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AMA

Hundreds attend AMA forum on asylum seeker health as doctors defy deportation plans, p3

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SPECIAL REPORT

MBS Review - **Where is it headed? What are the risks? pp5-9**

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In this issue

Cover: No more children behind bars: AMA President Professor Brian Owler with Australian Human Rights Commissioner Professor Gillian Triggs at the AMA Forum on asylum seeker health, Sydney

Asylum seekers are 'people like us': Owler

In the national interest: 350 doctors attend the AMA Forum on asylum seeker health in Sydney.

The AMA has ramped up the pressure on the major political parties over the health care of asylum seekers, calling for the immediate release of all children being held in immigration detention and moratorium on their deportation to Nauru and Manus Island.

As doctors and nurses at Brisbane's Lady Cilento Children's Hospital scored a major victory, forcing Immigration Minister Peter Dutton to temporarily relent on plans to send a one-year-old child being treated at the hospital back to Nauru, AMA President Professor Brian Owler told a forum in Sydney on asylum seeker health that the medical profession needed to take a stand on the treatment of those being held in detention, particularly children.

"There are times, in any nation, where the medical profession must act in the interests not only of our patients as individuals, or for patients in a health system, but it must act in the national interest," told the forum, organised by the AMA and attended by around 350 doctors. "I believe that is the case when it comes to the issue of children in detention and Australia's provision of health care to asylum seekers."

Professor Owler said organisations including the Human Rights Commission had documented evidence of the great physical, mental and emotional harm detention caused to children, and it was clear those being held in detention centres – particularly offshore – were being denied access to Australian-standard health care, with sometimes fatal results.

"The fact of the matter is that the prolonged detention of children is a state-sanctioned form of child abuse, and we call for it to stop," he said, a point reinforced by other speakers at the forum, including leading child health experts Consultant Paediatrician Professor Elizabeth Elliott; Clinical Professor, Paediatrics and Child Health, Professor David Isaacs; and Paediatric Nurse Alanna Maycock.

There are currently 67 children being held on Nauru and a further 80, including 37 babies, are slated to be sent there following a High Court ruling backing the legality of the Government's offshore detention regime.

Professor Owler said this was inexplicable, particularly given the admission of former and current Ministers that detaining children for prolonged periods did nothing to deter people smuggling.

He praised the actions of the doctors, nurses and administrators at Lady Cilento Children's Hospital in refusing to discharge baby Asha while the threat of being immediately deported to Nauru hung over her, and welcomed Mr Dutton's decision to allow her to be released into community care.

"We unequivocally support the doctors and nurses working in

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Asylum seekers are 'people like us': Owler

... from p3

Expert opinion (Left to Right): AMA President Professor Brian Owler, Paediatrics and Child Health Professor David Isaacs, Consultant Paediatrician Professor Elizabeth Elliott and Paediatric Nurse Alanna Maycock

Prolonged detention of children is abuse: Professor Owler

Lady Cilento. It is an absolute ethical obligation, not to mention moral obligation, of those doctors and nurses, to not release baby Asha into a situation where they believe there's likely to be harm," the AMA President said.

The Minister's backdown has been hailed as a victory by refugee advocates but, asked if the case could represent a turning point in Government policy, Professor Owler was more cautious.

"I hope so, but I fear not," he said, though he added there was hope that public opinion was beginning to change on the issue.

Asylum seeker policy is highly politically charged, and both the major parties are currently in lock-step on the issue.

Politicians used language to dehumanise refugees and deliberately confused their plight with issues of security and terrorism in the public mind, Professor Owler said.

He said the plight of baby Asha had helped the community to understand the gravity of the situation for those being detained.

Professor Owler said bipartisan political support had fostered a high degree of secrecy around the operation of detention centres and had enabled the passage of draconian laws threatening imprisonment for any who speak out about conditions in them.

Although the Federal Government said the intention of the Border Force Act was not to silence health workers, the AMA said it has legal advice that they are not exempt from its provisions, and has called for it to be amended.

Professor Owler said it was very concerning that bureaucrats rather than doctors had the ultimate say over the care of asylum seekers.

He said Australian Border Force Chief Medical Officer Dr John Brayley was "a good man", but did not have the power to order the transfer of detainees in need of medical care – in contravention of standards of care in the rest of the community.

It was "absolutely wrong" that such decisions rested with Department officials, the AMA President said, adding it further undermined the ability of doctors to act in the interests of their patients.

"It is imperative that medical practitioners working with asylum seekers and refugees put their patients' health needs first. And to do this, we must have professional autonomy and clinical independence without undue outside pressure," Professor Owler.

The AMA has called for the establishment of an independent statutory body of clinical experts to investigate and report on the health and welfare of asylum seekers.

Professor Owler said it was time for a re-think of the country's treatment of refugees and asylum seekers, especially children.

"We want to ask all of those people in the Australian community to examine their conscience, about what this country's doing to these children, about what's being done in their name, and call on our politicians to come up with a better way of responding to this problem, because we can't continue to subject children to harm and provide a level of service that's completely inadequate for these people," he said.

ADRIAN ROLLINS

Govt actions unhelpful, MBS Review head admits

Under review: representatives of almost 50 medical organisations attend an AMA Forum on the MBS Review.

The hand-picked head of the Commonwealth's Medicare Benefits Schedule Review has taken a veiled swipe at the Government over its handling of plans to axe 23 MBS items.

Confirming medical profession fears about the potential politicisation of the process, Professor Bruce Robinson told an AMA-hosted forum on the MBS Review that the taskforce co-ordinating the review had been given no say over a 28 December announcement by Health Minister Sussan Ley that an initial batch of 23 items had been recommended for removal from the MBS.

Professor Robinson told the forum, which was attended by representatives from almost 50 specialist colleges and societies, that the announcement was "something we did not have control over".

In her announcement, Ms Ley said the items were obsolete and no longer consistent with clinical best-practice. The Government suggested axing them would save around $6.8 million a year.

But Professor Robinson cast doubt on the scale of savings from the measure, and lamented that the Government's handling of the issue had tarnished medical profession support for the MBS review.

"The announcement was unfortunate, because it is one of those things that has caused criticism of the review process," Professor Robinson said, adding that "those items to be deleted are not going to save much money; it's a tidying up exercise."

AMA President Professor Brian Owler told the forum, the second organised by the AMA on the MBS Review, that the medical profession had taken part in the review with enthusiasm and goodwill, but that had been put at risk by the Minister's post-Christmas announcement, as well as the Government's unilateral action to unveil cuts to bulk billing incentives for pathology and diagnostic imaging services in the Mid-Year Economic and Fiscal Outlook (MYEFO).

"There's a lot of goodwill within the medical profession to work with Professor Robinson and the Taskforce to improve the MBS. We all want a more modern MBS that reflects modern medical practice that is going to benefit patients," Professor Owler said. "[But] if you engage the profession on that basis and then come out with an announcement in MYEFO, without any consultation or discussions...of course people are going to be upset."

Dr Michael Harrison, from the Royal College of Pathologists of Australia, told Professor Robinson that the Government's decision to axe bulk billing incentives for pathology services, taken without consultation, had "undermined the credibility of the [MBS] review".

"Our confidence in the review has been severely affected," he warned.

Much of the medical profession's concern about the Medicare review has centred on doubts about its over-riding purpose.

Professor Robinson told the forum the focus was to modernise the MBS and align it with current clinical practice.

"My task is not to save money", Professor Robinson said, and added that the taskforce did not have a savings target.

But the Government is intent on using the exercise to achieve savings, much of which will be used to help cut the Budget deficit. Ms Ley has indicated only half of any funds freed up as a result of the review will be re-invested in health.

Professor Owler acknowledged the review was like to deliver some savings (though probably not as many as the Government hoped), but warned the profession's goodwill and support was contingent on any savings made were "held within health, to provide better services to patients".

The forum was attended by representatives from 45 specialist colleges and associations including the Royal Australian College of Surgeons, the Royal Australian College of General Practitioners, and the Royal Australian College of Physicians.

ADRIAN ROLLINS

Mind the gap

The head of the Federal Government's MBS Review Taskforce has admitted there is "a bit of a risk" of a gap developing between the deletion of old Medicare items and the listing of up-to-date replacements.

In a frank assessment of the difficulties of modernising the MBS, Professor Bruce Robinson admitted there existed a tension between his taskforce and the Medical Services Advisory Committee (MSAC) over their respective roles in deleting and adding items to the Schedule.

The taskforce head said that while many of the clinicians who had volunteered to take part in the MBS review were impatient for change, the "extraordinarily rigorous" process used by MSAC in approving the listing of new services and procedures raised the prospect of a lengthy delay between the axing of an old item and its replacement by a new or updated one.

The issue was highlighted by AMA President Professor Brian Owler in his opening remarks to a forum on the MBS Review organised by the peak medical organisation.

Professor Owler warned of the risk that the Medicare review initiated by the Federal Government could result in an incomplete MBS unless the process to add new items to the schedule could be expedited.

"The concern is the ability of the MSAC process to deal with the number of recommendations that are going to be made – clearly there's going to be quite a number to come out of this process – and the time it takes through that process before procedures are put on," he said. "That means that you do have the potential for items to be taken away, and a potential gap before new items are put on."

The source of concern is two-fold: that the meticulous MSAC approval process will result in lengthy delays in the listing of new items; and that the Health Minister, keen to hold down spending, will be reluctant to approve new items.

On the former, Professor Robinson questioned whether MSAC itself was becoming an obstacle to reform of the MBS, and needed an overhaul, or at least a significant change in approach.

MBS Review Taskforce head Professor Bruce Robinson

"Is the MSAC process so rigorous that it is becoming an impediment to progress?" he asked.

The Minister has indicated that "no-brainer" changes that require a simple re-write should be expedited, but Professor Owler said consideration also needed to be given to fast-tracking clarifications or improvements that do not require a major MSAC review – an idea endorsed by Professor Robinson.

The MBS review taskforce head also sounded an optimistic note on the Government's openness to listing new items.

Professor Robinson told the AMA forum that Health Minister Sussan Ley was now "more open to new MBS items than she was a few months ago".

ADRIAN ROLLINS

Demand for health care slows, but why?

A slump in surgical procedures and diagnostic tests has prompted speculation that Federal Government cutbacks and multiple reviews are deterring patients from seeking treatment.

Official figures show growth in surgical, obstetric and diagnostic procedures slowed sharply in the last three months of 2015, and private hospital operators and diagnostic imaging groups have reported a marked decline in patient referrals to specialists and for scans.

While industry analysts suggest the slowdown could be a temporary aberration, health service operators speculate that Government rhetoric about waste and over-servicing, accompanied by spending cuts and a flurry of reviews, could be having a chilling effect on both patients and doctors.

According to Medicare, the number of surgical, obstetric and diagnostic procedures performed in the three months to 31 December was just 2.2 per cent more than the same period the previous year – well below the four-year average growth rate of 5.1 per cent.

Analysis by Credit Suisse and Macquarie Bank show annual surgical volume growth dipped below 3 per cent in mid-2015, down from 8 per cent two years earlier and the lowest point since 2010.

UnitingCare Health Chief Executive Richard Royle told the *Australian Financial Review* there was "definitely a downturn in private hospital volume" that had coincided with the Medicare Benefits Schedule Review and Government talk of waste and unnecessary medical procedures.

"I am wondering whether that might be having an impact on doctors and their preparedness to undertake activities, given there is now a federal review of what is going on in terms of billing," Mr Royal said.

Calvary Health Care Chief Executive Mark Doran told the newspaper that GPs referrals had declined.

"Look a consultations in GP-land," Mr Doran said. "We've noticed they're falling and, as a result, referrals to specialists are falling, and that is starting to show on the surgical side."

Radiology group Capitol Health has also reported a drop in demand.

The company reported that the number of CT scans performed was down on the same time the previous year and MRI growth was weaker than expected. Together, they contributed to a 52 per cent plunge in underlying net profit in the second half of 2015.

Capitol Health Managing Director John Conidi blamed the MBS Review and accompanying Government rhetoric about wasteful and unnecessary procedures.

"This is all about the negative effect that the Government has been spreading with review over the last nine months," Mr Conidi told the *Australian Financial Review*. "Behavioural patterns have changed. The volume of referrals is diminishing. The Government has done a great job in decreasing demand for services."

An analysis by the Parliamentary Budget Office (PBO) suggests the slowdown in Medicare activity, including referrals, will be sustained.

In a report released late last year, the PBO predicted that, even before the findings of the MBS Review, Medicare spending per person would fall by 1.4 per cent a year in real terms over the next decade.

The Federal Government's indexation freeze on Medicare rebates is expected to drive most of the decline, with the benefit paid for each MBS service projected to fall 0.8 per cent a year in real terms.

The outlook has prompted industry analysts to forecast slower growth for private hospitals and pathology services – a view big operators have rejected.

Healthscope said that although the MBS Review might find instances of over-servicing, but was also likely to identify under-servicing in some areas.

Ramsey Health Care said such analysis failed to take into account the increasing impact an ageing population was likely to have on demand for health services.

ADRIAN ROLLINS

Earnings, time limits part of MBS Review

In taking on the task of modernising the MBS, the taskforce led by Professor Bruce Robinson is not only conducting a line-by-line review of items, but considering broader issues around what practitioners do, how they are valued and what they should be paid.

Professor Robinson told a form on the MBS Review organised by the AMA that issues under consideration included:

Time limits

Professor Robinson said often a swings-and-roundabouts approach had been taken to inconsistencies in the remuneration for different items. He said this in effect meant a haphazard cross-subsidisation was occurring between items, and there should be greater rigour in assessing and recognising costs. "We should try to end up with a schedule that reflects costs," Professor Robinson said, and suggested one approach may be to set time limits on some items, though this would have to be "nuanced";

Relative value and remuneration

The MBS Review Taskforce is investigating remuneration amid complaints from practitioners, particularly GPs, who believe they are being "dudded" under the current Schedule. Professor Robinson said the taskforce needed to undertake the very difficult job of developing a methodology to analyse pricing structures, otherwise it would be simply taking a stab in the dark;

Surgical assistants

Professor Robinson sparked a heated response at the AMA forum after questioning the value of surgical assistants in many situations. Though he said surgical assistants were not a specific target of the MBS Review, around $70 million a year was spent on their services, and the taskforce would seek to identify instances where they were "not adding great value", and should not be part of the Schedule. AMA Professor Brian Owler and several other participants strongly defended the role of surgical assistants, which they said was in many instances vital. They added that the surgical assistant fee provided important support for training;

Former AMA President Dr Steve Hambleton with current AMA President Professor Brian Owler and Vice President Dr Stephen Parnis

Capital and clinical costs

The MBS Review is looking at ways to dissect the contribution that capital costs (medical equipment and machinery like in-office ultrasounds and the like) and professional expertise make to providing a service, in order to properly and recognise and reward investment;

Co-claiming

The MBS Review Taskforce is investigating instances where multiple items are claimed for a single service. Professor Robinson said that, aside from a few instances of intentional over-servicing, mostly problems were likely to arise from the ambiguous and confusing wording of item descriptors. He said the Taskforce's Principles and Rules Committee was examining the issue of co-claiming and improvements to descriptors.

ADRIAN ROLLINS

Countdown to new MBS

Main points

- Six committees have been reviewing 1100 items since September
- 23 items already identified as obsolete
- 25 more committees will begin reviews this year
- MBS review to finish in mid-2017

The overriding purpose of the Medicare Benefits Schedule Review appears to be up for grabs.

Despite protestations from the Federal Government that it is not primarily a cost-cutting exercise, that message has been undermined by Health Minister Sussan Ley's decision, soon after Christmas, to highlight recommendations to axe 23 items.

MBS Review Taskforce head Professor Bruce Robinson has said that was "unfortunate" and, at a forum on the Review organised by the AMA on 11 February, he insisted the goal was to ensure the schedule is aligned with current clinical practice, with any savings realised from removing and modifying existing items to be (hopefully) reinvested in health.

That is the goal signed up to by the practitioners who have agreed to take part in the review.

To achieve this the Taskforce plans to appoint a total of 31 specialist clinical committees to undertake the detailed work of reviewing existing Medicare items and recommending deletions, additions and modifications.

The first tranche of six committees – covering diagnostic imaging, ear, nose and throat surgery, obstetrics, pathology, gastroenterology and thoracic surgery – began work in September last year and are reviewing 1100 items between them.

A further 25 will be formed during this year, in areas including cardiology, dermatology, psychiatry, endocrine surgery, emergency medicine and intensive care, oncology and renal medicine.

Each committee will follow a five-step process to evaluate Schedule items: an initial triage of items in its area of specialty, to identify those that warrant further scrutiny; a rapid evidence-based review of each item singled out for attention; the presentation of a set of recommendations to the MBS Review Taskforce; a broader level of consultation across specialties undertaken by the Taskforce; and presentation of recommendations to the Health Minister.

Professor Robinson said the intention was to consult as widely as possible to ensure all those with an interest had an opportunity to make a contribution.

"I don't want this process to be shot down because people feel that they have not been represented," he told the AMA forum.

The Chair of the Obstetrics Clinical Committee, Professor Michael Permezel, provided an account of how his committee – which, among others, included four obstetricians, a GP and a midwife - had gone about its work.

Professor Permezel said the committee was keen to ensure money was not wasted, but wanted any savings it achieved to be reinvest in obstetric care.

He said among its targets, the committee was aiming at reducing unexplained variation in care, and improved support for rural obstetrics.

Professor Permezel said there were four possible recommendations for each item under review: to retain it; to abolish it; to amend it; or to create a new one.

His committee recommended the abolition of one item, and suggested three changes, including standardising the conditions tested for in the first routine antenatal visit.

Professor Permezel said his committee had received good support from the Health Department in undertaking its work.

The forum heard concerns that as the number of committees in operation increases, the Department's resources will become stretched.

Professor Robinson said the intention was to limit the number of committees in operation at any one time by progressively disbanding them as they completed their work.

He said the review itself was due to be completed in mid-2017.

ADRIAN ROLLINS

Cut jail time to build on Indigenous health gains

AMA President Professor Brian Owler with staff of the Ampilatwatja Health Centre

Soaring Indigenous imprisonment rates and a stubbornly wide life expectancy gap underline calls for the Federal Government to fully fund the National Aboriginal and Torres Strait Islander Health Plan.

AMA President Professor Brian Owler said the latest update on Indigenous health and welfare from the Close the Gap Steering Committee was "a mixed bag", showing improvement on measures such as child mortality and year 12 attainment, but weak gains in others.

The report found the target to halve the gap in child mortality by 2018 was on track, supported by a lift in immunisation rates that has seen more Indigenous children vaccinated by age five compared with their non-Indigenous counterparts, and Indigenous mortality rates, particularly from heart disease and stroke, are declining.

But the gap in life expectancy is not narrowing fast enough to close by the Council of Australian Government's 2031 target.

The Close the Gap report shows that between 2005 and 2012, the life expectancy of Indigenous men increased by 1.6 years to 69.1 years, and for Indigenous women 0.6 of a year to 73.7 years (the life expectancy of non-Indigenous men in 2012 was 79.7 year and women, 83.1 years).

But the report's authors cautioned that the improvements were within the margin of error "and could, in fact, be non-existent".

Indigenous life expectancy is improving at an annual rate of 0.32 years for men and 0.12 years for women, but the Steering Committee said this would have to increase to between 0.6 and 0.8 years annually to reach the 2030 target.

Driving much of the improvement has been a 40 per cent fall in deaths from heart attacks and strokes, and fatal respiratory illnesses have declined by 27 per cent.

Despite this, heart attacks a strokes remain a major killer, accounting for a quarter of all Indigenous deaths between 2008 and 2012, while suicide was the leading cause of death due to external causes.

"It is disappointing that the target to close the gap in life expectancy by 2031 is not on track," Professor Owler said. "This is a clear signal that we have to put politics aside and work together to reach this important milestone. Above all, we need consistent funding and support from all governments."

In his report on Closing the Gap, Prime Minister Malcolm Turnbull agreed that a more concerted effort was needed.

"As a nation, we are a work in progress, and closing the substantial gaps in outcomes between Aboriginal and Torres Strait Islander people and other Australians is one of our most important tasks," Mr Turnbull said. "There has been encouraging progress...but it is undeniable that progress...has been variable."

Continued on p11 ...

Cut jail time to build on Indigenous health gains

... from p10

AMA President Professor Brian Owler meets with members and directors of the Walungurru (Kintore) and Pintupi Homelands Health Service

Professor Owler said that to make improved gains, the Federal Government should reverse Budget cuts to programs like the Indigenous Advancement Strategy and the Indigenous Australian Health Program, and commit to genuine engagement with Aboriginal community controlled health services.

Nonetheless, a rapid narrowing of the health gap for infants and young children gives hope that eventually it will narrow for adults as well.

Though the infant mortality rate for Indigenous infants is 1.7 times that of other Australians, it declined 64 per cent between 1998 and 2012, making the gap 83 per cent narrower.

Close the Gap Campaign Co-Chair Dr Jackie Huggins said the long term impact of such improvements were yet to be seen and would take time to measure. The report advised no measurable improvements should be expected before 2018.

Furthermore, Dr Huggins said, “this should not be cause for complacency, because the overall health of Aboriginal and Torres Strait Islander peoples still lags behind the rest of the nation”.

The Campaign backed the AMA in calling for governments to reduce Indigenous incarceration rates.

It warned the nation was on track to have a record 10,000 Indigenous people behind bars this year, which is described as “a grim milestone”.

An AMA report highlighted that imprisonment exacerbated serious health problems and Indigenous incarceration rates needed to be reduced if the country was to close the health gap.

ADRIAN ROLLINS

The hope and the heartache

To improve Indigenous education and employment, governments must first ensure Aboriginal and Torres Strait Islander health and wellbeing, AMA President Professor Brian Owler has said.

Visiting remote Aboriginal communities following the release of the latest Close the Gap report, Professor Owler said that although there were encouraging signs of progress in some areas, without an overall lift in health efforts to boost standards of education and affluence would continue to fall short.

"The focus has often been on education, employment and training, but we need to get back to seeing health as the foundation that underpins all those things," the AMA President said.

Professor Owler made his comments during a visit to Alice Springs and two remote settlements to gain an on-the-ground appreciation of the health problems Indigenous communities face, and the issues affecting the delivery of health services in central Australia.

Meeting with Indigenous leaders, including members of the Central Australian Aboriginal Congress, Professor Owler discussed problems and barriers including inadequate funding, the difficulty of attracting and retaining medical staff, and the logistical challenges involved in providing health care to people living in remote areas.

Among the most pressing Indigenous health issues were diabetes, heart disease and poor nutrition. Professor Owler was told of the prevalence of type 2 diabetes in Aboriginal communities affecting not only adults but also children – including a girl just seven years old.

The AMA delegation inspected The Purple House, the Alice Springs-based service operated by Aboriginal controlled Western Desert Dialysis, which assists people suffering renal failure as well as working with communities to help reduce the incidence of kidney disease.

High rates of diabetes and heart disease in Indigenous communities are linked to inadequate access to healthy food and water and poor housing. For example, there are concerns that high sugar soft drinks are often more readily available than fresh water.

During his Northern Territory visit Professor Owler, accompanied by the Member for Lingiari Warren Snowden and senior AMA policy advisers Simon Tatz and Alyce Merritt, flew to two remote communities, Utopia and Ampilatwatja, where he was told not only about health problems, but also the progress that was being made.

AMA President Professor Brian Owler and and Member for Lingiari, Warren Snowden at Alice Springs hospital

Both communities have banned alcohol and report high rates of school attendance.

Professor Owler visited the health centres in both communities, and was impressed by the hard work and dedication of their doctors, nurses and other staff.

Working in hot and difficult circumstances with often limited resources, the centres work in close partnership with the communities they serve.

ADRIAN ROLLINS

Profit spike bears down on premiums

The nation's largest health insurer has reported a surge in profits, strengthening the Federal Government's hand in pushing for more modest premium increases.

Medibank Private's controversial drive to offload responsibility for complications including hospital-acquired infections on to private hospitals and patients has helped deliver the insurer a 58 per cent jump in net profit to $227.6 million in the six months to December.

The report of the profit spike, which has also been underpinned by crackdown on benefit payouts, came days after the fund complained it was under pressure from an increase in the range and frequency of member claims. The complaint was made in a bid to manage expectations about the size of any reduction in premiums for the coming year.

Health Minister Sussan Ley has asked health funds to resubmit their planned premium increases. Under current arrangements, each year health insurers are required to obtain Government approval for their premium hikes, which have averaged above 6 per cent in recent years.

Last month, Medibank Private flagged that it would resubmit its 2016, and on 11 February rival HBF announced it would seek a lower premium increase than the 5.96 per cent rise it first asked for.

The insurer, which had initially been critical of Ms Ley's call, said the Government's subsequent push to overhaul Prostheses List and reduce the cost of medical devices provided in private hospitals had been crucial.

"The Minister is now showing that she understands the need to relieve pressures on health funds and their members rather than simply demand that funds lower premiums," HBF Managing Director Rob Bransby told the *West Australian*. "We expect the change in prostheses pricing to deliver savings of millions of dollars to HBF and, ultimately, our members."

Ms Ley said HBF's announcement was an "encouraging sign" for consumers, and hoped it would encourage other insurers to follow suit.

"The Government is serious about working with the private health sector to deliver a better deal for consumers, and there are real opportunities to deliver real reform," the Minister said, adding that the insurers were holding $5.1 billion in excess capital.

Industry analysts said Medibank's profit growth would make it difficult for the fund to fight against lower premium increases, and one anticipates a rise of just 2 per cent from 1 April.

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

Cheaper hips path to lower premiums

Private health funds are under pressure to pass any savings from reform of prosthetic pricing on to consumers through more modest premium increases.

As part of her push to improve the value of private health cover, Health Minister Sussan Ley has appointed experienced health administrator Professor Lloyd Samson to lead a working group examining the way medical implants and devices are priced.

The Industry Working Group on Prostheses, which includes a representative from the AMA, will look at current arrangements under which the cost of around 9000 prostheses and implants used in the private health system is set, resulting in prices that are often double or more of those paid in the public sector.

Ms Ley said the pricing process meant the same pacemaker delivered through the private system cost $26,000 - twice as much as if it was provided through a public hospital.

“It doesn’t matter whether it’s the hospital or the insurer purchasing these devices, the cost will always ultimately fall to the consumer, and I want to take unnecessary pressure off premiums,” the Minister said.

Under the current system, the price of a prosthesis is set and can only be under-cut if a rival device has more than 25 per cent of the market.

The prostheses working group has been asked to look at ways to make the purchase of devices more competitive and efficient, and to ensure that the benefits of this are passed on to consumers.

Private health funds have long complained about the prices they are required to pay for prostheses, and estimate that up to $800 million a year could be saved by bringing prices more in to line with those paid in the public system.

The industry’s peak group, Private Healthcare Australia, said insurers spent $1.9 billion on prostheses last financial year – 14 per cent of total payouts.

The group said private patients in Australia paid far more for medical devices than those in comparable countries such as France, Japan and Italy, and much more than it cost the public sector.

“This is an unfair cost burden on private patients which the Government can address immediately,” PHA Chief Executive Dr Rachel David said, arguing for a system of reference pricing benchmarked against local and international charges.

But the Medical Technology Association of Australia (MTAA), which represents prostheses firms, said the price of medical devices had not changed in five years, and the growing payout reflected increased use of prostheses rather than a jump in cost.

The MTAA has accused insurers of attacking prosthesis prices to divert attention away from their premium increases, and warned the deregulation of the Prostheses List would “lead to an Americanisation of the health system, transferring too much power to private health fund accountants and away from treating clinicians”.

“The last thing a patient needs is to have their private health insurance company…determining which pacemaker their specialist can use to treat them, based simply on cost,” MTAA Chief Executive Susanne Tegen said. “That’s not what Australians expect from their health system.”

The Government’s review has also come under fire from smaller device manufacturers concerned that it will increase the market dominance of the big firms by allowing them to bundle overpriced routine products with devices only they can supply.

Changes to the pricing arrangement may also be resisted by some private hospital groups, which earn significant revenue from the supply and use of prosthetics.

The prosthesis review is taking place amid a broader assessment of the private health insurance system initiated by Ms Ley because of mounting consumer dissatisfaction with the value of private cover.

Ms Ley has asked health funds to resubmit plans for premium increases this year, based on their full financial position, rather than simply a tally of claims and benefits paid.

“Consumers have made it clear they don’t believe they’re getting value for money,” the Minister said.

Ms Ley said that claims and benefits constituted only part of the picture, “when we know insurers are holding an additional $5.1 billion capital in their pockets. The question I am asking insurers is: do they have some capacity to use this excess capital to deliver premium relief for their customers this year?”

The Samson review has been directed to report to the Minister in August.

ADRIAN ROLLINS

Insurers muscling in on care

Surgeons are facing demands to sign-off on the clinical necessity of a range of procedures as health funds intensify their push for a bigger say over the care provided by doctors and hospitals.

In the latest instance of the drive toward US-style health arrangements, *The Australian* has revealed that the nation's two largest health funds are demanding that doctors attest that procedures including operations on eye lids and tear ducts are medically justified and not purely cosmetic.

> "The Australian Society of Ophthalmologists told the newspaper that Medibank Private and Bupa were asking doctors to sign pre-eligibility forms for procedures they suspected might be cosmetic, even where a Medicare rebate is being claimed"

The Australian Society of Ophthalmologists told the newspaper that Medibank Private and Bupa were asking doctors to sign pre-eligibility forms for procedures they suspected might be cosmetic, even where a Medicare rebate is being claimed.

Medibank said the forms were needed because of changes in the definition of several potentially cosmetic procedures on the MBS, but Society President Dr Michael Steiner said funds were "putting themselves above Medicare".

The revelation came as infection control experts backed AMA warnings that the refusal of some insurers to cover the cost of treating hospital-acquired bugs will push up patient out-of-pocket costs and increase the pressure on public hospitals.

AMA President Professor Brian Owler cautioned last year that a deal between Medibank and the Calvary Health Care under which the insurer would no longer accept responsibility for 165 medical events it described as highly preventable, including hospital-acquired infections, was "a pivotal moment" for the health system.

Professor Owler warned that this would destabilise the health system by creating a situation in which private hospitals refuse to admit patients with complex needs or considered to be at high risk.

"We know that there will be patients that won't be able to be readmitted should they develop problems with their wound or other complications, and they will have to go to the public hospitals," the AMA President said. "There are other patients that won't be able to afford the out of pocket expenses that Calvary will have to charge, and they will have to be going to public hospitals as well."

His concerns have been backed by the Australian College for Infection Prevention and Control.

College President Professor Ramon Shaban said the causes of hospital-acquired infections were complex, and it was wrong to dump the costs onto patients.

Professor Shaban said a heightened risk of infection was often due to factors outside the control of patients, such as undergoing chemotherapy, and this should not be a reason to increase charges or even refuse treatment.

He said the College was concerned hospitals would seek to recover the costs of treating acquired infections from patients, and warned that "an even worse outcome would see hospitals refusing to admit a patient, or charging them a premium based on their risk of infection".

Medibank has argued that its arrangement with Calvary and other hospital groups was aimed at improving the quality of care.

But Professor Shaban said international experience showed financial disincentives did nothing to reduce the risk of infection.

Private hospitals themselves have been put on notice to improve the disclosure of information to patients.

The consumer watchdog has raised concerns about a lack of transparency from private hospitals in how they bill patients, citing the example of Calvary Health Care patients who faced additional charges if their hospital stay was shorter than anticipated.

The Australian Competition and Consumer Commission told the *Australian Financial Review* the intersection of hospital billing practices and health insurance policies can lead to unexpected results for the consumer and should, at the very least, be fully disclosed.

ADRIAN ROLLINS

Department giving GPs the PIPs

The Health Department is threatening to axe incentive payments to medical practices that fail to upload shared health summaries to the My Health Record system despite the fact that it is still under development.

In a move condemned by AMA Council of General Practice Chair Dr Brian Morton, the Department has advised general practices that unless shared health summaries for 0.5 per cent of their standardised whole patient equivalent are uploaded in May, they will no longer be eligible for payments under the e-health Practice Incentives Program (ePIP).

A Department spokeswoman told *Pulse+IT* magazine the eligibility requirement could be met by a single GP in the practice, and added that a tiered performance-based approach linked to levels of system use would be introduced from August, "subject to the outcome of consultations with the general practice community".

But Dr Morton condemned the Department's move, which he said was premature and had been undertaken without adequate consultation.

"It's going to be an appalling cock-up because they haven't listened to the profession, they've not listened to the stakeholders, and they're not giving us enough time," he told *Medical Observer.*

The Department is implementing the new eligibility requirements even though a trial of My Health Record's opt-out arrangements is not due to commence until mid-July, and numerous privacy issues have yet to be resolved.

"They should be holding off until the pilots have been run and the opt-out has actually happened," Dr Morton said.

The AMA has long flagged serious concerns with the approach the Department is taking to implementing the My Health Record (MyHR) system, which is intended to supersede the flawed Personally Controlled Electronic Health Record.

In a submission to the Health Department last year, the AMA argued that fundamental issues with the design of MyHR had to be resolved before any move to links its use to the ePIP.

It said that until shortcomings of the PCEHR such as incomplete and hidden information and a lack of take-up among consumers were fully addressed, it was premature to try to force doctors to adopt it.

"Until these problems have been rectified MyHR is neither a meaningful or functional tool, and it is unreasonable to expect GPs to actively use it," the AMA said at the time.

"If the MyHR is easy for practitioners to utilise, the information it contains is reliable, the system and record transparently interoperable, and practitioners can quickly and clearly recognise how it will enhance patient care then they will readily engage with it.

"However, we know that the MyHR is none of these things and using the PIP incentive to try and mandate use of the MyHR will not solve this."

The AMA said that, rather than a single practice-level ePIP payment, a better way to encourage GPs to use the system was to remunerate them through an MBS item or a Service Incentive Payment (SIP).

ADRIAN ROLLINS

Govt funding goes begging because of bungling

The Health Department has been accused of bungling a multi-million dollar program intended to boost GP training in rural areas.

AMA President Professor Brian Owler has taken the Department to task over revelations that fewer than 50 Rural and Regional Teaching Infrastructure Grants have been awarded, despite funding for double that number.

In its 2014-15 Annual Report, the Department advised that just 10 of 100 grants provided for by the Government in that year had been approved. Professor Owler said that since then a further 38 had been awarded, and negotiations on another "20 or so" were underway.

But the AMA President said this still fell well short of expected targets. In its 2014-15 Budget, the Government committed $52.5 million over three years to fund at least 175 grants worth up to $300,000 each.

There are ongoing concerns about the difficulty of recruiting and retaining doctors to practise in country areas, and the grant program was established to help rural clinics to expand their facilities to accommodate medical students and supervising GPs.

Professor Owler said the program's underperformance was particularly disappointing given the Government's crackdown on spending in most areas of health.

"Many health services and programs and organisations are struggling as the Government puts the Budget bottom line ahead of improving health outcomes," he said. "So it's a surprise to find an area of health where funding targets are not being met or, to put it another way, precious allocated health funding is not being spent."

The AMA President said the implementation of the program had been flawed – it took the Department four months to invite applications, and set a deadline during the 2014-15 Christmas-New Year holiday period.

"Give the Department's extensive experience with infrastructure grants, this should have been a straightforward exercise. Clearly it has bungled the process," Professor Owler said. "This ineptitude has wasted a rare opportunity to enable more medical students and GP registrars to experience and develop an interest in rural practice, and give patients better access to health services in their community."

He said that what made it all the more galling was that this had occurred at a time when the Government was slashing GP funding.

The episode also showed the destructive effect of health spending cuts.

Professor Owler said the financial uncertainty created by Government policies such as the Medicare rebate freeze and the MBS Review had made general practices increasingly risk averse.

In order to qualify, practices have to commit to matching the grant provided by the Government, and the AMA President said many were reluctant to make the investment in the current environment.

He said it was unsurprising that, given the lacklustre response, the Government was reconsidering its approach to infrastructure grant funding.

ADRIAN ROLLINS

Vaccination gaps leave communities at risk

Vaccination rates in some areas are so low that they are vulnerable to the spread of potentially dangerous diseases such as measles and whopping cough.

A report detailing child vaccination rates nationwide has found that although almost 91 per cent of children were fully vaccinated in 2014-15, in more than 100 postcodes less than 85 per cent were fully immunised, including just 73.3 per cent in the Brunswick Heads area on the New South Wales north coast.

The National Health Performance Authority report indicates that the country has a considerable way to go to achieve the target set by the Commonwealth, State and Territory chief health and medical officers for 95 per cent of all children to be fully vaccinated, though there were some encouraging signs of progress.

The NHPA found immunisation rates among one-year-old Indigenous children increased significantly in 14 per cent of geographical areas, and there was a big 8 percentage point jump in the rate outback South Australia.

The report also revealed improvements in Surfer's Paradise, and the eastern suburbs of Sydney.

The findings were released against the backdrop of concerted efforts nationwide to boost immunisation rates, most notably through the Federal Government's No Jab, No Pay laws, which deny family tax supplements and childcare benefits and rebates to parents who refuse to have their children vaccinated.

There have been anecdotal reports of surge in vaccinations before the commencement of the school year as the new rules loomed, but public health expert Julie Leask warned the causes of low vaccination rates were complex, and it was too early to assess the effectiveness of the No Jab, No Pay laws.

In her *Human Factors* blog (https://julieleask.wordpress.com/), Ms Leask, a social scientist at Sydney University's School of Public Health, said a significant percentage of the 84,571 children reported as not fully vaccinated were in fact up-to-date but there were errors in recording their status on the Australian Childhood Immunisation Register.

In other instances, parents were unaware of vaccination requirements, or encountered problems in arranging for the immunisation of their children.

Ms Leask said that without further research, it was impossible to know how many children were being denied immunisation because their parents objected to it.

She said there were encouraging accounts of some parents who were previously objectors arranging for their children to be vaccinated – including some who were "angry and resentful, feeling coerced into making the decision because they cannot afford to miss the payments".

But Ms Leask aired concerns about the implementation of the No Jab, No Pay laws.

She said Primary Health Networks and providers including GPs, nurses and Aboriginal health workers were being forced to work "very hard to implement a complex policy in a very short timeframe," with often inadequate resources.

Providers were in many cases being overwhelmed by demand and had not been provided with additional assistance, and were being denied access to the ACIR and so could not update patient details.

The importance of high rates of vaccination have been underlined by warnings that the world remains "significantly off-track" targets to eliminate measles, and that communities with immunisation rates below 90 per cent were at risk of fast-spreading outbreaks.

The Gavi Vaccine Alliance said that although the number of deaths from malaria worldwide had fallen substantially in the past decade, the disease still claimed 114,900 lives in 2014 – most of them children younger than five years.

Gavi said it had developed a new approach to support periodic, data-driven measles and rubella campaigns in addition to action to tackle outbreaks.

"Measles is a key indicator of the strength of a country's immunisation systems and, all too often, it ends up being the canary in the coalmine," Gavi Chief Executive Dr Seth Berkley said. "Where we see measles outbreaks, we can be almost certain that coverage of other vaccines is also low."

ADRIAN ROLLINS

Hollywood told to flick smoking habit

The World Health Organisation has called for a ratings system for films that show people smoking amid warnings that screen portrayals are luring millions of young people into the deadly habit.

While a major review has found evidence that smoking bans have delivered significant health benefits for non-smokers, the WHO is urging governments to do more to deter adolescents from trying tobacco.

Though the WHO Framework Convention on Tobacco Control, which came into effect in 2005, binds signatories to ban tobacco advertising, promotion and sponsorship, *The Lancet* said earlier this month that that films and television shows remain a potent way circumventing such restrictions by exposing young people to images of smoking.

Hollywood is yet to kick the tobacco habit – 44 per cent of all films it made in 2014 portrayed smoking, including 36 per cent of films rated suitable for young people.

The Lancet cited calculations by the US Centers for Disease Control and Prevention that seeing on-screen smoking would encourage more than 6 million youngsters to take up the habit in 2014 alone.

Though smoking rates among young people in Australia are low by international standards – just 3 per cent of 12- to 15-year-olds smoke, rising to 10 per cent of 16- to 17-year-olds – the WHO's call is seen as a way to further undermine the appeal of tobacco among young people, which was a major goal of the country's world-leading plain package legislation.

This comes against the backdrop of the rise of e-cigarettes and concerns they provide a pathway to smoking for young people.

A US study of young people who had never smoked traditional cigarettes found that almost 70 per cent who used e-cigarettes progressed to traditional smokes, compared with 19 per cent of those who had not.

Of some comfort in this regard are figures showing sales growth of e-cigarettes is slowing.

After expanding at a triple-digit pace in the past five years, sales growth in the US is expected to slow to 57 per cent this year and 34 per cent in 2017.

The latest evidence for the success of tobacco control measures has come from a group of Irish researchers who investigated the effect of smoking bans on health.

The study, published by the Cochrane Library, identified 33 observational studies showing evidence of a significant reduction in heart disease following the introduction of smoke-free workplaces and other public spaces.

The researchers found the greatest reduction in admissions for heart disease following the introduction of smoking bans was for non-smokers.

ADRIAN ROLLINS

Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
Dr Chris Moy	AMA Federal Councillor	NeHTA (National E-Health Transition Authority) Clinical Usability Program (CUP) Steering Group	18/2/2016
Dr Brian Morton	AMA Federal Councillor & Chair AMACGP	Consultation on-screen presentation of discharge summaries	21/1/2016
Dr Chris Moy	AMA Federal Councillor	Consultation on-screen presentation of discharge summaries	???/1/2016
Dr Richard Kidd	AMA Federal Councillor & Deputy Chair AMACGP	Consultation on-screen presentation of discharge summaries	19/1/2016
Dr Brian Morton	AMA Federal Councillor & Chair AMACGP	Practice Incentive Program Advisory Group (PIPAG)	18/2/2016
Dr John Gullotta	AMA Federal Councillor	TGA Medicines Shortages Working Group	12/2/2016
Dr Brian Morton	AMA Federal Councillor & Chair AMACGP	Meeting with expert panel reviewing pharmacy regulation and remuneration	1/2/2016
Dr Richard Kidd	AMA Federal Councillor & Deputy Chair AMACGP	Health Sector Group (HSG)	9/2/2016
Dr Stephen Parnis	AMA Vice President	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	10/2/2016
Dr Antonio Di Dio	AMA Member	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	10/2/2016
Dr Roderick McRae	AMA Federal Councillor - Salaried Doctors	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	10/2/2016
Dr Susan Neuhaus	AMA Federal Councillor - Surgeons	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	10/2/2016

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Your AMA Federal Council at work

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

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Name	Position on council	Activity/Meeting	Date
Dr Johnathon Burden	AMA Member	Meeting with Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) on improving practitioner experience with notifications	10/2/2016
Dr Brian Morton	AMA Federal Councillor & Chair AMACGP	GP Roundtable	19/1/2016
Dr John Gullotta	AMA Federal Councillor	NeHTA (National E-Health Transition Authority) eReferral Reference Group	25/11/2015
Dr Ian Pryor	AMA Member	MSAC (Medical Services Advisory Committee) Review Working Group for Paediatric Surgery, including Circumcision	8/12/2015
Dr Ian Pryor	AMA Member	MSAC (Medical Services Advisory Committee) Review Working Group for Percutaneous Coronary Artery Interventions	3/12/2015
Dr Brian Morton	AMA Federal Councillor, Chair of AMACGP	Profession Services Review Advisory Committee	2/12/2015

INFORMATION FOR MEMBERS

Searching for a hero

The Integrated Family and Youth Service (IFYS) are looking for a superhero. More precisely, a doctor who spent time in foster care as a child who would be willing to share their story.

Drawing on the fact that many superheroes depicted in popular literature, most notably Superman, were raised by foster parents, IFYS has developed a campaign called (with tongue firmly planted in cheek) 'Raise the next Superhero', to recruit foster families for the hundreds of children who enter care every month.

If you are a doctor who spent time in foster care while growing up, and would be willing to share your story, please contact Letitia at communications@ifys.com.au

AMA in the news

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

PRINT/ONLINE

AMA attacks health insurers' clawback, *Adelaide Advertiser*, 5 February 2015

Private health insurance customers could finally see a slowdown in the rate of premium rises, amid criticism of insurers for scaling back members' entitlements. AMA President Professor Brian Owler accused some insurers of scaling back members' coverage.

Sticking up for all children, *Northern Territory News*, 8 February 2016

The AMA wants all children who fall behind on their vaccination program to be allowed to catch up for free, calling for further Federal Government funding to boost immunisation rates. AMA President Professor Brian Owler said Government claims that health spending was unsustainable were not backed by evidence.

Medicare plan risks privacy, *Adelaide Advertiser*, 12 February 2016

A private company would know whether a patient had an abortion, herpes or was getting mental health treatment if the Government proceeds with a plan to privatise Medicare and medicine payments. The AMA is calling on the Government to change the system so a patient's Medicare rebate could be assigned directly to the doctor.

Anti-vax nuts crack at last, *The Sunday Telegraph*, 14 Februay 2016

Almost 260 extra children are being immunised every week as even the most hardened anti-vaccine fanatics change their view. AMA President Professor Brian Owler said people are starting to realise the anti-vaccination lobby does not hold weight, and some of the policies are starting to take effect.

Indigenous health vital, *The Herald Sun*, 18 February 2016

AMA President Professor Brian Owler, in Alice Springs visiting health groups and clinics, said the Closing the Gap report, released last week, indicated that health had fallen off the radar.

Bulk-billing on the rise despite mooted cuts, *The Australian*, 19 February 2016

Bulk billing rates have continued to rise despite health groups warning patients will be left out-of-pocket because of a Federal Government freeze on Medicare rebates. AMA President Professor Brian Owler said the plan to remove the bulk billing incentive from pathology services was a sign the co-payment had risen from the grave.

RADIO

Professor Brian Owler, 666 ABC Canberra, 8 February 2015

AMA President Professor Brian Owler discussed the AMA's Pre-Budget Submission. Professor Owler criticised the Federal Government for telling basic 'untruths' about health spending.

Dr Brian Morton, 2GB Sydney, 9 February 2016

AMA Chair of General Practice Dr Brian Morton discussed homeopathy. Dr Morton said he was concerned that people who chose homoeopathy might put their health at risk.

Professor Brian Owler, ABC News Radio, 11 February 2015

AMA President Professor Brian Owler talked about health spending and the MBS Review.

Professor Brian Owler, ABC South East NSW, 15 February 2016

AMA President Professor Brian Owler discussed hydrocephalus. Professor Owler said shunt registry for hydrocephalus could be used as a quality assurance tool in order to decrease blockages and infections which affect morbidity and increase costs to the health system.

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AMA in the news

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

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TELEVISION

Professor Brian Owler, ABC News 24, 28 December 2015

Landmark legislation will be introduced into Parliament to legalise medicinal cannabis. AMA President Professor Brian Owler said medicinal cannabis should be regulated in the same way as other narcotics.

Professor Brian Owler, CNN, 16 February 2016

AMA President Professor Brian Owler slammed Government policy on asylum seekers. Professor Owler said doctors who work with asylum seeker children face an incredible ethical dilemma, because they cannot allow children to be discharged into an unsafe environment.

Professor Brian Owler, SBS Sydney, 17 February 2016

Prime Minister Malcolm Turnbull said there would be no change to Australia's border protection policies despite an offer from New Zealand Prime Minister John Key to take in children headed for offshore detention. AMA President Professor Brian Owler said this was a complex issue, but the issue facing the AMA is to ensure the health care of asylum seekers and getting children out of detention.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

Road Safety

The 2016 Australasian Road Safety Conference 2016 (ARSC2016), the premier road safety conference for Australia, New Zealand and the Asia Pacific, will be held in Canberra from 6 to 8 September this year.

Hosted by the Australasian College of Road Safety (ACRS), Austroads, and The George Institute for Global Health, the theme for 2016 is "Agility, Innovation, IMPACT".

The Conference will have a special focus on harnessing the latest research, technology and policy innovations to produce the best road trauma reduction outcomes possible

The AMA continues to make an important contribution to the ongoing national campaign to reduce road fatalities and road trauma.

As a neurosurgeon, AMA President Professor Brian Owler frequently witnesses the tragic consequences of speeding, and has a strong personal commitment to improving road safety.

Professor Owler has been the face of New South Wales' Don't Rush campaign since 2010. This prominent advertising campaign has contributed to a reduction in speed and fatigue-related injury and death in that state.

But speeding, fatigue and risk-taking behaviours continue to contribute to too many lives being lost and harmed on Australian roads.

The annual economic cost of road crashes in Australia is enormous — estimated at $27 billion — and the social impacts are devastating.

Doctors play an important role in terms of assessing whether patients are fit to drive. Illness and disease may impair someone's ability to drive, temporarily or permanently.

The AMA website has a link to the National Transport Commission publication *Assessing Fitness to Drive: medical standards for licensing and clinical management guidelines. A resource for health professional in Australia (March 2012 as amended up to 30 June 2014)*, which can be used by doctors to help assess the fitness of a patient to drive.

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Privacy risk on Medicare outsourcing

The AMA has raised concerns that any move to outsourcing Medicare payments to the private sector could compromise patient privacy and further fragment their care.

Prime Minister Malcolm Turnbull has confirmed an overhaul of the Medicare payments system is under active consideration, with Health Minister Sussan Ley revealing the Health Department is investigating ways to digitise "transaction technology for payments".

Though the Government has not explicitly said it is looking at outsourcing the payments system to the private sector, the AMA said such a move would be in keeping with the Commonwealth's broader policy agenda to increasingly offload responsibility for funding and providing health care.

According to a report in the *West Australian* newspaper, the Government is well advanced in plans to outsource the processing of Medicare, Pharmaceutical Benefits Scheme and aged care claims and payments, as well as the administration of eligibility criteria.

The newspaper reported that the change was likely to be unveiled in the forthcoming Budget, with a call for tenders issued soon after.

It has been suggested that Australia Post, Telstra and the big banks, as well as overseas firms including Serco, Fuji-Xerox and Accenture, may bid for the work.

AMA Vice President Dr Stephen Parnis said such a move would raise serious privacy issues.

"There are concerns raised about the way that the administrators of these programs would handle confidential medical data; how their input may influence or undermine the doctor-patient relationship in terms of its funding," Dr Parnis told ABC Radio.

He said it raised the prospect that a Medicare benefit item "might be administered, or potentially even refused, by someone who isn't necessarily accountable to Government".

The outsourcing idea is the latest move by the Federal Government to change Medicare, after its failed attempts to introduce a GP co-payment, the institution of a four-year rebate freeze, a review of the Medicare Benefits Schedule, and cuts to bulk billing incentives for pathology and diagnostic imaging services.

But Mr Turnbull insisted that Government was "totally committed" to Medicare, and any change to its payments system was aimed at improving the service for consumers.

"What we are looking at, as we look at in every area, is improving the delivery of Government services, looking at ways to take the health and aged-care payment system into the 21st century," the Prime Minister told Parliament. "This is about making it simpler and faster for patients to be able to transact with Medicare to get the services they are entitled to."

Ms Ley said that "every day, Australians use cards to make 'tap and go' payments, and apps to make payments, and yet Medicare has not kept up with these new technologies".

She said the Health Department was working with "business innovation and technology experts to determine the best and most up-to-date payment technologies available on the market for consumers and health and aged care service providers".

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Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p24

The infrastructure of Medicare's payments system is more than 30 years old, and although it processes more than 370 million patient rebates each year, the system's age means it is becoming harder to add new types of payments.

The Opposition has slammed the outsourcing proposal, characterising it as an attempt to privatise Medicare, and there are concerns the policy would cause more than 1400 Department of Human Services workers involved in processing and payments to lose their jobs.

ADRIAN ROLLINS

Hospital funding crisis 'not our problem', says Commonwealth

The Commonwealth is on a collision course with the states over health spending after Treasurer Scott Morrison declared the second tier of government was on its own despite a looming $35 billion funding gap.

As the nation's treasurers prepare to meet next month, Mr Morrison has told his State and Territory counterparts that there would be no extra funding from the Commonwealth.

"We all have to manage our budgets," he told the National Press Club. "Asking for buckets of money doesn't solve your expenditure problem."

Several states have been pushing for tax reform, including a bigger slice of the Commonwealth's tax take, because of a looming shortfall in funding for hospitals and schools.

Changes unveiled in the 2014-15 Budget that are due to come into effect next year are expected to strip $57 billion from public hospital funding revenue over 10 years, creating what AMA President Professor Brian Owler said was "funding black hole" that would have dire consequences for patients.

"Public hospital funding is about to become the single biggest challenge facing State and Territory finances," Professor Owler said. "Without sufficient funding to increase capacity, public hospitals will never meet the targets set by governments, and patients will wait longer for treatment."

The AMA's annual Public Hospital Report Card showed that performance improvements have stalled and, in some instances, are going into reverse, as hospitals struggle with inadequate funding.

Almost a third of Emergency Department patients categorised as urgent are waiting more than 30 minutes for treatment, and elective surgery patients are, on average, waiting six days longer than they were a decade ago.

There had been hopes that Federal, State and Territory leaders would agree on tax changes at a meeting to discuss reform of the Federation next month that would put health funding on a firmer financial footing.

But the likelihood of the meeting appears to be rapidly receding after Prime Minister Malcolm Turnbull ruled out any changes to the GST, which was at the centre of reform plans advanced by several states, including South Australia and New South Wales.

Instead, the Commonwealth appears determined to divest itself as much as possible of responsibility for health funding.

Mr Turnbull said the Federal Government did not want to increase the total tax take "in net terms", and challenged the states to find their own sources of extra funds for health.

Papers prepared for the Council of Australian Governments meeting in December indicated that the Commonwealth and the states faced a combined health funding gap of $35 billion by 2030, and suggested closing it would require both spending restraint and an increase in tax revenue.

ADRIAN ROLLINS

Pathologists on the warpath

Pathology and diagnostic imaging providers have vowed to flex their political muscle as part of an election-year campaign to force the Federal Government to dump controversial cuts to bulk billing incentives.

In a stark warning to Government MPs, pathology and diagnostic imaging groups have vowed to mount a vigorous campaign over last December's decision to save $650 million by axing the bulk billing incentive for pathology services and reducing it for diagnostic scans.

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Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

... from p25

Emphasising their political impact, industry leaders said there were about 5000 pathology collection centres around the country that were used regularly by millions of Australians.

Sonic Healthcare Chief Executive Colin Goldschmidt told Fairfax Media that his company alone had around 2000 collection centres.

"We reach something like 1 million to 2 million patients per month through those collection centres," Mr Goldschmidt said. "We have access to a lot of people."

The Government's cuts have particularly angered pathology providers, who have not had an increase in the Medicare rebate for their services in 17 years.

Primary Health Care Chief Executive Peter Gregg said the decision was "ludicrous" because it would force providers to begin charging a co-payment, which would in turn deter some patients – including those with chronic conditions such as diabetes – from being tested as regularly, resulting in more serious and expensive health problems.

Mr Gregg told *The Australian* pathology services could not absorb any more Government cuts without changing their business model, and said Primary, which operates 71 medical centres, more than 2000 collection centres and 168 radiology clinics, had begun trials of co-payments for some pathology and diagnostic imaging tests to gauge their effect on demand.

Mr Goldschmidt said Sonic currently bulk billed 98 per cent of its services and, although it had not yet moved to introduce more co-payments, "we are tending in that direction".

But both executives insisted their preferred option was to block the bulk billing incentive cuts altogether.

The change was announced by the Government in its Mid Year Economic and Fiscal Outlook. Health Minister Sussan Ley argued the incentive, worth between $1.40 and $3.40, had done little to boost bulk billing rates, and had instead served to plump up the bottom line of providers like Primary and Sonic.

She said the companies could comfortably absorb the cut.

But AMA President Professor Brian Owler said the Government's real intent was to introduce a co-payment "by stealth" by forcing pathology and diagnostic imaging providers charge out-of-pocket expenses for their services.

"It's very clear that to be viable, that if these bulk billing incentives are taken away, then of course they're going to have to pass those fees onto patients," Professor Owler said. "That's what this strategy is all about. It's about the Government saying 'no, we're not paying any more; we're going to make the provider charge you a fee'."

The AMA President said the likely fee providers would have to charge would be considerably more than the incentive, because providers would have to introduce and operate billing systems, chase up bad debts, make provisions for losses and other additional tasks.

"They've got to actually introduce a whole new system to enable this to work, so of course they're going to start to charge more. They're not going to charge one of three dollars; it's going to be much more than that," he said.

Adding to the pressure on Government MPs, the ACTU has revealed it will mount campaign involving doorknocking and targeted advertising in Coalition marginal seats.

The campaign has been triggered by the cuts to bulk billing incentives and the Government's plan to outsource the Medicare payments system to the private sector.

ADRIAN ROLLINS

Health on the hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

No more pot luck on medicinal weed

Medicinal cannabis should become much more readily available under Federal Government plans to establish a single, national licensing scheme for the production and supply of the drug.

In an initiative cautiously welcomed by medical groups, Health Minister Sussan Ley has introduced legislation amending existing narcotics laws to allow for controlled cultivation of cannabis for medicinal and scientific purposes.

"For Australia, this is the missing piece in a patient's journey," Ms Ley said. "Importantly, having a safe, legal and reliable source of products will ensure medical practitioners are now at the centre of the decision-making process on whether medicinal cannabis may be beneficial for their patient".

There are already provisions in place to allow for the legal production and distribution of medicinal cannabis, which can be prescribed by authorised specialists.

But demand significantly outstrips supply, making it difficult and expensive for patients to obtain.

Ms Ley said the legislation would provide "the missing piece in the puzzle" by improving the availability of the drug.

"I am confident [that] creating one single, nationally-consistent cultivation scheme...will not only help speed up the legislative and regulatory process but, ultimately, access to medicinal cannabis products as well," the Minister said.

The AMA said its supports a nationally-consistent and evidence-based approach to the regulation, supply and use of medicinal cannabis.

In its submission to a Senate committee inquiry on the issue last year, the peak medical group said medicinal cannabis should be regulated in the same way as other therapeutic narcotic products, "in order to ensure it can be standardised and regulated in its pharmaceutical preparations and administration", reducing potential harm to users.

Medicinal cannabis has been used to reduce the incidence of nausea and vomiting in chemotherapy patients, as an appetite stimulant, and as a treatment for chronic pain.

But AMA President Professor Brian Owler said last year that there needed to be a considered and evidence-based approach to its use.

"There are some conditions where it clearly may be beneficial, and perhaps we don't need to have an in-depth trial on those sorts of indications. But there are clearly others where the evidence is actually not there," Professor Owler said. "We need to have proper trials and regulate it as a medication just like any other medication."

The Royal Australian College of Physicians said that although the move to establish a safe, legal and reliable national supply of the drug was welcome, significant details regarding who would be authorised to prescribe medicinal cannabis, and what appropriate dosages might be, were yet to be resolved.

"It still needs to be determined which type of medical specialist will be authorised to prescribe the drug," College President Professor Nicholas Talley said. "And we also have reservations that there is still no standard dose of cannabis, and that dosage can vary according to condition."

Ms Ley expects the legislation to have bipartisan support and to be passed in this session of Parliament.

ADRIAN ROLLINS

INFORMATION FOR MEMBERS

AMA Awards 2016 - Call for Nominations

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

1. AMA EXCELLENCE IN HEALTHCARE AWARD

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

The recipient of this award will be an individual who has made a major contribution to health care in Australia in one or more of the following criteria:

- Showing ongoing commitment to quality health & medical care; and/or
- Contributing to medical research within Australia; and/or
- Initiation and involvement in public health projects or health awareness campaigns; and/or
- Improving the availability & accessibility of medical education and medical training; and/or
- Advancing health & medical issues in the political arena; and/or
- Promoting awareness of the impact of social and economic issues on health; and/or
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field.

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

2. AMA WOMAN IN MEDICINE AWARD

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

- Showing ongoing commitment to quality care; and/or
- Contributing to medical research within Australia; and/or
- Initiation and involvement in public health projects; and/or
- Improving the availability and accessibility of medical education and medical training for women; and/or
- Contributing to medical politics.

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

3. AMA WOMEN'S HEALTH AWARD

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

- Promoting and contributing to public health initiatives; and/or
- Initiating, participating and promoting health awareness campaigns; and/or
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field of women's health.

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

Continued on p29 ...

INFORMATION FOR MEMBERS

AMA Awards 2016 – Call for Nominations

... from page 28

4. AMA MEN'S HEALTH AWARD

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

- Promoting and contributing to public health initiatives; and/or
- Initiating, participating and promoting health awareness campaigns; and/or
- Contributing to community needs as a health care provider; and/or
- Improving health care services in any field of men's health.

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

5. AMA YOUTH HEALTH AWARD

The AMA Youth Health Award goes to a young person or group of young people, 15-27 years of age, who have made an outstanding contribution to the health of young Australians by:

- Promoting and contributing to youth health initiatives; and/or
- Initiating, promoting or participating in youth health awareness; and/or
- Development of youth health promotion programs.

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

NOMINATION INFORMATION

Recipients of the awards will be informed as soon as possible after the panel has made its decision. Recipients may be invited to attend the 2016 AMA National Conference in Canberra at the end of May 2016, where the awards will be announced and presented.

Nominations for each award must include:

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

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

Alternatively, they may be mailed to:

'2016 AMA Awards'
Public Health Section
Australian Medical Association
PO Box 6090
KINGSTON ACT 2604

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

Birth defect fears deepen as Zika spreads

Evidence linking the rapidly spreading Zika virus to birth defects is mounting, adding to the urgency of efforts to develop a vaccine and underlining calls for co-ordinated international efforts to control its spread.

A recent spate of microcephaly cases involving women who were infected with Zika while pregnant - including one where the virus was found in a newborn's brain tissue - has strengthened suspicions the disease is responsible for severe abnormalities.

Thirty-four countries have been hit so far in the current outbreak, most of them in Latin America, according to the World Health Organisation. In Brazil alone, around 1.5 million cases have been reported, and a further 25,000 are suspected in Colombia.

But the disease has also spread to the Pacific. Ongoing transmission has been reported in Tonga, where 542 suspected cases have been identified, and Samoa.

Though there is no evidence of Zika virus transmission in Australia, Chief Medical Officer Professor Chris Baggoley has warned there is a "continuing risk" of the disease being imported into the country from infected areas – so far this year, seven cases have been confirmed, all involving returning travellers.

Disturbingly, two pregnant women who recently travelled to Zika-prone regions have tested positive to the virus – one if Victoria, the other in Queensland.

Health authorities have convened a Communicable Disease Network Australian working group to monitor the international outbreak and advise on public health measures.

Though the effects of the disease are considered relatively mild in adults, the WHO has declared the outbreak a public health emergency of international concern because of mounting fears it is causing serious birth defects.

WHO Director-General Dr Margaret Chan said last week that although a causal relationship between Zika virus infection in pregnancy and microcephaly (babies born with abnormally small heads) was not yet scientifically proven, it was "strongly suspected".

Evidence of a causative link between the virus and severe congenital abnormalities is strengthening.

Last month, a mother in Hawaii who was infected with the Zika virus during her pregnancy gave birth to a baby with microcephaly, and the US Centers for Disease Control reported on 10 February the Zika infection was evident in the case of two babies born with microcephaly who subsequently died, and two instances of miscarriage. In addition, the New England Journal of Medicine reported the case of a Slovenian woman who suffered a Zika-like illness while pregnant in Brazil. Her baby developed microcephaly, and the Zika virus was found in its brain tissue.

"The level of alarm is extremely high," Dr Chan said. "Arrival of the virus in some places has been associated with a steep increase in the birth of babies with abnormally small heads and in cases of Guillain-Barre syndrome."

In declaring a health emergency, the WHO has urged a coordinated international response to the virus threat, including improved surveillance of infections and the detection of congenital malformations, intensified mosquito control measures, and the expedited development of diagnostic tests and vaccines.

There is currently no treatment or immunisation for Zika, and although 15 companies or groups are working on a vaccine, the WHO has warned it is likely to be 18 months before one is ready for trial.

Their task is complicated by uncertainty about how the virus is spread. Though mosquitos are considered the prime culprit, there are suspicions it may also be spread though bodily fluids, particularly blood and semen.

As a precaution, the Australian Red Cross Blood Service has deferred collecting blood from donors who have travelled to countries with mosquito-borne viruses such as dengue and malaria.

The virus, which is closely related to the dengue virus, was first detected in 1947, and since 2012 there have only been 30 confirmed cases in Australia, all of them involving infection acquired overseas.

Members of the European Society of Clinical Microbiology and Infectious Diseases have warned that the next stage of the epidemic may involve the re-emergence of Zika in sub-Saharan Africa and, from there, southern Europe.

The Department of Foreign Affairs and Trade has advised pregnant women considering travelling to countries where the Zika virus is present to defer their plans.

All other travellers are advised to take precautions to avoid being bitten by mosquitos, including wearing repellent, wearing long sleeves, and using buildings equipped with insect screens and air conditioning.

ADRIAN ROLLINS

UK faces doctor exodus over work changes

There has been a surge in British doctors seeking work overseas after the United Kingdom Government moved to impose new contracts on junior doctors in the face of vociferous opposition from the media profession.

According to *The Independent*, the number of applicants for Certificates of Good Standing, used when applying for jobs offshore, soared to 300 (up from an average 29 a day) on the day Health Secretary Jeremy Hunt announced the Government was abandoning negotiations and would instead impose the new contract on doctors.

The British Medical Association, which has been representing junior doctors during the long and heated dispute, condemned the Minister's move as "a sign of total failure on the Government's part".

Chair of the BMA's junior doctor committee, Dr Johann Malawana, said that instead of working with the Association to reach an agreement in the best interests of patients, doctors and the NHS, the Government had "walked away".

The dispute, which has so far involved two 24-hour strikes by junior doctors causing the cancellation or deferral of thousands of medical procedures, was triggered by a push by Mr Hunt for new contracts which would put doctors on a seven-day week roster without any compensation for working "unsocial" hours.

During negotiations, concerns about long and unsafe shifts were addressed but the issue of remuneration for working Saturdays remains outstanding.

In a final offer presented to the BMA on 9 February, the Government's chief negotiator, Sir David Dalton said substantial agreement had been reached on safety and training issues, and outlined arrangements under which "the majority" of trainees working Saturdays would be paid a premium.

In a reply to Mr Hunt the following day, Dr Malawana acknowledged the concessions made on safe work limits and urged the Minister to accept the BMA's proposal that a small fraction of funds already allocated by the NHS to basic pay be redistributed to provide for unsocial hours payments for doctors.

""This would give you the cost neutrality you seek, and junior doctors the appropriate recognition for evening, nights and weekends," Dr Mulawana wrote. "If you are able to accept this model and withdraw the threat of imposition, we believe that our dispute with the Government would be concluded."

Instead, the following day the Health Minister announced the Government would go ahead with imposing the contracts on staff.

The BMA has warned the Government actions has created deep resentment among junior doctors and could undermine care in the future.

"This is clearly a political fight for the Government, rather than an attempt to come to a reasonable solution for all junior doctors," Dr Mulawana said. "The Government's shambolic handling of this process from start to finish has totally alienated a generation of junior doctors – the hospital doctors and GPs of the future - and there is a real risk that some will vote with their feet."

ADRIAN ROLLINS

Australian Medical Association Limited • ABN 37 008 426 793

Invitation for nominations for election to Federal Council

AREA NOMINEES

Invitation for nominations for election to Federal Council as Area Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Areas:

1. New South Wales and Australian Capital Territory Area • 2. Queensland Area • 3. South Australia and Northern Territory Area 4. Tasmania Area • 5. Victoria Area • 6. Western Australia Area

The current term of Area Nominee Councillors expires at the end of the AMA National Conference in May 2016.

Nominations are now invited for election as the Nominee for each of the Areas listed above.

1. Nominees elected to these positions will hold office until the conclusion of the May 2018 AMA National Conference. • **2.** The nominee must be an Ordinary Member of the AMA and a member in the relevant Area for which the nomination is made. • **3.** The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations. • **4.** Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA resident in the Area for which the nomination is made. • **5.** Nominations must be **emailed** to the Secretary General (atrimmer@ama.com.au). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 4 March 2016**. • **6.** A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters. • **7.** The ballot will by undertaken by electronic ballot.

The nomination form can be downloaded from: ama.com.au/system/files/AreaNomineeForm.pdf.

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: lmcdougall@ama.com.au).

SPECIALTY GROUP NOMINEES

Invitation for nominations for election to Federal Council as Specialty Group Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Specialty Groups:

1. Anaesthetists • 2. Dermatologists • 3. Emergency Physicians • 4. General Practitioners • 5. Obstetricians and Gynaecologists 6. Ophthalmologists • 7. Orthopaedic Surgeons • 8. Paediatricians • 9. Pathologists 10. Physicians • 11. Psychiatrists • 12. Radiologists • 13. Surgeons

The current term of Specialty Group Councillors expires at the end of the AMA National Conference in May 2016.

Nominations are now invited for election as the Nominee for each of the Specialty Groups listed above.

1. Nominees elected to these positions will hold office until the conclusion of the May 2018 AMA National Conference. • **2.** The nominee must be an Ordinary Member of the AMA and a member of the relevant Specialty Group for which the nomination is made. • **3.** The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations. • **4.** Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Specialty Group for which the nomination is made. • **5.** Nominations must be **emailed** to the Secretary General (atrimmer@ama.com.au). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 4 March 2016**. • **6.** A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters. • **7.** The ballot will by undertaken by electronic ballot.

The nomination form can be downloaded from: ama.com.au/system/files/SpecialtyGroupForm.pdf.

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: lmcdougall@ama.com.au).

SPECIAL INTEREST GROUP NOMINEES

Invitation for nominations for election to Federal Council as Special Interest Group Nominees

The Constitution of Australian Medical Association Limited (AMA) provides for the election, every two years, to the Federal Council of one Ordinary Member as a Nominee of each of the following Special Interest Groups:

1. Public Hospital Practice (previously called Salaried Doctors)

2. Rural Doctors

3. Doctors in Training

4. Private Specialist Practice.

The term of Councillors expires at the end of the AMA National Conference in May 2016.

Nominations are now invited for election as the Nominee for each of the Special Interest Groups listed above.

1. Nominees elected to these positions will hold office until the conclusion of the May 2018 AMA National Conference. • **2.** The nominee must be an Ordinary Member of the AMA and a member of the relevant Special Interest Group for which the nomination is made. • **3.** The nomination must include the name and address of the nominee and the date of nomination. It may also include details of academic qualifications, the nominee's career and details of membership of other relevant organisations. • **4.** Each nomination must be signed by the Ordinary Member nominated AND must be signed by two other Ordinary Members of the AMA Special Interest Group for which the nomination is made. • **5.** Nominations must be **emailed** to the Secretary General (atrimmer@ama.com.au). To be valid nominations must be received no later than **1.00pm (AEDT) Friday 4 March 2016**. • **6.** A nomination may be accompanied by a statement by the nominee of not more than 250 words to be circulated to voters. • **7.** The ballot will by undertaken by electronic ballot.

The nomination form can be downloaded from: ama.com.au/system/files/SIGForm.pdf.

For enquiries please contact Lauren McDougall, Office of the Secretary General and President (email: lmcdougall@ama.com.au).

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.

Not a member?

Join now,
www.join.ama.com.au/join

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