

## Personalised Medicine: What is it and how do we achieve it?

Affluent nations enjoy the highest level of health and longevity in the history of humanity, nevertheless, a substantial minority of the population suffer with chronic disease.

At the same time, national health budgets are escalating and the complexity of diagnostics and treatments is increasing. Biomedical research has been successful to the extent that most physiological processes are understood, and disease phenotypes have been described in exquisite detail, but less progress has been made in understanding the mechanisms and causal pathways of many diseases, which as a consequence remain incurable.

Personalised medicine aims to elucidate pathophysiological mechanisms of disease that will guide diagnostic and treatment decisions in individual patients. It assumes individual variation is important factor in disease manifestations. The Centre will build on recent progress elucidating rare diseases, technical developments that have made genome resequencing efficient and affordable, and recent discoveries that permit genetic variations to be replicated in animal models with accuracy, again quickly

ly and efficiently. These components will form the CPI pipeline for both discovery and proof of therapeutic principle that begins with individual patients, identified genetic variation, definition of cellular and biochemical defects that cause disease, and preclinical evaluation of possible therapeutics.

The CPI will focus on autoimmune disorders such as lupus and Sjogren's syndrome, inflammatory diseases such as sarcoidosis and vasculitis, and immune deficiency diseases, and will build on a long history of research into these conditions. Most of these conditions are chronic and incurable, and while we have clues about their pathogenesis, in most cases, the fundamental causes remain unknown. Diseases of the immune system are amenable to such analysis because lymphocytes and other white blood cells can be isolated from peripheral blood. Furthermore, while we have access to an increasing number of therapeutic options for treating some of these diseases, we require a better understanding of which patients will derive most benefit from targeted therapeutic agents.

On April 28, the Assistant Minister for Health Senator Fiona Nash launched the Centre for Personalised Immunology (CPI) at The John Curtin School of Medical Research (JCSMR). ANU Vice-Chancellor Professor Ian Young and Professor Chris Parish, Director



ANU Vice Chancellor Professor Ian Young, Professor Carola Vinuesa, Assistant Minister for Health Senator Fiona Nash, Professor Matthew Cook, JCSMR Director Professor Chris Parish, ANU DVC (Research) Professor Margaret Harding at the launch of the CPI.  
PHOTO: Karen Edwards, Multimedia, JCSMR

of JCSMR together with clinicians, researchers, patients and members of the public attended the launch and public lecture, delivered by the Centre Co-Directors Professor Carola Vinuesa and Professor Matthew Cook. The CPI consolidates research collaborations between researchers and clinicians in Canberra, Sydney and Melbourne. It represents an important development for biomedical research in Canberra, and as the first of its kind in Australia, the CPI also is a nationally important development towards personalised medicine.

At the moment, the Centre represents a research effort but

principal objectives of the Centre include development of policy that will guide the implementation of personalised medicine into routine clinical practice.

**More information:**  
<http://jcsmr.anu.edu.au/research/cpi>

**Canberra Doctor acknowledges the support of the Australian Medical Association and Australian Medicine in providing much of the 2014 federal budget information in this issue.**

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# TERRITORY TOPICALS – from President, Dr Andrew Miller

So now we know. The budget has been served up and the indigestion has begun.

I think I am not alone, however, when I express my **disappointment and frustration** with our current political milieu. I'm not going to dip into the he-said, she(he)-said banalities that seem to be the focus of what we so desperately refer to as political debate. What has **disappointed me is what was NOT said**. You may recall that the AMA expressed frustration that whilst health was seen by the community as a major consideration behind voting decisions, discussion of health policies was assiduously avoided by both major parties during the lead-up to the election. But now we find that our system is **"unsustainable"**, and that major change is needed.

I can understand some of the economic concerns regarding the long term fiscal security of our government. In the last 5 years we have seen two large reviews of fiscal policy; the Henry Tax Review in 2010, and our most recent Commission of Audit. Both of course were **deeply flawed by the politics that conceived them**; and we should not overlook the Costello Intergenerational Report in 2007. If we draw these disparate threads together it is possible for even this inveterate optimist to feel qualms about the long term future.

But is our **health system truly unsustainable**? As it now stands we have a first world health system that **in cost to government terms is the tenth lowest in the OECD**. In expenditure per capita we still rank in the lower half of OECD nations, about on a par with New Zealand; and considerably less than any of the larger Western European nations and of course much less than the USA. We have **fewer hospital beds per 1000 population than most OECD nations**, coming in 16th of 30; but come in slightly **better for acute care hospital beds**, at 13th. The number of **doctor consultations** per head of population has been steadily climbing but still places us about **half way up the list**, equal with Austria. But we should view this last statistic as very much a **Henry Ford statistic** since a low rate of consultations may reflect inequitable access as much as cost-efficient health care. As a case in point, the USA has consistently run at about 60% of our rate.

But before I leave this matter, I should point out that where out of pocket health expenditure is considered as a proportion of total health expenditure we land in the upper half of the list; interestingly 50% above the USA and almost double New Zealand. In cash terms we rate 26th out of 30 in out of pocket expenses, coming in under only Greece, USA, Belgium and Switzerland. The budget papers state that **"all patients will be asked to contribute to their**

**own health care costs"** (Department of Health Budget Outcomes 3, p 79) which in the light of the obvious data that **they already do and to a greater extent than the OECD median**, raises concerns about the real **underlying politics and philosophies** driving these policies. The language is about long term sustainability, value for money and maintenance of equitable access. Yet I find myself asking just how the members of the government are viewing the effects of this imposed price signal.

There appears to be a thread through the governments' thinking that **bulk-billing presents a moral hazard**, in other words the service is **devalued by its lack of perceived price**; and that therefore by applying a price signal the moral hazard is diminished. The risk of course falls to the government as the underwriter of health care as the owner of the universal health insurer, Medicare. Economists argue that health services display relative inelastic price effects on demand, meaning not unsurprisingly that demand for services is relatively unaffected by price. The clue to this thinking lies in the attempts by ministers to contextualise the GP co-payments; with beers, fags and coffee used as examples. But their thinking is **limited by an apparent total inability to understand all the dimensions of their own rhetoric about "Australians doing it hard"** which we heard time and time again when the carbon tax and its

putative effects on energy bills was being trumpeted in the election campaign. Let's be quite plain about this; either Australians will have to pay more for health care (and therefore less for something else) or not consume it so much.

It is painfully obvious that the **burden will fall most heavily on those who can least afford it**. Amongst these are the **indigenous members of our community**. The evidence shows that in the transfer of responsibility for indigenous health from DoH to PM&C there has been a significant funding cut. This has again been described as an efficiency measure. We know already that the **Aboriginal Health Services are battling with scaterological funding** that consumes valuable resources in compliance costs, but it seems apparent that the government sees the quid pro quo for reducing complexities as being a reduction in funds. These organisations and their communities will also be **impacted by the GP co-payment**. It seems that there is no outcome likely but adversity.

**We as a profession should also not unquestioningly wear the "blame" for health costs**. Medical services are certainly not the only driver of the rise in health costs; with medical services for primary care totalling about \$9.7 billion out of a total health expenditure of in excess of \$140 billion. In so far as out of pocket costs are concerned, **medical services account for about 12% of costs**,



Dr Andrew Miller

whilst pharmaceuticals contribute 40%.

The budget papers also included a swag of abolitions and mergers amongst government agencies, including particularly a number of health agencies. The expressed intent is to save money and improve efficiencies for both government and industry. Whilst it is true that the previous federal government had a penchant for creating single task agencies, the impact of some of these changes may not be to the benefit of the community. **The AMA has long advocated for a health system with a mix of private and public funding**; and we all understand that for the private sector to work well **we need a healthy private insurance industry**. But the **AMA is not a cat's paw for that industry** and will continue to advocate for the community to ensure that they get value for money. To this end there is concern regarding the abolition



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M.B., Ch.B., FRANZCR

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Presented by Dr Yli Song Wong  
MBBS, FRANZCR



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of the Private Health Insurance Administration Council and Private Health Insurance Ombudsman. The former's tasks will be subsumed into APRA and the Department of Health; and the latter's remit will be undertaken by the Commonwealth Ombudsman. I cannot see how the current level of transparency regarding private health care and the performance of our private insurers could possibly continue with these changes unless the **DoH itself undergoes a radical transformation in its own attitude to transparency.** I sincerely hope that the change is not designed to improve efficiencies for industry and government by concealing performance statistics and frustrating public oversight. And with regard to the issue of consumer protections, you would have to hope (blind hope perhaps) that the Commonwealth Ombudsman's resources are being upgraded and its staff up-skilled to be able to deal with an entirely new industry and its operating environment. We should remember that this organisation's brief has hitherto been limited to dealing with complaints made against commonwealth agencies, not the private sector.

The **other component of this ideal health system** is of course a robust and well-resourced public hospital system. Here too we see the axe has fallen, with the previous funding agreements for state hospitals torn up. We are told that it is for **our own good**, "in order to provide States and Territories with a stronger incentive to increase the efficiency of their public hospitals." (Dept of Health Budget Outcomes 4, p 97) How we may make cost savings in our public system is open to conjecture. I am sure that savings are possible in some services, but with our chronic overload at Canberra Hospital with occupancies well above the ideal 85-90% I would be most **concerned if we had to resort to "demand management"**. Clearly the federal government also expects a **shift**

**of demand for low cost or free services from general practice to emergency departments.** They have signalled a change to Medicare arrangements to allow the states to levy a co-payment similar to the GP co-payment for "GP-type patients".

**Now is the time for us to unite as a profession.** Governments know that doctors ain't doctors. We are a diverse group and if sundered into narrow competing interest groups we will be easily picked off. **All our patients stand to lose in this budget, and we do too.** The AMA will fight to make the government see sense, and ensure that the cross benches and Labor understand all the likely adverse impacts of the budget health provisions, and to do this we need your support and patience. **It is an easy matter to join, just phone or go on-line to our website. It is an easy matter to participate, and ultimately rewarding.**

This is my last column as President, I have handed to mantle to Liz Gallagher. I have enjoyed my term and hope that I have helped a little in my own muddling way. I would like to **thank the board members** who have provided me with wise, frank and fearless counsel; Toby Angstmann, Jo-Anne Benson, Suzanne Davey, Robert Hunt, James Ferguson, and in particular Iain Dunlop and Liz Gallagher who stepped into the breach at short notice when I had my health wobbles recently. I would also like to thank Christine Brill, our tireless CEO, who so gently kept me on the straight and narrow; and Kathryn Cassidy, Helen Longdon, Susan Massey, Lisa O'Shaughnessy and Andy Ozolins in our secretariat. Finally thanks should go to my dear and loving wife Georgina and our children, James, Thomas, Eleanor and Patrick who put up with an absentee dad. **If I have achieved anything it is only through the support of each and all of these.**

## New President for AMA (ACT)

At the 2014 annual general meeting held recently Dr Andrew Miller inducted Dr Elizabeth Gallagher as the President of the AMA (ACT) for the next two years.



Dr Gallagher is Canberra born and bred, having attending Padua primary school and St Clare's College, and she still has strong family ties in Canberra.

Dr Gallagher is an obstetrician and gynaecologist. She completed her medical degree at University of Newcastle in 1991, having first completed a Bachelor of Medical Science with Honours. There was no ANU Medical School or Canberra Clinical School at the time she commenced her degree. Dr Gallagher was admitted to Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists in 2001, and donates her time to an outreach O&G service for Aboriginal women in remote communities in the NT.

Dr Gallagher informed the meeting; "I did most of my specialty training in Newcastle, and my three children were born there. I did my post graduate training at John Hunter, Belmont, Gosford, Maitland hospitals and St Mary's Hospital in Portsmouth, England.

"I was really happy when I got the opportunity to move back to Canberra and spent my last two years as a registrar at Canberra Hospital.

"I spent the first year driving around saying to myself "I am home"; so I feel very strongly about what happens in our community.

"For the past 12 years, I have worked in private practice from rooms at the John James Medical Centre. I have also been a fractional staff specialist and more recently been a visiting medical officer at Canberra Hospital, so I have had, and continue to have, exposure to both the public and private health sectors.

"I have also had a strong need to be involved and to make a difference, and I am prepared to lobby for justice and fairness. I hope that over the next two years I can use this to serve you and to and advocate for you, the members and also our community to make sure we all get the best and fairest outcomes for everybody.

"The beauty of the AMA is that it represents all doctors – doctors in training and medical students who are our future, as well as those in the hospital system – salaried or practising privately – and those in the community".

Dr Gallagher said that she was looking forward to engagement with her colleagues and that members should feel free to contact her to discuss any concerns, issues, suggestions or ideas.

Dr Gallagher is the third woman to head the AMA in the ACT: Dr Marjorie Granger was President of the ACT Medical Association in 1965, and Dr Debbie McKay was elected President of the ACT Branch of the Medical Association in 1996.

In his final President's address to the AGM, Dr Miller paid tribute to his Board for their collegiality, support and sage advice and thanked them all, particularly retiring directors Dr James Fergusson and Mr Robert Hunt (treasurer) for their contribution and commitment to the profession in the ACT and the AMA particularly.

Dr Miller also welcomed Dr Guy Buchanan to the Board.

Dr Andrew Miller, was elected Treasurer and together with Dr Gallagher as President, the following directors, make up the board for 2014 – Dr Jo-Anne Benson, Dr Guy Buchanan, Dr Suzanne Davey, and Dr Iain Dunlop. The position of President-Elect is vacant.

Dr Gallagher reminded members that nominations for representative positions on the Advisory Council for the next two years, would soon be called and invited members to consider being involved in this important forum.

Dr Gallagher presented Dr Miller with a collection of his Canberra Doctor articles and media clippings as a memento of his AMA ACT Presidency.



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## President's Award presented to Dr Jo-Anne Benson



Dr Andrew Miller presented Dr Jo-Anne Benson with the 2013 President's Award. Dr Miller said in presenting the Award that Dr Benson has been actively involved in the Association's affairs since she joined in 1999 – a year after coming to Canberra to establish her practice in paediatric surgery.

Dr Benson is currently the honorary secretary of the AMA

ACT, a role she has held for many years and she has been, and remains, an active member of the Canberra Doctor editorial committee; has represented her colleagues on the AMA Council of Salaried Doctors and has attended nine AMA national conferences, either directly as a representative of her craft group or as an AMA ACT delegate.

## Comprehensive university-led review shows no link between vaccinations and autism

The first systematic international review of childhood vaccinations led by researchers from the University of Sydney has found no evidence of a link to the development of autism or autism spectrum disorders (ASDs).

The comprehensive review, published in the medical journal *Vaccine*, examined five cohort studies involving more than 1.25 million children, an additional five case-control studies involving more than 9,920 children obtained via systematic searches of international medical databases MEDLINE, PubMed, EBASE and Google Scholar up to April 2014.

Both the cohort and case-control studies revealed no statistical data to support a relationship between childhood vaccination for the commonly-used vaccines for measles, mumps, rubella, diphtheria, tetanus and whooping cough and the development of autism or ASDs.

Paper senior author Associate Professor Guy Eslick from the Sydney Medical School said these vaccines were the ones which had received the most attention by anti-vaccination groups.

"There has been enormous debate regarding the possibility of a link between these commonly-used and safe childhood vaccinations and the supposed development of autism," Associate Professor Eslick said.

"A rising awareness of autism cases and the claimed but not

proven link to childhood vaccinations has led to both an increased distrust in the trade between vaccine benefit outweighing potential risks and an opportunity for disease resurgence.

"This has in recent times become a major public health issue with vaccine-preventable diseases rapidly increasing in the community due to the fear of a 'link' between vaccinations and autism.

"This is especially concerning given the fact that there have been 11 measles outbreaks in the US since 2000, and NSW also saw a spike in measles infections from early 2012 to late 2012.

"Vaccine-preventable diseases clearly still hold a presence in modern day society, and the decision to opt out of vaccination schedules needed to be urgently and properly evaluated."

Associate Professor Eslick said to date there had been no quantitative data analysis of any relationship between autism, autism spectrum disorders and childhood vaccinations.

"Our review is the first to do so, and we found no statistical evidence to support this idea," he said.

"Our extensive international review found childhood vaccinations including measles, mumps, rubella, diphtheria, tetanus and whooping cough are not associated with the development of autism or an autism-spectrum disorder.

"Furthermore, our review found the components of the widely-used vaccines (thimerosal or mercury), or the measles, mumps and rubella combination vaccines (MMR) are not associated with the development of autism or an autism-spectrum disorder.

"The increase in parents deciding not to vaccinate their children has substantially decreased 'herd immunity' among populations, subsequently increasing the risk of catching potentially more serious infectious diseases.

"Thus the risks incurred by not immunising a child is increasing substantially as the level of immunisation coverage in the population falls.

"The data consistently shows the lack of evidence for an association between autism, autism spectrum disorders and childhood vaccinations, regardless of whether the intervention was through combination vaccines (MMR) or one of its components, providing no reason to avoid immunisation on these grounds."

**About *Vaccine*:** *Vaccine* is the pre-eminent journal for those interested in vaccines and vaccination. It is the official journal of The Edward Jenner Society, The International Society for Vaccines and The Japanese Society for Vaccinology. [www.elsevier.com/locate/vaccine](http://www.elsevier.com/locate/vaccine)



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# Patients and GPs to be left worse off by co-payment

The Federal Government's move to impose a co-payment for GP visits will deter people from seeking necessary medical care and could leave doctors \$13 out-of-pocket if they waive the charge for their patients, the AMA has warned.

Confirming widespread speculation that the Government would seek to push more of the cost of health care directly on to patients as it sought to hold down spending, the Budget included a \$7 charge for GP consultations, pathology tests and diagnostic imaging services.

Health Minister Peter Dutton said the measure was necessary to help address what he said was unsustainable growth in Medicare expenditure, citing figures showing it had more than doubled to \$19 billion in the past decade and was projected to reach more than \$34 billion by 2024.

Mr Dutton said that, from 1 July next year, all GP patients – including those previously bulk billed – would be required to make a co-payment, with the funds raised to be directed to the Medical Research Future Fund.

The co-payment will apply to A1, A2, A11, A22 and A23 GP consultation items. It will not be

applied to Chronic Disease Management items, health assessments and mental health items, or for services to Indigenous patients.

Budget savings worth \$3.5 billion over five years will come from an associated measure to cut Medicare Benefits Schedule rebates by \$5 for a standard GP consultation, with a similar reduction in rebates for out-of-hospital pathology services and diagnostic imaging tests.

Softening the blow for concession card holders and parents of children younger than 16 years, they will only be liable for the co-payment for their first 10 visits to the GP each year, and doctors will receive a Low Gap Incentive to hold the co-payment to no more than \$7. For each subsequent visit, doctors will continue to receive the incentive if they provide their services free.

Only those visits where the \$7 co-payment is applied count towards the 10-visit threshold. Those visits where there is no co-payment, or a smaller or larger co-payment is applied, do not count toward the threshold.

Furthermore, the 10 visit threshold includes pathology and imaging visits, so that the total co-payment exposure for concession card holders and children is \$70 a year.

But, although the Minister implied the co-payment would be compulsory, it has been clarified that it will not be mandatory for GPs to charge the co-payment, though they will be left significant-

ly out-of-pocket if they choose to waive the charge.

Under the Government's arrangements, doctors who decline to charge the co-payment will not be eligible for the Low Gap Incentive created to encourage the imposition of the charge.

In practice, it means that doctors who do not charge the \$7 co-payment will be penalised twice – they will incur the \$5 cut to their Medicare rebate, and they will forego the partial offset from the Low Gap Incentive.

For a standard consultation, GPs will receive just \$31.60, rather than \$44.60.

The AMA is concerned that this will hit many GPs as they come under pressure from patients, particularly those less well off, to waive the co-payment on compassionate grounds.

In an attempt to head off the risk that patients try to avoid the co-payment by seeking treatment at public hospitals instead, the Budget measure includes allowing State and Territory governments to impose a charge on people visiting hospital emergency departments with "general practitioner-like" complaints.

The GP co-payment is facing opposition in the Senate. Labor, the Greens and the Palmer United Party have indicated they oppose the measure in its current form, raising the prospect that the Government will have to modify their proposal to secure passage through the Senate.

AMA President Dr Steve Hambleton said the co-payment was an ill-conceived solution to a problem that did not exist.

Dr Hambleton said spending on GP services had virtually stalled in the past five years, while the pathology budget was capped and the Medicare rebate for radiology services had not risen in 10 years.

"This part of the Medicare payment system is not the problem," Dr Hambleton said.

Instead, the AMA President said, it was providing efficient care, and the Budget changes could lead to greater health expenditure down the track.

"A low income family of sick children will be needing to find multiple co-payments on one day, and higher costs for pharmaceuticals," he said.

"We already know that individuals defer visits to the doctor and do not have prescriptions filled with small co-payments.

"The very low income earners, the seriously mentally unwell, and the aged will be hardest hit.

"They may not be able to divert to emergency departments because the budget allows for payments to be raised at emergency departments too."

The AMA said that, nonetheless, there was a place for GP co-payments, as long as they were well designed and backed by a very strong safety net for disadvantaged patients.

One of the criticisms of the Government's proposal is that the

co-payment is charged on the first 10 visits made by concession card patients each year, rather than later visits, deterring them from seeking help at a time when medical care might be of greatest benefit.

There are also concerns that GPs, pathologists and radiologists will come under a great deal of pressure from patients to waive the co-payment and accept a lower Medicare rebate, essentially providing a de facto safety net.

Dr Hambleton said the co-payment also added yet another layer of administrative complexity and red tape for general practice: "Simple bulk billing will now be replaced with a complex system of part payments by patients, which GPs will have to track."

There is as yet little detail of how the co-payments will be implemented, and there has been no provision made for the extra infrastructure and processes GP practices will need to have in place to track patients and determine when they have reached the co-payment threshold.

To try to soften the blow and make the GP co-payment more politically palatable, the Government has announced that the revenue raised will be directed to help establish and grow the Medical Research Future Fund.

Dr Hambleton said the Fund was "a good thing, but we need both accessibility to primary health care and research – not one at the expense of the other".




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# Hospital cuts put GST increase in the frame

The Federal Government has sparked outrage among State and Territory governments after stripping them of \$20 billion for public hospitals.

AMA analysis indicates that the Commonwealth's decision to disavow public hospital funding guarantees made under the National Health Reform Agreement 2011 and change future funding arrangements will rip \$20 billion out of the system in the next five years.

According to the Budget, the Government will save \$1.8 billion between 2014-15 and 2017-18 by walking away from its funding guarantees, and will save an additional \$16.4 billion over five years by scrapping its National Health Reform Agreement commitments. It will also save hundreds of millions of dollars each year by dumping the efficient growth dividend payment that was due to kick in from 2017-18.

The move has angered State and Territory governments, and sparked warnings that hospital patients could face even longer delays for treatment.

"State budgets will be in danger of being overrun by public hospital cuts," AMA Vice President Professor Geoffrey Dobb said. "Patients will have longer waits for public hospital services."

Public hospitals need certainty of funding in order to plan for and provide services, and the AMA said the Commonwealth's decision to dump the funding guarantees it had given was a threat to every public hospital, both in the short-term during the introduction of activity-based funding arrangements, and in the longer-term.

But Treasurer Joe Hockey tried to disown the problem, saying that the responsibility for public hospitals rested with the states and territories, and how they made up the shortfall in hospital funding was up to them.

The Federal Government's move has been interpreted as a dare for the states, who have limited sources of revenue, to back an increase in the GST.

Queensland Premier Campbell Newman said the funding cut was unacceptable, and flagged he would push for an emergency Council of Australian Governments meeting on the issue.

"This whole thing seems like a wedge to get the states to ask for the GST to be raised ... we're prepared to take responsibility, full responsibility, for health and education, but we need proper secure revenue streams so that our populations, states and territories, can actually get the services they deserve," Mr Newman said.

NSW Premier Mike Baird said he thought the Federal Government's huge cuts to health and education funding would bring forward debate about an increase in the GST, and backed Mr Newman's call for an emergency COAG meeting.

But both the Victorian Government, which comes up for election later this year, and the WA Government, have poured cold water on the idea of an increase in the GST.

WA Premier Colin Barnett told the *Sydney Morning Herald* that "if I was to support an increase in the rate of the GST, as West Australian Premier, what I'd be doing is saying to West Australians, 'Pay more in GST so more money can go to the other states,' so I'm never going to support that. Any change to the rate or the coverage of the GST in terms of exemptions will only change if there is also a change to the distribution".

# Budget full of pain for patients

Families face a hefty hike in their medical bills, doctors will be hit by a further Medicare rebate freeze and the states will have to make up a massive shortfall in public hospital funding as the Federal Government acts to unload many of its health costs on to patients and the states and territories.

In one of the most severe budgets in years, the Abbott Government has sliced into Commonwealth health spending, reducing its contribution to the cost of health services, tightening safety nets, axing agencies and programs and forcing patients to pick up more of the tab for their health care and medicines.

As expected, the Budget included a patient co-payment for GP services, set at \$7 – offset to a large extent by a \$5 cut to the Medicare rebate – and the co-payment for Pharmaceutical Benefit Scheme medicines has been increased by \$5 to \$42.70.

Treasurer Joe Hockey said that "health services have never been free to taxpayers, so patients are

being asked to make a modest contribution towards their cost".

To discourage people from dodging the GP co-payment by seeking help at the nation's public hospitals, the states and territories will be allowed to impose a charge on people turning up to hospital emergency departments for treatment of "general practitioner-like" health problems.

While many of these measures have been the subject of speculation for weeks, the Budget also included some surprise announcements.

In an attempt to make the GP co-payment more politically palatable, the Government pledged that the money raised would be funnelled into the creation of a Medical Research Future Fund to invest in research.

In other sweeteners, it has doubled the Practice Incentives Program teaching payment, increased funding for the GP Rural Incentives Program and boosted funding for dementia research, bowel cancer screening, the head-space program and the Good Sports program.

But it also delivered a shock to the State and Territory governments by declaring it would wash its hands of responsibility for public hospital funding and leave it to the second tier of government.

AMA Vice President Professor Geoffrey Dobb said the Budget

changes made it a tough time to be unwell.

"Access to quality primary care will be more difficult for many Australians," Professor Dobb said. "Put together, the cuts and co-payments threaten fairness and equity in the health system."

"The AMA recognises the Government's priority is to achieve a Budget surplus, but it should not be achieved by costing health services out of the reach of ordinary Australians."

Professor Dobb said increased out-of-pocket expenses for patients when they see their GP, attend an emergency department, obtain medicine, get a pathology test or have an x-ray will make it more difficult for people to get the care they need.

"Many Australians already pay a co-payment, and there is a place for co-payments for patients with the right model – but this is not the right model," the AMA Vice President said. "It does not have the right protections."

But Health Minister Peter Dutton said the Government's Budget measures would help ensure Australians continued to have affordable access to quality health care in the long-term.

Mr Dutton said the GP co-payment, in particular, would "strengthen and modernise" Medicare and help make it sustainable.

# GP training boost, with caveats

The Federal Government has delivered a big boost to GP training as it moves to strengthen primary health care.

While the Government has been savaged over its plans for a \$7

co-payment for GP services, it has at the same time acted to improve GP training, committing almost \$240 million over five years to double the Practice Incentive Program Teaching Payment for general practice to \$200 for each three-hour session.

In addition, the Government has provided funding for up to 300

extra GP training places in 2015, taking the total number of places to 1500.

But these gains have been funded, in part, by the abolition of General Practice Education and Training Limited and axing the Prevocational General Practice Placements Scheme.

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# Medical research fund a Budget sweetener

The Federal Government will direct funds from unpopular measures including the GP co-payment and cuts to hospital and health prevention funding to create a dedicated fund for medical research.

Treasurer Joe Hockey has made the Medical Research Future Fund a major sales pitch for his first Budget as he tries to shift the focus of debate away from heavy cuts and imposts and dull some of the political pain the Government is likely to have suffered as a result of its tough Budget measures.

Money from the GP co-payment and other sources will begin to flow into the Fund from 2015, with plans for it to grow sufficiently to dispense about \$1 billion in research funds each year by 2022-23.

"The Medical Research Future Fund will receive all the savings from the introduction of a \$7 Medicare co-contribution, modest changes to the Pharmaceutical Benefits Scheme and other responsible changes in this Health Budget, until the Fund reaches \$20 billion," Mr Hockey said.

"I can think of no more significant benefit from community contributions in health than to invest in cure and discovery research," the Treasurer said. "As a result, it may be an Australian who discovers better treatments, and

even cures, for dementia, Alzheimer's, heart disease or cancer."

But, although the Fund will reach \$20 billion, only the interest from it will be used to fund research, and many details of the plan remain unclear, including who will own and derive financial benefit from any research breakthroughs that are commercialised.

There are also concerns about the capacity of the medical research community to absorb and efficiently use the big flow of funds, which will be in addition to money coming from the National Health and Medical Research Council.

AMA President Dr Steve Hambleton said that although the Fund was a welcome initiative, it should not come at the cost of more expensive access to GPs and medicine.

# Patients face hip pocket pain for specialist care

Patients will be left almost \$100 out-of-pocket when they see a specialist as a result of the Federal Government's decision to freeze the indexation of the rebate for specialist consultations.

AMA analysis shows that the move to pause indexation of the Medicare specialist attendance initial consultation item 104 for two years from 1 July will push the gap between the rebate and the AMA recommended fee to \$97.72 next year.

The blow-out in out-of-pocket expenses is particularly significant in light of the changes to the Medicare safety net also included in the Budget, with analysis by Deeble Institute for Health Policy Research Director Anne-marie Boxall suggesting they will effectively reduce support for patients faced with high out-of-pocket expenses.

In the Budget, the Government revealed plans to "simplify" Medicare safety net arrangements by replacing the Original Medicare Safety Net, the Extended Medicare Safety Net and the Greatest Permissible Gap measure with a single Medicare Safety Net.

The new Medicare Safety Net, to come into effect from 2016, will contribute towards out-of-pocket costs incurred for Medicare-eligible out-of-hospital services.

Under the new arrangement, there will be a safety net threshold of \$400 for concession card holders, \$700 for single adults and families that are eligible for Family Tax Benefit A, and \$1000 for all other families.

Once the annual thresholds have been met, Medicare will pay 80 per cent of any subsequent out-of-pocket costs, capped at 150 per cent of the Medicare Benefits Schedule fee. The out-of-pocket costs that accumulate to reaching these thresholds will also be capped at 150 per cent of the MBS fee.

Writing in *The Conversation* (to read more, visit <http://theconversation.com/a-new-simpler-medicare-safety-net-but-with-holes-26706>), Dr Boxall said this was significantly less generous than current arrangements, where the cap is set at 300 per cent of the MBS fee, and would leave patients incurring significant out-of-pocket costs worse off.

Significantly, if providers charge more than 80 per cent of the MBS fee, the additional amount will not be covered under the safety net, and it will not count towards meeting the threshold.

The AMA analysis suggests that, if specialists charge the recommended fee for an initial consultation, patient out-of-pocket costs will be almost 135 per cent of the MBS fee and the safety net will not cover almost \$40 of the out-of-pocket charge.

Dr Boxall said that although safety net eligibility thresholds are lower under the new arrangements, people will have to pay more of the high out-of-pocket costs than they do now.

"[The new Medicare Safety Net] will not provide protection for costs well in excess of the Medicare scheduled fee. And it's not clear yet whether caps for services that tend to have very high fees (such as obstetrics and assisted reproductive technology) will remain in place under the new arrangements," Dr Boxall said.

She said that although the Government should be congratulated for starting to tackle the excessively complex Medicare safety net arrangements, "it could have done better".

"To truly provide protection to the most vulnerable in our society, the safety net should have done two things. It should have covered all health services and products, not just out-of-hospital services. And, it should have shifted more of the risk of excessively high fees onto the Government rather than individuals," Dr Boxall said.

# New Chair for Avant Mutual Group

Avant announced recently that Professor Simon Willcock will become the new Chair of Avant Mutual Group Limited following Associate Professor Stuart Boland's decision to step down from the Board on 30 June 2014.



Professor Willcock is a current director of Avant Mutual Group, Avant Insurance and the Doctors' Health Fund and will take up the position of Chair from 1 July 2014. A General Practitioner, he is Discipline Head of General Practice at the University of Sydney.

He has previously held positions as the Chairman of General Practice Education and Training Ltd, a Commonwealth company responsible for general practice training on behalf of the government and Minister for Health and Ageing, and has also been on the Board of Health Workforce Australia.

"I am delighted to take up the position of Chair of Avant Mutual Group and look forward to continuing to work to provide the best medico-legal services for our members and to further increase the range of benefits that Avant provides to them.

"Our members provide vital health services across Australia and everyone at Avant is committed to ensuring that they can continue their valuable work knowing that they are supported by the highest standard of medico-legal advice," said Professor Willcock.

successful integration with MDAV and completed the acquisition of the Doctors' Health Fund in 2012.

"Today more than half of Australian doctors have chosen Avant for the medical indemnity insurance and its health Fund is the second fastest growing fund in the country.

"Stuart's contribution to Avant and the medical defence industry as a whole cannot be understated. He has been a passionate advocate for the industry and was a key player working with governments to reform the law around medical indemnity.

"Stuart will be missed by all at Avant and we wish him all the very best for the future," said Professor Willcock.

Associate Professor Boland has been Chair of Avant Mutual Group and its predecessor company UMP since 2003 and has taken Avant from the days of the medical indemnity crisis, to having a very strong financial position holding the highest level of net assets of any MDO in Australia.

"I would like to pay tribute to the outstanding work and leadership of Associate Professor Boland who leaves Avant with a strong board, highly capable management team, very high quality medico legal defence and advice service and a position of enviable financial strength.

"In his time as Chair Avant came strongly out the medical indemnity crisis, completed the

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# Visit to the chemist about to get more expensive

Patients will pay up to almost \$43 for prescriptions and will take longer to qualify for safety net relief as the Federal Government tries to rein in spending on subsidised medicines.

In a Budget measure expected to save \$1.3 billion over four years, people seeking to have their prescription filled from 1 January next year will face an extra \$5 on top of the current \$37.70 co-payment. Patients with a concession card will face an 80 cent increase to \$6.90.

Adding to the blow, the Government has announced that the safety net thresholds for general patients will increase by the consumer price index plus 10 per cent, while the threshold for concession card holders will increase by two prescriptions a year, from the current 60 prescriptions to 62 in 2015, and moving up to 68 in 2018.

Health Minister Peter Dutton said the hike in the PBS co-payment was necessary to help defray the mounting cost of providing subsidised medicine.

Mr Dutton said that for too long successive governments had ignored the remorseless rise in PBS spending as demand for medicines, including for new and expensive treatments, had increased.

"As more high cost medicines are listed, and more patients require access to these treatment, the cost to taxpayers will increase," the Minister said.

"This continual pipeline of new, potentially lifesaving listings is one reason why longer term growth in PBS spending is expected to average between 4 and 5 per cent a year.

"The Government must manage this to continue to keep medicines affordable for the many Australians who need them."

Even with the co-payment increases and tighter safety net thresholds, Government spending on the PBS is set to increase, from \$9.2 billion in 2014-15 to \$10.3 billion by 2017-18.

This will include increases in the price of five medicines – cholesterol treatment Simvastatin, gastric reflux drug Rabeprazole, arthritis medication Methylprednisolone and blood pressure drug Pindolol – estimated to cost an extra \$8.1 million in the next five years.

While the Government has slapped additional costs onto patients, it has allocated \$16.5 million to enable medical practitioners to lodge paperless claims for PBS medicines dispensed from hospital medication charts, a measure it said would not only cut red tape for doctors but reduce the risk of dispensing errors for patients.

The AMA and other health advocates have raised concerns that increasing the cost of medicines will put a barrier in the way of people who need treatment, undermining their health and increasing the likelihood that they will need more expensive care – including possibly hospitalisation – later on.

# Medicare Locals no more

The Federal Government has announced that network of 61 Medicare Locals will be replaced with a smaller number of primary health networks (PHNs) as part of measures to streamline the health bureaucracy and reduce duplication of services.

In a measure that is expected to be revenue neutral for the Budget, Health Minister Peter Dutton has revealed that the Government will establish a system of PHNs to take over the primary health care coordination role that had been assigned to Medicare Locals.

Though the Minister did not specify how many PHNs there will be, it is believed that they will be significantly fewer in number than the Medicare Locals.

The decision draws heavily on the recommendations of the Horvath review in to the Medicare Locals system, which found the network established by the previous Labor Government had delivered inconsistent and unsatisfactory outcomes.

Mr Dutton said general practice would be "at the centre" of PHNs, which were expected to align much more closely with existing State and Territory health network arrangements to ensure effective working relationships and reduced duplication.

"PHNs will be more locally relevant, accountable and responsive through local health professionals' involvement in Clinical Councils and consumer-led Community Advisory Committees," the Minister said.

In line with the Minister's desire to increase private sector involvement in the delivery of health care, Mr Dutton said the PHNs would work equally with public and private providers "to develop innovative health solutions for people living in their communities. They will also provide practice support to individual general practices to encourage high quality services."

The AMA has long expressed dissatisfaction with the Medicare Locals system, and a survey of doctors found that many felt Medicare Locals were of little relevance, provided limited support and, on occasion, operated in competition with existing medical services.

In its submission to the Horvath Review late last year, the AMA recommended reforms that

focussed on moving to a network of primary health controlled organisations that were led by, and responsive to, GPs; that focused on supporting GPs in caring for patients, working collaboratively with other health care professionals; were not overburdened by excessive paperwork and policy prescription; were focused on addressing service gaps, not replicating existing services; and were better aligned with Local Hospital Networks, with a strong emphasis on improving the primary care/hospital interface.

Mr Dutton said improved primary health care was fundamental to better health outcomes, including the management and prevention of chronic disease.

"While there are some Medicare Locals providing good services, we want to ensure money is not wasted on administration. We want to ensure money can be moved to improve services," the Minister said.

PHNs will be established following a public tender process to be held later this year. Medicare Locals will continue to operate until 1 July next year, when the PHNs will commence operations.

# Rural infrastructure grants

Almost \$53 million has been allocated over the next three years to fund infrastructure upgrades at more than 175 general practices in rural and regional areas.

GP infrastructure grants is a well-regarded program that the AMA believes has delivered substantial benefits for patients and

doctors for relatively minor expense.

The Government said the funds would be used to add con-

sulting rooms and spaces for teaching and training.

"The investment will strengthen the rural health workforce and improve health service delivery in these communities," the Budget said.

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# Budget divides the nation, young and old, rich and poor

The Australian Council of Social Service said it was deeply concerned that those in our nation who carry the greatest burden from spending cuts in the Budget are those who can least afford it.

"The Budget divides rather than mends. It entrenches divisions between those with decent incomes, housing and health care and those without them. It undermines the fabric of our social safety net with severe cuts to health, disability support, income support, community services and housing programs," said ACOSS CEO Dr Cassandra Goldie.

"A few measures are in the right direction, targeting those for whom the age of entitlement should be coming to an end: Abolishing the Seniors Supplement, Capping Family Tax benefit part B at \$100 000, introducing a levy for people earning over \$180,000, and taking super payments into account in assessing eligibility for the Senior's Health Card. Corporate welfare is also shaved. However, most of these measures will inflict little damage or will only be felt for a short time.

"The real pain of this budget – crushing and permanent – will be felt by people on low incomes, young people, single parents, those with illness or disability, and those struggling to keep a roof over their heads. These are the groups doing the heavy lifting' for the Budget repair job.

"One of the most disturbing targets of this budget are our young people. The new rules will deny income support to young people up to 29 years, for six months of every year, unless exempted, and then force them into work for the dole. It will deny them Newstart Allowance until 24 (a loss of \$48 per week), and move more young people on DSP to Newstart or Youth Allowance, a cut of at least \$166 per week. We are excited about the investment for older workers who lose their jobs, but why treat the young and the old so differently?

"Poorer families will also be worse off as a result of the freezing of family payments for 2 years, the \$7 co-payments for doctor's visits and other services, the fuel excise, and the increasing costs of PBS medicines. And no investment in lifting the abysmally low unemployment benefit (Newstart Allowance) for the individuals and families living the most meagre lives, in an otherwise wealthy country.

"For people on low incomes, housing is the biggest cost of living problem. Yet, this Budget offers no guarantee of future funding for homelessness services, and cuts funding to the NRAS, the one bright light for creating new affordable housing.

"To then cut funding for community services, including financial counselling and emergency relief – small amounts in big budget terms – just seems a cruel blow.

"We were told on election night that the new government would not leave anyone behind, now we find its first Budget places the most vulnerable directly in the firing line," Dr Goldie said.

"The Government managed to find room in the budget to deliver a \$4 billion tax cut for business, and major investments in infrastructure and defence.

"For a decent society, we need a budget that brings us together, rather than pulls us apart," Dr Goldie said.

## Social security

"The safety net is being pulled out from under young people in this Budget. Unemployment is twice as high for young people yet school leavers who struggle to find a job could be deprived of income support for 6 months of every year. It is not realistic to expect parents on low incomes to support their young people until they reach 29, and many young people out of paid work don't

have parental support. Removing the Youth Connections program that provides career counselling and support to early school leavers will only make matters worse.

"Most people with disabilities on the DSP payment want a job but employers are often reluctant to take them on, especially people with mental illness. Shifting people to the lower Newstart Allowance will leave them \$166 a week worse off without getting them a job.

"The age pension is a vital safety net for older people. Indexing it to the CPI instead of wage movements would reduce it by around \$80 a week in a decade's time. We oppose increasing the pension age any further until Newstart Allowance is increased. Without doing so will only leave more people on the lowest incomes worse off.

## Health and education

"The Medicare co-payment and cuts in schools funding move us closer towards a two tier system in health care and education – where those who can pay get first class service and those who can't afford it are relegated to second class.

"People on low incomes can't afford GP visits unless they are bulk billed. Already many people have to choose between feeding their families and buying the medicines they need. The health system can't afford to leave people to get sicker.

## Housing

"The effective cessation of the NRAS scheme for investors in low cost housing will make it even harder for people on low incomes to keep a roof over their head.

## Debt levy

"The proposed debt levy is a much fairer way to pay for essential services such as health care and the NDIS as the population ages than the harsh 'user pays' approach. However, the proposed levy lacks a clear purpose, it is introduced when it's least needed and withdrawn just when it's needed most – in 2017, exactly when more revenue is needed for essential programs like the National Disability Insurance Scheme.

"The public supported a levy to help finance NDIS and has long supported a levy to help pay for health care. Any new levy should build on these firmer foundations.

"The levy would return to government a fraction of the massive tax cuts given to high earners over the 2000s which were clearly unaffordable both then and now.



## Check out our new arrivals!

### New Volkswagen Golf R

VOLKSWAGEN'S fastest and most powerful Golf to date, the new-generation R, launches in showrooms this week carrying the same \$10,000 premium over its GTI sibling as the old one.

Intriguingly, VW's increase comes three months after sister company Audi slashed \$11,300 from the price of the S3 when it launched the new-generation in December. A cost premium that was once more than \$20,000 has narrowed to \$5500 for the dual-clutch auto versions.

Golf R highlights include a fifth-generation front-biased Haldex-coupling 4MOTION AWD system channelling 206kW of power (up 18kW) and 380Nm of torque (up 50Nm) through all four 19-inch wheels shod in 235/35 R19 rubber, with torque allocated to where grip is needed most. The zero-to-100km/h sprint is cut by seven-tenths to 5.0 seconds dead, while fuel consumption is down a substantial 18 per cent to 7.1 litres per 100km of 98 RON on the combined cycle.

The re-worked 1984cc EA888 engine is 44kW more powerful in Australian tune than the GTI engine on which it is based. It retains unique features such as a wastegate that stays shut at low boost and only releases waste gases under heavy use, thereby minimising losses and turbo lag.

Unique to the R is a fully switchable stability control system that can be switched off for track work with a long press of a button. The R is also lowered by 20mm over the regular Golf and 5mm lower than the GTI.

Cosmetic enhancements beyond the lower body include 19-inch wheels with 10mm fatter tyres than the GTI, Bi-xenon headlights with newly designed LED day-time running lights, dark red LED tail-lights and quad chrome tail-pipes.

Standard equipment inside the cabin includes a 5.8-inch touch-screen to display satellite-navigation, media and entertainment, and the five driving modes, a reversing camera, keyless start (with a starter button) and parking sensors.



### New Audi S3

AUDI'S all-new S3 sedan is now on sale in Australia from \$62,200 plus on-road costs, making it \$2200 more expensive than the existing S3 hatch.

The new range-topping A3 variant pairs the familiar turbocharged and quattro all-wheel-drive underpinnings of the Sportback hatch with a sleek three-box sedan body that offers an extra 45 litres of rear cargo space (425 litres compared with 385L) with the rear seats in use.

The newest S3 sits 25mm lower than the regular A3 sedan and features the same 206kW/380Nm EA888 2.0-litre turbo-petrol engine as the S3 hatch and Volkswagen Golf R. Power is sent to all four wheels via a six-speed S tronic dual-clutch automatic transmission

Acceleration from 0-100km/h takes 5.0 seconds, while fuel consumption is a claimed 6.9 litres per 100km. While the sedan may command a premium over the Sportback, it is also cheaper than its closest on-paper rival, Mercedes' \$64,900, much less-powerful 155kW CLA250 Sport AWD.

Standard equipment includes bi-Xenon headlights with LED daytime running lights and LED tail lights, "MMI Navigation plus" sat-nav, Park Assist with front and rear sensors and reversing camera, and 18-inch alloy wheels in a 'five-parallel' spoke design.



### New Mercedes GLA

MERCEDES-BENZ has fitted the final piece to its compact-car puzzle by introducing the GLA-Class crossover to its line-up this week.

Following on from the B-Class hatch, the reborn A-Class and the CLA four-door coupe, the GLA is the smallest member of Benz's SUV family sitting well under the ML, GL and G-Wagon as well as the mid-size GLK that is expected to join the line-up next year. The GLA is available in three specification levels including 200 CDI diesel, 250 4Matic all-wheel-drive petrol and GLA45 AMG performance flagship, however due to global production constraints only the CDI is available at launch, with the others to follow in the coming months.

Is Mercedes' attractive compact crossover up to the task of taking on the likes of the BMW X1 and top-selling Audi Q3?



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# Reinventing the wheel in primary health care is a waste of taxpayer dollars

The Federal Government's decision to scrap Medicare Locals by July 2015 and re-invent the wheel in the primary health care system all over again is a waste of taxpayer funds.

Australian Medicare Locals Alliance Chair, Dr Arn Sprogis said tonight this is a shocking decision affecting frontline health services and it will impact on the health and wellbeing of Australians around the country.

"Tonight's Federal Budget has delivered another round of expensive changes for the health system with no added benefits, in spite of the fact that Australia already has a model in place for organised primary health care," Dr Sprogis said.

"In an environment of fiscal constraint how can this government justify the expense of re-tendering and re-configuring the primary health care system less than three years into major reform that is already delivering results," he said.

"It doesn't make economic or policy sense to scrap the organised primary health care system that's already been established through Medicare Locals," he said.

"This decision will see thousands of jobs go across the country and disrupt the continuity of care for patients and health services at the frontline.

"Medicare Locals are already delivering on the vision for primary health care laid out by Professor John Horvath AO in his Review of Medicare Locals.

"When comparing the outcomes of the ML Review, that has informed the Health Minister's decision, with the original objectives for Medicare Locals, the facts are that we already have in place the structures to meet the Government's objectives for primary health care. So why throw the baby out with the bath water?"

"The Federal Government has chosen to ignore the gains made through the national network of 61 Medicare Locals and not use the foundations laid as a basis upon which to build an even better primary health care system.

"At the end of the day, the new model for organised primary health care offered by the Health Minister will create unnecessary costs and disruption and an unnecessary layer of bureaucracy, with no foreseeable gains in system effectiveness or efficiency and no foreseeable improvements in overall health outcomes for patients.

"The model for organised primary health care is already in place. Medicare Locals need to be built upon and the national network of Medicare Locals is willing to work with the Government to do just that," Dr Sprogis said.



# States, consumers to bear the burden of this health budget

Minister Dutton's first health budget looks like a magician's sleight of hand, with the cost burden shifted to the states and consumers; GPs given some sweeteners to manage co-payments; and a medical research fund which is big on promises but small on detail.

The introduction of co-payments will hurt those who require care the most – the elderly and those with chronic disease.

"Australians already have high out-of-pocket expenses for medical care and many avoid or delay medical care due to cost," says Alison Verhoeven, Chief Executive, Australian Healthcare and Hospitals Association (AHHA). "The Commonwealth Fund recently reported 22% of Australians cite cost as a barrier to care."

"Evidence from numerous sources shows that the elderly and those with chronic disease are hit hardest by co-payments resulting in them delaying or avoiding seeking care. We should be implementing systems that improve access to health care for those most in need – not creating more barriers."

"Despite high levels of bulk-billing, we already have a significant number of patients who present to a public emergency department when they might have seen a GP, a decision related to their perception about the urgency or complexity of their condition and their ability to access an appointment with their GP. The introduction of co-payments threatens to drive more people from GPs to public hospital emergency departments that are already stretched, a concern raised by the Victorian Treasurer at the recent COAG meeting."

"The provision for emergency departments to charge a co-payment is impractical, and will require additional staff and infrastructure to manage billing procedures. Already we have heard the Western Australian Health Minister, Dr Kim

Hames, indicate that he would be uncomfortable with the imposition of payments for emergency department care."

"Of even greater concern to the states and territories will be the lack of clarity around funding for hospitals beyond the next two financial years. Health and hospital funding will be swept up into the broader review of Commonwealth-state funding relations, to be examined in a Federation White Paper. In the delivery of major infrastructure and services such as hospitals, two years is a very short planning cycle and the states and territories will face major challenges as they attempt to manage their health budgets."

"Investments in bowel cancer screening, youth mental health, some rural workforce initiatives, dementia research and ongoing support for e-health are welcomed. However the lack of focus on preventive health is very short-sighted, and the medical research fund will be limited both by lack of funding clarity and its very narrow view of health," says Alison Verhoeven, AHHA Chief Executive.



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## Budget goes exactly the wrong way for Diagnostic Imaging patients

The Federal Government's Budget announcement to further cut Medicare rebates on vital diagnostic imaging services will have a severe impact on both vulnerable patients and imaging practices.

"The government has gone exactly the wrong way on rebates," said Dr Sue Ulreich, Vice President of the Australian Diagnostic Imaging Association (ADIA), which represents the private diagnostic imaging sector - responsible for more than 80% of all Medicare-funded diagnostic imaging services nationally.

"For diagnostic imaging, rebates have been frozen since 1998, and they desperately need to be increased - but instead the government has actually cut them by \$5."

This simply means diagnostic imaging, an essential service for millions of Australians, will be put further out of reach for those who need it most.

ADIA is pleased that the Government will introduce its recommendations to better support investment in quality imaging equipment to the benefit of patient health, but overall considers this budget to be a missed opportunity to address severe needs within the sector.

"Diagnostic imaging is now virtually indispensable in all aspects of medical diagnosis and treatment, from arthritis through to

guiding brain surgery. Sadly, this Government does not seem to understand how hard it already is for many patients to access diagnostic imaging services with gaps averaging \$88 - and \$157 for MRI.

"These Budget measures will not protect the disadvantaged or improve their access," Dr Ulreich said. "They are also complex and carry a high administrative cost."

ADIA believes this Budget shows the Government has a false impression of diagnostic imaging - that it is a cost and not the cost-saver it truly is.

"Early diagnosis and better treatment provided through diagnostic imaging saves money because it improves patient treatment - people get better faster," Dr Ulreich said.

## Cancer Council welcomes new bowel cancer screening and medical research investment

At least 35,000 Australian bowel cancer deaths will be prevented thanks to a \$95.9 million, four-year plan to finalise Australia's National Bowel Cancer Screening Program in the 2014-15 budget.

Cancer Council Australia CEO, Professor Ian Olver, applauded the Minister for Health, Peter Dutton, for committing to the completion of the program, which was introduced 10 federal budgets ago.

"Bowel cancer is the second-largest cause of cancer death in Australia, yet most cases can be

cured if detected early," Professor Olver said.

"Our research shows the Government's commitment to bring the program's full implementation date forward by 14 years will prevent at least 35,000 bowel cancer deaths over the next forty years.

"By filling in additional gaps in the bowel cancer screening program from July next year, the benefit in lives saved will be maximised while full roll-out occurs."

Professor Olver also commended the Government for its unprecedented commitment to medical research investment through its proposed \$20 billion futures fund.

"Minister Dutton was always adamant that the Government would be guided by the evidence when it came to major investments

in cancer care," he said. "We are seeing that with the \$95.9 million for bowel cancer screening.

"Importantly, the new funding shows the Government's preparedness to invest in programs that will realise their full health and economic potential over the longer term.

"We look forward to working closely with the Abbott Government on its research program to help ensure that future investments are also based on the best available evidence.

"The renewed commitment to medical research should put the Government in a position to collect and disseminate independent evidence to address the changing needs of an ageing population and challenges such as obesity."

## Bupa's response to the federal budget

Leading health and care company, Bupa, has welcomed key initiatives in the 2014 budget, but expressed concern about the impact of some measures on its customers and residents in the health insurance and aged care sectors.

Confirmation of the redirection of Aged Care Workforce Supplement funds is particularly welcome, as is the government's commitment to continue working with the health insurance industry on price regulation and broader health system reform. However, decisions to merge health insurance regulators into other agencies bodies, freeze health insurance rebate tier indexations and remove the Aged Care Payroll Tax Supplement are disappointing and will put additional pressure on Bupa's members and residents.

Managing Director of Bupa's health insurance business, Dwayne Crombie, said he was concerned by moves to merge key industry regulators into existing agencies.

"Health insurance operates within a complex commercial and regulatory structure and as such, we need dedicated regulators who understand the unique nature of the sector and our community rated environment," he said.

"For that reason, we would hope there is capacity to retain a dedicated, industry-specific function within those agencies and we are keen to discuss that option further with the government before the changes take effect."

Mr Crombie commended the government's continued support for health insurance members, but expressed surprise at the decision to freeze rebate income tiers.

"In recent federal budgets, changes to the private health

insurance have created significant affordability pressures for our members. We know this government is committed to supporting the 12 million Australians who have health insurance and are pleased that, despite a tough fiscal environment, there are no further permanent changes to the private health insurance rebate this year," he said.

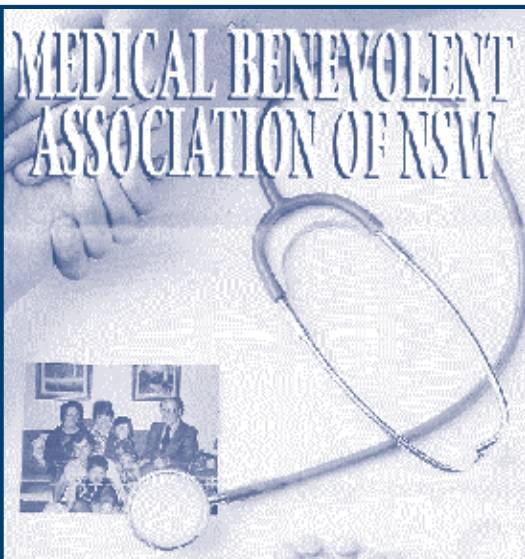
"Nonetheless, we are disappointed that bracket creep from the freeze on rebate income tiers will result in many more people having their rebate level reduced than would otherwise be the case. This just adds to cost of living pressures for those who are already being squeezed pretty hard."

Louis Dudley, Managing Director of Bupa's aged care business in Australia, welcomed the redirection of Workforce Supplement funds but said the business had grave concerns about the removal of the Payroll Tax Supplement.

"We are pleased that the government has delivered upon its election commitment to maintain and redirect funding earmarked for the workforce supplement. This supplement is a vital support for the sector as we strive to overcome one of our toughest challenges - attracting and retaining dedicated people to deliver high quality care to our residents," said Mr Dudley.

"The decision to remove the payroll tax supplement however, will skew the competitive landscape in aged care and has the potential to stymie growth.

"The supplement was originally introduced to even out the competitive playing field in aged care, as payroll tax only impacts a small proportion of industry providers. To remove the supplement in isolation skews the competitive landscape, which will negatively impact innovation and investment in the sector at a time when demand is increasing rapidly," he said.



## Assisting Canberra Doctors and their families too!

The Medical Benevolent Association is an aid organisation which assists medical practitioners, their spouses and children during times of need.

The Association provides a counselling service and financial assistance and is available to every registered medical practitioner in NSW and the ACT.

The Association relies on donations to assist in caring for the loved ones of your colleagues.

For further information please phone Meredith McVey on 02 9987 0504



# Older Australians will be worse off

Older Australians have fared poorly in the 2014 Budget with hits to the age pension, introduction of co-payments for health care, changes to aged care, and the abolition of measures to improve housing affordability.

Ian Yates, Chief Executive of leading seniors advocate COTA Australia said despite the Treasurer's apparent public anxiety about the impact of an ageing population, this budget has no real strategy to address it.

"Reducing pensioners living standards is a poor substitute for a comprehensive strategy for an ageing Australia.

"The ageing population comes with both challenges and opportunities and measures in this Budget simply tinker around the edges without putting in place any sustainable measures to plan for the demographic change."

## Pensions

Mr Yates said older people will justifiably see the changes to the indexing of the aged pension, to begin in 2017, as a major attack on their quality of life.

"Far from 'improving' the pension system as the Government claims, the changes to the pension arrangements mean pensioners will be at least \$80 a week worse off in ten years from the change in indexation alone.

"This is a massive cut to the income of older people who simply can't afford to absorb it. As a result we will see many older people slip back below the poverty line.

"It is staggering that the Federal Government has gone further and faster in its changes to pensions that was even recommended by the Commission of Audit."

## Health

Mr Yates said older people are the major users of Australia's health care system, so introducing \$7 co-payments for GP visits, pathology and diagnostics and 80c for medicines will put basic health care out of reach for many seniors, even with the caps that have been put in place.

"Out of pocket health expenses are already a barrier for older people to visit their doctor or take their medications and these new measures will simply exacerbate the problem.

"This is turn will mean conditions which may have been easily treated in the early stage will

worsen and put pressure on the more intensive and expensive end of the health care system – hospital care and surgery.

"As such this initiative is counter-intuitive, is likely to cost the government more over the long term and will lead to poorer health outcomes for many older Australians.

"Older people are in fact being hit with a triple whammy as large users of healthcare and medicines, getting sluggish for visiting a doctor, having a blood test and then and filling their prescriptions."

## Aged care

Mr Yates welcomed the fact that the bulk of the current aged care reform package would continue intact, although COTA is concerned about some of the aged care measures in the Budget.

"The biggest concern is the projected cut to the rate of real growth in the Commonwealth Home Support Program, from six per cent a year to 3.5 per cent after 1 July 2018," Mr Yates said.

"In addition, the axing of the Aged Care Payroll Tax Supplement will see aged care providers pass on more than \$650 million to consumers over the next four years in higher accommodation charges.

"Giving aged care providers back the \$1.5billion Aged Care Workforce Supplement over five years will do nothing for development of the aged care workforce however we welcome its redirection to community aged care providers and residential care, and we welcome the 20% increase in the viability supplement for rural and remote providers.

"Older people will also welcome the bringing forward of community aged care packages over the next couple of years which will help address the existing extreme shortage of care for people in their own homes."

"There needs to be a comprehensive review of the ageing population and retirement requirements which looks at pensions, superannuation and mature age employment in its entirety instead of making piecemeal decisions which at the moment seem to target those who can least afford it."

*COTA Australia is the peak policy development, advocacy and representation organisation for older Australians, representing COTAs in every State and Territory and through them over 500,000 older Australians.*

# \$8.5 billion ripped out of health care

"The Government has traded the Medicare card for the credit card in requiring millions of Australians to pay out of pocket towards their primary medical care.

"The introduction of a \$7 co-payment to see the GP, the prospect of charges to attend public hospital EDs, plus a \$5 increase in PBS fees, shatters the notion of universal access to primary care under Medicare," said Consumer Health Forum of Australia's Chief Executive, Adam Stankevicius

"This budget slashes \$8.5 billion from the health budget over four years, while slugging consumers with extra charges to see the doctor and to get prescription medicines.

"Other shocks are the \$635 million cut to dental spending over four years when poor oral health is widespread among low income Australians, \$121 million cuts for indigenous health "rationalisation" and nearly \$100 million in cuts to eye health services.

"This is a retrograde health Budget that will shock Australians who thought this Government was the best friend Medicare ever

had. It not only imposes a cost barrier to get medical care on those who often need it most, but it also appears to deny the stark realities associated with the steady rise of chronic illness in Australia.

"The removal of the Australian Preventive Health Agency and proposed shrinking of Medicare Locals reveal a disturbing absence of recognition of the pressing health needs of Australia in 2014.

"While these two initiatives showed plenty of room for improvement, they nonetheless involved an earnest attempt to take on the big drivers of obesity and other chronic conditions like poor diet and exercise, and to counter the lack of locally coordinated and comprehensive health care.

"Replacing the 61 Medicare Locals with a handful of much bigger primary health organisations is more than likely to lead to more bureaucratic, and more remote entities less able to respond flexibly to local issues.

"This health budget offers the distant prospect of a \$20 billion medical research future fund but fails to recognise the extraordinary out of pocket costs consumers already face to access essential health care.

"Meantime busy doctor's practices and emergency depart-

ment will have to spend precious time and resources extracting payments from patients when the available evidence questions the benefit of such co-payments.

"As the co-payments are not scheduled to start until July 2015, we suggest that Health Minister Dutton, use the next year, as proposed by the Commission of Audit, to explore health cost options more deeply.

"CHF believes there is great scope to cut waste – such as reducing the hundreds of thousands of avoidable hospital admissions and curbing unnecessary procedures – before erecting cost barriers to primary care," Mr Stankevicius said.

"While there are a number of welcome initiatives, these have been more than overwhelmed by the "savings" measures in this, the toughest health budget in years," Mr Stankevicius said.

"We hope that the current uncertainty about the future of E-health and health flexible funding arrangements, which fund many essential community health programs, is resolved quickly so these services can continue."

*Consumers Health Forum of Australia is an independent not for profit organisation representing over 2 million health consumers.*



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# Future of general practice workforce in limbo as training hit hard by budget

General practice training was hit hard in this week's Federal Budget announcement despite a pre-election promise of no healthcare cuts, leaving the future general practice workforce in limbo says the Royal Australian College of General Practitioners (RACGP).

The Federal Government confirmed the abolishment of General Practice Education and Training (GPET) and the consolidation of its functions into the Department of Health (DoH). It also announced the cessation of the Prevocational General Practice Placements Program, (PGPPP) set to achieve net savings of \$115.4 million over four years.

Under the changes, GPET's policy, program and workforce planning functions will be transferred to the DoH by 31 December 2014. Until this date, GPET will continue to retain management of the Australian General Practice Training Programme (AGPT) and PGPPP Scheme as well as the selection process for an increased 2015 AGPT registrar cohort.

RACGP President, Dr Liz Marles said the Government has risked destabilising general prac-

tice training by implementing these measures at a time when Australia is trying to build its primary healthcare workforce.

"A training entity with its roots firmly planted within the profession is best placed to build a robust and sustainable general practice workforce through the effective delivery of general practice training.

"The RACGP will engage in discussions with the Federal Health Minister, Peter Dutton and the DoH to ensure these changes in training arrangements do not affect the quality of general practice training.

"To inform these discussions, I and RACGP CEO, Zena Burgess will be engaging with stakeholders on ways in which the profession can ensure a stable training environment for the future of general practice training.

"Supervisors, medical educators and training directors have long established relationships, experience and skill in facilitating education and their engagement and involvement, alongside the RACGP will guarantee a sustainable general practice workforce equipped to meet community specific needs," said Dr Marles.

The RACGP is currently responsible for setting the general practice curriculum and vocational standards, accreditation of education providers and administration of the Fellowship of the RACGP

(FRACGP) and Fellowship of Advanced Rural General Practice (FARGP); leading to the credentialing of specialist general practitioners.

"The RACGP is committed to the delivery of high quality education and professional development to ensure Australian GPs are in a position to provide the best possible care for patients at a standard deserved and expected by the community.

"The RACGP's role will continue to be central in setting standards, accreditation and curriculum as well as supporting our Members, new fellows and registrars through the RACGP's Continuing Professional Development program, events and collegial activities.

"General practice workforce shortages are at a level that warrants urgent strategic Government attention and quality training programs, which are intrinsically linked to the strength of the workforce, must not be compromised.

"It is essential the general practice profession remains at the heart of all training models if we are to ensure all Australians have continued access to high quality, community appropriate and affordable healthcare services," said Dr Marles.

*The RACGP is committed to achieving the best possible health outcomes for all Australians and looks forward to working with the Government in building a robust and viable general practice profession.*

# Co-payments are no cure for healthcare

The Australasian College for Emergency Medicine (ACEM) strongly opposes the Federal Government's moves to remove the restriction on State and Territory Governments from charging patients presenting to hospital Emergency Departments (EDs) for General Practitioner (GP) like attendances.

"The introduction of an ED co-payment makes no sense, and using fees to discourage patients from seeking medical treatment is a very poor outcome for the Australian health system. Emergency doctors will not refuse to provide care for those in need", said ACEM President Dr Anthony Cross.

Requiring EDs to collect a co-payment from patients who should be seen by a General Practitioner will be an impossible measure for hospitals to implement. "It is rarely possible to determine who is a 'GP-like' patient upon their presentation at the ED", said Dr Cross. "This can only be definitively ascertained after a patient has been assessed and treated in an ED – trying to identify patients who should be seen by a GP at the time they attend the ED is fraught with danger, likely to be grossly inaccurate and unfairly applied."

Many common symptoms of minor conditions can be indicative of more serious conditions or a major illness needing immediate attention. "I am sure that no one wants to see the situation where someone presenting with a head-

ache leaves the ED because they can't pay, and then goes on to have a major stroke", Dr Cross said.

Emergency departments are not setup to collect revenue, and administering this scheme will require significant resources, which will only direct further funds away from essential clinical services. This will further clog up EDs, with queues of patients waiting to make their 'co-payment'. "Not only is this proposal an unfair deterrent to people seeking medical care, it will likely end up costing significantly more than any revenue which it will raise", Dr Cross added.

"What is intended as a short-term cost saving measure will cost a great deal more in the long run, and the government's efforts to put a price on healthcare will ultimately only lead to poorer health outcomes for all Australians", Dr Cross said. People will delay seeking potentially life-saving treatments and the management of chronic conditions will be seriously impacted. Instead ACEM urges the Federal Government to work with the States and Territories, the medical profession and healthcare sector to find real solutions to ensure the sustainability of the Australian health system.

The Australasian College for Emergency Medicine (ACEM) [www.acem.org.au/](http://www.acem.org.au/)

*ACEM is a not-for-profit organisation responsible for the training and ongoing education of emergency physicians, and for the advancement of professional standards in emergency medicine, in Australia and New Zealand. ACEM, as the peak professional organisation for emergency medicine in Australasia, has a vital interest in ensuring that the highest patient care and emergency department standards.*

# New measures to counter blood borne viruses and STIs

The Australian Government is investing \$22.45 million over four years for prevention programmes to help address increasing rates of sexual transmissible infections (STIs) and blood borne viruses including HIV, hepatitis B and hepatitis C.

Federal Health Minister Peter Dutton has said that people with STIs were at least two to five times more likely than uninfected people to acquire HIV.

In 2012, more than 230,000 Australians were living with chronic hepatitis C infection – predominantly through sharing needles. More than 207,000 have hepatitis B.

"These diseases are preventable," Mr Dutton said.

"That's why it is critical we strengthen our efforts, support health service providers and tailor our safe sex and prevention messages so that they actually connect with the people most at risk."

Mr Dutton said the programme targets priority populations including gay and bisexual men, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse Australians, young people, people in rural and regional areas, and people who inject drugs.

The Government's programme comprises the following initiatives:

- \$7.2 million to reduce high rates of STIs among Aboriginal and Torres Strait Islander priority populations, particularly in regional and remote settings.
- \$1 million for point of care demonstration testing projects to increase the HIV testing rate by offering tests which provide rapid results.
- \$5.1 million for needle and syringe programmes,

particularly in rural and regional areas.

- \$4.6 million to increase uptake of testing and treatment for hepatitis B among priority populations.

"The programme will also provide \$4.5 million to support the 20th International AIDS Conference in Melbourne in July 2014, including the participation of priority populations at the conference and the development of new national strategies for blood borne viruses and STIs," Mr Dutton said.

"Australia has been a leader in minimising the spread of these infections and the new investment will build on this work.

"The public health messages around blood borne virus and STI prevention, including safe sex, are not getting through to some groups and unless we act now the significant increases in transmission rates will only increase further," Mr Dutton said.

**For further information go to: [www.health.gov.au/](http://www.health.gov.au/)**



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# HealthPathways: enabling general practice and specialists to work together to manage patients

By Dr Rashmi Sharma, ACT Medicare Local Chair and Dr Walter Abhayaratna, Clinical Director, Division of Medicine, Canberra Hospital

ACT Health and ACTML are commencing a robust engagement with local clinicians to establish *HealthPathways* locally. To be effective, *HealthPathways* requires joint stewardship by GPs and specialists (hospital-based and private) and service delivery partners.

*HealthPathways* offers opportunities for ACT GPs and specialists (both hospital-based and private) to become involved in the development process by participating in *HealthPathways* activities such as Clinical Work Groups, which aim to identify issues affecting each party's ability to deliver optimum patient care and management, how, when and where to refer patients and propose solutions to issues identified.

The focus of the Clinical Work Groups is to overcome roadblocks struck when localising pathways for the ACT.

All too often we hear about the primary care-acute care 'divide'. Sometimes it's GPs complaining about not hearing back after a referral is made to a specialist colleague.

Sometimes it's specialists – in both the public and private system – bemoaning patients being referred with inadequate work-up or clear reason. And then there's the system we all work in itself: its escalating costs and its fragmentation doing nothing but cause frustration to clinicians, families and patients alike. The common lament is that it is all too overwhelming to fix.

The fact is all clinicians make a valuable contribution to the care of the Canberra community and have valuable ideas about how

things can be improved. This applies equally to the private primary and specialist sector as it does to public clinicians. What can we do to get the whole system working better? What would be the characteristics of a health system that was organised so that it was using its resources most effectively, the patient journey was smoother and the experience of all clinicians working in the system more rewarding?

*HealthPathways* offers an exciting opportunity to embed a proven system improvement process which promotes more efficient, effective patient journeys in health care and supports enhanced integration between the primary health care and secondary/tertiary health care sectors. *HealthPathways* reflects the referral lines or 'pathways' which link patients to the best treatment, local service or specialist.

A 'HealthPathway' is developed on a condition by condition basis and is effectively a local agreement between GPs and specialists about how best to manage and refer patients. Doctors will have web-based access and *HealthPathways* will go a long way to addressing the common complaint about lack of up-to-date information for doctors about what services are available for their patients.

To implement the *HealthPathways* system improvement program

in the ACT, ACT Health and ACT Medicare Local (ACTML) are working together with the support of Coast City Country General Practice Training (regional GP training provider).

*HealthPathways* began in New Zealand in 2007. The Canterbury District Health Board aimed to create a more efficient 'connected' health system that delivered the right healthcare to patients and that established an environment for ongoing change to meet health needs for the next 20 years. This was in recognition that 'business as usual' was not a sustainable model. Over time it has resulted in significant improvements in the way general practice, hospitals and specialists share the care and clinical management of patients in NZ. ACT can benefit from this experience, as well as from other Medicare Local regions that have recently begun to implement this program.

The anticipated benefits for GPs, public and private specialists of *HealthPathways* include:

- information on how to assess and manage medical conditions and how to work up and refer patients appropriately to local specialists and services
- better relationships between GPs and specialists
- local information about local private and public specialists and health and social care services, including information for patients, reference materials and educational resources
- a dynamic system with new pathways constantly under development and existing pathways regularly reviewed in light of changing evidence,

technology and local circumstances

- ease of use – it's designed to be used at the point of care and doesn't require patient information to be entered
- clinical leadership and the opportunity for GPs, private and public specialists to drive plans to improve the system
- improved access for patients to outpatient clinics by facilitating discharge from specialist clinical review before after handover to general practice

We've seen the success in Canterbury, NZ, with over 600 pathways generating significant and measurable improvements in the efficiency and effectiveness of patient care, including significant reductions in patient waiting times and hospital bed days. These existing health pathways and the addition of some 150 already developed in the Australian context by a number of other Medicare Locals in collaboration with their hospital networks are able to be utilised as templates for ACT *HealthPathways*.

Already, some early topics for health pathway development have been identified for the ACT including liver conditions, heart failure, COPD and diabetes. If these are clinical topics of interest to you, we encourage you to consider getting in touch with us about being involved in developing our local pathways.

ACTML and ACT Health plan to launch Pathways to clinicians' desktops in September this year. Implementation of *HealthPathways* ACT will be supported by a comprehensive 'change and adoption' strategy. This will ensure all clinicians are familiarised and supported to use Pathways in their every-

day work. This will also ensure that the recommendations for system and service improvement identified by the Clinical Work Groups are taken forward.

The pathways element of *HealthPathways* will help us all be better clinicians, connected and delivering the best quality care we can to our patients. The Clinical Work Groups put clinicians in the driver's seat to designing a better system. To be truly whole-of-system, the Pathways collaboration needs to engage clinicians working in both public and private capacity. Private specialists with an interest in learning more about the priorities for pathway topics and in becoming involved in these groups are welcome to contact us. The details are listed below.

With robust engagement from clinicians in both the private and public sectors, clinical leadership and co-design with patients, *HealthPathways* has the potential to make fundamental improvements to health care in the ACT.

For more information regarding *HealthPathways*, please contact Leah Peut – ACTML *HealthPathways* Coordinator: [healthpathways@actml.com.au](mailto:healthpathways@actml.com.au) ACTML is planning a series of education sessions for health practitioners on *HealthPathways* and will promote these widely when they are scheduled.

All members of the AMA are welcome to attend and participate.



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- Top Floor Aspect



## Annexe Suites 1-3, 173 Strickland Crescent, Deakin

Also located on the campus is a 364sqm semidetached building known as "The Annexe". The tenancy offers a resplendent fit-out ideal for medical users, including reception area, waiting rooms, consultation space and limited laboratory facilities. Tenancies within this precinct rarely become available and this presents a good opportunity for a new tenant to move in and start practising, given the existing fit-out. Car-parking for clients is located directly at the front door.

- 364sqm\* ground floor medical suite
- Attractive terms offered
- Signage rights available



## Level D, Building 27, University of Canberra, Bruce

Located on the top floor of this brand new, architecturally designed building is a rare opportunity to secure commercial accommodation in the rapidly expanding University of Canberra Campus. The 120 hectare (296.4acres) campus, a haven for tall trees and native wildlife, is within walking distance of the shopping and entertainment complex of Belconnen, and just 12 minutes by regular bus service or car from the Canberra CBD.

Building 27 houses seven laboratories including teaching and research facilities. Any interested party will need to be a similar commercial user to the existing mix within the building. Offering 370sqm of open-plan space, this tenancy is available immediately. Ideal for research-based organisation's looking to forge a relationship with the University.

- Brand new building
- Amazing panoramic top floor aspect
- University campus amenities and services



## Level D, University of Canberra Health Hub, Bruce

Building 28, also known as the UC Health Hub, was recently completed in a joint venture with the Federal Government. Anchored by an Ochre Health Care GP Super Clinic on the first two floors, level 3 is further utilised by the University Faculty of Health student run clinics. With the proposed sub-acute medical facility/hospital site directly opposite, and the new suburb of Lawson already under construction, the Health Hub will be the pre-eminent medical precinct in Belconnen.

Available now for lease is Level D, the top floor of the Health Hub Building, which is comprised of 1,063.3sqm of NLA. The efficient floor plate is afforded an abundance of natural light, with an economical lighting design and an attractive fourth floor aspect with views across the campus.

The University is happy to consider a sub-division of this floor dependent on the end user. This is the ideal opportunity for the discerning medical or associated business, with the precinct experiencing significant growth in both the commercial and residential sectors.

- Health Hub anchored by Super Clinic
- Designated car park for tenants/visitors
- University of Canberra convenience

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# New board members for Australasian Medical Publishing Company (AMPCo)

AMPCo  
Australasian Medical Publishing Company

The Australasian Medical Publishing Company (AMPCo), publisher of the *Medical Journal of Australia* and the *Medical Directory of Australia*, has restructured its Board and made some new appointments.

The Secretary General of the Australian Medical Association (AMA), Ms Anne Trimmer, said the former CEO of print and distribution group, PMP Limited, Mr Richard Allely, has been appointed independent Chair of the AMPCo Board.

Mr Allely's broad experience also includes time as Group General Manager (Financial) of Fairfax Limited and as Chief Financial Officer of Tenix Pty Limited.

Mr Allely takes up his position from 1 July 2014.

The current chairman, Dr Steve Hambleton, will step down at the end of the month when he completes his term as AMA President. Dr Hambleton will remain on the Board as the AMA nominee.

Dr Elizabeth Feeney, a current AMPCo Director, has been

appointed an AMA nominee to the Board. This appointment will take effect upon the expiry of her current term as AMA Treasurer.

Mr Rowan Dean, a columnist with the *Australian Financial Review* and the *Sydney Morning Herald*, and Associate Editor of *The Spectator Australia*, has been appointed independent Non-Executive Director of AMPCo.

Mr Dean is well known as a panellist on ABC TV's *The Drum*, and Sky News's *Contrarians*, *Paul Murray Live*, and *The Nation*. His background is in advertising and commercial film-making, including a period as Executive Creative Director of Euro RSCG Australia.

External Director and Deputy Chairman, Dr Roderick McRae, and External Directors, Dr John Kessell and Dr Peter Ford, have retired from the Board. Ms Trimmer said the appointments and changes – approved by the Federal Council of the AMA – follow a comprehensive review of the governance of the AMPCo Board.

"The skills and background of the two independent Directors align well with the skills required for the AMPCo Board," Ms Trimmer said.

"Their industry leadership roles and experience in strategic capability and leadership; audit,

accounting and financial management; governance and risk management; marketing, digital media and communications; and knowledge of the publishing industry, will help steer AMPCo through a challenging period for the publishing industry.

"They will be complemented by Dr Hambleton and Dr Feeney, who bring to the Board a deep understanding of the AMA and its objectives for AMPCo, a familiarity with AMPCo's business, and intimate knowledge of the health system, the medical profession, and the broader health sector."

The Federal Council of the AMA has decided to keep the fifth AMPCo Board position open until early 2015, to allow time to identify additional skills that might be needed to complete the Board.

Ms Trimmer said that the AMA and AMPCo are grateful to Dr Kessell, Dr Ford, and Dr McRae for their many years' service to the Board.

"Their support and dedication to the goals and activities of AMPCo are recognised and appreciated," Ms Trimmer said.

**AMPCo is a wholly owned subsidiary of the AMA.**

# Secure mental health facility to be given priority

A proposed new secure mental health facility in Canberra's south will be given priority in the planning process through a new bill introduced into the ACT House of Assembly recently.

Minister for the Environment and Sustainable Development, Simon Corbell, introduced the Planning and Development (Symonston Mental Health Facility) Amendment Bill 2014 into the Legislative Assembly.

"There is an immediate need for a medium to low secure mental health facility in the ACT and the government will give this project priority through amendments to the Planning and Development Act," Mr Corbell said.

"The changes to the current laws will allow the proposal to be fast-tracked, while still allowing for the important community consultation processes through the development application to take place.

"The facility will accommodate approximately 25 beds and

will provide services for low and medium security patients."

The bill is in response to a motion passed by the ACT Legislative Assembly in August 2013 where the Assembly confirmed its support for the facility to be constructed on the former Quamby Youth Detention Centre site in Symonston.

The Assembly agreed that the project should be fast tracked and to consider project specific legislation which would expedite the planning process and allow construction of the secure mental health facility to commence as soon as possible.

"To minimise any delay in relation to the construction of the facility the bill introduces the concept of a 'special variation' of the Territory Plan that is specific to the Symonston site.

"This 'special variation' will eliminate the need for a full Territory Plan variation process, which can take six to 18 months.

"This bill delivers specific legislation for this project that will ensure this vital facility is assessed through the planning process without delay", said Mr Corbell.



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# Expert committee recommends new screening test to help prevent cervical cancer

A new screening approach to help prevent cervical cancer has been recommended by the Medical Services Advisory Committee (MSAC) whose findings from its last meeting have been released.

The Medical Services Advisory Committee (MSAC) has recommended to the Australian Government that a new cervical screening test for women should replace the current Pap smear.

The independent expert committee accepted the latest scientific evidence that shows this new screening approach will work even better by detecting human papillomavirus (HPV) infection, which we now know to be the first step in developing cervical cancer.

Following a comprehensive review of the current evidence of the latest medical research, scientific developments and evidence around cervical cancer, MSAC has recommended for both HPV vaccinated and unvaccinated women that:

- an HPV test should be undertaken every 5 years;
- cervical screening should commence at 25 years of age;

■ women should have an exit test between 70 and 74 years of age; and

■ women with symptoms (including pain or bleeding) can have a cervical test at any age.

MSAC found that a HPV test every five years is even more effective than, and just as safe as, screening with a Pap test every two years.

MSAC also determined that a HPV test every five years can save more lives and women will need fewer tests than in the current two yearly Pap test program.

HPV vaccinated women still require cervical screening as the HPV vaccine does not protect against all the types of HPV that cause cervical cancer.

The procedure for collecting the sample for HPV testing is the same as the procedure for having a Pap smear. A doctor or nurse will still take a small sample of cells from the woman's cervix to send away to a laboratory to be examined.

Cervical screening is provided by doctors and nurses in general practices, family planning clinics, women's health centres, rural and remote clinics, and Aboriginal and Torres Strait Islander health services.

The MSAC recommendations build upon Australia's national school-based HPV vaccination programme by recommending the establishment of the world's first national cervical screening pro-

gramme, using a primary HPV test, to prevent cervical cancer.

The MSAC recommendations will now be considered by government after extensive consultation with state and territory health authorities, medical and pathology experts and community stakeholders.

Until these recommendations are considered, women should continue to have two-yearly Pap tests, which have already successfully halved the incidence and mortality of cervical cancer over the past 22 years.

Pending policy approval of these recommendations, it is anticipated that changes will not be implemented prior to 2016.

The MSAC recommendations are posted at: [www.msac.gov.au](http://www.msac.gov.au)

## THE NOTICE BOARD!

### Lectures for retired doctors

The 2014 program of lectures for retired doctors will take place at **The Clinical School Auditorium at Canberra Hospital** at 10 am on Monday mornings, starting on 21 July.

A cup of tea or coffee will be available after each lecture to enable discussion on the day's topic and meeting with friends. All retired doctors, whether registered or not, and any others who wish to attend, will be welcome. Please enter the dates in your diary now.

**Monday 21 July** Dr Simon O'Connor: The Management of Arrhythmias  
**Monday 28 July** Dr Kathleen Tymms: Drugs in Arthritis  
**Monday 4 August** Dr Nicole Gorrdard: Medical Oncology in the Ageing

*Note: a lift is available for those who find the stairs to the first floor daunting*  
Dr John Biggs, Convenor.

### An open letter from the Department of Psychology at Macquarie University

#### Understanding the Information Needs of Health Professionals Working With Mental Health or Substance Use Disorders

Dear Health Professionals,

We would like to invite you to participate in a study about the information needs of Australian mental health providers. The purpose of the study is to establish how a variety of different professionals working with people experiencing mental health and/or substance use disorders typically access and use information to inform their practice, as well as their attitudes towards integrating research into practice.

You will be asked to answer some open-ended questions such as where you access practice-related information, how you use information to make different kinds of treatment decisions; as well as some demographic information and a structured scale about attitudes towards research. These responses will all be **anonymous** and not linked to any identifiable details. The survey should take approximately 15 to 20 minutes to complete.

To participate go to: [https://mq.edu.qualtrics.com/SE/?SID=SV\\_391Y0vFKbQbbyxn](https://mq.edu.qualtrics.com/SE/?SID=SV_391Y0vFKbQbbyxn)

To thank you for participating in the online survey, you can choose to enter the draw for either an iPad Air (16GB with Wifi) or ASUS Transformer Book T100 (winners choice).

Should you have any queries or concerns, we will be more than happy to discuss them with you. You can contact the research team through **Dr Erica Crome** [Erica.crome@mq.edu.au](mailto:Erica.crome@mq.edu.au) or **9850 8670** or **A/Prof Andrew Baillie** [Andrew.baillie@mq.edu.au](mailto:Andrew.baillie@mq.edu.au) or **(02) 9850 9436**.

### Express your interest for membership of the ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases

The ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases (SHAHRD) was formed in 2001 to provide strategic advice to the Minister of Health from consumer and community perspectives, on issues related to the health and well-being of all ACT residents in the areas of sexual health and blood borne viruses.

ACT Health is seeking expressions of interest (EOI) from suitable applicants to fill one vacancy on SHAHRD. The appointment is for a four year period.

Appointments to SHAHRD are made on the basis of demonstrated skills and attributes of individual applicants, and consideration of the current skills and attributes already represented across the membership.

Applicants should address the following criteria in their EOI:

A demonstrated interest in the wellbeing of people affected by sexually transmissible infections and blood borne viruses;  
Demonstrated links and networks with people affected by sexually transmissible infections and blood borne viruses;  
A commitment and ability to consult with people affected by sexually transmissible infections and blood borne viruses, and to present their views; and  
An ability and commitment to contribute to the work of SHAHRD.

Interested persons should note that SHAHRD membership is not remunerated.

EOIs including a current curriculum vitae should be posted to ACT Health, Policy & Government Relations Branch, Chronic and Primary Health Policy Unit, GPO Box 825, Canberra, ACT 2601 or emailed to [stephanie.marion-landais@act.gov.au](mailto:stephanie.marion-landais@act.gov.au).

**The deadline for expressions of interest is 5.00 pm Tuesday, 10 June 2014.**

**For further information email or phone Stephanie Marion-Landais on 6205 1875**



# Calvary John James Hospital is 'expecting'

After months of waiting, Calvary John James Hospital located in the Canberra suburb of Deakin welcomed the arrival of their newly refurbished maternity ward with the official opening and blessing of the Ward by Arch Bishop Christopher Prowse on Wednesday the 30 April 2014.

The \$1.2 million refurbishment covers all patient accommodation within the Maternity Ward including bathrooms, soft furnishings such as chairs, wardrobes and bed tables; a new Nurse Call system, new televisions, patient lounge, delivery suites, corridors and reception area.

CEO of Calvary John James Hospital, Mr Shaune Gillespie said the refurbishment provides expecting mums and dads a comfortable and relaxed environment to bring their precious new born into the world.

"The refurbished Maternity Ward is fresh, modern and full of light, with double blinds being installed in every room so our new parents can enjoy the sunshine without losing any privacy as the second blind works as a block out.

"We are proud of the refurbishment and the facilities we can offer expecting mums and dads during this special time of their life," Mr Gillespie said.

Calvary John James Hospital has four birth suites and 26 beds of which 20 are single rooms, enabling the partners to stay together.

All maternity services are offered at Calvary John James Hospital including ante natal care, delivery and post natal care, Level 2 Special Care Nursery, 24 hour doctor coverage, breast feeding workshops, Lactation Consultants and physiotherapy classes.

An Intensive Care Unit, imaging and pathology are also available if required and to make the stay even more inviting is Zouki's Café and the Headquarters Hair Salon.

Calvary John James Hospital welcomes over 1,100 babies to the ACT each year.

"Expecting parents are welcome to visit our Maternity Ward, with tours taking place at 3pm on Saturday and Sundays," Mr Gillespie said.

# NSW Medical Student's Council opposes the Federal Government's plans to introduce a \$7 GP Co-Payment Fee

The New South Wales Medical Student's Council (NSWMSC) opposes the Federal Government's plans to introduce a \$7 co-payment fee for Australians visiting their General Practitioners. This is in response to the 2014 Federal Budget announced by the Hon. Joe Hockey MP on the 14th of May 2014.

NSWMSC Chair, Mr John Cherry, said introducing a co-payment for General Practice appointments unfairly targets those most vulnerable in our society.

Mr Cherry adds, "Our health system has equity of access for all. Regardless of your financial position, you are guaranteed access to world class medical services. A GP co-payment would abolish this and place undue pressure on our health

system by forcing patients to present to already crowded emergency departments. In addition, many patients may be forced to delay their medical appointments until conditions become chronic, resulting in more costly management plans.

"The NSWMSC understands that a proportion of each co-payment fee will go towards funding medical research. While we welcome the renewed focus on medi-

cal research, we do not believe eroding uniform access to health-care is an appropriate way to fund new research.

"While there may be a need for medical research, the Federal Government should prioritise the health of individual Australians first."

The NSWMSC also supports the campaign "CoPayStories" run by NSW medical student Dave Townsend which aims to raise awareness about the detrimental effects of the \$7 co-payment system.

The New South Wales Medical Students' Council is the representative body for over 4000 medical students across seven New South Wales universities.



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## Make a donation to assist your colleagues in need

The Medical Benevolent Association of NSW (MBANSW) is a free and confidential service for doctors in need and their families and others in NSW and ACT. The Association is able to provide social work counselling support and short term financial assistance in times of crisis.

Contact with the MBANSW is through the Social Worker, Meredith McVey on 02 9987 0504 or via the website www.mbansw.org.au.

If you are not sure how to make a referral or if you are worried about a colleague, you are most welcome to contact the Social Worker and talk through your concerns.

Donations to assist colleagues in need are tax deductible.

You can donate online through the MBANSW website www.mbansw.org.au or by contacting the Finance Officer on 4739 2409.

You can also donate using the donation slip and reply paid envelope which has been mailed out with the Annual Appeal letter.

Thank you for assisting the MBANSW to support your colleagues in need.





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