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AMA Family Doctor Week 2015

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YOU AND YOUR FAMILY DOCTOR: THE BEST PARTNERSHIP IN HEALTH

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Practices dumping bulk billing as Medicare rebate freeze bites

Pensioners and the chronically ill are being charged up to $30 to see their GP as cash-strapped medical practices squeezed by the Federal Government's Medicare rebate freeze are being forced to abandon bulk billing and begin charging even their most disadvantaged patients.

In a development that bears out warnings from AMA President Professor Brian Owler that the four-year rebate freeze for GP services amounted to the introduction of a GP co-payment "by stealth", numerous doctors and practice managers have contacted the AMA to report how they had been forced to increase patient charges – and in at least one case, shut down – because of a growing shortfall in the Government's contribution to the cost of care.

Among them is Tasmanian GP Emil Djakic, whose Ulverstone and Penguin practices have just introduced a $30 charge for the hundreds of patients who had previously been bulk billed.

Dr Djakic said it was a difficult decision given the tough financial circumstances of many of his patients, but the practice's own financial position made it unavoidable.

He said that absorbing the full impact of the Medicare rebate freeze would have cost the practice $60,000 a year – $240,000 if it remains in place for four years – which would have undermined its viability.

"In our practice, we have charged those who are better off to help provide services at a discount for those less well off," Dr Djakic said. "But we have now reached an inflexion point, triggered by the rebate freeze, where it is increasingly unaffordable."

The practice, which has a 10 full-time equivalent GP workforce, has been bulk billing about 75 per cent of patients. Under changes that came into effect from 1 July, every patient will be charged a $30 fee for the first consultation of the financial year. Any subsequent charges are at the discretion of the individual practitioner, though Dr Djakic said staff were asked to be mindful of the growing gap between the value of the rebate and practice costs in deciding whether or not to ask for a contribution.

Dr Djakic said the practice was bracing for an increase in defaulted payments, but added that so far patients had been surprisingly receptive to the change.

He said the lack of widespread outrage showed the Federal Government had been "incredibly deft" in introducing this latest version of a GP co-payment.

"Just from the viewpoint of a political exercise in shifting costs onto the patient from the Government, it has been very elegant," Dr Djakic said.

While some practices are increasing patient charges, others are succumbing to the accumulated financial strain caused by the ever-diminishing value of the Medicare rebate.

In Redfern, doctors operating a small practice that has served the community for 34 years have made the painful decision to shut down.

Dr Marie Healy, who for the past 11 years has worked at the practice owned and operated by Dr Adrian Jones, said rising running costs, inadequate Medicare rebates and the inability of a high proportion of patients to pay a gap fee had over time made the practice's financial position increasingly perilous.

"Yes, Redfern house prices are very high, but there is still a lot of disadvantage here," Dr Healy said. "We have a lot of patients who are concessional, are elderly, who have chronic diseases, who have diabetes and who are on multiple meds."

Dr Healy said she bulk billed around two-thirds of her patients because they could not otherwise afford the care they need, and the Federal Government's original plan to impose a $7 patient co-payment had sent many "into a tizz and caused a high level of anxiety".

She said two years ago the practice introduced a gap fee for non-concession patients, concession patients seeking a second opinion, and patients who needed a mental health plan, and it increased the charge on 1 July.

Last year, to further trim costs, it dropped out of the practice accreditation system because it was "too costly".

But Dr Healy said that, with such a high proportion of patients on concession cards who were simply unable to pay, the extra revenue from gaps fees proved to be insufficient to keep the doors open.

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Practices dumping bulk billing as Medicare rebate freeze bites

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The accumulated financial pressure from years of increasingly inadequate Medicare rebates meant that when the rebate freeze came into effect, it was the proverbial straw that broke the camel's back, she said.

"Adrian Jones is a very conscientious and ethical doctor who is always doing stuff free for patients – visiting an elderly patient at home because they can't come in, filling out forms for them – but it all hits the bottom line, and we just can't keep doing it."

Other practices have indicated they can no longer afford to bulk bill patients and have, or soon will, begin charging patients – including full pensioners – a fee.

In addition to abandoning bulk billing, many are also looking to cut costs and make savings, including by trimming work hours, deferring equipment and facility upgrades and purchases, and reducing services.

The Government expects the Medicare rebate freeze will save it $1.3 billion by mid-2018, but Professor Owler said that cost was simply being dumped onto patients and doctors.

"This funding shortfall has to be met by patients and practices," he said. "While the rebates have remained unchanged, the costs of providing quality medical services, such as wages for practice staff, rent, electricity, technology, and insurance are increasing every year. Medical practices cannot absorb these increasing costs for four years in a row and remain viable."

Dr Healy said she felt the rebate freeze was part of a general assault by the Federal Government on primary health care that was particularly difficult to stomach when it had recently concluded an $18.9 billion, five-year deal with the pharmacy sector.

The AMA President warned the freeze would also have a significant effect on private health insurance, including forcing up premiums.

"Some private health insurers have indexed their schedules of medical benefits, which means they are covering the Government's shortfall, but others will not index their medical benefits until the Government lifts the freeze," he said. "This will put upward pressure on the costs of medical services and private health insurance premiums."

ADRIAN ROLLINS

Patients, doctors forced to mind the gap as rebate freeze bites

Many private health funds are refusing to index their benefits while the Federal Government persists with its Medicare rebate freeze, adding to the financial pressure on medical practitioners and their patients.

While health insurer HCF has launched a "known gap" scheme, in addition to its existing "no gap" schedule, to help offset the effects of the ongoing Medicare rebate freeze, other funds are holding steady, fuelling fears increasingly inadequate benefit payments will force doctors to either close down or raise patient out-of-pocket costs.

In a statement released to mark the third year since Medicare rebates for specialist consultations and operations were last indexed, and the passing of the first year of a projected four-year freeze on GP rebates, AMA President Professor Brian Owler warned that the Government's policy threatened the viability of many practices.

Professor Owler said the Government was using the rebate freeze, which will save it $1.3 billion over four years, to transfer the increasing cost of providing care onto doctors and their patients.

"The rebate indexation freeze is a co-payment by stealth," he said. "While the rebates have remained unchanged, the costs of providing quality medical services continue to rise. This funding shortfall has to be met by patients and practices."

While the Medicare rebate has been held flat, underlying inflation is growing at an annual rate of 2.35 per cent, wages are increasing by 2.3 per cent and the cost of hospital and medical services are rising by 6.5 per cent a year.

"Practice costs such as wages for practice staff, rent, electricity, technology, and insurance are increasing every year," the AMA President said. "Medical practices cannot absorb these increasing costs for four years in a row and remain viable."

Professor Owler said the Medicare rebate freeze was also having a significant effect on private health insurance, including forcing up premiums.

Some health funds have decided to index their benefits despite the freeze on Medicare rebates, but others have held theirs down unless or until the Commonwealth increases its payouts.

Health fund HCF has responded to the stand-off by introducing a known gap scheme to complement its existing no gap arrangement with many practitioners.

Doctors signing up to the known gap deal will receive a smaller benefit from HCF than those participating in the no gap scheme, but will have the option of charging HCF-insured patients and out-of-pocket expense.

The known gap arrangement came into effect on 1 July and HCF has asked providers to nominate either it or the no gap scheme. They cannot be part of both.

See also MBSfreeze puts onus on health funds to do the right thing, p21

ADRIAN ROLLINS

Future of public hospitals up for grabs at leaders' retreat

Radical plans that could see the Federal Government dump all responsibility for public hospitals onto the States or pay for hospital treatment through a Medicare-style benefit scheme are up for discussion when Prime Minister Tony Abbott meets with his State and Territory counterparts at a special leaders' retreat later this week.

The Prime Minister called the retreat to discuss reform of the Federation, and the division of responsibility for health services, particularly the funding and operation of public hospitals, is expected to be a central plank of the talks.

Since coming to office, the Abbott Government has engaged in a high-stakes stand-off with the States and Territories over public hospital funding. In its first Budget, it disowned funding guarantees made under the National Health Reform Agreement and reduced the indexation of post-2017 funding to CPI plus population growth, ripping $57 billion out of the public hospital system over 10 years.

The move is seen as part of a broader gambit by the Federal Government to pressure the states into looking at alternate sources of revenue, including increasing the GST or broadening its base.

Treasurer Joe Hockey last week increased the pressure on the States by declaring that each level of government should be responsible for raising the revenue needed to pay for the services they provide.

Mr Hockey said reforms discussed at the leaders' retreat must include "the States taking responsibility for their own budgets in order to ensure they can afford their ever-increasing expenditure – such as the costs of their public hospital systems as our population ages".

The tactic has echoes in the Government's current strategy - likened by AMA President Professor Brian Owler to introducing a patient co-payment "by stealth" – to freeze the indexation of Medicare rebates until mid-2018, forcing many practices to cut bulk billing and introduce or increase patient charges in order to remain financially viable.

The AMA is a fierce critic of both policies, and Professor Owler – who will deliver a nationally-televised address to the National Press Club wednesday - warned of an "impending crisis" for the nation's public hospitals unless more money was injected into the system.

Professor Owler said public hospitals were facing a "perfect storm" of increasing demand, missed performance targets and major funding changes.

"The combination of these factors will have devastating consequences for our public hospital system," he told the AMA National Conference in late May.

State and Territory leaders, particularly NSW Premier Mike Baird, are similarly outraged by the Federal Government's tactic. Mr Baird warned earlier this year that the States simply "do not have the capacity to meet those health costs on their own".

The Queensland Government estimates the Commonwealth's decision to claw back public hospital finding will leave the State $11.8 billion worse off by the middle of next decade, with serious consequences for the quality and availability of care.

"Unless these federal funding cuts are reversed, there will be a shortfall in funding for Queensland hospitals – and a resultant decline in the quality and timeliness of services – from July 1, 2017," it warned.

It is in this heated atmosphere that the leaders are expected to discuss ideas for future hospital funding, including those prepared by the Department of Prime Minister and Cabinet.

In its Green Paper, it makes five suggestions, including the Federal Government shifting full operational and funding responsibility for public hospitals onto the States and Territories, the creation of an MBS-style hospital benefits scheme, jointly funded individualised patient care packages, or the establishment of a single national or regional agencies to purchase health services.

Grattan Institute Health Program Director Professor Stephen Duckett and colleague Peter Breadon said introducing a Hospital Benefits Schedule was a promising idea that could see a return to shared incentives by exposing both the Commonwealth and States to the cost of growing demand for hospital care.

Although many of the factors forcing health costs up have little to do with the structure of the Federation, the *Reform of the Federation Green Paper 2015* said improving the way the health system was funded and operated could improve prevention and care while making better use of funds – particularly by providing funding on the basis of outcomes rather than activity.

Professor Owler said that, whatever the funding model that might be developed, it needed to ensure public hospitals were

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Future of public hospitals up for grabs at leaders' retreat

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given the resources they need to meet the growing demand for care while also providing the quality teaching and training that the next generation of doctors required.

He said that pushing responsibility for public hospital funding back to the States and Territories without providing them with the means to generate more revenue would be "irresponsible".

Mr Baird declared public hospital funding was the most significant finance issue facing the States and Territories, and Professor Owler said he was particularly concerned about prospects for the smaller jurisdictions, some of which had areas of significant disadvantage and inequitable access to care, but which had limited revenue-raising capacity to fund improvements on their own.

"If the planned changes [announced in the 2014 Budget] go ahead, there will be serious consequences for frontline clinical services," he said.

ADRIAN ROLLINS

How to pay for health?

Government funding reform options (as set out in Department of Prime Minister and Cabinet's *Reform of the Federation 2015 Discussion Paper*)

Option 1

States and Territories handed full responsibility for public hospitals – the Commonwealth would withdraw all funding.

Option 2

Hospital benefit scheme

The Commonwealth would establish an MBS-style benefits scheme to fund a proportion of the cost of each hospital procedure, with the States and Territories asked to cover any gap between benefit and service cost.

Option 3

Individual care packages

The Commonwealth, States and Territories jointly fund individualised care packages for patients with, or at risk of developing, chronic or complex conditions.

Option 4

Regional Purchasing Agencies

The two tiers of government would jointly establish agencies to purchase health services for patients in their catchment areas.

Option 5

National Health Purchasing Agency

Commonwealth-funded agency to commission full suite of services, from primary through to acute, to meet community need.

Signs not good for flu season

The nation's top medical officer has issued an urgent call for people, particularly vulnerable groups including pregnant women, the elderly and those with chronic illnesses, to get vaccinated against the flu amid signs the nation is headed for its worst season on record.

Official figures show that so far this year more than 14,124 have caught the flu – double the long-term average for the period – and a third higher than for the same time last year.

In a worrying sign that the flu season is gathering momentum, figures compiled through the National Notifiable Diseases Surveillance System show that in in just one month, from 5 June to 6 July, an extra 4911 laboratory-confirmed cases were reported, including almost 2000 in the first week of July.

Underlining the seriousness of the illness, the Health Department said it had so far been notified of 36 deaths associated with influenza since the beginning of the year, with the likelihood that number will rise sharply as the rate of infection accelerates.

Commonwealth Chief Medical Officer Professor Chris Baggoley specifically urged people considered to be at risk, including those aged 65 years and older, Indigenous Australians, pregnant women, and those with cardiac disease and chronic respiratory conditions and illnesses, to take advantage of the free vaccine provided by the Government.

"Flu is highly contagious and spreads easily from person to person, through the air, and on the hands," Professor Baggoley said. "We need to get higher uptake [of the vaccine] among these groups."

The Chief Medical Officer emphasised the importance of doctors and other health professionals in helping ensure people were vaccinated against the disease.

"Immunisation is still the best form of protection from influenza, and health care professionals play an essential role in ensuring high uptake," he said.

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Signs not good for flu season ... from p7

> "There have been claims that the delay to the vaccination program has contributed to the strong start to the flu season by leaving a large number of people unprotected"

The National Seasonal Influenza Immunisation Program began late this year because of a rare double strain change in the vaccine to cover two new strains of the virus - one of which caused havoc in the northern hemisphere.

In the US alone, around 100 children were reported to have died from the flu during the northern flu season, and there was also widespread illness among the elderly.

For the first time under the national immunisation program, Australians have access to single-dose vaccines covering the four most common flu viruses, including three quadrivalent formulations.

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

There have been claims that the delay to the vaccination program has contributed to the strong start to the flu season by leaving a large number of people unprotected, and Professor Robert Booy of the Influenza Specialist Group told the Herald Sun fewer people had been vaccinated that "we would have liked".

But Health Minister Sussan Ley said the Government was ahead of where it was last year in acquiring vaccine doses.

Ms Ley said that so far in 2015 4.5 million doses had been bought under the National Immunisation Program, 200,000 more than were distributed in 2014.

She did not say how many of these doses had been administered.

Ms Ley said the flu season usually peaked in August and September which, given that it usually takes around three weeks following vaccination to develop immunity, meant people needed to get themselves vaccinated as soon as possible.

Promisingly, early figures suggest vaccinations are helping to reduce the number and severity of infections.

The pilot Flu Tracking surveillance system, a joint University of Newcastle, Hunter New England Area Health Service and Hunter Medical Research initiative that collects data from a weekly online survey, has so far identified only low levels of influenza infection.

But it found that 3.4 per cent of those not vaccinated against the flu suffered fevers and coughs, and 2.1 per cent had to take time off work, while among those vaccinated, 2.7 per cent had coughs and fevers and 1.6 per cent reported having to take sick leave.

The results underline calls from AMA Vice President Dr Stephen Parnis for people, particularly elderly and vulnerable patients and health professionals, to make sure they are vaccinated against the flu.

Dr Parnis said it was important for doctors, nurses and other health workers to get the flu vaccine, for the sake of their own health as well as that of their patients

ADRIAN ROLLINS

Medibank throws weight around as hospital talks break down

The nation's biggest insurer has been accused of behaving like a school yard bully after a breakdown in contract negotiations with a group of private hospitals.

In a development industry players warn could result in patients with chronic and complex conditions being forced out of the private hospital system, Medibank Private has insisted on strict contract clauses that would exonerate it from paying benefits for "highly preventable adverse events".

> "Private hospitals have accused the insurer of exploiting its market power to increase profits rather than benefit its policyholders"

The issue hit headlines earlier this month when the insurer, which was privatised last year, walked away from talks with Calvary Health Care after the Catholic provider did not accede to its demands.

Private hospitals have accused the insurer of exploiting its market power to increase profits rather than benefit its policyholders.

Australian Private Hospitals Association Chief Executive Officer Michael Roff said Medibank Private's take it or leave it approach to negotiations with Calvary was unreasonable and "arguably unconscionable, given Medibank's market power. It will not help the thousands of Australian patients who are their customers."

Medibank has drawn up a list of what it describes as "highly preventable adverse events" such as falls and infections that should be covered by health providers rather than the insurer.

But Calvary said Medibank's demands were unreasonable because many of the 165 outcomes included on the list were common complications.

Mr Roff said Medibank had developed the list without input from the industry.

"It appears that much of it is not based on accepted clinical standards or evidence-based data, and does not consider the risk profile of particular patients," Mr Roff said.

He said if hospitals caved into Medibank's demands, the insurer would not pay, or would provide a reduced benefit for, incidents including infections in cancer patients who are undergoing treatment that leaves them vulnerable to infection, and bleeding and haemorrhage in patients with blood clotting disorders.

"If Medibank is serious about improving safety and quality in healthcare as opposed to improving its profitability, it would work collaboratively with hospitals, doctors and experts in the field through processes and structures that already exist in correctly defining the 'highly preventable adverse events'," he said. "We challenge Medibank to subject its list to the independent review of an authoritative body such as the Australian Commission for Safety and Quality in Healthcare. Failure to do so will indicate they are putting shareholder interests ahead of the welfare of their members."

But Medibank said it has insisted on the contract conditions as a way of providing hospitals with incentives to provide quality care.

In a letter sent to doctors with patients at Calvary Health Care hospitals, Medibank's Executive General Manager of Provider Networks and Integrated Care, Dr Andrew Wilson, said the insurer was committed to "working collaboratively with medical specialists to ensure our members receive quality health care outcomes".

"We understand that the medical profession wants to provide the highest quality health care to Australians," Dr Wilson wrote. "Medibank supports this goal by negotiating contracts that have the right incentives to ensure the hospitals where you work deliver the best care and outcomes for our members."

But Mr Roff warned that demands by Medibank that providers pay for patient readmissions within 28 days of a procedure could force private hospitals to become much more selective about admissions.

"If Medibank does not reconsider its current approach, it may result in private hospitals reluctantly reviewing their service mix and not offering services for complex cases," he said. "It is possible this could lead to more complex patients and those with chronic conditions being forced to rely on the public system."

Health industry analysts view the episode as evidence of a swing in the balance of power away from hospitals toward insurers, though Medibank has yet to test its hard-line position in negotiations with the nation's two largest private hospital groups, Ramsay and Healthscope. Contracts with these two groups are not due for renewal until next year.

ADRIAN ROLLINS

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

Medibank-Calvary contracts stand-off: what it means for doctors and patients

Medibank Private Ltd has announced that its contract with private hospitals operated by Calvary Health Care will end on 31 August this year.

Medibank cited a breakdown in negotiations over the rates Medibank pays for services provided by Calvary hospitals and new quality criteria for the failure to renew the contract, while Calvary has stated the new demands are financially rather than quality driven.

> "Medical practitioners can call Medibank's dedicated 'doctor hotline' on 1300 130 460 for further information"

This will not affect the fees paid by Medibank to medical practitioners.

However, medical practitioners will need to ensure patients insured with Medibank seek information directly from Medibank about their out-of-pocket costs for accommodation, theatre and other items if they are admitted to a Calvary Health Care hospital.

Medibank has advised that it will continue to pay benefits for hospital expenses at the current contracted rates for any procedures pre-booked before 31 August, for a period of:

- nine months if the pre-booking is obstetrics-related
- six months if the pre-booking is to treat a chronic condition, e.g. chemotherapy or dialysis
- two months for all other pre-booked admissions.

After this, Medibank will pay previously-contracted Calvary Health Care private hospital expenses at 'second tier' rates which are set at 85% of Medibank's average contracted rate.

Medical practitioners can call Medibank's dedicated 'doctor hotline' on 1300 130 460 for further information.

GEORGIA MORRIS

My Aged Care changes

This is a sponsored article provided by the Department of Social Services as part of Family Doctor Week

A number of changes to the aged care system came into effect on 1 July this year that will have an impact on older people and may affect the way you refer these patients.

The improvements to the aged care system include better access to aged care services via My Aged Care, the new Commonwealth Home Support Programme (CHSP) and the expansion of Consumer Directed Care (CDC) for all Home Care Packages.

My Aged Care

From July 2015, if you are discussing a patient's aged care needs or concerns you can refer them to My Aged Care who can assist your patient with information and support to find appropriate services that meet their needs.

My Aged Care is an Australian Government initiative which supports older people and their families in accessing aged care information and services.

The My Aged Care functions have been expanded to make it easier for people to access information, have their needs assessed and be supported in accessing aged care services. The new functions include:

- electronic referrals to service providers reflecting client preferences, and
- a central client record – accessible by the client, their representatives, and relevant assessors and service providers.

Information is contained on the My Aged Care website (www.myagedcare.gov.au) and contact can be made via the national phone line (1800 200 422) which operates from 8.00am to 8.00pm weekdays and 10.00am to 2.00pm on Saturdays local time, wherever a person lives.

For information about referring patients to My Aged Care, visit the Department of Social Services website at www.dss.gov.au/MyAgedCare.

Commonwealth Home Support Programme

The new Commonwealth Home Support Programme (CHSP) provides entry-level home support for older people who need assistance with daily activities to help them remain living independently at home and in their community. Carers of these patients also benefit from the programme.

Key features include:

- streamlined, entry level support services such as cleaning, washing and making meals; and
- standardised entry and assessment through My Aged Care.

Home Care Packages and Consumer Directed Care

For patients with more complex long term needs, a Home Care Package may be more appropriate. Home Care Packages provide a coordinated range of personal support and clinical services that are tailored to meet individual needs.

Services include:

- personal services such as bathing and showering;
- help with nutrition, hydration, meal preparation and diet;
- management of skin integrity;
- continence management; and
- help with mobility and dexterity.

All Home Care Packages are now delivered on a Consumer Directed Care (CDC) basis.

CDC gives the patient more choice and flexibility. It means they will have more control over the types of care and services they access and the delivery of those services, including who delivers the services and when.

For more information about the changes, or to refer a patient, go to www.myagedcare.gov.au or call the My Aged Care contact centre on 1800 200 422 (Mon-Fri 8am to 8pm, Sat 10am to 2pm), from anywhere in Australia.

Energy drinks deliver deadly jolt to heart

Young people turning to heavily-caffeinated energy drinks to fuel themselves for partying, sport or just to get through the day are putting themselves at heightened risk of heart attacks and chronic heart problems.

In a finding that suggests the marketing and consumption of so-called energy drinks should be much more tightly regulated, a detailed American study of their use has found they are associated with "adverse cardiovascular events", including sudden and deadly heart attacks, ruptured arteries, heart arrhythmia, tachycardia and elevated blood pressure, particularly among adolescents and young adults.

It came as the mother of a teenager who died from cardiac arrhythmia after consuming two cans of Monster Energy Drink every day for three years has launched a wrongful death suit in Alameda County, California, against the manufacturer in a case that could set a legal precedent for the marketing and regulation of energy drinks.

"By unleashing the new 'beast' of energy drinks, we have now seen significant morbidity and mortality in susceptible patients," the study's authors said. "Young consumers are at a particularly high risk of complications due to hazardous consumption patterns, including frequent and heavy use."

The study, *Cardiovascular complications of energy drinks*, published in the latest edition of the journal *Beverages*, documented numerous cases where people died or suffered serious cardiovascular problems after consuming energy drinks.

These include a 28-year-old man who collapsed while playing basketball after drinking three cans of energy drink five hours before the match. He was rushed to hospital suffering ventricular tachycardia and died three days later.

In another case, a 25-year-old woman with a pre-existing heart valve problem died from intractable ventricular fibrillation after drinking a 55 millilitre bottle of Race 2005 Energy Blast with Guarana and Ginseng. Subsequent tests found the drink contained caffeine at a concentration of 10 grams a litre – more than 60 times that in cola drinks – and the caffeine in the woman's bloodstream was concentrated at 19 milligrams a litre, around double the level found in regular coffee drinkers.

The drinks have also been associated with potentially fatal spasms of coronary arteries. One case involved a man, 28, who drank between seven and eight cans of energy drink over a seven-hour period before and during motocross racing. Soon after he stopped he suffered a cardiac arrest, and was found to have had a coronary artery vasospasm doctors believe was precipitated by high levels of caffeine and taurine in his blood.

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Energy drinks deliver deadly jolt to heart

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In addition to heart attacks and arterial spasms, energy drinks have also been associated with surges in blood pressure that can lead to rupture of arteries, and with the impairment blood vessel linings.

> "... it was clear that consuming energy drinks was associated with "cardiovascular events including death", and urged much greater attention be paid to their use"

The authors said that while some of the cases involved people with pre-existing and underlying cardiac condition, many others did not. They reported the results of a review of 17 cases where people suffered heart attacks or other cardiac "events" after consuming energy drinks and found almost 90 per cent were younger than 30 years of age, and the majority did not have a cardiac abnormality.

While energy drinks advertise high concentrations of caffeine – around 80 milligrams in cans of Red Bull, Monster and Rockstar, and more than 200 milligrams in a 60 millilitre can of 5-Hour Energy compared with around 35 milligrams in a can of cola – researchers said other common ingredients, particularly taurine, which can interfere with the regulation of the cardiovascular system, could also have potentially severe consequences.

The researchers admitted that "confounding variables", such as strenuous exercise, genetic predispositions and the simultaneous use of alcohol or recreational drugs meant that many deaths could not be attributed to energy drinks alone.

But they said it was clear that consuming energy drinks was associated with "cardiovascular events including death", and urged much greater attention be paid to their use.

The US Food and Drug Administration reported 18 deaths associated with energy drinks between 2004 and 2012, and the researchers said that because the FDA reporting system typically captured between 1 and 10 per cent of actual adverse events, it was likely there were at least 180 deaths associated with energy drinks during that period.

Given the widespread consumption of energy drinks – Australia's Food Regulation Standing Committee found that sales of energy drinks in Australia and New Zealand jumped from 34.5 million litres in 2001 to 155.6 million litres in 2010 – the study's authors have called for greater awareness of the danger they present, particularly for young people, who are typically the biggest consumers.

"Children, young adults and their parents should be aware of the potential hazards of energy drinks," the authors said. "Physicians should routinely inquire about energy drink consumption in relevant cases, and vulnerable consumers such as young persons should be advised against heavy consumption, especially with concomitant alcohol or drug ingestion."

The researchers said there was no rigorous scientific evidence that energy drinks boosted energy or improved physical or cognitive performance, and there needed to be public education campaigns to highlight the hazards and dispel the myths about their benefits.

They called for eventual limits on the caffeine content of energy drinks and restrictions on their sale to young people, echoing calls from the AMA and the Country Women's Association.

The AMA has for several years raised concerns about the health effects of energy drinks and their heavy consumption among young people, including children.

In 2013, the-then AMA President Dr Steve Hambleton demanded that the caffeine content of energy drinks be reduced, or their sale restricted to adults, following evidence linking them to serious effects in young people, including tachycardia and agitation.

In 2009, the death of a young woman was linked to caffeine from energy drinks, and a study published in the *Medical Journal of Australia* found 297 calls relating to caffeinated energy drinks were made to the NSW Poisons Information Centre between 2004 and 2010, 128 of which resulted in hospitalisation.

Two years ago the Country Women's Association of New South Wales submitted a petition with 13,600 signatures to Federal Parliament calling for a ban on energy drink sales to everyone younger than 18 years.

Both the AMA and the CWA have highlighted inconsistencies in food standards that limit the amount of caffeine in soft drinks to a maximum of 145 milligrams per kilogram, but impose no similar limit on energy drinks.

ADRIAN ROLLINS

Nation pays high price for unnecessary tests, unproven treatments

Cracking down on inefficient and clinically unnecessary practices like over-ordering diagnostic tests, prescribing inappropriate medications and using unproven or speculative treatments could save the health system more than $15 billion a year, a leading epidemiologist has said.

In a provocative speech to the AMA National Conference in which he called for a transformation in the way in care is conceived and delivered, Associate Professor Ian Scott said up to 30 per cent of health spending was wasteful or went on procedures and treatments that were of little benefit or could actually be harmful.

A/Professor Scott, who is director of Internal Medicine and Clinical Epidemiology at Brisbane's Princess Alexandra Hospital, said while some interventions and treatments, like vaccination programs, public health campaigns, chemotherapy, renal dialysis and some cancer screening programs were effective uses of scarce health funds, the pay-off from many other practices was more questionable.

He questioned the bias in the medical profession to provide intensive care, including "heroic interventions", for very ill patients – 30 per cent of health funds are spent on health care in the last year of life, including $2.4 billion on providing hospital care to the elderly – and suggested a more conservative approach involving a shift in focus away from treatments that do not improve survival beyond six months or enhance quality of life.

One of the oft-cited sources of inefficiency and cost blow-outs in the health system is in the area of diagnosis, including the tendency to over-prescribe diagnostic tests.

Much of this has been attributed to the rise of "defensive medicine", which MDA National Manager of Medico-legal and Advisory Services, Dr Sara Bird, defined as the ordering of treatments, tests and procedures "primarily to help protect the doctor from liability", rather than to substantially advance patient diagnosis or treatment.

Dr Bird, who addressed the same AMA National Conference policy session as A/Professor Scott, said that although the incidence of defensive medicine was difficult to measure, evidence suggested it was widespread.

In the United States, 96 per cent of specialists practising in fields at high risk of litigation confessed to practising defensively, including 43 per cent who reported ordering unnecessary diagnostic imaging tests.

Dr Bird said the situation appeared to be similar in the United Kingdom, where almost 80 per cent of hospital-based doctors said they practised defensive medicine, including 60 per cent who admitted ordering unnecessary tests and 55 per cent who said they made unnecessary referrals.

In Australia, research indicates that doctors who have been the subject of legal action are much more likely to practise defensively – 55 per cent ordered more tests and 43 per cent made more referrals than was considered usual.

A/Professor Scott said that in addition to unnecessary tests, often clinicians provided treatments that were of little or no value.

He lauded the National Prescribing Service's Choosing Wisely initiative, under which so far more than 200 routinely used treatments have been placed under scrutiny.

The Federal Government has also commissioned a review of Medicare Benefit Schedule items, led by Sydney Medical School Dean Professor Bruce Robinson, to scrutinise and assess the appropriateness of more than 5500 listed services.

AMA President Professor Brian Owler has cautiously welcomed the reviews.

Professor Owler said that although it was important to rigorously assess the value and appropriateness of procedures and treatments, it was vital the process was not driven primarily a search for savings, and that it had the support and involvement of medical colleges and societies.

A/Professor Scott warned of "indication creep", where a treatment proved to be of benefit to one group of patients is uncritically applied more broadly , such as cardioverter defibrillators, cardiac resynchronisation pacemakers and transcatheter aortic valves.

He urged a much more considered and cautious approach to the use of new interventions until there was rigorous evaluation of their safety and effectiveness.

A/Professor Scott said told the conference that clinical guidelines should take into account cost-effectiveness in recommending interventions.

He said often less intensive and cheaper management regimes for conditions such as bleeding peptic ulcers and urinary tract infections in children were just as safe and effective as higher-intensity regimens.

A/Professor Scott recommended that analyses of the comparative cost effectiveness be an integral part of the assessment of each new service or intervention.

He told the conference this cost-effectiveness approach should also inform the selection of patients for a particular treatment.

The epidemiologist said interventions should be targeted to those who would derive greatest benefit.

ADRIAN ROLLINS

OBITUARY

Vale Dr David Game, distinguished GP and medicSA editor

Dr David Aylward Game was born in Adelaide on 31 March 1926, the fourth son of a bank manager and a nurse. On 14 May, in his 90th year and having played bridge at the Adelaide Club that morning, he died suddenly at his desk while attending to computer tasks. The table was, as usual, meticulously set for dinner.

David was educated at St Peter's College, Adelaide, and the University of Adelaide, where on his first day he met fellow medical student Patricia Jean Hamilton. They married immediately after graduation and were the first married couple to receive their MBBS degrees on the same day. In 1953, David commenced general practice from their first home on Payneham Road, but as the family grew to include their four children - Ann, Philip, Timothy and Ruth, they moved to Rokeby in Royston Park.

From his early years as a family doctor, David became an advocate for general practice as a specialty in its own right, a cause which became an abiding passion and the source of great achievement. He was a founding member of the Royal Australian College of General Practice, in which he held a number of key roles, including that of President from 1974 to 1976.

In 1980, he received the college's highest accolade, the Rose Hunt Award. He represented the College at a number of international meetings, and in 1970 became involved in the formation of the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians, with its somewhat peculiar acronym WONCA, and was its President from 1983 to 1986.

Among the many anecdotes about David's experiences in these roles with various dignitaries, there is a wonderful story about Prince Philip confusing WONCA with wombat, leading to the establishment of the Honorary Wombat Award for retiring presidents, David's having pride of place in his office.

David was a pioneer for the involvement of GPs in public and teaching hospital work, holding positions at the Adelaide Children's, Modbury and Royal Adelaide hospitals. He is the only GP to have been granted an emeritus appointment at the RAH.

Early in his career, he involved students and family medicine program graduates in his private practice, and between 1991 and 1998 was medical director of the South Australian Postgraduate Medical Education Association. In 1983, he was appointed an Officer in the Order of Australia for service to general practice.

He was a Fellow and Life Member of AMA South Australia, filled many important roles for the SA Branch, and was editor of *medicSA* from 2004 to 2012, during which time it won the award for best State publication twice. His significant contributions saw him awarded the AMA(SA) President's Award in 2006.

This exceptionally generous and caring man is greatly missed, not only by his four children, six grandchildren and four great-grandchildren, but by his colleagues and many friends.

In the weeks since his death, tributes have arrived from around the world and, in particular, from his WONCA colleagues in countries including the United States, UK, Singapore, South Africa, Holland, Nepal, India, Jordan and Ireland.

The AMA honours the work of this distinguished South Australian general practitioner.

** This article was supplied by medicSA, where it was first published last month.*

Putting a DJ in da house

Even in the age of the smart phone and all the information and distractions it puts at a person's fingertips, doctor waiting rooms can be a source of tedium and dread for some.

Stacks of *National Geographic, House & Garden* and *People* magazines can help entertain and divert, and some practices even have a television tuned to the news in the corner.

But the Phonographic Performance Company of Australia (PPCA) says that businesses, including medical practices, often overlook the calming and soothing potential of music in helping pass the time and tempering anxious thoughts.

It has been well established that music can exert a powerful influence on emotions and moods.

A paper looking at the effects of background music (*The effects of background music on health and well-being* by University of London academic Susan Hallam in *Music*, *Health*, *and Wellbeing*, edited by Raymond MacDonald, Gunter Kreutz, and Laura Mitchell, 2012), cited evidence from a range of studies pointing to the many and varied ways people respond to music – often to the benefit of their health.

For instance, a 1995 review of the use of music in hospitals found it was associated with reduced perceptions of pain, anxiety and stress, enhanced the effects of anaesthetics and analgesics and reduced the length of hospitalisation.

In particular, Hallam wrote, calming background music has been shown to have a direct impact on biological indicators of stress such as cortisol and blood pressure, in addition to perceived anxiety).

"Perhaps the most striking example of the power of music to impact on health comes from research on babies born prematurely," Hallam wrote. "In comparison with groups not provided with background music, exposed groups gain weight, increase food intake and reduce their length of stay in hospital."

These findings support the results of research commissioned by the PPCA regarding the benefits of background music to businesses.

The non-profit organisation, which licenses the playing of recorded music in public places, commissioned an online survey of 500 small and medium sized businesses in April and May, 83 per cent of which thought music helped reduce the tedium of waiting for service, and 76 per cent thought it provided a distraction.

But before rushing to install sound system in the waiting room, practices should also be mindful of the potential pitfalls of background music.

Hallam warns that where people do not have control of the music they are subjected to, or where it is a poor 'fit' with their mood, self-perception or needs it can fuel, rather than allay, anxiety.

"If background music is imposed, whether in a public space, in an on-hold telephone situation, or at home it could, in some cases, cause extreme distress," she wrote.

For example, a large survey of people's views of background music played in public places in the United Kingdom found that a third found it annoying (another third reported not noticing it).

More significantly, the hard-of-hearing found background music to be particularly problematic. Eighty six percent reported that it frequently drowned out speech and announcements, which was especially an issue in restaurants.

Another consideration for business is the potential effect on staff. Hallam cited a the results of a survey conducted by the UK Noise Association in 2007 which found that 40 per cent of employees disliked it, almost a third tried to ignore it, and just 7 per cent said they actually liked it.

ADRIAN ROLLINS

AMA in the news

YOUR AMA HAS BEEN ACTIVE ON POLICY AND IN THE MEDIA ON A RANGE OF ISSUES CRUCIAL TO MAKING OUR HEALTH SYSTEM BETTER. BELOW IS A SNAPSHOT OF RECENT MEDIA COVERAGE.

PRINT/ONLINE

Doctors, teachers face gags under immigration laws, *Sydney Morning Herald*, 4 June 2015

Doctors and teachers working in immigration detention facilities could face up to two years in prison if they speak out against conditions in the centres or provide information to journalists. AMA President Professor Brian Owler said this was the first time doctors had been threatened with jail for revealing inadequate conditions.

Medical research fund could be 'slush' fund: Labor, *The Age*, 5 June 2015

The Abbott Government could raid its Medical Research Future Fund to pay for election promises and "pet projects" under proposals before federal Parliament, Labor has claimed. AMA President Professor Brian Owler said decisions about which research projects would be funded needed to be made at arm's length from the minister.

Help for violence victims, *Northern Territory News*, 5 June 2015

A new resource to assist doctors in providing better support for victims of family violence was launched by the AMA at the AMA National Conference. AMA President Professor Brian Owler said the medical profession had a key role to play in the early detection, intervention and treatment of patients who has experience family violence.

Experts fear flu season shaping as the worst on record, *The Saturday Age,* 6 June 2015

The first five months of 2015 have been the worst on record for influenza, with experts warning Australia could be in for a rotten flu season. AMA Chair of General Practice Dr Brian Morton said Australia tended to follow the northern hemisphere's flu season, which had been severe due to the emergence of new flu strains.

Banned flu drug still being given to children, *Sunday Mail Brisbane*, 7 June 2015

A disturbing number of doctors have ignored multiple warnings against administering the flu vaccine Fluvax to children younger than five years, even though there are safe alternatives. AMA President Professor Brian Owler said this risked undermining an otherwise safe vaccine schedule.

Leakedtrade deal terms prompt fears for Pharmaceutical Benefits Scheme, *The Guardian*, 11 June 2015

The leak of new information on the Trans-Pacific Partnership agreement (TPP) shows the mega-trade deal could provide more ways for multinational corporations to influence Australia's control of its pharmaceutical regulations. AMA president Professor Brian Owler said while doctors were very concerned at the possible effects on Australia's health care system, their fears were routinely dismissed by Trade Minister Andrew Robb.

Save the planet for better health, *The Canberra Times*, 24 June 2015

The biggest boost to public health this century could come from action to tackle climate change, such as shutting down coal-fired power plants and designing better cities, according to a Lancet Commission report. AMA President Professor Brian Owler said the Australian health system was not prepared for climate change.

'Whistleblowers' challenge Australia's law on reporting refugee conditions, *CNN*, 2 July 2015

More than 40 doctors, nurses, teachers, and other humanitarian workers have signed an open letter to the Australian government, challenging a new bill that could put whistleblowers in jail for disclosing the conditions of Australian detention centres. AMA President Professor Brian Owler said the act puts doctors in a dilemma when treating detainees and asylum seekers if they have concerns about the provision of their health care.

Medibank dust-up sparks care debate, *The Saturday Age*, 11 July 2015

AMA President Professor Brian Owler said the contract clauses being pushed by Medibank Private that put financial risk for unplanned patient readmissions and preventable falls back on private hospitals are evidence the newly listed market leader has shifted its priority to shareholders.

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AMA in the news

YOUR AMA HAS BEEN ACTIVE ON POLICY AND IN THE MEDIA ON A RANGE OF ISSUES CRUCIAL TO MAKING OUR HEALTH SYSTEM BETTER. BELOW IS A SNAPSHOT OF RECENT MEDIA COVERAGE.

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RADIO

Professor Brian Owler, 666 ABC Canberra, 28 May 2015

AMA President Professor Brian Owler talked about the issues surrounding the bulk billing of GPs. Professor Owler said a doctor can bulk bill and this means they can accept the amounts from Medicare.

Dr Brian Morton, 5AA, 3 June 2015

AMA Chair of General Practice Dr Brian Morton discussed medicines on the drug subsidy scheme will rise in price on July 1. Dr Morton said that any medicine that currently costs consumers less than $36 will be hit by the rise.

Professor Brian Owler, 702 ABC Sydney, 4 June 2014

AMA President Professor Brian Owler talked about Medicare. Professor Owler said there have been a number of reviews but, these have never really been dealt with the schedule as a whole.

Professor Brian Owler, ABC Classic FM, 11 June 2014

AMA President Professor Brian Owler discussed health issues including the “Don’t Rush” road safety campaign, neurosurgery, and vaccinations.

Dr Brian Morton, 3AW, 29 June 2015

AMA Chair of General Practice Dr Brian Morton talked about issues with Dr Google. Dr Morton said it could be beneficial when trying to understand a treatment a patient is undergoing.

Professor Brian Owler, 612, 13 July 2015

AMA President Professor Brian Owler discussed diabetes in Australia. Professor Owler said the majority of type 2 diabetes cases were preventable and encouraged people to eat healthier food and get regular exercise.

TELEVISION

Prof Brian Owler, ABC Brisbane, 29 May 2015

The AMA has warned that doctors’ fees could go up if the freeze on Medicare rebates for GP visits continues, and that even patients with private health insurance could end up paying more

Prof Brian Owler, Channel 9, 31 May 2015

A new online tool to help doctors identify and respond to family violence has been rolled out. The resource launched by the AMA allows doctors to provide information on support services.

Dr Stephen Parnis, Channel 7, 13 June 2015

AMA Vice President Dr Stephen Parnis discussed warnings Victoria was on the verge of a whooping cough epidemic. Dr Parnis said deaths from whooping cough were not common but were entirely avoidable.

Dr Brian Morton, Channel 10, 20 June 2015

AMA Chair of General Practice Dr Brian Morton warned of a spike in emergency department admissions, with the price of some of the most common Pharmaceutical Benefits Scheme prescription medications set to rise.

Don’t let her drink dirty water

World Vision

malaria, typhoid, dysentery, cholera, diarrhoea, intestinal worm infection, ... dirty water can kill.

6,000 children are dying every day – and it’s because they don’t have clean water. So they’re forced to drink water that could make them sick with diarrhoea, cholera and typhoid.

The good news is, problems like dirty water can be solved. You can help children access clean water through World Vision’s Water Health Life program by providing practical and effective solutions.

From $39 a month your support will help drill boreholes, protect water sources and provide health and hygiene training. You’ll be helping communities to make long-term changes that ensure a clean water supply and basic sanitation.

Stop dirty water killing children,support Water Health Life:
visit **worldvision.com.au** or call **13 32 40.**

Water Health Life
Basic Needs. Permanent Solutions

Your AMA Federal Council at work

WHAT AMA FEDERAL COUNCILLORS AND OTHER AMA MEMBERS HAVE BEEN DOING TO ADVANCE YOUR INTERESTS IN THE PAST MONTH:

Name	Position on council	Activity/Meeting	Date
Dr Richard Kidd	AMA Federal Councillor	GP Roundtable telco - MERS briefing	17/6/2015
Dr Gino Pecoraro	AMA Federal Council Representative for Obstetricians and Gynaecologists	Diagnostic Imaging Advisory Committee	19/6/2015
Dr Brian Morton	AMA Federal Councillor, Chair of AMACGP	NMTAN chronic disease subcommittee meeting	23/6/2015
		UGPA	17/6/2015
		Primary Health Care Advisory Group	4/6/2015
Dr Richard Kidd	AMA Federal Councillor	DVA Stakeholder Engagement Design Workshop	16/6/2015
		Aged Care Gateway Advisory Group meeting	12/6/2015
Dr Chris Moy	AMA Federal Councillor	Australian Medical Council Inter-Professional education workshop	9/6/2015
Dr Tracey Soh	N/A - AMA ACT member	PBS Authority medicines review - opioids roundtable	27/5/2015
Dr Omar Khorshid	AMA Federal Council Representative for Orthropaedic Surgeons	MSAC (Medical Services Advisory Committee) Review Working Group on Arthroscopic Hip Procedures	29/5/2015
Dr Roderick McRae	AMA Federal Councillor	ACHS Council meeting	25/05/2015
Dr Stephen Parnis	AMA Vice President	National Medical Training Advisory Network	19/05/2015
Dr Danika Thiemt	Chair AMA Council of Doctors in Training	National Medical Training Advisory Network	19/05/2015
A/Prof Robyn Langham	AMA Federal Councillor - Victoria nominee and Chair of AMA Medical Practice Committee	Australian Health Practitioner Regulation Agency's (AHPRA) Prescribing Working Group (PWG)	7/5/2015
Dr Richard Kidd	AMA Federal Councillor	Aged Care Gateway meeting	4/5/2015
Dr Andrew Miller	AMA Federal Council Representative for Dermatologists	PBS Authority medicines review reference group	13/4/2015
Dr Brian Morton	AMA Federal Councillor, Chair of AMACGP	GP Roundtable	8/4/2015
		UGPA	25/03/2015
		GP Roundtable	17/3/2015
Dr Chis Moy	AMA Federal Councillor	PCEHR Safe Use Guides consultation (KPMG/ ACSQHC)	11/3/2015

Your AMA Federal Council at work

WHAT AMA FEDERAL COUNCILLORS AND OTHER AMA MEMBERS HAVE BEEN DOING TO ADVANCE YOUR INTERESTS IN THE PAST MONTH:

Name	Position on council	Activity/Meeting	Date
Dr Richard Kidd	AMA Federal Councillor	PCEHR Safe Use Guides consultation (KPMG/ ACSQHC)	10/3/2015
Dr Stephen Parnis	AMA Vice President	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	5/3/2015
Dr Antonio Di Dio	AMA Member	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	5/3/2015
Dr Roderick McRae	AMA Federal Councillor - Salaried Doctors	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	5/3/2015
Dr Susan Neuhaus	AMA Federal Councillor - Surgeons	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	5/3/2015
Dr Robyn Langham	AMA Federal Councillor - Victoria nominee and Chair of AMA Medical Practice Committee	Australian Health Practitioner Regulation Agency's (AHPRA) Prescribing Working Group (PWG)	5/3/2015
A/Prof Brian Owler	AMA President	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia	5/3/2015
		Meeting with Royal Australasian College of Surgeons and Australian Plastic Surgery Association Presidents	4/3/2015
Dr Andrew Miller	AMA Federal Council Representative for Dermatologists	MSAC (Medical Services Advisory Committee) Review Working Group for Skin Services	20/2/2015
Dr Chris Moy	AMA Federal Councillor	NeHTA (National E-Health Transition Authority) Clinical Usability Program (CUP) Steering Group	19/2/2015
Dr David Rivett	AMA Federal Councillor	IHPA Small Rural Hospitals Working Group	5/2/2015
Dr Richard Kidd	AMA Federal Councillor - Queensland nominee and MPC Aged Care representative	Gateway Advisory Group	9/2/2015

MBS freeze puts onus on health funds to ‘do the right thing’

BY PETER ARONEY, CEO, DOCTORS’ HEALTH FUND

“Australian Medical Association (AMA) figures show the freeze will save the Government almost $2 billion by mid-2018”

The Federal Government’s four-year freeze on the Medicare Benefits Schedule (MBS) is a bitter pill for doctors to swallow and in some cases, disillusioned patients with private health insurance will face higher out-of-pocket expenses for treatment.

Announced in this year’s Budget, the freeze on Medicare rebates until July 2018, is putting the onus on health funds to ‘do the right thing.’

Health funds face the decision of whether to index their medical schedule - effectively picking up part of the tab for the Government’s savings – or freeze their schedule and pass on the inevitable cost of inflation to their members.

Australian Medical Association (AMA) figures show the freeze will save the Government almost $2 billion by mid-2018, with more than half of this coming from medical specialists, their patients and health insurers as the value of the Medicare rebate declines and the cost of providing care rises.

The cost of indexing

Inevitably, funds that ‘do the right thing’ and index their schedule to maintain the level of cover for their members, face the prospect of applying higher premiums. In light of our consumerism-driven society and a focus on the price of health insurance, it’s difficult for fund members to reconcile more pressure on premiums.

Protecting the doctor-patient relationship

It is important that the medical profession and funds work together to encourage the government to update the MBS so that it realistically reflects the value of medical services. While this dialogue takes place, it is imperative that the keystone of the doctor-patient relationship is protected.

Doctors’ Health Fund is proof that these outcomes can be achieved. Since its inception in 1977, it has shown leadership by being the only fund that pays medical benefits up to the AMA list of medical services and fees on our Top Cover. Doctors’ Health Fund believes that the AMA fees provide fair and reasonable remuneration to doctors for their years of training, expertise and experience. Our fund also supports patients having access to benefits that enables their choice of doctor and deliver a realistic benefit for the work performed by that doctor.

The fallout of not indexing

Alternatively, there could be significant ramifications for members of funds who have not indexed their schedule in line with doctors’ fees. In addition to facing greater out-of-pocket costs for surgery, we could see members increasingly ‘shopping around’ for a treating doctor who will meet their health fund’s medical schedule. Indeed, their health fund may even encourage them to do so. Whilst an informed market is the most efficient in any economic theory, in a care paradigm this has the potential to disrupt the patient-doctor relationship; arguably the cornerstone of any sound and effective health care system.

Coupled with these impacts, is the fact that financial hits due to large out-of-pocket expenses for treatment often come as a surprise to members, leaving them questioning why they have been paying for health insurance for years and years. Of course, doctors and their practice staff face this issue every day - and at an increasing rate. If Australian health funds truly

believe in our health care industry and patient choice, they too need to do the right thing and index their schedules.

For more information, call Doctors’ Health Fund on 1800 226 126, or visit our website.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Sceptical doctors reject Govt assurances on gag laws

Doctors have staged protests around the country against new laws that threaten to imprison health workers who speak out about conditions in immigration detention centres.

Despite assurances from Immigration Minister Peter Dutton secrecy provisions in the Australian Border Force 2015 Act would "not restrict anyone's ability to raise genuine concerns about conditions in detention, should they wish to do so through appropriate channels", doctors and other health workers earlier this month attended rallies protesting against what they saw as Government's attempts to prevent disclosure of abuse and other serious shortcomings in the care of detained asylum seekers.

Paediatric registrar Christy Norwood, who attended a Sydney rally, told the *Sun Herald* the law went against her ethical obligations as a practitioner.

"It is our job to report anything, and to speak out for children who are vulnerable," she said.

Psychologist Nicholas O'Dwyer, who was also at the rally, told the *Sun Herald* the Act "contradicts the Hippocratic Oath" by preventing health workers from reporting on the welfare of their patients.

Critics, including leading medical practitioners and barristers, have complained the laws, which threaten all detention centre staff – including health workers – with imprisonment for any unauthorised disclosure of information, target whistleblowers and will further deepen the secrecy surrounding the operation of immigration detention centres.

The AMA and other medical groups have called for an amendment to the law to explicitly protect health workers and allow them to advocate on behalf of their patients.

AMA President Professor Brian Owler said an Australian Human Rights Commission documenting cases of child sexual abuse at Australian-run detention centres demonstrated the need for greater transparency in their operation.

"One of the problems that we've got here is an issue of transparency. I think there are a lot of people, particularly doctors, that have been very concerned about the provision of health care.

"The standard of health care, particularly in offshore centres such as Nauru and Manus Island, is well below that we would expect on the mainland, and I think having some sort of independent health group as there used to be, indeed, to actually oversee that and provide some sort of transparency, that gives the Australian people the reassurance that we're actually fulfilling at least the obligations of providing good health care to people that are in detention, is something that we really want to carry through."

Dr Ai-Lene Chan, a GP who worked at the Nauru detention centre, together with colleagues Dr Peter Young and Dr David Isaacs, has warned that the new laws place doctors working in detention centres in an increasingly invidious position.

"The restrictions placed on doctors working in immigration detention results in health care that cannot be consistent with Australian codes and clinical standards," the doctors said, noting that pathology tests frequently go missing, IT communications are regularly disrupted and the supply of medicines is underdeveloped.

The doctors warned that the Australian Border Force 2015 Act would only serve to compromise care even further.

It said the restrictions it put in place would fundamentally compromise vital aspects practice like sharing clinical information and research, and engaging in professional discussion.

"The Australian Border Force Act directly challenges professional codes of ethical conduct, including the safeguard of clinical independence and professional integrity from demands of third parties and governments," they wrote. "The legislation aims to silence health professionals and others who advocate for their patients."

But Mr Dutton said claims the Government wanted to gag whistleblowers with "legitimate" concerns were wrong.

"Any person who makes a public interest disclosure, as defined within the Public Interest Disclosure Act 2013, will not be subject to any criminal prosecution under the ABF Act," the Minister said. "While the Government will take action to protect operationally sensitive information, such as personal information or information which compromises the operational effectiveness or response of our officers, the airing of general claims about conditions in immigration facilities will not breach the ABF Act."

Mr Dutton said the Australian Border Force would investigate

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Health on the hill

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POLITICAL NEWS FROM THE NATION'S CAPITAL

leaks of "operationally sensitive" information, but added "the public can be assured that it will not prevent people from speaking out about conditions in immigration detention facilities".

ADRIAN ROLLINS

World medical leaders join condemnation of detention centre gag laws

The World Medical Association has joined calls for the Federal Government to dump new laws that threaten imprisonment for doctors who speak out about the health of asylum seekers held in immigration detention centres.

As pressure mounts on the Government to amend its controversial Border Force Protection Act to protect whistleblowers, World Medical Association President Dr Xavier Deau and WMA Chair Dr Ardis Hoven have written to Prime Minister Tony Abbott to protest against the law, which they said effectively silenced doctors who addressed the health conditions of asylum seekers.

"This is in striking conflict with basic principles of medical ethics," Dr Deau and Dr Hoven wrote in their letter. "Physicians have to raise their voice, if necessary publicly, when health conditions of their patients, be those free or in detention, are unacceptable."

The WMA leaders declared their support for doctors who advocate for their patients and speak out.

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

Dr Ai-Lene Chan, a GP who worked at the Nauru detention centre, together with colleagues Dr Peter Young and Dr David Isaacs, has warned that the new laws place doctors working in detention centres in an increasingly invidious position.

"The Australian Border Force Act directly challenges professional codes of ethical conduct, including the safeguard of clinical independence and professional integrity from demands of third parties and governments," they wrote. "The legislation aims to silence health professionals and others who advocate for their patients."

Separately, a group of more than 40 health, teaching and welfare workers who have worked at the Manus Island and Nauru detention centres have written an open letter to the Government pledging to campaign against the Border Force Act provisions.

Dr Deau said the provisions of the Border Force Protection Act were "effectively an attempt by the Australian government to gag physicians by making their advocacy for the health care of asylum seekers in Australian detention camps a criminal offence. Such a procedure is not acceptable".

But Immigration Minister Peter Dutton has attempted to hose down the criticism by declaring that whistleblowers had nothing to fear under the new Act.

"Any person who makes a public interest disclosure, as defined within the Public Interest Disclosure Act 2013, will not be subject to any criminal prosecution under the ABF Act," the Minister said. "While the Government will take action to protect operationally sensitive information, such as personal information or information which compromises the operational effectiveness or response of our officers, the airing of general claims about conditions in immigration facilities will not breach the ABF Act."

But Mr Dutton's statement has so far failed to allay concerns that doctors raising legitimate concerns about the treatment of asylum seekers will not face prosecution.

Royal Australian College of Physicians President Professor Nick Talley said the law "attempts to tie our hands to prevent us from fulfilling our duty for a vulnerable group of children and adults with complex health care needs".

ADRIAN ROLLINS

Govt storms against wind farms

The Abbott Government has increased its intervention in the wind energy sector, issuing a draft directive to the Clean Energy Corporation to cease investing in wind farms.

Prime Minister Tony Abbott said last week that the CEFC should not invest in established technologies that can easily attract private funding.

"As long as [the Corporation] exists, it might as well be as useful as possible and ... invest in new and emerging technologies, the things that might not otherwise get finance," the Prime Minister said.

Earlier in the month, Mr Abbott has linked wind farms to adverse health effects and his Government has created a Wind Farm

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Commissioner to hear complaints about their operation.

Declaring that he would like to see the number of wind generators around the country cut, Mr Abbott told Sydney broadcaster Alan Jones that he understood the concerns of those who complained inaudible low frequency sound generated by wind farms caused headaches, nausea, sleeplessness and other health problems.

"I do take your point about the potential health impact of these things," the Prime Minister said. "When I have been up close to these wind farms, not only are they visually awful, but they make a lot of noise."

Mr Abbott made his comments just days after acoustic experts told a Senate inquiry there was no evidence that people were physically affected by low-frequency sound like that emitted by wind turbines.

Members of the Association of Australian Acoustic Consultants told the Senate inquiry into wind turbines on 10 June that several studies detected no perceivable physical reaction to so-called infrasound.

"We can measure the level of infrasound in a windfarm, and we know what that level is, and we can measure it inside rooms, and that has been done on a number of occasions," Chair of the AAAC's windfarm subcommittee, Chris Turnbull, said.

"If we replicate that level at the same character, and the same frequencies, that person is essentially exposed to the same level of infrasound in terms of character and level [as a windfarm]," he said. "To date, all of the studies have suggested that there is no reaction to that level of infrasound."

The testimony came weeks after the National Health and Medical Research Council released the results of a three-year investigation involving the review of more than 4000 papers that concluded there "is currently no consistent evidence that wind farms cause adverse effects in humans".

"Overall, the body of evidence that directly examined wind farms and their potential health effects was small and of poor quality," the NHMRC reported. "There is consistent by poor quality evidence that wind farm noise is associated with annoyance, as well as less consistent, poor quality direct evidence of an association between sleep disturbance and wind farm noise."

The Council's conclusions follow an exhaustive process involving the use of independent reviewers to scrutinise the NHMRC's methodology in reviewing the scientific literature and evidence, as well as public consultations and a revised and updated literature review.

They echo the AMA's own conclusion that there is no evidence to back assertions that wind farms cause headaches, dizziness, tachycardia or other health problems.

In a Position Statement released last year, the AMA said that if wind farms did directly cause adverse health effects, there would be a much stronger correlation between reports of symptoms and proximity to wind farms than currently existed.

The AMA Position Statement on *Wind Farms and Health 2014*, which can be viewed at https://ama.com.au/position-statement/wind-farms-and-health-2014, concluded that "available Australian and international evidence does not support the view that the...sound generated by wind farms... causes adverse health effects".

The NHMRC, however, has not closed the book on the issue, indicating that further research into the possible health effects of wind farms on people within 1500 metres "is warranted".

The latest furore over the health effects of wind farms has come just weeks after the Government negotiated a cut in the Renewable Energy Target (RET) from 41,000 to 33,000 gigawatt hours.

Mr Abbott lamented that the Government had been unable to secure an even deeper reduction, which was arrived at following months of haggling between the major parties that destabilised the renewable energy industry and deterred investors.

"What we did recently in the Senate was reduce...capital R-E-D-U-C-E, the number of these things that we are going to get in the future," the Prime Minister said, "I would frankly have liked to have reduced the number a lot more, but we got the best deal we could out of the Senate, and if we hadn't had a deal...we would have been stuck with even more of these things."

There is mounting speculation the Government will put off an announcement of its post-2020 renewable energy target until next month.

The Government is expected to nominate a target as part of preparations for the United Nations' climate change conference in Paris at the end of the year, which has been organised to forge a fresh international agreement emission reduction goals beyond 2020.

"We'll take a very strong and credible position to Paris, and it will build on the strong and credible work in emissions reduction that's already been achieved here in Australia," Mr Abbott said.

ADRIAN ROLLINS

Research

St John's Wort not necessarily a safe option*

A popular herbal medicine used in the treatment of depression has been found to cause the same adverse reactions as prescription antidepressants

St John's Wort, according to new research by the University of Adelaide in South Australia, can produce the same adverse reactions as fluoxetine, and serious side effects can occur when the two drugs are taken together.

University of Adelaide pharmacology PhD student Claire Hoban warns that St John's Wort, like all herbal medicines, is a drug and can therefore cause serious side effects.

The study found that St John's Wort caused dangerous increases in body temperature and blood pressure.

"There is a common belief that because something is natural and can be purchased from a health food shop without a prescription, it's safe. However, people need to start thinking of St John's Wort, and other herbal medicines, as a drug and seek advice from a qualified healthcare practitioner to be sure they use it safely," said Hoban. "It's concerning to see such severe adverse reactions in our population, when people believe they are doing something proactive for their health with little risk."

The research found 84 reports of adverse reactions to St John's Wort and 447 to fluoxetine.

Hoban said the fewer confirmed cases of side effects for St John's Wort, could stem from fewer people using St John's Wort and that adverse reactions for herbal medicines largely go unreported because they are not considered drugs.

"We found that the reported reactions for St John's Wort were very similar to fluoxetine, which included anxiety, panic attacks, dizziness, vomiting, amnesia and aggression," she said.

Dr Ian Musgrave, Senior Lecturer, Discipline of Pharmacology School of Medical Sciences at the University of Adelaide, said the real danger is that people can access St John's Wort without a prescription so there is no control over the dosage or what drugs people are using it with.

"Most people taking St John's Wort will not have any adverse reactions; however, those who do take it should tell their doctor and pharmacist," said Dr Musgrave.

He said doctors and pharmacists need to know about all the drugs their patients take, not just prescription drugs, because herbal medicines like St John's Wort can have serious reactions with some pharmacy medicines, like antidepressants, the contraceptive pill and some blood thinners.

"Based on this research, I'd also like to see bottles of St John's Wort containing improved warnings of the potential adverse reactions," he said.

** This story is supplied by The Lead South Australia news service*

Surgery not always the answer for appendicitis – study

Automatically sending patients with appendicitis to the operating theatre may not be the best course of treatment, according to Finish researchers.

Researchers found almost 80 per cent of patients with an inflamed appendix, commonly known as appendicitis, did not need to have their appendix surgically removed if given a 10-day course of antibiotics.

Lead author Dr Paullina Salminen from Turku University Hospital in Finland said that for more than a century, appendectomy has been the standard treatment for people with acute appendicitis.

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“Now, we know only a small proportion of appendicitis patients need an emergency room operation,” Dr Salminen said.

“The majority of appendicitis is the milder form, making up to almost 80 per cent of the cases of appendicitis.”

The researchers randomly assigned 530 patients with acute appendicitis to appendectomy or a 10-day course of antibiotics.

They found that appendectomies were 99.6 per cent successful, and that the 10-day antibiotic course was 73 per cent successful – though 27 per cent of patients treated with antibiotics had to have their appendix removed within a year of treatment.

Nonetheless, the researchers found no major complications from delaying surgery.

These results suggest that patients with CT-proven uncomplicated acute appendicitis should be able to make an informed decision between antibiotic treatment and appendectomy.

Dr Edward Livingston, co-author of an accompanying editorial, said that appendectomies have become so routine that when someone comes in with appendicitis they get whisked into the operation room.

He said the ability to diagnose appendicitis has improved with CT scans almost perfect at picking up the inflammation.

Antibiotics have also improved, are very powerful and can kill anything in the appendix that can cause infection, Dr Livingston said.

“These changes make us rethink how we approach appendicitis,” Dr Livingston said.

“Appendicitis of this type is not an emergency. You can always give somebody antibiotics and see how they do, and if the appendicitis comes back you can take out their appendix and not have complications related to the delay.”

The research was published in the *Journal of the American Medical Association.*

KIRSTY WATERFORD

Optimism has no effect on cancer survival – study

The belief that cancer patients who remain upbeat and optimistic will improve their chances of survival has been debunked by an Australian study.

Researchers from Swinburne University in Melbourne investigated more than 400 cancer patients to determine associations between hope, optimism, anxiety, depression, health utility and survival in patients starting first line chemotherapy for metastatic colorectal cancer.

They found that whether a patient had depression or was motivated to follow a prescribed course of treatment did affect survival, but not feelings of optimism, hope or anxiety.

Lead researcher Professor Penelope Schofiel said that previous studies linking optimism to cancer survival were riddled with significant methodological flaws, and that a prevailing belief around optimism improving cancer survival came with the unintentional implication that patients were responsible for the outcome of the disease.

Professor Schofield told *6minutes* that, “if the disease progresses, a patient might feel they weren’t sufficiently positive or didn’t have the right mindset, and it is their fault that the disease progressed.”

The pressure to be positive might also lead to patients concealing their psychological distress from their doctors, she said.

Co-author Associate professor Nicholas Wilcken said that is can be a difficult balancing act between praising the patient for optimism while delivering bad news about their prognosis.

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"One needs to gently modify optimism without taking away hope. It's about relieving the patient of a certain burden from being badgered about being happy, "A/Professor Wilcken said.

"Everyone deals with things differently."

Importantly, the study found a relationship between depression and survival, and the authors said there needed to be further research to understand the nature of the association.

They said that if a causal mechanism was identified, it could open up new possibilities for treatment.

The research was published in the *Supportive Care in Cancer* journal.

KIRSTY WATERFORD

Paracetamol-induced liver failure an English-speaking problem

Researchers have identified major differences between European countries in the rate at which people suffer paracetamol-induced acute liver failure, with some at six times the risk of others.

Paracetamol is extensively used to combat pain, but when taken above the recommended dose it can cause severe liver damage. In extreme cases, the damage can be so severe that it leads to complete liver failure, often requiring a liver transplant.

Researchers examined the amount of paracetamol-linked acute liver failure in France, Greece, Ireland, Italy, Netherlands, Portugal and the UK between 2005 and 2007, comparing how frequently it occurred and how much paracetamol was sold.

The average rate of acute liver failure across the participating countries was one case for every six million inhabitants per year, but was as high as one case for every 286,000 people in Ireland, compared with the equivalent of just one instance for every 180 million people in Italy. The results were similar when looking at the frequency of acute liver failure for each tonne of paracetamol sold. Ireland had one event per every 20.7 tonnes of paracetamol sold, compared with Italy, where there was one event for every 1074 tonnes sold.

The researchers also found that paracetamol overdose represented 20 per cent of all causes of acute liver failure across Europe, but increased to 52 per cent in Ireland and 28 per cent in the UK. However, this dropped to only one per cent in Italy, and there were no cases recorded in Greece. Additionally, the researchers found that while France had the highest per-person use of paracetamol, it had the third lowest acute liver failure transplant rate.

Lead researcher Associate Professor Sinem Ezgi Gulmez said that, overall, they found a six-times higher risk in Ireland and a two-fold higher risk in the UK compared with the average of the countries participating in the study.

A/Professor Gulmez also highlighted that the highest rates of overdose for acute liver failure per metric ton of paracetamol sold per person were found in the two English speaking countries.

"Since we do not have event rates for overdoses not leading to liver failure, we cannot conclude anything about the rates of non-acute liver failure overdoses in the different countries, but indicators point to more common use of paracetamol poisoning in these countries," A/Professor Gulmez said.

"The differences in the figures for harm caused by paracetamol within different countries in Europe are not marginal, and suggest that there are some underlying causes.

"Paracetamol overdose is a serious public health issue, and we should start looking into hepatotoxicity associated with paracetamol at normal doses."

The research was published in the *British Journal of Clinical Pharmacology.*

KIRSTY WATERFORD

Ebola fight not yet over

Canberra-based medical services provider Aspen Medical International is working with the United States Government to assist in efforts to head off a fresh outbreak of the deadly Ebola virus in Liberia, where the disease has re-emerged.

Aspen Chief Executive Bruce Armstrong told the recent AMA National Conference that the company, which had been contracted by the Australian Government to operate an Ebola treatment centre in Sierra Leone at the height of the epidemic late last year and early this year, has also been engaged by USAID to manage and operate Ebola treatment units in Liberia.

Aspen's contract with USAID was originally due to expire in May, but has been extended to October amid reports that six people have been infected, including two who have died.

The World Health Organisation declared an end to the Ebola outbreak in Liberia on May 9, but on June 29 health authorities confirmed a teenage boy had the disease. Since then, five more cases have been identified in the Monrovia area, sparking fears of a fresh outbreak.

In his speech to the AMA National Conference, Mr Armstrong detailed Aspen's to the Ebola outbreak, particularly its work on behalf of the Australian Government.

In early November last year, Prime Minister Tony Abbott acceded to pressure from AMA President Professor Brian Owler, other health groups and the international community for Australia to directly contribute to efforts to tackle the world's worst ever Ebola outbreak in West Africa.

On 5 November, Mr Abbott announced that Aspen had been contracted to operate a 100-bed Ebola treatment centre built by the British Government in Sierra Leone.

Mr Armstrong said that within five weeks of the announcement, the centre admitted its first Ebola patient, and by the time it closed at the end of April it had admitted 216 patients, 36 of whom were successfully treated for Ebola. A further 120 patients were monitored and discharged after testing negative for the disease.

The Aspen chief said he was particularly pleased that throughout the operation, none of the 73 Australian and New Zealand staff, nor any of the more than 250 locally-engaged workers, were infected with Ebola.

The WHO has reported that, as at 8 July, 27,573 people were confirmed or suspected to have been infected with Ebola, including 11,246 who died from the disease – making it by far the worst outbreak on record.

The UN agency declared that the latest cluster of cases in Liberia was a separate outbreak to that resolved in May and warned that, although the ability to trace the chain of infection was much improved, "significant challenges remain" in tackling the disease.

"A residual lack of trust in the response among some affected communities means that some cases still evade detection for too long, increasing the risk of further hidden transmission," it said. "The exportation of cases to densely populated urban areas such as Freetown and Conakry remains a risk, whilst the origin of the new cluster of cases in Liberia is not yet well understood."

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

AMA Fee List Update 15 June 2015

The AMA List of Medical Services and Fees (AMA List) has been updated to amend existing items and include new items. These items are provided in the Summary of Changes for 15 June 2015, which is available from the Members Only area of the AMA website at https://ama.com.au/article/ama-list-medical-services-and-fees-15-june-2015

The AMA Fees List Online is available from http://feeslist.ama.com.au. Members can view, print or download individual items or groups of items to suit their needs. The comma delimited (CSV) ASCII format (complete AMA List) is available for free download from the Members Only area of the AMA Website (www.ama.com.au). To access this part of the website, simply login by entering your username and password located at the top right hand side of the screen and follow these steps:

1) Once you have entered your login details, from the home page hover over **Resources** at the top of the page.

2) A drop down box will appear. Under this, select **Fees List**.

3) Select first option, **AMA List of Medical Services and Fees – 15 June 2015**.

4) Download either or both the CSV (for importing into practice software) and **Summary of Changes** (for viewing) detailing new, amended or deleted items in the AMA List.

If you do not have Internet access please contact us on (02) 6270 5400 for a copy of the changes.

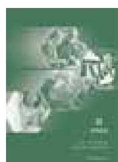
AMA Member Benefits

AMA members can access a range of free and discounted products and services through their AMA membership. To access these benefits, log in at **www.ama.com.au/member-benefits**

AMA members requiring assistance can call AMA member services on

1300 133 655 or **memberservices@ama.com.au**

UpToDate: NEW offer for AMA members! UpToDate is the clinical decision support resource medical practitioners trust for reliable clinical answers. AMA members are entitled to discounts on the full and trainee subscription rates.



Fees & Services List: A free resource for AMA members. The AMA list of Medical Services and Fees assists professionals in determining their fees and provides an important reference for those in medical practice.

Careers Advisory Service: Your one-stop shop for information and resources to help you navigate through your medical career.

CPD Tracker: Record your continuing professional development (CPD) online with the AMA's CPD Tracker, a free service for members.

Amex: American Express is a major partner of the AMA and offers members special discounts and extra rewards on a range of credit cards, merchant services and offers for existing AMA cardholders.

Volkswagen: AMA members are entitled to a discount off the retail price of new Volkswagen vehicles. Take advantage of this offer that could save you thousands of dollars.

AMP: AMA members are entitled to discounts on home loans with AMP.

Hertz: AMA members have access to discounted rates both in Australia and throughout international locations.

OnePath: OnePath offers a range of exclusive insurance products for AMA members.

Qantas Club: AMA members are entitled to significantly reduced joining and annual fees for the Qantas Club.

Virgin Lounge: AMA members are entitled to significantly reduced joining and annual fees for the Virgin Lounge.

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www.join.ama.com.au/join