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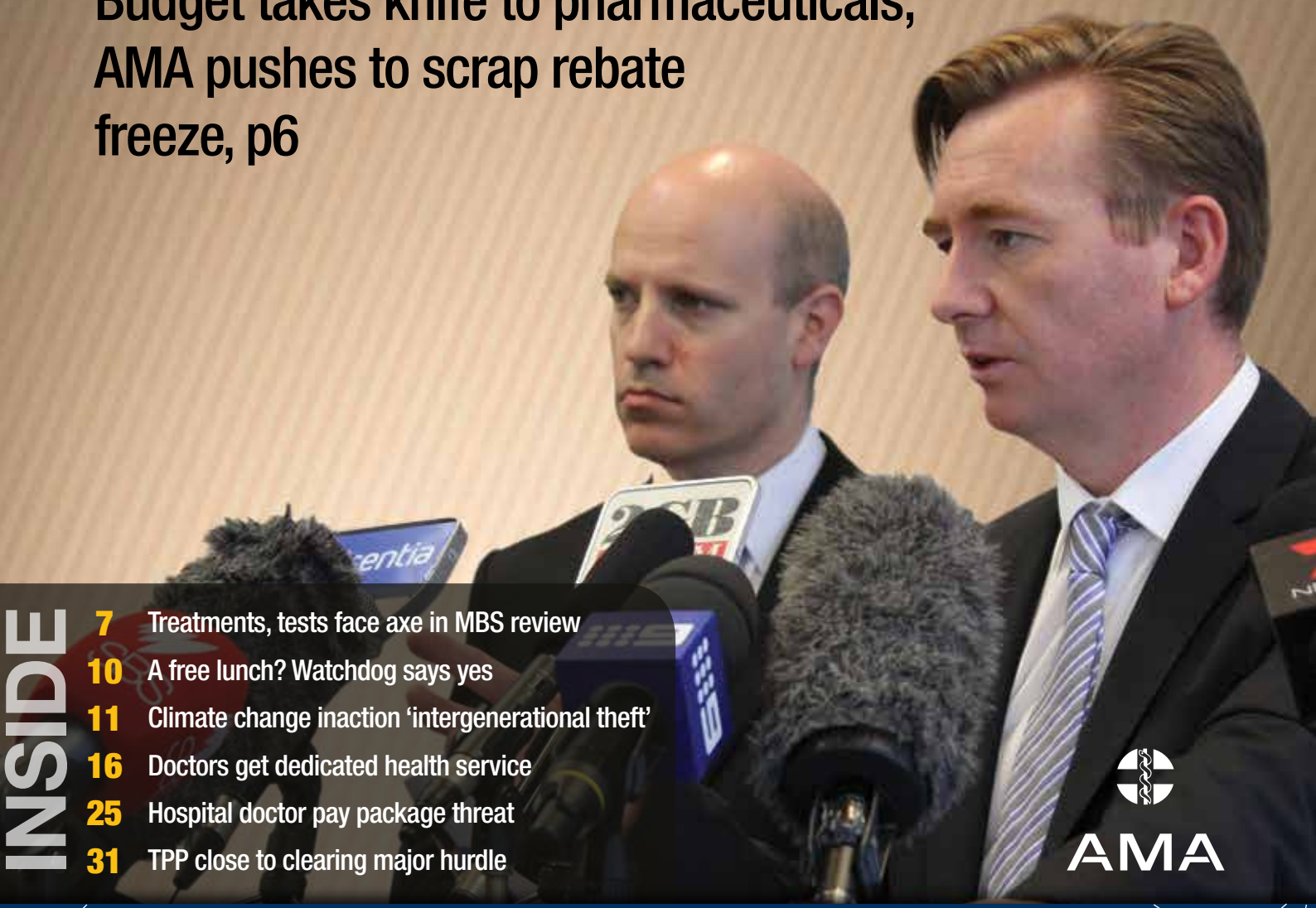
War on drugs

Budget takes knife to pharmaceuticals; AMA pushes to scrap rebate freeze, p6



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AMA

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Columns

Climate change failure would be 'intergenerational theft of the worst kind'

BY **AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER**

> "As the world continues to warm, there will be significant and sometimes devastating impacts of climate change — particularly for human health"

Climate change is a significant worldwide threat to human health that requires urgent action. There is overwhelming evidence that the global climate is warming and human factors have contributed to the warming. It is happening gradually, but there is no doubt that it is warming. The AMA supports that evidence.

As the world continues to warm, there will be significant and sometimes devastating impacts of climate change — particularly for human health.

Last month, along with the President of the highly respected Australian Academy of Science, Professor Andrew Holmes, I launched the Academy's much-anticipated report — *Climate change challenges to health: Risks and opportunities*.

The report brings together the latest comprehensive scientific evidence and knowledge on the serious risks that climate change poses to human health. It suggests a pathway for policy makers at all levels to prepare for the health impacts of climate change.

Both the AMA and the Academy of Science hope it will be a catalyst for the Federal Government to show leadership in reducing greenhouse gas emissions ahead of the United Nations Climate Change Conference in Paris later this year.

Not only does the report outline a case for policies to mitigate climate change, but it is also a call to action for all Australian governments to prepare for the health impacts of climate change. Policies and institutions must be in place now to ensure that Australia can adapt to the health consequences of climate change — these phenomena are inevitable.

As the climate warms, and we experience more extreme weather events, we will see the spread of diseases, disrupted supplies of food and water, and threats to livelihoods and security.

The health effects of climate change include increased frequency of extreme weather events such as heat waves, flooding and storms. In Australia, we are already experiencing weather extremes with prolonged drought and bushfires in some areas, and severe storms and floods in others. Not only can these cause illness and death, but there are significant social impacts as well.

Climate change will dramatically alter the patterns and rate of spread of diseases, rainfall distribution, availability of drinking water, and drought. International research shows that the incidence of conditions such as malaria, diarrhoea, and cardio-respiratory problems is likely to rise.

The Academy of Science recommends that Australia establish a National Centre of Disease Control to provide a national and coordinated approach to Australia's response to climate change.

Such a centre would prioritise research and data collection to better evaluate and anticipate where the burden of disease from climate change would have the greatest effect, and be able to respond accordingly.

Doctors and other health workers need to be informed by sound, up-to-date data. For example, we need to know when a disease that is traditionally found in tropical regions has moved south.

This will allow health authorities to plan and allocate health personnel and services to deal with changing patterns of disease.

All these events will affect the health of Australians and the health of the people in other countries in our region.

We are already seeing forced migration of people from areas, such as in the Pacific region, that are no longer habitable or productive. As forced migration increases around the world, there will be conflict and threats to food security and sustainability.

Nations must start now to plan and prepare.

If we do not get policies in place now, we will be doing the next generation a great disservice.

It would be intergenerational theft of the worst kind — we would be robbing our kids of their future.

The Australian Academy of Science Report, *Climate change challenges to health: Risks and opportunities* is available at https://www.science.org.au/sites/default/files/user-content/documents/think-tank-recommendations.pdf.

Immunisation – why there is no room for complacency

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

There has been ongoing public discussion about the growing number of parents who have registered as conscientious objectors to immunisation.

These parents not only put the health of their own children at risk, but they also jeopardise the health of those who essentially rely on public immunity – neonates and the immunosuppressed are clear examples.

Data released from the National Health Performance Authority highlighted geographic areas across the nation where rates of childhood immunisation have become dangerously low. Despite media reports that immunisation was dropping in affluent areas, the reality is that declines have been observed across the socioeconomic spectrum.

The AMA has always been a strong and vocal advocate for immunisation. It has participated on many immunisation committees and has provided advice for key documents and policies. The AMA has also partnered with other reputable organisations, such as the Australian Academy of Science, to promote resources that increase public awareness of the importance of immunisation.

In recent weeks, the Federal Government has taken steps to increase rates of childhood immunisation. It will no longer allow parents who remain registered as conscientious objectors to continue receiving social security payments that have long been linked to the immunisation schedule. Resources have also been made available to GPs to identify children without all the necessary immunisations, and to provide catch up programs.

There is no doubt that a small group of parents will remain committed to their anti-vaccination stance, in spite of the overwhelming evidence to the contrary. However, the Government's recent decisions should result in an increasing number of children receiving catch up vaccinations. They may also cause some parents to reconsider their stance. GPs, with their expertise and reassurance, will be essential to this process.

But medical practitioners should also take a leaf out of their own book and promptly immunise themselves against seasonal influenza.

Influenza contributes to high rates of morbidity and mortality among our patients, and a significant amount of serious illness and time off work for many doctors.

AMA Vice President Dr Stephen Parnis puts his arm on the pro-vax line

We can become unwitting disease vectors, and even put our families at risk.

I note and lament the fact that the number of Australian doctors getting flu vaccinations has been too low.

Annual influenza immunisation for clinicians and other health care workers is recommended by the World Health Organisation, the Centres for Disease Control and Prevention, the World Medical Association and the Australian Immunisation Handbook.

A significant reason for low vaccination rates in this context is practical. We tend to be very busy, and that can lead to our own health needs dropping down the priority list.

While it may involve some level of reprioritisation, workplaces can and should assist clinicians and other health care staff to ensure that time is available in order to get immunised.

Furthermore, incorporating some flexibility into the seasonal influenza vaccine programs by having immunisations available on more than one date and outside standard working hours, is likely to help.

Please make your own influenza immunisation a priority this season, and encourage your colleagues to do the same.

Medicare a timely focus for AMA National Conference

BY AMA SECRETARY GENERAL ANNE TRIMMER

> "A highlight of the National Conference will be the appearance of former Prime Minister, Julia Gillard, as guest speaker at the Leadership Development Dinner"

With May comes the AMA's National Conference, this year to be held in Brisbane with the theme of *Medicare: midlife crisis?*

The theme was initially selected with Medicare hitting its 30 year milestone in 2014. It has become even more topical with the announcement in the past couple of weeks of the Government's planned stocktake of the Medicare Benefits Schedule through comprehensive clinician-led reviews. As the AMA said in its media release on the issue, it is important that the MBS represents and promotes high quality contemporary medical practice.

The MBS Review Taskforce and the Primary Health Care Advisory Group are both led by experienced clinicians, Professor Bruce Robinson and immediate-past AMA President Dr Steve Hambleton. The AMA welcomes the opportunity to ensure Medicare reflects best practice clinical care and provides the highest quality and easily accessible services to patients.

A highlight of the National Conference will be the appearance of former Prime Minister, Julia Gillard, as guest speaker at the Leadership Development Dinner. The Leadership Development Dinner is directed specifically to doctors in training and junior doctors, with a spotlight on the place of leadership in the profession.

Policy sessions at the National Conference include a debate on ethics, stewardship and patient care; funding of public hospitals to support quality performance; and an examination of funding models for general practice.

The Annual General Meeting, to be held in conjunction with the Conference, celebrates one year since the adoption of the new Constitution with its governance changes for the AMA. From an organisational point of view, these changes have been highly effective, allowing a greater Board focus on strategy. The Board has been able to focus on investment in building member benefits, improving communications, delivering digital engagement, and securing the organisation's infrastructure. Some of the results of this activity will be on show at the National Conference.

The governance changes have resulted in Federal Council having more time to devote to debate on medico-political matters, as was the intention. Recent meetings have covered issues as diverse as the review of the National Registration and Accreditation Scheme for health professions, an audit of the AMA's public health position statements, and a debate on the role of pharmacy. New items of work have commenced, such as the revision of the AMA's policy statement on methamphetamine, which is highly topical – the Federal Government has focused attention on the scourge of this drug in our communities.

At its most recent meeting, the Federal Council supported the recognition of rural doctors as a special interest group, supported by a Council of Rural Doctors. AMA's rural doctors were particularly outspoken during the recent outcry over the Government's proposed changes to Medicare rebates for general practice. Rural practices would have been very hard-hit with the proposed changes to reimbursement for level A/B consultations – a point well-understood by Minister Sussan Ley, who is a rural MP.

While the AMA has always valued its rural members, the recognition of a special interest group, and the creation of the Council of Rural Doctors, will give a stronger voice to their interests.

Govt launches war on drugs in hunt for savings

> "The Prime Minister has said on a number of occasions that there would, first of all, [be] no cuts to health, but second of all, has said that there will be no new health initiatives without the broad support of the medical profession" - Brian Owler

The AMA is pressing the Federal Government to end the Medicare rebate freeze and boost public hospital funding after the Pharmaceutical Benefits Scheme was targeted for hefty Budget savings.

At the time of going to press, the Government was tipped to use the 12 May Budget to announce changes in the PBS that could achieve savings worth almost $5 billion.

According to *The Australian Financial Review*, the changes involved the introduction of a three-year time limit on original brand-name drugs included in the price disclosure regime, a $1 prescription co-payment discount to slow the rate at which patients reach the PBS safety net threshold, and the removal of over-the-counter painkillers from the PBS.

Medical services, particularly general practice, were expected to be left largely untouched by the Budget as the Government, bruised by the widespread outcry over its attempts last year to introduce a co-payment for GP services, instead turned to the pharmaceutical sector for savings.

Prime Minister Tony Abbott had promised a "boring" Budget, and prior to the Budget's release AMA President Associate Professor Brian Owler said he had sought assurances from the Government that there would not be any surprise announcements on health.

Asked about speculation the health portfolio had been targeted for $7 billion of savings – though it was not clear whether or not this would be inclusive of PBS savings - A/Professor Owler said that would be "a very big surprise for the AMA and, I'm sure, doctors and the Australian public".

"I heard some of those rumours...and I put those questions directly to the Minister for Health, who has reassured me that that is not going to be the case," he said. "The Prime Minister has said on a number of occasions that there would, first of all, [be] no cuts to health, but second of all, has said that there will be no new health initiatives without the broad support of the medical profession. So, I would be very surprised if those sorts of measures were introduced without talking to the AMA or other health groups."

The Government's hunt for savings in the PBS has come at an awkward time for the pharmaceutical industry, which is embroiled in negotiations with the Commonwealth over the next five-year Community Pharmacy Agreement, which is due to come into effect from 1 July when the current $15.4 billion deal expires.

The Pharmacy Guild of Australia has been pushing for an enhanced role for pharmacists, including administering flu vaccinations and conducting health checks, to help offset reduced income growth from the dispensing of medicines under the Commonwealth's price disclosure arrangement with drug manufacturers.

But its bargaining position has been undermined by a Commonwealth Auditor-General report scathing about the current agreement, including revelations that funds earmarked for professional development had instead been diverted into a "communications strategy".

And a Government-commissioned competition review has recommended that restrictive rules on the number and location of pharmacies be scrapped, including allowing supermarkets to provide pharmacy services.

The review said the restrictions were anti-competitive and did nothing to improve access to medicines, particularly for patients living in rural and remote areas. The Government is considering the review's findings.

ADRIAN ROLLINS

Medicare review 'not a savings exercise', Ley promises

The AMA has told the Federal Government its plan to update the Medicare Benefits Schedule to eliminate inefficiencies and reflect advances in medical practice should not be used to cut health spending and warned it could be undermined by the ongoing Medicare rebate indexation freeze.

Health Minister Sussan Ley has launched a review of the Schedule, to be led by Sydney Medical School Dean Professor Bruce Robinson, to scrutinise and assess the appropriateness of the more than 5500 services listed.

In parallel, the Minister has also appointed immediate-past AMA President Dr Steve Hambleton to head a Primary Health Care Advisory Group to recommend improvements in providing care, particularly for patients with mental health problems and chronic and complex illnesses.

AMA President Associate Professor Brian Owler said doctors supported the MBS review, but it should not be simply a cost-cutting exercise.

"There's no doubt that the Government is looking for savings, but as I've said to both the [Health] Minister and the Prime Minister, we're not going to participate in a review that simply is about saving money," A/Professor Owler told ABC radio. "What we're happy to do is participate as a profession to make sure that we get a schedule that reflects modern medical practice, but it's not going to be a hit-list of savings. It's not going to be something that just looks at trying to take money out of the system."

Ms Ley sought to allay fears the review was solely driven by the need to pare back health spending, insisting that "this is not a savings exercise".

"I expect that savings and efficiencies may well come from it, but I'm not going to predict that because, while we start this process, we don't know exactly what our initial scoping of the MBS will determine," the Minister said, adding that no savings target had been set.

But A/Professor Owler said that while ever the Government's four-year freeze on Medicare rebate indexation remained in place, there was justifiable concern that the Government's overriding objective was to cut health spending.

"The AMA and the medical profession will work closely with the Government and the [MBS Review] Taskforce to ensure Medicare reflects best practice clinical care and provides the highest quality and easily accessible services to patients," he said. "But the ongoing freeze of Medicare rebates threatens to undermine the good intentions of these reviews."

A/Professor Owler indicated in early March that he was in discussions with Ms Ley about how restructuring aspects of the MBS could improve patient outcomes and achieve efficiencies that would obviate the need for an extended rebate freeze.

He said the freeze would threaten the viability of many GP practices, cut bulk billing rates and push up patient out-of-pocket expenses.

"Freezing Medicare rebates for four years is simply winding back the Government's contribution to patients' health care costs. The freeze will also have a knock-on effect that could ultimately lead to higher private insurance premiums and higher out-of-pocket costs for patients," he said. "If doctors absorb the freeze, their practices will become unviable."

Ms Ley told ABC radio she regretted the freeze, but added it was necessary for "fiscal responsibility".

She said the freeze would not be withdrawn in the May Budget, but expressed hope that it could be removed earlier than 1 July 2018, as currently planned.

"I would like it to be removed earlier than that. I'll be working towards removing it earlier than that, and I very much hope that it will be," the Minister said. "Yes, it's here in the up-coming Budget...but I would like to see it go. It freezes what I might call an inefficient Medicare system."

A/Professor Owler said it was reassuring that the MBS Review and the Primary Health Care Advisory Group were both being led by eminent and highly-regarded clinicians, making it likely their recommendations would be based on frontline medical evidence and experience.

"We've got some eminent people that are going to be involved in these reviews. And this has to be clinician-led. It has to be based on evidence," he said. "And if the review delivers some savings - and there will be some savings I expect that can be found - then we'd be very happy to participate in that, as long as some of those savings are actually re-invested back into health care as well."

Ms Ley said there were several examples where the MBS system did not support best clinical practice, such as creating incentives for GPs to order x-rays for patients with lower back pain, and to encourage en masse tests for vitamin D and folate deficiencies.

"I believe the biggest modernisation that needs to happen is because the clinical practices and the equipment and the technology are moving faster than the MBS updates," the Minister said. "So, where you use scopes to look down people's throats and look at cancers, they weren't done in the same way years ago. They're now much different."

Medicare review 'not a savings exercise', Ley promises

... from 7

The MBS Review and the Primary Health Care Advisory Group's work will also be accompanied by a crackdown on Medicare rorting.

Ms Ley said that although the "vast majority" of doctors acted appropriately and conscientiously, a "small number do not do the right thing in their use of Medicare. Their activities have a significant impact on Medicare and may adversely affect the quality of care for patients".

Shadow Health Minister Catherine King said the Opposition cautiously welcomed the MBS review, but remained "deeply suspicious" about the Government's intentions.

Ms King said Labor began an MBS review while in Government, and changes it made would save $1 billion over the next five years.

But she said it was "crucial [the review] not be used as just another excuse to rip money out of health", and called for any savings made to be reinvested in the health care system.

Ms Ley said each of the three taskforces was expected to provide recommendations by late this year.

"Basically, there's wide agreement the Medicare system in its current form is sluggish, bloated and at high risk of long-term chronic problems and continuing to patch it up with bandaids won't fix it," Ms Ley said. "Not imposing a savings target allows us to work with doctors and patients to deliver high-quality health policies that focus on delivering the best health outcomes for every dollar spent by taxpayers."

ADRIAN ROLLINS

MBS review savings must stay in health: AMA

AMA President Associate Professor Brian Owler says he has received assurances from Health Minister Sussan Ley that any savings realised from the review of the Medicare Benefits Schedule will be ploughed back in to funding new treatments.

Ms Ley provoked a surge of concern about the review last week when she told Sky News that any money freed up by the process would be diverted into the $20 billion dollar Medical Research Future Fund rather than being reinvested in new MBS items.

"If there are savings, it [sic] will go into the Medical Research Future Fund, as we promised in the last Budget," the Minister said.

But A/Professor Owler told News Corp he had sought assurances from Ms Ley that this would not be the case.

"I clarified with the Minister's office, and if there are savings identified through the review, these would be reinvested into health rather than the Medical Research Future Fund," the AMA President said.

The AMA has backed the creation of the Fund, but has been highly critical of plans to pay for it using money taken from patients and primary health care, such as through GP co-payments, various forms of which have been proposed and dumped by the Government.

Although several savings measures to free up money for the Fund have come into effect, including the abolition of stand-alone health agencies, the Government is yet to set up the Fund amid speculation its size and scope will be considerably reduced.

But A/Professor Owler has previously said the money was there to get the Fund going, and last week he repeated his challenge to the Government to set it up.

"If the Fund is so important, why hasn't it yet been established?" he told the *Northern Territory News*.

Earlier, the AMA President commented on rumours the health portfolio had been targeted for $7 billion of savings in the forthcoming Budget.

"That would be a very big surprise for the AMA and, I'm sure, doctors and the Australian public," he said. "The Prime Minister has said on a number of occasions that there would, first of all, [be] no cuts to health, but second of all, has said that there will be no new health initiatives without the broad support of the medical profession.

"So, I would be very surprised if those sorts of measures were introduced without talking to the AMA or other health groups.

"I heard some of those rumours...and I put those questions directly to the Minister for Health, who has reassured me that that is not going to be the case. But, obviously, we will be watching the Budget very closely."

ADRIAN ROLLINS

Wasteful, unnecessary treatments and tests face the axe

More than 200 routinely used treatments have been placed under the microscope as doctors, led by medical colleges and societies, take part in a national crackdown on unnecessary, costly and potentially harmful tests, procedures and medications.

Groups including the Royal Australian College of General Practitioners, the Australasian College for Emergency Medicine, the Royal Australian College of Physicians, the Royal College of Pathologists of Australasia and the Australasian Society of Clinical Immunology and Allergy have already joined the National Prescribing Service's Choosing Wisely initiative aimed at improving the appropriateness of care.

It has been estimated that up to $15 billion a year is spent on unnecessary and unproven treatments and therapies that inconvenience patients, tie up precious medical resources and could be harmful.

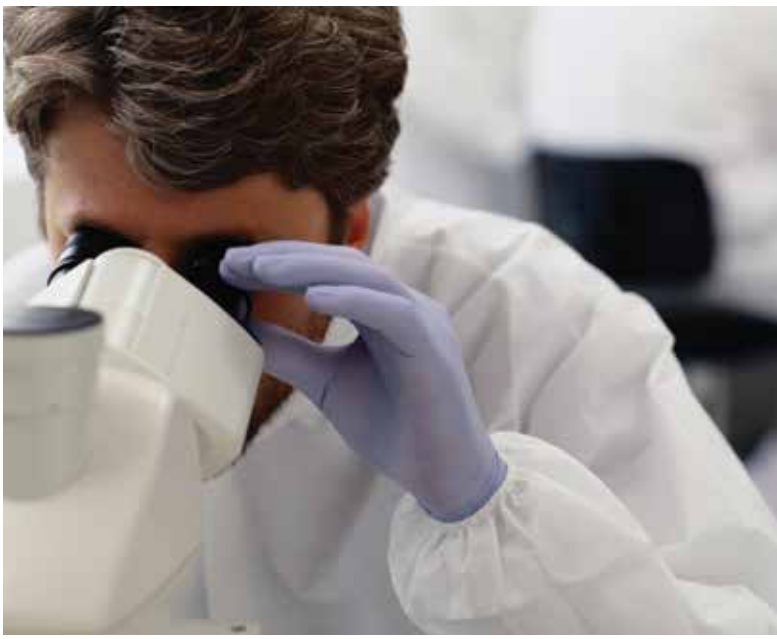
NPS Medicinewise Chief Executive Dr Lyn Weekes said patients frequently assumed that more care was better, when often the opposite was the case.

Many procedures and tests like x-rays and CT scans, carried costs and risks as well as benefits, while others, such as spinal injections of steroids to treat non-specific back pain, were not supported by evidence of their effectiveness.

Dr Weekes said the intention was to encourage "informed conversations" between and among doctors and patients about the appropriateness of proposed treatments.

Medical colleges and societies have already identified a range of tests and procedures whose use warrants much closer scrutiny, including:

- the long term use of proton pump inhibitors, which are widely used to treat reflux and peptic ulcers and cost $450 million last financial year;
- routine blood glucose self-monitoring for type 2 diabetics on oral-only medication, with test strips costing $143 million a year;
- conducting stress and ECG tests on asymptomatic, low-risk patients;
- widespread screening for vitamin D deficiency;
- PSA testing for prostate cancer in asymptomatic men;
- x-rays for non-specific lower back pain;



- routine use of CT scans for head injuries; and
- routine cervical spine imaging in trauma cases.

AMA President Associate Professor Brian Owler said Choosing Wisely was a welcome initiative, and it was important that it had the support and involvement of medical colleges and societies.

"The involvement of the medical colleges will ensure clinical stewardship and leadership in health care resources," A/Professor Owler said.

He said it was important that the criteria used in identifying tests, treatments and procedures was "reasonable and transparent", because it would help build confidence in the process.

There is likely to be considerable cross-over between the lists prepared through the Choosing Wisely initiative, and the tests, treatments and procedures that come under scrutiny the Medicare Benefits Schedule review announced by Health Minister Sussan Ley.

A/Professor Owler said both programs were an important opportunity to help ensure that the best use was being made of scarce health funding and resources.

ADRIAN ROLLINS

Free lunches are fine, says competition watchdog

Drug companies will have to disclose all payments and gifts provided to doctors except for food and drink under conditional arrangements approved by the consumer watchdog.

The Australian Competition and Consumer Commission has given Medicines Australia until October next year to ensure that all "transfers of value" made by pharmaceutical firms to doctors – except meals and beverages – are publicly disclosed, tightening reporting provisions set out in the industry's new code of conduct.

> "Under the code's reporting regime, all transfers of value to health professionals, including sponsorships and speaking and advisory board fees, are to be disclosed"

The ACCC said it was concerned that, in the latest version of the code, doctors had to consent to having the details of individual payments disclosed (otherwise they would be included in aggregate figures), and could withdraw consent after receiving any transfer of value.

The ACCC said it accepted that the new transparency regime, which was developed in consultation with the AMA and other medical groups, was a "significant and important" change toward greater transparency, but Commissioner Dr Jill Walker said it needed to go further.

"Having taken this crucial step, it is important to ensure that the significant benefits of the regime are realised," Dr Walker said. "In this context, the ACCC is requiring the regime to be strengthened to ensure that all relevant transfers of value are reported, and that the data is accessible."

Under the code's reporting regime, all transfers of value to health professionals, including sponsorships and speaking and advisory board fees, are to be disclosed.

But Medicines Australia has set a $120 cap on how much can be spent on any one meal and said such payments would not be included in the disclosure regime – a decision the ACCC has accepted.

"In reaching this view, the ACCC notes that food and beverage costs are secondary to the more direct transfers of value, a $120 per meal cap applies, and that ongoing reporting would impose a significant administrative burden on companies," the regulator said.

But the ACCC warned it would reconsider its position if there was a significant and unreasonable jump in spending on food and drinks.

And the watchdog cautioned that its authorisation of the code did not amount to endorsement: "Rather, it provides statutory protection from court action for conduct that meets the net public benefit test, and that might otherwise raise concerns under...competition provisions".

AMA Council of General Practice Chair Dr Brian Morton told *The Age* it was common sense to exclude capped meals from the disclosure regime, and dismissed as "insulting and naïve" suggestions doctors would be influenced in their clinical practise by a free meal.

ADRIAN ROLLINS

Govts must prepare for inevitable health effects of climate change

"This is too important an issue for the Australian community when it comes to the health consequences, for politicians to argue about the science. They are not scientists"

Increasing numbers of Australians will fall victim to heatwaves and storms, be at greater risk of contracting exotic diseases and find it increasingly expensive and difficult to get safe water and quality food as global temperatures rise, a report on the health effects of climate change has warned.

The Australian Academy of Science study, backed by the AMA, predicts that, with global temperatures likely to rise by at least 2 degrees Celsius by the 2100, Australians will confront an increasingly difficult and challenging environment marked by spreading disease, stressed ecosystems, disrupted food and water supplies, increasingly wild and extreme weather, and rising international tensions and conflict.

Scientists expect that diseases like mosquito-borne dengue and chikungunya will spread south as temperatures increase, while water will be increasingly infested with algal blooms, livestock will be at greater risk of zoonotic infections, and longer and harsher heatwaves and storms will threaten the lives of many – particularly the elderly and very young. Agricultural production will become more difficult, increasing the cost and scarcity of quality food, and there is likely to be international unrest and upheaval as areas become uninhabitable and life-sustaining resources come under increasing stress.

AMA President Associate Professor Brian Owler, who helped launch the *Climate change challenges to health: Risks and opportunities* report on 30 April, said it was "inevitable" that climate change would affect human health, and that the grim outlook underlined the urgent need for national and international leadership and action in mitigating climate change and preparing for its serious effects on health.

A/Professor Owler said the country had not been well served by the Government's approach to climate change policy to date.

"We have been subjected to a lot of non-scientific debate," he said. "We need to get past the fact that climate change has become a political battleground and a political football.

"This is too important an issue for the Australian community when it comes to the health consequences, for politicians to argue about the science. They are not scientists."

Govts must prepare for inevitable health effects of climate change

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The AMA President said he did not expect the Government to act in ways that would adversely affect people in their daily lives, but it needed to assume a leadership role on the issue and back up policies with institutions and activities that would protect the public against the effects of climate change.

The Academy's report recommended the establishment of an Australian Centre for Disease Control to unify and coordinate disease surveillance and responses to outbreaks, an idea that A/Professor Owler backed.

"We need to be well prepared as a medical community, but also to make sure the public health policies are put in place," he said. "A Centre for Disease Control is something the Government should closely look at."

One of the report's authors, Dr Allie Gallant, said the fatal consequences of extreme heatwaves and storms had already been dramatically demonstrated in recent years.

The study found that more people (374) died during a searing heatwave that struck Victoria than in the subsequent devastating bushfires (173 deaths).

Co-author Celia McMichael, daughter of recently deceased renowned climate scientist Tony McMichael, warned that climate change was also likely to have a profound effect on Pacific Island nations, with the prospect that many people would be displaced.

A/Professor Owler said the report should give the Government impetus to provide leadership on ways of mitigating the effects of climate change, and to help inform the plan of action it will take to the United Nations' Paris Climate Change Conference in November.

"The Report's recommendations will assist all our governments prepare for the inevitable health and social effects of climate change and extreme weather events, and must be a key reference for the Federal Government in the development of the action plan it takes to the Paris Climate Change Conference," he said.

"The Paris Conference objective is to achieve a legally binding and universal agreement on climate from all nations of the world, and the AMA believes Australia should be showing leadership in addressing climate change and the effects it is having, and will have, on human health."

The Australian Academy of Science Report- Climate change challenges to health: Risks and opportunities can be viewed at: https://www.science.org.au/sites/default/files/user-content/documents/think-tank-recommendations.pdf

The AMA released a Position Statement on Climate Change and Health in 2004, which was updated in 2008, and can be found at https://ama.com.au/position-statement/climate-change-and-human-health-2004-revised-2008

The AMA is currently updating this Position Statement.

The World Medical Association's 2011 Declaration on Climate and Health can be viewed at: http://www.wma.net/en/20activities/30publichealth/30healthenvironment/Durban Declaration on Climate and Health Final.pdf

A video message on climate change and health from A/Professor Owler can be viewed at: https://docs.google.com/a/ama.com.aulfile/d/OB2MDuYDSoCyJMOVMZDcyTUJ2clk/edit

ADRIAN ROLLINS

Painkillers to go off-script in the hunt for savings

The AMA has warned vulnerable patients must not be hurt in the Federal Government's drive to achieve huge savings from the Pharmaceutical Benefits Scheme.

The Federal Government is considering an option to save up to $3 billion from the PBS by axing prescriptions for over-the-counter painkillers and other medicines and allowing pharmacists to offer discounts on the patient co-payment.

In a major shake-up to the PBS as negotiations over the multi-billion dollar Community Pharmacy Agreement intensify, Health Minister Sussan Ley has revealed the Government is looking at removing from the scheme Panadol, aspirin, antacids and other medicines that can be bought without a prescription.

While such medicines can be cheaply and readily bought from supermarkets and other outlets, many patients are currently purchasing them through the PBS to help them to cheaply and quickly reach the safety net threshold - $1453.90 for general patients and $366 for concession card holders – after which all medications are free.

But the Australian Medical Association has cautioned of the risk of harm to patients if the Government's principle focus is cost-cutting.

AMA Vice President Dr Stephen Parnis said doctors wanted to be sure that, in any changes, "the most vulnerable groups are protected".

Ms Ley told the *Australian Financial Review* the PBS contained a number of "perverse disincentives and some perverse incentives" that were costly for both the Government and patients.

"The Government is paying a lot of money for people to access Panadol and other over-the-counter medications at their chemist on script," the Minister said. "There's a really strong argument why, under the supervision of the Pharmaceutical Benefits Advisory [Committee], we look to taking over-the-counter medications off the Pharmaceutical Benefits Scheme, and in the process get a better deal for consumers."

In addition, the Government is considering allowing pharmacies to offer a co-payment discount of up to $1 per prescription for patients who opt for cheaper generic versions of their medicines.

The measure would serve two purposes – to encourage greater use of generic medicines and so save money for the PBS, and to slow down the speed with which patients reach the safety net threshold.

Ms Ley told the *AFR* that "allowing pharmacies to reduce what patients pay is one of the key ingredients that I want to see come out of this [Community Pharmacy] Agreement: that medicines remain affordable".

But the *AFR* said, both proposed changes sit at "extreme odds" with measures adopted in last year's Budget to increase the PBS co-payment and the safety net thresholds, for a claimed saving of around $1.3 billion over four years. Legislation enshrining the changes is yet to be passed by Parliament.

They also come as the Therapeutic Goods Administration's Advisory Committee on Medicines Scheduling considers whether to make many common painkillers sold by pharmacists available by prescription only.

It has been proposed that about 150 codeine medications including Mersyndol, Codral Cold and Flu Tablets, Nurofen Plus and Panadeine, currently available over-the-counter at chemists, be reclassified at schedule 4 medicines, which would mean they could only be dispensed with a prescription.

The change has been recommended amid reports an increasing number of patients are taking excessive quantities of codeine, often in conjunction with ibuprofen, causing severe gastrointestinal damage and internal bleeding.

Australians are heavy users of pharmacy-only codeine products – more than 1.3 million packets are sold each month – and more than 1000 people were treated for codeine dependency in 2012-13.

The proposed changes also come as the Government negotiates with the Pharmacy Guild of Australia over the next Community Pharmacy Agreement, which is due to come into effect from 1 July when the current $15.4 billion deal expires.

The Guild has been pushing for an enhanced role for pharmacists, including administering flu vaccinations and conducting health checks, to help offset reduced income growth from the dispensing of medicines under the Commonwealth's price disclosure arrangement with drug manufacturers.

But the Guild's bargaining position has been undermined by a Commonwealth Auditor-General report scathing about the current agreement, including revelations that funds earmarked for professional development had instead been diverted into a "communications strategy".

ADRIAN ROLLINS

Rebate freeze will leave mentally ill 'in the cold'

Many people suffering mental illness will be left stranded without treatment unless the Federal Government drops its plan to freeze Medicare rebate indexation to mid-2018, psychiatrists have warned.

The AMA Psychiatrists Group said the prolonged indexation freeze would push up out-of-pocket costs and increase the financial pressure on patients using the private system, which treats about 70 per cent of all mental health patients.

"Given that many patients treated in the private sector find it difficult to access appropriate care in an already stretched public sector, there are concerns that this would leave many patients and their families 'in the cold'," the report said.

In the lead-up to the federal Budget, the AMA has intensified the pressure on the Government to dump the rebate freeze, warning it will push up patients costs, reduce access to care, cut bulk billing rates and force some GP clinics to close.

But Health Minister Sussan Ley has indicated there will not be a change of policy in the Budget, though she hinted at the possibility the freeze could end early if a review of the Medicare Benefits Schedule and other efficiency measures delivered sufficient health budget savings.

In a report to the AMA Federal Council, the AMA Psychiatrists Group also expressed alarm at what it said was an increasing push by insurers to demand patients divulge details of their medical records.

The group said patients often gave funds access to their medical records "because they are too afraid of losing their insurance cover if they refuse".

The group said that both it and the Royal Australian and New Zealand College of Psychiatrists were concerned about the development, which was "eroding the confidential and therapeutic nature of the relationship between a patients and a psychiatrist".

"In some cases, this can have a clinically detrimental effect on the patient," the report said.

The RANZCP, supported by the AMA Psychiatrists Group, has launched an investigation into the issue.

In its report, the group also highlighted the valuable work being undertaken by the Private Mental Health Alliance to help inform mental health policy.

The Alliance owns and operates the Centralised Data Management Service, which collects admission and discharge information from all private hospitals operating psychiatric beds.

"The CDMS has become the cornerstone for the provision of high quality mental health care in the private hospital sector," the group said. "The CDMS is helping the private sector and the Australian Government answer fundamental questions that can be asked of any health system – who receives what services, at what cost, and with what effect."

The current agreement under which the AMA provides funding to the Private Mental Health Alliance expires in June, and negotiations are underway for a new three-year agreement from 1 July. The Federal Government has deferred a decision on any contribution it might make until after it has fully considered the outcomes of the National Mental Health Commission's review of services, which was publicly released last month. No announcement is expected until after the May Budget.

ADRIAN ROLLINS

Haikerwal departs top World Medical Association position

Dr Mukesh Haikerwal

The international standing of the medical profession is high, with governments around the world regularly seeking the counsel of the World Medical Association and national organisations on health matters, according to outgoing WMA Chair of Council Dr Mukesh Haikerwal.

Dr Haikerwal, who served as WMA Council Chair for four years until losing a run-off for the position last month, said many doctors and other health professionals continued to work in extremely challenging conditions, but their commitment to the welfare of patients meant that the profession was well-respected and influential.

"The profession is highly regarded and its contribution is sought after," the former AMA President said, though he warned, "a lot of work has to be done to retain that place, with on-going advocacy on the behalf of patients and doctors".

Dr Haikerwal said one of the most gratifying achievements of his four-year term was the development of the medical profession in Africa, particularly the creation of national medical associations.

He was particularly pleased by the founding of the Zambian Medical Association last year by doctors who had received WMA-sponsored training and support in organisational skills.

"It has now become the go-to organisation for the Parliament of Zambia on health issues, and Zambia is preparing a bid to host the WMA Conference in 2017. They have gone from zero to hero in very quick time," Dr Haikerwal said. "This is the work that is so gratifying, bringing the medical viewpoint into national debates by building the capacity of organisations."

But he said there were also disturbing developments, particularly increased violence against doctors and other health professionals.

Dr Haikerwal said increasingly in countries as diverse and China, Turkey, the United States and in Eastern Europe, reduced health spending meant that an increasing proportion of patients were not receiving the care they expected, often resulting in violent – and sometimes fatal – attacks on doctors, nurses and other health workers.

Dr Haikerwal said it had been a great honour to serve as WMA Chair, a position which, coming from Australia, had been "a double-edged sword".

"It was fantastic, because Australia is so highly regarded across the globe as a voice of reason and creative thinking and not locked into alliances," he said. "But the negative is that it is a long way to get anywhere."

Dr Haikerwal has been succeeded by immediate-past American Medical Association President Dr Ardis Hoven, who was elected to become the WMA's first woman Chair at its 200th Council meeting in Oslo last month.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Mental health survey for GPs

General practitioners are being invited to take part in a brief survey to identify current practices when working with families where a parent has a mental illness.

GPs are often the first point of call for a person seeking help for a mental health problem, and it has been estimated that more than 12 per cent of all GP visits in a year are mental health-related.

The Children of Parents with a Mental Illness (COPMI) national initiative – funded by the Federal Government to benefit children and families where a parent experience mental illness – is collating information on the process a GP follows when a parent with a mental illness seeks help.

Participating GPs are asked to fill out an anonymous and confidential questionnaire which takes about 20 minutes to complete.

It can be found at: http://monasheducation.az1.qualtrics.com/SE/?SID=SV_29uecngqheOp3Xn

Once completed, GPs will also be invited to take part in a 30 minute telephone interview. If you are involved in the interviews you will receive a $75 Coles/Myer gift voucher for your time.

If you want any further information about the study, please contact Dr Caroline Williamson at COPMI – williamsonc@copmi.net.au

Doctors get their own dedicated national health service

All doctors and medical students will have access to a health service dedicated to meeting their needs no matter where they live and work following a landmark agreement between the AMA and the Medical Board of Australia.

The Medical Board has contracted the AMA, through its wholly-owned subsidiary Doctors Health Services Pty Ltd (DHS), to ensure specific health services for medical practitioners and students are accessible nationwide.

The deal is the culmination of years of work to provide doctors with nationally consistent health services that cater specifically for their needs amid concerns that often practitioners have gone untreated for significant health problems that not only harm them but may place their patients at risk.

The Medical Board announced last year that it would fully fund a national health program for doctors and medical students, and Chair Dr Joanna Flynn said the contract with the AMA was an important milestone in achieving that goal.

"The Board is committed to supporting the wellbeing of all doctors and medical students in Australia," Dr Flynn said. "Creating health services that are accessible and fair to everyone – and are targeted to meet doctors' needs - is a really important contribution we are proud to make."

The announcement of a dedicated national health program for medical practitioners has come just weeks after the medical community was rocked by the sudden death of four young doctors in Victoria. And a 2013 *beyondblue* report showed that psychological distress, burnout and suicide were disturbingly common among doctors and medical students.

There are long-standing concerns that many doctors with mental health problems, issues of substance abuse and physical ailments have been reluctant to seek help for fear it will harm their career.

There has been a call to rigorously address the reasons some doctors find it hard to seek and obtain help, including the culture of the profession, the work environment, the training culture, and mandatory reporting.

While there has been a gradual increase in the number of health services specifically for doctors, AMA Vice President Dr Stephen Parnis recently said current arrangements were inadequate, and the AMA had for a long time strongly advocated for a national model to support the work of the services that make up the Australasian Doctors' Health Network.

AMA President Associate Professor Brian Owler said the establishment of Doctors Health Services would deliver on that goal.

> "Critically, the services will remain at arm's length from the Medical Board to ensure that doctors and medical students trust these services and use them at an early stage in their illness"

While the Medical Board will fund the program, A/Professor Owler emphasised that it would play no role in its operation or the delivery of services.

"Critically, the services will remain at arm's length from the Medical Board to ensure that doctors and medical students trust these services and use them at an early stage in their illness," he said.

Existing doctor health services will be invited to express interest in continuing as a provider. Under the new contract arrangements, they will be required to provide confidential triage and referral services, health advice and education, training for practitioners to treat other doctors and facilitation of support groups.

DHS will have a five-member Board including an AMA representative, a doctor in training representative and a medical practitioners with experience in providing doctor health services. The Board will be supported by an expert advisory committee made up of service providers, medical students, doctors in training and AMA representatives.

ADRIAN ROLLINS

AMA in action

The health effects of climate change grabbed national attention earlier this month when AMA President Associate Professor Brian Owler helped launch an Australian Academy of Science report warning of the need for the country to prepare for increased heatwaves and extreme weather events, the spread of diseases and pathogens, stress on water supplies and food production, and increased international tension and conflict over life-sustaining resources. A/Professor Owler told those attending the launch at Australian Parliament House that governments needed to provide leadership in preparing to meet the "inevitable" health consequences of climate change, warning that to do otherwise would be tantamount to "intergenerational theft". A week earlier, the AMA President was in Turkey where, as a guest of the Turkish Medical Association, he attended events and ceremonies to mark the 100th anniversary of the Gallipoli landings and the terrible slaughter that occurred on all sides of the conflict, as well as the remarkable efforts of military medical officers, nurses, stretcher bearers and others in trying to save lives, heal the wounded, and give succour to the dying.

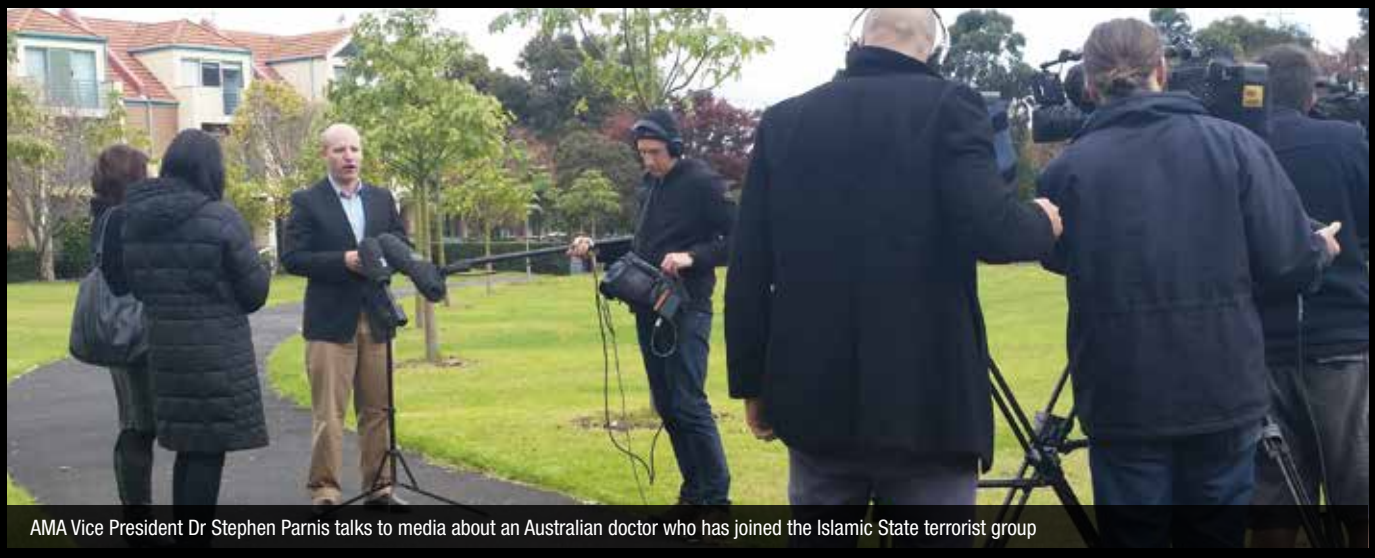
AMA Vice President Dr Stephen Parnis conducted numerous media interviews on topics including immunisation, not least the importance of health workers ensuring they were vaccinated against influenza, and the case of an Australian doctor who has joined the Islamic State terrorist group in Syria. AMA officials also attended a workshop organised by the Students as Lifestyle Activists group, which works to promote healthy eating and behaviour among children and young people.

ADRIAN ROLLINS

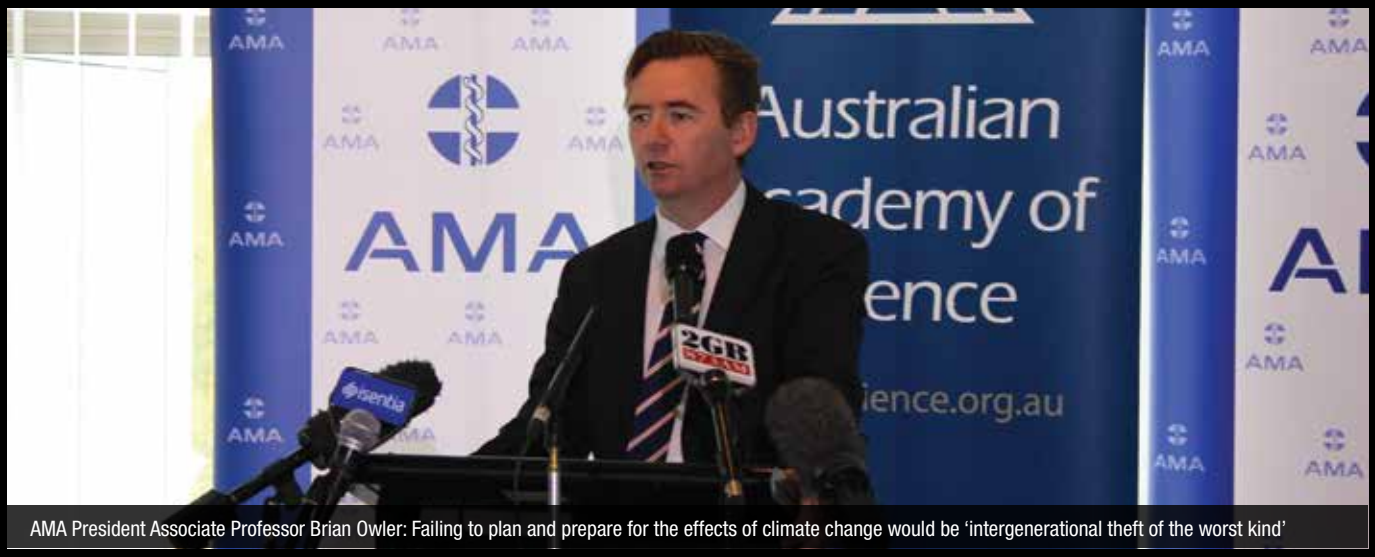
AMA President Associate Professor Brian Owler (centre left): 'The best way to honor the memory of the ANZACs is to advocate for peace'

Spreading the healthy word: Students as Lifestyle Activists workshop in Sydney

AMA President Associate Professor Brian Owler (r) with Australian Academy of Science President Professor Andrew Holmes at launch of Climate Change Challenges to Health: Risks and Opportunities report



AMA Vice President Dr Stephen Parnis talks to media about an Australian doctor who has joined the Islamic State terrorist group



AMA President Associate Professor Brian Owler: Failing to plan and prepare for the effects of climate change would be 'intergenerational theft of the worst kind'

The political economy of general practice

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

> "One of the problems with a grand system such as Australia's general practice is that people take it for granted. They overlook the fabulous cover it provides, day in and day out. Those driven by a myopic obsession to save money are seduced by general practice as a field rich unto harvest"

In 2003 I worked in New York. Before my son could be enrolled in the local school he had to have a "full medical exam" – not by a general practitioner (although I am not sure that we could have found one), but by a paediatrician. At the appointed time we turned up and James was ushered into a change room by one of several pleasant practice nurses and instructed to strip and put on a paper gown. James asked if they had made a mistake: he was not, as far as he or we knew, bound for the operating theatre.

He had the statutory "exam" and "bloods were done", including cholesterol. It cost us more than $US380 ($484).

Months later an insect flew into his ear one morning on the way to camp. Frightening and distressing stuff. Once again, we visited the paediatrician and he could not get the insect out so we were referred to an ear, nose and throat person on the other side of Manhattan. He was, like the paediatrician, a very pleasant man, and enjoyed showing James the insect extraction for the few moments it took on a TV screen large enough to watch the Superbowl in comfort. That insect cost us $US1500 ($1912).

This is what happens when you don't have a prevalent, good-quality general practice system. Let's do a counterfactual. James would have been assessed for school entry without fuss by our general practitioner. His immunisations would have been checked. In five, or perhaps 10, minutes we would have been on our way. Cost? Less than $100. And the insect? The general practitioner may well have been able to do the extraction.

One of the problems with a grand system such as Australia's general practice is that people take it for granted. They overlook the fabulous cover it provides, day in and day out. Those driven by a myopic obsession to save money are seduced by general practice as a field rich unto harvest.

Anybody who is not asleep or otherwise seriously distracted would not freeze the money managed through Medicare for general practice. And yet the current Government, at least before the present Minister began to reintroduce sanity into the health portfolio, proposed exactly that. It is, as I have said before, the triumph of a thought bubble over policy. It brings to mind the biblical story of the expectations placed on the Israelites by Pharaoh, wanting them to make ever more bricks with less clay and straw. We know what happened in the end with that one. Pharaoh's wizards and soothsayers were no match for Moses. A thorough dudding followed.

So Minister – please – fix that problem. It is easily done with the introduction of a high-quality price indexation mechanism such as is available in quality accounting stores, and is as cheap as chips.

The recently announced reviews of the Medical Benefits Schedule and Pharmaceutical Benefits Schedule make prima facie good sense. It hardly needs a lot of pondering to conclude that if things are being done that are wasteful they should stop. Low-hanging fruit abounds, and small savings could follow from picking it.

Sooner or later, a political leader in health will realise, as did Moses, that health is not about activity-based funding for brick-making or the price of clay or straw. The ultimate purpose of the health care system, including and especially general practice, is to practise sane, sound, effective health care for the community.

That should be the starting point for comprehensive policy work. Oh, I sympathise if that sounds like a lot of work, but it is a lot of work. Policy is hard work. Blowing a thought bubble or two is easy. Will Moses please stand up?

Better a doctor than a bean counter

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

In what seems like a case of crying over spilled milk, Terry Barnes, the former advisor in the Howard Government, who likes to claim he kicked off the recent MBS co-payment debate, has criticised the appointment of former AMA President Dr Steve Hambleton to lead the Primary Health Care Advisory Group.

Mr Barnes has reason to be personally concerned. Should the Government start listening to the expertise of those with frontline experience in the delivery of health care when developing health policy, then self-proclaimed policy experts might justifiably be nervous.

> "The AMA has its plan for improving care for patients with chronic and complex needs, and has been in ongoing discussions with the Government around chronic disease reform"

Along with the formation of this group, Health Minister Sussan Ley also announced a comprehensive review of the Medicare Benefits Schedule (MBS). The AMA is happy to support a process that seeks to modernise the MBS, as opposed to one with the primary objective of saving money.

For some time now, we have been actively considering how caring for the chronically ill could be better targeted, supported and funded. The AMA has its plan for improving care for patients with chronic and complex needs, and has been in ongoing discussions with the Government around chronic disease reform.

The Primary Health Care Advisory Group has been tasked with investigating new options for funding care for people with complex and chronic illness. This will include looking at innovative care and funding models. Any reforms must focus on appropriately funded patient-centred and GP-led comprehensive, quality and coordinated care.

The Department of Veterans' Affairs (DVAs) Coordinated Veterans' Care (CVC) program is one such model. This program supports GPs and the general practice team to proactively manage and coordinate primary and community care for Gold Card holders most at risk of an avoidable hospitalisation. This program was developed drawing on the work of the Primary Care Collaboratives, the Coordinated Care Trials, and in consultation with GPs.

How can we better reward and support quality care? It is a question that the AMA has been considering for a while. Incentives that support continuous quality improvement will contribute, as would a funding system that encourages and supports longitudinal care. The challenge is ensuring patient care is enhanced and not compromised.

Models that encourage tick-a-box medicine, that restrict patient access to needed care, that dictate provider, that deny access to Medicare benefits, and that interfere with the doctor/patient relationship would be unacceptable to the AMA. Reforms must also recognise that not all the work involved in caring for patients is done with the individual patient in front of you.

Coordinating patient care pre- and post-hospitalisation, following up on diagnostic testing, liaising with specialists, pharmacists, other allied health providers and family members, are all critical elements of quality general practice, yet go largely unrecognised in current funding arrangements.

With the challenges of an ageing population and the increasing incidence of chronic disease, now is the time for greater investment in general practice. If the Government does find savings from its review processes, these must be channelled back into health care – including more funding support for general practitioners to do what they do best.

How to best fund general practice into the future is an issue that will be further explored at the AMA National Conference, to be held in Brisbane on 29 to 31 May, particularly in the session *Funding quality general practice – is it time for change?*

Irresponsibility propagated by the media is denying patients care

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

I, like most GPs, have seen patients refuse scientifically validated care on the basis of almost magical beliefs that a diet of fruit juices and dietary supplementation can beat cancer, or other ailments.

It is hard to quantify the annual morbidity and mortality from such misinformation, but it is significant.

Worse still, those propagating such information often do so for personal gain. The recent, much-publicised example of Belle Gibson is not a lone example of such toxic behaviour. So called "natural medicine" is rife in Australia, where we are guesstimated to spend up to $2 billion a year on "alternative care".

Many bogus remedies are promoted via the internet, and mainstream media run with some of the more sensational poultices and treatments, adding to their credibility.

I most certainly believe in freedom of information, but this should come with a responsibility not to misinform. When misinformation is undertaken for personal gain and leads to demonstrable harm, there should substantive penalties, including prison terms.

So what of the internet providers, mainstream media and publishers who carry such harmful content? What is their responsibility? To merely wash their hands with a "buyer beware" caveat is about as morally defensible as a police officer turning a deaf ear to a crime victim.

And what are our politicians, ever keen to ramp up regulation of health professionals, doing to stop the rot and redirect public money spent on nonsense medicines towards better health outcomes? In two words "damn little".

They also believe in the hands off, "buyer beware" approach as being an intrinsic protector. Phraseology such as, "if it seems too good to be true, do not trust it" abounds.

Sadly, such a, "let's leave it to people's commonsense" approach is not working.

If you as a patient are, say, offered a 90 per cent cure rate with surgery, chemotherapy and radiotherapy, all of which involve some pain to get the gain, or are given a testimonial that you can be cured with no pain and simply dietary change, the choice is not an easy one.

In this day and age, it should be made much easier for Australians to make informed health decisions with easily understandable, freely available, online, up-to-date information for patients, funded by Government and which must be broadly publicised.

Silence is consent, as the hospital posters plastering our walls tell us. The behaviour we ignore is that which we accept.

It is time to take the gloves off and stop tip-toeing around the lucrative mega business that is the "natural" health industry.

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

Reclaiming our future

BY DR DANIKA THIEMT, CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

To have striven, to have made the effort, to have been true to certain ideals — this alone is worth the struggle - *Sir William Osler*

'*Back in my day*...' is a phrase that every doctor in training is familiar with. Whether it ends with '*...I used to work 60 hour shifts*', or '*...people used to die of this condition*', it is blindingly clear that the medical world that you and I are a part of today is not the same one that our senior colleagues entered upon their graduation.

> "I watch my colleagues promote primary health, fight for the health of those in need, or give up their own needs to change the health of someone else, and I am struck by just how powerful we can be as a profession"

I found myself using a similar phrase just last week. While I didn't jump to the cliché bestowed upon me by others many a time, I did find myself imparting wisdom about a medical world we left behind just a few short years ago, and was struck by the speed in which our environment is changing.

As I watch medicine evolve around me, it is easy to be proud of a profession that gives everything they can to their patients. I watch my colleagues change medical practice with their research, marvelling at all the names I recognise in the *Medical Journal of Australia* every month. I watch my colleagues battle day in and day out to make clinical practice just a little safer or more efficient.

I watch my colleagues promote primary health, fight for the health of those in need, or give up their own needs to change the health of someone else, and I am struck by just how powerful we can be as a profession.

Conversely, some days make it hard to remember that we work in one of the best health systems in the world. Some days, I watch the hospital system that I belong to bursting at the seams, with more patients and more doctors than ever before.

I watch my over-worked colleagues fight an impossibly bureaucratic system, just to achieve something that they believe is in the best interests of their patients. Put simply, I watch a health system in crisis being propped up by the hard work of those with limited resources and a whole lot of patience.

As we draw near to the 2015 AMA National Conference, this idea of change remains central. When we gather in Brisbane next week, the AMA hopes to provide a platform for Australia's leading doctors to share their ideas on how we preserve the health system in the midst of this changing landscape.

This year, CDT's policy session, '*General Practice Training – Reclaiming Our Future*' looks at the recent plight of our general practice colleagues. This session will explore the impact of the abolition of General Practice Education and Training Ltd, the expansion of GP training places and proposals for governance arrangements with a view to making some clear recommendations about GP training and governance.

The only constant to all of this change is that none of it comes about through inaction. It only comes about through the hard and persistent work of those who want to change the system for the better. It is those who stand for what they believe to be right to whom we owe the most; both in what is right for their patients, and what is right for our colleagues.

While I watch the medical world evolve around me, I can't help but think about what it will look like tomorrow.

I urge you to consider the change that you would like to see when you look back in years to come, and to be part of that change.

The AMA and CDT will continue to fight for our profession, for our health system and for our patients. Join us today to help shape medicine tomorrow.

AMA continuing support for public hospital employed Members

BY DR ROD MCRAE, CHAIR, AMA COUNCIL OF SALARIED DOCTORS

More than two years ago, Treasury's Not-for-profit Sector Tax Concession Working Group (WG) released a consultation paper reflecting upon various tax concessions for the not-for-profit (NFP) sector.

The main area of concern for salaried doctors was Fringe Benefits Tax Concessions.

At that time, the AMA and the Australian Salaried Medical Officers Federation made a joint submission supporting the retention of current concessions and highlighting how essential it would be to have a cautious approach to any potential taxation reforms in this area.

The submission noted that public hospitals rely on salary packaging arrangements to ensure that they can compete with the private sector for medical practitioners (and other staff), and any changes would effect recruitment and retention in the public hospital sector.

The submission also highlighted the particular significance of any changes for regional hospitals, the additional administrative and compliance burden they would create, and the impact on industrial entitlements.

The Working Group's final report conceded that removing the concessions altogether without arrangements to provided similar support would have a significant impact. It proposed an alternative support payment to employers, possibly through the tax system, to replace these FBT concessions.

Soon after it was elected, the Abbott Government announced that it would no proceed with tax changes for not-for-profits, and instead said the issue would be addressed as part of its White Paper on tax reform.

In March this year, Treasurer Joe Hockey announced a 'conversation' on tax by releasing the *Re:think Tax discussion paper.*

The AMA is once again concerned by the possibility the Government will consider changes that will undermine salary packaging arrangements for our members, which are now such an extremely important consideration in the employment terms and conditions for salaried doctors.

The AMA supports a fair, efficient and equitable taxation system, and believes the current tax concessions available to the NFP sector strike a sensible balance and reflect practical public policy by supporting the recruitment and retention of qualified and experienced staff in areas that would otherwise struggle to be able to compete with the private sector.

As State and Territory health budgets dwindle, NFP tax concessions are a relatively small way in which the Commonwealth can contribute to the smooth operation of public hospitals without the impost of direct funding.

> "Public hospitals are far too important for us all to fall victim to cheap political point-scoring"

The loss of experienced staff that could occur if FBT and other tax concessions are withdrawn would do immeasurable damage in terms of quality health outcomes, teaching and research in a sector already under great stress from multiple "efficiency dividends".

History has shown that our health system requires solid long-term strategies to remain efficient, as opposed to quick-fix initiatives underpinned by a drive for cost-cutting. Changing the current tax concession arrangements is unlikely to lead to any improvement in patient care.

This taxation review, like the last one, needs to proceed with caution and ensure that it thoroughly assesses the impact of potential reforms, including downstream effects.

It isn't all about achieving a notional line entry in a balance sheet. Public hospitals are far too important for us all to fall victim to cheap political point-scoring.

The AMA will be making a submission on this current discussion paper, as will many other concerned organisations, and I trust that good judgment will prevail and not permit interference with this ultimately small fiscal issue when balanced with the health care of the nation.

Managing the AMA List

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

The AMA List of Medical Services and Fees (the List) plays a significant role in lobbying Government on what it costs to provide medical care. It also provides an important and valuable tool for doctors to assist us with our fee setting and indexation.

Historically, items in the List have broadly aligned with items on the Medicare Benefits Schedule (MBS) by applying Government decisions for funding of medical services as amendments and additions to the List.

But the Government's increasing tendency in recent years to look for ways to curb spending on health has changed the nature of its funding decisions. Typically, Government changes are no longer by way of simple amendments and additions, but now involve further restrictions and limits on how items may be used.

Consequently, there has been a need to develop a new approach to managing the AMA List and how it should align with the MBS in the future.

The first significant deviation from the Government's traditional MBS approach was in 2007 when it introduced a specific age-limited item for the Healthy Kids check on the Medicare schedule.

Since that point, governments of both persuasions have pursued budget and health reform agendas that have severely limited the MBS by not allowing or significantly delaying many clinically appropriate procedures from being included on the Schedule.

A clear example was sacral nerve stimulation for urinary incontinence, which was recommended for MBS funding in 2008 but was not introduced on the Schedule until almost 18 months later.

Governments have also withdrawn MBS funding for clinically relevant services by justifying the measure as a minor procedure that should form part of a standard consultation. We saw this with the removal of joint injections.

In the years since, we have also seen governments include brakes on health spending by imposing further restrictions to item descriptors and placing additional caveats on how services can be delivered. Typically, such restrictions have not been specific recommendations of the Medical Services Advisory Committee, but have been introduced by the Department of Health to limit health expenditure.

As time has passed, it has become more difficult to maintain alignment of the AMA List with the MBS.

To maintain the List as a tool to demonstrate the costs of medical care, and to assist us in our fee setting, there is a need to set key principles for managing the List, rather than just automatically accepting Government policies.

This has included identifying circumstances where the List should no longer automatically align with the MBS because:

- the Government either delays or withdraws Medicare funding for clinically relevant medical services on the MBS;
- the medical specialty groups propose changes to MBS items to reflect current clinical practice, and the Government defers implementation of the changes;
- the service does not reflect appropriate clinical practice or is not listed on the MBS but is considered by the AMA as being a clinically relevant service; or
- the MBS service:
  - + is required to be performed according to specified clinical guidelines;
  - + precludes the billing of a consultation on the same day;
  - + specifies the training, qualifications and/or competencies of the treating medical practitioner; or
  - + is restricted to particular requirements of other Government programs, such as the Pharmaceutical Benefits Schedule.

In this regard, the AMA welcomes the Government's recent announcement of the MBS Review Taskforce and Primary Health Care Advisory Group to consider how services can be aligned with contemporary clinical evidence and improve health outcomes for patients.

We are also pleased that both groups will be led by eminent and highly-regarded clinicians, and will be based on frontline medical evidence and experience. We hope that a positive outcome of these reviews will enable better alignment of the MBS and the AMA List.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Cash-strapped hospitals face FBT threat

Public hospitals could be hit by tax concession changes that would undermine their ability to attract and retain staff, the AMA has warned.

AMA Vice President Dr Stephen Parnis has urged the Abbott Government to proceed cautiously amid speculation that hospitals are being targeted to have their fringe benefit tax concessions reduced or abolished.

Dr Parnis said public hospitals relied heavily on the concessions to help them compete with the private sector in recruiting and retaining doctors and other highly trained staff.

"Traditionally, public hospitals have been a less attractive area of practice for doctors because private sector work generally attracts greater remuneration when compared with the salaries and conditions available to most doctors who work primarily in public hospitals," he said. "Ill-conceived and rushed reforms could significantly affect the ability of public hospitals to recruit and retain staff."

Even before any tax concession changes are made, there is mounting evidence that the public hospital system is under strain.

The AMA's Public Hospital Report Card, released a day before Prime Minister Tony Abbott met with the nation's premiers and chief ministers, showed that elective surgery waiting times remain stubbornly high (for the fourth year in a row the national median waiting time in 2013-14 was 36 days), admission delays remain unsatisfactory and the proportion of beds per population is shrinking.

Hospitals are missing key performance targets even before major Commonwealth funding cuts hit. In last year's Budget the Government announced changes that Treasury figures show will rip $57 billion out of the public hospital system in the next 10 years.

AMA President Associate Professor Brian Owler warned the looming funding cuts would create "a perfect storm" for public hospitals already struggling to cope, and would cause patient waiting times to blow out.

"Public hospitals and their staff will be placed under enormous stress and pressure, and patients will be forced to wait longer for their treatment and care," he said. "Funding is clearly inadequate to achieve the capacity needed to meet the demands being placed on public hospitals."

Hopes of short-term funding relief for cash-strapped public hospitals were dashed when a meeting of the nation's political leaders last month decided to defer discussions on the issue to a special retreat to be held in July.

Mr Abbott convinced his State and Territory counterparts to delay talks on health financing for consideration as part of proposals to reform the Federation.

Mr Abbott said the country needed to take a "very holistic look" at the way it funded public hospitals to ensure "we get the best possible value for our dollar, because we're under pressure".

"Sure, the states and territories are under pressure for their hospital funding, but we're under pressure for our tax take," the Prime Minister said. "No-one is volunteering to pay more tax. So, we need to handle this in a way which acknowledges the need for ever-better health services, but which also appreciates that resources are not unlimited, and that's what we want to be able to discuss in an honest and candid and collegial way as part of the leaders retreat later on in July."

In a letter to Assistant Treasurer Josh Frydenburg, Dr Parnis urged the Government to take a similarly considered approach to any change to hospital tax concessions.

He said the current framework of concessions have developed over 25 years to support the ability of hospitals to recruit and hold on to high-quality staff.

He warned any watering down of FBT or other tax concessions would hit regional hospitals particularly hard.

The Federal Government has already initiated a review of the overall tax system, and Dr Parnis said there should not be any pre-emptive changes to tax arrangements until the process had "run its course".

"It would be premature for the Government to do anything until this work is completed, [and] it would be disruptive and counterproductive to hit the overburdened public hospital sector with another shock," the AMA Vice President said.

ADRIAN ROLLINS

PHNs give many Medicare Locals new lease of life

Medicare Locals are involved in more than half the organisations selected by the Federal Government to succeed them, details of successful Primary Health Network applicants show.

The 28 preferred Primary Health Network operators announced by Health Minister Sussan Ley include at least 18 in which Medicare Locals are a dominant or major partner, including

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for PHNs in Northern and South Western Sydney, North West Melbourne, Gippsland, South Brisbane, Adelaide, Perth (both North and South), Tasmania, the Northern Territory and the ACT.

The Government has committed $900 million to create 31 PHNs to replace Labor's Medicare Locals scheme, which is being shutdown following the results of the Horvath Review that found many were top-heavy, expensive and failed in their primary goal of supporting seamless patient care.

Ms Ley said that, by being much more closely aligned with the boundaries of state Local Hospital Networks and having a clearer focus on outcomes, the PHNs would ensure far better integration between primary and acute care services.

The Minister said the PHNs would work directly with GPs, hospitals, other health professionals and the community to ensure better care, including by reducing the merry-go-round of treatment experienced by many patients with chronic and complex conditions.

"Primary Health Networks will reshape the delivery of primary health care across the nation," Ms Ley said. "The key difference between Primary Health Networks and Medicare Locals is that PHNs will focus on improving access to frontline services, not backroom bureaucracy."

But, ironically, Medicare Locals appear to be the backbone of many of the consortiums that have successfully tendered to operate PHNs – a fact acknowledged by the Minister.

Many of the successful PHNs were harnessing skills and knowledge from a range of sources, including allied health providers, universities, private health insurers and "some of the more successful former Medicare Locals".

"There's no doubting that, individually, there were some high-quality Medicare Locals across the country," Ms Ley said. "However, there were also plenty that haven't lived up to Labor's promise."

The AMA was a leading critic of Labor's Medicare Local scheme because it had limited the involvement of local GPs.

At the time the Horvath Review was released, AMA President Associate Professor Brian Owler said that while some individual Medicare Locals had performed well in improving access to care, "the overall Medicare Local experiment has clearly failed, largely due to deliberate policy decisions to marginalise the involvement of GPs".

Concerns have also been expressed that private health funds might try to use PHNs to interfere in the provision of primary care, and insurers Bupa and HCF have been involved in supporting tenders for four PHN consortia, including the Partners 4 Health consortium in Brisbane North, and the WA Primary Health Alliance covering the three Western Australian PHNs (Perth North, Perth South and Country WA).

But, according to an investigation by *Medical Observer*, the insurers will have no operational role and were involved strictly as support players.

Partners 4 Health is the trading name of Metro North Brisbane Medicare Local (MNBML), and Chief Executive Abbe Anderson told *Medical Observer* HCF and Bupa were just two of many groups that had backed the successful application from her organisation.

"While MNBML has the support of a wide range of key participants – including those listed – I think we had over 30 organisations that provided us with letters of support and endorsement in our application," Ms Anderson said. "But the PHN itself will be governed and managed by the same organisation that has been running the ML since its inception."

ADRIAN ROLLINS

Ley wants 'bipartisan national approach' to mental health

The Federal Government wants to set up an all-government working group dedicated to overhauling the nation's dysfunctional mental health system following a searing critique from the National Mental Health Commission.

Health Minister Sussan Ley said the Commission's "disturbing" analysis showed clear failures in the system, and argued the need for a co-ordinated national approach to improve the care of the mentally ill.

"The National Mental Health Commission's Review...paints a complex, fragmented, and in parts, disturbing picture of Australia's mental health system," Ms Ley said. "I acknowledge there are clear failures within both the mental health sector and governments, and we must all share the burden of responsibility and work together to rectify the situation."

The Minister said the scale of the problem meant it required more than a band-aid approach, and that consultation and collaboration between governments was essential.

"I intend to seek bipartisan agreement to revive a national approach to mental health at tomorrow's COAG meeting of Health Ministers," she said.

Health on the hill

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In its four-volume report, released by the Government last month after copies were leaked to the media, the Commission questioned the effectiveness of almost $10 billion spent each year on mental health services, and urged an increased focus on prevention and early intervention.

"It is clear the mental health system has fundamental structural shortcomings," the review said. "The overall impact of a poorly planned and badly integrated system is a massive drain on peoples' wellbeing and participation in the community."

The Commission has argued that changing to a "stepped care approach", with a major focus on prevention and early intervention, would reduce the severity and duration of mental health issues, ultimately slowing demand for expensive acute hospital care and lowering the incidence of long-term disability.

Controversially, the Commission recommended the Commonwealth reallocate "a minimum" of $1 billion from acute hospital funding to community-based mental health services from 2017-18.

But AMA President Associate Professor Brian Owler has rejected the suggestion, warning that public hospitals were already under-resourced. The AMA's annual Public Hospital Report Card showing the nation's hospitals are struggling to meet performance benchmarks under pressure from a remorseless increase in demand from patients and a squeeze on funding.

The Report Card found there had been improvements in patient waiting times for treatment, by the AMA President warned these gains were threatened by the Federal Government's move to take almost $3 billion from public hospital finding by 2017, and to cut the indexation rate of its subsequent contributions.

A/Professor Owler said the changes were creating a "perfect storm" for the nation's public hospitals, and would inevitably lead to longer waiting times for patients.

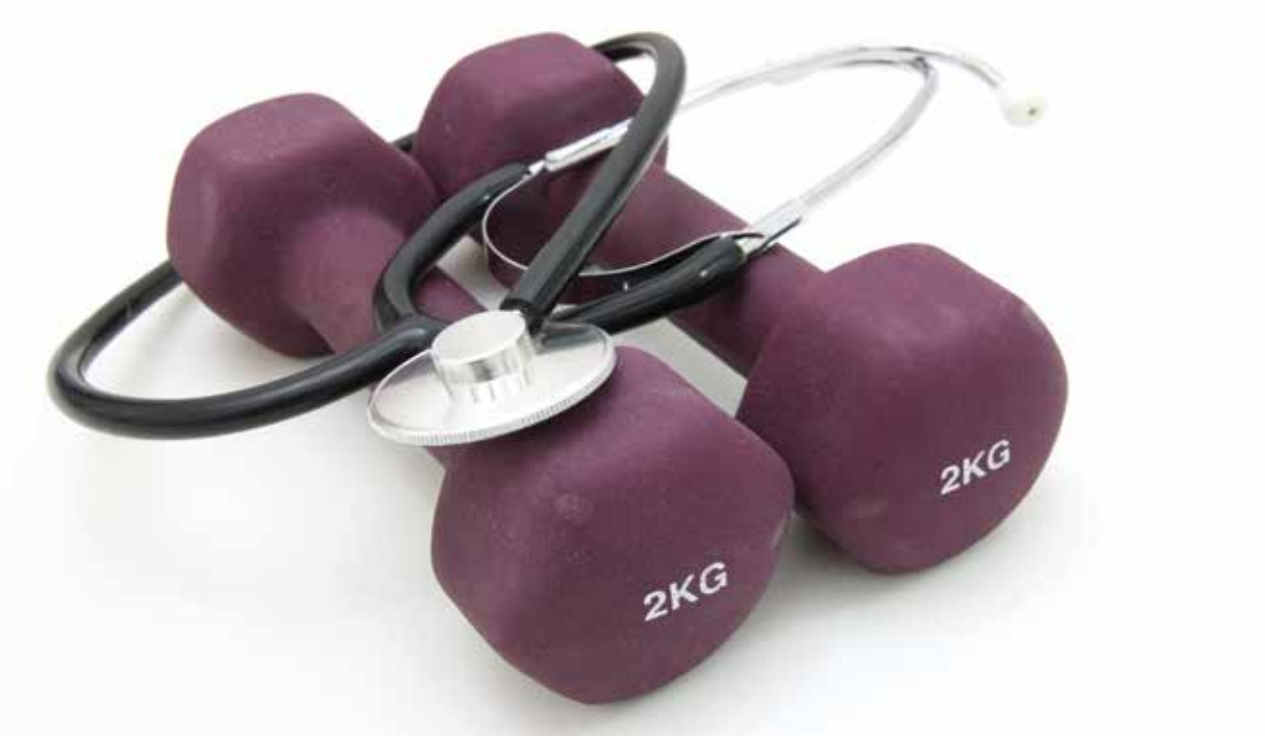
State and Territory leaders are expected to confront Prime Minister Tony Abbott over reduced Commonwealth hospital funding at a special leader's retreat in July. Treasury figures the Commonwealth will short-change them by $57 billion over ten years.

But Ms Ley moved to allay at least some of their concerns by rejecting the Commission's suggestion to reallocate a further $1 billion from hospitals.

"The Government does not intend to pursue the proposed $1 billion shift of funding from state acute care to community organisations, as we want to work collaboratively in partnership with other levels of Government," the Minister said. "While many recommendations offer positive ideas, others are not conducive to a unified national approach."

ADRIAN ROLLINS

GP training – the path ahead



This is a tumultuous time for GP practice and training.

A four-year freeze on Medicare rebate indexation is expected to force many doctors to abandon bulk billing for their patients, and may even threaten the viability of some practices, while the adoption and subsequent abandonment of several different proposals for a patient co-payment have jolted the specialty.

To top it all, the Government has launched a major overhaul of the GP training system, axing key bodies including General Practice Education and Training and the Prevocational General Practice Placements Program (PGPPP) in last year's Budget.

Understandably, it is has been a deeply unsettling period for GPs that has done little to encourage aspiring family doctors to take up the speciality.

In a step toward giving shape to the new training system, Health Minister Sussan Ley last month revealed the Australian General Practice Training program would be delivered through 11 training regions, and announced the creation of the profession-led General Practice Training Advisory Committee to advise the Government on the design and delivery of training.

In addition, a tender process to select GP training providers for each of the regions is to get underway in time to enrol students in 2016.

But there remain many unanswered questions about the provision of GP training - the AMA, for example, has proposed a community residency program for junior medical officers to fill what it sees as a gaping hole left by the abolition of the PGPPP.

The issue of GP training and what can be done to attract trainees and ensure they get a quality education will the focus of discussion during a key session at the AMA National Conference being held in Brisbane from 29 to 31 May.

The *General practice training – the future is in our hands* session, to be held on Saturday, 30 May at 2.15pm, will feature presentations from leading GP practitioners and educators.

On the following pages, three of the presenters, Dr Penny Need, Dr Sally Banfield and Dr Danielle McMullen, give their views on what lies ahead for GP training and the specialty.

GP training – the path ahead

Quality selection, training vital to safeguarding GP future

By Dr Penelope Need, Director of General Practice training at Southern Adelaide Local Health Network; tutor in Medical Professional and Personal Development, University of Adelaide; Partner, Pioneer Medical Centre, Tea Tree Gully, South Australia.

General practice training is having its first shake up since the implementation of the training providers more than 10 years ago.

The last couple of years have seen large numbers of applicants. General practice is a specialty of choice for many junior doctors. We need to keep it that way.

Quality general practice training is mandatory if we wish to maintain high standards in primary care.

General practice is a challenging career. Future GPs need to be carefully selected and trained to a high standard.

We all know that primary care is the most cost effective area of the health system. Why then is it being targeted for so much reform?

I have a tutorial group of nine year 3 medical students, none of whom have a GP. If these carefully selected medical students don't see the value in general practice then how can the rest of the community?

At interviews, potential GP registrars can tout "continuity of care", but is this still a reality?

Access is a real issue in general practice at the moment. Chronic disease management, and an aging and increasingly overweight and mentally distressed population puts a strain on well-meaning general practitioners.

The current model of funding rewards throughput. Is this what we want to see into the future? Are we going to be palliating our own patients or leaving it to the ambulance officers?

Pharmacists are providing vaccinations, physiotherapists are requesting referral rights. Why? How has this gap been created that someone wants to fill?

That other catch cry of general practice, "holistic care", is also under threat.

The solution to these problems starts with selection. We need to select appropriate individuals. Selecting rural students has been shown to increase rural retention.

We then need to ensure they are adequately trained.

The loss of the Prevocational General Practice Placements Program is a real blow for general practice. It was vital for improving inter-professional communication and respect. Emergency, medicine and surgery are all mandated in internship. Why not primary care? Like anything, until you are exposed to general practice you do not understand the complexity and the challenges.

The AMA is looking at alternative models of reviving prevocational exposure to general practice. I personally feel this is vital for the ongoing health of the profession.

Just because we have a lot of applicants for general practice training does not mean that we will have a lot of quality GPs in another three years. We need to select the right people for the job and train them to a high standard.

Maybe a litmus test - would you be happy to be treated by doctors trained under this program? Don't be like my third year medical students - everyone needs a good GP. Let's just hope there will be enough to go around.

Into the great unknown

Dr Danielle McMullen

As 2015 rolls rapidly on, current and future GP registrars grow ever more nervous about the uncertainties in GP training from 2016.

We've all heard about the GP co-payment, frozen Medicare rebates and planned changes to level B consultations.

But there is another, at least equally important, issue lurking quietly in the corner. In its 2014 Budget, the Commonwealth announced radical changes to GP training across Australia. General Practice Education and Training, which had coordinated and overseen the GP training provided by regional training providers (RTPs) since 2001, closed its doors last December and its functions were transferred to the Department of Health. In December this year, the RTPs will also be wound up, and their replacements are yet to be announced.

The boundaries for the new training organisations have recently been released. But, for current registrars in particular, these raise more questions than are answered given we still don't know who will form these new organisations and what the transition process will look like.

GP training – the path ahead

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The tender process for new training organisations has not yet begun, much less been completed. As the days and weeks and months tick by we grow ever more nervous as to when these doctors will have any certainty about their training location and governance.

In addition to the significant changes to vocational training, the 2014 Budget also scrapped the Prevocational General Practice Placements Program, which was the only avenue for prevocational doctors in their intern or PGY2 year to experience the general practice environment. This gaping hole in the general practice workforce pipeline will result in fewer interested GP trainees, and throw general practice back to being an option of last resort.

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

Change is coming – that is for certain. And time is running short but it's not out yet. We need urgent clarity and real consultation to plan and shape the future of general practice training in Australia.

In the short term, registrars need certainty around the transition to new training organisations. In the longer term, we need to ensure these organisations continue to provide the high quality, flexible general practice training we've become accustomed to.

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

Changes to the GP training environment

By Dr Sally Banfield, an Australian College of Rural and Remote Medicine (ACRRM) trainee with Northern Territory General Practice Education in Central Australia, and is likely to complete vocational training in 2016 with an AST in remote medicine.

Like any changes, those made to the GP training environment in last year's Federal Budget pose obvious threats but significant opportunities.

The medical community needs to remain united to sustain high-quality training and meet the diverse health needs of our country. To improve the training system, the experience, feedback and input of trainees is essential.

GP registrars often encounter undifferentiated patients and are required to make decisions on their own early on in their careers. We rely heavily on a broad prevocational training experience, followed by a well-structured and supportive vocational training program.

Currently, the delineation of training responsibilities between Government, colleges, regional training providers and the individual is often difficult to navigate.

Large variations in the delivery of vocational training programs mean confusion and often frustration for the registrar trying to meet the requirements for Fellowship.

As trainee numbers increase, both supervision and education capacity is being stretched, and new training methods need to be explored and shared between providers. This can all be improved in this time of change.

Current issues include defining the training and education roles of the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine and the regional training providers.

The potential for greater college involvement could provide a more seamless general practice training pipeline, with a stronger link to our profession and our colleagues.

Ultimately, we need a system that challenges, supports and mentors registrars to meet the requirements for safe independent practice.

The sustainability of the 'apprenticeship model' of training relies on a system that supports the large investment supervisors, educators and registrars put into excellence.

The newly formed GP Training Advisory Committee must continue to foster medical education, supervision and research opportunities for trainees.

The profession must work closely with Government to ensure the ultimate goal of meeting health equality for our community.

This change to the GP training environment can place further focus on drivers for servicing the most disadvantaged. We should use our increasing evidence base to influence selection and training delivery to drive change in workplace shortages.

This will need support from all sectors of the health care system across the training pipeline.

The transition will create points of tension and hurdles to overcome; but we should use this as an opportunity for development.

The Government and the medical profession need to continue to involve future general practitioners in this conversation. Collectively, we have the vision and the passion to meet the future needs of our community.

TPP close to clearing major hurdle

The controversial Trans-Pacific Partnership trade deal has moved a large step toward completion after a last-minute deal between Republicans and the White House looks close to delivering President Barack Obama crucial “fast track” authority to negotiate the agreement.

The TPP, which would encompass 12 countries – including Australia - that together account for about 40 per cent of global production, has been mired in controversy over the secrecy of negotiations and concerns it will contain provisions that increase the cost of life-saving drugs by extending pharmaceutical patents and will enable companies to challenge governments that enact public health policies such as tobacco plain packaging.

Congressional leaders have agreed on the terms of a Bill that would give President Obama Trade Promotion Authority, which is crucial to the future of the TPP because it would give him the power to negotiate a deal that would be subject to a simple yes-or-no vote in Congress, with no amendments.

This would give other negotiating partners, including Australia, confidence that the negotiated terms of the agreement would not be subsequently changed by political horse-trading in Congress.

But the vote on the Bill could be close.

While most Republicans in the Congress – where they hold a majority in both chambers – are expected to support the Bill, the TPP is fiercely opposed by many Democrat members of Congress because of concerns the agreement would lead to job losses and lower wages, particularly in the country’s embattled manufacturing industry.

And analysts warn that the terms of the Bill impose lengthy delays in getting any trade accord approved, with the possibility that it might not reach Congress until October, when the selection process for presidential candidates will be well underway, increasing the risk the TPP will become a political football among presidential hopefuls.

Under the deal struck by the White House with the Republicans, the President will have to notify Congress of the accord’s completion 90 days before he intends to sign it, and the full agreement will have to be made public for 60 days before the president gives his final assent and sends it to Congress. Congress could not begin considering it for 30 days after that.

ADRIAN ROLLINS

TPP fears despite Government assurances

There is mounting disquiet the massive Trans-Pacific Partnership trade deal will saddle the country with more expensive medicines and hobble public health measures despite assurances to the contrary from the Federal Government.

Public health experts have warned a leaked draft of the deal's investments chapter show the agreement would enable companies to sue governments over public health policies that harm their interests.

La Trobe University public health expert Deborah Gleeson, Australian National University Professor of Health Equity Sharon Friel and ANU Research Fellow Kyla Tienhaara wrote in *The Conversation* that although the draft chapter contained a footnote specifying Australia would be exempt from so-called investor-state dispute settlement provisions, this exclusion was conditional and limited.

The analysis came as the World Medical Association Council passed a resolution calling on government's negotiating trade deals to ensure that public health was prioritised over commercial interests by including wide exclusions for health policies and did not include provisions that compromised access to medicines and diagnostic, therapeutic and surgical techniques.

In particular, the WMA urged governments to oppose provisions to allow patenting of diagnostic, therapeutic and surgical techniques, the prolongation of patents by making minor changes to existing drugs, and the manipulation of patent conditions to block the entry of generic substitutes.

Trade Minister Andrew Robb has insisted the Government will not sign up to any deal that make the country worse off, and has negotiated 'carve-outs' from the investment provisions for health and environmental public policy.

Senior Coalition Senator Marise Payne told the Senate on 18 March that the Government would "not accept any outcome in the TPP that would adversely affect Australia's health system".

"We will not sign up to any international agreement that restricts the Australian Government's capacity to govern in Australia's own interests," the Senator said.

But AMA Vice President Dr Stephen Parnis told the ABC's *7.30 Report* that "the details really matter here".

"If he [Mr Robb] says the PBS is protected but the agreement extends intellectual property rights or patent laws I favour of pharmaceutical companies, then the reality will be the opposite," Dr Parnis said.

Dr Gleeson and her colleagues warned that not only are carve-outs for Australia in the agreement still up for negotiation, but are they limited to specific areas such as the Pharmaceutical Benefits Scheme, the Medicare Benefits Scheme, the Therapeutic Goods Administration and the Office of the Gene Technology Regulator.

They said the very broad definition of investments used in the TPP could well leave the Commonwealth exposed to the sort of legal action launched by major tobacco companies against the country's ground-breaking plain packaging laws.

The experts said a safeguard in the draft chapter to protect actions taken by governments to protect public health and safety included a loophole of a kind that was already being used by US investors in a case against a national park in Costa Rica.

"The problems and loopholes characterising the latest leaked TPP draft throw doubt on the Government's claims that it's taking the concerns of health stakeholders as seriously as the interests of big transnationals," Dr Gleeson and her co-authors said. "They highlight exactly why it's vital for the draft text to be made public and subjected to independent scrutiny before it is signed."

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Historic collection of radiology material

Interested in the history of radiology and radiation oncology?

The Royal Australian and New Zealand College of Radiologists houses one of the largest collection of historic material in Australia.

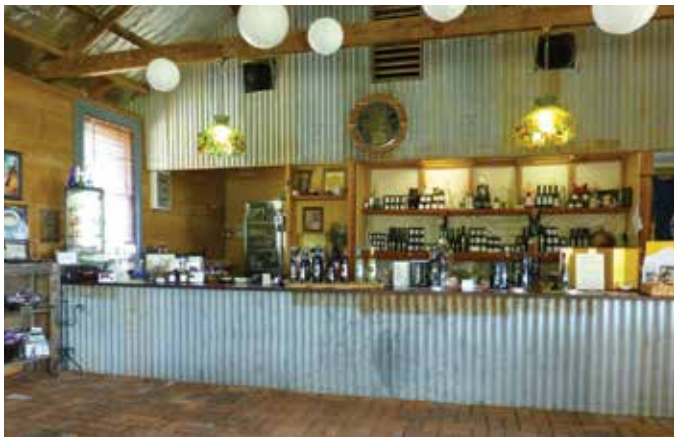
The Trainor/Owen Collection is a combined library, archive, and museum housing unique material relating to the history of radiology and radiation oncology.

The Collection includes an original print of Roentgen's report of his discovery of X-rays, early human and veterinary X-rays, historic apparatus and equipment, mementoes and ephemera including medals and stamps, photographs, rare books and deposited personal papers.

So on your next trip to Sydney, contact the Royal Australian and New Zealand College of Radiologists Archivist to organise a visit or contact them to pick their brains over all things radiology – archives@ranzcr.edu.au, 02 9268 9725.

Wicked virgins in Rutherglen

BY DR MICHAEL RYAN



Never let a wine tasting opportunity go by. While watching my daughter play water polo in Albury, the wife and I had a window to sneak off to the historic town of Rutherglen. Gold and wine are classic combinations throughout Victoria.

In the 1860s, Lyndsay Brown started some four hectares of plantings. Amid the gold rush he was credited with saying "*Dig, gentlemen dig, but no deeper than six inches, for there is more gold to be won from the top six inches than from all of the depths below*".

The Rutherglen area seemed perfect for fortifieds such as Muscats and Toquays. The terroir, including hot days and cool nights, gives the grapes its own ethereal stamp, with ripe fruit and acid production. These multi-decade aged fortifieds are akin to liquid gold.

The waning fortified market in the 1950s saw the vineyards close to extinction. But the area's vingerons adapted by producing table wine, and ever since Rutherglen has been sneakily producing blockbusters. It is known for Durif, a table wine which is a cross of Shiraz and Peloursin that was created by Dr Durif in 1880 in Montpellier. It has mildew resistant properties.

Olives have been prolific in the area, as exemplified by the Wicked Virgin Olive Grove and Boutique Winery five minutes from the center of town. More important to me has been its wine production under the label of Calico Town; named after the sea of tents in the gold rush. John and Laurel Nowacki established olives and vines in 1999. They were school teachers, turned publicans.

It was a pleasure to meet them, together with winemaker Andrew Briedis on our recent visit. The tannin-stained hands of the men was testament to their close connection with the vintage - they hand pick and hand make the wines. Laurel is a sensational cook and I challenge any one to find better slow cooked lamb shanks than hers.

The cellar door is a converted shearing shed. It has some stained glass windows giving it a heavenly touch. The walls are adorned with memorabilia. The winery also includes the newly appointed Wicked Virgin Cottage, which provides ideal accommodation for touring tasters, and the century-old still has been luxuriously appointed and decorated with local artistic works.

WINES TASTED

1. 2013 "The Kimberly" Trebbiano

A light yellow color. Oozing white peach notes with grassy citrus overtones. Gentle fruit flavors with moderate acid make this an excellent lunch wine. Have with a goat's cheese salad.

2. 2014 The Miners Daughter

While rose in colour, technically this is a light Shiraz. Oodles of strawberries, perhaps some five spice, makes this an alluring wine. Gentle tannins hold up the restrained fruit. Mesmerizing wine that cuts its own groove; needs a margherita pizza.

3. 2013 The Prospektor

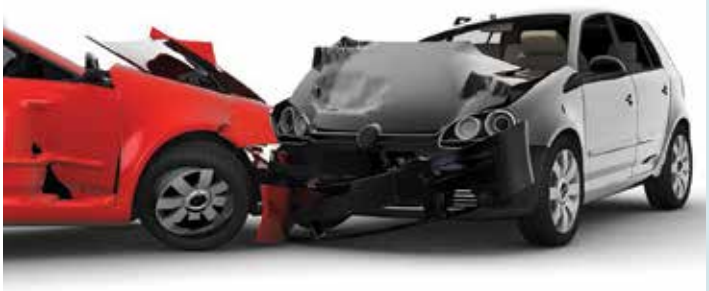
A blend of Durif, Sapperavi (an old tannic Georgian grape) and Shiraz. Notes of spicy plums and red cherries. Earthy, brambly aromas add complexity to its bouquet. The ripeness of Shiraz is voluptuous, the rustic Durif adds complexity, and the Sapperavi gives structure. The blending makes this a great example of a winemaker's wine. Perfect with Laurel's lamb shanks.

4. 2012 Heritage Durif

Inky dark purple. Stewed plums, licorice, earthy tobacco notes fill the bouquet. Secondary notes of herbs start to reveal themselves. This is a plush wine with well-structured tannins aged in French oak. It sits in the Shiraz- Zinfandel spectrum of big wines. Awesome aging potential. Enjoy with hard aged cheeses and dark 70 per cent chocolate.

Premium case of diminishing returns

BY **DR CLIVE FRASER**



It's almost five years since it became mandatory for all doctors in Australia to have medical indemnity insurance.

I come from the low tax state, Queensland, where it was never essential to have indemnity insurance, though public Queensland doctors had always had discretionary cover for work performed at a public hospital.

The discretionary nature of that cover was tested at times, leading to a bitter dispute between Visiting Medical Officers and Queensland Health.

At that time, I was unimpressed by the disingenuous nature of Queensland Health's insurance, and ventured onto talk-back radio to vent my spleen.

I was introduced as "Doctor Bruce from the Sunshine Coast", lest my true identity become known and my employer discipline or dismiss me for daring to speak publicly.

My point back then was that if I wasn't properly insured, then the patients weren't covered either.

Next time I'll have to choose a more discrete moniker because, after getting off the air, I had three friends call me to ask whether that was yours truly on the radio.

I do recall as a medical student being told to never practice without insurance, and it was always my routine to ask colleagues who they were insured with before entering into an on-call arrangement.

As more international medical graduates arrived from countries with differing degrees of litigation, this became a more interesting conversation.

One newly-arrived colleague told me that he was indemnified "by the Church" who owned the hospital that he worked at.

Could there be any better cover than that, I wondered!

It's hard to imagine how anyone would even dream of practising as an un-insured doctor, but national legislation eventually mopped up the recalcitrant.

In the same breath, it doesn't make sense to not insure your car, or does it?

Having owned a car that is 18 years old and worth about $3000 (if I'm lucky), I have dutifully forked out $750 every year for fully comprehensive cover.

At first that seemed cheap, when I considered that my car had cost me $68,000 in 1997.

But that $750 has seemed to become increasingly steep as my car drifts further south in value.

Unlike lawyers who have a four-figure excess on their indemnity policies, doctors don't pay any excess at all, which will always be comforting when that inevitable writ arrives.

I've just done the maths with an on-line tool that tells me I have a 42 per cent chance of having a complaint made against me to a regulator in the next two years, which reminds me that I must practice even more defensively.

In my practice, that might mean refusing to see anyone where there might be any risk of self-harm or any possibility of a side-effect arising from the prescribing of complex medication regimes.

It's a bit like owning a car but never driving it, just in case you have an accident.

Excesses in motor vehicle insurance can be steep. My current policy carries an excess of $600 for myself, and another $1300 if an un-listed driver younger than 18 years crashes my car.

That means I'm paying a premium of $750 a year for a car which, if written off, might return me a payout of $1100.

I've done my sums and decided to down-grade to a third party property policy for $150, and to keep the number of the wreckers in my glove box if I have a bingle.

Well done I thought.

There is, after all, no point in paying for insurance you don't really need.

Now that brings me to reviewing my life insurance.

Do I really need it?

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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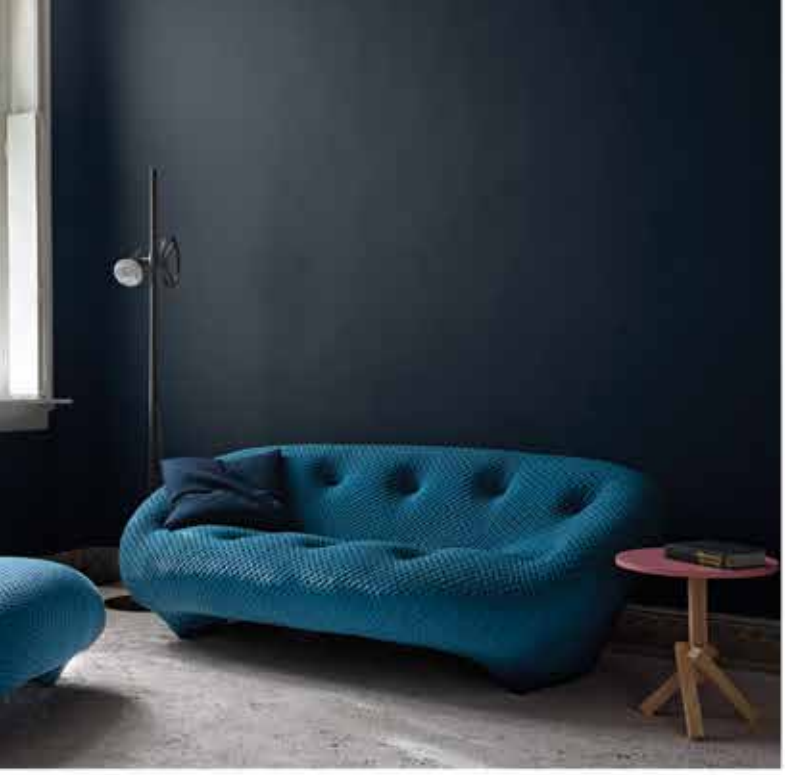

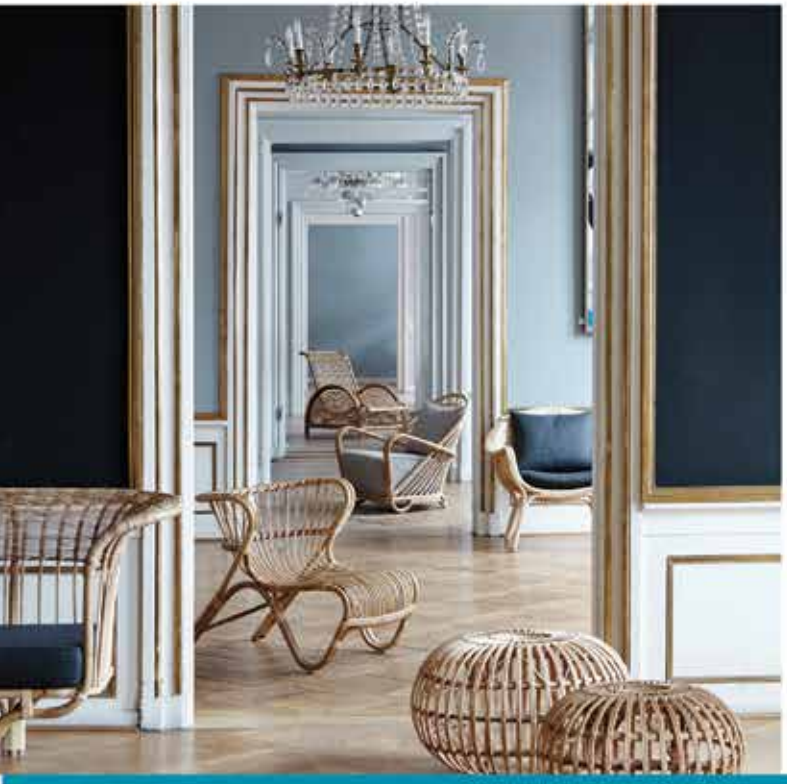

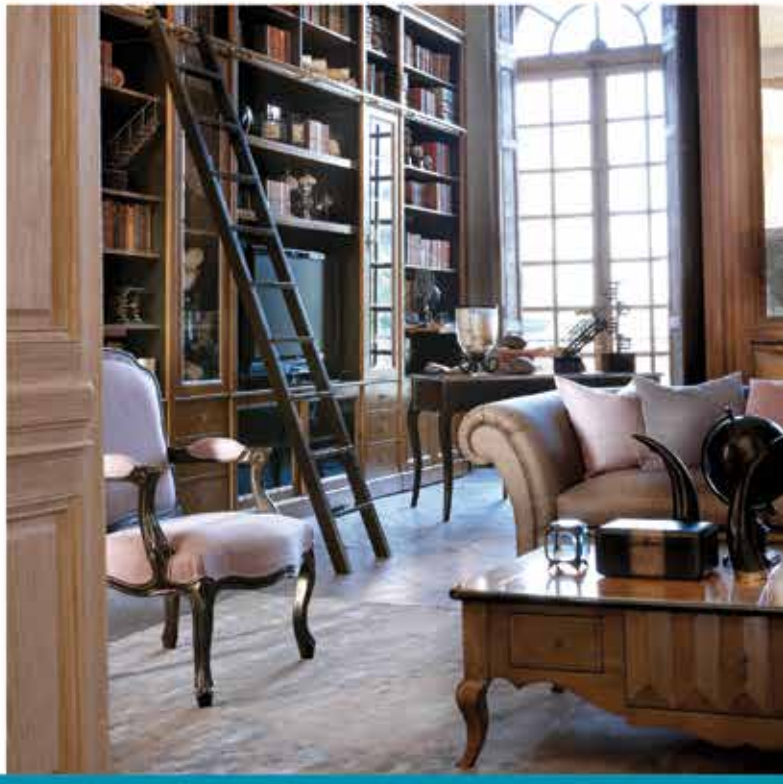

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