AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

AMA NATIONAL CONFERENCE
All the news, action & colour pp14-29

A new start

AMA changes leadership…but fight against rebate freeze, hospital cuts continues, p6

INSIDE

AMA

ISSUE 28.05 JUNE 20 2016

AUSTRALIAN
Medicine

Managing Editor: John Flannery
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford
Contributors: Maria Hawthorne
Odette Visser
Graphic Design: Streamline Creative, Canberra

Advertising enquiries

Streamline Creative
Tel: (02) 6260 5100

Australian Medicine is the national news publication of the Australian Medical Association Limited. (ACN 008426793)

42 Macquarie St, Barton ACT 2600
Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499
Web: www.ama.com.au
Email: ausmed@ama.com.au

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AMA LEADERSHIP TEAM

President
Dr Michael Gannon

Vice President
Dr Tony Bartone

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Cover: New AMA President Dr Michael Gannon is congratulated by his predecessor Professor Brian Owler at the AMA National Conference in Canberra.

Holding the Government to account

BY AMA PRESIDENT DR MICHAEL GANNON

> "We need to break the idea that health is a cost. It is an investment in the future of our community. Without good health, you cannot have a healthy society or, for that matter, a productive economy. Spending on health is not just another budget line to be cut or held down"

I was greatly humbled and honoured to be elected as President of the AMA at last month's National Conference in Canberra.

It is an exciting and challenging time to assume such an important position – in the midst of a close, hard-fought federal election campaign, with health at the top of the agenda. I want to make sure that it stays there.

I am talking to all sides of politics about the issues that matter to you and your patients. Getting rid of the Medicare rebate freeze and increasing funding for public hospitals are top priorities.

The rebate freeze is unfair and it is wrong. We know that it is pushing many practices to breaking point. Some are being forced to introduce patient charges for the first time, others are having to increase their fees. Either way, patients lose out and health suffers.

It is bad policy because it causes people to think twice before seeing their doctor. It will mean more people turning up at hospital – the expensive end of the health system.

Hospitals are already under enough pressure. All levels of government need to realise that an ageing population and epidemics like obesity and drug use are pushing demand up.

We need to break the idea that health is a cost. It is an investment in the future of our community. Without good health, you cannot have a healthy society or, for that matter, a productive economy. Spending on health is not just another budget line to be cut or held down.

I will criticise the Government when they deserve it. I will speak up fearlessly when they produce bad policy.

But I want such criticisms to be the start of the conversation, not the end. I want to engage constructively with all sides of the political debate, and to find better ways forward.

I want to invigorate a conversation on the medical workforce. We need more training positions, not more medical students - and certainly, not more medical schools. The workforce we train should meet the needs of the community it is there to serve. We can do better for rural Australia.

The AMA has a long history of advocating for the sick, the vulnerable and the voiceless. That will continue under my leadership. I have committed myself to continuing the AMA's work in closing the gap between Indigenous and non-Indigenous health outcomes. I want to do more on mental health. I will hold the Government to account on the health care of asylum seekers.

I congratulate Dr Tony Bartone on his election as AMA Vice President. He is a much valued colleague and friend. I look forward to working closely with him in the next two years to advance the interests of patients and AMA members.

I pay tribute to the tireless work of my predecessor, Professor Brian Owler, and former AMA Vice President Dr Stephen Parnis, in advocating on behalf of patients and our community.

I look forward to the next two years as AMA President with great energy and enthusiasm.

Squeezing GPs and training a bad health outcome

BY AMA VICE PRESIDENT DR TONY BARTONE

With the Federal election looming, the AMA has been tirelessly working to make sure that health is a core priority for the major parties and for the voters.

The AMA's *Key Health Issues for the 2016 Election* was released in early May and sets a clear path forward for a major campaign targeting a range of issues including the freeze on MBS indexation. The campaign rightly also focuses on public hospital funding certainty, workforce training issues, the retention of bulk billing incentives for pathology and diagnostic imaging, tackling chronic disease, prevention, Indigenous health, rebuilding rural infrastructure and supporting recruitment and retention rurally, physical activity and tobacco.

All members, with the help of your AMA, are asked to join together in campaigning for a better deal for our practices and our patients

The first of these issues, the immediate removal of the rebate freeze, has already drawn a positive response from the ALP, which has committed to reinstating indexation of the MBS rebate.

But ending the rebate freeze is only one of many issues to be addressed.

Public hospitals need funding certainty at a level consistent with population growth and demographic changes. Access and equity is paramount here, as it is in other sectors. Appropriate access to outpatient clinics and elective surgery is predicated on robust funding which is targeted and patient focussed.

Clearly, the workforce planning strategy needs urgent attention as appropriate postgraduate training opportunities are severely lacking. Solving this is core business and central to our election priorities document. The AMA will continue to fight for all doctors in training to have access to appropriate postgraduate training opportunities,

Nowhere is the AMA's advocacy more tangible than in general practice. In recent weeks we have released materials to support GPs across the country to inform patients about the impact of the Medicare freeze. At the end of many consultations across the country, GPs are talking to their patients about just how little is the value the current Government seems to place on GPs or the patients we care for.

Squeezing GPs and their capacity to provide high quality care for patients will only result in poor outcomes for patients and higher downstream costs as more people turn up to emergency departments or are admitted to hospitals.

We are already seeing general practices reviewing their billing practices. Some practices are on the brink. Rents, wages and utilities are all going up, and many practices now face a tough choice – pass these increasing costs on to patients or see their viability further undermined.

Access to dedicated general practice terms for our doctors in training during their prevocational years is also essential. General practice is the only major specialty where this is not readily available, and this needs to change. These experiences can foster interest in a long-term career in general practice, give these doctors a better understanding of general practice and foster better relationships with our other specialist colleagues.

One of the truly successful health care policies in recent times has been the GP infrastructure grants. These have been used to support access to expanded primary care services as well as teaching and training. Nowhere is this more important than in rural Australia, where GPs are the backbone of health service delivery.

I am delighted to have been elected as the AMA Vice President. My commitment is to always listen and engage with members and seek your feedback. These are challenging times as the Government seeks to fix its fiscal problems. Our strength lies in our membership.

Government needs to appreciate that health is an investment in society and long-term economic performance, not a cost, and that good policy development will see long-term benefits in terms of improved health outcomes and the sustainability of our health system.

Change at the top

BY AMA SECRETARY GENERAL ANNE TRIMMER

AMA elections are over for another two years, with Dr Michael Gannon being elected as President and Dr Tony Bartone elected as Vice President on the closing morning of the National Conference. On behalf of the Federal AMA secretariat I acknowledge the contributions made by Professor Brian Owler and Dr Stephen Parnis over the past two years.

> "That leadership carries considerable responsibility in influencing Government decisions for the benefit of members and their patients. Dr Gannon and Dr Bartone are well-equipped to continue that task…"

The AMA plays a leading role among not just health advocacy organisations, but all advocacy organisations in the national capital. That leadership carries considerable responsibility in influencing Government decisions for the benefit of members and their patients. Dr Gannon and Dr Bartone are well-equipped to continue that task, both having recently completed terms as State Presidents of AMA Western Australia and AMA Victoria respectively.

It is an interesting time for the leadership change within the AMA in the midst of a Federal election. The Labor Party has made significant promises in health spending, including lifting the freeze on Medicare rebates from 1 January 2017. At the time of writing, neither party had released commitments on funding for public hospitals. These are the AMA's two major election issues, as detailed in its key issues document, *Key Health Issues for the 2016 Federal Election.*

The AMA National Conference is the key annual policy meeting of the AMA. While it is open to all doctors, members and non-members, the core delegates are nominated by the State and Territory AMAs, the specialty groups, and the special interest groups, together with members of Federal Council.

The Annual General Meeting accepted a proposed change to the Constitution to reshape delegate representation in future years, with representatives of the practice groups plus State and Territory AMAs, and members of Federal Council. The current practice groups are general practice, doctors in training, rural doctors, public hospital doctors, and doctors in private specialist practice.

Further work is underway by a working group of Federal Council to look at the structure and composition of Federal Council itself to ensure that it properly reflects the modern AMA membership.

The National Conference was a great success, with a relevant and wide-ranging program. Highlights included a debate on assisted dying which will contribute to the ongoing process of reviewing the AMA's position statement. Tony Jones, of ABC Q&A fame, facilitated a highly engaging and respectful debate on the issue.

Another highlight was a panel discussion on Saturday morning with some of Australia's leading political journalists on the upcoming Federal election and the place of health policy in the debates leading to the election. It was a riveting session.

Shadow Health Minister Catherine King and Australian Greens leader Senator Richard Di Natale addressed the Conference on Friday morning, and Health Minister Sussan Ley addressed the Conference dinner on Saturday night.

All sessions were relevant and interesting.

Federal Council and the Board have had several discussions about the format of the National Conference in the years when there is no AMA election.

While there is a commitment to retaining the Conference as an annual event, there is the prospect of a more open and flexible format in non-election years, with broader participation by AMA members. I welcome the comments of members on this topic.

Rebate freeze 'must go': Gannon

New AMA President Dr Michael Gannon has declared that the Medicare rebate freeze is "unfair…and wrong", and must be scrapped.

In his first public statement following his election at the AMA National Conference, Dr Gannon reaffirmed the peak medical organisation's commitment to overturning the freeze, which he warned could force some doctors to abandon bulk billing and begin charging patients up to $25 a visit.

> "The Federal Government's decision to extend the current freeze on Medicare rebates an extra two years to 2020 has provoked outrage among GPs and the broader medical profession"

"GPs are at breaking point. They can't take too many more cuts," he said. "I would not be surprised if those practices that move away from bulk billing, and decide to invest in the infrastructure required to collect the fees, turn around and collect something like a fee between $15 and $25".

The Federal Government's decision to extend the current freeze on Medicare rebates an extra two years to 2020 has provoked outrage among GPs and the broader medical profession. The AMA has mounted a nationwide campaign against the policy, which is also the target of television ads by the Royal Australian College of General Practitioners that warn patients the freeze means "you will pay more".

Dr Gannon has assumed the presidency in a highly politically-charged environment, with the nation embroiled in one of the longest Federal Election campaigns in decades. Opinion polls have the two major parties locked in a close contest.

Dr Gannon has held discussions with Health Minster Sussan Ley, Shadow Minister Catherine King and Greens leader Richard Di Natale, and promised to "pursue a consultative style [to] try and find constructive ways forward".

He said there was an opportunity to improve the AMA's relationship with Ms Ley, and said the AMA should "always try and be constructive when it criticises policy of governments or opposition to come up with alternatives".

Dr Gannon warned that, "when you criticise Government on any area of policy you need to realise that there might be a cost in that area or in other areas of your agenda".

But he said the Medicare rebate freeze had to go, and reiterated the AMA's support for Labor's policy to end the freeze. Both Labor and the Greens have promised $2.4 billion to reinstate rebate indexation from 1 January next year.

Dr Gannon called for the Coalition to "change tack" on the freeze.

"Unravelling the freeze is so important," he said, adding that such a move should be the start of a broader discussion about improved support for general practice.

"Successive governments have under-invested in quality general practice. That is the cornerstone of the health system," he said. "High quality primary care reduces the need for more expensive hospital admissions. Unravelling the freeze is not a solution to the underfunding of general practice. We need to do so much better."

The AMA President also attacked Commonwealth cuts to public hospital funding.

"I don't think that there's room to cut hospital funding; in fact, quite the opposite," Dr Gannon said.

While the AMA needed to be "responsible" in calling for greater health funding, he lamented that both the Federal and State tiers of government had failed to comprehend the rise in hospital costs stemming from the ageing population and health epidemics like obesity and drug use.

But Dr Gannon said his advocacy would not be limited to general practice and hospital, and the AMA's "very strong" platform on social issues would continue under his leadership.

He said he was committed to "continuing the AMA's long history in trying to close the gap between Indigenous and non-Indigenous Australians", and also made particular mention of mental health and "speaking up for people who can't speak for themselves".

ADRIAN ROLLINS

The AMA will speak up on asylum seeker health

Doctors "must speak up" on the health care of asylum seekers, new AMA President Dr Michael Gannon has said.

Indicating the Government would continue to come under pressure over the treatment of asylum seekers and refugees being held in detention, the WA obstetrician said the issue was "core business" for the AMA.

"Asylum seekers and refugees, ethically and under law, are entitled to the ethical protections of the Australian Government, Australian law, the Australian people," he said. "That means that doctors must speak up. That is a core ethical principle of medical care, that you speak up when patients are not being treated well."

But he clarified that any comments he made regarding asylum seekers would be confined to issues affecting their health: "If you ever hear me talking about it, I'll be talking about the health of asylum seekers, I won't be making any comments about broader policy".

Dr Gannon said the AMA needed to be "smart" and recognise that when it raises politically contentious issues, "there are risks to other elements of [its] agenda".

"The AMA must always be fearless in speaking up on social issues, even if there is a cost. But we need to be smart, and recognise that there can be a cost to the relationship," he said.

"I would love to build a more constructive relationship with the Turnbull Government if they're re-elected, but we will speak up fearlessly when they produce bad policy. If they produce policies that aren't good for the health of Australians, then we will criticise them."

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

AMA Fee List Update – 1 July 2016

The AMA List of Medical Services and Fees (AMA List) will be updated on the 1 July 2016 to amend existing items and include new items. These items are provided in the Summary of Changes for 1 July 2016, which will be available from the Members Only area of the AMA website at https://ama.com.au/article/1-november-2015-31-october-2016-current

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

1) Once you have entered your login details, from the home page hover over **Resources** at the top of the page.
2) A drop down box will appear. Under this, select **Fees List**.
3) Select first option, **AMA List of Medical Services and Fees – 1 July 2016.**
4) Download either or both the CSV (for importing into practice software) and **Summary of Changes** (for viewing) detailing new, amended or deleted items in the AMA List.

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

Rebate freeze will cost avg GP almost $110,000

The Medicare rebate freeze will leave a full-time GP $109,000 worse off by the time it is lifted in 2020, and practices will need to charge patients at least an extra $11.40 per visit just to maintain their income, a study on the impact of the policy shows.

Researchers at Sydney University's Family Medicine Research Centre – which is due to close down on 30 June - have reported that the rebate freeze, which has been in place since 2014 and is due to remain until June 2020, will cost practices hundreds of thousands of dollars in lost income – underlining concerns it will force many to abandon bulk billing and begin charging patients if they are to remain financially viable.

The researchers, Christopher Harrison, Clare Bayram and Helena Britt, estimated that GPs would lose 9.4 per cent of their income if they did not pass the costs of the freeze on to their general patients.

They said that for an average full-time GP, who bills 7680 consultations a year, this would amount to a loss of $40,000 in 2019-20 alone, and total loss of $109,000 over the six years the freeze is due to be in place.

This was likely to result in extra charges for patients, the researchers said.

"The 9.4 per cent reduction in income may force GPs who bulk bill to cover their loss by charging general patients a co-payment," they said.

They estimated that GPs would need to charge a minimum of $11.40 just to hold their income at 2014-15 levels, but admitted it was likely to be substantially higher because their estimates did not take into account the administrative costs of setting up a billing system, increased bad debts, the impact of previous fee freezes and the income lost when a GP bulk bills a general patient facing financial hardship.

"It's therefore likely that GPs who opt to charge a co-payment will charge more than our estimates," they said, and cited the results of an *Australian Doctor* poll showing a majority would charge $25 or more for a standard consultation.

The findings of the study echo concerns raised by AMA President Dr Michael Gannon that the rebate freeze was pushing many practices to "breaking point".

"We know that...some are being forced to introduce patient charges for the first time, others are having to increase their fees," Dr Gannon said. "Either way, patients lose out and health suffers."

> "Adding to the pressure on patients and doctors, the researchers estimated that the Government's proposed increases in co-payments for Pharmaceutical Benefit Scheme medicines would hit elderly patients particularly hard"

The AMA President said the freeze was "bad policy" because it would cause many patients to consider delaying seeing their doctor, exacerbating their health problems and making it more likely they would eventually need expensive hospital treatment.

The Family Medicine Research Centre academics warned the freeze would hit practices treating disadvantaged and chronically ill patients the hardest.

"The freeze is likely to have a greater impact on practices that serve socioeconomically disadvantaged people, as the practices would have to absorb the reduction in gross income, which may not be viable," they said.

Adding to the pressure on patients and doctors, the researchers estimated that the Government's proposed increases in co-payments for Pharmaceutical Benefit Scheme medicines would hurt elderly patients the most.

The increases, which have so far been blocked in the Senate, would push the PBS co-payment for general patients to $43.30, and for concessional patients to $7.

The researchers estimated that aged pensioners would, on average, be left $29.65 a year worse off as a result of the changes.

ADRIAN ROLLINS

"If in doubt, sit them out" – new guidelines for concussion in sport

Immediate-past AMA President Professor Brian Owler (R) launches the Concussion in Sport Position Statement with Australian Institute of Sport Chief Medical Officer Dr David Hughes

Children and teenagers with suspected sport-related concussion should be kept from training or playing for at least two weeks after their symptoms clear, new guidelines developed jointly by the AMA and the Australian Institute of Sport recommend.

The nation's leading medical and sporting bodies teamed up to develop new guidelines and resources for dealing with concussion on the sporting field.

"Concussion is something that occurs on the sporting fields. It's not just something that occurs for professional athletes," outgoing AMA President, Professor Brian Owler, said at the launch of the new website, concussioninsport.gov.au.

"This resource is designed for those coaches, trainers, teachers, parents – those people who are dealing with injuries that happen on sporting fields on Saturday mornings, or on school days.

"I hope that parents and coaches can use this resource. It gives them some reassurance, and we can get some better management of concussion and make sure that we avoid some of the problems that can come along if people don't pay enough attention to it."

AIS figures show a 60 per cent rise in the number of people admitted to hospital for sport-related concussion over the past decade. It is estimated there are as many as 100,000 sports-related concussions each year.

But general knowledge about concussion management at a community sporting level in Australia is poor.

"I've been in sports medicine for 25 years, and I have to say that I still find each case of concussion challenging," AIS Chief Medical Officer, Dr David Hughes, said. "I certainly know from my discussions with athletes, parents, and coaches that concussion is an issue that causes a certain amount of anxiety and concern, and rightly so."

The concussioninsport.gov.au website provides simple but specific advisory tools for athletes, parents, teachers, coaches and medical practitioners.

"There are videos that are recorded by experts from the sporting world, and also GPs, emergency doctors and myself as a neurosurgeon," Professor Owler said.

"It shows the important things that people need to look out for, and also gives some pretty clear instructions on how to manage concussion in terms of return to training and returning to play."

The website, and the joint AMA-AIS Position Statement on *Concussion in Sport*, recommends that children avoid full-contact training or sporting activity until at least 14 days after all symptoms of concussion have cleared.

"We've erred on the side of caution," Professor Owler said.

"No-one is going to have ill-effects from sitting out two weeks of sport. But we know that if people go back too early, then they risk having more concussion, and it's the compounding effects of concussion that can actually end their playing careers."

Dr Hughes said there was growing evidence that children were more susceptible to, and took longer to recover from, concussion.

"It's not the most conservative policy in the world," Dr Hughes said. A group in Scotland has recommended a four week break, but he said the evidence did not support such a long period.

He said the policy was closely aligned with World Rugby's current policy on children in sport, and "we certainly feel strongly that children should not be treated the same way as adults when it comes to concussion in sport."

The joint AMA-AIS Position Statement on *Concussion in Sport* and a new website, concussioninsport.gov.au, were released at the 2016 AMA National Conference in Canberra.

The Position Statement can be viewed at:

https://ama.com.au/system/tdf/documents/AMA_AIS_Concussion%20in%20Sport%20Position%20Statement%202015.pdf?file=1&type=node&id=44298

MARIA HAWTHORNE

AMA calls for fair go for bush health

The AMA has encouraged all major political parties to deliver significant real funding increases for health care in regional, rural and remote Australia.

Immediate-past President Professor Brian Owler made the appeal when he launched the AMA's plan for *Better Health Care for Regional, Rural, and Remote Australia* at Parliament House last month.

> "The AMA plan focusses on four key measures – rebuilding country hospital infrastructure; supporting recruitment and retention; encouraging more young doctors to work in rural areas; and supporting rural practices"

Professor Owler said that the life expectancy for those living in regional areas was up to two years less than the broader population, and up to seven years less in remote areas, and needed to change.

"It is essential that Government policy and resources are tailored and targeted to cater to the unique nature of rural health care and the diverse needs of rural and remote communities to ensure they receive timely, comprehensive, and quality care," Professor Owler said.

The AMA plan focusses on four key measures – rebuilding country hospital infrastructure; supporting recruitment and retention; encouraging more young doctors to work in rural areas; and supporting rural practices.

The plan encourages Federal, State and Territory governments to work together to ensure that rural hospitals are adequately funded to meet the needs of their local communities. More than 50 per cent of small rural maternity units have closed in the past two decades.

Professor Owler said rural hospitals needed modern facilities, and must attract a sustainable health workforce.

"We need to invest in hospital infrastructure," Professor Owler said. "When hospitals don't have investment, when their infrastructure runs down, it makes it much harder for rural doctors to service patients in their communities."

He called on the Council of Australian Government (COAG) to consider a detailed funding stream for rural hospitals, backed by a national benchmark and performance framework.

Professor Owler visited a rural GP practice at Bungendore and spoke with the local doctors about the issues and barriers of delivering high quality timely health care to the community.

"General practice is the backbone of rural health care, providing high quality primary care services for patients, procedural and emergency services at local hospitals, as well as training the next generation of GPs," Professor Owler said.

"Rural GPs would like to do more, but face significant infrastructure limitations in areas such as IT, equipment, and physical space.

"Rural general practices need to be properly funded to improve their available infrastructure, expand services they provide to patients and support improved opportunities for teaching in general practice."

The AMA has recommend that the Government fund a further 425 rural GP infrastructure grants, worth up to $500,000 each, to assist rural GPs.

Professor Owler added that timely access to a doctor was a key problem for people living in rural areas, with the overall distribution of doctors skewed heavily towards the major cities. He said the burden of medical workforce shortages fell disproportionately on communities in regional, rural and remote areas.

The number of GP proceduralists or generalists working across rural and remote Australia has steadily been declining. In 2002, 24 per cent of the Australian rural and remote general practice workforce consisted of GP proceduralists. By 2014, this level had dropped to just under 10 per cent.

The AMA and the Rural Doctors Association of Australia have together developed a package that recognises both the isolation of rural and remote practice and the need for the right skill mix in these areas.

The AMA *Better Health Care for Regional, Rural, and Remote Australia* is available at https://ama.com.au/gp-network-news/ama-plan-better-health-care-regional-rural-and-remote-australia

KIRSTY WATERFORD

Radiologists abandon campaign on promise of Govt review

The Coalition has convinced the diagnostic imaging industry to drop its campaign against cuts to bulk billing incentives in exchange for a review of the commercial pressures the sector is working under.

After last month striking a peace deal with pathologists to end a damaging campaign over the axing of bulk billing incentives for pathology services, the Government has headed off similar action by the nation's radiology providers.

> "The Minister's announcement came just days before the Australian Diagnostic Imaging Association planned to launch a public campaign warning that cuts to bulk billing incentives"

Health Minister Sussan Ley announced on 5 June that the Coalition, if re-elected, would commission an "independent evaluation...of the commercial pressures facing diagnostic imaging providers".

Ms Ley said the evaluation would also be used to help identify ways to make Government spending more targeted and efficient.

"Advancing technology in many areas of the health system creates a much more efficient and automated service, leading to decreased costs," the Minister said. "However, this is not the case for most diagnostic imaging services, which need specialist doctors to supervise the examination and analyse the results, not machines.

"This independent evaluation will ensure we can work together with the diagnostic imaging sector to pinpoint exactly where possible improvements can be made in the broader system, and ensure this significant additional investment is targeted where it will have the most benefit for patients."

Ms Ley said up to $50 million a year could be saved through greater efficiencies in Government spending.

The Minister's announcement came just days before the Australian Diagnostic Imaging Association planned to launch a public campaign warning that cuts to bulk billing incentives, coming on top of an 18-year freeze on patient rebates, would push the cost of crucial of crucial diagnostic and treatment services beyond the reach of many patients, including those with cancer.

The Association said the average out-of-pocket costs for x-rays, ultrasounds, CTs and MRIs had reached $100, and practices were "extremely concerned" that the freeze on rebates would "continue to drive more patients away from essential diagnosis and treatment".

But, following Ms Ley's announcement, Association Chief Executive Officer Pattie Beerens said she was confident the Coalition's plan, which includes maintaining the bulk billing incentive for concession card holders and children, a three-year moratorium on changes to Diagnostic Imaging Services Table and a resumption of rebate indexation in 2020, would "show a path" to adequate Medicare rebates.

"We had to fight the case for patients and we are really pleased that our advocacy has resulted in the diagnostic imaging sector and the Government working constructively to achieve a positive outcome for patients, providers and taxpayers," Ms Beerens said.

ADRIAN ROLLINS

Labor plans long-term reform

Labor has committed to establishing a national commission to develop and drive reforms to the health care system if it wins the 2 July election.

In a speech to the AMA National Conference, Shadow Health Minister Catherine King announced that a Shorten Government would form the Australian Healthcare Reform Commission to end a "boom and cycle" in health reform.

> "This boom and bust cycle in health care reform is not helping find, let alone embed, solutions to problems such as how we provide funding and incentives for things the health care system does not do…" - *Ms King*

Ms King said solutions to some of the "big and difficult questions in health care" extended well beyond the lifecycle of any one Parliament, but were often a casualty when government changed hands.

"This boom and bust cycle in health care reform is not helping find, let alone embed, solutions to problems such as how we provide funding and incentives for things the health care system does not do – avoiding hospital admissions, for example," Ms King said.

"These and many more challenges…require long-term thinking and long-term solutions."

The Shadow Minister said the Commission would assume the functions of many organisations abolished or downgraded by the Coalition Government, including the National Health Performance Authority, the Independent Hospital Pricing Authority, the Australian National Preventive Health Agency and Health Workforce Australia.

Under Labor's plan, the Commission would develop and evaluate proposed reforms, advise Federal, State and Territory governments, and would be given the resources to implement change.

"It will be tasked with rolling out agreed structural reforms to our health care system, including changes to funding agreements and payment systems," Ms King said.

In addition to its other work, the Commission would assume the functions of the Australian Commission on Safety and Quality in Health Care, and would include a new Centre for Medicare and Healthcare System Innovation, charged with developing and evaluating new payment and service delivery models.

Ms King said the Centre would include the functions of the current MBS Review, and vowed that any savings realised by the review process would be reinvested in new models of care.

Under Labor's plan, the Commission will report to the Council of Australian Governments through the standing committee of health ministers.

Ms King said the body would be funded from the consolidation of existing agencies and resources within the Health Department.

ADRIAN ROLLINS

Greens make multi-billion commitment to chronic care

General practices would receive $1000 for each chronic disease patient enrolled with them under a plan outlined by Australian Greens leader Senator Richard Di Natale.

Upping the ante on Coalition policies regarding support for the treatment of chronic illness, Senator Di Natale told the AMA National Conference the Greens would inject $4.3 billion over four years to boost care.

Under the plan, not only would practices get an extra $1000 for each patient with a chronic illness who voluntarily enrolled with them, but $2.8 billion would be allocated to being allied health services within the public system and bolster Primary Health Networks to coordinated team-based care.

"Stretched GPs need a system which is set up to really support them in working with a team to better plan and organise care, and to improve outcomes for chronic disease patients over time," Senator Di Natale said.

The Greens leader said the $4.3 billion commitment amounted to a "dramatic refocusing of our primary care sector to effectively respond to chronic disease", and would establish a blended payment system that would complement the existing fee-for-service structure.

"As a former GP myself, I know the pressure that doctors are under to focus on responding to the immediate ailments of patients," Senator Di Natale said. "But chronic illnesses are complex, and effective management requires long-term treatment and monitoring of symptoms by a range of health practitioners, working together."

The Greens announcement follows the Government's Health Care Homes initiative earlier this year, under which medical practices would receive bundled payments to provide integrated and coordinated care for patients with complex and chronic illnesses.

The Government has committed $21 million to a two-year trial of up to 200 Health Care Homes involving around 65,000 patients.

The AMA has welcomed the Health Care Home proposal but is critical that not more money has been allocated to the trial.

Senator Di Natale echoed the criticism, arguing that although the Health Care Homes initiative showed a welcome focus on an important area of care, "the trial is inadequately resourced and lacks any real detail".

"Our plan is detailed, commits the funding necessary to be a success, and in the long-term will lead to savings as we better manage chronic disease and avoid hospital admissions," he said.

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

AMA NATIONAL CONFERENCE 2016
KEYNOTE SPEAKERS

Only the Coalition has a credible, affordable plan for health: Ley

Health Minister Sussan Ley speaking at the AMA National Conference Gala Dinner at Old Parliament House, Canberra

Only the Coalition has an affordable and sustainable vision for the future of the nation's health care system, according to Health Minister Sussan Ley.

Seeking to frame the debate over health policy in terms of economic and financial management, Ms Ley told the AMA National Conference Gala Dinner that although Labor and the Australians Greens had unveiled policies with hefty price tags, only the Coalition had the fiscal discipline to be able to afford its health promises.

Labor has made health a centrepiece of its bid to win the 2 July election, announcing a succession of attention-grabbing policies including a $2.4 billion commitment to end the Medicare rebate freeze, $971 million to scrap increases to PBS co-payments and safety net thresholds, and $35 million for palliative care.

Not to be outdone, the Greens have matched Labor's policy to resume Medicare rebate indexation, and have promised an extra $4 billion for public hospitals, $4.3 billion to support chronic disease treatment and $2 billion for domestic violence services.

But Ms Ley claimed that neither Labor nor the Greens had shown how they could afford their commitments, and claimed the Coalition was the only party with a credible and affordable plan.

The Minister recently likened the approach of her political opponents to the use of a placebo: "Simply throwing more money at the system is tantamount to 'placebo policy': it may make some feel better but it won't treat the cause."

Ms Ley said a key focus of the Government was to lower the barriers patients face by reducing fragmentation across the health system and improving the coordination of care.

She said the Health Care Homes initiative was trialing a new way of funding the treatment of chronic and complex illnesses to ensure patients received integrated and coordinated care.

The Minister said the recent decision to inject an extra $2.9 billion into public hospitals was accompanied by a greater focus on patient outcomes, quality and safety.

Ms Ley recently suffered a hiccup on the campaign trail when she admitted that she had been overruled by Treasury and Finance in arguing against an extension of the Medicare rebate freeze.

But she told the AMA dinner that she looked forward to continue working with the medical profession to develop policies and identify efficiencies and savings so as to ensure that, in a constrained budgetary environment, every health dollar was used to maximum effect.

ADRIAN ROLLINS

AMA NATIONAL CONFERENCE 2016
KEYNOTE SPEAKERS

Nation 'can't afford' barriers to care: King

Opposition Health Minister Catherine King speaks to delegates about Labor's health plans

AMA advocacy was "critical" in convincing Labor to make its $2.4 billion commitment to reinstate Medicare rebate indexation, Shadow Health Minister Catherine King told the AMA National Conference.

Highlighting what she said was a "huge gulf" between the major parties on health policy, Ms King said Labor's promise to end the rebate freeze formed part of its plan to strengthen primary care, enhance preventive health efforts and reduce health inequality.

The Coalition has seized on figures showing that bulk billing has climbed to record levels to dismiss warnings that the rebate freeze will force many doctors to abandon bulk billing and begin charging patients.

But Ms King said the freeze would eventually result in higher out-of-pocket costs for patients.

"Sooner rather than later we know that the freeze will result in less bulk billing, and more and higher co-payments," the Labor frontbencher said.

"When one in 20 Australians already skips or delays seeing a GP because of cost, that is not something we can afford to let happen.

"When our population is ageing and chronic disease is growing, we should be investing more in primary care, not less."

Ms King said similar concerns underpinned Labor's $971 million plan to scrap increases of between 80 cents and $5 to Pharmaceutical Benefit Scheme co-payments and changes to safety net thresholds.

"Cost is a barrier for access to prescription drugs," she said. "We know that up to one in eight Australians doesn't fill their scripts because medicines are already unaffordable for them."

Ms King admitted that the policies, together with other health measures including an extra $15 million for Indigenous health, more than $25 million for cancer treatment and research and $35 million for palliative care, were expensive.

Labor has said it will fund the measures by axing the Coalition's $50 billion business tax cut.

Ms King said the decision to fund these health policies had not been easy "given the current fiscal circumstances and competing demands. But in the end, budgets come down to choices and values".

ADRIAN ROLLINS

AMA NATIONAL CONFERENCE 2016
KEYNOTE SPEAKERS

Greens promise billions for hospitals, Medicare

Australian Green's Leader and health spokesperson Senator Richard Di Natale talks about Australia's health policy direction

The Australian Greens have committed to a multi-billion dollar boost to Medicare and hospital funding as part of a drive to increase investment in health.

Greens leader Senator Richard Di Natale told the AMA National Conference that his party would not only match Labor's $2.4 billion promise to ditch the Medicare rebate freeze but would provide an extra $4 billion to restore Commonwealth funding for public hospitals, including providing 50 per cent of growth funding.

Senator Di Natale said the policies reflected the Greens' commitment to universal and equitable access to health care, and an end to what he said was the Government's "shameless exercise in cost shifting".

Though opinion polls indicate the Greens stand no chance of forming government in their own right, they show that the election contest is finely balanced, opening the possibility the Greens could play a crucial balance of power role in forming the next government – making their views on health policy potentially significant.

In his speech, Senator Di Natale lambasted the Coalition's cuts to health spending and detailed plans to increase Commonwealth support for hospitals, GPs, allied health workers and health services for Indigenous Australians and other disadvantaged patients.

"We should never be fooled, by those who see health as a cost more than an investment, into believing that cuts to the heart of the health system are a necessity," he said, arguing that Australia's spending on health was around the average among developed economies.

Senator Di Natale said that while it was important to ensure health funds were spent effectively, health expenditure would increase.

"As exciting new treatments become available and our country's demographics change, we will need to spend more on health care to enjoy a better quality of life," he said. "That, we believe, is a clear and legitimate choice for a wealthy nation to make. Spending more on health care is not unsustainable or irresponsible – it is a key priority and an investment we are luck to make."

On the highly controversial topic of assisted dying, Senator Di Natale said the Greens believed patients should have "access to voluntary euthanasia and physician care for dying with dignity".

The Greens leader said policies on Indigenous health, drug and alcohol treatment services and preventive health would be detailed later in the election campaign.

ADRIAN ROLLINS

AMA NATIONAL CONFERENCE 2016
KEYNOTE SPEAKERS

AMA has a responsibility to 'speak up': Owler

Prof Owler reflects on his time as AMA President and discusses the future direction for the AMA

Outgoing AMA President Professor Brian Owler has lashed the Coalition over its conduct of health policy in the past two years, accusing it of allowing short-term budgetary measures to triumph over long-term policy vision.

In a typically forthright speech in his last address to the AMA National Conference as AMA President, Professor Owler said decisions to extend the Medicare rebate freeze, slash public hospital funding and try to impose a GP co-payment had been driven by a focus on savings without regard for their impact on patients and health system.

"As confirmed by [Health Minister Sussan Ley] herself...the health portfolio is not run by the Minister for Health. It is run by Treasury and Finance," he said.

Professor Owler said the history of the last two years had shown that the Government had a problem when it came to health policy, "but the problems are not the making of the AMA [or] of an outspoken AMA President".

"The failures of this Government are of their own making – a failure to consult with genuine intent, a failure to listen."

The former President detailed how the Government set a combative tone for the relationship early on.

"In my first meeting as AMA President, I met with the Health Minister, Peter Dutton, who delivered an ultimatum: 'As I see it,' he said, 'the AMA can either support the Government's co-payment plans or you can be on the outside'."

Professor Owler said it was an easy choice: "I was not going to sell out our members, and I certainly wasn't going to abandon our patients".

He told the conference how the Government responded after asking the AMA to develop an alternative to its co-payment policy.

"We dutifully did this. We worked hard, we kept it in confidence, and we delivered it to the Minster," he said. "In return, the Minister ignored the plan and [described it] as a 'cash grab by greedy doctors'. So much for working closely with Minister Dutton."

Professor Owler said the Medicare rebate freeze was affecting the viability of medical practices, was punishing patients and was "not sensible policy. It affects the whole system".

He said it was pleasing that, as a result of intense AMA lobbying, Labor had committed end the freeze, and said it was not too late for the Government to follow suit.

In his speech, Professor Owler took aim at private health insurers, who he said wanted to introduce US-style managed care.

He said the medical profession needed to be "endlessly vigilant" to the threat.

"We must never let private health insurers undermine our health care system, whether it be by interfering with the doctor-patient relationship or by disturbing equity of access in general practice," he said. "Australians are...relying on you to defend against the actions of insurers, for whom the interests of shareholders come first, and patients are a distant second."

Professor Owler acknowledged that some AMA members had been made "anxious" by the Association's statements on asylum seeker policy.

But he said that with the AMA's influence came a "responsibility to speak up when governments overstep the mark – that is what happened with Australia's approach to asylum seekers".

The former President also highlighted AMA advocacy on Indigenous health and public health, including on family and domestic violence, road safety, alcohol, climate change, immunisation and physical activity.

ADRIAN ROLLINS

AMA NATIONAL CONFERENCE 2016
POLICY SESSIONS

On assisted dying

The AMA National Conference hosted a special policy session on the highly contentious issue of assisted dying as part of an on-going AMA policy review.

The session, moderated by ABC presenter Tony Jones, brought together a panel of doctors, ethicists and lawyers with a range of views on whether doctors should be involved in assisted dying.

The debate began with an account of the death of an elderly patient who had had a breathing tube removed without anaesthetic because the treating doctor was fearful that if they administered a drug they might be charged with causing their death.

The scenario prompted discussion of the degree to which doctors were uncertain about the law around assisted dying and the so-called double effect doctrine.

Professor of Ethics at the University of Queensland, Malcolm Parker, said it was "widely understood the doctor knowledge of the law in all sorts of areas is not particularly good," and many doctors were worried that if the treatment they provided had the effect of causing death, "they will get into trouble".

Avant Head of Advocacy, Georgie Haysom, said the issue hinged around intent: "If you intend to cause someone death, that is murder".

Dr Karen Hitchcock, who works in acute and general medicine at Melbourne's Alfred Hospital and last year wrote a *Quarterly Essay* on caring for the elderly, said there needed to be much greater education around the double effects doctrine, under which the death of a patient is a side effect of treatment.

"Double effect is the bedrock of medicine, which is to treat symptoms," Dr Hitchcock said. "We never treat life, we treat symptoms. So hastening death is not an issue. [Doctors] do not set out to kill; alleviating symptoms is the aim."

Associate Professor Mark Yates, a geriatrician at Ballarat Health Services, said the double effects doctrine "is used on a day-to-day basis" and, rather than changing its position on assisted dying, the AMA should devote its efforts to promoting good palliative care.

But Emeritus Professor Bob Douglas from the Australian National University said the double effects doctrine was "a nonsense", and was causing serious concern for both doctors and the broader community.

Professor Douglas agreed that there needed to be greater investment in palliative care and advance care planning, but said patients should have the choice of assisted dying.

"From the perspective of a patient, my concern is that when I get to the point of incurable illness and inevitable death, I don't want to put all my relatives through the pain and suffering of an unnecessarily elongated process," he said.

Professor Douglas said laws similar to those enacted in the US state of Oregon, which allow terminally ill adults to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications, would "give a lot of people comfort".

Dr Hitchcock said, however, that Oregon-style laws were unnecessary and could actually be harmful, by making the elderly and disabled feel pressured into seeking assisted dying, such as because of the fear of being a burden to their relatives.

"Every patient [already] has a right to choose to have treatment withdrawn," she said. "The main reason people request physician-assisted suicide is because of feelings of uselessness and hopelessness. If we give people the choice, it will influence them."

Dr Hitchcock disputed claims that Oregon-style laws put doctors at arms' length from killing their patients, arguing it was "ridiculous" to pretend that writing a prescription for a lethal dose of medicine was not an act.

"What we are proposing is that instead of [a palliative care team], doctors can give a patient a prescription to go ahead and kill themselves," she said. "We are talking about replacing the palliative care team with a script."

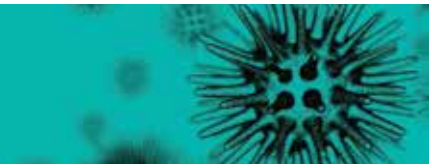
But Professor Douglas countered that just knowing assisted dying was an option could bring people enormous comfort, and experience showed that far from all who acquired a prescription for lethal medication went on to use it.

Figures published by the Oregon Public Health Division show that from the time the laws were introduced in 1997 to the end of 2013, 1173 had obtained prescriptions and 752 had used them. During 2013, 122 people were provided a prescription, and 71 had killed themselves.

AMA President Dr Michael Gannon, who initiated the policy review as Chair of the AMA Ethics and Medico-legal Committee, said the National Conference session would, along with 3500 responses to an AMA member survey, be used to help inform the AMA Federal Council's deliberations on the issue.

ADRIAN ROLLINS

AMA NATIONAL CONFERENCE 2016
POLICY SESSIONS



To perform, and to be seen to perform

Medical Board of Australia Chair Dr Joanna Flynn has raised the possibility that doctors be required to undertake communication skills training as part of their on-going professional development.

> "An AMA National Conference policy session on medical self-regulation was told that most complaints made about medical practitioners revolved around behavioural issues rather than technical performance"

An AMA National Conference policy session on medical self-regulation was told that most complaints made about medical practitioners revolved around behavioural issues rather than technical performance, prompting discussion about ways to improve the communications skills of doctors.

Panellist Associate Professor Matthew Thomas, a specialist in human factors and safety management, said that for too long technical and communication skills had been viewed separately, and he welcomed the move in recent decades to include interviews as part of the selection process for admission to medical school.

Dr Flynn raised the possibility that training in communication skills could be made a mandatory component of Continuing Professional Development (CPD) requirements, though she qualified this by adding that there was "no point in creating something meaningless".

But A/Professor Thomas said communication skills could be learned like any other, and should be a focus of training.

The discussion formed part of a broader debate about the regulation of the medical profession and assurance about the quality of care it provides.

In particular, the panellists discussed the implications of extended working lives, and the growing number of practitioners.

Dr Flynn said official figures showed that an increasing number of procedures were being performed by doctors over the age of 70, and the number of complaints per hours worked increased as practitioners got older.

The MBA Chair said cognitive decline and a loss of physical agility were aspects of ageing that could affect performance.

The Medical Board is currently considering the introduction of a revalidation process to ensure practitioners remain fit to practice medicine, and Dr Flynn said one of the aspects under consideration was whether revalidation should be "stratified" to address particular characteristics such as age, volume of work, and sole versus group practice.

Increases in the medical workforce also have implications for quality.

One of the concerns about sole practitioners was that they lacked an informal safety net of colleagues who could pick up problems in the way they practiced, she said.

By contrast, working in a group environment increased the ability to share workload, reducing the likelihood of errors caused by fatigue and pressures of time, and easing the pressure on individual doctors to provide round-the-clock care.

A/Professor Thomas said the development of a team-based approach to continuity of care was welcome: "The world is not going to end if there is an end to the 'one doctor, one patient' model of care".

He said working in a team could also provide an extra layer of assurance around performance, because any shortcomings in the performance of one practitioner would be extrapolated to the team – meaning all had a vested interest in maintaining high standards.

ADRIAN ROLLINS

AMA NATIONAL CONFERENCE 2016
POLICY SESSIONS

Health key in knife-edge election

The Coalition is likely to win the Federal Election but it could well find itself facing a hostile Senate or having to form a minority government, a panel of the nation's leading political journalists told the AMA National Conference.

The journalists, Channel Ten political editor Paul Bongiorno, *Australian Financial Review* political editor Laura Tingle, News.com national political editor Malcolm Farr, news.com health reporter Sue Dunlevy, and *West Australian* political editor Andrew Probyn, said that after going through five Prime Ministers in little more than three years, the electorate was hankering for stability.

"It doesn't feel like a shift is on," Ms Tingle said. "There is a lack of enthusiasm for change."

Mr Probyn said he expected the Coalition would win by a narrow three-seat margin at the 2 July poll, but others thought there was a considerable chance Prime Minister Malcolm Turnbull would fall short of an absolute majority and have to negotiate with minor parties and independent MPs to form government.

Ms Tingle said in Queensland it was unclear which way the voters who supported the Palmer United Party at the last election would go, and the absence of Campbell Newman from the political scene added to the uncertainty, while in South Australia the Nick Xenophon Team was polling very strongly.

"It makes it very difficult to tell what is going to happen," she said.

Mr Farr said the fact it was a double dissolution election added to the uncertainty, and warned that changes to Senate voting rules would help some independent candidates with a well-established profile, like Pauline Hanson.

Labor and the Greens have campaigned hard on health – both have made a $2.4 billion commitment to end the Medicare rebate freeze, and Greens have promised an extra $4 billion for public hospitals.

The AMA and other medical groups are pushing hard for the Coalition to match the other parties and ditch the rebate freeze.

But Mr Probyn said the Government was "utterly intent on locking in savings".

Ms Dunlevy warned the Government was unlikely to announce any big health reforms ahead of the election, and the best that health groups could hope for was to stem the flow of cuts.

She said the campaign being waged against the rebate freeze by the AMA, the Royal Australian College of General Practitioners and others was unlikely to bite politically while bulk billing rates remained at or near record levels.

> "In recent years the AMA has been successful in lobbying against several government measures, including twice forcing the Abbott Government to ditch plans for a patient co-payment"

"Bulk billing is at its highest level ever, which is why the freeze is not becoming a big election issue," she said. "So far you have got threats to ending bulk billing, but voters are not seeing it yet."

In recent years the AMA has been successful in lobbying against several government measures, including twice forcing the Abbott Government to ditch plans for a patient co-payment.

The panel said the AMA's effectiveness stemmed from the way it had positioned itself as a forceful advocate for the interests of patients.

"People are now saying that doctors are not only on their own side, but also on the side of patients," Mr Bongiorno said. "The way doctors have stood up to politicians, particularly on asylum seekers, has won them a lot of respect."

Ms Dunlevy said the lesson was that "it is not about your profession, it is about the patient".

"If what you are asking for is going to benefit patients, you are on the right track," she said.

ADRIAN ROLLINS

AMA NATIONAL CONFERENCE 2016
POLICY SESSIONS

Private health insurance – its role in the Australian health system

Women with private health cover are overwhelmingly choosing to use the public health system for their second baby, Medibank Private chief medical officer Linda Swan told delegates at the AMA National Conference.

In a policy session on the role of private health insurance in the Australian health care system, Dr Swan said expenditure and claims were exceeding patients' willingness to use their private cover.

"People are very clearly telling us that affordability is their No.1 issue," Dr Swan said.

Rising health care costs could not continue unless Governments and consumers were willing to pay more, or the expense of care could be reduced, she said.

Earlier that day, News Corp national health reporter Sue Dunlevy told the conference that she had been "forced" by the Government to take out private health insurance but was "determined not to use it" because of excessive out-of-pocket expenses.

"There's something crooked at the heart of the private health insurance industry in this country," Ms Dunlevy said.

But Professor John Horvath, the strategic medical advisor at Ramsay Health Care, had a more positive view of the future.

"Australia has an excellent health care system producing world-leading outcomes for patients," Professor Horvath said.

"Australia spends around 9 per cent of GDP on health care, of which 30 per cent is from private sources. This is lower than the OECD average, yet our life expectancy and outcomes are among the highest in the OECD."

Professor Horvath said the ongoing increase in demand for health care, and rising costs, meant payers – including governments – and consumers would continue to push for more value from their health care spend.

He said benchmarked performance reporting and clinician engagement, not "stick" approaches like financial penalties, would drive real improvements in quality, while digital technology would improve patient outcomes and enable hospitals to extend their care beyond hospital walls.

"This is all good news for patients," he said.

Ramsay has begun measuring and benchmarking with the International Consortium on Health Outcomes Measurement (ICHOM) to allow global comparison of specific medical conditions.

It is measuring outcomes in six specific areas:

- low back pain;
- hip and knee osteoarthritis;
- cataract surgery;
- coronary artery disease;
- depression and anxiety; and
- prostate cancer.

The measurements will take in readmission rates, returns to theatre, infection rates, falls, hand hygiene, pressure injuries, medication safety, and patient experience.

Ramsay is also adding new measures including quality of life following treatment, survival, and disease control.

It is also about to commence a trial of the Vanderbilt Program, to assess its effectiveness in managing poorly behaved Visiting Medical Officers who undermine a culture of safety and quality.

The Vanderbilt Program looks at behaviours such as not following a surgical checklist, not washing hands, and bullying of staff – all of which can lead to consequences such as surgical complications, high rates of infections or errors, lawsuits, and loss of staff.

The program is based on the principal of having a conversation with a physician around their behaviour and building up to authority conversations with clearly defined consequences.

Opinions from the floor were mixed. Some doctors said that the combination of more complex patients, procedures and medications would inevitably lead to higher expenditures.

Others said that in most industries, new technologies drive costs down, but in health care they increase costs.

MARIA HAWTHORNE

AMA NATIONAL CONFERENCE 2016
POLICY SESSIONS

Say no to all-male panels – change the culture of bullying and harassment

Tackling bullying and harassment in the medical profession is a long-term project, but one simple change could be made straight away – get rid of all-male panels, AMA Doctor in Training of the Year Dr Ruth Mitchell said.

Dr Mitchell made the call during a policy session at National Conference.

"There are things we can do in the here and now. If you say no to all-male panels, you will encourage diversity," Dr Mitchell said.

Dr Mitchell, who won the DIT award for her work on tackling bullying and harassment, said leadership on the issue was hard and expensive.

She said more must be done to engage bystanders, who witnessed bad behaviours and did not know how to respond.

"Ask myself – when I walk into a room, do I bring peace? Do I make the room a safer place?" she said.

Dr Mitchell said it was particularly troubling that a survey of doctors in training showed a rise in the number reporting that they had experienced bullying, discrimination or harassment in the past six months.

Mr Phil Truskett, the Royal Australasian College of Surgeons President, said more training was needed for medical professionals, who often did not know how to give feedback to trainee doctors in a constructive and respectful way.

Some surgeons still did not see that bullying and harassment were taking place, and were critical of the apology made by RACS last year, he said.

"The more senior colleagues, very eminent colleagues, thought we had thrown the baby out with the bathwater with the apology," Mr Truskett said.

"The reality was, it was a problem that they could not recognise."

Barrister Chris Ronalds SC said it was possible to change the culture, saying that when she joined the Bar, she was one of six women.

"The NSW Bar is a very different world than it was 25 years ago. Sexual harassment was rife and so was daily sexism and racism," Ms Ronalds said.

> "The panel said doctors needed confidence that the system would support them if they reported an issue, and that there were real and appropriate consequences for inappropriate behaviour"

"Judges used to bully and hound women practitioners and it was considered acceptable, as the natural order of things.

"I don't know why we were 25 years ahead of you (the medical profession) but change can happen."

The panel said doctors needed confidence that the system would support them if they reported an issue, and that there were real and appropriate consequences for inappropriate behaviour.

Ms Ronalds said that in any profession, internal complaint mechanisms were only successful if there was a culture that supported them.

"(There is) widespread under-reporting of inappropriate conduct (in the medical profession) for two main reasons – a fear of victimisation and an acceptance that nothing effective will be done, so there is no point in raising it," she said.

MARIA HAWTHORNE

AMA NATIONAL CONFERENCE 2016
AWARDS

Burma inspires proud Kamilaroi man

Outgoing AMA President Professor Brian Owler presents the AMA Indigenous Scholarship Award to Darren Hartnett

Darren Hartnett's father had always urged him to go into medicine, but it was not until the critical care nurse travelled to Burma as part of a medical team that he decided to take up the challenge.

Mr Hartnett went to Burma in 2010 as part of the Operation Open Heart Team organised through Sydney Adventist Hospital, when he was struck by the thought: "We are making a difference here; why am I not making a difference back at home?"

The question was given added potency when he learned not long after his grandfather died that he learned of his Aboriginal heritage.

"My grandfather never spoke about it because of the hurt involved – he was separated from his family when he was young and sent to work for a farmer. He did not have a choice," Mr Hartnett said. "It was one of those taboo subjects that was never spoken of when he was alive."

Now into the third year of a medical degree at Newcastle University, Mr Hartnett, who has spent much of his career as a nurse working in intensive care and coronary care at a major Sydney hospital, is considering working the New England area in critical care or as a rural GP – roles he hopes will involve helping Indigenous patients.

"I have always thought I would end up in critical care, but recently I have done placements with rural GPs and I have found it very rewarding," he said.

"Knowing that within the next few years I can be out in the community assisting our own Indigenous population makes me proud of the fact that I am a Kamilaroi man."

He is already contributing to the Indigenous community through his work for the Miroma Bunbilla Pre Medicine entry program, where he is helping aspiring Indigenous doctors.

His path ahead has been made easier by the fact he has been awarded the AMA Indigenous Peoples' Medical Scholarship for 2016.

To help make ends meet Mr Hartnett, who has two young children, has had to combine the workload of a full-time student with part-time work as a nurse. He said the $10,000 a year scholarship would make a huge difference in helping his family get through while he completes his studies.

The scholarship was established in 1995 with a contribution from the Commonwealth, and the AMA is looking for further sponsorships to support its commitment to Indigenous health.

ADRIAN ROLLINS

AMA NATIONAL CONFERENCE 2016
AWARDS

President's Award

Dr Paul Bauert OAM and Dr Graeme Killer AO

Dr Paul Bauret was awarded with AMA's most prestigious award, the President's Medal

Two doctors, one a passionate advocate for the disadvantaged and the other a pioneering force in the care of military veterans, have been recognised with the prestigious AMA President's Award for their outstanding contributions to the care of their fellow Australians.

Dr Paul Bauert, the Director of Paediatrics at Royal Darwin Hospital, has fought for better care for Indigenous Australians for more than 30 years. More recently, he has taken up the battle for children in immigration detention.

Dr Bauert arrived in Darwin in 1977 as an intern, intending to stay for a year or two. In his words: "I'm still here, still passionate about children's health and what makes good health and good healthcare possible for all children and their families. I believe I may well have the best job on the planet."

Dr Graeme Killer, a Vietnam veteran, spent 23 years in the RAAF before becoming principal medial adviser to the Department of Veterans' Affairs. Over the next 25 years, he pioneered major improvements in the care of veterans, including the Coordinated Veterans' Care project.

Dr Killer has overseen a series of ground-breaking research studies into the health of veterans, including Gulf War veterans, atomic blast veterans, submariners, and the F-111 Deseal and Reseal program. He was also instrumental in turning around the veterans' health care system from earlier prejudicial attitudes towards psychological suffering.

Dr Bauert and Dr Killer were presented with their awards by outgoing AMA President, Professor Brian Owler, at the AMA National Conference Gala Dinner.

Excellence in Healthcare Award

The Excellence in Healthcare Award this year recognised a 20-year partnership devoted to advancing Aboriginal health in the Northern Territory.

Dr John Boffa and Ms Donna Ah Chee were recognised for the ongoing support for Indigenous health with the AMA Excellence in Health Care Award

Associate Professor John Boffa and Central Australian Aboriginal Congress CEO Donna Ah Chee were presented with the Award for their contribution to reducing harms of alcohol and improving early childhood outcomes for Aboriginal children.

Associate Professor Boffa has worked in Aboriginal primary care services for more than 25 years, and moved to the Northern Territory after graduating in medicine from Monash University.

As a GP and the Chief Medical Officer of Public Health at the Central Australian Aboriginal Congress, he has devoted his career to changing alcohol use patterns in Indigenous communities, with campaigns such as 'Beat the Grog' and 'Thirsty Thursday'.

Ms Ah Chee grew up on the far north coast of New South Wales and moved to Alice Springs in 1987. With a firm belief that education is the key pathway to wellbeing and health, she is committed to eradicating the educational disadvantage afflicting Indigenous people.

Between them, the pair have initiated major and highly significant reforms in not only addressing alcohol and other drugs, but in collaborating and overcoming many cross-cultural sensitivities in working in Aboriginal health care.

Their service model on alcohol and drug treatment resulted in a major alcohol treatment service being funded within an Aboriginal community controlled health service.

AMA NATIONAL CONFERENCE 2016
AWARDS

AMA Woman in Medicine Award

An emergency physician whose pioneering work has led to significant reductions in staph infections in patients is the AMA Woman in Medicine Award recipient for 2016.

AMA Woman in Medicine Award winner, A/Professor Diana Egerton-Warburton receives her award from outgoing AMA President Professor Brian Owler

Associate Professor Diana Egerton-Warburton has made a major contribution to emergency medicine and public health through her work as Director of Emergency Research and Innovation at Monash Medical Centre Emergency Department, and as Adjunct Senior Lecturer at Monash University.

Her *Just say no to the just-in-case cannula* program has yielded real change in practice and has cut staff infections in patients, while her *Enough is Enough: Emergency Department Clinicians Action on Reducing Alcohol Harm project* developed a phone app that allows clinicians to identify hazardous drinkers and offer them a brief intervention and referral if required.

Associate Professor Egerton-Warburton has been passionate about tackling alcohol harm, from violence against medical staff in hospitals to domestic violence and street brawls.

She championed the first bi-annual meeting on public health and emergency medicine in Australia and established the Australasian College of Emergency Medicine's alcohol harm in emergency departments program.

In addition, she has developed countless resources for emergency departments to facilitate management of pandemic influenza and heatwave health, and has authored more than 30 peer-reviewed publications.

Professor Owler said Associate Professor Egerton-Warburton's tireless work striving for high standards in emergency departments for patients and her unrelenting passion to improve public health made her a deserving winner of the Award.

AMA Doctor in Training of the Year Award

Trainee neurosurgeon Dr Ruth Mitchell has been named the inaugural AMA Doctor in Training of the Year in recognition of her passion for tackling bullying and sexual harassment in the medical profession.

Dr Mitchell, who was a panellist in the Bullying and Harassment policy session at National Conference, is in her second year of her PhD at the University of Melbourne, and is a neurosurgery registrar at the Royal Melbourne Hospital.

Presenting the award, Professor Owler said Dr Mitchell had played a pivotal role in reducing workplace bullying and harassment in the medical profession and was a tireless advocate for doctors' wellbeing and high quality care.

MJA/MDA National Prize for Excellence in Medical Research

A study examining the impact of a widely-criticised ABC TV documentary on statin use won the award for best research article published in the *Medical Journal of Australia* in 2015.

MJA/MDA National Prize for Excellence in Medical Research Award Winners

Researchers from the University of Sydney, University of NSW and Australian National University found that tens of thousands of Australians stopped or reduced their use of cholesterol-lowering drugs following the documentary's airing, with potentially fatal consequences.

In 2013, the science program *Catalyst* aired a two-part series that described statins as "toxic" and suggested the link between cholesterol and heart disease was a myth.

The researchers found that in the eight months after program was broadcast, there were 504,180 fewer dispensings of statins, affecting more than 60,000 people and potentially leading to as many as 2900 preventable heart attacks and strokes.

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AMA NATIONAL CONFERENCE 2016
AWARDS

AMA/ACOSH National Tobacco Scoreboard Award and Dirty Ashtray

The Commonwealth Government won the AMA/ACOSH National Tobacco Scoreboard Award for doing the most to combat smoking and tobacco use, while the Northern Territory Government won the Dirty Ashtray Award for doing the least.

AMA Northern Territory reluctantly accepted the AMA-ACOSH Dirty Ashtray Award

The Commonwealth was commended for its continuing commitment to tobacco control, including plain packaging and excise increases, but still only received a B grade for its efforts.

The Northern Territory received an E grade for lagging behind all other jurisdictions in banning smoking from pubs, clubs, and dining areas, and for a lack of action on education programs.

State Media Awards

Best Lobby Campaign

AMA NSW won the Best Lobby Campaign award for its long-running campaign to improve clinician engagement in public hospitals.

The campaign started after the Garling Inquiry in 2008, which identified the breakdown of trust between public hospital doctors and their managers as an impediment to good, safe patient care.

It led to a world-first agreement between the NSW Government and doctors, signed in February 2015 by Health Minister Jillian Skinner, AMA NSW and the Australian Salaried Medical Officers' Federation NSW, to embed clinician engagement in the culture of the public hospital system, and to formally measure how well doctors are engaged in the decision-making processes.

Best Public Health Campaign

AMA NSW also took home the Best Public Health Campaign award for its innovative education campaign on sunscreen use and storage.

The campaign drew on new research which found that many Australians do not realise that sunscreen can lose up to 40 per cent of its effectiveness if exposed to temperatures above 25 degrees Celsius.

The campaign received an unexpected boost with the release of survey results showing that one in three medical students admitted to sunbaking to tan, despite knowing the cancer risk.

Best State Publication

AMA WA won the highly competitive Best State Publication award for its revamped *Medicus* members' magazine.

The 80-page publication provides a mix of special features, clinical commentaries, cover articles and opinion pieces to reflect the concerns and interests of WA's medical community and beyond.

The judges said that with its eye-catching covers, *Medicus* made an immediate impact on readers.

Most Innovative Use of Website or New Media

AMA WA won the award for its Buildit portal, a mechanism for matching trainee doctors with research projects and supervisors.

The judges described Buildit as taking the DNA of a dating app and applying it to the functional research requirements of doctors in training, allowing for opportunities that may have otherwise been missed.

National Advocacy Award

AMA Victoria won the National Advocacy Award for its courage and tenacity in tackling bullying, discrimination and harassment within the medical profession.

AMA Victoria sought the views and concerns of its members, and made submissions to both the Royal Australasian College of Surgeons' inquiry and the Victorian Auditor-General's audit of bullying, harassment and discrimination within state public hospitals.

The judges said that tackling a challenge within your own profession was a particularly difficult task, especially in the glare of public scrutiny, making the AMA Victoria campaign a standout.

MARIA HAWTHORNE

AMA NATIONAL CONFERENCE 2016

SOCIAL FUNCTIONS

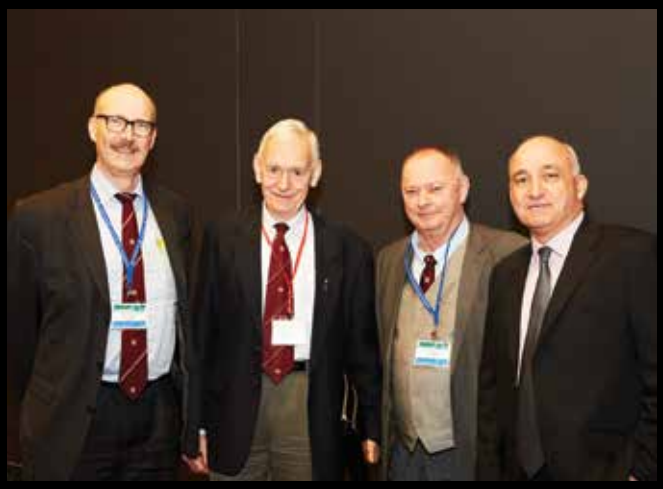
More than 200 doctors and medical students converged on Canberra in late May for the annual AMA National Conference.

While the Conference included sessions on weighty and meaty policy issues including assisted dying, workplace bullying and harassment, Indigenous health, the role of private health insurance and the importance of health issues in the Federal election campaign, there was also plenty of time for socialising.

Outgoing President Professor Brian Owler hosted a Cocktail Reception, and the Doctors in Training Council held their annual Leadership Development Dinner. But the biggest social event was the Gala Dinner at Old Parliament House, where young and old revelled into the night.

ADRIAN ROLLINS

AMA NATIONAL CONFERENCE 2016
SOCIAL FUNCTIONS



Keeping the skies clear

BY PROFESSOR STEPHEN LEEDER AND DR ANGELA BEATON*

The air turned sour in early May as Sydney coughed and wheezed its way through three days of smoke from hazard reduction fires. The weather was bright, warm and still, so the haze hung around long enough to be noticed.

Whether due to bushfires or back-burning, such events are rare. Large Australian and New Zealand cities enjoy comparatively good air quality. Emission control and careful monitoring and surveillance underpin this steady state.

Public concern rises when ventilation towers for underground Australian motorways are proposed, or when New Zealand cities breach national air quality standards. Professional and public scrutiny is intense, and disasters are averted. In Christchurch, for example, the combination of people learning to burn smoke-free and new technology such as ultra-low emission log burners have reduced the number of breaches in air quality (days per year). The quality of the air, like that of water, is an asset to be valued.

The World Health Organisation published its Global Urban Ambient Air Pollution Database last month (http://www.who.int/phe/health_topics/outdoorair/databases/cities/en/) which revealed a global picture that is much less happy. Not all big cities monitor air pollution. Of those that do – and the WHO database covers 3000 cities in just over 100 countries – the levels in 80 per cent raise concerns about human health.

The less affluent the city, the greater the likelihood of exposure to harmful levels of pollution, and the oldest, youngest and poorest are most vulnerable.

Almost all the monitored cities (with more than 100,000 inhabitants) in low and middle income countries did not meet agreed standards, compared with just over half of monitored high income cities. Poorer areas had poorer air quality — 98 per cent of cities in low and middle income countries with more than 100,000 inhabitants did not meet WHO air quality guidelines (some exceeding the guidelines by a factor of 10), compared with 56 per cent in high income countries.

The WHO points to the smallest particles in air pollution (PM 2.5 – where 50 per cent of the particles have a diameter greater than 2.5 microns) as the biggest worry.

While modelling the effects of pollution is tricky, the WHO estimates that over three million deaths can be attributed to air pollution each year. Chronic exposure to particulate matter was, it said, the "greatest environmental risk to health." The polluting matter includes pollutants such as sulphates, nitrates, and black carbon, which penetrate deep in the lungs and into the cardiovascular system. With particulate matter, the size of the particles is very important. Size determines both how long particles remain airborne to be inhaled, and whether they reach the deep regions of the lung where they can be absorbed. Only particles smaller than about 10 microns (PM10s, one thousandth of a millimetre) will reach the alveoli. Larger particles are deposited higher up in the respiratory system and are removed by the body's self-cleaning mechanisms – though they may then be swallowed and subsequently absorbed through the gastrointestinal tract.

In an article about the WHO report, the British Medical Journal observed that:

> *The world's most polluted city, according to the database, is Onitsha in Nigeria. It had the highest recorded levels of PM10s—an annual mean concentration of 594 micrograms per cubic metre of PM10. WHO's recommended level is 20 micrograms per cubic metre. London recorded 22 micrograms per cubic metre (PM10). India has many of the world's most polluted cities for smaller particles (PM2.5s).*
>
> *Nick Watts, the director of the UK Health Alliance on Climate Change, said, "Air pollution is the new silent killer for the UK, causing over 40,000 deaths every year from heart disease, stroke, and chronic lung disease. Rapidly phasing out coal-fired power will not only help relieve the pressure on an overstretched NHS, but also provide a common sense approach to meeting our climate change commitments."*

The challenge to us is similar, though not identical to, that with regard to global climate change. According to *The Economist*, emission-free electricity production in the UK is cheaper than power generated from fossil fuel, and avoids many of the problems with pollution.

There are technical problems to solve in making the change to alternative power sources – such as solar and wind – and Australia and New Zealand have the workforce to contribute to their solution in a profitable way.

It may be that in addressing greenhouse gas emissions, we also help to improve health.

** Dr Beaton is a Research Associate the Menzies Centre for Health Policy, University of Sydney*

A Circle and a Pool

BY DR HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

Dr David Rivett (OAM) has been on the AMA Federal Council in various roles since 1997 and inaugural Chair of the Rural Medical Committee/Council of Rural Doctors (CRD) since 2003. During his dedicated service he has brought the voice of the rural doctors to the media, to Parliament and to the AMA Federal Council. He has been heavily involved in the current successful correction of the rural classification scheme, and has advocated that the rural doctors group become a voting member of the Federal Council.

During this time there was a return of rural AMA membership, an increase in specialist outreach to the outback, and the facilitation of an accord between the AMA, Rural Doctors Association of Australia and the Colleges. The AMA recognised Dr Rivett's outstanding contribution by inducting him into the AMA Roll of Fellows in 2000.

The conclusion of a term does not mean a force is ending.

The Aboriginal Peoples of Australia have a different schemata concerning endings.

Unlike the linear Western concept of birth being a start of life, and death being the end of a life, the traditional Australians look at these events as part of a cycle. A cycle and a continuity.

Superimposed on this life/death cycle is a pool of life force, a connection to country. It is an energy that is steadfast, undying, inexplicable, a power greater than themselves, as old as the oldest dreaming. From this pool a life is born, a new baby, to grow and to cycle back to the pool of life force after living a life here in this four-dimensional existence.

Along the way back to the originating pool, the new life grows through infancy, the teen angst, adulthood, and geriatrics. Then the life force leaves, back to the Pool of Life.

The disruptions along the way on this circular journey are: Coca-cola and other sugary soft drinks; witnessing of mummy being hit; being hungry, then obesity; chronic otitis media; rheumatic fever; teenage STIs; early pregnancy for the females; possible incarceration for the males; diabetes; alcoholism; perhaps suicide; early heart disease; renal failure and disability.

What keeps the process alive is an underlying belief in this cycle. A faith and trust and respect for traditional ways, family, lands, justice.

This Cycle of Life schema can also describe non-Aboriginal processes such as changes in government, AMA governance, the ending of Divisions/Medicare Locals and the start of PHNs.

What screws up these bodies is collegial discord, distrust of government agendas, self-serving agendas, lack of resources, lopsided budgets, MBS stupidities, lack of good intent, miscommunication, system disease and membership dis-ease. What works for us is that we are doctors, part of the healing profession - we are good people.

As the incoming chair of the Council of Rural Doctors, I take on the challenge of continuing and cycling back to the same pool of good energy and ideas from which David Rivett drew. Good ideas, unselfish mentors, and the continued belief in us, the Rural Doctors.

I am grateful that Dr Rivett has formed a solid Council, and ask for his support, and support from both urban and rural doctors, to seek out and counter the disruptions that threaten the life and the good Ol' "Country Doc".

Reducing inequity part of a doctor's calling

BY DR JOHN ZORBAS, CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

Equity. It's all the rage these days. Companies, organisations and individuals in positions of authority and leadership are practically falling over themselves to espouse their want for a world free of inequity.

And indeed, if you speak to most people about the world we live in, they'll be quick to point to the social advances of the last few decades as evidence for why things aren't really that bad. "We've come a long way!" they'll say. "Things aren't that bad!" "It's never been easier!"

Thing is though, nobody ever seems to ask those who are in positions of inequity. Or at least, if they do, they never make the headlines.

They don't enjoy the same position of power in society and therefore don't get the big PA microphone and the soapbox from which to pronounce the end of inequity as we know it. This matters to doctors because we know all too well that inequity is alive and present. We see it in our emergency departments, we see it in our rooms and we see it in our communities. As said by Rudolf Virchow and so eloquently recalled by my colleague, AMSA President Elise Buisson at the recent AMA National Conference, "the physician is the natural attorney of the poor".

So let's accept that there are palpable inequities in today's society, and will most likely always be, in one form or another. Let us also accept that most people recognise these inequities and would fix them if they only knew how.

It's hard to believe that the majority of people are genuinely that evil. Much like the glacial pace of innovation in health care, it's more often the case that the systems we've built are the machines of harm, filled with people constantly striving to minimise the damage.

So, where to begin. Thanks to a mother with an incredible bullshit filter (never could quite pull the wool over her eyes), I've in turn become someone who respects actions rather than words. The AMA Council of Doctors in Training recently met with the Australian Indigenous Doctors Association (AIDA) to discuss vocational training and what can be done to help Indigenous pre-vocational doctors transition through to fellowship.

It's one thing to recognise that we don't have enough Indigenous doctors in Australia to have a truly representative workforce, but it's another to implement measures that result in graduating fellows. To this end, we plan to work with AIDA over the coming year to identify how to best support Indigenous trainees through their training, and ensure cultural safety in the workplace. We want to celebrate initiatives such as the Royal Australian College of Surgeons Reconciliation Action Plan and scholarships for Aboriginal and Torres Strait Islander SET trainees.

We want to recognise the Australasian College of Dermatology for offering a designated Aboriginal and Torres Strait Islander training position, with support to complete their training.

We want to help the other colleges follow suit. Ideas like this might not be ground-breaking and they might not be sexy, but they achieve results. Only a workforce with Indigenous doctors as leaders can truly serve a population like Australia.

We can argue about equality and equity for an endless amount of time, but I notice a common thread when we do.

It seems that we all too often focus on our own personal perspectives when we consider inequity, rather than the systemic issues that cause the inequity in the first place. We cage our defence in language around "free loaders", "dole bludgers" and "queue jumpers", to justify why inequity exists in the first place. We can keep doing that, and it will be to our own detriment.

Alternatively, we can focus on removing systemic barriers in our workforce, our community and our personal lives. I'd much rather see the results of a fair race, and just how far forward that race can take our profession.

Public hospitals need funding certainty

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

I am pleased to report that the newly-named AMA Council of Public Hospital Doctors (CPHD) held its first meeting for 2016 in Canberra on Saturday 7 May. Most states and territories were represented, although I note that in future this method of representation may change.

It was a very productive meeting, with a full agenda and much discussion. State and Territory reports were, as always, interesting and reflective of the enormous activity taking place around the country in the areas of interest to the CPHD.

I reported on the March Federal Council meeting, which Prime Minister Malcolm Turnbull and Health Minister Sussan Ley both attended. It was a great opportunity for the AMA to bolster its advocacy at the highest levels.

The meeting included discussion of the 2016-17 Budget and the additional $2.9 billion funding for public hospitals recently agreed at COAG. This funding applies from 2017-18 to 2019-20. Separate to this, the Department of Health Budget Fact Sheet for Hospitals includes an additional $1 billion for hospitals over the Budget estimates.

Under the new agreement, which will operate until June 2020, the Commonwealth will contribute 45 per cent, rather than 50 per cent, of growth funding, and it will be capped at 6.5 per cent of growth. If growth exceeds 6.5 per cent, the Commonwealth will adjust its contribution. Exactly how the growth cap will operate is yet to be determined.

While these figures appear generous, they are nowhere near enough to adequately fund public hospitals.

The Independent Hospital Pricing Authority (IHPA) will continue to set the National Efficient Price and Cost (NEP and NEC) for use with Activity Based Funding (ABF). The continued use of ABF is clearly preferred to the Commonwealth's original decision to switch to annual indexation by CPI and population growth. However, ABF and the NEP, as currently implemented, both have shortcomings.

The AMA has advocated that these shortcomings should be addressed, including the need to give appropriate regard to quality, performance and outcomes; a change in focus away from reducing costs to the lowest common denominator; and ensuring NEP methodology does not lock in the historically low costs of an underfunded and underperforming system, and provides for adequate indexation.

A longer-term public hospital funding agreement is expected to be developed to commence from 1 July 2020. This agreement will be developed by the Commonwealth and the states and territories, and will be considered by COAG before September 2018.

Let's hope a more adequate arrangement is put in place at that time.

The AMA Public Hospital Report Card released earlier this year showed recent improvements in performance are slipping.

The Government is looking for minor savings from anywhere it can find them to fund primary care of patients with chronic disease to keep them out of hospital. It is probable that this will only delay the inevitable presentation of patients at hospital.

The MBS Review continues, with conditional support from the AMA. To date, a few items have been highlighted.

The Private Health Insurance Report Card was launched at the Federal Council meeting in March and created some media traction.

Private health insurance remains an issue of affordability with knock-on effects for public hospitals as patients reduce or dump their cover as unaffordable or useless.

The AMA is highlighting the questionable policies that insurers are offering that are of little apparent value. The insurance industry's focus on medical fees is misleading - they comprise just 15 per cent of fund payouts, while hospitals account for 70 per cent.

During the Federal election, the AMA will being advocating on a number of issues, including:

- the need for significant new investment in public hospitals, with reinstatement of reductions in National Health Reform Agreement funding as an upper benchmark;
- the need for a plan to provides certainty of sufficient funding for at least a decade, including shielding hospital funding from the vagaries of the short-term political cycle; and
- essential improvements to ABF and the NEP processes, as consistently identified and advocated by the AMA.

We hope for a reinvigorated CPHD in 2016, with more contact and a greater involvement in broader AMA advocacy. I hope to hear from many of you over the next year to keep issues of interest to the CPHD on our agenda.

PBS Authority problems – what you can do

BY **DR ROBYN LANGHAM**

Any doctor who prescribes PBS 'authority required' medicines knows that the authority approvals phone line has been plagued with outages and other network problems in recent months.

The Department of Human Services, responsible for managing the phone line, has in most cases cited 'carrier caused' faults. But this explanation doesn't help patients get timely prescriptions or give back valuable practice time lost.

What to do if the phone line is down

Most doctors don't know that 'emergency provisions' apply if there is an outage or other reason the approvals phone line isn't available.

When the emergency provisions are in effect, doctors can prescribe up to the maximum quantity and repeats as specified on the current PBS schedule. Due to legislative requirements, you must still attempt to call 1800 888 333 in the first instance. You also need to endorse the prescription with the words 'Emergency authorised by the Department of Human Services Medicare Program', and note the time and date you tried to call.

For drugs on the Highly Specialised Drug Program, doctors need to also mark the prescription with the letters 'HSD', the hospital prescriber number, and number of days of treatment.

Unfortunately, for increased quantities or repeats, you will still have to call back at a later time to get the authority approval.

After ongoing complaints from the AMA, the Department of Human Services also has set up a webpage [http://www2.medicareaustralia.gov.au/pext/pbsolmonitor/external/pbsol_status.jsp]

that prescribers can check to see if the phone line is still down, and whether emergency provisions are in place. Unfortunately, without this link, the webpage is almost impossible to find on the Medicare website. And yes, after we pointed this out, the Department will attend to this, too.

What you can do to help make the approvals phone line (nearly) obsolete

After considerable AMA lobbying, an online system for obtaining approvals for authority medicines is now being trialled. This online system will negate the need to call the approvals phone line for nearly all 'authority required' medicines.

Around 30 volunteer prescribers, including AMA members, are testing the online system, which will be available to all prescribers from 1 July.

However, the online system will only be available via login to the Government's Health Professionals Online System until medical practice software providers include this functionality in usual prescribing software.

The AMA has written to the Medical Software Industry Association urging it to communicate to its members that the development of this functionality is a high priority for doctors.

You can help by contacting your medical software provider directly. The more who agitate for this, the more likely the software development will be fast-tracked, and the more likely that waiting on the phone will be a thing of the past.

What about written applications for 'complex medicines' approvals?

Relief is also in sight for streamlining the approvals process for authority medicines requiring written applications.

Changes to Australia Post delivery times are causing delays to the turn-around of written applications for approvals that are required for 'complex medicines' (biologics) and which must be posted to, and manually authorised by, Department of Human Services' staff located in Hobart.

In response to our complaints, the Department has agreed to develop a secure email facility which will allow doctors to lodge written requests for authorities and supporting documentation via email. We've been told this will be available from 1 October. Watch this space.

Ford farewell

BY DR CLIVE FRASER

In October Ford will cease manufacturing in Australia forever.

General Motors and Toyota will follow suit next year.

Ford started assembling cars in Australia in 1925 with the Model T and then the Model A.

Over the years there have been some great milestones. Ford Australia built the world's first utility in 1934.

After World War Two, it assembled a succession of models from Britain, including the Pilot, Prefect, Consul, Zephyr, Zodiac, Anglia, Escort and Cortina - all right-hand drive and meant for British roads.

The Laser (Mazda's 323) was assembled by Ford in Australia from 1981 and the Telstar (Mazda's 626) from 1983.

But there was only ever one model made by Ford in Australia that we could call our own, the Falcon.

First produced in 1960, there was a lot of North American DNA in this car to begin with.

Even the Ford manufacturing plant at Broadmeadows in Melbourne had a roof that could disperse snow, compliments of its Canadian design.

Without import tariffs the locally made 1960 XK Falcon could finally compete with the Holden on price.

The XK had more powerful engines (2.4 litre with 67kW and 2.8 litre with 75kW) versus the FB Holden (2.3 litre with 56kW).

A 1960 XK Falcon manual cost $2264, and Ford offered a two-speed automatic option for an extra $248.

Early Falcon models weren't noted for the durability of their suspension. Our outback roads weren't as smooth as the American highways they were designed for.

But the evolution of Falcon models spawned memorable cars, like the 1971 XY GTHO Phase 3, which at the time was the fastest four-door production car in the world.

By 1972, the XA Falcon was totally locally designed, and the model line-up included a two-door hardtop.

The XB hardtop was immortalized in the Mad Max movies, and one sits alongside the Batmobile in a Miami motor museum.

Falcon sales peaked in 1995 with 81,366 sedans and wagons and 8313 utes and vans.

For years, Falcon and Holden sold (roughly) equally well. But the release in 1997 of Holden's popular VT Commodore, followed soon after by the unpopular AU Falcon, saw a plunge in the Falcon's market share from which it never recovered.

The final FG X Falcon was released in 2014.

Altogether, three million Falcon's hit Australian roads, andf the 2016 FG X is arguably the best looking of all.

It's a shame that there are so few of them out there.

My nostalgic trip to the local Ford dealer was like visiting a ghost town, and the salesman even apologized for the lack of activity.

He did have a shiny new Mustang to show me, but there was no delivery of that model until 2017.

There was only one new Falcon FG X to view.

Ford's website prices a standard Falcon FG X sedan with the four litre non-turbo engine (195kW) and six speed automatic at $39,925 drive-away.

The four cylinder two litre EcoBoost engine (176kW) is a $319 option.

It's almost as powerful as its six cylinder brother, but it's much more economical, lighter and nicer to drive.

So why haven't punters been buying the Falcon FG X, if it's so good?

The end of the model line has savagely hit re-sale values.

A check of the RedBook shows that a 12 month old 2015 four litre FG X will trade for $14,500 to $16,700 and sell privately for $18,400 to $20,600.

That's some serious depreciation of at least 50% in only one year.

As it's such a nice car I reckon it's still a bargain (in the second-hand market).

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