AUSTRALIAN
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Malcolm in the house

Prime Minister comes to AMA, meets Federal Council, p6

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Cover: Health Minister Sussan Ley addresses the AMA Federal Council at AMA House, while Prime Minister Malcolm Turnbull and AMA President Professor Brian Owler look on

Continuity with plenty of change

BY AMA PRESIDENT PROFESSOR BRIAN OWLER

The political world in Canberra became very exciting all of a sudden in mid-March.

Following months of speculation about double dissolutions, early elections, and early Budget night, Prime Minister Turnbull turned things on their head with a late Friday afternoon visit to the Governor General, which slipped under the usually forensic media radar.

The reason for the visit was to set the path, according to the Constitutional rulebook, for shifting the Budget a week earlier to 3 May and putting in train all the wheels of Government for a possible 2 July double dissolution Federal election – if the PM should choose to pull the trigger.

The other string to the PM's bow was to recall the Senate on April 18 to discuss contentious Bills, primarily legislation to re-instate the construction industry watchdog, the ABCC.

All this chicanery came to light when the Prime Minister called a sudden press conference in Canberra on the morning of Monday 21 March. It caught the Press Gallery by surprise.

As the Prime Minister revealed his crafty plan, he commenced a heavy round of media interviews – by the PM and his Cabinet.

From these interviews emerged what many interpreted to be the PM's slogan for the 2016 Election – Continuity with Change. This phrase was uttered by the PM and senior Ministers at every opportunity, regardless of the fact it had been lifted from the US television series, The Veep.

The beauty of this slogan is that the AMA can now commandeer it to advocate for what we want to happen with the Australian health system. We want continuity, and we want change – plenty of change.

We want continuity of the pillars of the health system – a strong balance between the public and private systems, properly funded public hospitals, strong investment in general practice, and a focus on prevention.

But recent Government policy – especially the ill-directed reforms announced in the 2014 Budget – has undermined these foundations. And that is why we need the change. We need the change in Budget announcements and in the Government's health policies for the election.

When people are sick and injured, we need to provide them with affordable and easily accessible care in hospitals, in aged care, in general practice, in the community, and in their homes.

And we need to educate and help people to achieve healthier lifestyles by being active, and avoiding harmful habits and substances. This will reduce the strain on health services.

These core issues are under threat from the Government's current policy direction.

The Government must change its policies of funding cuts and program cuts from its first two Budgets, and instead invest heavily in the health system to build capacity to meet current and future needs.

The Prime Minister must make public hospitals, primary care, and prevention the centrepiece of his pronouncements in coming months.

The first elements of 'change' must be to lift the Medicare patient rebate freeze, reverse the cuts to pathology and radiology, and restore public hospital funding to proper levels.

Our public hospitals are under pressure, and our primary care system, especially general practice, is facing huge challenges as more Australians are experiencing chronic and complex conditions that require ongoing care.

Significant new health funding is needed, but it needs to come with a clear vision and a clear strategy about how to best invest this funding. And it needs collaboration and genuine consultation with the medical profession.

We thank the Prime Minister for promoting a slogan that fits well with the AMA's vision for a better and more sustainable health system – continuity of the foundations that have served us well, and change to the elements that must be funded and supported to serve the health needs of future generations of Australians.

A prescription for a modern health system

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Prime Minister Turnbull's visit to the AMA on 17 March to meet with Federal Council was a significant event. It enabled the PM to hear first-hand from the nation's leading doctors – from across the profession and across the country – and to have a few myths dispelled along the way.

> "... the days of a patient presenting to their GP with a single problem are long gone, and emergency presentations are more complex and time-consuming than even a generation ago"

AMA Vice President Dr Stephen Parnis meets with Prime Minister Malcolm Turnbull at AMA House on 17 March

The PM asked my colleagues Saxon Smith (AMA NSW President) and David Mountain (WA, Emergency Physician Representative to Federal Council) why emergency department presentations were continuing to go up every year in Australia, placing increasing pressure on our overburdened public hospitals.

Their answers were swift, clear and firmly based on evidence.

Our population is not only growing, but getting older, and getting older often means living with multiple chronic illnesses. Our success as a medical profession and a health system means that life expectancy and quality has never been greater.

This is the holy grail – a longer, happier and more productive life. Something to which we all aspire.

But it also means that medical presentations are more complex than ever before – the days of a patient presenting to their GP with a single problem are long gone, and emergency presentations are more complex and time-consuming than even a generation ago.

This is why Abbott Government attempts to impose major cuts to general practice in the form of co-payments Mark 1 and 2 provoked unprecedented levels of anger among GPs across Australia, and were successfully opposed by the AMA.

It is also why the Federal Government's inadequate funding formula for public hospitals sees us struggle to meet performance targets, let alone prepare for the funding cliff that kicks in on 1 July next year.

And it is why the ongoing freeze to Medicare indexation makes it much harder to maintain a universal system of health coverage into the future.

Doctors are leaders, and we are always up for a challenge. We are intellectually and ethically committed to improving patient care and our health system at every opportunity.

We have long championed measures to improve the efficiency and effectiveness of healthcare, including:

- enhanced IT systems to reduce duplication and errors;
- reducing unwarranted variation in healthcare;
- increasing generalist skills in the medical workforce;
- maximising continuity of care via the patient's GP; and
- enhancing sensible public health measures to promote prevention over cure.

But we cannot achieve this when ongoing budget cuts pull the rug out from underneath us.

These fundamental health matters will be the subject of intense scrutiny in the months and years ahead, irrespective of election outcomes.

Leadership – now and in the future

BY **AMA SECRETARY GENERAL ANNE TRIMMER**

> "While health is unlikely to be the number one issue in the election, it is one that touches every Australian and can have a significant impact in marginal seats"

With the country facing an election in the near future, the Prime Minister, Malcolm Fraser, and Minister for Health, Sussan Ley, joined the March meeting of AMA Federal Council to hear from Council members first-hand about current challenges doctors have identified in the health system. A more detailed report can be read elsewhere in this edition of *Australian Medicine*.

While health is unlikely to be the number one issue in the election, it is one that touches every Australian and can have a significant impact in marginal seats.

I outlined in the last edition of *Australian Medicine* the key areas for AMA advocacy in the lead up to the Federal election, with more to be published in coming editions once an election date is announced.

The AMA's own election season is underway.

I have advised members of the outcome of the uncontested positions on Federal Council. There is a handful of contested positions, electronic balloting for which will be undertaken in April. Two positions received no nominations – the position on Federal Council representing rural doctors and the new position representing private specialist practice.

Following my recent call for expressions of interest, I have received a very encouraging response, with many members expressing interest. A further process will determine the appointment of representatives to fill these casual vacancies.

Last year, a working group of Federal Council reviewed the representation of members at the AMA National Conference. The revised structure will be put to members at this year's Annual General Meeting in May.

Delegates to National Conference in future years will be drawn from practice groups, rather than specialties and special interest groups as they are now (aside from the State-nominated delegates). This better aligns with AMA advocacy and representation.

At its March meeting, the Federal Council agreed to undertake further work to review the structure and composition of Federal Council itself. This is part of the ongoing governance reform of the AMA which commenced two years ago with the establishment of a Board and the separation of governance from medico-political policy, which is reserved for Federal Council.

The separation of power has been highly effective in freeing the Federal Council to concentrate on policy and establishing robust processes for the Board to oversee the company.

One of the areas of focus for the AMA in meeting its mission statement of *leading Australia's doctors* is the role that the AMA plays in developing the next generation of medico-political leaders. Future reforms to the structure and composition of Federal Council, and its committees, councils and working groups, will take into account the contribution to be made by the next generation of doctors.

In a similar vein, the Board has approved the establishment this year of a future leaders program, directed to those who have taken on leadership positions within the AMA within the past five years.

More information about the program, together with calls for applications, will be released in the near future.

Turnbull's hospital pass

It must be election time: Health Minister Sussan Ley addresses the AMA Federal Council at AMA House, while Prime Minister Malcolm Turnbull and AMA President Professor Brian Owler look on

Prime Minister Malcolm Turnbull has indicated financial relief for the nation's beleaguered public hospitals will depend on finding additional sources of revenue, delivering a blow to hopes of averting a multi-billion dollar funding crisis set to hit the system from next year.

Mr Turnbull told a meeting of the AMA Federal Council that hospital funding was "a big issue", and he fuelled speculation of a pre-election spending boost after revealing he was "in discussions" with premiers and chief ministers on the matter.

But the Prime Minister gave no sign his Government was contemplating a major change in the policy course set by the Coalition in 2014 when it announced funding changes that would rip $57 billion out of the public hospital system between 2017 and 2025.

Instead, he reinforced the need for more effective health spending, signalling there would be no let-up in the pressure on doctors, nurses and other health professionals to deliver greater efficiencies.

"Hospital funding is a big issue," Mr Turnbull said. "It is something I am in discussions with chief ministers and state premiers [about], and we have COAG before not very long, where we will seek to take that issue forward."

"[But], the big issue is where additional funding will come from."

> "... the Prime Minister gave no sign his Government was contemplating a major change in the policy course set by the Coalition in 2014 when it announced funding changes that would rip $57 billion out of the public hospital system between 2017 and 2025"

Several premiers, most notably Mike Baird in NSW and Jay Weatherill in South Australia, had proposed an increase in the GST – partially offset by other tax changes – to increase the health budget, but the Prime Minister reiterated his Government would not contemplate an increase in tax revenue.

"We have to recognise that Australians already pay high taxes," Mr Turnbull said. "This is not a low-tax country, so getting better value [for health spending] is vital."

Instead, while praising advances in the quality and effectiveness of health care, he exhorted health service providers to greater efficiency.

The Prime Minister said rising health expenditure was "often seen as an admission of failure, [but] the reality is that we are getting a lot more for it", in terms of longer and healthier lives.

However, funding constraints meant that "the pressure is to get better and more effective outcomes" for the same outlay.

Q&A at AMA House

Following one-on-one talks with AMA President Professor Brian Owler, Mr Turnbull was joined by Health Minister Sussan Ley in meeting with AMA Federal Councillors, who grilled the pair on significant aspects of Federal Government health policy including public hospital funding, the Medicare rebate freeze, pathology and diagnostic imaging bulk billing incentives, medical workforce training and emergency department performance targets.

Several AMA Federal Councillors including Dr Tim Greenaway, Dr Saxon Smith and Dr David Mountain challenged the PM and Health Minister on the scale of the Federal Government's cuts to hospital funding, pointing out the sharp growth in demand for hospital services occurring around the country.

Mr Turnbull questioned why there was a sharp rise in the number of patients showing up at hospital emergency departments, speculating that some of it may be due to a failure in primary care.

But Dr Mountain and Dr Smith explained that as people lived longer, they developed multiple health problems that could compound one another and quickly escalate, requiring expensive and complex emergency care.

Questioned on the Medicare rebate freeze, Ms Ley said on-going Budget deficits meant the Government was not in a position to restore rebate indexation, and was instead examining new models of primary care arising out of the recent review.

Addressing the cut to bulk billing incentives, the Health Minister said it was "not healthy" that the pathology sector was dominated by two providers, and said the major issue raised by pathologists she consulted with was not the incentive cut, but rents charged to co-locate with medical practices.

Ms Ley added that bulk billing incentives for concession card radiology patients had not been touched, supporting their access to care.

On medical training, Ms Ley said she was concerned to find ways to get more "generalist" practitioners into rural areas. The Minister said she did not believe in using Medicare provider numbers and other methods to bond doctors to work in particular areas, but the problem of luring more doctors into rural practice was one that "we do have to collectively solve".

The Minister said the Government understood concerns around the establishment of a third medical school in Perth, but expressed doubts that the decision could be "unravelled".

ADRIAN ROLLINS

Shine a light on murky insurance deals: AMA

Health insurance premiums are being inflated by commissions and many consumers are being lured into unnecessarily switching cover because of murky arrangements between health funds and insurance comparison websites, the AMA has warned.

Releasing its inaugural *Private Health Insurance Report Card*, the nation's peak medical organisation has urged greater Government scrutiny of health insurance industry practices which is says may be distorting the market and undermining the value of private health insurance cover.

As consumer anger over looming premium price hikes builds, the AMA has developed the Report Card to help consumers understand how the market operates and enable them to make better informed choices regarding their health cover.

Launching the Report Card, AMA President Professor Brian Owler said it was common for patients coming to hospital for surgery shocked to discover they were not covered, forcing them to cancel or defer treatment or facing unexpected out-of-pocket costs.

"The AMA wants every person who has private health insurance to know what their policy covers them for, and to review it every year to make sure it continues to meet their needs," Professor Owler said.

The Report Card addresses two of the biggest gripes of policyholders – gaps and shortcomings in cover, and out-of-pocket fees.

It sets out the level of cover each of the nation's 35 insurers provides and it details differences in the benefits paid by eight funds for 22 common procedures, including birth, hip and knee replacement, cataract surgery, coronary bypass, vasectomy, haemorrhoid treatment and breast biopsy.

The AMA said there were four main levels of cover, from top private hospital through to public hospital-only policies that President Owler said were junk and should be banned.

He said often policies had misleading names that implied they would provide a much higher level of cover than they actually did, creating the risk that consumers would be caught out when they were most in need.

"There are a lot of policies on offer that provide public hospital-only cover. These are better known as 'junk' policies, because they do not support patient choice of doctor or timing for health services or procedures," Professor Owler said. "It is the AMA's view that junk policies should be banned outright."

Even where a treatment is covered by insurance, patients may still be left with out-of-pocket expenses if the benefit paid by the insurer falls short.

For privately insured patients, Medicare pays 75 per cent of the MBS fee, and health funds 25 per cent or more. The bulk of services are provided by doctors with no gap, when Medicare and the health fund between them cover the full total cost of treatment. Sometimes, there is a 'known gap', where practitioners charge a fee a set amount above the benefit.

But the Report Card shows that the benefits paid by insurers vary considerably, and the AMA "strongly recommends" that patients seek an estimate from their doctor, including the cost of any implant, and then talk with their insurer prior to treatment.

The AMA has released its Report Card amid concerns that premium increases set to come into effect from 1 April will spur thousands to consider downgrading their cover.

Earlier this month, Health Minster Sussan Ley claimed a victory of sorts after convincing 20 of the nation's 35 private health funds to lower planned premium increases, a move she said had saved consumers $125 million.

But the average 5.59 per cent increase is virtually treble the inflation rate, and is expected to feed consumer dissatisfaction with the value of private health insurance.

> "The AMA wants every person who has private health insurance to know what their policy covers them for, and to review it every year to make sure it continues to meet their needs" – *Professor Owler*

Professor Owler said it was important that consumers were fully informed and aware about the consequences of taking out cheaper cover, which would usually entail more restrictions and exclusions, as well as higher excess.

He said it was particularly worrying that people looking to hold their premium costs down would be duped into taking out junk policies.

"If people have one of the junk policies, the AMA urges them to consider carefully what cover they really need," the AMA President said.

In addition to the quality of cover on offer, the AMA has raised concerns about the operations of websites that compare health insurance policies.

Professor Owler said these 'free' comparator sites earned often exorbitant commissions from insurers, either a fixed percentage of a premium or a fixed fee per sale, which could act as an incentive to get consumers to switch policies.

Either way, the fees could make up a sizeable proportion of the total insurance premium, he said, urging a greater level of transparency and Government scrutiny.

The Australian Competition and Consumer Commission last year issued a report highly critical of the quality and accuracy of information provided by the health funds.

Echoing AMA concerns, the watchdog warned that comparator websites often included only a selection of insurers or policies on offer, and added "they may have commercial relationships with, or receive financial inducements from, listed businesses".

Ms Ley has launched a review into the private health insurance industry to examine regulation of the sector, including the setting of premiums, as well as other issues including the industry's push into primary health care; a possible relaxation of community rating principles; and a proposal to replace health insurance rebates with Medicare-style payments for hospital care.

The *AMA Private Health Insurance Report Card 2016* can be viewed at: https://ama.com.au/ama-private-health-insurance-report-card-2016

ADRIAN ROLLINS

The high cost of comparing

Insurance comparison websites iSelect and Compare the Market have confirmed they earn hefty commissions from health insurers for signing up people to new policies.

Compare the Market has revealed insurers pay it a flat 27.75 per cent of the first year's premium on each health policy it sells, and iSelect Chief Executive Scott Wilson told *The Australian Financial Review* his company receives a commission in "the mid-30s" per cent of the first year premium for each policy sold – an average of $804 per policy sold in the second half of 2015.

The revelations underline AMA concerns that comparator websites earn big commissions that act as an incentive to get people to switch policies.

Both the AMA and the consumer watchdog, the Australian Competition and Consumer Commission, are worried that comparator websites are helping inflate premiums by charging big fees, and are distorting the market by only including a fraction of the providers and policies on offer in its comparisons.

A lot of money is at stake.

In all, the *AFR* reported, iSelect sold 130,000 policies through its website last year – about 20 per cent of the national total.

The industry is sensitive to criticisms, and Compare the Market disclosed its fee structure earlier this year in a bid to reassure consumers.

iSelect's Mr Wilson dismissed AMA and ACCC concerns, claiming commissions did not influence the policy recommendations made by its advisers, and that his service actually saved insurers money.

"Our sale prices are not influenced by our commissions. The individual adviser does not know what the commissions are from individual funds," he said.

Mr Wilson said that, compared with the cost of operating branches and running advertising campaigns, comparator services such as his were a cheap way for insurers to market themselves.

ADRIAN ROLLINS

Beware, there is a lot of junk out there

The nation's biggest health funds are promoting multiple insurance policies that are junk or provide barely more cover than Medicare, an AMA investigation shows.

An analysis of the policies offered by the nation's 33 private health funds has found that Medibank Private, NIB, HCF, HBF, which together account for more than 55 per cent of the health insurance market, are marketing products that, because of multiple exclusions, provide barely more cover than Medicare or, in many instances, provide no additional entitlement at all – what the AMA President Professor Brian Owler has called "junk policies".

The AMA's inaugural *Private Health Insurance Report Card* shows that Medibank's Young Hospital and Accident Cover policies, which can cost couples up to $2410 a year before rebates, have so many exclusions that the Choice consumer group described them as "effectively useless". Other insurers including NIB, HCF, HIF Australian Unity and Defence Health are also marketing similar policies that often exclude cover for some of the most common serious illnesses such as cancer, stroke and heart disease.

In addition, 20 funds were selling policies that provide no more cover than Medicare.

Professor Owler said it was very concerning that there were a lot of policies on the market that did not provide the cover that many consumers might expect – catching them out when they needed it most.

"Our Report Card shows that there are a lot of policies on offer that provide public hospital only cover," the AMA President said. "These are better known as 'junk' policies, because they do not support patient choice of doctor or timing for health services or procedures. There are also a lot of policies on the market that will not provide the cover that consumers expect when they need it."

Many consumers, particularly younger people, are taking out basic cover with multiple exclusions – including junk policies – to avoid the Medicare Levy Surcharge and the annual 2 per cent Lifetime Health Cover loading.

But Professor Owler said many insured patients were surprised to find they did not have cover for common treatments, and urged consumers to consider carefully what cover they really needed.

With the cost of private health insurance constantly rising, and with private health insurers regularly changing what is covered and not covered by their products, the AMA believes it is important that families and individuals are better informed about the health insurance cover they are purchasing," he said. "The AMA wants Australians to know their insurance product – and know it thoroughly."

An AMA comparison of benefits paid for a range of common procedures including hip and knee replacements, cataract surgery, colonoscopy and heart surgery found wide variation in cover, underlining the importance of patients seeking estimates of costs and extent of benefits before undertaking treatment.

The *AMA Private Health Insurance Report Card 2016* can be viewed at: https://ama.com.au/ama-private-health-insurance-report-card-2016

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

2016 AMA Media Awards
Nominations now open

State and Territory AMA's are invited to submit entries in the following categories:

+ Best Public Health Campaign
+ Best Lobby Campaign
+ Best State Publication
+ Most Innovative Use of Website or New Media
+ National Advocacy

Criteria for these awards are available at https://ama.com.au/article/2016-ama-media-awards or by emailing kwaterford@ama.com.au

Nominations are due by 22 April 2016

Watchdog wants to dob on doctors

The medical workforce watchdog will have the power to inform employers and places of practice of any change in the registration status of doctors under legislative changes being sought by the Australian Health Practitioner Regulation Agency.

Responding to a report critical of its handling of a serious case involving the preventable deaths of several babies, the Agency will gather and share more information regarding doctors under investigation and has asked for changes to its legislation to enable it to disclose more details to employers.

The changes are part of a detailed set of measures intended to address serious shortcomings identified by an investigation into its handling of the Djerriwarrh Health Service scandal, in which 10 babies died in two years – including seven deaths considered to have been avoidable.

AHPRA commissioned consultancy KPMG to examine how its Victorian office handled the matter after it was revealed it took 28 months to investigate a complaint about one of the doctors working at the health service in Bacchus Marsh, Victoria.

The Victorian Health Minister said the case involved a "catastrophic failure" of clinical governance at the health service, and ordered sweeping changes to its management.

For its part, AHPRA admitted that it had "taken longer than it should have" to investigate the complaint made to it about on the health service's doctors.

In its report, KPMG said the watchdog needed to exercise better risk assessment, to throw more resources at investigating high-risk complaints, to operate with greater transparency, to address perceptions of being "pro-practitioner" and to critically evaluate its performance.

ADRIAN ROLLINS

When not doing something may be the best choice

X-rays for sprained ankles, antibiotics for ear infections and colds and colonoscopies to screen for bowel cancer are among more than 60 tests, treatments and procedures medical experts say should be avoided because they are wasteful and unnecessarily risky.

Fourteen specialist colleges, societies and associations have taken the lead in identifying 61 tests and procedures that should no longer be used because they expose patients to harm, undermine the effectiveness of lifesaving antibiotics and are a poor use of scarce health dollars.

The list, compiled under the Choosing Wisely initiative of NPS Medicinewise, includes many practices and treatments often considered routine and uncontroversial, but which evidence shows achieve little and are potentially harmful.

An area of particular focus is the use of antibiotics, amid fears that they are being overused, fostering bacterial resistance and the rise of superbugs impervious to known medicines.

In changes that could improve patient outcomes and potentially save millions of dollars, doctors and parents are being urged to make much more careful use of antibiotics, including in the treatment of middle ear infections in children, and in the treatment of colds and other upper respiratory tract infections.

The Royal Australian College of General Practitioners (RACGP) has recommended against the initial use of antibiotics for children aged between two and 12 years with a middle ear infection, where a review is possible in the following 24 to 48 hours.

AMA President Professor Brian Owler said it was important advice that would avert unnecessary treatment while helping to preserve the effectiveness of antibiotics.

“In the case of an ear infection, if there is a chance of review in 24 to 48 hours and the ear looks red, just come back and have a review rather than going straight to antibiotics, so that we try and reduce this over-prescribing of antibiotics,” Professor Owler told Channel Nine’s Today show.

> "Part of the problem here is not just to educate doctors in terms of when antibiotic prescribing is or isn't called for, it is also to educate parents and patients themselves so that we don't prescribe too many antibiotics ..."
> *- Professor Brian Owler*

The AMA President said it was advice aimed not only at doctors, but also parents and patients.

"Part of the problem here is not just to educate doctors in terms of when antibiotic prescribing is or isn't called for, it is also to educate parents and patients themselves so that we don't prescribe too many antibiotics, because we know if we do that we are likely to see more resistant infections. That's going to mean that people's infections are going to be much harder to treat in the future," he said.

Two Bond University academics, Professor of Clinical Epidemiology Tammy Hoffmann and Professor of Public Health Chris Del Mar said the Choosing Wisely initiative was important not because of the money that could be saved, but because of a change in a approach that it represented.

They wrote in *The Conversation* that clinicians were guilty of doing too much rather than too little, and Choosing Wisely helped to signal "a very important departure from normal business for clinicians – thinking about not doing things".

"The premise behind Choosing Wisely is not about cost-cutting. It is one of the few existing processes for dealing with the one-way ratchet caused by more treatments and tests being generated every year, all of which increases the amount of things that can – but not necessarily should – be provided to patients," they wrote.

Other therapies that have come under question include chest x-rays, one of the test most commonly ordered by GPs.

The RACGP has advised that GPs should no longer, as a matter of routine, order chest x-rays for patients with acute uncomplicated bronchitis.

The Royal Australasian College of Surgeons, meanwhile, has recommended against CT scans for suspected appendicitis without first considering an ultrasound, the Australian Physiotherapy Association has advised that there is "no advantage from routine imaging of non-specific low back pain", and the Australian and New Zealand Society of Palliative Medicine has advised against the use of stomach feed tubes for patients with advanced dementia.

Professor Owler said the initiative demonstrated that doctors were keen to get rid of wasteful and potentially harmful practices, and supported efforts to improve the effectiveness of health spending.

He said doctors took seriously their responsibility as stewards of the health care system, and were constantly reviewing their practices and the evidence to ensure patients received the best possible care.

His comments were echoed by Australasian College of Dermatologists President Associate Professor Chris Baker, who said that one of the challenges of modern medicine was to determine which of the multiplicity of tests and treatments available were of benefit to patients.

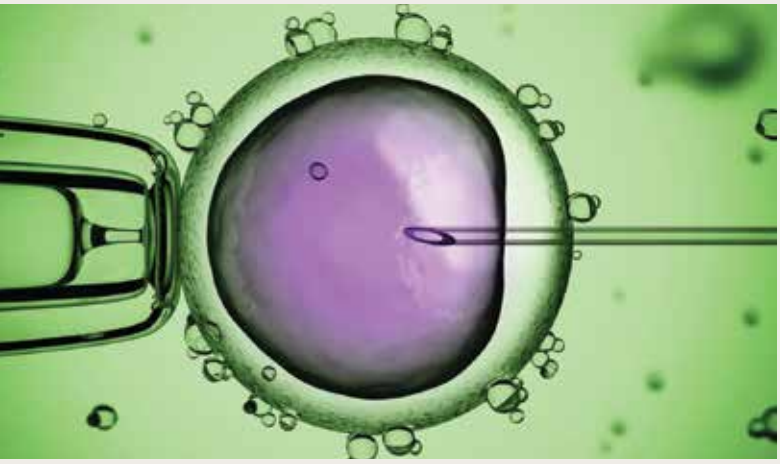
A/Professor Baker said his College had identified several instances where the use of antibiotics was unnecessary and could help undermine their effectiveness, including in the treatment of acne vulgaris, epidermal cysts and redness and swelling of both lower legs.

The Choosing Wisely campaign is running in parallel with, but is unrelated to, a Federal Government taskforce review of the Medicare Benefits Schedule, which was set up last year and is not expected to complete its work until 2017.

The goal of updating the MBS to reflect modern clinical practice has been backed by the AMA, but there are concerns that the Government wants to use it primarily as a cost-cutting exercise that will be quick to de-list old treatments but slow to add new ones.

ADRIAN ROLLINS

Stop it before people get hurt



Scientists have urged a crackdown on practitioners charging as much as $60,000 for stem cell therapies that are unproven and potentially dangerous.

The Australian Academy of Science has issued a report lauding the potential of stem cell technology to deliver enormous advances in medical treatment such as regenerating or replacing damaged or lost tissue and tailoring the use of medicine.

But it said so far only a very small number of stem cell treatments had been rigorously assessed for clinical use, including bone marrow transplants and skin grafts, and warned that therapies being touted for a range of conditions from sports injuries and cancer to autism, Alzheimer's disease and multiple sclerosis were unproven and could pose significant risks, including promoting the development of tumours.

The rapid development of stem cell technology has blindsided regulators. Currently, autologous cells are exempt from regulation under the Therapeutic Goods Act, a loophole the Academy says is being exploited to market stem cell treatments to often desperate patients.

"The majority of clinics marketing these interventions to Australians claim that they represent effective and accepted medical practice with little or no risk," the Academy's report, *The Stem Cell Revolution*, said.

Even more worrying, the report said, some practitioners were offering very new technologies, such as cellular reprogramming to generate patient-specific stem cells, "despite the fact that these cells currently have no known or proven clinical benefit, and are associated with significant risks such as the potential for tumour formation".

The Academy said the fact that such treatments were being freely marketed in Australia showed the weakness of current regulatory arrangements, which allowed for the use of cellular products that "fall far below the evidentiary standards of most other industrialised countries".

Last year, the Therapeutic Goods Administration undertook public consultations on the issue, but is yet to make a recommendation on whether there should be a change to regulation.

The Academy is concerned "rogue" practitioners promoting unproven stem cell treatments could undermine the development of stem cell technology in Australia, particularly if they prove harmful or fatal.

Chair of the Academy's National Committee for Cell and Developmental Biology, Professor Richard Harvey, said stem cell technology held out great promise and should not be allowed to be derailed by the actions of a few.

"Medical science is now moving towards the point where it will be possible to take cells from one part of a person's body and turn them into any other type of cell for use in replacement of lost cells or repair of damaged tissue in diseases such as Alzheimer's disease, multiple sclerosis and cardiovascular disease," Professor Harvey said. "Stem cells also have the potential to revolutionise how we understand disease pathology."

He said Australia had the potential to become a world leader in stem cell research, but it would require a "national strategic effort".

"We can make organs in a dish and correct disease-causing genetic defects in a patient's own cells: it's an exciting time for stem cell researchers and new breakthroughs are making headlines almost daily," he said. "We must continue to strategically support this vital area, and see it as priority area of research for Australia if we are to reap the benefits for humanity, save on our health care bill, and continue to be a world leader."

The Academy's report recommended investment in students and early-career stem cell researchers, improved patient access to clinical trials, the establishment of a national centre to foster turning scientific discoveries into clinical practice, the creation of stem cell banks and setting out clear boundaries for health professionals using stem cells in their medical practice.

It said that, at a bare minimum, the boundaries of acceptable practice should reflect the standards of conduct set out by the AMA and the Medical Board of Australia, and any registered practitioners who breach the code should be the subject of sanctions.

ADRIAN ROLLINS

A real knees up

> "In a development that could transform the lives of thousands and reduce the need for costly joint replacement surgery, scientists at the Melbourne Stem Cell Centre have reported "excellent" results in a trial of the use of stem cells to manage osteoarthritis and isolated cartilage lesions"

Patients suffering osteoarthritis and other debilitating knee complaints have reported major improvements in pain and mobility following injections with their own stem cells.

In a development that could transform the lives of thousands and reduce the need for costly joint replacement surgery, scientists at the Melbourne Stem Cell Centre have reported "excellent" results in a trial of the use of stem cells to manage osteoarthritis and isolated cartilage lesions.

Interim results of the trial show there was a statistically significant improvement in pain and function after one month, and after nine months more than 65 per cent of patients aged 41 to 60 years experienced at least a 50 per cent reduction in pain.

The researchers, led by the Centre's Chief Clinical Investigator, Dr Julien Freitag, were particularly excited by the progress of a 26-year-old patient with osteo chondritis dessicans.

The patient, who had undergone seven major knee operations in 12 years, joined the trial in June last year and MRI scans since then show that his cartilage has begun to regrow and pre-existing damage to the knee is starting to reverse.

While the privately-funded trial is yet to be completed, Dr Freitag said the interim results were "extremely encouraging", and confirmed that the promise of regenerative therapies such as the use of stem cells was now "closer to reality".

He said MRI analysis showed consistent stabilisation and a halt to the progress of arthritis in test subjects, and regrowth of cartilage in some.

Importantly, the improvements have been sustained beyond 12 months.

The technique involves using liposuction to obtain a sample of the patient's stem cells, which are isolated and expanded before being injected back into them.

The results have been so promising that patients in the trial's control group have been invited to undergo the treatment after 12 months of data collection.

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

Military should get annual check up

Australian Defence Force personnel would undergo annual mental health checks under plans backed by the AMA to tackle rates of depression, post-traumatic stress disorder and suicidal thoughts in the military.

A parliamentary committee inquiring into the mental health of soldiers, sailors and air force personnel found that although in the short term they were no more prone to mental health problems than the broader community, the nature of their work meant the types of problems they experience are not the same.

> "Military personnel were found to be less prone to alcohol abuse, but they were more likely to suffer depression, and to think about and plan suicide"

The 2010 ADF Mental Health Prevalence and Wellbeing Study found that 22 per cent of Defence personnel experienced a mental disorder in the previous 12 months, roughly similar to that found in a sample of general members of the community, while almost 7 per cent who suffered multiple problems.

But although, in the short term, the prevalence of problems was approximately the same, over their lifetime, ADF personnel were found to be more at risk of mental health problems.

Military personnel were found to be less prone to alcohol abuse, but they were more likely to suffer depression, and to think about and plan suicide. The most common mental health problem, however, was anxiety, particularly post-traumatic stress disorder.

AMA President Professor Brian Owler said this reflected the particular characteristics of their work, including experiences during deployment overseas and long absences from family and support networks.

Professor Owler said a recommendation from the Foreign Affairs, Defence and Trade References Committee for annual mental health screening was a welcome proposal.

"Annual screening would help ensure that mental health problems are identified at a much earlier stage, would support early intervention, and lead to much better mental health outcomes for affected personnel," the AMA President said.

He also endorsed the Committee's call for a unique identifier number for veterans linked to their service and medical records.

In 2013, the Federal Government gave in-principle support to a similar idea put forward by the Joint Standing Committee on Foreign Affairs, Defence and Trade, but Professor Owler said there appeared to have been little progress made on it since.

"A unique or universal identifier could help improve health outcomes for these patients," Professor Owler said.

The AMA President said it would support the transition of personnel out of Defence Force-funded health services into those provided by the Department of Veterans' Affairs or the mainstream health system, and would enable tracking of the health of former ADF personnel over time, which was critical to research.

He said there was strong support for the idea among veterans' groups, and called on the Government and bureaucracy to fast-track the initiative.

ADRIAN ROLLINS

United effort needed to close health gap

Genuine collaboration across the political divide is needed if good intentions about close the gap on Indigenous health is to result in tangible improvements, AMA President Professor Brian Owler has said.

Professor Owler said that although there had been welcome progress on some measures of Indigenous wellbeing, a multipronged approach involving all levels of government and their agencies was vital if significant and enduring advances were to be achieved.

"As a nation, we have changed the way we talk about Aboriginal and Torres Strait Islander health and, as a nation, we can now take the next step to close the health and life expectancy gap," the AMA President said in a statement to mark National Close the Gap Day.

"A genuine partnership between governments, across the political spectrum, would be a catalyst to achieving significant and much-needed health and lifestyle improvements for all Indigenous Australians."

Government figures show smoking rates among Indigenous people are coming down, and the nation is on track to halve the mortality rate for Aboriginal and Torres Strait Islander children by 2018.

But Professor Owler said they continued to suffer from a high incidence of treatable and preventable conditions including type 2 diabetes, rheumatic heart disease, kidney disease and scabies.

Furthermore, Indigenous people were much more likely to have undiagnosed and untreated chronic conditions, and to suffer several problems simultaneously.

Combined, these factors have meant that Indigenous people are, on average, dying 10 years earlier than other Australians.

The Federal Government led by Tony Abbott turned the policy focus on to school attendance and employment, but Professor Owler said good health was fundamental to improvement in other areas and should be a priority.

"We have seen encouraging improvements in some areas of Aboriginal and Torres Strait Islander health and wellbeing over recent years, but we need to see consistency of positive outcomes across the country and across the major health indicators," he said. "Much more needs to be done to close health inequality gap between Indigenous and non- Indigenous people [and] health should be a foundation that underpins improvements in other measures."

The AMA has been a long-standing supporter of the Close the Gap campaign, and Professor Owler said National Close the Gap Day was an important reminder for all Australians to act to improve Indigenous health equality.

"It is inexcusable that Australia, one of the world's wealthiest nations, can allow three per cent of its citizens to have poorer health and die younger than the rest of the population," he said. "Closing the gap is everybody's business."

ADRIAN ROLLINS

AMA in action

The AMA has been at the centre of the action in the past two weeks.

Prime Minster Malcolm Turnbull and Health Minster Sussan Ley came to AMA House in Canberra on 17 March to meet with AMA President Professor Brian Owler and the AMA Federal Council. The Prime Minister had one-on-one talks with Professor Owler before attending a meeting of the Federal Council, which was also attended by Ms Ley. Councillors used the opportunity to press Mr Turnbull and Ms Ley on key aspects of health policy including public hospital funding, the Medicare rebate freeze, cuts to pathology and diagnostic imaging bulk billing incentives and rural medical training.

The AMA made a substantial contribution to the national debate about private health insurance, releasing its inaugural *Private Health Insurance Report Card* to help consumers navigate the labyrinthine private health insurance market. The Report Card ranked the polices offered by each insurer according to the cover they provided, and compared the benefits paid by several of the major funds for a selection of common treatments.

Professor Owler backed a Choosing Wisely initiative in which several medical colleges and societies identified more than 60 treatments and procedures that should no longer be used, particularly involving the use of antibiotics. The AMA President also met with the group Grandmothers Against Detention, who were protesting outside Parliament House. Aside from doing many radio, television and newspaper interview, AMA Vice President Dr Stephen Parnis attended several important AMA meetings and met with Shadow Assistant Health Minister Stephen Jones to discuss medical workforce issues.

ADRIAN ROLLINS

Prime Minister Malcolm Turnbull talks with AMA President Professor Brian Owler and the AMA Federal Council during a visit to AMA House on 17 March

AMA Vice President Dr Stephen Parnis (L) meets with Shadow Assistant Health Minister Stephen Jones to discuss medical workforce issues

Choose wisely: AMA President Professor Brian Owler urges more careful use of antibiotics in an interview on ABC News 24

AMA President Professor Brian Owler meets with members of Grandmothers Against Detention protesting outside Parliament House, Canberra

Know your health insurance: AMA President Professor Brian Owler discusses the AMA's inaugural *Private Health Insurance Report Card* on Chanel 9's Today Show

Hospital funding, the medicare rebate freeze, bulk-billing incentive cuts, medical training and rural health were among issues raised when Prime Minister Malcolm Turnbull and Health Minister Sussan Ley met with AMA President Professor Brian Owler and the AMA Federal Council at AMA House on 17 March

E-cigs: a help or a harm?

In December, the AMA issued a Position Statement on *Tobacco Smoking and E-Cigarettes* in which it called for nationally consistent controls on the marketing and advertising of e-cigarettes, including a ban on sales to children. The AMA has raised concerns that e-cigarettes are appealing to young people, undermining tobacco control efforts, and says there is no evidence to support their use as an aid to quitting smoking.

Below, AMA member Dr Colin Mendelsohn, a tobacco treatment specialist, raises objections to the AMA's current position on e-cigarettes, and the AMA responds.

Is the AMA statement on e-cigarettes consistent with evidence?

BY DR COLIN MENDELSOHN, TOBACCO TREATMENT SPECIALIST, THE SYDNEY CLINIC*

** Dr Colin Mendelsohn has received payments for teaching, consulting and conference expenses from Pfizer Australia, GlaxoSmithKline Australia and Johnson and Johnson Pacific. He declares to have no commercial or other relationship with any tobacco or electronic cigarette companies.*

The recent AMA statement on smoking takes a very negative position on electronic cigarettes (e-cigarettes).

While there is still much to learn about e-cigarettes, there is growing evidence to support their effectiveness and safety for smoking cessation and harm reduction. Many experts feel that e-cigarettes are a potentially game-changing technology and could save millions of lives[1].

The AMA position statement does not reflect the current evidence in a number of areas. For example, there is currently no evidence for the AMA's statement that "young people using e-cigarettes progress to tobacco smoking" (the gateway effect). In the UK, for example, regular use of e-cigarettes by children is rare, and is confined almost entirely to current or past smokers[2]. Research in the US has found that increased adolescent access to e-cigarettes is associated with lower combustible cigarette use, rather than the opposite being true.

Understandable concerns are raised that increasing the visibility of a behaviour that resembles smoking may 'normalise' smoking and lead to higher rates of tobacco use. However, since e-cigarettes have been available, smoking rates have continued to fall. In the US, daily smoking by adolescents has dropped to a historic low of 3.2 per cent. Adult smoking rates in the US and UK are also at record lows.

A recent independent review of the evidence commissioned by the UK public health agency, Public Health England (PHE), concluded that e-cigarettes are around 95 per cent less harmful than smoking[3]. This assessment includes an estimate for unknown long-term risks, based on the toxicological, chemical and clinical studies so far. Any risk from e-cigarettes must be compared to the risk from combustible tobacco, which is still the largest preventable cause of death and illness in Australia.

Three meta-analyses and a systematic review[4] suggest that e-cigarettes are effective for smoking cessation and reduction. The evidence indicates that using an e-cigarette in a quit attempt increases the probability of success, on average, by approximately 50 per cent compared with using no aid or a nicotine replacement therapy (NRT) purchased over-the-counter.

Most of the research to date has used now-obsolete models with low nicotine delivery. Newer devices deliver nicotine more effectively, and have higher quit rates.

In the UK, e-cigarettes are now the most popular quitting method, and are used in 40 per cent of quit attempts. In the UK alone, there are currently more than one million smokers who have quit smoking and are using e-cigarettes instead, with considerable health benefit[5]. It has been estimated that each year in England, many thousands of smokers quit using e-cigarettes and would not otherwise have quit if e-cigarettes had not been available.

... from p20

Many organisations disagree with the AMA's view that "currently there is no medical reason to start using an e-cigarette". The Australian Association of Smoking Cessation Professionals, Public Health England and the UK National Centre for Smoking Cessation and Training recommend e-cigarettes as a second-line intervention for smokers who are unable or unwilling to quit smoking using approved first-line therapies.

In the health care setting there is empirical evidence that combining e-cigarettes with counselling and other pharmacotherapies, such as varenicline and NRT, can improve outcomes further[6].

The UK's Medicines and Healthcare Products Regulatory Agency recently licensed an e-cigarette which will be available on the National Health Service in 2016. It can be prescribed by doctors to help smokers quit, and will be provided free.

In Australia, we need to have an evidence-based debate on the potential benefits and risks of e-cigarettes. Careful, proportionate regulation of e-cigarettes could give Australian smokers access to the benefits of vaping while minimising potential risks to public health. The popularity and widespread uptake of e-cigarettes creates the potential for large-scale improvements in public health.

The AMA has made a major contribution to reducing smoking rates in the past. It is well placed to take a leadership role in this debate to ensure that the potential benefits from e-cigarettes are realised.

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6. Hajek P, Corbin L, Ladmore D, Spearing E. Adding E-Cigarettes to Specialist Stop-Smoking Treatment: City of London Pilot Project. J Addict Res Ther. 2015;6 (3) http://dx.doi.org/10.4172/2155-6105.1000244

For a full list of references, go to: https://ama.com.au/ausmed/e-cigs-help-or-harm

Clarification on the AMA's position

The recently updated AMA Position Statement *Tobacco Smoking and E-Cigarettes* - 2015 states:

that the AMA has significant concerns about e-cigarettes. E-Cigarettes and the related products should only be available to those people aged 18 years and over and the marketing and advertising of e-cigarettes should be subject to the same restrictions as cigarettes. E-cigarettes must not be marketed as cessation aids, as such claims are not supported by evidence.

As noted in the background to the Position Statement, the evidence supporting the role of e-cigarettes as a cessation aids is mixed and low-level.

The stance taken by the AMA on e-cigarettes is consistent with that of the World Health Organisation, Cancer Council Australia, the National Heart Foundation, the National Health and Medical Research Council (NHMRC) and the Therapeutic Goods Administration (TGA) - the latter two organisations being the key decision makers on whether or not e-cigarettes have a role in smoking cessation in Australia.

It is worth noting that a number of smoking cessation aids, backed by evidence, are already available through the Pharmaceutical Benefits Scheme.

The assertion that there is no evidence that e-cigarettes are a potential gateway for young people to progress to tobacco smoking is incorrect.

The AMA's Position Statement refers to international research[1] showing that some young people who use e-cigarettes do in fact progress to tobacco smoking. Given the risk, the AMA supports a precautionary approach for children and young people.

E-cigarettes will continue to be topical. Research is being published regularly and the AMA will continue to monitor the issue.

The AMA Position Statement, which covers a range of issues, can be viewed at: https://ama.com.au/position-statement/tobacco-smoking-and-e-cigarettes-2015

1 For example see, Primack, BA., Soneji, S., Stoolmiller, M, Fine, MJ & Sargent, D. (2015). Progression to traditional cigarette smoking after electronic cigarette use among US adolescents and young adults. JAMA Pediatr. and Bunnell RE, Agaku IT, Arrazola R, Apelberg BJ, Caraballo RS, Corey CG, Coleman B, Dube SR, King BA.(2014). Intentions to smoke cigarettes among never-smoking U.S. middle and high school electronic cigarette users, National Youth Tobacco Survey, 2011-2013. Nicotine and Tobacco Research. 2014.

Election timing fuss distracts from real issues

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

A federal election looms and speculation about the date is rife.

But, as *Guardian* columnist Lenore Taylor wrote recently, while attention is focussed on 'when?', 'what?' is pushed aside. What are we being asked to vote for in this election?

Thousands of future university students have no idea, Taylor says, what their courses will cost, whichever party if elected; thousands of pregnant women do not know what will happen to maternity leave payments; those approaching retirement are uncertain about the safety of their superannuation.

"Most Australians rely on public hospitals in a medical emergency, but their future is also unclear. State governments, and now the Australian Medical Association, are warning that the $57 billion in cuts in Abbott's first budget are about to create a funding 'crisis', a crisis that will mean patients wait longer for treatment and some services will have to close," Taylor writes. "They are far more important to most Australians than the industrial relations laws that will be used to justify any double dissolution poll."

In short, interest in the date of the election is rather like fussing over the precise GPS location of the deck chairs.

It is, of course, fashionable – take the US as the prime example – for democratic politics to be a shambles. In Australia, there is no contest between health policies that are carefully reasoned and rigorously critiqued; no statement of purpose about why we plough so much public money into health care. That should be the first line of a health policy document.

Now, one might argue that we don't need policy to guide the day-to-day provision of the health care that makes up 90 per cent of what we do in general practice and in hospitals.

True. But if we are to be adaptive, making the most of the future rather than sleeping peacefully on the beach waiting for the waves to wake us, then we should be expecting policy statements that we can read and appraise critically.

The problem with there being no statement of purpose is that the health system becomes vulnerable to depredation by groups such as big corporates in general practice, whose dominant interest is making money.

Observations in the US and Europe suggest that we should be moving in the direction of a single payer for health care, so that there is interchangeability of hospital and community services to enable the most effective management of the growing number of patients with multiple chronic problems.

Instead, we hear mutterings about hybrid models of health insurance and more dependence on out-of-pocket payments – attractive to the economisers but the road to a more expensive, Americanised model. Why else would Medicare payments to general practitioners be frozen, other than to send people down this perilous path?

There is no light at present that would enable us to see clearly and make a choice between contestants for our vote about the direction for health care.

The quest for greater efficiency is important in the use of the health dollar, and that underpins the review of the MBS and other parts of Medicare and proposals contained in the Hambleton review of primary care. But it is only a small part of a foundation block for a comprehensive national health policy.

That policy should, first up, say what as a nation we value about health care and its purpose, what relative contributions we expect from Government and from our pockets, what we think about equity and a fair go – in 2016, not 1976 – and what we are willing to invest in achieving it.

It should tell us what we are planning to do about general practice, especially in the near future.

It should say what we expect of our citizens with regard to caring for their own health, and what we can expect from the health system.

It should also spell out the way forward in relation to prevention of the major epidemics of obesity and chronic illness, mental disorder and alcohol and hence, what we are willing to invest in preventing and treating these problems.

This is a highly political question, because many of the major preventive strategies, as we have seen in relation to road safety and tobacco, are community movements, requiring commitment from parts of Government other than health, including education and transport, as well as private sector players such as the food industry.

So, rather than obsessing about when an election will be held, we should agitate to pin down the major contestants about their policies for health and health care.

At present, we don't have more than the occasional clue, and that is a serious risk factor.

Grattan Institute – long on rhetoric, short on evidence

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

Many GPs would have been dismayed by the recently released Grattan Institute report, *Chronic failure in primary care*, which suggested that GPs were failing in the prevention and management of chronic disease.

The Report itself is a contribution to the ongoing national discussion about how to best manage the growing incidence of chronic disease given our ageing population and busy yet sedentary lifestyles. However, it was blatantly wrong for the Institute to claim GPs are failing in this critical part of primary health care delivery.

> "The underlying message in the Institute's report is that funding for chronic disease management in this country needs to be reformed. That is something the AMA has been saying for years"

The Institute's report was quick to use words like "failing" and "ineffective", yet presented very little evidence to back its claims up.

The Institute's report uses data on Service Incentive Payments (SIP) under the Practice Incentive Program to infer that GPs management of diabetes is sub-par. Yet the Organisation for Economic Cooperation and Development says Australia has one of the lowest rates of hospital admissions per 100,000 population for uncontrolled diabetes. The SIP data only accounts for a specific item of care claimed - it does not account for care provided outside the shackles of that item but within the confines of another.

The underlying message in the Institute's report is that funding for chronic disease management in this country needs to be reformed. That is something the AMA has been saying for years.

As our *Pre-Budget Submission 2016-17* highlights, current MBS arrangements for Chronic Disease Management (CDM) items are administratively burdensome, do not accord with accepted clinical practice and do not effectively reward or encourage longitudinal care. Where patients have a high level of clinical need and are more prone to avoidable hospitalisation, more proactive and coordinated funding models are needed.

An example is the Department of Veterans' Affairs Coordinate Veterans Care program, which was developed with extensive consultation and input from the general practice profession, and one that is showing positive outcomes.

In its submission to the Primary Health Care Reform Advisory Group, the AMA expressed support for, among other things, blended payment models which complement current funding arrangements, reform of CDM items to strengthen the role of a patient's usual GP, reduced red tape and streamlined patient access to GP referred allied health, and rewards for longitudinal care.

In addition, the AMA recommended the adoption of proactive models of care coordination, the introduction of a quality improvement incentive under the Practice Incentives Program that is informed by better data collection, and the introduction of non-dispensing pharmacists in general practices to improve medication management, particularly for patients with chronic disease.

To tackle the growing burden of complex and chronic disease a long term view is needed, along with greater investment in general practice to realise better health outcomes and to reduce the pressure on our hospitals from the down-stream costs of fragmented health care.

For any new funding model to be successful, it will need to be relevant to the Australian context, carefully designed in consultation with the profession, and fully tested.

Capitation no fix for GP underinvestment

BY DR DAVID RIVETT, CHAIR, AMA RURAL MEDICAL COMMITTEE

> "The truth is that general practice is not broken. Rather, it is severely underfunded. It is doing a great job on the pittance it receives"

As I write, I have just left AMA Federal Council, where we were graced by the attendance of both the Prime Minister, Malcolm Turnbull, and the Health Minister, Sussan Ley.

I would love to say I have news of great importance or excitement to report from this, but I do not. Of note, the Health Minister advised that the report of the Primary Health Care Reform portion of the MBS review would be released "very soon". As it hit her desk last November, this is well overdue.

Hopefully, any "brave" new forward directions will be trialled in small areas and thoroughly assessed then refined before any widespread roll-out.

However, with the Health Minister and Prime Minister both declaring that we have to find savings, and the Royal Australian College of General Practitioners stating chronic disease care can be done better while calling for patient enrolment in a "medical home" (that is, capitation as the solution), GPs are likely to soon be caught between a rock and a hard place.

The truth is that general practice is not broken. Rather, it is severely underfunded. It is doing a great job on the pittance it receives.

Patient rebates have been eaten away by a rotten indexation formula, cunningly applied since the birth of Medicare, which has driven payments per consultation down in real terms annually, and which takes absolutely no account of practice costs. Despite this, GP outcomes on what measures we have are up there with the best in Organisation of Economic Cooperation and Development comparators.

So, how do GPs keep the doors open? They spend less time with patients, and rely increasingly on Enhanced Primary Care items to subsidise consultations.

Is this a good outcome? No, it is not.

How can it be fixed? Well, any sane person would increase rebates for longer consultations, thus rewarding more time spent with patients, and buttress this with indexation reflecting practice costs and CPI.

How can the situation be made rapidly worse? That answer is easy... by freezing rebates.

Which is just what our political masters have done, on the advice of heaven knows which uninformed never-to-be-named bureaucrat.

To suggest dire underfunding can be fixed by "capitation" which, unlike "fee for service", gives a certainty of expenditure to Government, is naïve and simplistic.

The RACGP should not continually call for capitation without rock solid assurances of greatly increased funding to general practice flowing from such a change. To continue to do so will lead the profession into a very dark place. Cloud cuckoo land is too kind a term to apply to such flatus-filled thought bubbles.

Next Federal Council will be my last, and I wish my successor well in the role, and trust he or she will keep the AMA focussed on rural and regional health care needs.

It has been a great privilege to be involved with Federal Council, the outstanding Councillors who serve on it, and the staff of the federal AMA office.

Hospital resourcing – bad now, but full-blown crisis looms

BY DR ROD McRAE, CHAIR, AMA COUNCIL OF PUBLIC HOSPITAL DOCTORS

Welcome to the Council of Public Hospital Doctors (CPHD). This new designation is considered to better describe members of what used to be the Council of Salaried Doctors, and allows us all to choose our membership category more accurately.

I hope more doctors based in public hospitals will choose to identify with this membership category option, as opposed to their medical craft group, when it comes to renewing their AMA membership.

> "The AMA's position is that bullying and harassment should not occur or be tolerated in the medical workplace, and complainants should not face barriers to reporting"

Since my last article, in which I mentioned workplace wellbeing and the AMA's newly-released Position Statement on Workplace Bullying and Harassment, the Senate has referred the medical complaints process to the Community Affairs References Committee for inquiry and report. Submissions close in May, and AMA will provide one into this important inquiry.

The terms of reference include the prevalence of bullying and harassment in the medical profession, barriers to reporting, the roles of the Medical Board of Australia and Australia Health Practitioners Regulation Agency in investigating bullying and harassment, and the desirability of requiring complainants to sign a good faith declaration. These are all complex issues with no easy answer.

The AMA's position is that bullying and harassment should not occur or be tolerated in the medical workplace, and complainants should not face barriers to reporting.

Whether the MBA and the over-stretched AHPRA have a closer role to play in this remains to be seen but, in the meantime, it is up to employers to be vigilant and proactive in dealing with complaints. What we don't need is yet another layer of bureaucracy, or complaints being shuffled around from one entity to another without benefiting a colleague experiencing torment.

Another key area for public hospital doctors is, of course, cuts to public hospital funding.

Public hospitals now face a real funding crisis from 2017, when the full impact of the Federal Government's decision to strip $57 billion of hospital funding from the states and territories through to 2025 begins to impact.

In March, AMA President Professor Brian Owler said that public hospitals, doctors, other health workers, and patients are under increasing pressure as a result of reduced capacity, and that things will only get worse without a massive injection of long-term guaranteed funding from the Federal Government in the Budget.

It's grim. Currently, 32 per cent of patients presenting to an ED classified as 'urgent' are not seen within the recommended 30 minutes. Doctors and hospitals will always do the best by their patients, but these severe cuts mean the system as a whole won't be able to cope, and doctors and hospital staff will bear the not insignificant brunt. Indigenous Australians and other vulnerable people will be some of the worst affected by these cuts. As usual, though, once seen, the patients receive world-class treatment.

It's bad right now, but about to explode into a full-blown crisis.

The Government needs to properly fund public hospitals and stop trying to fill budget gaps with short term, knee-jerk solutions that have disastrous effects in the long term.

No doubt I'll see some of you very soon at National Conference in Canberra, where these and other issues will be on the agenda.

I look forward to seeing State and Territory representatives at our upcoming meeting in May. We have a lot to discuss and we will be setting the CPHD agenda for the year. It is important that we all engage as fully as possible to keep the AMA informed of policy matters key to CPHD members, and address referrals to it.

Good data beats an opinion every time

BY **AMA VICE PRESIDENT DR STEPHEN PARNIS**

> "This incredible stuff up is a dramatic (and expensive) example of what can happen if you don't do your homework, and get the right data"

Some years ago, NASA lost a $US125 million probe sent to Mars because their engineers failed to convert imperial to metric measurements when transferring vital data before the craft was launched.

This incredible stuff up is a dramatic (and expensive) example of what can happen if you don't do your homework, and get the right data.

Back on Earth, reliable data to get workforce planning right has never been more important.

As Australia tries to ensure that our future medical workforce matches growing and changing community need, we run the usual risks of having ideology and buck-passing interfere with sound decisions.

A significant and instructive example of where good workforce data is proving its worth is the annual update of the Skilled Occupations List (SOL) by the Department of Education and Training.

Some background: the SOL is used for Australia's points system for independent permanent migration. The list nominates occupations that would benefit from independent skilled migration to meet the medium- to long-term skills needs of the economy.

In essence, the system focuses on occupations which are expected to be in short supply. Immediate skills shortages are addressed in other ways, such as through the 457 visa program.

Engineering, construction, commerce and health occupations dominate the SOL. The Department uses labour market migration information and general economic and demographic data to determine what occupations are included on the list. Bodies such as the AMA are invited to comment on whether these specialised occupations should stay.

You would probably be surprised to know that there are more than 30 medical specialties and sub-specialties on the SOL. They have been there for years, and the listing has not kept pace with the times. Quite frankly, the data the Department has been depending on has been hopelessly incomplete and out-of-date.

But things are changing for the better.

As part of the consultation process for the current annual review of the SOL, we recently met with the Department to discuss the medical categories, and our fundamental concerns. Relevant colleges and societies also attended.

The clear message that was conveyed to the Department of Education and Training was that it must look to the data being generated by National Medical Training Advisory Network (NMTAN) - a view that its officials appeared to agree with.

Importantly, the Department had received submissions from its colleagues at the Department of Health whose used NMTAN data to show that a range of specialties were in a position of balance or oversupply, and should be removed from the SOL.

This is a promising sign that NMTAN is evolving into the instrument we expect, to illuminate and help resolve workforce problems. The AMA asserts that all future decisions about the medical occupations included on the SOL should be based on NMTAN's up-to-date information.

It is important to get this right.

It's clear that Australia does not need to bring in large numbers of doctors when a ready supply of local graduates is coming on stream.

Otherwise, medical workforce planning will come crashing down to Earth.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Hospital funding deal 'not enough'

A deal to inject as little as $1 billion from the Commonwealth into the public hospital system was being mooted ahead of last week's Council of Australian Governments meeting amid warnings it will not be enough to sustain services in the face of spiralling demand.

As *Australian Medicine* went to print, speculation was mounting that Prime Minister Malcolm Turnbull was close to arranging a deal with his State and Territory counterparts to provide a multi-billion dollar funding boost to public hospitals amid warnings that $57 billion of cuts unveiled by the Abbott Government in 2014 would plunge the system into financial crisis and cause a blow-out in waiting times.

Less than a week after meeting with AMA President Professor Brian Owler and the AMA Federal Council on 17 March, Mr Turnbull told reporters he would "have more to say in the lead-up to [the COAG meeting] relating to health and schools and so forth".

At the AMA meeting, the Prime Minster showed keen interest in reports from Council members that public hospitals were experiencing a rapid increase in demand that vastly outstripped the pace of population growth.

Mr Turnbull wanted to know why this was occurring, and was told a big factor was increased life expectancy, which meant that patients were more likely to present with multiple chronic health conditions that were more expensive and complex to treat, placing huge demands on hospital resources.

These stresses have been reflected in the AMA's Public Hospital Report Card released earlier this year, which showed that improvements in the performance of public hospitals had already stalled, and in some respects were starting to go backwards.

Professor Owler said this was only going to get worse as big Budget cuts began to bite next year, and warned that suggestions the Federal Government might stump up just $1 billion over four years, to be shared among the states, would not be enough.

It is understood the Government was considering an increase in the tobacco excise and reduced tax breaks for superannuation to provide the extra funds.

Some states are pushing for an extra $10 billion and Professor Owler said a figure of $6.7 billion had been suggested.

"[The] figure of $6.7 billion has been talked about over the next four years to deal with both health and education, …I'm afraid that's just not going to cut the mustard. It's not going to mean that states can continue to provide the level of services that patients expect and deserve," he said. "By any stretch of the imagination, cobbling together $6.7 billion over a four year period for states and territories to fund health and education is just not going to make it."

Professor Owler said the Commonwealth needed to dump plans to index hospital funding at inflation plus population growth, which he said was completely inadequate to ensure hospitals were able to maintain their services.

ADRIAN ROLLINS

A July poll?

It appears increasingly likely the country will go to the polls on 2 July after Prime Minister Malcolm Turnbull brought forward the Budget and recalled Parliament to debate controversial industrial laws.

A week after pushing through Senate voting reforms, Mr Turnbull announced the Federal Budget would be delivered on 3 May, a week ahead of schedule, and Parliament would resume on 18 April so the Senate could debate legislation to reinstate the Australian Building Control Commission.

By bringing forward the Budget, the Prime Minister has created room to call an early July election if, as is expected, the Government fails to muster the support in the Senate it needs to pass the ABCC Bill.

The Government needs the support of six crossbench Senators to have the legislation become law, but just two have indicated they would back it. Three have said they will oppose it, and three others are uncommitted.

If the Bill is rejected, it would give Mr Turnbull a trigger to call a double dissolution election, which the Government hopes – thanks to the Senate voting reforms - would wipe out many of the minor party and independent Senators and deliver it a working majority in the upper house.

If the Government goes ahead with a 2 July poll, it means the AMA National Conference will take place in the thick of the election campaign, providing an opportunity to boost health and health funding as an election issue.

ADRIAN ROLLINS

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Putting a cost on sickly sweet

The Turnbull Government is facing calls to emulate its British counterpart and introduce a tax on sugary drinks in the 3 May Budget as part of measures to reduce the nation's waistline.

In a move lauded by celebrity chef Jamie Oliver and public health advocates, UK Chancellor George Osborne last month made a surprise announcement that the British Government would impose a sugar levy on the soft drinks industry, taxing them according to how much sugar they put in their products.

Mr Osborne said the measure was being introduced to help tackle child obesity, citing estimates that within a generation half of all boys and 70 per cent of girls in Britain could be overweight or obese.

"I am not prepared to look back at my time here in this Parliament, doing this job, and say to my children's generation, 'I'm sorry. We knew there was a problem with sugary drinks. We knew it caused disease, but we ducked the difficult decisions and we did nothing'," the Chancellor said.

Under the tax, set to come into force in 2018, soft drinks with more than five grams of sugar per 100 millilitres, such as Fanta, would be taxed at 18 pence (A34 cents) a litre, and those with more than eight grams per 100 millilitres, such as full-strength Coca-Cola, would be taxed at 24 pence (A45 cents) a litre. Pure fruit juices and milk-based drinks will be exempt.

The British Government expects the tax to raise $A974 million, and will use the revenue to increasing funding for school sports programs.

Mr Oliver said the British move would "travel right around the world", and called on the Turnbull Government to "pull its finger out" and introduce a similar levy in Australia.

The idea of a sugar tax had been backed by the British Medical Association, which had recommended a duty on sugar-sweetened beverages that increased prices by at least 20 per cent as a useful first step in encouraging the widespread adoption of healthier eating habits.

But so far there seems little appetite for the idea in the Australian Government, and it is meeting stiff resistance from the beverage industry.

Coca-Cola is among a group of companies planning to sue the British Government over the tax, and parent company Coca-Cola Amatil told The Age that the measure would be ineffective in combating obesity.

The company said a sugar tax was "not the solution to this complex problem", arguing that obesity was increasing despite a 26 per cent decline in per capita sugar contribution from carbonated soft drinks.

However, while not explicitly calling for a sugar tax, the AMA has nonetheless said that taxation should be among the instruments used by the Government to help people make healthier food choices.

There is evidence that a levy on soft drinks can change consumer behaviour. When Mexico introduced a 10 per cent tax on sugary drinks three years ago, sales fell 6 per cent.

But critics, including the beverage industry, claim that it has just shifted the problem, with consumers looking for their calories elsewhere, such as in fruit juices or sweetened milk-based drinks.

The AMA has cautioned against a focus on any one single nutrient or aspect of diet, and said tackling obesity would require a broad range of measures that may include a price signal such as a tax, but should also involve action to reduce the exposure of children to the advertising and promotion of unhealthy foods in general – not those only containing added sugar, but also those high in saturated fat and added salt.

It has made a submission to Free TV Australia, the peak television industry group, highlighting concerns about the marketing of unhealthy foods to children during broadcasts and called for designated child viewing times to be increased and restrictions on advertising of processed foods at peak viewing times, such as live sports broadcasts.

ADRIAN ROLLINS

Research

Two energy drinks a day may send a doctor your way

Many Australians turn to energy drinks to reduce fatigue, increase wakefulness, and improve concentration and performance, but a study has found that drinking more than two energy drinks a day can cause adverse heart reactions, including a fast heartbeat, heart palpitations, and chest pain.

Researchers from the University of Adelaide surveyed patients aged 13 to 40 years who attended an emergency department in South Australia with heart palpitations, and found 70 per cent had consumed some version of an energy drink.

Dr Scott Willoughby, co-author of the study, said that the study was able to find a direct link between energy drink consumption and hospital admissions for adverse heart reactions.

"Of the patients surveyed, 36 per cent had consumed at least one energy drink in the 24 hours prior to presenting at the hospital, and 70 per cent had consumed some sort of energy drink in their lifetime," Dr Willoughby said.

"Those patients who were heavy consumers of energy drinks were found to have significantly higher frequency of heart palpitations than those who consumed less than one a day.

"And importantly, fast heartbeat, heart palpitations, and chest pain was seen in energy drink consumers who were healthy and had no risk factors for heart disease."

AMA Vice President, Dr Stephen Parnis, told the *Herald Sun* that people did not realise the serious health repercussions of energy drinks, some of which have the same amount of caffeine as 10 or 20 cups of coffee.

"Poisoning is not too strong a word to use for the effects of these drinks on some people," Dr Parnis said.

"I have seen teenagers present in emergency with heart rates of 200 beats per minute or who are so stimulated that their behaviour is extremely distressing to their parents and the people around them.

"At the bare minimum, energy drinks should come with warning labels.

"I think that preventing sales of these drinks to people under 18 is something that we need to look at very closely."

The study was published in *International Journal of Cardiology.*

KIRSTY WATERFORD

Lead exposure link to violent crime

Australian children who are exposed to higher lead levels are more likely to commit violent crimes later in life, Macquarie University research has found.

The research backs up previous findings that lead exposure increases impulsiveness and crimes of aggression.

Lead author, Professor Mark Taylor, and his team took air samples from six New South Wales suburbs and looked at criminal statistics in the same areas over a period of 30 years.

They found that, after taking into account relevant socio-demographic variables, concentrations of lead in the air accounted for 29.8 per cent of the variance in assault rates 21 years after childhood exposure.

Research

... from p29

Importantly, the findings were consistent between states – in Victoria, more than 32 per cent of the variance in rates of death by assault 18 years following lead exposure, and in New South Wales the figure was 34 per cent.

In Australia, historically there have been three sources of lead exposure: in paint, petrol, and from mining and smelting emissions.

The researchers found the link between exposure and assault persisted regardless of whether the lead came from smelting or petrol.

Professor Taylor said more specific information was needed to prove that lead exposure caused aggressive behaviour and that, given the findings, lowering lead exposure would be beneficial.

"The results indicate that measures need to be taken to lessen exposure to lead in areas where environmental air levels remains high, so as to avoid any long-term neurodevelopmental consequences," Professor Taylor said.

The study was published in *Environmental Health.*

KIRSTY WATERFORD

Gender differences more than skin deep

Differences between men and women run deeper than previously realised, with research showing the effect of gut bacteria on your health depends on whether you are male or female.

Victoria University researchers have found that even when the balance of gut bacteria look the same in each gender, the results show that certain bacteria, such as streptococcus, lactobacillus and clostridium, can behave differently in males and females.

The researchers studied gut bacteria in chronic fatigue sufferers and found specific bacteria were related to debilitating symptoms.

The researchers say the findings could change the one-size-fits-all approach in which digestive issues, particularly in people with chronic fatigue, are treated.

Lead researcher and PhD candidate Amy Wallis said the research team found that high levels of streptococcus bacteria

in the gut was related to more problems for men, but less for women.

"This, and other results with lactobacillus bacteria, show that caution is needed when using probiotics as, in some cases, it could do more harm than good," Ms Wallis said.

With 70 per cent of the immune system sitting in the gastrointestinal tract, Ms Wallis said disturbance in gut bacteria is directly linked to physical health, and has been connected to autoimmune disease.

"There are trillions of bacteria in the gastrointestinal tract which play intricate and complex roles in achieving and maintaining both a balanced gut and optimal health, so an imbalance can have wide-reaching effects," Ms Wallis said.

"We can no longer assume that a certain type of bacteria is going to do the same job in males and females, and now need to consider that each gender may respond differently to the same treatment."

The research team also found evidence supporting the microgenderome in humans. Microgenderome is the relationship between bacteria, the immune system and sex drives.

The study was published in *Scientific Reports*.

KIRSTY WATERFORD

Rich told: stop taking from the poor

Rich countries have been urged to reduce their reliance on overseas-trained doctors and improve workforce planning to help address severe shortages of medical practitioners in developing nations.

A dramatic upsurge in the number of doctors has averted fears of a world-wide doctor shortage, but the Organisation for Economic Cooperation and Development said large numbers were flocking to wealthy nations from Africa, exacerbating problems with access to care among the poor.

According to the OECD report *Health Workforce Policies in OECD countries: Right Jobs, Right Skills, Right Places*, there were 3.6 million doctors practising among its member countries in 2013, up from 2.9 million in 2000 – a 24 per cent increase in just 13 years.

Much of this increase has been driven by a sharp expansion in medical school intakes and training programs.

Australia has been part of a global trend toward boosting medical school intakes – since 2004, the number of medical school places has soared by 150 per cent to reach more than 3700, creating problems further along the training pipeline, where there has not been a commensurate increase in capacity.

But the growth in doctor numbers has also been fuelled by recruitment from overseas.

The report found that 17 per cent of all active doctors working in OECD countries came from overseas, and though a third originated in other OECD nations, "large numbers also come from lower-income countries in Africa that are already facing severe shortages".

While the United States and the United Kingdom are the two most popular destinations for overseas-trained doctors, Australia is among the most heavily reliant on them to help plugs gaps in the medical workforce.

They comprise about a quarter of all doctors working in Australia, and make up more than 40 per cent of those practising in rural and remote regions.

The OECD said this reliance was coming at a heavy cost to poor countries that were training doctors, only to see many of them emigrate rather than ease the local shortage.

OECD Secretary-General Angel Gurria said that with the threat of a global doctor shortage averted, it was time to focus attention on improving the distribution of the medical workforce to ensure all had access to high quality care.

"The evolving health and long-term care needs of ageing populations should stimulate innovation in the health sector, where attention should focus on creating the right jobs, with the right skills, in the right places," Mr Gurría said. "Countries need to co-operate more to ensure that the world gets the strategic investments in the health workforce that are necessary to achieve universal health coverage and high-quality care for all."

The AMA has anticipated the OECD's call, late last year releasing a Position Statement recommending that Australia not recruit doctors from countries which have an even greater need for them.

Australia is already a signatory to the World Health Organisation's Global Code of Practice on International Recruitment of Health Personnel, which calls for improved workforce planning to allow nations to respond to future needs without relying "unduly" on the training efforts of other countries, particularly low-income ones.

AMA Vice President Dr Stephen Parnis said that improved workforce planning was an "urgent priority".

The Abbott Government abolished Health Workforce Australia and absorbed its functions within the Health Department, a move Dr Parnis condemned as short-sighted.

In its final report, the HWA confirmed that Australia had sufficient medical school places, and instead urged attention on improving the capacity and distribution of the medical workforce – a task that the AMA hopes the National Medical Training Advisory Network will be able to fulfil.

A particular concern is difficulties in recruiting and retaining doctors in rural and regional areas.

The OECD has urged countries to use a mix of financial incentives, regulations and technologies such as telemedicine to help reduce regional disparities in access to care.

The Federal Government has announced the establishment of 30 regional training hubs and an expansion of the Specialist Training Program, but the AMA has voiced doubts that these initiatives on their own will be enough, and has instead called for a third of all domestic medical students to be recruited from rural areas.

The Government has so far resisted the suggestion, and Health Minister Sussan Ley told the AMA Federal Council last month that she was "not interested" in imposing regulations that would tie doctors to practice in a particular geographic area.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

AMA AWARDS 2016 – Call for Nominations

The AMA is seeking nominations of people or groups who have made an extraordinary contributions to health care and public health. Nominations are sought in the following categories:

1. AMA Excellence in Healthcare Award

The AMA Excellence in Healthcare Award is for an individual, not necessarily a doctor or AMA member, who has made a significant contribution to improving health or health care in Australia. The person may be involved in health awareness, health policy or health delivery.

Nominations for this award can be submitted by any member of the community.

2. AMA Woman in Medicine Award

The AMA Woman in Medicine Award is for a female member of the AMA who has made a major contribution to the medical profession.

Nominations for this award may only be made by a member of the AMA.

3. AMA Women's Health Award

The AMA Women's Health Award goes to a person or group, who does not necessarily have to be a doctor or female, but who has made a major contribution to women's health.

Nominations for this award can be submitted by any member of the community.

4. AMA Men's Health Award

The AMA Men's Health Award goes to a person or group, who does not necessarily have to be a doctor or male, but who has made a major contribution to men's health.

Nominations for this award can be submitted by any member of the community.

5. AMA Youth Health Award

The AMA Youth Health Award goes to a young person or group of young people, aged 15 to 27, who have made an outstanding contribution to the health of young Australians.

Nominations for this award can be submitted by any member of the community.

Nomination Information

Nominations for each award must include:

- a personal statement by the nominator describing the merit of the nominee/s in relation to the criteria for the relevant award;
- a current Curriculum Vitae for the nominee/s; and
- any additional supporting documentation relevant to the nomination.

Submission of nominations electronically is preferred. Nominations, including all required documentation, should be emailed to awards@ama.com.au.

Alternatively, they may be mailed to:

'2016 AMA Awards'
Public Health Section
Australian Medical Association

PO Box 6090
KINGSTON ACT 2604

The closing date for receipt of nominations for each award is COB Friday 22 April 2016.

Thrills by Koonunga Hilll

BY DR MICHAEL RYAN

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Penfolds deserves credit where it is due.

It's easy to knock the big players, especially when they are owned by multinational companies and seem to be run by those "faceless men". Their growing and buying prowess enable good quality wines with consistency.

While there are price increases that cause a little Globus, such as Bin 389 selling for $85 when I remember buying it for about $12, Penfolds seems to understand the market, and over the years have brought several moderately-priced but good quality wines to the table.

Exhibit A is Koonunga Hill Shiraz Cabernet, which was first released in 1976. It has always had a dominant Shiraz component, ranging from 50 to 65 per cent. The concept came about because of the need for a good, consistent quality, affordable wine.

When it first came out, Koonunga Hill was about $2 a bottle, while bread was 30 cents a loaf, petrol cost 30 cents a litre and a newspaper cost 12 cents. Based on movements in the CPI, $2 in 1976 is worth $12 now, while other methods of calculating value put it as high as $22. All of which suggest that, at between $11 and $16 today, Penfolds have been consistent in pricing Koonunga Hill.

The Koonunga Hill vineyards in the north of the Barossa were first planted in 1973. Today, Shiraz and Cabernet find their way into bottles of Grange, 707 and 389. The Koonunga Hill range is now sourced from Barossa, McLaren Vale, Coonawarra, Langhorne Creek, Padthaway and Border Town. It is usually fermented in stainless steel and receives mild oak exposure in three to four-year-old oak barrels.

The 2014 release is representative of the vintage. Some early poor fruit set with a middle season deluge, but a long ripening period. Fragrant Shiraz and Cabernet are the stand outs. This is the vintage that got me re-invigorated about Koonunga Hill.

The 20014 Shiraz Cabernet , Shiraz and Cabernet Sauvignon are outstanding, as I will describe below. There have been Chardonnay, Riesling, Semillon Sauvignon Blanc and Cabernet Merlot blends as well.

In 2006, the Koonunga Hill "Seventy Six" Shiraz Cabernet was released in honour of its 30 year history. This wine used substantial quality fruit and 10 per cent new American oak, but only costs about $25.

WINES TASTED

1. 2014 Koonunga Hill Shiraz

Classic dark red to purple. The nose is a mix of dark plums, hints of spiced figs. Some mocca notes, with aniseed developed in the glass. An elegant Shiraz by Penfolds standards. Really nice forward fruit, with a pinch of lip-smacking tannins. Overall, a fragrant enjoyable Shiraz. Cellar 10 years.

2. 2014 Cabernet Sauvignon

More purple than garnet in colour. Concentrated cassis notes, with hints of cabernet dust. Mild oaky aromas with savoury spices that develop as decanted. Typical Cabernet structure, with juicy forward fruit and well-structured tannins. Quite a well-integrated wine. Cellar eight years.

3. 2014 Shiraz Cabernet

Dark purple in colour. While the name suggests the wine should be an amalgam of the Shiraz and Cabernet, it cuts its own jib. Complex fragrant prunes and damson plums are balanced by spicey oakey notes. Genuinely well-fruited and a seamless structure makes this an outstanding sub-$20 wine.

MGB – turning back time

BY DR CLIVE FRASER

Last month's column reviewed a modern classic sports car, the award-winning fourth generation Mazda MX-5.

The inspiration for such a successful model lies a long way back in 1924 with the British car-maker, Morris Garages.

They had produced a succession of re-bodied sports cars based on other vehicles.

There was an MG TA, TB, TC, TD and TF, all two-seater excitement machines.

In 1955 they released the MGA, a more modern, affordable and stylish two-seater roadster.

Impractical for commuting, shopping and picking up the in-laws, it was perfectly suited to driving on a Sunday afternoon anywhere in the sometimes sunny British countryside.

But many more were exported than sold at home.

Following that success came the MGB in 1962.

Quite a few mechanical components from the MGA migrated into the new MGB.

The gearbox was identical, with four speeds and no synchromesh on first gear.

The differential was the same, save for a slightly reduced final drive ratio to take account of the wheels going from 15 inch to 14 inch rims.

The engine grew from 1.5 to 1.8 litres for more performance, but was still roughly based on the BMC B-Series engine dating back to 1947.

Another leftover from the past was the early electrical system, which was a pair of six volt batteries in series, with the positive terminal going to the earth.

But on the outside the MGB's styling was fresh and modern, and still looks good today.

While earlier MGs were constructed body-on-frame, the MGB was the world's first sports car with crumple zones and a monocoque chassis - not bad for 1962.

With more modern design and construction, the MGB had a roomier cabin than the MGA, even though it was physically smaller.

Some MGB variants even squeezed in a rear seat.

The MGB sold well, particularly in the United States, and 523,836 cars were produced at Abingdon, Berkshire until 1980 – and 9000 of them were assembled in Australia from completely knocked down (CKD) kits.

My secretary owned one of these for years.

It was lovingly maintained by a neighbour who was a retired mechanic.

It hardly ever broke down, and even though she parted company with it years ago it still provides happy memories of topless motoring, wind in the hair, 100 per cent visibility and lots of admiring glances from fellow motorists.

But it was the lucrative United States export market that unwittingly hastened the end of the MG, with their increasing demands for safety and emissions compliance.

In 1974, in order to meet US regulations about headlamp height, the body was raised by one inch, which trashed the handling.

And to add insult to injury, the beloved chrome grille was then replaced by a plastic bra modelled after Sabrina (aka the well-endowed Norma Ann Sykes) to meet 5 mph impact regulations.

In 1975, the UK spec twin SU carburettors were replaced in the US by a single Stromberg unit.

Further modifications to meet tougher emissions standards cut power output down from 71kW to 52kW.

Reliability was also seriously compromised, and the MGB was nose-diving towards mediocrity.

There had been a V8 variant on offer from 1973 onwards and, due to its all-aluminium construction, the V8 motor was 20kg lighter than the iron four cylinder power-plant.

But the MGB was losing its way. These dysplastic changes meant that it didn't really go, sound or look like a real MG anymore.

It is against this background of nostalgia that a loyal group of MG lovers has come together and are taking their newer MGs and turning them back into replicas of the older models.

No need for a cosmetic surgeon to undertake this operation.

To find out how to turn back time in your MGB stay tuned.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

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: 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.

doctorportal Learning: AMA members can access a state of the art CPD tracker that allows CPD documentation uploads, provides guidance CPD requirements for medical colleges, can track points against almost any specialty and provides access to 24/7 mobile-friendly, medical learning.

Learning.doctorportal.com.au

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.

Career Advisory Hub: Is your one-stop shop for expert advice, support and guidance to help navigate your medical career. Get professional tips on interview practice, CV reviews, and application guidance to get competitive edge to reach your career goals.

Amex: As an AMA member, receive no-fee and heavily discounted fee cards including free flights and travel insurance with range of Amex cards.*

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.

Hertz 24/7: NEW! Exclusive to the AMA. AMA members can take advantage of a $50 credit when renting with Hertz 24/7.

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.

MJA Bookshop: AMA members receive a 10% discount on all medical texts at the MJA Bookshop.

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Join now,
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You can find the full range of AMA member benefits here:
ama.com.au/member-benefits