensure the bonds of care and support that developed between injured diggers and local Maltese in the early years of World War One are not neglected.

"It shows that the links between Australia and Malta are much closer than just the post-World War Two period of immigration," he said.

ADRIAN ROLLINS



Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

GP training confusion: call for urgent talks

The AMA has voiced “grave concerns” about the Federal Government’s handling of far-reaching changes to general practitioner training under the shadow of looming doctor shortages.

AMA President Associate Professor Brian Owler has written to Health Minister Sussan Ley seeking an urgent meeting to discuss the implementation of changes to GP training announced in last year’s Budget.

A/Professor Owler warned the Minister that the medical profession was “fast losing confidence in the process, and history shows that the last time GP training was reformed by the Government it took many years to recover”.

In its 2014-15 Budget, the Federal Government abolished General Practice Education and Training (GPET) and the Prevocational General Practice Placements Program (PGPPP), axed funding to the Confederation of Postgraduate Medical Education Councils and absorbed Health Workforce Australia and GPET within the Health Department.

Under the sweeping changes, the Health Department will have responsibility for overseeing GP training.

The changes have stoked warnings that, combined with cuts to valuable programs and fears of massive hikes in student fees, they pose a serious risk to the quality and viability of general practice training, placing the profession at long-term risk.

Concerns have centred on the short time frame to implement the changes, the Department’s lack of experience in managing training programs, and the profession’s loss of supervision over training.

A/Professor Owler said expert AMA representatives who have been consulting with the Government and Health Department on the implementation of the changes have been alarmed by on-going delays and a lack of detail being provided by the Department on crucial matters such as the funding of professional oversight and governance arrangements.

“Unfortunately, we are now in a position where we simply do not know what the structure and delivery of GP training will look like beyond 2015,” the AMA President said in his letter to Ms Ley.

He said briefing papers provided by the Health Department for those attending its stakeholder meetings were “generally scant on detail and do not adequately deal with key issues, such as the future role of the GP Colleges”.

A/Professor Owler said the overwhelming view in the medical profession was that the Colleges should be given responsibility for the governance and management of GP training.

Anxiety about the changes has been heightened by predictions the nation could face a critical shortage of doctors in the next decade.

The ageing of the GP workforce and the struggle to attract students to specialise in general practice has contributed to forecasts of a shortfall of 2700 doctors by 2025 unless there is a major investment in training.

Last month Health Minister Sussan Ley re-announced the allocation of \$157 million to extend the life of two medical training programs – the Specialist Training Program and the Emergency Medicine Program – through to the end of 2016.

Ms Ley said the programs were being sustained for an extra year while the Government continued to consult with the medical Colleges and other stakeholders about reforms to come into effect in 2017.

“This consultation will focus on in-depth workforce planning to better match investments in training with identified specialties of potential shortage and areas that may be over-subscribed into the future,” the Minister said. “Workforce planning is something that doctors and health professionals have been raising with me during my country-wide consultations to ensure those areas of expected shortages are addressed sooner rather than later.”

But Shadow Health Minister Catherine King condemned what she described as a “short-term fix”.

Ms King said the Government had thrown the entire field of specialist medical training into chaos by delaying confirmation of contracts just weeks before candidate interviews were due to commence.

Ms King warned that any cut to funding to specialist training would result in fewer specialists working in areas where they are needed most.

ADRIAN ROLLINS

Govt urged to back successful training scheme

The AMA has urged the Federal Government to extend the life of a scheme that has delivered a major boost to medical specialist training in rural and ‘non-traditional’ settings.

The Australian National Audit Office has reported that the Medical Specialist Training Program (STP) set up by the Rudd Government to help stave off a looming shortage of medical specialists has been a success, filling 833 training positions since 2010 – almost 90 per cent of them outside the major teaching hospitals and 40 per cent of them in rural and regional areas.





Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p30

But the scheme is due to wind up by the end of the year unless there is a further injection of funds, prompting AMA President Associate Professor Brian Owler to call for on the Government to renew its commitment to the program.

“The AMA believes the ANAO endorsement of the STP should allow the Department of Health to immediately finalise funding arrangements beyond 2015, which is a matter of urgency,” A/Professor Owler said.

The program was set up at the start of the decade amid warnings the nation was facing a shortage of medical specialists, particularly in general surgery, pathology, radiology, dermatology obstetrics and gynaecology, without a substantial increase in training positions.

While most specialist training positions are provided by State and Territory governments at public teaching hospitals, since 2000 these have been supplemented by the Commonwealth, which boosted the number of positions it funded from 360 in 2010 up to 900 by last year.

Under the expanded scheme, the Federal Government typically provides between \$100,000 and \$153,000 a year for each full-time position, with such training taking from between three to six years to complete.

The Audit Office found that the scheme has been well-subscribed, reporting that 93 per cent of training positions have been filled. Last year, 467 people applied for 150 grants.

It said the Health Department's decision to funnel the grant funds through the specialist colleges, and to seek the advice of the colleges and state health services in the selection of applicants, had contributed to the success of the scheme overall.

“The STP has been successful in utilising non-traditional settings to expand the number of training positions for specialist trainees, with 89 per cent of STP-funded positions being located in non-traditional settings,” the Audit Office said, adding that the expanded range of work environments provided for trainees through the program had improved the quality of training.

“Overall, the additional specialist trainee positions funded by the STP have boosted the availability of specialist services, including in regional and rural areas,” the ANAO said.

A/Professor Owler said the STP had “added value” by increasing the number and range of training opportunities.

“Under the STP, specialist trainees have the opportunity to see and treat conditions that are not common in public hospitals,” he said.

But the Federal Government, which is the throes of framing its second Budget, has yet to commit the extending the scheme beyond this year, adding to concerns about the adequacy of training arrangements for doctors.

Rapid growth in the number of medical graduates has outpaced increases in places further along the training pipeline, and there are fears that the absorption of Health Workforce Australia into the Health Department will undermine efforts to improve medical workforce planning, raising the risk that doctor shortages, particularly of specialists, may get worse.

HWA warned in 2012 that the nation faced a shortage of 2700 doctors by 2025 without improvements and increases in medical training, particularly in rural areas and in specialties such as radiology, psychiatry, pathology, ophthalmology, obstetrics and gynaecology.

ADRIAN ROLLINS

Patients could get caught in metatata net

The AMA has raised concerns the Federal Government's contentious data retention laws could be used to compromise patient privacy and potentially undermine the doctor-patient relationship.

AMA President Associate Professor Brian Owler has written to federal MPs including Attorney-General George Brandis, Communications Minister Malcolm Turnbull, Shadow Attorney-General Mark Dreyfus and Shadow Communications Minister Jason Clare raising concerns about the potential for the laws to be used to gather detailed information about a person's medical condition and health status.

“Metadata can potentially be used to create a profile of an individual based on access to health services,” A/Professor Owler wrote. “This might include the services they may call, emails to and from health providers, SMS appointment reminders and the like. When aggregated, this information could reveal a great deal about someone's health status.”

Under the laws, telephone companies and internet service providers are required to retain the details of every electronic communication they handle, including the identity of a subscriber and the source, destination, date, time, duration and type of communication. The information stored, known as metadata, does not include the content of a message, phone call, email or an individual's web-browsing history.

Under the legislation, passed with bi-partisan support late last





Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p31

month, 85 security and policing agencies will have access to an individual's metadata for up to two years after it is created.

The Government has argued that the laws are crucial to thwarting terrorist activities and preventing serious crime, and has sought to reassure the public that the powers would be used carefully and sparingly.

But law experts and civil liberties groups have raised fears about scope for intrusion on individual privacy.

University of New South Wales law professor George Williams wrote in *The Age* that the laws would "permit access to the data of every member of the community. Where, for example, the information relates to doctors and their patients, or lawyers and their clients, a government agency will not need to gain a warrant, or to consider whether accessing this information is in the public interest."

In his letter to the MPs, A/Professor Owler noted that the Law Council of Australia had also expressed concern about the

detail of the legislation's wording, "including with regard to potential access to health information".

Greens Senator Penny Wright, who was among those who opposed the legislation, warned the measure could have the effect of deterring people from seeking medical help, including online support services.

"With [the] increasing use of online services for mental health, there is a serious risk that this Bill will undermine people's trust in these online services, with a flow-on risk to access to mental health services and the mental health generally," Senator Wright said in *Australian Doctor*.

A/Professor Owler has told senior Coalition and Labor MPs they need to address such concerns "to assure people and health professionals alike that the privacy of health information remains protected".

ADRIAN ROLLINS

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Take some leisure time with these special rates just for AMA members.

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Hertz



The much-maligned Merlot



BY DR MICHAEL RYAN

It's hard not to discuss the red grape Merlot without touching on the recent Hollywood movie *Sideways*.

The film's main character, Miles, has several tantrums in which he declares his disdain for "insipid" Merlot (though, ironically, his most precious wine is a 1962 Cheval Blanc, which is 95 per cent Merlot and 5 per cent Cabernet Franc). The consumption of Merlot dropped off noticeably in the wake of the character's tirades.

But the variety has not always been so out of favour. It got a kick along in Australia in the 1990s when many female drinkers searched out Merlot as they ventured from Chardonnay into the realm of the reds. It makes sense, as Merlot can be a silky fruit-driven wine with subtle tannins, and usually cost less than \$20.

But few Australians realise it is the most widely planted grape in France, and about the fifth most common variety in the world. Its father is Cabernet Franc, which adds structure with tannin and anthocyanin, and its mother is a wild French grape called Magdeline Noir des Cheventes.

Its spiritual home is the right bank of the Gironde River in Bordeaux, where both Pommerol and St Emillon are powerhouse planters.

It is suited to wetter conditions, with the ability to ripen one to two weeks earlier than the finicky Cabernet Sauvignon it is often blended with.

Merlot is renowned for the filling of the "doughnut hole" in Cabernet Sauvignon. It is often said that the Merlot is Cabernet Sauvignon without the pain, and it has the potential for high yields and higher alcohol levels. Cabernet Franc, Malbec and Petit Verdot make up the classic five Bordeaux blend grapes.

It has found its way across cooler Europe from north-east Italy (places such as Friuli and Trentino), appearing in Slovenia and Romania, among other areas.

In the warmer Tuscan region, it is blended with Sangiovese to make the sought-after "Super Tuscan" reds.

Merlot is a well-known grape in the United States, where it is grown in Napa, Sonoma and Washington State.

Chile and Argentina also grow it well - for many years in Chile, Carmenere, its cousin, was thought to be a powerful rich strain of Merlot.

Australian wine growing was drawn into the Merlot revolution when many growers backed its 'new wave' status in the 1990s. It was first planted in 1980, but then disappeared before being

resurrected after 1988. However, poor clone selection, weak understanding of growth characteristics and incompetent wine making techniques have contributed to its decline from its earlier Cinderella status.

But the public isn't stupid with its palate, and wineries in the Adelaide Hills, Coonawarra, Barossa/Eden Valley, Margaret River and the Yarra Valley have redeemed this noble grape to produce great Merlots.

Hats off also to our Kiwi cousins. Some of the NZ Merlots are a thinking person's red that stand out in the sea of Pinot Noir, and the Gimblet Gravels area of Hawkes Bay excel.

WINES TASTED

- 2012 Parker Estate Coonawarra Merlot** - A bright red in colour. Nice, lively red fruits, hints of plum and herbal notes. The palate is refined, with moderate fruit and good structure with a mid-palate finish. This wine evolves over an hour and is great with some roast smoked chicken (skin on with juicy fat). Cellar four to five years.
- 2012 Irvine Song Hill Barossa Merlot** - James Irvine is the king of Merlot. His Grand Merlot is genius in a bottle. This competitively priced Merlot has some dark red colours. Aromatic, juicy stewed plums integrate with good vanillin notes from the oak. The palate is plush, with mid-palate integrated tannins. Very nice with chicken cacciatore. Cellar five to seven years.
- 2013 Kim Crawford Hawkes Bay Merlot** - A very dark purple. The nose is intense, with prunes and spicy dates. The aromas are of a foreign nature with brambly, mineral overtones. Sharp anterior palate with good acidity, but little tannin effect. A good value wine for under \$20 dollars, if you are in need of a NZ fix.
- 2010 Kendall-Jackson Sonoma California** - Intensely purple. Another foreign nose with prunes, licorice and earthy tones. Exceptional fruit and massive oak, American and French. Full, juicy palate, almost port-like, with nicely balanced tannins. One Big Merlot! I really enjoyed this with some nine-plus baked wagyu.



Mini Cooper S Restoration (Part 3)

BY DR CLIVE FRASER



After spending so much time, energy and money on the restoration of the Mini Cooper S, it's great to see that it's finally on the home stretch.

With the re-built engine installed and running it's now time to add some of the finishing touches.

Forty-five years of UV light and wear and tear can take its toll on all of the window and door rubbers, but fortunately they are all still available for purchase at \$600 for a full set.

The seats have been re-upholstered, and the cabin is all back in one piece at last.

So, it's finally time to take the Mini back out on the road.

The engine ticks over nicely and, with the gearbox completely re-conditioned, everything should be as good as new.

But alas, there is a problem.

The gears aren't changing freely, and it's necessary to double de-clutch on every change.

That means slightly revving the engine in neutral to try to match the revolutions of the input and output shafts, particularly when down-shifting.

How could this be? After all, the Mini had a brand new clutch.

Further investigation revealed that the culprit was a worn clutch pedal pivot bush.

The movement in the loose bush meant that, even when the clutch pedal was fully depressed, the other end of the shaft just wasn't moving through its full range of movement and, therefore, the clutch was not fully disengaging.

Once discovered, it was a simple fix for a problem too subtle to spot on the re-build.

So what was the Mini like on the road?

Well, frankly, just a little disappointing!

It is, after all, a 45-year-old design which lacks all of the modern engineering that makes 2015 cars feel so refined and smooth.

There's no power steering, no air conditioning and the performance is sluggish compared to a modern turbo-powered car.

In the event of an emergency there is no ABS, no airbags or crumple zones and crashing in a Mini was never meant to be injury-free.

So, for a total investment which could have bought a fairly new hot hatch, was the whole job worthwhile?

Well yes, I think so.

Because restoring the Mini was never about making a profit.

It was about restoring a piece of motoring history and bringing the little car back to its full glory, just like it was when it left the factory.

Would my friend tackle the whole job again?

He'd have to think about that.

PS Once completed my friend reluctantly decided to sell the Mini.

It didn't last long on carsales.com.au, and the new owner really didn't pay a premium for all the time and effort that had gone into the restoration.

He mentioned that he was thinking about changing a few things on the car, like installing a stereo system.

Expecting that might happen, my friend advised the new owner that he'd pre-wired the car for whatever stereo he might install, but he also warned the new owner that whatever he did from here that changed the car from its original stock build would de-value it.

Proving the point that it's often better to leave things alone and stick with the original, particularly if it has stood the test of time.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

1970 Mini Cooper S

Engine:	1275cc 4 cylinder OHV
Power:	45 kW @ 5550 rpm
Torque:	91 Nm @ 3000 rpm
	0-100 km/h in 12 seconds
	Top speed 148 km/h
	7.3 l/100km

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