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AUSTRALIAN
# Medicine
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## AMA LEADERSHIP TEAM

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# In this issue



Cover: "Family violence it not just a law and order issue; it's a health issue": AMA President Associate Professor Brian Owler and Law Council of Australia President Duncan McConnel launch family violence toolkit for medical practitioners at AMA National Conference, Brisbane.

# Collegiality in the medical profession

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

The AMA is the peak body representing the medical profession. But what is a profession?

The Professional Standards Council describes a profession as a disciplined group of individuals who adhere to ethical standards, and possess special knowledge and skills in a widely-recognised body of learning derived from research, education, and training at a high level.

Importantly, however, a profession is also prepared to apply this knowledge and exercise these skills in the interest of others.

We apply our knowledge and skills to teaching medical students and training our successors.

We apply our knowledge and skills to health promotion and preventative health.

And we apply our knowledge and skills to advocate for better health services and better access to health services.

This is what being a doctor means. It is part of our professionalism, and that is why we make choices like the AMA did in opposing the GP co-payment. It is the right thing for the profession. And it is the right thing for our patients.

When we are talking about professionalism and what it means to be a profession, we have to start by talking about looking after those starting out in our profession.

I started my medico-political career as an angry medical student.

I saw that Governments were all too willing to use medical students and training as a political issue. Like all doctors, I am concerned for our current medical students and trainees.

The doctor I am is a factor of the training and support I received as a medical student and a trainee.

I want the doctors and students of the future to benefit from this same strong collegiate training.

I don't want students standing five or six deep around every patient, struggling for clinical experience. Our students and our patients deserve better.

We know medical students and trainees are already struggling to access required levels of clinical exposure.

Our trainees and students are already anxious about whether they will be able to get a training place and a job.

That is why the AMA, AMA WA, and AMSA went public with strong criticism of the Federal and West Australian Governments' decision to fund a new medical school at Curtin University.

The funding would be far better spent providing training places for students already in the system.

Another quality of a profession, and this must be particularly true of the medical profession, is that individuals care for each other as colleagues.

In recent months, we have seen coverage of the impact on our colleagues who have not received that care and support, or who have been directly sexually harassed or bullied.

On behalf of the AMA, I say again that sexual harassment and bullying are unacceptable.

While the issues of harassment have been prominent in the media, achieving cultural change is not just about stopping bullying and harassment.

It is about promoting female leaders and championing gender equality.

It is about ensuring that all doctors – male and female – can access appropriate parental leave and, if they wish, flexible work arrangements.

We will also continue our role in supporting doctors and students at an individual level.

I have said many times that some of my proudest moments as a State AMA President were when the AMA advocated successfully on behalf of individuals - particularly when they find themselves in difficult circumstances, often not of their own making.

This has also been a core part of my Federal Presidency – providing a voice for people who, for whatever reason, do not have a voice that is heard by our political leaders, the public, and the media

This is an important role for the AMA, and one we will continue.

# Talking about dying won't kill you

BY **AMA VICE PRESIDENT DR STEPHEN PARNIS**

> "You'll stay with me?'
> Until the very end,' said James."
>
> — J.K. Rowling, Harry Potter and the Deathly Hallows

Recently, it was National Palliative Care Week, and it had as its theme *Dying to Talk; Talking About Dying Won't Kill You*.

The aim was to get people to talk about death and dying, to normalise death and, most of all, to prepare for it, so that a patient's wishes and needs at the end of life can be met.

The AMA has publicly promoted the importance of advance care planning, the need for patients (and their loved ones) and doctors to work together to discuss death and dying, to establish a patient's values and goals of care at the end of life, and to identify a substitute decision-maker.

But while we may encourage our patients to think about death and dying, as a profession we often struggle to come to terms with it ourselves.

I do not mean our own deaths. As doctors, we know a lot about death – we understand what is realistic and what is not in terms of prognosis, and we have a good idea of what investigations and treatment we would, or more likely would not, accept as part of our own end of life care.

But many members of the profession may struggle to accept the inevitable death of their own patients.

As doctors, we often measure success in terms of saving or, more accurately, prolonging life. But do we give adequate emphasis to quality of life?

It is helpful (though confronting) to consider our response if the patient chooses not to undergo that additional treatment. Is the patient giving up on us? Or worse, is the patient somehow failing us by not responding to, or no longer desiring, treatments that focus on the prolongation of life?

Of course not!

Death and dying is not about us as doctors. It's about the patients – their individual experiences, their perspectives and values around end of life care.

The medical profession is in a unique position to lead the wider community in a healthier understanding of the end of life. But to do that effectively, we must also examine our professional culture and rhetoric around death and dying.

I pay tribute to colleagues who work in palliative care. They do an exceptional job. But we cannot leave palliative care to this relatively small group.

I think there should be a 'whole of profession' approach to end of life care where, regardless of career choice, medical students and doctors are trained in palliative care.

In the vast majority of circumstances, the death of the patient should not be regarded as a failure of care. Equally, an emphasis on quality of life, and the fulfilment of agreed goals of care at the end of life, should be seen as successful medical care.

I believe that the care provided within the Australian health system would be significantly enhanced if:

- a patient's goals, values and health care needs were identified earlier;
- there was greater access to palliative care and related services;
- there was better communication, continuity and co-ordination of care; and
- more doctors and health care personnel became actively involved in providing end of life care.

Care for the dying should never occur in isolation – our nursing, allied health and community service colleagues are essential to supporting patients and their families. The professionalism of these multidisciplinary teams is something of which we can be immensely proud.

I conclude by encouraging you discuss these matters within your communities, and within our profession.

Talk to your colleagues about how you can better care for patients as they approach the end of their life.

Remember, talking about dying won't kill you.

# Firm foundations set for future growth

BY AMA SECRETARY GENERAL ANNE TRIMMER

The Annual General Meeting of Australian Medical Association Limited was held in conjunction with National Conference at the end of May. The Chair, Dr Elizabeth Feeney, reported on the changes in governance of the company that had occurred over the past 12 months. Dr Feeney also reported on the work that had been undertaken in building a firm foundation for the company for the coming years.

In presenting the Annual Report to members of the company I reiterated the Chair's message, that 2014 had been a year focused on building a robust and stable platform for future growth of the AMA. There has been significant investment in governance, information technology, building infrastructure, and in membership analytics.

Membership is the key in any membership organization, and many of the investment decisions taken by the Board during 2014 address this issue. The first national member survey, undertaken in mid-2014, provided rich data on AMA membership, and the national database provides a good understanding of the demographic profile of the membership.

The investment In information technology has delivered a secure and reliable system; the website has been upgraded; the decision has been taken to invest in a major upgrade to the iMIS member database in 2015; and the doctorportal platform has been substantially expanded with more comprehensive tools and resources, including a much more sophisticated CPD tool.

The major asset of the company, AMA House, has been substantially refurbished during 2014-15 to improve the core heating, air conditioning, and electrical services, and to address structural wear and tear reflecting the age of the building.

In addition to the governance changes, the committees of Federal Council have been re-energised with the creation of several smaller committees and working groups to address specific policy issues.

On the financial front 2014 was a steady year, with both income and expenses up slightly.

There was an extraordinary income item from the sale of AMPCo House in Clarence Street, Sydney. The board of the subsidiary company, Australasian Medical Publishing Company Proprietary Limited (AMPCo) took advantage of a buoyant Sydney property market to sell the building, and the business will relocate in mid-2015 to premises that are more fit for purpose.

I reported in detail on the financial position of AMPCo, given the recent interest in the decision of the AMPCo board to outsource production elements of the *Medical Journal of Australia*.

In the third quarter of 2013, the company had been in a perilous financial position. This was largely due to declining revenue from advertising in the MJA, combined with increased publishing costs.

In November 2013, the AMA Federal Council received a detailed report on the future of its subsidiary, including its governance, operations, and options for the sale of AMPCo House.

The changes agreed by Federal Council at that time have informed the subsequent actions of the AMPCo Board, which was established in mid-2014 with a new governance structure, a smaller board, and the inclusion of two external members with deep experience in publishing and advertising.

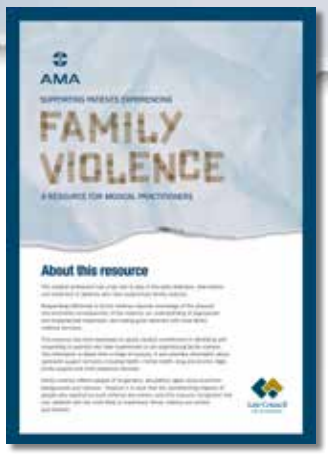
As a result of concerted efforts by management and the Board, it was apparent to the Board that longer-term changes were required to ensure the financial stability of the company and the survival of the MJA. In the three financial years 2012-2014, the combined losses from the editorial side of the business amounted to $1.56 million.

These losses were offset by income earned in the database licensing business, but were not sustainable long term. This resulted in the decision to outsource some elements of production, including sub-editing and related administration under a contract for services.

The report to the company's AGM concluded with an overview of likely developments that include an enhanced audit and risk function; a review of the company's investment strategy; increased investment in digital projects and offerings; and an expansion of the shared services functions across the AMA Group.

With strong foundations set down in 2014 the company looks forward to a period of growth in 2015.

# AMA develops GP toolkit to help victims of family violence




AMA President Associate Professor Brian Owler has urged caution in any attempt to make the reporting of family violence mandatory amid an anticipated surge in victims coming forward and seeking help given heightened national awareness of the issue.

Speaking at the launch of a joint AMA/Law Council of Australia toolkit providing guidance and resources for GPs dealing with instances of family violence, A/Professor Owler said that while it was mandatory to report child abuse, governments should be careful about extending this to include adults.

"It's a complex issue and what you don't want to do…is set up a system where you might deter people from coming forward and having a conversation with their GP," the AMA President said. "What you say to the doctor is something that should be kept in confidence, except in very extreme circumstances. We need people to have confidence in actually being able to disclose to their GP that there may be an issue at home and feel safe about doing that."

The toolkit, prepared by the AMA in consultation with the Law Council of Australia, gives GPs vital information on how to detect and discuss family violence, assess risk, understand legal obligations and provide details of support services and resources for victims and their children.

A/Professor Owler said GPs were often the first port of call for victims of family violence, so it was important that they knew how to discuss the issue and where to access the resources and information needed to help victims and their families.

"There is likely to be more people coming forward…and so it's important that our GPs are prepared when people do come forward that they have the right resources and the right information to allow and assist them to prescribe the right treatment," he said.

The pervasiveness of family violence has been underlined by Australian Bureau of Statistics/Australian Institute of Criminology research showing one in six women suffer physical or sexual violence at the hands of their current or former partner, and a quarter suffer emotional abuse.

In a sign of the extent to which family violence is underreported, the study, conducted in 2012, found 58 per cent of women had not reported the attack to police and almost a quarter had never sought advice or support.

The AMA President said family violence could be "a very uncomfortable and difficult issue", not only for victims but also for GPs, who might have both the victim and the perpetrator as patients.

A/Professor Owler said one of the important features of the toolkit was that it started from the very basics, describing what GPs needed to look for to identify potential victims, and providing crucial advice on how to broach the issue in a way that made people safe and comfortable about talking of what was happening in their home.

He said often patients would see their doctor with an unrelated complaint, and the toolkit helped GPs to ask the right questions as a way of initiating the discussion.

Importantly, he added, the toolkit also talked about what should not be asked when someone disclosed they were a victim of family violence, such as asking 'what might you have done to avoid this?', which could be taken as implying blame.

Law Council of Australia President Duncan McConnel said the toolkit was an important step in improving the co-ordination of services to help victims of family violence, which was "not just a law and order issue. It's a broader issue, and in particular it's a health issue".

Mr McConnel said one of the big barriers encountered by victims seeking help was the fact that they had to go through a "sort of revolving door of seeking help from different service, after different service, after different service. It's been identified as a critical issue".

He said it was important that doctors helping a victim of family violence knew how to get help and who to contact, including being able to identify safe houses, specialist legal services and other supports.

The *Supporting parents experiencing family violence – a resource for medical practitioners toolkit* can be downloaded at: https://ama.com.au/article/ama-family-violence-resource

ADRIAN ROLLINS

*See Family Violence key statistics on page 8 …*

# Family violence – key statistics


## Of women attacked by a current or former partner:


Source: ABS Personal Safety Survey 2012; Australian Institute of Criminology. For more information, visit: http://www.anrows.org.au/sites/default/files/Violence-Against-Australian-Women-Key-Statistics.pdf

# AMA wants to recruit pharmacists to primary health team

Patients would suffer fewer adverse reactions to medicine and be almost $50 million better off while governments would save more than $500 million under an AMA plan to integrate pharmacists into general practice.

In a major pitch to improve patient care, reduce unnecessary hospitalisations, and boost cost-effective GP-led primary care, the AMA has developed a proposal to employ non-dispensing pharmacists in medical practices.

It is estimated that a quarter of a million hospital admissions each year are related to the use of prescription drugs, costing the country $1.2 billion, while around a third of patients fail to comply with directions for taking their medicines, undermining their health, causing adverse reactions and wasting taxpayer dollars.

AMA President Associate Professor Brian Owler said that integrating non-dispensing pharmacists within general practices as part of a GP-led multidisciplinary health team could go a long way to addressing these problems, improving patient health and cutting costs.

“Under this program, pharmacists within general practice would assist with things such as medication management, providing patient education on their medications, and supporting GP prescribing with advice on medication interactions and newly available medications,” A/Professor Owler said. “Evidence shows that the AMA plan would reduce fragmentation of patient care, improve prescribing and use of medicines, reduce hospital admissions from adverse drug events, and deliver better health outcomes for patients.”

The proposal, developed in consultation with the Pharmaceutical Society of Australia, could prove a game-changer in fostering closer collaboration between GPs and pharmacists.

It has come amid a concerted push by some in the pharmaceutical sector to encroach upon areas of medical practice in an effort to offset declining revenues from dispensing medicines, including authorising pharmacists to administer vaccines and conduct health checks.

The AMA has warned governments that allowing pharmacists to practise outside their field of expertise could put patients at risk, undermine continuity of care and increase health costs.

The AMA stressed that under its new proposal, pharmacists working within general practices would not dispense or prescribe drugs, nor issue repeat prescriptions, and would instead focus solely on medication management, including advising GPs on prescribing, drug interaction and new medicines, reviewing patient medications and monitoring compliance, improving coordination of care for patients being discharged from hospital with complex medication regimes, and ensuring the safe use and handling of drugs.

# AMA wants to recruit pharmacists to primary health team

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The proposal calls for medical practices to be awarded Pharmacist in General Practice Incentive Program (PGPIP) payments similar to those to support the employment of practice nurses.

The AMA has proposed that practices receive an incentive payment of $25,000 a year for each pharmacist employed for at least 12 hours 40 minutes a week, capped at no more than five pharmacists, meaning practices can receive no more than $125,000 a year – except those in rural and remote areas, which would be eligible for a loading of up to 50 per cent.

An independent analysis of the proposal commissioned by the AMA and conducted by consultancy Deloitte Access Economics estimated that if 3100 general practices joined the PGPIP program it would cost the Federal Government $969.5 million over four years.

The consultancy said that the average annual pharmacist salary was $67,000 plus on-costs, meaning only clinics treating 3000 or more standardised whole patient equivalents (an age-weighted measure based on GP and other non-referred consultation items in the MBS) would be likely to participate.

But the Deloitte report said the outlay would be more than offset by substantial savings in other areas of the health system, calculating that for every $1 invested in the PGPIP, taxpayers would save $1.56 in other areas of the health system.

In particular, Deloitte estimated that, as a result of the program:

- a drop in the number of patients hospitalised because of adverse reactions to medications would save $1.266 billion;
- fewer prescriptions subsidised through the PBS because of better use of medicines would save $180.6 million;
- patients would save $49.8 million because of fewer prescriptions and the attached co-payments; and
- Medicare would save $18.1 million because fewer patients would see their GP as a result of an adverse reaction to their medicine.

In all, Deloitte said the initiative would deliver a net saving of $544.8 million over four years for the health system, and the benefit-cost ratio improves with each year the scheme is in operation.

“The policy will likely to lead to improved compliance and persistence with medication regimens, which will result in improved health outcomes for patients,” the Deloitte report said. “This will result in significant avoided financial and economic costs for both the patient and the health system, as well as avoided broader economic costs such as lost productivity that arise when a health condition is treated and managed sub-optimally.”

The Deloitte report can be found at https://ama.com.au/article/general-practice-pharmacists-improving-patient-care

ADRIAN ROLLINS

# Incentives hold out promise of better after hours care

The Federal Government has promised patients will find it simpler and easier to see a GP at night or on weekends following the reinstatement of incentives for medical practices to provide after hours services.

In a move strongly supported by the AMA, Health Minister Sussan Ley has announced that almost $99 million will be provided next financial year to pay practices that operate extended hours or make arrangements for their patients to receive after hours care.

Ms Ley said access to after hours GP care was an issue that was raised consistently during her consultations with the medical profession and the community since becoming Minister, and the incentive would give "positive support" to practices that ensured their patients had access to after hours care.

The reinstatement of the incentive was a key recommendation of the review of after hours primary health services led by Professor Claire Jackson, and followed widespread dissatisfaction with the arrangement under the previous Labor Government to give Medicare Locals responsibility for co-ordinating and funding after hours services.

AMA President Associate Professor Brian Owler applauded the Minister for moving so swiftly to reinstate the Practice Incentives Program After Hours Incentive.

A/Professor Owler said the AMA had been calling for the return of the PIP funding "for some time" because of the benefit it would provide to both patients and practices.

"The new PIP payment structure will encourage and support general practices to provide after hours coverage for their patients, which will in turn ensure continuity of care," the AMA President said. "Individual practices will now have greater control over after hours services for their patients, [and] patients will benefit."

To pay for the reinstatement of the PIP incentive, the Government has scrapped the After Hours GP Helpline and redirected funds freed up by the abandonment of the Medicare Locals network.

Though some complained that the Helpline has provided a vital service, the Jackson review found there was little evidence it had reduced the pressure on rural doctors to attend after hours call-outs or improved continuity of care. It recommended that the service be scrapped and the funds instead directed into GP incentives.

While details of eligibility requirements for the incentives are yet to be released, the scheme –which commences on 1 July - will offer five payment levels depending on the degree of service provided.

They range from the very basic, level 1 service involving "formal" arrangements for patients to seek after hours care at another provider, through to a full service model where a practice has staff rostered on around the clock, seven days a week.

The incentive would rise from $1 for each Standardised Whole Patient Equivalent (an age-weighted measure based on GP and other non-referred consultation items in the MBS) at a level 1 practice, rising to $11 per SWPE at the top end.

The Minister said all practices would be required to inform patients of their after hours arrangements, and to ensure that correct details were provided in the National Health Service Directory.

"Under these new arrangements, patients will be able to easily find out what after-hours services are available, including services provided by arrangement outside of the patient's usual general practice," Ms Ley said.

The reintroduction of the after hours PIP has coincided with the Federal Government's move to scrap Medicare Locals and replace them with larger Primary Health Networks.

Importantly, the Government has specified a different role for PHNs regarding the provision of after hours services than that fulfilled by the Medicare Locals.

Under the new arrangement, PHNs will be required to work with "key local stakeholders" to plan, co-ordinate and support after hours health services, with a particular focus on "addressing gaps in after hours service provision, 'at risk' populations and improved service integration".

A/Professor Owler said the change in focus and function was welcome.

"The Government has listened and responded to AMA concerns about giving responsibility for after hours funding to Medicare Locals, which has proven to largely be a failure and simply increased red tape for practices," the AMA President said. "While the new Primary Health Networks will still have a role to play in ensuring community access to after hours health services, their focus will be on gaps in service delivery."

ADRIAN ROLLINS

# Size counts as incentive change helps some costs others

GPs working in some of the nation's smallest towns and most remote communities are set to receive a hefty increase in Commonwealth subsidies, while around 5000 working in major regional cities will lose thousands of dollars in incentives under changes to a program intended to attract doctors to work in rural areas.

Assistant Health Minister Fiona Nash has announced that incentives for doctors to live and work in 450 small towns across the country will be raised under changes to the GP Rural Incentives Program (GPRIP).

Under the changes, the annual incentive for doctors working in towns with fewer than 5000 residents will increase from $12,000 to up to $23,000, and the incentive for practitioners working in remote areas will be increased from $47,000 to as much as $60,000.

But the qualifying time to receive the incentive has been increased from six months to two years for doctors in rural and regional areas, while doctors in remote locations will have to wait 12 months.

And an estimated 5000 doctors working in regional centres with a population of more than 50,000 will lose their incentive payments under the changes, which come into effect from 1 July.

The change is being implemented as the AMA lobbies the Federal Government to establish a training program to give junior doctors experience in a rural general practice.

The AMA has urged the Commonwealth to adopt the recommendation of the Independent Expert Panel – which it established to advise on the redesign of the GPRIP – for the introduction of "a program that provides a high quality community medicine and general practice training in rural and remote areas through extended placements for junior doctors".

The recommendation follows the Government's decision last year to scrap the Prevocational General Practice Placements Program, which left general practice as the only major specialty without a program for prevocational training experience – something AMA President Associate Professor Brian Owler said was vital to sustaining and building the GP workforce.

"This sort of experience can influence junior doctors to pursue a career in general practice, and it can also give doctors who choose other specialties a valuable insight into how general practice works," A/Professor Owler said. "A carefully targeted prevocational GP training program can also help boost rural and remote workforce numbers".

The GPRIP has been overhauled following the Government's decision late last year to dump the discredited Australian

Standard Geographical Classification – Remoteness Area (ASGC-RA) classification system and instead use the Modified Monash Model (MMM) to guide the allocation of resources.

While doctors in large regional centres will lose incentives payments under the revamped incentives system, Senator Nash said the new arrangements were much better aligned with community need.

The Minister said under the current system, around $50 million was being paid out each year to doctors working in 14 large regional centres, including Townsville and Cairns.

The scheme created incentives for doctors to remain in well-serviced cities which had little trouble attracting doctors, she said.

"The new GPRIP system will deliver a fairer system for smaller towns; redirecting money to attract more doctors to smaller towns that have genuine difficulty attracting and retaining doctors," Senator Nash said. "It makes more sense to use that money to attract doctors to where the greatest shortages are - small rural and remote communities, not big regional cities. This means bigger incentive payments will go to doctors who choose to work in the areas of greatest need."

The AMA was among several health groups that welcomed the move to dump the ASGC-RA classification system and replace it with the Modified Monash Model, but had urged the Government to include transition arrangements for any changes to incentive payments.

The Association said it would assess the impact of the Government's decision to cut incentive payments to GPs in large regional centres from the beginning of next month.

ADRIAN ROLLINS

# Budget small business tax concessions – what they mean for doctors

Cutcher & Neale partner Jarrod Bramble: "Tax planning has never been simpler"

Many doctors stand to gain from Federal Government changes to small business taxation arrangements announced in the Federal Budget, according to accounting expert Jarrod Bramble.

Mr Bramble, a partner in New South Wales-based accounting firm Cutcher & Neale, said medical practitioners in private practice, visiting medical officers with fee for service, sessional fee or simplified billing arrangements, and staff specialists with rights of private practice were all in a position to take advantage of small business concessions outlined in the budget, including a 1.5 percentage point tax cut and a $20,000 instant asset write-off.

Mr Bramble that practitioners operating as a small business with an aggregated annual turnover of less than $2 million would be eligible for an immediate write-off of assets purchased after Budget night that cost less than $20,000.

"Tax planning has never been simpler," he said. "[It] means, in most cases, an item purchased for less than $22,000, including GST, will receive a GST credit of $2000 and benefit from a tax saving of $9800. This effectively halves the cost of new plant and equipment, as well as motor vehicles."

The arrangement will be in place until 30 June 2017.

Mr Bramble said that assets pooled in prior years with a closing balance of $20,000 or less during the two years from 30 June 2015 will also be eligible for the immediate write-off.

The change also means that professional expenses incurred in setting up a practice will, from 1 July, be immediately deductible, where previously they had to be written off over five years.

Practitioners who operate using an eligible corporate structure (including an annual aggregated turnover of less than $2 million) would also receive a cut in the company tax rate from 30 to 28.5 per cent and, where a medical professional carries on the business as an individual, they would be eligible for a maximum $1000 rebate.

But Mr Bramble warned proposed changes to fringe benefits tax arrangements would impose a $5000 cap on the FBT exemption

for meal and entertainment expenses, affecting the salary packaging benefits for public and not-for-profit hospital staff.

The Government intends to impose the cap from 1 April next year, giving doctors just 10 months to maximise the benefit of current arrangements, Mr Bramble said.

The accountant also urged doctors to use vehicle log books if they wanted to be able to claim more than a maximum annual deduction of $3300.

He said deductible trips for a log book included travel between hospitals, journeys from home to a patient's house and then to a practice, trips between a practice and a hospital, doctors on call who have dispensed advice from home before travelling, and travel to conferences, workshops and other education events.

Mr Bramble also noted that the Government's four-year freeze on Medicare rebates meant by mid-2018 their value would be 7 per cent less than now.

ADRIAN ROLLINS

# Patients to be hit by pill price hike

Changes to pharmacist dispensing fees negotiated by the Federal Government will force the cost of the nation's most commonly prescribed medicines up, leaving hundreds of thousands of patients out of pocket.

The Federal Government claims patients will get vital medicines more cheaply and much quicker following changes to the way pharmaceuticals are supplied under deals with industry it claims will save taxpayers $6.6 billion over the next five years.

But Health Department officials admitted at a Senate Estimates hearing earlier this month that the introduction of a new $3.49 pharmacist handling fee to replace the existing 15 per cent mark up arrangement would push up prices.

The *Herald Sun* said the change would add between $2 and $3 to the cost of nine of the 10 most commonly prescribed medicines, costing some patients an extra $18 a month.

The revelation tarnishes earlier claims by Health Minister Sussan Ley said patients could save more than $100 a year under agreements the Commonwealth has struck with the pharmaceutical industry, while efforts to accelerate the listing of new medicines on the Pharmaceutical Benefits Scheme were beginning to pay off.

Ms Ley has signed a five-year deal with the Generic Medicines Industry Association to slash the cost of generic pharmaceuticals, including halving the price of common medicines for cholesterol, heart conditions and depression, potentially saving taxpayers about $3 billion over five years.

According to the Government, the changes mean that from October next year the cost of the widely-used cholesterol drug Atorvastatin could drop from $14.60 to $10.68, while the heart medicine Clopidogrel would fall from $14.01 to $10.38 and the depression treatment Venlafaxine would cost $11.65 instead of $16.52.

But consumer groups have warned that the decision to pay pharmacists a flat $3.49 fee (indexed to inflation) for dispensing medications instead of receiving a percentage of the price, will push the cost of many cheap medicines up.

The Consumer Health Forum said figures in the agreement showed consumers would "directly contribute" $8.2 billion to pharmacy owner remuneration in the next five years – around 34 per cent of the $23.6 billion to be paid to pharmacies for PBS medicines.

Forum Chief Executive Leanne Wells said that under the current agreement, consumers contributed 29 per cent of total payments.

The agreement includes bigger incentives for pharmacists to offer patients the option of using cheaper generic versions of medicines, backed by a $20 million media campaign.

The Government has already obtained the pharmacy industry's grudging acceptance of an optional $1 discount on patient co-payments, and it has also negotiated agreement on lower prices for branded drugs for which there is no generic substitute.

In a measure expected to save about $1 billion, the Government will cut the price it is prepared to pay for branded medicines by 5 per cent after they have been listed on the Pharmaceutical Benefits Scheme for five years.

The Commonwealth is also implementing changes to how it calculates the price it pays for medicines when they go off-patent. Currently, the Government determines market price using a weighted average of the price of all brands.

# Patients to be hit by pill price hike

... from p14

But under the new arrangement, expected to come into effect from October next year, the original 'premium' brand will be excluded from the calculation, driving the average price down.

"Removing originator brands from price calculations for everyday medicines could see the price of common generic drugs halve for some patients, whilst also saving taxpayers $2 billion over five years," Ms Ley said.

The Government also expects to save $610 million over five years by closing loopholes around the way combination drugs – where two separate medicines are combined to create a new patented medication – are subsidised.

As previously flagged, the Commonwealth also expects to save $500 million remove several low-cost over-the-counter medicines such as everyday painkillers from the PBS.

The Minister said Government efforts to speed up the listing of new medicines were also working, pointing out that there had been 652 new and amended listings on the PBS since it was elected in September 2013, compared with 331 listings during the previous three years.

Ms Ley said the chief independent scientific adviser on medicines, the Pharmaceutical Benefits Advisory Committee took an average of just 17 weeks to recommend whether or not a drug should be listed on the PBS – a turnaround that was one of the fastest in the world.

"We understand the importance of ensuring Australians have fast access to affordable medicines when and where they need them, and we are investing heavily to deliver this," the Minister said.

PBAC's operations have been reinforced by the appointment of leading cardiovascular disease specialist Professor Andrew Wilson as Chair, and Ms Ley said the Government would soon introduce legislation to expand PBAC's membership from 18 to 21 in recognition of its increasing workload and the complexity of matters being considered by it.

"Expanding the capacity of the PBAC to deal with complex medicines is another important step to ensure Australians benefit from new medicines sooner," she said.

And the Government expects Australia patients to get improved access to leading-edge medications with the launch of a website providing a one-stop shop regarding clinical trials happening around the world.

Evidence indicates that almost half of all phase three clinical trials conducted in Australia fell short of their patient recruitment targets, and Ms Ley said the website would make it easier for patients to find out about trials and take part in ground-breaking medical research.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

## Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.

# AMA National Conference

AMA President Associate Professor Brian Owler (centre left): 'The best way to honor the memory of the ANZACs is to advocate for peace'

**More than 250 delegates and observers revelled in three days of high level health policy discussions, ceremonies and a lot of socialising at the AMA National Conference in Brisbane on 29 to 31 May.**

**The Conference which had as its theme, Medicare: midlife crisis?, drew together practitioners, academics, operators, students, trainee doctors and media from across the country and internationally, to discuss and debate the latest challenges in health, from climate change, family violence and the treatment of asylum seekers to general practice funding and training, the outlook for public hospitals and the pitfalls of defensive medicine.**

**Speakers included former Prime Minister Julia Gillard, who addressed the Leadership Development Dinner, Health Minister Sussan Ley, Shadow Health Minister Catherine King, Queensland Health Minister Cameron Dick and Aspen Medical CEO Bruce Armstrong, who detailed Australia's response to the West Africa Ebola outbreak.**

**Participants had plenty of opportunity to socialise, including at the President's Cocktail Reception, the Leadership Development Dinner and the Gala Dinner.**

**To see more details of the Conference, including video of each of the Conference sessions and policy debates, go to: https://ama.com.au/nationalconference**

ADRIAN ROLLINS

# Australia 'a climate change laggard'

The Federal Government needs to take "much more" action on climate change if the nation is to mitigate its most harmful effects on human health, AMA President Associate Professor Brian Owler has warned.

In an address to the AMA National Conference, A/Professor Owler defended the AMA's advocacy on climate change against critics who claimed the issue lay outside the Association's realm of expertise.

The AMA President said that although medical practitioners did not have expertise in climate science, they were well placed to comment on the likely health effects of climate change, which included the likely spread of mosquito-borne diseases into formerly temperate areas, increased deaths from heatwaves, storms and other extreme weather, and the health impact of changes in nutrition as farming patterns are disrupted.

"Our perspective is to come at climate change from the health perspective," he said. "The best scientific evidence is that there is going to be climate change and there will be health consequences."

Earlier this year, the AMA helped launch and Australian Academy of Science report on the health effects of climate change, and A/Professor Owler said that, just as doctors followed the scientific evidence on the efficacy of vaccinations, so they also followed the evidence on changes to the world's climate.

He said that, while the issue had become heavily politicised, the overwhelming weight of evidence showed that it was occurring and "the vast majority of AMA members understand the importance that we mitigate against climate change and its potential health impacts".

"There is overwhelming support at [the AMA] National Conference for the AMA to speak out on this issue," A/Professor Owler said. "The health effects can be quite far reaching, and what we don't want to see is people ignoring climate change."

The Federal Government is coming under mounting pressure to take more action on climate change ahead of the next round of United Nations talks in Paris in November.

The AMA's call for more work to mitigate its health effects have been echoed by the World Medical Association, which late last month called for the issue to be given a higher priority at the Paris talks.

WMA President Dr Xavier Deau said he was very concerned that crucial health issues were being ignored in the build up to the Paris meeting, and that time was running out for the voice of the health community to be heard.

The call came as a leading British think tank singled out Australia as a "climate change laggard" among the world's developed countries.

The UK-based Grantham Institute on Climate Change and Environment reported that Australia was the only developed country to "take a legislative step backwards" from action on climate change.

A/Professor Owler said the Government's approach to climate change was going to be very important in the lead-up to the Paris summit, "but so far the Government's response has been disappointing. We want to see more action on climate change".

ADRIAN ROLLINS

# Providing high quality care doesn't pay

Current funding arrangements for general practice do not reward quality care and must be overhauled, the AMA National Conference has been told.

While not calling for the current fee-for-service model to be scrapped, speakers at the policy session *Funding quality general practice – is it time for change?* said better patient outcomes could be achieved with changes to the way doctors are remunerated.

Former GP of the Year and Clinical Director of the Australian Primary Care Collaboratives Program Dr Tony Lembke told the Conference that although Australian practitioners provided high quality care, funding arrangements placed road blocks in their way.

Dr Lembke said there was a tension for general practitioners between their professional aspirations to provide quality care and the demands of running a business.

"The more I look after disadvantaged patients, those with chronic disease, or who are in aged care; the more time I spend training students, the less my income is," he said. "That is a bizarre sort of system."

Dr Tim Ross, National Medical Director for health insurer Bupa, said a shift was underway toward more team and community-based care, and the way GPs were remunerated needed to change to reflect and support a different model of providing care.

Bupa last year began trials of GP clinics where patients make a private payment for treatment which emphasises follow-up care and close co-ordination with specialists.

Dr Ross said he expected the Commonwealth to eventually adopt a capitation model of payment, where GPs are paid an annual fee to care for a patient, rather than be paid by service.

This would be part of a blended model including bundled payments from government, fees for services rendered and financial rewards for quality care, including outreach to patients.

He said a team-based approach to care would mean patients seeing a physiotherapist, psychologist or other allied health professional would not need to see their GP in order for funding to occur.

But AMA President Dr Tony Bartone said that providers carried the risk in a system of bundled payments, and the funding model encouraged cherry picking of patients.

Dr Bartone said the fee-for-service model often got a bad rap for issues that had more to do inadequate indexation of Medicare rebates and poorly designed Medicare Benefits Schedule items.

He said there was no evidence that any alternative funding models were superior to fee-for-service, a point admitted to by former AMA Presdient Dr Steve Hambleton, who has been appointed by Health Minister Sussan Ley to lead the Primary Health Care Advisory Group.

> "there is no clear winner in terms of which [payment] system is better for outcomes, but we all know there are places where we can do better, [where] we can align the business and professional imperatives better"

The Group has been established to make recommendations on how to provide better care for chronically ill patients and those with mental health conditions, as well ways to improve the co-ordination between hospitals and primary care, and to look at "innovative care and funding models".

Dr Hambleton told the Conference the work of the Group, which is due to report in November, would be evidence-based.

Currently, he said, "there is no clear winner in terms of which [payment] system is better for outcomes, but we all know there are places where we can do better, [where] we can align the business and professional imperatives better".

"It does not mean we throw out fee-for-service, but is there a way to say that, if you spend longer [with a patient], if you think about it longer and spend time planning a bit longer, how do you reward that?

"At the moment, the short you spend [with a patient], the less time you spend, the less you think and the less you talk, the more you get paid," Dr Hambleton said.

A video of the policy session can be viewed at: https://ama.com.au/media/ama-national-conference-29-may-2015-session-2

ADRIAN ROLLINS

# Sickest, smallest to be hit hardest by Commonwealth cuts

AMA President Associate Professor Brian Owler: 'I fear for the smaller states'


'People will have to wait longer for surgery, appointments' - Queensland Health Minister Cameron Dick

The Federal Government has been warned that more people are likely to die because of an increasing shortfall of thousands of doctors, nurses and other health professionals in public hospitals as a result of Commonwealth cutbacks.

AMA President Associate Professor Brian Owler said the Abbott Government's decision to reduce public hospital by $57 billion over 10 years would have a devastating effect on the State and Territory health systems.

"The AMA has warned of a perfect storm if funding is not increased," A/Professor Owler said. "We already see hospitals struggling to achieve performance targets. We know that overcrowding, we know that delays in getting into a bed from the emergency department, is not just a matter of the headlines, it is matter of increased morbidity. People have more complications or are more likely to die if they spend more and more time in an emergency department."

The AMA National Conference was told that in Queensland alone, the Federal Government's decision to slash growth in public hospital funding from 2017 will rip $11.8 billion out of the State health system over 10 years, resulting in 1503 fewer doctors and 5319 fewer nurses being employed in the time.

A/Professor Owler said the outlook for the smaller states and territories, which had limited revenue-raising capacity, was particularly worrying.

"I really fear for those states, because we know that their economies are quite small. They don't have the ability to make up the shortfall in revenue, and those states are going to be really badly affected," he said.

Queensland Health Minister Cameron Dick told the AMA National Conference that the Commonwealth was shoving more of the burden of public hospital funding on to the states.

Mr Dick released modelling by his Department showing that the Commonwealth's share of national efficient public hospital expenditure would peak at 35.5 per cent in 2016-17 before rapidly falling away to just 32.1 per cent by 2024-25 – virtually 10 percentage points below the level committed to in the 2011 National Health Reform Agreement.

"There will be greater pressure on the hospital system as a result," the Queensland Minister said. "People will have to wait longer for surgery, people will have to wait longer for patient appointments. We will not be able to deliver the services we need. As the population gets older and costly medical technology increases, there will be a gap."

AMA Tasmania President Dr Tim Greenaway described to the AMA National Conference how the Commonwealth funding cut would hit his State particularly hard.

Tasmania has the nation's oldest, fattest, poorest and – by many measures – least healthy population, and Dr Greenaway warned the Federal Government's policy would only make the situation worse.

Despite having greater health needs than most other states and territories, Tasmania's spending on health care ($1275 per capita) is below the national average ($1735 per capita), and Dr Greenaway said the Commonwealth's funding cuts would only

# Sickest, smallest to be hit hardest by Commonwealth cuts

... from p19

"lock in" the State's inadequate investment in health, "which will inevitably increase health disparity".

The states and territories are furious the Federal Government has walked away from its commitments under the National Health Reform Agreement, and the issue is set to be near the top of the agenda when Prime Minister Tony Abbott meets with his State and Territory counterparts to discuss reform of the Federation at a leader's retreat in July.

A/Professor Owler said the Federal Government's decision was indefensible.

"It's up to the Commonwealth to live up to its responsibility to make sure that all Australia's get access to the services they deserve," he said, adding that the squeeze on hospitals would also have a significant effect on doctor and nurse training.

AMA Tasmania President Dr Tim Greenaway: Commonwealth public hospital funding cuts will 'inevitably increase health disparity'

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

## AMA Careers Advisory Service

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

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

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

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

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

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

# AMA ramps up pressure over asylum seeker health

Mounting evidence about the serious and far-reaching physical and psychological harm being suffered by detained asylum seekers has fuelled calls for the AMA to intensify its lobbying on the controversial policy.

As the medical profession contemplates new laws that threaten to imprison medical practitioners who blow the whistle on shortcomings in the health care of asylum seekers, the AMA National Conference has called for an urgent update of AMA policy to take into account offshore processing and indefinite detention.

Meeting on 31 May in Brisbane, the Conference unanimously passed a motion requesting the AMA Federal Council to review the AMA *Health of Asylum Seekers 2011* policy, with particular attention to "new evidence of ongoing and permanent damage being inflicted on detainees as a consequence of the 19 July 2013 law".

The law, introduced by the Rudd Government, provided that asylum seekers would only be processed in offshore detention centres in Nauru and Papua New Guinea, and would be resettled there – or in a third country - if their claims were successful. None arriving after 19 July 2013 would be settled in Australia.

Darwin-based paediatrician Dr Paul Bauert, who moved the motion, said that as a result of the law, asylum seekers, including children, were being detained for lengthy periods, often in "abominable" conditions.

Dr Bauert told the conference that such detention was causing "on-going damage" to detainees and was unethical.

Speaking in support of the motion, child psychiatrist Dr Choong-Siew Yong said the Government's policies had created a "toxic environment" in immigration detention centres that would have long-term harmful effects, particularly on children, and urged action.

"As doctors, we cannot just stand by and watch," Dr Yong said.

The AMA conference also raised concerns about provisions in the Australian Border Protection Act 2015 passed last month under which doctors or any other detention centre workers who disclose health care failures could be imprisoned for up to two years.

The AMA conference unanimously supported a notice of motion from Doctors for Refugees co-founder Dr Richard Kidd asking the AMA Federal Council to lobby the Government to exempt from prosecution medical practitioners who blow the whistle on poor health care in detention centres.

Dr Kidd said doctors had a duty to make the welfare of their patients their top priority, and this inferred both a right and a responsibility to disclose failures in care.

The AMA conference's call for action has come amid intensifying concern about the health and welfare of asylum seekers, particularly those held in offshore detention centres.

Earlier this year, the results of an Australian Human Rights Commission inquiry were released showing 233 assaults recorded at detention centres between January 2014 and March 2014 involved children, and there were 33 incidents of reported sexual assault.

And the Royal Commission into child sex abuse, which has conducted a large number of high profile public hearings into horrific instances of abuse and the failure of institutions including churches, schools, and group homes to protect children in their care, is investigating the management of the nation's immigration centres.

Immigration Department Secretary Michael Pezzullo confirmed to a Senate Estimates hearing late last month that the Royal Commission had been in contact with the department and were preparing a notice requiring it to hand over documents.

ADRIAN ROLLINS

# No crisis, but change is needed: Ley

'If we dont make changes, we will face a funding crisis': Health Minister Sussan Ley

Shadow Health Minister Catherine King: Need for a 'serious conversation' about rewarding quality care

"We need to shift from a fragmented system based on individual transactions, to a more integrated system that considers the whole of a person's health care needs"

Health system funding is not in crisis but there needs to be an overhaul of the way the Federal Government pays for GP and hospital services, Health Minister Sussan Ley told the AMA National Conference.

Setting out markers for the future direction of Government health policy, Ms Ley put doctors and state governments on notice that there will be changes to how the Commonwealth funds health care.

But, in a marked change of tone from her predecessor Peter Dutton, the Minister dropped warnings that health spending was unaffordable and embraced a collaborative approach to change.

"The Government is not claiming that we are in a health funding crisis," Ms Ley said, though she added that, "we are saying that we have to be realistic. If we don't make changes now, we will face a funding crisis."

While the Government has dumped the idea of a GP co-payment, Ms Ley nevertheless said the current fee-for-service model of GP remuneration had to change.

"We need to shift from a fragmented system based on individual transactions, to a more integrated system that considers the whole of a person's health care needs," she said. "Innovative and blended funding models will be needed to provide appropriate care for patients with complex, ongoing conditions."

In a warning for adherents of the current fee-for-service model, this is one area of health policy where there appears to be bipartisanship.

In her speech to the AMA Conference, Shadow Health Minister Catherine King said that, "I don't for a moment suggest we abandon fee-for-service," but warned there needed to be a "serious conversation" about whether it was best serving patients and rewarding good care.

# No crisis, but change is needed: Ley

... from p22

Ms King said there were hundreds examples across the country of practices providing innovative and preventive care, often involving multidisciplinary teams led by GPs, but "the system as it works at the moment...does not provide incentives to reward this sort of activity. Nor does it reward outcomes".

The issue of GP funding was the focus of a separate policy session at the Conference (see Providing high quality care doesn't pay, px), where several presenters expressed concern of any change to funding arrangements that was not backed by sound evidence.

Among the speakers, AMA Victoria President Dr Tony Bartone said there was as yet no substantiated claim that alternative funding arrangements would deliver better patient outcomes than the fee-for-service model.

But Ms Ley said part of the change was aimed at ensuring better care for patient with complex and chronic conditions, as well as those with mental health problems.

She added that the Primary Health Networks being set up to replace Medicare Locals would be funded to "commission health and medical services to fill gaps".

The Commonwealth has been heavily criticised for last year's decision to axe the popular Prevocational General Practice Placements Program and abolish General Practice Education and Training, but at the Conference Ms Ley announced that competitive tenders for general practice training had opened. Successful bidders will receive funding to administer the Australian General Practice Training program, including co-ordinating and overseeing placements for GP registrars.

Tenders close on 10 July, and successful bidders will be funded from 1 October this year to the end of 2018.

ADRIAN ROLLINS

Australian Medicine's roving camera captured the festivities at AMA National Conference 2015, including at the Leadership Development Dinner, the President's Cocktail Reception and the Gala Dinner.



temporary
literature

# Taking stock of progress in public health

BY **PROFESSOR STEPHEN LEEDER, EMERITUS PROFESSOR**
PUBLIC HEALTH, UNIVERSITY OF SYDNEY

Thirty years ago I was in Canberra visiting the late, great Sidney Sax, one of Australia's master craftsmen of public health and health service planning, then at the top of his game.

He came to Australia in 1960 as one of the South African diaspora (in his case via the-then Rhodesia) who felt seriously constrained, as socially concerned public health practitioners and physicians, by apartheid.

> All that educating, lobbying, fighting, taxing, plain packaging and banning advertising has been 'about' something hugely worthwhile

In Australia, Sax made a dazzling array of contributions to aged care, beginning in geriatrics and long-term health care, and then moving to health services administration and social welfare, through State and Commonwealth health departments and commissions.

It was late Friday afternoon and we had finished our business. Sid invited me to his home for coffee before my flight home. As we pulled into his garage and he turned off the ignition key, he just sat, silently contemplating. After what seemed much more than a minute he turned to me with a wry smile and said, "I always like to stop at the end of the week and ask myself what was that all about?''

Good question. We might benefit from asking that of ourselves each week, whatever our professional craft.

Think for a moment about tobacco and our success in controlling it.

It has taken great effort to claw smoking rates down from 34 per cent in 1980 to less than 20 per cent today in most of Australia. But the important thing is that it has happened.

All that educating, lobbying, fighting, taxing, plain packaging and banning advertising has been 'about' something hugely worthwhile. Hundreds of thousands of premature deaths and years of disability have been avoided.

And in relation to the health of our Indigenous people, great progress has been made as control of community health services has moved increasingly into Indigenous hands

I was present in Perth in the late 1980s when Neal Blewett, then Federal Health Minister, and Gerry Hand, Minister for Aboriginal Affairs, were debating and laying the foundations for the first national Aboriginal Health Strategy.

It took Aboriginal participation with novel seriousness. Sitting beside Gerry throughout the conversation was Charles Perkins, his departmental adviser, whose views were not often the same as those of his minister! But they conferred on almost every point.

Thousands of people have since contributed valiant efforts to closing the gap between Indigenous and non-Indigenous levels of health, by no means always successfully or happily. But they have made remarkable progress in Indigenous maternal and infant survival, infection control and immunisation. Huge challenges persist in diabetes, obesity, heart disease, renal disease, mental illness, alcohol and tobacco control, violence and trauma.

But, on the figurative Friday afternoon, we can say, in answer to our pre-weekend question, that we have been 'about' making steady progress with a big and complex problem.

How can we keep important public health matters, which often need decades of slog, alive after the first media fizz has gone?

I once asked Neal Blewett how he kept HIV/AIDS on the Hawke Government agenda for so long and to such outstanding effect.

His answer was, "I created a crisis each week in Cabinet!" Maybe jest, but advocates Simon Chapman and Mike Daube, with whom I have discussed Blewett's comment, confirm its central truth.

As doctors, we can bring to public attention, regularly and repeatedly, the crises caused by domestic violence, for example.

The rewards can be wonderful in the long term if our advocacy slowly changes social attitudes, as we have seen happen in relation to tobacco, where smoking is no longer normal, and helps achieve the steady, small gains we have made in Indigenous health.

# GP pharmacists, a healthy prescription

BY DR BRIAN MORTON, CHAIR, AMA COUNCIL OF GENERAL PRACTICE

The AMA recently provided its proposal to the Government for integrating pharmacists into general practice.

The Pharmacists in General Practice Incentive Program (PGPIP) proposal aims to provide general practices with funding to support the employment of a non-dispensing pharmacist as part of the GP-led multidisciplinary team.

This initiative would support GPs and pharmacists working collaboratively to improve patient health through better use of medicines. Integrating pharmacists into the general practice team will reduce fragmentation of patient care by utilising pharmacists' complimentary skills within the practice rather than outside of it. Pharmacists will be able to work directly with GPs and their patients in delivering quality patient care.

Evidence shows that where pharmacists work within the general practice, advice regarding medication use and prescribing is better targeted, more useful and better received. By having pharmacists in our practices, we'll be able to ensure better patient compliance with their medication regime through better understanding. Our pharmacist will be able to conduct medication reviews, advise us on the latest medications and will be able to provide prescribing advice to reduce the risks to patients of adverse drug events. By working collaboratively with our pharmacist, we will be able to better care for our patients and reduce the costs to the health system from medication non-compliance and adverse drug events.

The AMA strongly believes that it is important to encourage the employment of pharmacists within the general practice team. Our approach contrasts starkly with that of the Pharmacy Guild, which would prefer to fragment care and have pharmacists working in roles for which they are not properly trained. We are promoting a collaborative approach that delivers investment in general practice and better care for our patients.

The Pharmaceutical Society of Australia (PSA) has backed the AMA's proposal, recognising that it would represent an opportunity for its members to have a rewarding and challenging role in a general practice environment. It is certainly the case that there are a large number of pharmacists who are frustrated at their current career prospects, and the dominance of the Pharmacy Guild in determining the future of pharmacy in Australia.

The case for the AMA's model is strong. Independent analysis by Deloitte Access Economics found that it would save the health system $1.56 for every dollar invested in the AMA's proposed funding model. It makes clinical and economic sense.

Health Minister Sussan Ley said during the recent AMA National Conference that she was interested in talking about workforce reform in primary care. Our model delivers on this challenge, while continuing to recognise the central role of general practice and the need to ensure that patient care is well co-ordinated.



# When it comes to politics, dollars outweigh reason

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

The Federal Government's changes to GP Rural Incentive Program payments are now on the Department of Health website for all to see.

Go to ruralhealthaustralia.gov.au to see the details. An interactive map will show you your classification, and a fact sheet outlines your future payments, if any.

Payments to new rural practitioners will begin after two years of rural service or one year of remote service.

A line will be drawn under the existing scheme from 30 June, and those with accrued entitlements will be paid out in October this year. Payments under the new classification scheme will commence on 1 July 2016, and they will escalate with years served, peaking after five years of rural or remote service.

As with any reconfiguration, there will be winners and losers.

Towns with more than 50,000 people are excluded, and outer urban incentives will end.

The AMA argued strongly for the grandfathering of existing payments to doctors who will be excluded under the new classification, but this was rejected.

Initial assurances from the Department are that the net total spend will be maintained. Not having access to any detailed financial modelling, and having been told previously by the Department that they had no funds for such modelling, I find such an assurance seriously straining my faith in its credibility.

One lesson from this is that GPs must recognise that, as with any government funding to general practice, GRIP payments come with no certainty into the future.

Overall, I personally feel that the change to using the Modified Monash classification system is a better, more focused way of spending scarce government resources than its predecessor.

However, specialists other than GPs should have been included.

On a different note, perhaps we all need to get out our cheque books and start a political slush fund with annual contributions from all doctors. Why on earth would I make such a heinous suggestion you may ask?

For an answer, simply go online and look at the Pharmacy Guild donations to State and Federal branches of the major political parties.

Look at the generous annual increases flowing in the Pharmacy Agreement compared with the freeze on Medicare rebates, and you may say it is time we got down and dirty too.

And, to rub salt into the wound, we see opinion polls telling us that the public rates pharmacists equal to medical practitioners in the trustworthiness stakes.

Who said money cannot buy happiness?

INFORMATION FOR MEMBERS

## Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

# Back to the future of e-health

BY DR JOHN ZORBAS, CO-CHAIR, AMA WA DOCTORS IN TRAINING

*Dear science, cheers for the iPods*
*White goods, yeah thank you for the cyborgs*
*Top work on the light bulb*
*That was quite cool*
*But where's my hoverboard?*

Seth Sentry - Dear Science

E-health is undoubtedly the hoverboard of health care. Ever since we started digitising information, people have been talking about the digital health revolution.

Now, I'm not one to stamp on enthusiasm, but we've hardly realised the dream of digital health care. I could have sworn I was promised rooms full of fancy holographic touch screens with super suave doctors curing people with the swipe of a hand. All I have now is a printer that must be suffering from some fairly serious catatonia, as it refuses to talk to any other electronic device in my house.

You see, this is exactly the problem with e-health. We've focused on the technology and the end game. We unfairly expect e-health to be this magical panacea that will one day spring forth fully formed, like Athena from the head of Zeus.

Australia has had its share of e-health failures, in the form of programs like HealthConnect and the Better Medication Management System. We can all point to a number of successful health IT projects in any number of practices or hospitals, but they remain just that: silos of success with no greater reach.

The National e-Health Transition Authority is viewed by many as a success and by others as a failure. For my part? I think expectations on NEHTA were too high in the early phases and it was therefore unavoidable that stakeholders would be disenfranchised with the process. However, even the staunchest critic is hard pressed to criticise the e-health standards that this country now has thanks to the work of NEHTA, Standards Australia and others.

Health care remains the white whale of information communication and technology, and there's a very good reason for it.

Health care is a socio-technical industry. For all the technical expertise in the world, you can't change health care without the engagement of those who receive it and those who provide it.

> "Fundamentally, e-health isn't about fancy fondleslabs and amazing applications. It's about information. Good health care is about having the right information available at the right time, so that doctors can synthesise that information into knowledge for the benefit of the patient"

Social hierarchies in health are formidable, primarily because health is an extremely human industry.

This isn't to say that a shiny e-health future and satisfied social hierarchies are mutually exclusive. Dr Rhonda Jolly, in her 2011 parliamentary review of e-health in Australia, holds up Denmark as an example of how successfully addressing social concerns led to a much easier technical exercise when it came to the actual delivery of health. By contrast, the United Kingdom is cited as an example of the complete opposite.

So where are we? Are we Denmark or the United Kingdom?

Fundamentally, e-health isn't about fancy fondleslabs and amazing applications. It's about information. Good health care is about having the right information available at the right time, so that doctors can synthesise that information into knowledge for the benefit of the patient. At its core, the concept is a simple one, but the task of delivery is gargantuan by comparison, and we should expect that it will take time.

Doctors have always had patient best interests at hand, and putting an "e" in front of the word doesn't change the mechanics.

We'll get our hoverboard in good time and, when we do, it'll be the right fit for an Australian context. In the meantime we need to engage the process with enthusiasm to help reach those lofty goals and to do what we've always done: safeguard our patients and our health care system.

Quickly now, before my printer asks me for my clothes, my boots and my motorcycle.

# Aspiring interns victims of Federation's flaws

BY JAMES LAWLER

At the moment, students from around Australia are preparing applications for internships in 2016. For many, this will be a fairly straightforward process - they will have grown up in a certain area, studied in that area, and want to continue to work in that area.

Unfortunately, this will be a stressful time for many others.

> "Both State and Federal governments have tried to address this, but each has done so in a different way, and this has led to an overly complex system"

Over the past decade, the number of medical students commencing medical studies has nearly doubled, meaning that every year we graduate a record number of students. While this is important to address shortages of doctors, particularly in rural areas, it has meant that some international students who have studied in Australia and want to continue working here, have had to move overseas upon graduation in recent years.

Both State and Federal governments have tried to address this, but each has done so in a different way, and this has led to an overly complex system.

State governments provide funding for almost all internships in Australia. When prioritising applicants, New South Wales places domestic applicants who have studied in that state first, followed by domestic interstate applicants. But in Victoria, international students from Victoria are picked ahead of those domestic applicants from interstate.

This might seem like a small point for workforce planners, but the overall system is ridiculous. Applicants who are preparing at the moment will begin finding out where they are placed in mid-July, however the process of allocation won't finish until late November, and in a few special cases will continue even longer.

Say that I apply for an Internship in New South Wales, but that I also want to apply to a hospital in Queensland. I'd certainly get a position in New South Wales in the first round, but might not get one straight away in Queensland.

However, a month later, Queensland will have a few more positions available, so they might send me an email and ask me to head north. If I'm responsible, I'll accept it quickly and notify New South Wales. In turn, they will email an applicant who might have accepted a spot in South Australia; South Australia will take one from Western Australia – it is essentially a game of musical chairs.

To add to the drama, the Federal Government's Commonwealth Medical Internship Initiative funds up to 100 positions in private settings, usually in regional Australia, but their allocation won't start until mid-way through the process.

This might be fine if it didn't mean that people miss out, but I'm afraid that it does.

Despite the fact that there were more individual applicants than there were internship positions last year, some hospitals actually weren't able to fill positions by early January (when they were still offering jobs). Many of international students, afraid that they won't be able to get an internship, take up offers to work overseas when they get one.

Australia became a Federation more than 100 years ago because, while the states wanted to maintain a degree of independence, there were things they could do collectively which would be much more effective.

The current system of internship application and allocation is a case in point. It involves a duplication of process and takes bureaucrats months to achieve an outcome that a computer algorithm should be able to resolve much more quickly.

*James Lawler is the President of the Australian Medical Students' Association. You can follow him on twitter @jmslwlr or @youramsa.*

# Medical services for aged care residents treading water

BY DR CHRIS MOY

In February, the AMA Medical Practice Committee launched a survey seeking feedback on factors affecting the delivery of medical care in the aged care sector, particularly in residential aged care facilities (RACFs). Similar surveys were undertaken in 2012 and 2008. There were 392 responses to the survey.

On the whole, the survey results do not indicate any real change in the provision of medical care to residents since 2012.

This year, we were particularly interested in practice type. We asked respondents whether they worked solo, in small groups or partnerships, in large group or corporatised arrangements, or for one of the major corporates.

Of the respondents who attend RACFs, 74 per cent work in non-corporate arrangements (including 14 per cent in solo practices and 50 per cent in small partnerships), while 26 per cent work in large group or corporatised arrangements. This breakdown largely reflects the composition responses to the survey – 79 per cent of respondents were in non-corporate arrangements and 21 per cent worked in large group or corporatised set-ups. Given the sample size, it was difficult to conclude any bias against RACF for different practice arrangements.

Overall, respondents who currently attend RACFs indicated they are seeing more patients per visit than they were seeing in 2012 and 2008, and are accommodating more non-contact time per patient. The average reported amount of non-contact time per patient was 17.5 minutes (ranging up to 4 hours per patient).

Despite this, they are spending the same amount of time with each patient as reported in 2012, indicating that the quality of the care has not decreased. Respondent comments also reflected that many particularly enjoy visiting their RACF patients, finding the work rewarding.

To complete the picture, we also looked at the Medicare data on services provided to patients older than 65 years in RACFs, and the number of Aged Care Access Incentive (ACAI) scheme payments to GPs.

The Medicare data shows that, for the first time, there has been a slight decrease in the number of GP consultations per resident, down from 15.1 in 2012-13 to 14.5 in 2013-14.

Data for the Federal Government's Aged Care Access Incentive (ACAI), which aims to encourage GPs to provide increased and continuing services in RACFs, shows the number of providers who qualified and received ACAI payments increased slightly (up 2 per cent) from 5310 in 2012-13 to 5435 in 2013-14. However, over the same period, the number of RACF residents increased by 10 per cent, and the ratio of GPs who qualify for ACAI has decreased from one ACAI GP for every 31 residents to one for every 34 residents.

> "What is clear is that we need a new strategy. We need to break down the silo mentality between medical practitioners, aged care providers, ambulance and acute services and public hospitals"

All this suggests that the provision of medical care to RACFs has not appreciably changed since 2012.

What is clear is that we need a new strategy. We need to break down the silo mentality between medical practitioners, aged care providers, ambulance and acute services and public hospitals.

Increased collaboration between these individuals and organisations will improve the care of residents, in particular by reducing inappropriate or unwanted admissions to hospital, which are distressing for the patient and put added pressure on our already strained hospitals.

There is also a need for meaningful incentives to encourage after hours care by the usual treating GP, so they can help prevent unnecessary hospital transfers. Currently, financial disincentives and communication gaps can result in residents being transferred to hospital even when they have advanced care directives in place that indicate that they do not want to be transferred.

It is essential we engage with the aged care sector about providing the right environment in RACFs for the provision of subacute care to support and retain those that already attend RACFs, and to encourage more medical practitioners to work in the sector.

You can view the AMA 2015 Aged Care Survey at: https://ama.com.au/article/2015-ama-aged-care-survey-report

# Waste not, want not - ethics, stewardship and patient care

BY DR MICHAEL GANNON

When it comes to managing health care resources, doctors must balance their primary ethical obligation to care for the patient with their secondary obligation to use health care resources wisely.

At times, these obligations may conflict – but focussing on stewardship allows doctors to find an equitable and realistic balance between the needs of the patient and the need for the wider community to keep health care affordable.

The essence of stewardship is avoiding waste - it is not about denying care based on scarcity of resources, otherwise known as rationing.

How do we become effective stewards of health care and avoid waste without being seen to ration care?

How do we deal with health care administrators, third party payers and governments who place unreasonable constraints on our ability to make treatment recommendations based on our patients' health care needs, rather than the cost of care?

How do we manage patients (and family members) who make unreasonable health care demands, requesting treatments that are simply ineffective or inappropriate for their health care needs?

And what about the ever present fear of litigation – isn't 'defensive medicine' the best way to practice?

At this year's AMA National Conference, I chaired a policy session on stewardship, *Waste Not, Want Not: Ethics, Stewardship and Patient Care.*

The purpose was to assist doctors to become better stewards of our health care resources through learning how to:

- identify the medico-legal challenges to effective stewardship;
- communicate with patients about resource use; and
- participate in initiatives that identify and discourage ineffective care at the institutional level, as well as in the wider community.

The session's presenters, Dr Ian Scott, Dr Sara Bird and Dr Lynn Weekes, were truly engaging.

Dr Scott, Director of the Department of Internal Medicine and Clinical Epidemiology at Princess Alexandra Hospital in Brisbane, outlined 10 clinician-led strategies to maximise value in Australian health care.

Dr Bird, Manager of the Medico-Legal and Advisory Services of MDA National, provided a medico-legal perspective on stewardship in relation to the practice of defensive medicine.

Dr Weekes, the CEO of NPSMedicineWise, presented the ChoosingWiselyAustralia campaign, whose goal is to enhance quality care by reducing unnecessary care.

We are truly indebted to our presenters and appreciate the time they took to engage with our delegates during a lively question and answer session following their presentations.

The AMA's job now is to develop a policy on ethics and stewardship to assist our advocacy.

We want to ensure there is a culture of stewardship within the medical profession.

This clearly begins at medical school and continues throughout a doctor's career with continuing professional development.

Doctors need to be informed of the cost of treatments and procedures, and be guided in making responsible treatment recommendations that balance efficiency with the primacy of patient care.

We also need to ensure that any system-level initiatives to reduce wastage involve the profession, and do not compromise our professional judgement and clinical independence to act in the best interests of individual patients and advocate for the wider public health.

I strongly encourage all members to visit the AMA website and view the presentations, along with the question and answer session from the policy discussion session *Waste Not, Want Not: Ethics, Stewardship and Patient Care*. They can be viewed at https://ama.com.au/media/ama-national-conference-30-may-2015-session-2.

# Sky-high Indigenous imprisonment rates a health disaster

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

Imprisonment is rarely good for health, particularly if you are an Indigenous Australian.

But, tragically, Indigenous people are far more likely to be locked up than other Australians, exacerbating health problems and sending many into a downward spiral of illness and premature death.

The figures are stark.

In 1991, the Royal Commission into Aboriginal Deaths in Custody identified extraordinary rates of incarceration among Indigenous Australians compared with the rest of the community, and established a link with poor general and mental health.

But, despite the Royal Commission's recommendations, the situation has got significantly worse.

Among Aboriginal and Torres Strait Islanders, the adult imprisonment rate soared 57 per cent between 2000 and 2013, while juvenile detention rates increased sharply between 2000-01 and 2007-08, and have fluctuated ever since at around 24 times the rate for non-Indigenous youth.

Currently, almost a third of all prisoners are Aboriginal, including 48 per cent of juveniles held in custody.

Not only that, but the rate of reoffending is astronomical. In fact, repeat offending and re-incarceration is a large contributor to this high rate of imprisonment.

Shocking though these statistics are, they do not begin to describe the suffering and distress experienced by incarcerated Indigenous people, their families and communities.

Mental illness and mental health problems, including alcohol and drug abuse, contribute significantly to their rates of imprisonment and recidivism.

Being incarcerated, in turn, exacerbates existing conditions in prisoners. And, without appropriate and effective treatment within prison, mental illness and mental health issues are a major factor in poor outcomes for people released from prison, including suicide, death from overdose or injury and reoffending.

Social disadvantage and a history of upheaval culminating in trauma and grief clearly contribute to the high level of imprisonment among Indigenous Australians.

Many studies published since 2000 have highlighted that Aboriginal people already have a higher prevalence of significant psychological distress when compared to the non-Aboriginal population, disrupting social and emotional wellbeing and causing post-traumatic stress disorder, depression and substance abuse.

Alcohol is well-known as a common precursor to offending among Indigenous Australians, with indications that it could be a factor in up to 90 per cent of all Indigenous contacts with the justice system.

Once incarcerated, Aboriginal prisoners are at greater risk of developing or exacerbating a mental illness. Ninety-three per cent of Aboriginal women in jail, and 81 per cent of men, have some form of mental illness. Altogether, 30 per cent of Aboriginal women and 20 per cent of Aboriginal men in jail have attempted suicide, and 33 per cent of Aboriginal women and 12 per cent of Aboriginal men suffer from post-traumatic stress disorder.

It is apparent that there is a complete lack of appropriate services to meet complex social, cultural and health needs.

A clearer understanding of some of the drivers of incarceration of Aboriginal and Torres Strait Islander men and women is needed, as are better interventions through culturally appropriate health and disability services before entering custody, during imprisonment, at the time of release and post-release.

There are several things that can and should be done to end this vicious cycle of illness, abuse and incarceration for Indigenous people, including making it much easier for Indigenous offenders to get into diversion programs for alcohol and drug-related offences; establishing Indigenous-specific diversion programs linked to Aboriginal community controlled services; improving the level of health services for Indigenous prisoners; comprehensive health screening for those entering prison, and channelling them into appropriate treatment; and research and develop performance indicators to guide effective health services for Indigenous offenders.

These matters will be considered in the AMA's Indigenous Health Report Card, which will be released later this year.

# Giving general practice the prevocational training program it deserves

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Strange, is it not, that one of the major medical specialties in Australia cannot offer junior doctors the chance to find out more about that branch of medical practice before they choose their career direction. Imagine if it was surgery or anaesthesia.

Like all of my colleagues, I was surprised when general practice was left in this position after the Federal Government decided to axe the Prevocational General Practice Placements Program (PGPPP) in last year's Budget.

> "To be sure, the PGPPP was an expensive program, but the lack of warning about its closure was disappointing; the AMA and other stakeholders could have worked with the Government to reform the program and make it more cost effective"

The loss of the PGPPP also undermined efforts to deliver more training and care in the community, despite universal acceptance that we need to supplement the traditional hospital-based approach to medical training if we are to properly equip our future medical workforce.

Some background: the PGPPP was the successor to the Rural and Remote Area Placement Program. It initially funded 280 twelve-week placements in 2005, and by the time it was closed down it was flourishing, funding 900 placements a year, with many more wanting to take part.

To be sure, the PGPPP was an expensive program, but the lack of warning about its closure was disappointing; the AMA and other stakeholders could have worked with the Government to reform the program and make it more cost effective.

One of the first initiatives of the AMA Medical Workforce Committee when it was established late last year was to respond to the Government's decision and develop a proposal to support more prevocational training in general practice for junior doctors. The result has been the Community Residency Program (CRP).

The principal aim of the CRP is to encourage more young doctors to choose a career in general practice. And for those who decide to work in other specialties, it will help them to understand and appreciate general practice, how it functions, and the role it plays in the health system.

Our proposal shares some of the features of the old PGPPP, but it could be delivered at significantly lower cost and with less bureaucracy.

We have deliberately chosen not to nominate specific participation targets, but instead have outlined a set of design and funding principles. Junior doctors would undertake rotations of up to 13 weeks in general practice, which would help them to experience life as a GP and improve their clinical experience.

When the PGPPP was lost, the AMA feared a decline in the general practice workforce overall, but especially in rural and remote areas, where community need for GPs continues to grow.

I was therefore pleased that the Independent Expert Panel – established to report on the public consultation and advice to Government on the redesign of the General Practice Rural Incentives Program – recommended last month that the Government re-introduce a program to provide junior doctors with a rural general practice experience as part of their prevocational training.

Our CRP proposal certainly meets the panel's recommendation. Let's hope Health Minister Sussan Ley sees it this way as well, for rural general practice and the profession as a whole.

The AMA believes the CRP is worthy of the Government's consideration as a way to invest in our future medical workforce, surely a more sensible approach than simply opening more medical schools.

Details of the AMA Community Residency Program for JMOs are available at https://ama.com.au/submission/community-residency-program

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