



2014 AMA National Conference
BUMPER ISSUE

Download the *Australian Medicine*
app, free at your favourite app store



A U S T R A L I A N

Medicine

The national news publication of the Australian Medical Association

Budget backlash

**AMA changes leadership but not message:
overhaul co-payments, reinstate hospital funds**

**AMA National Conference: all the news, action
and colour, 40 pages, beginning page 17**

INSIDE

- 7** 'Four-minute medicine' fears over Budget cuts
- 9** Public hospitals face funding crunch
- 10** Doctor training casualty of short-term Budget fix
- 67** ABC pulls Catalyst show over statins claims
- 69** Anti-vax message rubbished
- 70** E-health set for overhaul



Follow us on



AMA

WHEN IT COMES TO SAFETY, ENVIRONMENTAL COMMITMENT, SECURITY, ENGINEERING PERFORMANCE AND RETAINED VALUE SUBARU IS SIMPLY A SMARTER WAY TO ADD VALUE TO YOUR FLEET.



The Fleet and Corporate Sales team are ably equipped to support business clients with their vehicle purchase needs. Our Fleet and Corporate Sales message is a simple one.

We offer:

- Commitment to our customers;
- Engineering performance;
- Environmental commitment and continuous improvements;
- Enhanced security features;
- Active and passive Safety; and
- Renowned Retained Value.
- 3 year Roadside Assistance¹.
- 3 year unlimited kilometre manufacturer's warranty².

Subaru is simply a smarter Fleet choice.

OUR ALL-WHEEL DRIVE RANGE

FORESTER - SUV

Designed to give you the capability and flexibility you need to run your business whether it be in the city or country. All new Generation features economical Stop-Start technology which makes it ultra fuel efficient. In fact, Lineartronic™ CVT transmission models produce less than 188 grams of CO₂ per km. Also available in a Diesel variant with manual transmission.

LIBERTY - Sedan and Wagon

Every driver puts different performance demands on their vehicle. That's why we don't make just one Liberty – we make several, with some variants available in both sedan and wagon. The well-appointed Liberty range also offers great economy with Lineartronic™ CVT transmissions delivering less than 186 grams of CO₂ per km.

OUTBACK - SUV

Allows you to take on challenging conditions with confidence. With its technological advancements and appointments the Outback is fit for business, both in the city and the country. Also available in a Diesel variant with manual transmission and Lineartronic™ CVT.

IMPREZA - Sedan and Hatch

Impreza is packed with cutting-edge features, technology and style. Different from the ground up, it's the small car with a totally new perspective. It features economical Stop-Start technology which makes it ultra fuel efficient. In fact, Lineartronic™ CVT transmission models produce less than 160 grams of CO₂ per km.

LIBERTY EXIGA - Wagon

The Subaru Liberty Exiga 2.5i combines seven-seat luxury with the versatility and driving confidence of Symmetrical All-Wheel Drive and the safety of Vehicle Dynamics Control. Standard state-of-the-art Lineartronic™ CVT and a long wheel base provide a comfortable and smooth drive for you and your passengers.

XV - SUV

XV breaks the mould, blending exceptional SUV capability with exhilarating handling, innovative design and electrifying lines. It features economical Stop-Start technology which makes it ultra fuel efficient. In fact, Lineartronic™ CVT transmission models produce less than 160 grams of CO₂ per km.

For AMA Members wanting to know more about our Fleet benefits, contact your Fleet Specialist at your nearest Subaru Retailer, please call **1800 22 66 43** or visit us at **subaru.com.au**



¹ 3 years Roadside Assistance Program is standard upon activation with relevant Motoring Club in each state, conditions apply. ² See subaru.com.au/warranty for details.

Fleet &
Corporate



Managing Editor: John Flannery
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford
Contributor: Sanja Novakovic
Graphic Design: Streamline Creative, Canberra

Advertising enquiries

Streamline Creative
Tel: (02) 6260 5100

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

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

Australian Medicine welcomes diversity of opinion on national health issues. For this reason, published articles reflect the views of the authors and do not represent the official policy of the AMA unless stated. Contributions may be edited for clarity and length.

Acceptance of advertising material is at the absolute discretion of the Editor and does not imply endorsement by the magazine or the AMA.

All material in *Australian Medicine* remains the copyright of the AMA or the author and may not be reproduced without permission. The material in *Australian Medicine* is for general information and guidance only and is not intended as advice. No warranty is made as to the accuracy or currency of the information. The AMA, its servants and agents will not be liable for any claim, loss or damage arising out of reliance on the information in *Australian Medicine*.

News 7-15, 67-69

Special feature 17 AMA NATIONAL CONFERENCE

Regular features

- | | |
|-------------------------------|----------------------------|
| 5 PRESIDENT'S MESSAGE | 63 RURAL HEALTH |
| 6 SECRETARY GENERAL'S MESSAGE | 64 AMSA |
| 58 PUBLIC HEALTH OPINION | 65 ETHICS AND MEDICO-LEGAL |
| 59 GENERAL PRACTICE | 66 HEALTHY AGEING |
| 60 DOCTORS IN TRAINING | 70 HEALTH ON THE HILL |
| 61 SALARIED DOCTORS | 71 WINE |

AMA LEADERSHIP TEAM



President
Associate Professor
Brian Owler



Vice President
Dr Stephen Parnis

One call does it all.



One call and we'll find, insure and salary package your ideal car. It's that easy.

Call: 1300 128 142 | www.AMAleasing.com.au



DISCLAIMER: For full terms and conditions please visit our website.



BY AMA PRESIDENT
ASSOCIATE PROFESSOR
BRIAN OWLER

“ The
traditional public
hospital funding
blame game
between the
Commonwealth
and the States
– which we
thought may
have gone away
– will be back
bigger than ever
”

Budget of broken dreams

The 2014 Federal Budget is still in the news.

Recent Budgets have raged for a day or two, maybe a week, but this one is still up in lights. The Government has not been able to move on to other things, like bedding it down.

The Senate will decide its future, but groups such as the AMA will help determine how the Senators view the impacts of the Budget on their constituents – and influence how they vote.

The AMA believes that the proposed changes in health policy have the potential to dramatically change the way health services are delivered in this country, but not necessarily for the better.

The combined impact of the GP co-payment, the Medicare rebate freeze, co-payments for pathology and radiology, co-payments for visits to emergency departments, and cuts to public hospital funding will hit the most vulnerable patients and place enormous pressure on the capacity of our public hospitals.

The Government's measures will have an alarming impact across the health system and they indicate a massive shift in the universality of healthcare.

There has been a lot of focus on GP co-payments, but people need to realise that it's not just about that.

The AMA is not against co-payments, in principle. But we are against the co-payment model the Government has adopted. There are insufficient protections, and there is a cumulative effect.

A lot of people do not realise that there has also been a \$5 cut in the Medicare patient rebate.

We are most concerned about vulnerable patients in our society, particularly Indigenous Australians, those in aged care, the working poor, and those with chronic disease.

There is the example of a young woman that might present, for instance, with a breast lump.

If that's investigated and the patient has follow-up in pathology and radiology, the total co-payments add up to about \$63 in terms of co-payments alone – but even more given the loss of the diagnostic imaging bulk billing incentive. And you can add medicines on top of that. That is a lot of money for people on low incomes or people who are elderly or chronically ill. It all adds up.

The safety net is a limit of 10 co-payments for people with concessions and people under 16 years of age.

But there are many people that fall outside of that safety net, particularly those with chronic disease. And so even a total of ten \$7 co-payments, \$70, for some people, particularly if there are a number of people in the family, is prohibitively expensive.

There is no doubt that the co-payment will be a big problem for patients in aged care and for the doctors who treat them.

There are red tape issues for medical practices, too. I do not think the Government has grasped the extent of the impact of these co-payments across

the health system.

The AMA is also worried about the impact on preventive health care. There is a new financial barrier for people to have vaccinations. The latest figures show a decline in the vaccination rate. The co-payment could contribute to a further decline, which would be devastating for public health.

The debate so far has been centred on the co-payments, but I think the public hospital funding changes will explode once people turn their attention to the cuts.

The traditional public hospital funding blame game between the Commonwealth and the States – which we thought may have gone away – will be back bigger than ever.

There was a commitment under the National Health Reform Agreement that the Commonwealth would fund 50 per cent of gross funding for our public hospitals. That seems to have now disappeared.

And even though the Federal Government is putting more money into public hospitals, to fund a growth rate of CPI plus population is certainly well below the growth rate in the budgets for health for the states, which is usually around 6 or 7 per cent.

It means that the states will have a shortfall.

It's going to affect front-line clinical services. It's going to affect the training of our young doctors that are coming through to be the GPs and other specialists that we need to maintain the sort of standards of health and quality of health care that we've all come to know and enjoy.

The AMA will be doing what it can to get changes to these policies.



BY AMA SECRETARY
GENERAL ANNE TRIMMER

“ This significant step forward in the governance of the AMA provides the opportunity for more effective processes to develop strategy and policy, with greater engagement with members ”

National Conference a timely celebration of the AMA

The AMA National Conference was held over the last weekend of May in Canberra with the theme *Global Practice: Australian Perspective*.

As the Conference followed soon after the Federal Budget, there was plenty of opportunity for delegates to discuss the impact of the Budget during one of the plenary sessions.

The debate on the Budget and its impacts followed presentations by both Health Minister Peter Dutton and Shadow Health Minister Catherine King. Delegates had a plethora of questions to put to the speakers.

Following the official opening by outgoing AMA President Dr Steve Hambleton, the keynote address was delivered by the United States Ambassador to Australia, John Barry, who provided an entertaining overview of the US Government's strategies to address global and domestic health challenges.

The Conference theme was evidenced in several of the plenary sessions, ranging from variation in medical practice to global health vocational training. As part of this, a panel featuring medical association leaders from countries in Africa, Asia and Britain explored regional

challenges in medical practice. Dr Margaret Mungherera, President of the World Medical Association and a practising psychiatrist, brought home the reality of access to medical services for many in the world when she pointed out that in her home country of Uganda there is one psychiatrist to every million people!

Amid the serious work of the Conference, there was also much to celebrate, including the admission of three distinguished members - Dr Alex Markwell, Dr Stephen Parnis, and Dr Stephen Wilson - to the AMA Roll of Fellows. At the Conference dinner the rarely-awarded AMA Gold Medal was presented to Dr Mukesh Haikerwal for his outstanding services to the medical profession and to the community. Dr Hambleton presented the President's Award to the family of Dr Bernard Quin, a Victorian doctor who paid for his devotion to his patients with his life, executed by Japanese troops occupying Nauru during the Second World War. Dr Quin was presented as an exemplar of all those doctors who have given their lives for their patients. Dr Quin's large family attended what was a very moving ceremony.

Among other highlights of the weekend were

the adoption of a new AMA Constitution at the Annual General Meeting by an overwhelming majority of members and to acclamation of the meeting. This significant step forward in the governance of the AMA provides the opportunity for more effective processes to develop strategy and policy, with greater engagement with members. More on this to come.

On the last morning of the Conference there was a very challenging plenary session on the demands of caring for those who serve in combat. The military theme ran through the Conference with Dr Brendan Nelson, now Director of the Australian War Memorial, as the entertaining guest speaker at the Leadership Development Dinner.

The Conference concluded with the election of the President and Vice President which took place under the new Constitution. The outcome of the voting was the election of Associate Professor Brian Owler as President and Dr Stephen Parnis as Vice President. With the induction of the new office bearers and a fitting tribute to outgoing President Dr Steve Hambleton, the Conference came to an emotional but satisfying close.



'Four-minute medicine' threat to health care

The Federal Government's \$5 cut to the Medicare rebate and associated financial penalties for doctors who bulk bill could see the rise of 'four-minute medicine' as doctors are forced to churn through patients to stay afloat, AMA President Associate Professor Brian Owler has warned.

As he prepares to meet with key Senators including Clive Palmer, Nick Xenophon and the Australian Greens, A/Professor Owler said Federal Budget measures including the \$7 co-payment for GP, pathology and radiology services, disincentives for bulk billing, emergency department charges and cuts to public hospital funding would have an "alarming" effect on the health system and amounted to a massive shift in the universality of health care.

In a promising sign that the Government is prepared to consider changes to what Prime Minister Tony Abbott admitted was "perhaps the most difficult policy change in this Budget, the Prime Minister indicated his willingness to accept "refinements" to the co-payment measure to secure its passage through the Senate.

The Government is under political pressure

to re-craft the policy because of hostility in the Senate. Labor and the Greens have announced their outright opposition to what they call a GP tax, and the Palmer United Party, Australian Motoring Enthusiast Party, and independent Senator Nick Xenophon have all indicated they will not support the measure in its current form.

A/Professor Owler said the AMA was not opposed to co-payments per se: "Many of our doctors already charge a co-payment, and we've always said that doctors should charge the fee that they feel is appropriate for their services".

But he said the AMA was concerned that, in its current form, the co-payment proposal did not include adequate protections for the most vulnerable patients – the aged, those with chronic disease, Indigenous Australians and people with mental illness – did not provide sufficient support for preventive health measures such as vaccinations, and threatened the viability of many medical practices.

A/Professor Owler said the AMA was keen to talk with the Government about possible changes, adding that Mr Abbott's recent



remarks were encouraging.

"The AMA is willing to work with the Government to come up with better solutions," he said. "We note the Prime Minister's comments... about being open to some refinements of the policy, and I hope that's a signal that there is some room to make the changes that protect those most vulnerable in society, but also make sure that doctors, particularly in diagnostic imaging – where the viability of some practices may be affected by these proposals – is able to be considered, and appropriate changes made."

A/Professor Owler said the focus of public

debate on the \$7 co-payment for GP services meant that so far other equally concerning changes had been largely overlooked, including the \$5 cut to Medicare rebates, the decision to withhold low-gap incentive payments for doctors who continue to bulk bill, the inclusion of pathology and diagnostic imaging services in co-payment arrangements and a further extension in the freeze on Medicare rebates.

He warned that the multiplier effect of the co-payments could leave patients substantially out-of-pocket, while doctors who decided to continue bulk billing their patients would have to absorb a big hit to their income.

'Four-minute medicine' threat to health care ... FROM P7

He cited the example of young woman who saw her GP about a lump in her breast, and was then referred on for pathology and diagnostic tests. A/ Professor Owler said such a patient could be up for \$63 in co-payments for just that one episode of care.

He added that doctors who bulk billed faced a cut of up to \$13 for each consultation – the \$5 rebate cut, the foregone \$2 contribution from the co-payment and the loss of the low-gap incentive – warning this could have ramifications for care.

The AMA has voiced concerns that, through its co-payment policy, the Federal Government was effectively forcing doctors to implement social policy by making them choose who they should continue to bulk bill.

A/Professor Owler said doctors working in disadvantaged areas were likely to come under particular pressure from their patients to continue to bulk bill, confronting them with some difficult decisions to make about the provision of care.

"If a large proportion of their patients can't afford to pay the co-payment, then those practices might still be bulk billing, but it will be the GP that bears the cost, and who will be financially worse

off," A/Professor Owler told the *Sydney Morning Herald*. "The only way they could do it would be to see more patients. Instead of doing six-minute medicine, they'll go to four-minute medicine. That's not something we want to see happening."

The AMA President said there was a lot of scope to make the policy better, and the Association was working with key stakeholders, including in pathology and diagnostic imaging, about how it could be improved in a way that supported the viability of practices and protected the vulnerable while still retaining a co-payment.

He lamented that this was the work that the Government should have undertaken developing the proposal before the Budget.

"There are a number of things that we need to work through, and the disappointing thing about this proposal that has clearly come out of Treasury and Finance without reference to health policy," A/ Professor Owler said. "The AMA is now doing the policy work, which really should have been done [by the Government] way in advance before this Budget announcement was made.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Statutory Review of the Personal Property Securities Act

The Personal Property Securities Register (PPSR) is the register where details of security interests in personal property (not real estate) can be registered and searched. A supplier of personal property can register their interest on the PPS Register to protect their right to repossess property if the customer fails to make appropriate payments. This can affect businesses that lease equipment, for example, including medical practices.

The main legislation governing the PPSR is the Personal Property Securities Act 2009 (the Act). The Government is now undertaking a review of the Act, to consider its operation and effects. The review will pay particular attention to the experience of small businesses.

An interim report is due by 31 July 2014 with recommendations on priority actions for the Government to consider, focussing on issues raised in relation to small businesses. The final report is due on 30 January 2015 and is expected to make recommendations on how to improve the Act.

The AMA encourages members affected by the PPSR and the Act to provide comments by email at ppsareview@ag.gov.au. Initial submissions relevant to small business are sought by 6 June 2014, with other submissions open until 25 July 2014.

Full details are available at the Attorney General's website.

Public hospitals face funding crunch

Hard-won improvements in the performance of public hospitals have been put at risk by the Federal Government's shock decision to walk away from State funding guarantees and slash the growth rate of future funding, effectively ripping billions of dollars out of the system, the AMA has warned.

As figures were released showing a fall in elective surgery waiting times in New South Wales hospitals and an improvement in emergency department performance nationwide, AMA President Associate Professor Brian Owler cautioned the gains might prove to be temporary given the Government's cuts to hospital funding.

In the Budget, the Commonwealth disavowed public hospital funding guarantees made under the National Health Reform Agreement and reduced the indexation of post-2017 funding to CPI plus population growth, changes the AMA estimated would strip \$20 billion from the public hospital system in the next five years.

A/Professor Owler said the cuts endangered hard-won improvements in the performance of public hospitals.

There has been a substantial increase in the number of patients being seen and cleared from public hospital emergency

departments within the four-hour target, according to National Health Performance Authority figures released late last month.

The Authority reported that among the nation's best performing major metropolitan hospitals, 80 per cent of patients departed emergency departments within four hours between October and December last year, a 10 percentage point jump from the same period in 2011.

Even among the worst performing major metropolitan hospitals, there was a 16 percentage point improvement to 51 per cent over the same period.

"[This was] an impressive improvement in the face of an increase of almost 57,000 patient presentations at major metropolitan hospitals over this period," the Authority said.

In NSW, the Bureau of Health Information reported that 99 per cent of elective surgery was conducted on time in the last quarter of 2013, up from 93 per cent in the same period in 2010.

"We're pleased that there has been an improvement in elective surgery and emergency department performance in these figures," A/Professor Owler. "It does show the hard work that doctors and nurses are doing in our emergency departments to treat the numbers of people



coming through, but also the increased acuity of the patients that are actually presenting to our emergency departments."

The AMA President said the improvements were down to the efforts of hospital staff as well as investments made through the National Partnership Agreement.

"These improvements are a direct result of the specific funding that was provided by the Commonwealth to the State and Territory governments to increase the capacity of public hospitals, [and] reflect the efforts of dedicated and hardworking doctors and nurses working around the clock in our emergency departments and in other areas of the hospitals that need to work efficiently to allow patients to be admitted from emergency" he said. "We need to build on these improvements."

But A/Professor Owler warned the Federal Government's hospital funding changes put these gains at risk.

"The Improving Public Hospital Services agreement has now ceased, and there

is no replacement in sight," he said. "[In addition], there has been a significant reduction in funding guaranteed for public hospital services in the National Health Reform Agreement. This means that there is no certainty that hospitals will be able to maintain capacity to reach the four-hour target of 90 per cent by 2015."

Adding to concerns is the possibility that patients seeking to dodge the \$7 Medicare co-payment will instead turn up at public hospitals for treatment.

"We all have fears that patients, instead of seeing their general practitioners, but also [those] accessing pathology and diagnostic imaging services, will default to our public hospital system," A/Professor Owler said. "Our public hospital system is also taking a cut under this Budget, and it's going to be ill-equipped to be able to deal with any increase in demand that might be provided by the GP, diagnostic imaging and pathology co-payment."

Adrian Rollins

COMMENT

Doctor training a casualty of short-term Budget fix

The viability of the general practice profession has been jeopardised by the Federal Government's sweeping changes to medical training, the specialty's peak body has warned.

The decision to axe specialist training agencies and absorb them within the Health Department, combined with cuts to valuable programs and fears of massive hikes in student fees, has fuelled concerns the medical training system, already under pressure, will prove increasingly inadequate, placing the profession at long-term risk.

In its Budget, the Federal Government abolished General Practice Education and Training (GPET) and the Prevocational General Practice Placements Program (PGPPP) while axing funding to the Confederation of Postgraduate Medical Education Councils and absorbing Health Workforce Australia and GPET within the Health Department.

It redirected some of the savings from

these decisions to double the Practice Incentive Program Teaching Payment for general practice instruction to \$200 for each three-hour session, and lift the number of GP training places from 1200 to 1500 next year.

But the peak group United General Practice Australia, which includes the AMA, the Royal Australian College of General Practitioners, the Australian General Practice Network, General Practice Registrars Australia, the Australian College of Rural and Remote Medicine and the Rural Doctors Association of Australia have warned the changes risk compromising the profession.

In a joint statement, UGPA declared that "the Government's plan poses serious risks to general practice training including: loss of general practice education expertise for the delivery of training; disengagement of supervisors; the withdrawal of teaching practices and the

reduced appeal of general practice as a career"

"Planned reforms to general practice financing may also discourage practices from employing registrars," it added.

Taken together, UGPA said, the changes "pose a significant risk to the viability of the general practice profession and access to quality care for all Australians".

The peak group said the Health Department had no experience in facilitating general practice training, and the decision to put training programs out to tender risked making price, rather than quality, the overriding consideration – with implications for patient care.

Chair of the AMA Council of Doctors in Training, Dr James Churchill, said there was a risk that workforce planning expertise would be lost, and the momentum recently gained around improving the planning and coordination of medical training – including through the establishment of the National Medical Training Advisory Network – would be dissipated.

Dr Churchill said the decision to axe the PGPPP, which had provided up to 975 places for junior doctors to gain experience in general practice, could put hundreds of prevocational places in jeopardy.

In a column in this edition of *Australian*

“ the Government's plan poses serious risks to general practice training including: loss of general practice education expertise for the delivery of training; disengagement of supervisors; the withdrawal of teaching practices and the reduced appeal of general practice as a career ”

Medicine, Dr Churchill wrote that "these decisions reek of short sighted cost shifting".

He warned of the prospect that medical degrees may soon cost hundreds of thousands of dollars as fees are deregulated and universities seek to cope with an average 20 per cent cut in federal funding for places.

He and Australian Medical Students' Association President Jessica Dean said the changes risked discouraging students from rural areas and lower socioeconomic backgrounds from embarking on a medical career.

Adrian Rollins

AMA IN THE NEWS

Your AMA has been active on policy and in the media on a range of issues crucial to making our health system better. Below is a snapshot of recent media coverage.

Print/Online

Anger and praise for budget moves, *Sunday Herald Sun*, 11 May 2014

Australians face the end of free bulk-billed visits to the GP in the Federal Budget with the introduction of a new \$7 co-payment. Former AMA President Dr Steve Hambleton said the move could reduce GP visits by up to 120 million consultations.

Call to lift drinking age to 21, *The Daily Telegraph*, 13 May 2014

Health experts are pushing for a rise in the minimum drinking age from 18 to 21, saying it will stop young men from getting into alcohol-fuelled punch-ups and car crashes.

Medical changes savaged, *Herald Sun*, 14 May 2014

Changes to Australia's health system will cause chronic pain for Australia's most sick and force all to wait longer in hospital queues. Former AMA Vice President Professor Geoffrey Dobb said the chronically ill, the elderly, and low income families would suffer.

Bulk objection to seven dollar injection, *Courier Mail*, 15 May 2014

The Abbott Government's plans to slug patients \$7 more

to see a doctor are set to be blocked in the Senate. Former AMA President Dr Steve Hambleton said if there will be a seven dollar charge and if there is extra staff to handle the billing, GPs may decide that to stay in business they need to charge more.

Sneaky health fund rise, *Herald Sun*, 15 May 2014

Almost half a million health fund members will lose up to \$1500 in government health fund tax rebates under a sneaky move in the Budget. Former AMA President Dr Steve Hambleton warned the fairness of Australia's health system would be destroyed by new charges announced in the Budget for doctors, medical tests, and prescriptions.

Dutton tells GPs to use windfall to help the needy, *The Australian*, 16 May 2014

Health Minister Peter Dutton said we need to make sure that free services are provided to the small number of people who can't afford to provide for themselves. AMA President Associate Professor Brian Owler expressed concerns about the burden placed on patients who were not included in the safety net.

\$7 children vaccinations, *Sunday Mail Adelaide*, 18 May 2014

The Abbot Government will not make any exemption on the \$7 co-payment for parents who vaccinate their children. Former AMA President Dr Steve Hambleton said there

should not be further barriers placed in front of people regarding immunisation.

No secrets in health overhaul, *Adelaide Advertiser*, 20 May 2014

Australians would be automatically signed up to an e-health record and have to opt-out if they wanted to keep private details about abortions and mental health issues under changes to the PCEHR program. Former AMA Vice President Professor Geoffrey Dobb said if it was left to individuals to put information in the records, it is less likely they would be relied upon by health professionals on the front line of care.

Heavy impact on vulnerable, *The Australian*, 14 May 2014

Pensioners, welfare groups, and doctors have attacked the Federal Budget's impact on the most vulnerable. Former AMA Vice President Professor Geoffrey Dobb said access to quality primary care would be more difficult for many Australians.

\$7 doc fee bloopers, *Courier Mail*, 22 May 2014

Embarrassing bloopers by Prime Minister Tony Abbot and Treasurer Joe Hockey reveal they don't understand who will be forced to pay their controversial new \$7 GP fee. The AMA accused Mr Hockey of also getting it wrong when he said the chronically ill would not be hit by the fee.

Alarm as thousands of children unvaccinated, *Adelaide Advertiser*, 22 May 2014

Almost three thousand South African children are going unvaccinated because their parents wrongly believe that immunisation is bad. The AMA supports education, rather than the withholding of benefits, for parents who refuse to vaccinate their children.

AMA IN THE NEWS

... FROM P11

No co-payment yet buy some patients already skipping visits to doctor, *Sydney Morning Herald*, 23 May 2014

Patients in poorer areas are already cancelling visits to the doctor in response to the \$7 Medicare co-payment. Former AMA President Dr Steve Hambleton said the reports, while isolated, were a concern.

Confusion reigns says AMA, *Canberra Times*, 23 May 2014

Doctors are unhappy about the bulk billing changes announced in the Budget, warning there could be perverse outcomes. Former AMA President Dr Steve Hambleton said the \$7 co-payment was causing confusion and some patients believed it was already in effect.

Less red tape over GP scrips, *The Australian*, 23 May 2014

Health Minister Peter Dutton attended the AMA National Conference with a commitment to reduce red tape for doctors, as the controversy over planned co-payments continues.

Royal Australian Colleges of GPs criticises co-payment system, *Australian Financial Review*, 24 May 2014

The words white coat lobby can strike fear into the hearts of politicians of all

stripes. That is why the importance of the conciliatory tone of outgoing AMA President Dr Steve Hambleton on the \$7 medical co-payment should not be underestimated.

Parents jabbed in the wallet, *Adelaide Advertiser*, 24 May 2014

Parents who rethink their opposition to vaccination are being slugged up to \$1400 to get their children immunised because of no longer free access. AMA Chair of General Practice Dr Brian Morton said he sees no reason why it should not be given late in life for free.

Envoy's call for collaboration, *Weekend Australian*, 24 May 2014

US Ambassador John Berry told yesterday's AMA National Conference in Canberra that Australians had already made a remarkable advances in medical science.

Patients care plan faces overhaul, *Weekend West*, 24 May 2014

The Federal Government is looking at revamping Medicare payments to doctors for treating patients suffering chronic conditions such as diabetes and asthma. In a speech to the AMA National Conference, Health Minister Peter Dutton

defended the need for the harsh Budget measures.

Anti-tobacco crusade a winner, *Hobart Mercury*, 24 May 2014

Tasmania has been named joint winner of a national anti-smoking award because of the state's comprehensive bans on smoking in public spaces. Former AMA President Dr Steve Hambleton said the ACT and Tasmanian Governments had both shown strong commitment to tobacco control.

AMA's no to co-payment plan, *Sunday Canberra Times*, 25 May 2014

Doctors in the AMA have voted to oppose the co-payment system as laid out in this month's Federal Budget, which outgoing AMA President Dr Steve Hambleton said was 'game changing' for public hospitals.

D'oh! Doctors label Homer's favourite drop dangerous, *Sunday Canberra Times*, 25 May 2014

Former AMA President Dr Steve Hambleton has labelled plans by Woolworths to stock Duff beer in their BWS and Dan Murphy's stores as dangerous and increasing the social acceptability of alcohol misuse.

New AMA president to battle \$7 GP fee, *Canberra Times*, 26 May 2014

New AMA President Associate Professor Brian Owler has indicated no let-up in the fight against the seven dollar budget co-payment for GP visits and medical tests.

Doctors warn \$7 GP impost risks children's immunisation, *Age*, 27 May 2014

Charging parents a \$7 fee could deter them from taking their children to the doctor for routine immunisations. AMA President Associate Professor Brian Owler said we don't want to see barriers put up to immunisation programs.

Meet healthcare's new guardian, *Australian Financial Review*, 29 May 2014

New AMA President Associate Professor Brian Owler said the AMA aims to maintain a healthy dialogue with the Abbott Government. Associate Professor Owler said the AMA would always take the most appropriate course of action.

Outrage as anti-vaccine zealots claim it causes SIDS, *Sunday Telegraph*, 1 June 2014

The Ant Vaccinations Sceptic Network has been caught out claiming a link between immunisation and sudden infant death syndrome (SIDS). AMA President Associate Professor Brian Owler said it was appalling to link vaccines to a serious child health issue.

AMA boss warns of 'four-minute medicine', *Age*, 2 June 2014

Doctors could be forced to churn through patients more quickly in order to absorb cuts to their income linked to the proposed GP co-payment. AMA President Associate Professor Brian Owler doctors in disadvantaged areas would face pressure from their patients to continue bulk-billing.

AMA IN THE NEWS

... FROM P12

Web drug scripts get high-risk warning, *Canberra Times*, 3 June 2014

Online prescription services are undermining GP and pharmacy standards and can put patients at risk. AMA Chair of General Practice Dr Brian Morton said a patient's death could be a trigger to strictly regulate online prescription services.

Co-payment threat to docs, *Australian Financial Review*, 3 June 2014

AMA President Associate Professor Brian Owler said doctors aren't against a co-payment but the specific proposal in the budget creates big problems for many doctors, particularly those with practices with overwhelming numbers of bulk-billed patients or patients with chronic diseases.

Hospitals miss targets, *Sydney Morning Herald*, 5 June 2014

More than a third of patients in five of Sydney's major hospitals are failing to be treated in emergency departments within four hours. AMA President Associate Professor Brian Owler said he suspected the removal of federal incentives to meet targets would only reduce the likelihood of hospitals meeting their benchmarks.

Fears those too poor for GP will swamp hospitals, *Sydney Morning Herald*, 6 June 2014

Hospital emergency departments are experiencing more and more pressure from seriously ill patients. AMA President Associate Professor Brian Owler said the payment could turn hospitals into a default for people needing medical treatment and testing.

Radio

Dr Steve Hambleton, 3AW Melbourne, 7 May 2014

Former AMA President Dr Steve Hambleton discussed the importance of exercise and a good diet to avoid cholesterol-related problems, workers compensation, and a shift away from sick-notes.

Dr Steve Hambleton, 2CC Canberra, 8 May 2014

Former AMA President Dr Steve Hambleton talked about doctors no longer giving out sick notes but rather notes that say what a person can or cannot do. Dr Hambleton said that with issues like influenza people should not go to work, because the disease will spread.

Dr Steve Hambleton, 666 ABC Canberra, 12 May 2014

Former AMA President Dr Steve Hambleton discussed the possible impact of the Government's plan to introduce GP co-payments. Dr Hambleton holds concerns for low income earners, Aboriginal people and Torres Strait Islanders, and those with mental illness.

A/Prof Brian Owler, 5AA Adelaide, 13 May 2014

AMA President A/Prof Brian Owler talked about the Federal Budget. A/Prof Owler said that the GP co-payment is going to affect everyone.

Professor Geoffrey Dobb, 2UE Sydney, 13 May 2014

Former AMA Vice President Professor Geoffrey Dobb discussed the \$20 billion Medical Research Future Fund. Professor Dobb said this is good news for medical research in Australia and is a very forward-looking initiative.

Professor Geoffrey Dobb, 2GB Sydney, 13 May 2014

Former AMA Vice President Geoffrey Dobb explains who will pay the \$7 co-payment announced in the Federal Budget and the AMA's opposition to the extra cost being applied in emergency departments.

Dr Steve Hambleton, 702 ABC Sydney, 14 May 2014

Former AMA President Dr Steve Hambleton discussed the Federal Budget

and the GP co-payment. Dr Hambleton said the aim is to make the population healthier, but the rebates mean many areas of healthcare will be unable to bulk-bill.

Dr Steve Hambleton, ABC NewsRadio, 16 May 2014

Former AMA President Dr Steve Hambleton discussed the proposed GP co-payment. Dr Hambleton said the AMA is concerned about the impact on low income earners.

Dr Steve Hambleton, 612 ABC Brisbane, 22 May 2014

Former AMA President Dr Steve Hambleton discussed the Medicare co-payment. Dr Hambleton agreed with Dutton that people need to maximise the time they spend with GPs and value the health service, but the idea that people are getting unnecessary health service is not correct.

A/Prof Brian Owler, 4BC Brisbane, 26 May 2014

AMA President A/Prof Brian Owler talked about the AMAs fight against GP co-payments. A/Prof Owler said protections are needed for those with chronic illnesses and those with financial struggles.

A/Prof Owler, 2UE Sydney, 26 May 2014

AMA President A/Prof Brian Owler discussed alcohol advertising during sport and Australia's problem with alcohol-related violence.

AMA IN THE NEWS

... FROM P13

A/Prof Owler, 2GB Sydney, 26 May 2014

AMA President Associate Professor Brian Owler talked about the Federal Budget, particularly the GP co-payment. A/Prof Owler said we need to make sure there is a proper safety net for those who cannot afford the co-payments.

Dr Stephen Parnis, 774 ABC Melbourne, 26 May 2014

AMA Vice President Dr Stephen Parnis talked about the deregulation of university fees. Dr Parnis said medical graduates with five hundred thousand dollars in debt will discourage a lot of people that would make good doctors from going into the field.

A/Prof Brian Owler, 702 ABC Sydney, 27 May 2014

AMA President Associate Professor Brian Owler discussed referrals to specialists after seeing a GP. Associate Professor Owler said the GP is the corner stone of the health system and GP's referrals last for 12 months after which the patient will need a new referral to be able to claim

the Medicare rebate.

A/Prof Brian Owler, 774 ABC Melbourne, 2 June 2014

AMA President Associate Professor Brian Owler talked about the GP co-payment. A/Prof Owler said the Medicare rebate is also going down by \$5 under the scheme and medical practices cannot survive bulk-billing under the scheme unless they reduce the amount of time they spend with patients

A/Prof Brian Owler, 702 ABC Sydney, 3 June 2014

AMA President Associate Professor Brian Owler talked about a leading British neurosurgeon has claiming cyclists who wear helmets are wasting their time. A/Prof Owler said helmets save lives and prevent head injuries.

Dr Brian Morton, 6PR Perth, 3 June 2014

AMA Chair of General Practice Dr Brian Morton talked about the risks of purchasing prescription drugs online. Dr Morton said there is a concern that it will

lead to fragmentation of care as people will visit the doctor less.

A/Prof Brian Owler, 5AA Adelaide, 3 June 2014

AMA President Associate Professor Brian Owler discussed the impact the proposed \$7 Co-payment would have on GPs as well as vulnerable patients.

TV

Dr Steve Hambleton, Channel 7 Perth, 9 May 2014

Former AMA President Dr Steve Hambleton discussed a patient taking medicinal marijuana to help treat her illnesses. Dr Hambleton said medical research and clinical trials need to be conducted to determine the long term side effects of the drug.

Dr Steve Hambleton, ABC1 Peth, 20 May 2014

Doctors and patients are increasing their campaign against the Treasurer's proposed \$7 Medicare co-payment. Former AMA President Dr Steve Hambleton said under the proposals, there will be a co-payment for everyone.

Dr Steve Hambleton, ABC News 24, 22 May 2014

Former AMA President Dr Steve Hambleton talked about the confusion of the Medicare co-payment already causing a drop in appointments. Dr Hambleton said the co-payment will change patient's behaviour.

Dr Steve Hambleton, ABC News 24, 25 May 2014

Former AMA President Dr Steve Hambleton talked about the AMAs decision to oppose the Federal Government's proposed GP co-payment. Dr Hambleton said the AMA National Conference has called on the Federal Council to engage with the government on this issue.

A/Prof Brian Owler, ABC1 Brisbane, 25 May 2014

AMA President Associate Professor Brian Owler talked about the GP co-payment. A/Prof Owler said AMA members do not necessarily oppose a GP co-payment, but they are worried about the vulnerable people in society.

A/Prof Brian Owler, Sky News, 2 June 2014

AMA President Associate Professor Brian Owler talked about the GP co-payment on Sky News. Associate Professor Owler said the problem with this proposal is there are inadequate protections in place for the most vulnerable in society such as those with chronic diseases.



Your AMA Federal Council at work

What AMA Federal Councillors and other AMA Members have been doing to advance your interests in the past month

Name	Position on council	Activity/Meeting	Date
Dr Richard Whiting	AMA Representative for Physicians	ACSQHC WA consultation workshop on the draft National Consensus Statement on End-of-Life Care in Acute Hospitals	6/5/2014
Professor David Mountain	AMA Representative for Emergency Physicians	ACSQHC WA consultation workshop on the draft National Consensus Statement on End-of-Life Care in Acute Hospitals	9/4/2014
Dr Robyn Langham	AMA Representative for Victoria	Medicines Australia Code of Conduct Review Panel	9/4/2014
Dr Brian Morton	AMA Chair of General Practice	RACGP (Royal Australian College of GP's) OPTIMIST (Open Primary care Technology that is Interoperable Meaningful Useable and Safe) Meeting	9/4/2014
Dr David Rowed	AMA Member	RACGP (Royal Australian College of GP's) OPTIMIST (Open Primary care Technology that is Interoperable Meaningful Useable and Safe) Meeting	9/4/2014
Dr Ian Pryor	AMA Member	MSAC (Medical Services Advisory Committee) Review Working Group for Paediatric Surgery	8/4/2014
Dr Steve Hambleton	Former AMA President	Panel member The George Institute for Global Health World Health Day forum	2/4/2014
		Meeting with Chair of the Medical Board of Australia and CEO of AHPRA	1/4/2014
		PPFASD (Parliamentarians for the Prevention of FASD Foetal alcohol spectrum disorder)	26/3/2014
		Presentation to Australian Private Hospitals Association National Congress on expanding the contribution of the private health sector	24/3/2014
		Spoke at International Primary Health Care Reform Conference on driving quality primary care	19/3/2014
Dr Iain Dunlop	AMA Chair of Federal Council	Health Technology Assessment Consultative Committee	1/4/2014
Professor Geoff Dobb	Former AMA Vice President	IHPA Stakeholder Advisory Committee	11/3/2014



While you look after others, we'll look after you

We believe Australians who choose a career looking after others deserve a comfortable retirement.

Join the super fund that puts members first.

Call us on **1300 650 873** or visit
firststatesuper.com.au



GLOBAL PRACTICE

Australian Perspective



2014 AMA National Conference

23 - 25 May, National Convention Centre, Canberra

AMA National Conference special report

Held just a week after the Federal Budget, it was inevitable that pressing concerns about the Medicare co-payment, public hospital funding cutbacks and other controversial Government measures would figure large in the deliberations of the AMA National Conference.

On its first day, 23 May, the Conference – staged at the National Convention Centre, Canberra – heard directly from the Government about the reasoning underpinning the Budget when Health Minister Peter Dutton delivered an address, followed by his political opponent, Shadow Health Minister Catherine King. Many issues surrounding the Budget were canvassed during a dedicated policy session the following day.

But the three-day Conference was about much more than just the Budget. Under the overarching theme 'Global practice: Australian perspectives', the conference encompassed five

policy sessions featuring world-class speakers talking on issues including the prevalence and prevention of non-communicable diseases, the challenges faced by medical practitioners in different countries, the development of vocational training in global health, variations in medical practice and caring for those who have served the country overseas.

The Conference also made several decisions fundamental to the direction and operation of the AMA, including the election of a new President and Vice President and the adoption of a new Constitution.

And it was an occasion to recognise the achievements and contributions of AMA members and organisations through numerous awards, as well as rare opportunity for the far-flung AMA family to get together.

To view videos and photos of conference proceedings, visit: ama.com.au/nationalconference

Adrian Rollins





Key events/issues

Federal Budget - the debate

Medicare co-payment - the politics

The AMA is pushing for urgent talks with the Federal Government to overhaul its controversial plans for a co-payment for GP, pathology and radiology services amid concerns the policy will hurt the disadvantaged and increase the burden on doctors.

In one of his first statements as newly-elected AMA President, Associate Professor Brian Owler, said that although the AMA was not opposed to patient co-payments, the Government's current plan was flawed and he was keen to discuss changes with the Government.

"The current proposal has come from a very economic angle, and I think some of the assumptions and the reasoning behind it is a bit skewed," A/Professor Owler told the *Australian Financial Review*. "What we need to do is to work with the Government to make sure that we not only protect our

doctors and members' practices, but we also make sure that we protect the most vulnerable in society.

"That sort of detail and issues for patients haven't really been thought through in the current proposal.

"The Minister has indicated his willingness to talk about these issues, and I hope, particularly for...the most vulnerable in society, that we can get the outcome we need."

The Abbott Government's first Budget, particularly its proposal for a \$7 co-payment for GP visits and out of hospital pathology and diagnostic imaging services, was the subject of extensive discussion at the AMA National Conference, including contributions from Health Minister Dutton, his Opposition counterpart Catherine King, health economist Professor Elizabeth Geelhoed, AMA Council of General Practice Chair Dr Brian Morton and numerous Conference delegates.

The Conference passed a resolution

calling on the Government to re-work its co-payment plans to include adequate protection for vulnerable patients, enable doctors to waive the co-payment in exceptional circumstances without penalty, and to cover the costs for practices of collecting and tracking patient co-payments.

In a major speech to the Conference, Mr Dutton argued that the co-payment was a vital part of the Government's strategy to rein in health spending growth and make it sustainable.

"The Government has heeded warnings about unsustainable expenditure growth," the Minister said. "We are taking a realistic, long-term view...aimed at making real change to set our health system on a sure path."

There has been much confusion and uncertainty about the co-payment.

Medical practices have reported patients cancelling appointments because of the mistaken impression the co-payment had already come into effect, while the fundamental purpose of the policy has remained unclear.



'Government has heeded warnings of unsustainable health spending growth' Health Minister Peter Dutton

The Government has presented it as a way to discourage unnecessary visits to the GP, and has tried to back political opponents into a corner by directing the \$3.5 billion to be saved by cutting the Medicare rebate by \$5 into the unheralded Medical Research Future Fund.

But the strategy has muddled the waters around whether the co-payment's primary purpose is to improve the efficiency of primary health spending or redirect funding from primary health into medical research.



Medicare co-payment - The politics ... FROM P18

In their post-Budget speeches, Prime Minister Tony Abbott and Mr Dutton have emphasised the importance of sending a 'price signal' to patients about the cost of health care.

Mr Abbott, who admitted the Medicare co-payment was "perhaps the most difficult policy change in this Budget", said it was nonetheless an important measure because it sent a "necessary price signal, because visits to the doctor might be free to most patients, but they certainly haven't been free to the taxpayers of this country".

Mr Dutton told the AMA Conference the aim was to discourage bulk billing, which had spread to the extent that even the better off received free care.

"Bulk billing was intended to be for patients who could not afford to pay a full fee," the Minister said. "It was not intended to be a drawcard to attract patients from one practice to another.

"That is why the Government is introducing the [co-payment]. It represents a balance between introducing a price signal and maintaining access for people who need care."

But the Government has so far failed to convince many that its co-payment is the right policy prescription.

United General Practice Australia, which comprises seven peak medical organisations including the AMA, the Royal Australian College of General Practitioners, the Australian General Practice Network and the Rural Doctors Association of Australia, said the co-payment as devised in the Budget needed to be overhauled.

UGPA said the \$5 cut to the Medicare rebate exacerbated the financial pressure on GPs and, combined with the co-payment, made it harder for vulnerable people to see a doctor.

Health economist Professor Elizabeth Geelhoed, of the School of Population Health at the University of Western Australia, said the co-payment was flawed both in terms of equity and efficiency.

In particular, it would discourage those who needed medical care the most from seeking treatment, adding to the nation's health bill in the longer term, she said.

Senate opposition

The proposed co-payment may struggle to see the light of day in the face of strong opposition and criticism in the Senate from Labor, the Greens, the Palmer United Party

and independent Senators.

Shadow Health Minister Catherine King told the AMA Conference the Labor Party was implacably opposed to the \$7 co-payment.

"[The co-payment] is a solution based on a problem that does not exist," Ms King said. "Australia does not have a higher level of GP consultations than the OECD average and, with an ageing population, increasing rates of obesity, diabetes and heart disease, policymakers should be focusing on measures that keep the population healthy and out of hospital."

The Greens have committed to opposing the co-payment, as has Palmer United Party head Clive Palmer, who told the ABC his party's Senators would "definitely oppose the co-payment."

"You imagine being a pensioner and earning \$300 a week and you're 87 and you've got to go to the doctor four or five times a week," Mr Palmer said. "That takes up one-third of your income because of the co-payment. I care about Australians and I'm not going to back down."

The united front of the three parties means passage of the co-payment will be virtually impossible unless the Government is able to negotiate a deal.

Mr Dutton told the National Press Club late



Shadow Health Minister Catherine King: Co-payment a 'solution based on a problem that does not exist'.

last month that the Government would not back down from the co-payment, but was open to compromise. He said Mr Palmer had the opportunity to talk through his concerns with the Government.

"The first option [for Mr Palmer] is the Greens option, which is to block everything and negotiate on nothing, essentially to be an obstructionist," the Minister said. "The second model is ... somebody who is willing to add to or improve in their eyes the policy that's before them."

Adrian Rollins



Medicare co-payment - the economics



National Conference delegates queue up to have their say on the Budget changes

The health of vulnerable patients will suffer and doctors will be left out-of-pocket under the Federal Government's Medicare co-payment plan, the AMA National Conference was told.

In a sobering assessment of the likely effect of the Government's co-payment policy, Chair of the AMA Council of General Practice Dr Brian Morton warned it could end up costing the health system more by causing less bulk billing, even briefer GP

consultations, fewer nursing home visits, increased diagnostic testing and more prescriptions.

Health economist Professor Elizabeth Geelhoed, of the School of Population Health at the University of Western Australia, told the Conference the short-term savings from the co-payment would eventually prove costly because those who most needed medical care would be among the least likely to seek it because of cost.

The co-payment and bulk billing

The Federal Government has framed the \$7 co-payment for GP, pathology and radiology services as a savings measure necessitated by what it considers to be unsustainable growth in health expenditure.

Health Minister Peter Dutton said that in the past 10 years spending on the Medicare Benefits Schedule had increased by 130 per cent and, if left unchecked, the cost of Medicare would double in the next decade, while spending on public hospitals would surge 150 per cent.

Confronted with these facts, Mr Dutton said, "no-one could deny that action had to be taken. This Government has heeded the warnings about unsustainable expenditure growth".

Part of its response has been to impose a \$7 co-payment – comprising a \$5 cut in the Medicare rebate and \$2 payment to doctors – which is expected to save \$3.5 billion over five years.

It means the rebate for the most common Medicare item, a Level B consultation, will be cut from \$36.30 to \$31.30. To soften the blow for the most vulnerable, the co-payment will apply to just the first 10 visits each year by concession card holders

and children younger than 16 years. After 10 visits, their Medicare rebate will be reinstated to its former level.

Mr Dutton said it was reasonable to ask patients "to take more personal responsibility for their health, through modest contributions to the cost of their care", and made it clear that the current high rate of bulk billing (around 82 per cent) was in the Government's sights.

"Bulk billing was intended to be for patients who could not afford to pay a full fee. It was not intended to be a drawcard to attract patients from one practice to another," he said.

Co-payments will not be mandatory, giving doctors the scope to continue to bulk bill their patients but, Mr Dutton warned, the Government made "no secret that we encourage GPs to ask the patient for a contribution, and we incentivise accordingly".

Just how punitive these incentives are was detailed by Dr Morton in his presentation to the Conference.

Dr Morton said doctors who waived the co-payment and continued to bulk bill some or all of their patients would find themselves up to 34 per cent out of pocket for each service.



Medicare co-payment - the economics ... FROM P20

Services provided without a co-payment did not count toward the 10-visit threshold for concession card patients and children, making it in the doctor's interest to impose the \$7 charge.

"Of course, there are times where the patient just can't pay," Dr Morton said. "GPs will still have the discretion in such cases to waive the co-payment. The kicker is that every time a GP does so, they will take a loss [of \$5 or 14 per cent for non-concession adults and up to 34 per cent for children and concession card patients].

"If this sting is not enough of a deterrent, remember the service won't count towards the 10-service threshold," he said. "Habitual waiving of the co-payment will ensure the patient never reaches the threshold, and will see the GP absorbing a loss of between 14 and 34 per cent for every service."

Dr Morton said this meant doctors would have to think very carefully about which patients they would bulk bill, and under what circumstances.

Unintended consequences

Central to the co-payment is the market economy assumption that as the cost of a service goes up, demand will slow.

But Professor Geelhoed said this was based on a bad misreading of the structure of Australia's health system and the nature of health care, and how different it was from a market-based system.

In a market, prices are set by supply and demand, whereas in the health system they are heavily influenced by Government, she said. Furthermore, in market models of the economy, demand is driven by want, whereas in health it is driven by need. And the market approach assumes perfect information, whereas in health practitioners have much greater knowledge than patients.

Professor Geelhoed said that although it was unclear how patients would respond to the co-payment, it was already known that the less wealthy saw their doctor less often and ended up in hospital more frequently, partly as a consequence of leading riskier and less healthy lifestyles.

The co-payment was likely to exacerbate these trends, undermining the efficiency and equity of the health system, she said.



'Doctors will have to think carefully about who they bulk bill': AMA Council of General Practice Chair, Dr Brian Morton

Dr Morton warned the policy could have a lot of unintended consequences.

The Sydney GP cited the example of a patient on Warfarin who switched from monthly to quarterly visits because of the co-payment. He said the treating doctor might need to consider putting the patient onto a longer acting but much more expensive anticoagulant as a result.

Dr Morton said the pathology and radiology co-payments could also distort decision making around diagnostic tests. Instead

or ordering just one test, a doctor might instead order several at once to minimise the cost to their patient.

He also raised concerns about whether it would discourage parents, especially from lower socioeconomic areas, to defer or forego vaccinations and other preventive health measures.

Dr Morton said the consequences of such changes in the way medical care is accessed and provided would not be good.



Medicare co-payment - the economics ... FROM P21

"If patients become more discretionary with their GP visits – as the Government is banking on them doing – what will the implications for patient health be?

"I can tell you. There will be increased suffering, enhanced morbidity, [and] lengthier recovery times. It could also turn a preventable or treatable prognosis into a complex, chronic or terminal one."

He said the co-payment would likely increase the incentive for doctors to shorten consultation times and increase the temptation to increase the reliance on medicines as a quick fix to get one patient out the door and another one in.

Practical considerations

Added to this were practical issues primary health providers would have to take into account in implementing the co-payment, including reviewing billing policies, informing patients about the co-payment, reconsidering the timing and frequency of lodging rebate claims, and tracking child and concession patients to measure when



National Conference delegates deliberate on the Federal Budget

they reach the 10-visit threshold.

"Many practices who submit patient claims don't so in real time – they batch the claims and send them at the end of the day, every couple of days, [or] at the end of the week," Dr Morton said. "Identifying when a concession card holder or under 16 has reached the 10-service threshold in

real time is going to be problematic."

He added that practices which bulk billed their patients would need to overhaul their billing practices and provide multiple payment options, increasing overheads.

"These will not only add to business expense, but also the practice's

administrative burden," Dr Morton said. "Each payment system will have its own set of reports and reconciliations. Outstanding payments and bad debts will have to be managed."

Where to from here?

AMA President Associate Professor Brian Owler has indicated the Association is keen to talk with the Government about how the co-payment should be overhauled to provide greater protection for vulnerable patients such as the aged, Indigenous, children and those with mental illness.

Dr Morton warned that, flawed though the co-payment policy was, the medical profession should think carefully about whether it would be wise to reject it outright.

As unpalatable as the Medicare rebate cut was, it was unlikely to be undone, and, "Government alternatives for cost control could be far worse".

Professor Geelhoed said consumers put a greater value on services they had to pay for, so co-payment "in some guise may be part of an eventual reform solution".

Adrian Rollins

COMMENT

Discover the opportunities in general practice

General practice offers the opportunity to subspecialise and undertake procedural work, while becoming an integral part of a community. The Australian General Practice Training (AGPT) program is your pathway to becoming a GP.

To find out more visit gpel.com.au



Care to
Discover
GPET.COM.AU

AGPT



Australian Government
General Practice Education
and Training Limited



@AGPT_GPTraining



Hospital funding becomes mired in blame game once more

The Abbott Government's "unconscionable" decision to slash future contributions to public hospital funding has reignited the wasteful Federal-State blame game and will cut treatment to thousands of patients, the AMA National Conference was told.

In one of his last speeches as AMA President Dr Steve Hambleton lamented that the Commonwealth's Budget decision to walk away from hospital funding guarantees to the states and change the indexation of future contributions had delivered a major set-back to efforts to end the political tug of war over public hospital financing and would lead to much fewer additional hospital beds than had been planned.

Dr Hambleton said that during his five years as AMA Vice President and then President, policy over public hospital funding had gone virtually full circle, from the familiar Commonwealth-State stand-off to "an attempt to implement the AMA plan for a single funder... to an unconscionable abrogation of responsibility to the public hospital sector".

"The Commonwealth Government has used a very blunt instrument to deal with [forecasts of growth in hospital

expenditure], and in what appears to be a very brutal way for the states and territories," the former AMA President said.

No more hospital funding guarantees

In the Budget, the Federal Government disavowed public hospital funding guarantees made under the National Health Reform Agreement 2011 and scaled back indexation of its contributions from mid-2017 to the consumer price index and population growth rather than the efficient growth dividend.

AMA analysis shows that the combined effect of these measures will be to strip \$20 billion from public hospitals over the next five years.

At an emergency meeting held in the aftermath of the Budget, all State and Territory leaders (except WA Premier Colin Barnett) declared that the Commonwealth's unilateral termination of hospital funding agreements was unacceptable, and warned that, as a result, funding for 1200 extra hospital beds would be axed and there would be an annual \$300 million a year cut in concessions for pensioners and seniors.

But Health Minister Peter Dutton told the AMA National Conference that much of the commentary on the Budget decision was "dead wrong".

"We are not reducing funding for public hospitals," Mr Dutton said, pointing out that the Commonwealth's contribution would grow by 9 per cent a year in the next three years before scaling back to 6.5 per cent annual growth from 2017.

"What we will not be doing, unlike the previous Government, is providing open-ended funding guarantees for inefficient and unrestrained growth," he said.

"Hospitals," Mr Dutton said, "are the responsibility of the states and territories".

New AMA President Associate Professor Brian Owler said that although Mr Dutton was correct to say the Commonwealth's contribution to public hospitals was increasing, "it's a reduction from the funding that they agreed to put into the health system under the National Health Reform Agreement".

A/Professor Owler, a neurosurgeon at the Children's Hospital at Westmead, Sydney, told the *Australian Financial Review* that "it's one thing to say it's the states' problem and push it back to the states, but at the end of the day it is about patients, their health care, and if the states don't have the ability to fund it, then front line medical services are going to suffer".



Hospital funding becomes mired in blame game once more ... FROM P24

Dr Hambleton said the Commonwealth's decision had derailed hopes for a concerted national effort on health reform, and instead the country would be plunged into yet another debate on tax transfers and the adequacy of the GST.

"The battles over public hospital funding appear to be never ending," he said. "The nation cannot afford for public hospitals to be used as pawns in political battles over sovereignty and reform of the Federation. [They] need certainty of funding arrangements to plan for and deliver services."

Emergency department access

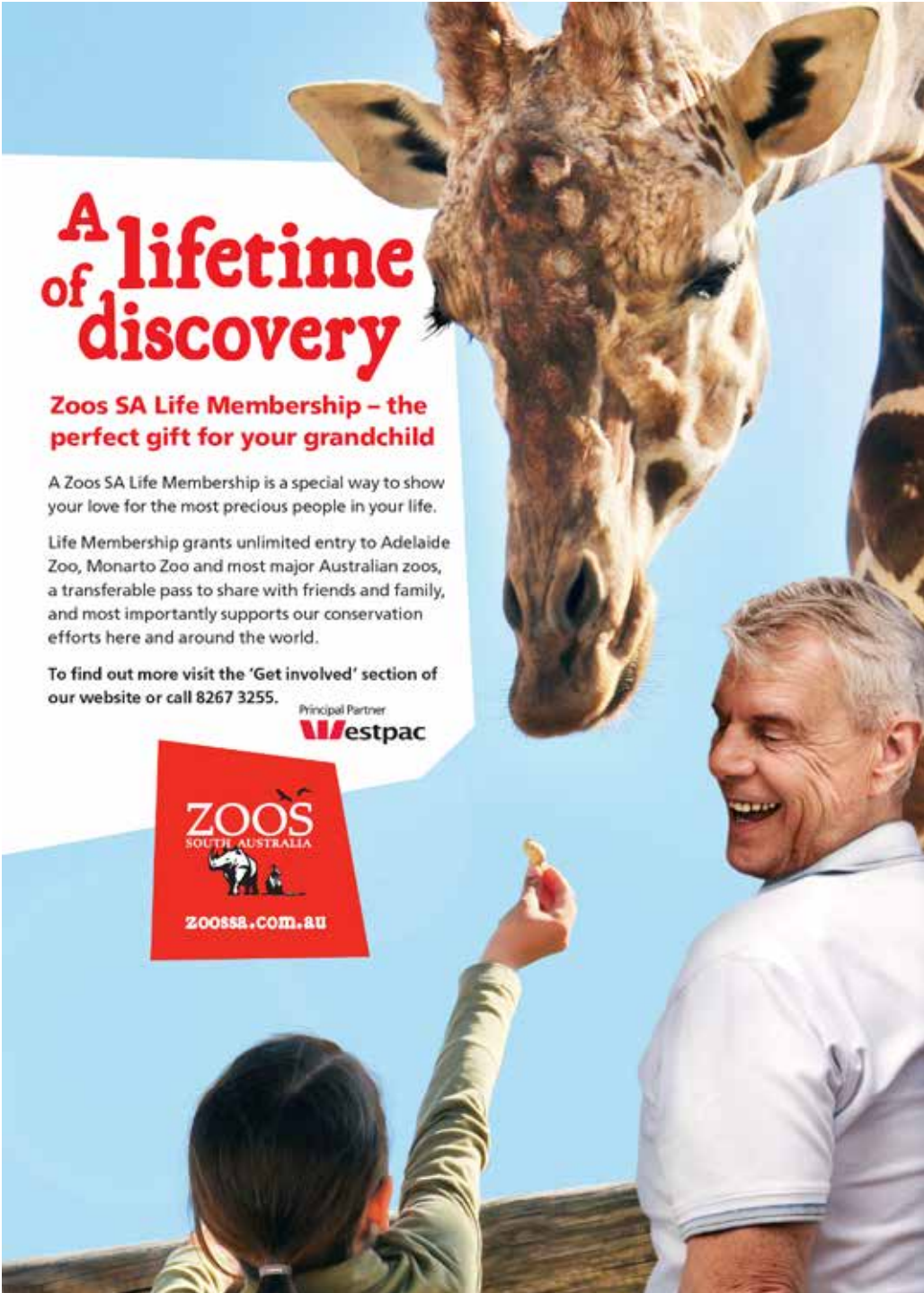
As part of its plans to introduce a Medicare co-payment, the Federal Government has relaxed rules to allow public hospital emergency departments to charge a co-payment for patients presenting with 'GP-like' health complaints – a measure deemed necessary to prevent patients trying to dodging the GP co-payment from clogging public hospitals EDs.

But Newly-elected AMA Vice President and emergency physician Dr Stephen Parnis said there were serious practical and ethical issues around implementing such a charge.

"In emergency departments, we treat people according to medical need," Dr Parnis said. "We would hate to see people not seek emergency treatment when they needed it."

He said the idea of trying to assess patients for the seriousness of their conditions when they arrived at emergency departments would be too hard to implement: "The only way you can really assess whether or not someone is an emergency case is once you have treated them".

Adrian Rollins



A lifetime of discovery


Zoos SA Life Membership – the perfect gift for your grandchild

A Zoos SA Life Membership is a special way to show your love for the most precious people in your life.

Life Membership grants unlimited entry to Adelaide Zoo, Monarto Zoo and most major Australian zoos, a transferable pass to share with friends and family, and most importantly supports our conservation efforts here and around the world.

To find out more visit the 'Get involved' section of our website or call 8267 3255.

Principal Partner
Westpac

ZOOS
SOUTH AUSTRALIA

ZOOSSA.COM.AU



Medicine calls finally get answered

The widely-loathed PBS Authority Prescription system is to be reviewed as part of Federal Government efforts to cut down on red tape, potentially saving doctors and patients thousands of hours wasted waiting for telephone calls to be answered.

Health Minister Peter Dutton revealed at the AMA National Conference that he had initiated a review of the Authority Prescription scheme following AMA calls that the system be streamlined.

But the Minister knocked back the AMA's suggestion that the system be scrapped altogether, arguing that "there are occasions when the Authority system is important to ensure that patients are only given medicines that are safe and appropriate".

There are currently 447 PBS-listed medicines that can only be prescribed with the specific approval of the Department of Human Services.

Doctors complain that they regularly experience lengthy delays waiting for calls to the Authority Prescription line to be answered.

Recently-released Department of Health figures show that only half of all calls to the service between October last year and

February this year were answered within 30 seconds, with 16 per cent of callers forced to wait two minutes or longer to speak with a clerk.

In its submission to a systematic review of authority listed medicines being conducted by the Pharmaceutical Benefits Advisory Committee, the AMA said doctors spent the equivalent of 25,000 patient consultations each year waiting for their calls to the Authority free call service to be answered.

The AMA said the pointlessness of the system was underlined by the fact that only 2.8 per cent of calls to the service did not result in prescription authorisation.

"Allowing patients to get the medicines they need as quickly as possible is an absolute priority for the Government," Mr Dutton told the AMA National Conference, adding that "we are also committed to reducing unnecessary red tape and paperwork for health professionals when they prescribe medicines".

The Government said the review would "build on the PBAC's consideration of a submission from the AMA that recommended the movement of a number of medicines from Authority Required to Authority Required (Streamlined)".

The Review will look at the criteria used in assessing whether or not access to a medicine should be subject to authorisation, as well as examining all current Authority Required listings.

The Review will be conducted in tranches, with those medicines subject to most authority requests to be assessed first.

This group of medicines includes cancer treatments, as well as multiple sclerosis and arthritis drugs, and the results of the assessment will be presented to a PBAC meeting in November.

Treatments for psychiatric, cardiovascular and eye conditions will be included in the second tranche, which will be considered at a PBAC meeting in March next year.

The final tranche of medicines, which will include drugs used in palliative care, will be considered in July next year.

Former Chair of the AMA Therapeutics Committee, Professor Geoffrey Dobb, said last month that the Department's efforts to push more medicines onto the streamlined Authority list (which means doctors do not need to get prior Department authorisation but just include the relevant four-digit code on the prescription) was welcome, but more needed to be done.

"Moving more medicines into streamlined approval arrangements is an encouraging

development, but we need to keep the pressure on [the Department] to allocate proper resources to the phone line service," Professor Dobb said.

Mr Dutton said he expected the review to result in savings of more than \$7 million a year, with a significant number of medicines removed from the Authority list.

He said the review would be undertaken in consultation with the AMA, the Royal Australian College of General Practitioners, the Society of Hospital Pharmacists, Medicines Australia and other groups.

The terms of reference for the review will be finalised by the PBAC at its meeting next month.

The draft terms of reference can be viewed at:

<http://www.pbs.gov.au/info/reviews/authority-required-listings>

In a further move to cut the administrative burden on doctors, Mr Dutton told the AMA National Conference that from early 2016 five of the 10 current PIP Incentives would be collapsed into a single measure centred on continuing quality improvement in general practice.

"We will continue to work with the AMA and others to finalise details of the new incentive and improvements to PIP," the Minister added.

Adrian Rollins





General practice put in jeopardy by training changes

The Federal Government has been told its move to scrap GP training agencies and programs risks undermining access to quality care and puts the viability of the profession in jeopardy.

In a strong response to the abolition of General Practice Education and Training and the end of the Prevocational General Practice Placements Scheme, the nation's peak general practice groups, including the AMA, have issued a joint warning that the decision "poses serious risks to general practice training".

"The plan, including very short implementation time frames, poses a significant risk to the viability of the general practice profession and access to quality care for all Australians," the groups said in the joint statement.

In its Budget, the Federal Government announced savings from the abolition of GPET and Health Workforce Australia would help fund an extra 300 GP training places, a doubling of the PIP payment for three-hour GP training sessions to \$200, \$300,000 infrastructure grants for up to 175 general practices and \$35 million for the GP Rural Incentive Program.

"These investments will allow more medical graduates to pursue careers in general practice, and more doctors to practice in areas of greater patient need," Health Minister Peter Dutton told the AMA National Conference.

But United General Practice Australia (UGPA), which includes the AMA, the Royal Australian College of General Practitioners, the Australian General Practice Network, General Practice Registrars Australia, the Rural Doctors Association of Australia and several other groups, said the changes would undermine GP training and called for urgent talks with the Government.

UGPA said they would reduce the appeal of general practice as a career, result in the loss of GP education expertise and deter practices from employing registrars and offering training.

It was particularly concerned about the decision to fold the functions of GPET within the Department of Health.

"The [Department] has no experience in facilitating general practice training," UGPA said. "The decision to put the general practice training program out to tender

risks a decision being made on price, rather than quality and the long-term interests of the patients."

The group said GP training must be profession-led and apprenticeship-based, and accreditation must remain with specialist medical colleges.

The criticism, combined with widespread discontent over the introduction of a Medicare co-payment, suggests the Government faces a formidable task in soothing medical profession concerns.

Mr Dutton attempted to go part of the way at the AMA National Conference, where he put some flesh on the Government's plans to abolish Medicare Locals and replace them with Primary Health Networks (PHNs).

The Minister said that from July next year 61 Medicare Locals would be replaced with a smaller, but not-yet specified, number of PHNs.

"Absolutely essential to their future and their success is that they need to engage properly with general practice and have GPs at the centre of the model," Mr Dutton said.

The Minister said PHNs would "better match" local hospital network boundaries [of which there are 123], and would have well-defined roles.

"They will not be direct providers of services, but will link up services to meet community needs and keep people out of hospital - either in the first instance, if

clinically appropriate to do so, or to stop inappropriate admissions," Mr Dutton said.

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

The AMA has long expressed dissatisfaction with the Medicare Locals system, and an AMA 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 focused 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 coordination between primary care and hospitals.

Adrian Rollins



COMMENT

EXPRESSIONS OF INTEREST

MEMBERSHIP OF THE ADVISORY COMMITTEE ON MEDICINES SCHEDULING (ACMS) AND THE ADVISORY COMMITTEE ON CHEMICALS SCHEDULING (ACCS)

Medicines and chemicals scheduling is a classification system that controls how substances will be made available to the public. Medicines and chemicals are grouped into Schedules that require similar regulatory controls over availability to protect public health (e.g. Schedule 4 – medicines only available on prescription; Schedule 5 – substances requiring appropriate labelling and packaging).

The Department of Health is seeking expressions of interest from experts interested in contributing to the work of the national scheduling framework via membership on the Advisory Committee on Medicines Scheduling (ACMS) or the Advisory Committee on Chemicals Scheduling (ACCS).

ACMS and ACCS

ACMS and ACCS are statutory expert advisory committees under the Therapeutic Goods Act 1989. They are responsible for providing advice to the Secretary of the Department of Health on the level of access required for medicines and chemicals.

To be considered for a position on either of these committees, applicants should have expertise in an area relevant to the assessment of substances that warrant restricted access.

Specifically for the ACMS, applicants should have expertise in at least one of the following fields:

- regulation of scheduled medicines in Australia
- toxicology or pharmacology

- clinical pharmacology
- pharmacy medicines
- medical practice
- consumer health issues relating to the regulation of therapeutic goods
- industry issues relating to the regulation of therapeutic goods.

For the ACCS, applicants should have expertise in at least one of the following fields:

- regulation of scheduled chemicals in Australia
- veterinary medicines or veterinary pathology
- industrial or domestic chemicals
- agricultural or veterinary chemicals
- clinical aspects of human poisoning
- occupational health issues, particularly as a medical practitioner
- consumer health issues relating to the regulation of chemicals.

Remuneration and travel will be determined by the Remuneration Tribunal.

Further information on these positions and to receive an EOI application pack, email SMP.committees@health.gov.au.

EOI are due to the department by 22 June 2014.



Key events/issues

AMA changes leadership



Sydney neurosurgeon Associate Professor Brian Owler has been installed as the AMA's 23rd Federal President following elections held at the AMA National Conference.

A/Professor Owler, immediate-past President of AMA New South Wales, won

the endorsement of his colleagues in a contest with long-standing AMA Vice President Professor Geoffrey Dobb for the position.

In a wholesale changing of the guard at the head of the organisation, emergency physician Dr Stephen Parnis, immediate-

past AMA Victoria President, was elected as Vice President, prevailing in a three-way contest with former AMA Queensland President Dr Richard Kidd and former Chair of the AMA Federal Council Dr Roderick McRae.

The position of AMA President became vacant following the decision of incumbent Dr Steve Hambleton to step down following a gruelling three-year term during which he was at the forefront of national debate on health policy while simultaneously steering the Federal AMA through a period of internal upheaval.

A/Professor Owler is a driving force and the face of New South Wales' 'Don't Rush' anti-speeding campaign, and he appears on billboards and in television ads warning of the risks and damage associated with road accidents.

He has also been a prominent campaigner for stronger laws to minimise alcohol-related violence, and greater community education about the health harms caused by alcohol abuse.

In his acceptance speech, A/Professor Owler paid tribute to Dr Hambleton and Professor Dobb, who he said had together provided strong and effective leadership for the AMA and ensured its national pre-eminence in national debates on health policy and issues affecting the medical



profession had been maintained and enhanced.

In particular, he said, Dr Hambleton had given the AMA a calm, effective and persuasive voice on the national stage during a politically turbulent period while at the same time managing the organisation through a difficult period when it was without a Secretary General.



AMA change's leadership ... FROM P29



Associate Professor Brian Owler at the AMA National Conference



Dr Stephen Parnis received congratulations upon his election as AMA Vice President

"The last three years have not been easy for Steve," A/Professor Owler said. "There were times that he really kept the AMA going, [but] from the outside you would never guess the difficulties we had."

While spending countless hours ensuring the AMA continued to operate smoothly, Dr Hambleton at the same time ensured the medical profession's views on an enormous range of medical and health policy issues were heard loudly and clearly, the new AMA President said.

A/Professor Owler told the Conference Dr Hambleton's third year in office was a stand-out for the quality and breadth of his advocacy and work in advancing the interests of patients and doctors, including through

the successful Scrap the Cap campaign, the Federal election, the e-health review and – most recently – the Queensland public hospital dispute, where his ability to build consensus and thrash out a solution acceptable to all was outstanding.

A/Prof Owler said Professor Dobb had been an excellent Vice President and support for Dr Hambleton throughout his presidency.

"The hardest thing about the [AMA President] election we have been through is that I admire Geoffrey and respect Geoffrey as much as anyone," the AMA President said. "His contribution in the past few years has been enormous."

Dr Parnis, who has in the past campaigned vigorously on emergency access targets in hospitals and improving work conditions for hospital doctors, told the Conference he was honoured and humbled to have been elected AMA Vice President.

"The office itself is not the issue, it is what you can achieve in that role," Dr Parnis said. "I ask you to watch very closely over the next couple of years, because I intend to give this job everything I have got. I promise the new President my utter support, loyalty and good counsel."

Both men have been elected to a two-year term.

Adrian Rollins



COMMENT



National Conference endorses constitutional change

The AMA Federal Council has been relieved of administrative and governance responsibilities and freed up to concentrate on formulating policy under changes to the AMA Constitution endorsed by the AMA National Conference.

The Conference gave overwhelming support to the changes, which AMA Secretary General Anne Trimmer has said will advance the twin objectives of the AMA: to protect and advanced member interests, and to influence health policy and debate.

The Constitutional changes have been the subject of lengthy discussion within the AMA, and seek to modernise the governance of the organisation and lay the groundwork for a more efficient structure.

Under the changes, responsibility for overseeing the day-to-day administrative and governance functions of the organisation have been invested in a Board of Directors.

The Board comprises the AMA President Associate Professor Brian Owler and Vice President Dr Stephen Parnis, a

representative from each of AMA NSW, AMA Western Australia, AMA South Australia, AMA ACT, AMA Victoria, AMA Queensland, AMA Tasmania and AMA Northern Territory, and a nominee from the Doctors-in-Training Special Interest Group.

The Board is directed under the Constitution to take account of, and promulgate, the medico-political policy decisions of the Federal Council.

At a meeting immediately following the National Conference, an interim executive of the Federal Council comprising A/ Professor Owler, Dr Parnis, former Treasurer Dr Elizabeth Feeney, former Chairman of Council Dr Iain Dunlop and two Federal Council nominees was appointed to carry out the functions of the Board of Directors until its first meeting, due in the next couple of months.

A/Professor Owler told the Conference the changes would "liberate the Federal Council to be the policy making body it should be".

Adrian Rollins



INFORMATION FOR MEMBERS

Free tool to track registration requirements

The AMA has developed a free online tool to help doctors to keep track of the information they need to meet the Medical Board of Australia's annual continuing professional development (CPD) requirements.

Each September, practitioners, when renewing their Medical Board registration, may be required to provide evidence they have complied with the Board's CPD requirements.

The AMA CPD Tracker has been developed to enable doctors to progressively gather and organise the information needed to substantiate declarations made to the Board about CPD, so that evidence can be quickly and easily produced on demand.

The AMA CPD Tracker can be used to:

- List courses completed, including the organisation that accredited the CPD activity;

- Store all certificates of completion;
- Keep a log of practice-based reflective activities, including clinical audits, peer reviews and performance appraisals; and
- Log hours spent on online learning, reading journals, teaching and other activities.

The system keeps a tally of hours, enabling practitioners to keep track of what needs to be completed before the end of the registration year.

The Tracker has been developed taking full account of the requirements set out in the Medical Board's Continuing Professional Development Registration Standard.

The service is free to AMA members. Non-members can subscribe for an annual fee of \$250.

To register for the product, please sign up here.



Keynote speeches

The AMA a voice of judgement and reason on health



Dr Steve Hambleton gives his last speech as AMA President

Former AMA President Dr Steve Hambleton has urged the Association to remain a strong, intelligent, principled and constructive voice for health reform in the face of Federal Government changes that pose “significant risks” to Medicare and the health system.

In his final speech as President, Dr Hambleton told the AMA National Conference that, as the nation’s leading

health lobby, the Association was listened to carefully by Government, and had a responsibility to be a voice of sound judgement and reason on issues affecting both the medical profession and the health of the broader community.

“Others look to us for leadership and example,” Dr Hambleton said. “It is vital – always – for the AMA to be in a position where its views are heard and seriously considered by the Government of the day.

“If we oppose something, we must explain why, and offer a better alternative. If we are going to tear something down, we need to propose something better to go in its place.

“That is advocacy. That is engagement. This is part of the way we influence the Government.”

The former President said the AMA’s skills of persuasion had never been of greater importance than now, given the scale of the Abbott Government’s plans to transform the health system.

“It is change that is possibly more radical and far-reaching than the Rudd reforms that I confronted when elected Vice President five

years ago,” Dr Hambleton said.

“The reform agenda of the Government poses significant risks and challenges for Medicare and the health system – and we are talking about the very structure of Medicare - our universal health system.”

The former President said the changes also included opportunities for the profession, but to make the most of these the AMA would have to continue to be an active and constructive contributor to policy discussions.

“Our message [has been] that everybody in politics has to get smarter about health policy, especially about how we spend health funding.

“It was going pretty well until Budget night. People just got very dumb all of a sudden.”

Dr Hambleton backed his call for constructive engagement by citing significant recent successes in AMA advocacy, including the Scrap the Cap campaign that saw the proposed \$2000 limit on tax deductions for self-education expenses scrapped by the incoming Coalition Government, and the resolution of the Queensland public hospital contracts dispute.

“This was genuine trench warfare,” he said. “The Queensland Government was determined to not take a backward step. They underestimated the profession. They

underestimated the AMA.

“Our cause was the right one – and we won. This was a truly great moment for the AMA, and I was proud to be a part of it.”

The AMA’s influence was obvious on other issues as well, including its concerns about Medicare Locals and GP Super Clinics – both programs which have been abandoned by the Abbott Government – and the need to overhaul the Personally Controlled Electronic Health Record system, which has been reviewed.

Dr Hambleton paid tribute to his colleagues for their support and good counsel during his three years as AMA President and two years as Vice President.

He gave particular recognition to immediate past AMA Vice President Professor Geoffrey Dobb, his predecessor as President, Dr Andrew Pesce, current AMA Secretary General Anne Trimmer and her predecessor Francis Sullivan, AMA Executive Officers Dr Liz Feeney, Dr Iain Dunlop, Associate Professor Brian Owler and Dr Stephen Parnis, the AMA Federal Council, the AMA Secretariat, as well as his wife Deb and their children.

“It is a great honour to be AMA President,” he said. “It is not easy. There are many challenges but, if we stand together, we can achieve many things.”

Adrian Rollins





Keynote speeches

Personal loss underlines call for end of disease



Aiming for an AIDs free generation: US Ambassador to Australia, John Berry

United States Ambassador to Australia John Berry recalled the anguish of seeing his partner waste away with AIDs in a deeply personal and powerful speech to the AMA National Conference.

Issuing a call for governments and communities around the world to work

together to improve health and beat disease, Ambassador Berry said all global health challenges were also “personal”.

In a moving illustration, he recounted how, in 1985, on just their second date, his partner revealed he had AIDs and said he understood if he did not want to take the

relationship further.

“I told him that ‘It’ would be a damn silly reason to abandon something that might turn out to be true love, and true love it was – for nearly 10 years,” Ambassador Berry said. “But, in 1996, this horrible disease had shrunk my six-foot-two, 200-pound athlete partner to less than 100 pounds. In June of that year, he died in my arms.

“Thankfully, the world responded to the terrible ‘It’ of 1985 – the disease we know as AIDs. As a result of passionate engagement and research, new drugs have given hope – and life – to millions.”

Ambassador Berry said HIV remained one of the world’s biggest killers, but deaths from AIDs were down 30 per cent from 2005, and he urged governments around the world, including Australia and the US, to do more and commit to an AIDs-free generation.

He said the international effort against AIDs, and programs such as the Global Fund, vaccination campaigns and transnational medical research efforts showed what could be accomplished when nations worked together.

The Ambassador cited as an example child and maternal health programs that had helped halve child mortality and maternal

death rates between 1990 and 2012.

Ambassador Berry said the US and Australia were also partners in what was one of the most exciting and important research projects yet – understanding the human brain.

Brain research has become a major focus of the Obama Administration – last year, President Barack Obama launched the BRAIN Initiative to investigate brain function, and has backed it with \$300 million in 2014 and 2015 alone.

“The President hopes that we can eventually map the brain as we did with the human genome,” Ambassador Berry said.

Like the human genome project, the BRAIN Initiative is conceived as a transnational effort, and Ambassador Berry said he was excited by the opportunities for collaboration between US and Australian neuroscientists, who he said were at the forefront of work in the field.

“Your first-class research facilities like the Queensland Brain Institute and Melbourne Brain Centre are not just cutting edge, but are ‘leading edge’ in worldwide efforts to tackle these challenges,” he said.

Adrian Rollins



COMMENT



Policy sessions

Variation in medical practice: are Australians getting world-class health care?

Speakers:

Professor Anne Duggan, Senior Medical Adviser, Australian Commission on Safety and Quality in Health Care

Dr Rob Grenfell, Director of Cardiovascular Health, Heart Foundation

Professor Michael Buist, Chair of Health Services, School of Medicine, University of Tasmania

Revelations of major discrepancies in the treatment provided to patients with similar conditions but living in different areas formed the backdrop for a detailed discussion of variation in medical practice at the AMA National Conference.

Senior Medical Adviser to the Australian Commission on Safety and Quality in Health Care, **Professor Anne Duggan**, told the Conference that an investigation into medical practice variation in Australia had found patients in some areas of the country

were more than seven times as likely to undergo cardiac catheterisation as those living in other areas, while the variation was up to 11-fold for knee arthroscopy and four times for hip replacements.

The findings, part of a joint Commission/Australian Institute of Health and Welfare report (see <http://www.safetyandquality.gov.au/publications/exploring-healthcare-variation-in-australia/>), were echoed in data presented to the conference by the Heart Foundation's Director of Cardiovascular Health, Dr Rob Grenfell.

Dr Grenfell said figures provided by Victorian hospitals showed that up to a third of patients who had suffered a myocardial infarction needed to be readmitted to hospital.

While the tendency of patients to stop taking their medication after a couple of years was part of the problem, research also showed that a significant proportion



Professor Michael Buist highlights the human cost of co-payments

were not given the medication they needed when they were discharged, and there were inconsistent care plans.

"I often comment that the correct term for patients should in fact be punters," Dr Grenfell told the Conference. "I would be worried about family members with heart failure as to what care they may receive."

Such evidence has raised concerns about how health care is delivered, including equity of access to care, the extent to which advances in treatment are adapted and adopted, as well as the lack of a

system to monitor the outcome of common treatments.

In a forthright presentation to the Conference, Chair of Health Services at the University of Tasmania, **Professor Michael Buist**, highlighted the prevalence of preventable human error in clinical care.

He cited a 1999 study showing that 11 per cent of patients died because of the failure of hospital staff to attend, while other fatalities were attributed to an inability to following procedure, absentmindedness, "cognitive failure" and other shortcomings.



Variation in medical practice: are Australians getting world-class health care? ... FROM P34



'Patients should be called punters': Dr Rob Grenfell



'The art of medicine is to deal with uncertainty': Dr Stephen Parnis



Wide national variation in medical practice: Professor Anne Duggan

Professor Buist said clinicians needed to look at patients as people, while hospital quality and safety units needed to engage with clinicians, particularly junior doctors and nurses.

Professor Duggan said that while "not all" variation in treatment was problematic, and in fact could be due to differences in population, patient preferences and practise innovation, there were obviously many instances where it was unwarranted and signalled possible problems including inappropriate care, safety and quality issues or inadequate resources.

AMA Vice President Dr Stephen Parnis, who chaired the session, said the practice of medicine was often fraught with uncertainty, and part of the "art of medicine is to use one's professional training, skills and experience to deal with that uncertainty".

Dr Parnis said that "dealing with unwarranted variation in practise can set the course for cost containment and improving safety and quality".

Dr Grenfell said there needed to be better and more accurate data collection regarding treatment and outcomes, including tracking readmissions.

He said the focus of reform also had to change.

"We have had a financial reform agenda [in health], not a clinical reform agenda. We need a focus on actual clinical improvement, empowering clinicians and, hopefully, patients to drive change," Dr Grenfell said.

Adrian Rollins





Policy sessions

The global challenge of non-communicable diseases

Speakers:

Professor Rob Moodie, Professor of Public Health, Melbourne School of Population Health

Associate Professor Harry Minas, Global and Cultural Mental Health Unit, Melbourne School of Population Health

Professor Mike Daube, Director, Public Health Advocacy Institute

The unwillingness of governments to adequately regulate tobacco and alcohol and to educate people about the health risks posed by poor diet and inactivity was contributing to the rapid spread of non-communicable diseases to industrialising countries, the AMA National Conference was told.

In a policy session that set the scene for ensuing discussions about aspects of global health, Melbourne School of Population Health faculty members

Professor Rob Moodie and **Associate Professor Harry Minas**, along with **Public Health Advocacy Institute Director Professor Mike Daube** warned that rapid industrialisation in Asia, Africa, South America, the Middle East and other parts of the world was bringing with it the unwanted scourge of lifestyle-related diseases.

Professor Moodie said that in the two decades to 2010, heart disease had emerged to become the world's most prevalent disease, and stroke had risen to be third most common, displacing killers such as diarrhoea, respiratory infections and pre-term birth complications.

The mounting death toll from heart attacks and strokes had been associated with rapid increases in the consumption of alcohol, tobacco, sugar and unhealthy fats in developing countries.

In the 12 years to 2009, Professor Moodie



Increasing recognition of mental health in non-communicable diseases: Professor Harry Minas

told the Conference, alcohol consumption in low income countries had grown at an annual rate of almost 3 per cent, compared with just 1.1 per cent in wealthy nations, while the discrepancy regarding tobacco use was even more marked – growing by 2 per cent a year in developing countries at a time when its consumption had virtually stagnated in the developed world.

Increasing affluence had also brought with it unhealthy changes in diet. People in low income countries were guzzling an extra 5.2 per cent of soft drink and 2 per cent of

processed foods each year – about double the growth rate in high income nations.

Driving the point home, Professor Moodie revealed that in Indonesia 40 per cent of boys aged between 13 and 15 years smoked, as did almost 70 per cent of men. By comparison, among Australian men, the smoking rate has dropped to around 20 per cent.

Professor Moodie and Professor Daube told the Conference the consumption of tobacco, alcohol, soft drinks, packaged foods and other harmful products in



The global challenge of non-communicable diseases ... FROM P36



'Failure to prevent NCDs a political, not medical, failure': Professor Rob Moodie



Big tobacco, food, alcohol aggressively grooming new markets overseas:
Professor Mike Daub

developing countries was being driven by corporations armed with massive marketing budgets and decades of experience in pressuring policy makers and consumers while at the same time sidelining public health initiatives.

Professor Daube showed just how big such promotion efforts were. He cited Nielsen research showing that \$150 billion - a quarter of all global advertising expenditure - was spent on promoting food, fast food alcohol and tobacco last year.

Underlining what was at stake for such companies, in Australia alone tobacco and alcohol between them generated around \$14 billion of revenue each year, Professor Daube said.

Professor Moodie said such companies were investing heavily in low income countries, attracted by the opportunities for growth unencumbered by few, if any, public health measures, citing Phillip Morris's recent \$190 million upgrade to its manufacturing facilities in Indonesia.

Advertising was just part of the armoury such companies brought to bear, he said.

"Failure to prevent NCDs is a political, not medical, failure," Professor Moodie said. "Alcohol and ultra-processed food and drink industries use strategies similar to the tobacco industry to undermine effective public health policies by biasing research findings, co-opting policy makers and health professionals, lobbying against regulation...[and] blatantly ignoring codes of conduct".

Associate Professor Harry Minas, of the Global and

Cultural Mental Health Unit at the Melbourne School of Population Health, told the Conference that until recently the importance of mental health as part of the effort against NCDs had been overlooked, but that was beginning to change.

People with mental illness generally smoke more than the general population, and are significantly more likely to die from heart disease and respiratory disorders, but the scarcity of mental health specialists and a lack of political interest had meant the incidence of NCDs among the mentally ill had generally been overlooked, Professor Minas said.

He said the country could not afford to continue to overlook the suffering caused by NCDs among those with mental health problems.

Professor Daube said the success of tobacco control efforts in Australia to date provided a guide to what to do and what could be achieved.

He told the Conference that success did not come quickly or easily, and depended on people and groups forming coalitions, fostering consensus, devising comprehensive policy prescriptions and articulating clear messages.

Those taking on the tobacco, alcohol and fast food industries needed to understand how governments operated, work with media, lobby to curb industry marketing and expose the tactics of opponents of regulation.

Adrian Rollins





Policy sessions

Practising globally: regional challenges

Speakers:

Dr Margaret Mungherera, President,
World Medical Association

Sir Sabaratnam Arulkumaran, President,
British Medical Association

Professor Teerachai Chantarojanasiri,
Vice President, Thailand Medical
Association

Doctors feeling hard pressed by the seemingly endless demand for their services should spare a thought for World Medical Association President, **Dr Margaret Mungherera**.

In her native Uganda, Dr Mungherera is one of just 36 trained psychiatrists, serving a population of 36 million people. To even begin to meet the need for their specialist knowledge and skills, Dr Mungherera and her colleagues focus much of their effort on training, research and supervision, amplifying their reach by instructing health

workers.

It is a similar story across Africa and, indeed, much of the developing world, where millions – through lack of money and human resources – have access to only the most rudimentary of health services.

In a number of African countries, Dr Mungherera said, governments were beginning to take steps toward the creation of national health systems, but such work was still in its infancy, and faced many significant barriers, among them a shortage of doctors and other health workers, a lack of hospitals and other infrastructure, and the cost of medicines and other treatments.

One of the most pressing problems is the lack of trained doctors.

Dr Mungherera said Africa's medical workforce was very young – 90 per cent of doctors were less than 10 years out of medical school.

Added to this inexperience was problem, shared by countries such as Australia, of encouraging them to practise where the need was greatest.

"The biggest problem in Africa is that 95 per cent of the population live in rural areas, but just 5 per cent of doctors work in rural areas," she said.

In an attempt to address this problem, several governments have resorted to bonding medical students with obligations to practice in rural areas upon graduation, but Dr Mungherera said this was not only a violation of the right of people to practice where they want, it had the effect of discouraging people who might have undertaken medical training.

In addition to internal migration from the country to the city, African doctors often migrated overseas, lured by much better pay and conditions than they could expect in their home country.

Added to this brain drain, many of those who remained in their home country moved out of clinical practice into non-clinical jobs, including working for international organisations which, again, offered better money than might be had in public or private practice.

Dr Mungherera said the WMO and medical groups within Africa were working on innovative ways to harness the skills and knowledge of doctors who have chosen to work abroad.

She said the WMO was working on a scheme to encourage expat African doctors visiting home to give lectures, conduct ward rounds, undertake research or even donate a month of their time to local clinical practice.

In addition, 20 national African medical associations were in talks about harmonising their qualifications to make it easier for doctors to migrate to other countries within the continent, as a way to retain their skills within the region.

Though Thailand's 23 medical schools train far more doctors – 2500 a year – than most Africa countries, Vice President of the Thailand Medical Association, Professor Teerachai Chantarojanasiri, said his country had a similar problem with access to care, particularly in rural areas.

"Although we are producing 2500 doctors a year, it is still not enough," he said. "Access to health care has improved but demand and supply is not equal."



Practising globally: regional challenges ... FROM P38

As in Australia and Africa, most doctors graduate to the cities and larger towns, leaving a gap in care for the large proportion of Thais who continue to live in rural areas.

Professor Chantarojanasiri said the country relied on an army of 20,000 health volunteers in rural villages and communities to provide primary care.

Medical students whose training is paid for by the Government are obliged to work in the public health system for three years upon graduation, and students from well-off families often paid to train overseas, particularly the United States, in order to avoid this obligation, Professor Chantarojanasiri said.

British Medical Association President, **Sir Sabaratnam Arulkumaran**, said that Britain, like Australia, faced the challenge of an ageing population, which raised the prospect of increasing national health bill as the number of people who required complex care for an extended period during their latter years of life expanded.

"The problem at the moment is the increasing proportion of people over 65 years," he said. "The birth rate is 2.1 and the replacement level is 2.6, and although we are prolonging life expectancy, we need to increase healthy life expectancy."

Adrian Rollins



Overseas conflicts and disasters: the challenge of caring for those who serve

Speakers:

Lieutenant General Peter Leahy, former Chief of Army, Australian Defence Force

Major General Professor Jeffrey Rosenfeld, and immediate past ADF-Reserves Surgeon General

Commodore Duncan Wallace, Psychiatrist, ADF Centre for Mental Health

The AMA National Conference has called for better care for Australian Defence Force (ADF) personnel and veterans, including improved coordination between Government agencies, health services and doctors, and research to identify emerging health issues.

The National Conference unanimously supported a motion committing the AMA to develop a policy to improve the health and wellbeing of Defence Force personnel and veterans following presentations from former Chief of Army **Lieutenant General Peter Leahy**, Navy psychiatrist **Commodore Duncan Wallace** and immediate past ADF-Reserves Surgeon General, **Major General Professor Jeffrey Rosenfeld**.

Lieutenant General Leahy, Major General Professor Rosenfeld and Commodore Wallace spoke at the Conference's *Overseas Conflicts and Disasters: the challenge of caring for those who serve* session, chaired by new AMA President Associate Professor Brian Owler.



High Anxiety: Commodore Duncan Wallace highlights anxiety disorders in the ADF

The Conference was told that, since 1999, more than 45,000 members of the ADF had served overseas, with almost half undergoing multiple deployments.

AMA President Associate Professor Brian Owler said many had paid a heavy price for their devotion to their duty.

"Members of our armed forces put themselves in harm's way on a daily basis, facing risks to both their physical and mental health," the AMA President said. "Doctors have a proud history of caring for our servicemen and women, and we want to improve the care they receive."





Overseas conflicts and disasters: the challenge of caring for those who serve ... FROM P39



'Bomb blast injuries ... the worst I have seen': Major General Professor Jeffrey Rosenfeld

Commodore Wallace told the Conference that in Afghanistan alone, 40 Defence personnel were killed and more than 260 wounded in action, including seven who suffered traumatic limb amputations and 38 cases where traumatic brain injury was the primary diagnosis.

Lieutenant General Leahy, who is Chair of the Soldier On charity, said changes in the nature of conflict and improvements in medical care meant that many soldiers were surviving wounds that would once have proven fatal.

As a consequence, he said, they were returning home with much more severe injuries, including amputations, fractures, hearing loss, traumatic brain injuries and multiple severe wounds.

Major General Professor Jeffrey Rosenfeld detailed to the Conference just how severe these injuries could be,

particularly the prevalence of bomb blast injuries as a result of improvised explosive device attacks.

"Bomb blasts are very severe injuries, the worst I have seen," he said. "The thing about these injuries is that they are a triad of trauma, including the blast wave effect that damages internal organs, the penetration of fragments from the bomb, and then the heat effects from the hot air blast causes burns."

Major General Professor Jeffrey Rosenfeld said advances in training, technology and resources meant many soldiers survived severe injuries.

He said medic training was focused around the importance of providing effect care in the first five minutes following trauma (referred to as 'Platinum Five').

He said experience in Afghanistan and Iraq had seen the re-emergence of tourniquets as a life-saving tool, because "what is killing wounded soldiers is bleeding".

Major General Professor Jeffrey Rosenfeld said all soldiers carried a tourniquet, and it had saved many lives.

But he admitted trauma care was only part of the story.

"It is not just what happens in Afghanistan," he said. "It is clearly what happens back home [as well]."

Commodore Wallace said that, in addition to their physical wounds, many personnel suffered mental health problems as a result of their service.

He said research showed anxiety disorders were more

common among ADF members than the broader community.

In 2010, the 12-month prevalence of all anxiety disorders was 14.8 per cent in ADF members, compared with 12.6 per cent among the general population.

Unsurprisingly, post-traumatic stress disorder was much more common among Defence personnel. The 12-month prevalence of PTSD among ADF members was 8.3 per cent, compared with 5.2 per cent in the broader population, and the incidence of obsessive-compulsive disorder among ADF personnel was more than twice that of Australians in general.

Commodore Wallace said the extent of depressive disorders among ADF personnel was particularly marked – a 6.4 per cent it was more than twice that in the general population.

The speakers told the Conference that one of the biggest problems was getting returned Defence personnel with mental health issues to admit they had a problem and seek help.

Lieutenant General Leahy said among soldiers there was a stigma attached to admitting they had a mental health problem, and Commodore Wallace cited research showing that almost 37 per cent delayed seeking help because they feared it would prevent them from being redeployed, 27 per cent felt such an admission would harm their career prospects, 27 per cent were concerned others would treat them differently, and 25 per cent thought it would make them seem weak.



Overseas conflicts and disasters: the challenge of caring for those who serve ... FROM P40

In his book *Exit Wounds*, retired Major General John Cantwell wrote that although much had been done by the ADF in recent years to address mental health and promote awareness of the problem, “much of the target audience isn’t listening, or can’t bring themselves to admit that the message is aimed at them”.

Commodore Wallace said the ADF provided a range of services and support, but noted the rehabilitation success rate was higher for personnel with physical injury (72 per cent return to work) as opposed to mental health problems (40 per cent).

Lieutenant General Leahy said that for many soldiers, the transition out of the ADF was particularly difficult and problematic.

He said that despite improvements in recent years, there remained problems for soldiers leaving the ADF to access Department of Veterans’ Affairs services, and there was a lack of support for the families of returned servicemen and women during what could be a difficult transition to civilian life.

Associate Professor Owler said many returned from overseas service with multiple co-morbidities and complex care needs, providing a challenge for carers and health services.

“The medical profession has shown an enormous commitment to the care of ADF personnel and veterans over many years.

“Many doctors have and are serving in the ADF, or are part of the framework of health services put in place by the ADF and the Department of Veterans’ Affairs.

“But things can be done better, and the AMA is keen to work with the ADF, the Department of Veterans’ Affairs and personnel and veterans themselves on ways to improve the delivery and integration of services, so that all get the care they need.”

The resolution passed by the AMA National Conference has called for the development of AMA policy in a number of key areas:

- research to monitor the health of ADF personnel and veterans injured during ADF operations, to identify emerging health issues and better inform the future delivery of health services;
- arrangements for seamless health care delivery to ADF personnel and veterans, including the relationship between the Department of Veterans’ Affairs (DVA), ADF health services and other health care providers;
- the development of a unique service/veteran health identifier to improve the coordination of health care for ADF personnel move across to either DVA health care arrangements or Federal/State funded services; and
- exploring the potential to expand existing non-liability health care arrangements for veterans to a broader range of conditions beyond those currently identified.



Persistent stigma about mental health among veterans: Lieutenant Peter Leahy

Adelaide surgeon **Dr Susan Nuehas**, who moved the motion, said the draw-down of troops serving overseas, particularly in the Middle East, presented a unique opportunity for the nation to get the treatment of its veterans right.

“We have an opportunity not to repeat the mistakes of the past,” Dr Nuehas said. “This is a rare opportunity in health care, and it is important that the AMA has policies formulated to ensure that veterans get clear, comprehensive care.”

Adrian Rollins



COMMENT



Policy sessions

Global health vocational training: has its time come?

Speakers:

Associate Professor Rosemary Aldrich, Director of Medical Services, Calvary Mater Hospital, Newcastle

Dr Georgina Phillips, emergency physician, St Vincent's Hospital, Melbourne

Dr Suman Majumdar, infectious diseases physician, Burnet Institute, Melbourne

Dr Vincent Atua, Director, Emergency Department, Modilon General Hospital, Madang, PNG

Medical colleges have been put on notice that years of neglect of global health in vocational training has to end, as increasing numbers of doctors clamour for opportunities to train and work in the speciality.

Global Ideas Forum founder **Dr Lloyd Nash**, who chaired the session, said increasing awareness of, and exposure to, yawning inequities in health care around the world was driving demand among medical students, junior doctors and even well-established practitioners for global health

training.

But, Dr Nash said, the fact that few medical colleges included global health in their vocational training curricula meant that many seeking to develop a career in global health were either frustrated or left largely to their own devices in piecing together a career path.

Dr Suman Majumdar said a survey of medical students identified three main obstacles standing in the way of people pursuing a career in global health – not realising that it was an option; family and personal choices; and training pathways.

Dr Majumdar said that it can be daunting for doctors-in-training interested in global health that, which colleagues in other specialties have a clear six-year training pathway, there is nothing similar for them.

Associate Professor Rosemary Aldrich had a similar experience, albeit at a later stage in her medical career. She recounted how, when she went looking for global health training opportunities, she drew a blank.

A/Professor Aldrich, who is part of a group of like-minded doctors who have developed a draft Global Health Practice Curriculum that is being considered by the Royal Australasian College of Physicians, said that at the time there was a gap in global health training opportunities for

experienced specialists.

One of the obstacles most commonly raised is discussions about global health training is the challenge of identifying appropriately skilled and experienced supervisors to oversee in situ training in resource poor countries.

But **Dr Georgina Phillips** told the Conference this was far from an insurmountable problem.

Dr Phillips talked of the success of the Visiting Clinical Lecturer Program she helped set up involving the Divine Word University and the Modilon General Hospital in Madang, PNG.

She said under the program, advanced emergency medicine trainees lived at Divine Word University and provided academic, clinical and bedside teaching for rural health students, as well as working alongside their PNG colleagues.

Dr Phillips said, where a placement lasted longer than three months, the VCLP was recognised as a valid site of training by the Australasian College for Emergency Medicine.

The Conference heard a first-hand account from Modilon General Hospital Emergency Department Director Dr Vincent Atua about what the Program had meant for his hospital and patients.

Dr Atua said the arrangement had resulted in “huge improvements” in the delivery of emergency care, including a much better organisational culture.





Global health vocational training: has its time come? ... FROM P42

An important spin off, he said, was the development of a Primary Trauma Care course, which had seen 500 local primary health care workers receive training in trauma care.

Dr Atua said that, so far, eight local specialist emergency physicians had been trained with support from physicians and instructors who had come to PNG under the Visiting Clinical Lecturer Program.

Dr Nash said one of the biggest concerns for colleges was that they lacked the systems and expertise to provide the necessary personal support for trainees working in resource poor countries.

But he told the Conference that, rather than trying to develop such capacity in house, it made more sense to look at developing partnerships with organisations like Australia Volunteers Abroad, which already had extensive experience arranging for the safe and effective placement of staff in challenging environments.

Dr Suman Majumdar said a survey of medical students had identified

Adrian Rollins



INFORMATION FOR MEMBERS

AMA Careers Advisory Service

From graduates preparing their first resume to experienced doctors seeking to carve out a new career path in the Commonwealth public service, the AMA Careers Advisory Service is been on hand to provide practical advice and information.

Since the Service was launched in September, AMA Careers Consultant, Kathryn Morgan, has handled dozens of inquiries from members looking for help and advice on advancing their careers, both within medicine and beyond.

The Careers website, which is at: <http://careers.ama.com.au/>, gives members access to both general and specific careers advice and information. In addition to direct links to external websites and specific sources of information, the Service also offers practical advice for medical professionals as their medical careers advance.

The Careers Service provides information and support relevant to all stages of an individual's career, from medical students looking for assistance preparing internship applications - particularly writing resumes and covering letters - through to doctors in training who want to brush up their interview skills to give them a competitive edge at all-important medical college interviews.

But the Service is not only there for those in the early stages of their medical careers. It has also helped qualified medical professionals looking to apply their skills and expertise in jobs beyond

medical practice. Among these have been those looking for non-clinical roles in Commonwealth and State public services that take advantage of their skills and experience.

The Service is constantly updating content on its website, including listings of career-related events being staged across the country, and uses feedback from members to help add and develop resources.

Members are encouraged to visit the website, if they haven't done so already, and we welcome feedback, which can be submitted via the online feedback form on the website.

There will be further updates on developments in the Careers Service in coming months as we develop more ways to assist members along their medical career path.

If you or your colleagues would like to convene a skills workshop facilitated by Kathryn, please contact her at:

**Phone: (02) 6270 5410;
1300 884 196 (toll free)**

Email: careers@ama.com.au



Other resolutions

AMA puts vaccinating pharmacists on notice

The AMA has stiffened its resistance to attempts by pharmacists, nurses and other health professionals to exceed the limits of their training and encroach on areas of medical practice.

The AMA National Conference endorsed a strongly-worded motion proposed by Dr Xavier Yu and Dr Stuart Day highlighting concerns that the push by several occupational groups to expand their scope of practice is happening without adequate scrutiny and is putting patients at risk.

The issue has leapt to national prominence after the Pharmacy Board of Australia late last year declared that it believe vaccination was within the current scope of practice of pharmacists, and the Queensland authorised a trial under which pharmacists were given authority to administer vaccinations.

Concerns have been fuelled by remarks earlier this year from Health Minister Peter

Dutton in which he said he was willing to contemplate an expansion in the range of services pharmacists could provide.

"I don't believe pharmacists want to be doctors, nor retailers," the Minister told the Australian Pharmacy Professional Conference on 13 March. "[But] the time is right to commence a discussion about the future of pharmacy... so I am open to discussions about an agreement which pays for tangible services and interventions that will provide better patient outcomes."

In the motion adopted by the AMA National Conference, it said it was "extremely concerned" that patient safety and quality of care had been put at risk by the expansion of roles of non-medical health practitioners into areas outside their range of expertise.

The National Conference has called on the AMA Federal Council to "demand that all Health Ministers ensure that non-medical health practitioner boards enforce limits on scope of practice to those validated by comprehensive assessment on education, training and competence".

It said that Government should consult with the AMA on any proposals to substitute for the role of medical practitioners be rigorously assessed "to ensure the community continues to receive health care to the high standards they currently enjoy and deserve".

Adrian Rollins

End persecution of Turkish doctors: AMA

The AMA has added its voice to international condemnation of the Turkish Government over its decision to prosecute doctors who provided emergency care for demonstrators injured during anti-government protests last year.

At least people died and 8000 people were injured in clashes between protestors and security forces during the demonstrations, which began as a rally against a proposed park redevelopment but quickly turned into a full-blown protest against the rule of Prime Minister Recep Tayyip Erdogan.

Last month, two doctors were among more than 250 people put on trial for their role in the protests.

Turkish newspaper *Today's Zaman*

reported that Dr Selcan Yüksel and Dr Erenç Yasemin Dokudag were charged with "praising a criminal, insulting religious values and damaging a mosque".

Dr Yüksel, of Istanbul Medical School's Çapa Hospital, said she had to get off a minibus at Kabatas on the day of the incident because the roads had been blocked. When she saw injured people being taken to the Bezm-i Alem Valide Sultan Mosque, she ran to their assistance, acting on her "doctor's reflexes," according to the *Today's Zaman* report.

Dr Yüksel told the court: "There were people under the influence of tear gas, people who had been hit by canisters, people who had broken limbs and people bleeding. I entered the mosque to help people as a doctor with training in treating trauma and general surgery. There were a lot of people. If we hadn't helped them, many people would have died, or people with broken body parts could have lost limbs."

Dr Dokudag said it was "an extraordinary situation, like an earthquake or a flood. We are being accused of praising a criminal, insulting religious values and damaging a mosque. This can't possibly have been our purpose. We acted on our professional reflexes. We were taught that it is a crime not to do what we did."



End persecution of Turkish doctors: AMA ... FROM P44

The AMA National Conference unanimously passed a resolution calling on the Turkish Government to immediately drop legal action against the doctors.

The call came as international medical leaders – including World Medical Association (WMA) President, Dr Margaret Mungherera; British Medical Association President, Sir Sabaratnam Arulkumaran and Vice President of the Thailand Medical Association, Professor Teerachai Chantarojanasari – attended the AMA National Conference in Canberra to discuss global health issues.

The WMA, along with 10 international medical organisations, has raised concerns over the actions taken against the Turkish Medical Association and provisions contained in the new Turkish health law that criminalise emergency medical care and require routine reporting of all confidential patient information to state authorities.

Outgoing AMA President Dr Steve Hambleton said the Turkish government had an obligation to respect the sacred duty of physicians to care for those in need and to uphold people's right to health care.

"The AMA agrees that Turkish judicial authorities should safeguard international principles of medical neutrality and medical ethics and ensure doctors are not sanctioned on the grounds of having complied with these principles," Dr Hambleton said. "The AMA strongly encourages other

medical organisations, both domestically and internationally, to publicly support the Turkish doctors and their right to adhere to the principles of medical ethics and medical neutrality."

"The AMA will be raising this matter with the Australian Government," Dr Hambleton said.


The resolution passed by the AMA National Conference called for the AMA to:

- strongly advocate for the rights of doctors in Turkey to provide medical care to the ill, injured, and unwell in any situation without fear of physical, professional, or legal sanctions from their government and ministries;
- publicly condemn the new laws in Turkey, which are not compatible with a democratic or just civil society, and are both an infringement of citizens, and their doctors, civil liberties, and grossly unethical;
- immediately join with, and add its support to, other like-minded medical groups who have already acted on this issue, and to encourage other medical groupings nationally and internationally to do so; and
- immediately call for the Australian Government, as a friend and ally of Turkey, to advocate that the Turkish government rescind these laws and end the persecution of doctors carrying out their professional duty.

Adrian Rollins



RESTORE SIGHT FOR JUST \$25




**We need to perform
12,000 operations each month**

Three out of four people who are blind can have their sight saved or restored. In some developing countries the operation to overcome cataract blindness can take only 20 minutes and cost just \$25.

Each month, our goal is to restore sight to 12,000 people. Donate now to help us continue Fred's work.

DONATE NOW
1800 352 352
www.hollows.org.au

 **The Fred Hollows
Foundation**



Awards

Dr Haikerwal recognised for gold medal service to health

Former AMA President and prominent GP Dr Mukesh Haikerwal has been awarded the prestigious AMA Gold Medal, the Association's highest honour, in recognition of his outstanding service to the medical profession and the community.

In one of his last acts as AMA President, Dr Steve Hambleton bestowed the award on Dr Haikerwal in a ceremony at the AMA National Conference Gala Dinner.

Dr Hambleton told the dinner Dr Haikerwal had been a leading figure in the medical profession for many years, and his long list of significant and enduring achievements warranted the Association's highest accolade.

"In the last two decades, Dr Haikerwal has been an extraordinarily active and committed member of the AMA, advancing

the interests of members and patients at almost every level of the organisation," Dr Hambleton said.

Dr Haikerwal has long-standing involvement in the AMA.

He became an AMA Victoria State Councillor in 1995, rising to be State President in 2001 and, four years later, became the Federal AMA President.

The Melbourne-based GP has held numerous important and demanding positions within the Association, including Chair of the Taskforce on Indigenous Health and the Committee on the Care of Older People, as well as serving on the General Practice, Public Health, Therapeutics, and Doctors in Training committees.

But, impressive though this record of involvement is, the criteria for the Gold Award make it clear that it is not to be bestowed "by virtue only of holding any office or position within the Association".

There have been just 22 other recipients of the AMA Gold Medal, including Professor

Ian Frazer, Sir Gustav Nossal, Dr Brendan Nelson, Professor Fiona Stanley, Professor Robin Warren and Professor Barry Marshall.

In explaining his decision to nominate Dr Haikerwal for the Gold Medal, said he had been at the forefront of many issues pivotal to the health care system.

"He played a significant role in securing the future of medical practice during the indemnity crisis, he led the profession in embedding the principle and practice of informed financial consent, he highlighted the glaring deficiencies in the care of Indigenous Australians, and called attention to the risks posed by the burgeoning number of medical school places without accompanying provision for the capacity of the training pathway," Dr Hambleton said.

"Not only this but, as AMA President, he confronted the spectre of medical racism, and led the AMA in condemning abuse of international medical graduates."

One of Dr Haikerwal's abiding passions has been to advance the adoption and integration of information technologies into the practice of medicine, because of the potential to enhance the safety and quality



Dr Mukesh Haikerwal receives the AMA Gold Medal from Dr Steve Hambleton

of treatment as well as improve efficiency of, and access to, care.

Dr Hambleton said Dr Haikerwal had been instrumental in putting the AMA at the centre of the e-health debate, leading the Association's enthusiastic support for the adoption of e-health.

 MORE P47



Dr Haikerwal recognised for gold medal service to health ... FROM P46

"It is an issue that remains both essential, yet unresolved, but not for want of effort by Dr Haikerwal, who continued to work hard on e-health following his presidency, most recently as the Clinical Lead for the National E-Health Transition Authority."

Dr Hambleton said that, since leaving the AMA Presidency in 2007, Dr Haikerwal has continued to be an influential figure.

In 2008-09, he was a Commissioner on the Australian Health and Hospitals Reform Commission, which recommended major changes including the introduction of activity-based funding in public hospitals and the establishment of local hospital networks.

He is regular contributor to public debates and is looked to as a trusted advisor by Health Ministers across the political spectrum.

"Dr Haikerwal's contribution has extended beyond this nation's shores," Dr Hambleton said.

"He has been a member of the World Medical Association's Council since 2007, and in 2011 became the first Australian to be elected as Chair of the world body. In this position he has fostered the pursuit of ethical care, professional standards and the freedom of doctors to treat all people."

"Dr Haikerwal has been a keen and selfless supporter

of the AMA for many years, and has been a generous mentor and source of support for many of the Association's leaders.

"Amid all this, he has continued to maintain a busy general practice, and showed tremendous courage and determination to resume work after suffering serious injuries in 2008."

Dr Haikerwal has been recognised for his outstanding contribution with a string of honours, including the Centenary Medal, Fellowship of the AMA, the AMA President's Award and being made an Officer of the Order of Australia.

"Dr Haikerwal is a most deserving recipient of the AMA Gold Medal," Dr Hambleton said.

Adrian Rollins



A doctor's courageous dedication to his patients finally recognised

A Melbourne-based doctor whose extraordinary dedication to his patients ended up costing him his life has been posthumously awarded the AMA President's Award at the AMA National Conference.

In a moving ceremony, outgoing AMA President Dr Steve Hambleton presented the family of Dr Bernard Quin with the Award in recognition of his dedication and sacrifice.

Dr Quin, a Victorian GP and member of the British Medical Association (Victoria Division – now AMA Victoria) was



Dr Steve Hambleton presents the Presidents Medal to Dr Bernard Quin's son, Father Peter Quin

executed by Japanese troops occupying Nauru during the Second World War.

Before the war, Dr Quin, accompanied by his wife and five children, worked for eight years on Nauru as the Australian Government Medical Officer, providing health care for the local inhabitants - many of whom had leprosy - as well as the island's expat community.

When Nauru was attacked by German raiders, Dr Quin took his family to Melbourne before returning to the island at the request of the Australian Government (who made him an honorary captain) to provide medical care for Australian troops and the local population.

At the end of 1941, the Japanese began bombing Nauru, and the Australian troops withdrew. But Dr Quin and four other Australians, including the island's Administrator Lt Colonel Frederick Chalmers and pharmacist W. Shugg, courageously elected to stay, a decision that ended up costing them their lives.





A doctor's courageous dedication to his patients finally recognised

... FROM P47



The Japanese invaded and occupied the island in mid-1942, and took Dr Quin and the other Australians prisoner.

They endured months of privation, including virtual starvation, such that by the beginning of 1943 Dr Quin was unable to walk.

The end came in March that year, when a US squadron bombed the island and Dr Quin and his compatriots were executed by the Japanese troops in retaliation.

Dr Hambleton said the story was harrowing and confronting, but Dr Quin's conduct was inspiring.

"Dr Quin would have known the risks to his own safety by staying on Nauru after the Australian troops had left," the AMA President said. "His professionalism and dedication to the Nauruan people led him to make a truly courageous decision to stay, to not abandon them, and for that decision he paid with his life."

Dr Hambleton said Dr Quin was far from the only casualty in the story. His wife Mary and five children knew that his personal safety was at risk, but did not find out for two years that he had died. He never had a funeral.

To add to their anguish, their loss has never been officially recognised, the AMA President said: "The Australian War Memorial cannot formally recognise Dr Quin as he was not a serving member of the Australian Armed Forces, nor was he assisting Australian military forces when he was killed".



Dr Steve Hambleton with the Quin family following the award ceremony at the National Convention Centre, Canberra

Dr Hambleton paid tribute to the tireless efforts of Dr Quin's family to have his sacrifice acknowledged, and said the AMA was proud to recognise his devotion to his patients.

"It is fitting for the AMA to offer him proper recognition and to uphold Dr Quin as an exemplar of the provisions of the Declaration of Geneva, by which a doctor pledges to consecrate his or her life to the service of humanity.

"We are proud and honoured to recognise his exceptional service as a medical practitioner – his selfless commitment and

devotion to the people of Nauru embodies what it truly means to be a doctor."

Dr Hambleton said that, in honouring Dr Quin, the AMA also paid tribute to "those members of our profession who have put their patients' needs above their own in order to provide ongoing care for others, and who have never been formally acknowledged".

The award was accepted by Dr Quin's son Peter, who attended the ceremony with more than 50 family members.

Adrian Rollins





SA dodges a bullet as Victoria runs out of puff on tobacco control

A last-minute decision to ban smoking in outdoor dining areas spared the South Australian Government the ignominy of being the joint recipient of the malodorous AMA/ACOSH Dirty Ashtray Award at the AMA National Conference.

In a ceremony before more than 100 guests, AMA Victoria President Dr Tony Bartone was forced to accept the Award – bestowed on the State or Territory that in the past year has done the least to protect its citizens from the hazards of smoking – after the SA Government’s move two days earlier to prohibit smoking in alfresco dining areas and restore funding for anti-smoking campaigns left Victoria alone at the bottom of the nation’s tobacco control league table.

The judges of the annual AMA/ACOSH National Tobacco Scoreboard, now in its 20th year, gave the Victorian Government a C for its failure to crack down on smoking in a wide range of public locations areas including outdoor eating areas, entrances to buildings, hospital grounds, and areas adjacent to ventilation ducts.

In addition, Victoria was castigated by the judges for failure to take specific action on rates of smoking among pregnant women, new mothers and those with a mental illness.

They lamented that the State, which had for many years had been the national leader in tobacco control, had fallen

behind the other jurisdictions in its actions to protect Victorians from the effects of tobacco, and needed to reinvigorate its efforts.

By contrast, both the Australian Capital Territory and Tasmania were both given an A grade.

The ACT was recognised for its “excellent legislation addressing exposure to passive smoking as well as comprehensive legislation on restrictions on tobacco marketing”.

It was also given credit as the first jurisdiction to withdraw government investments from the tobacco industry and, in addition to a prohibition on all point-of-sale advertising, it is considering limiting the number of retailer licences, restricting tobacco sale hours and jacking up license fees to sell tobacco.

Tasmania received marks for its vigorous anti-smoking campaigns and strong passive smoking laws, and received kudos for some of the most comprehensive and effective laws against smoking in public places and work vehicles in the nation. In addition, the State prohibits all point-of-sale advertising, with no exemptions and has comprehensive bans on retailer and customer reward schemes for tobacco products.

New South Wales, Western Australia, Queensland, South Australia and the Northern Territory were all awarded a B grade, indicating that while they deserved credit for continuing to act on smoking, they could and should be doing more.

The New South Wales Government lost marks because of its decision to cut spending on mass media anti-smoking



An unimpressed AMA Victoria President, Dr Tony Bartone, reluctantly accepts the Dirty Ashtray Award from Dr Steve Hambleton

campaigns, while the WA Government was told it needed to close a loophole that allowed smoking in beer gardens, the Queensland Government tarnished its record by allowing exceptions to the ban on smoking in licensed venues and investing tobacco companies, an issue that also cost the Northern Territory points.

Adrian Rollins



COMMENT



Anaesthetics pioneer applauded by colleagues

A Melbourne-based anaesthetist who has won international recognition for her investigations into the phenomenon of patient awareness during anaesthesia has been recognised with the AMA Woman in Medicine Award.

Head of Research at Royal Melbourne Hospital's Department of Anaesthesia and Pain Management, Professor Kate Leslie, was presented with the award by outgoing AMA President Dr Steve Hambleton during a ceremony at the AMA National Conference.

Dr Hambleton said the award was made in recognition of Professor Leslie's outstanding contribution to improving the quality of care for patients in Australia and internationally, as well as her service to the medical profession.

"Professor Leslie is a leader in every sense of the word," Dr Hambleton said.

"Not only is she recognised internationally for the contribution she has made to understanding and improving the use of anaesthetics, she is immediate past president of the Australian and New Zealand College of Anaesthetists, is immediate past Chair of the Committee of Presidents of Medical Colleges, has extensive research interests and is directly engaged in teaching the next generation of anaesthetists."

Professor Leslie's work on patient awareness has helped refine the administration of anaesthetics, including through the use of brain monitoring.

"Every year, millions of patients are given anaesthetics, and Professor Leslie's work has helped make their use safer, with fewer complications and adverse events," Dr Hambleton said.

Professor Leslie has published more than 140 research papers and made more than 170 research presentations, and has devoted countless hours to her profession, including helping train aspiring anaesthetists and undertaking vital work accrediting the education programs of specialist colleges and hospitals, both in Australia and internationally.

"Professor Leslie's long list of achievements make her a deserving winner of the AMA Woman in Medicine Award," he said.

Adrian Rollins

Time to bust the myths on Aboriginal health

Decades spent caring for remote Indigenous communities on the wrong side of the nation's infamous health gap has left 2014 AMA Indigenous Peoples' Medical Scholarship winner, Wayne Ah-Sam, determined to bring health inequality to an end.

For almost 20 years, Mr Ah-Sam, a proud Kalkadoon/Gungandji man, did what he could as an Aboriginal health worker to improve health and relieve suffering in far-flung communities across Australia's Top End.

But, two years ago, Mr Ah-Sam realised a new approach was needed.

"I had seen a lot of health issues and inequality which have greatly impacted on our people's health," the father of four said.

"I felt that, as a health worker, I was only scratching the surface of a deep-rooted problem.

"I felt that I could do more to help my people's plight, which forced me to make a decision – stay as a health worker, or maybe study medicine."

Now in his second year of a Bachelor of Medicine degree at the University of Newcastle, Mr Ah-Sam believes that, as a doctor, he will be able to achieve much more to improve Aboriginal and Torres Strait Islander health.

"I want to be a voice for my people as I sit at the table with the policymakers to maybe influence or effect changes that have positive outcomes," he said.

"There are a lot of negative stereotypes and myths about Aboriginal people and their health.

"Our health can be different and better, just by the changing attitudes, views and beliefs of the broader Australian community and the powers that be."

Outgoing AMA President, Dr Steve Hambleton, presented Mr Ah-Sam with the AMA Indigenous Peoples' Medical Scholarship, valued at \$9000 for each year of study, in a ceremony at the AMA National Conference.

Dr Hambleton said the scholarship was designed to





Time to bust the myths on Aboriginal health

... FROM P50



Dr Steve Hambleton with Wayne Rah-Fam

encourage and support Indigenous students who are preparing for careers in medicine, particularly those intending to work in Indigenous communities, and Mr Ah-Sam was a worthy recipient.

"The AMA understands and supports the unique contribution Indigenous health professionals and Aboriginal-controlled health services can make to close the gap and improve the health of Indigenous people," Dr Hambleton said.

Mr Ah-Sam said he intended to "return

home" once he finished his degree.

"I see myself returning to country and going to where I am needed the most – somewhere in an Indigenous remote community back home," he said.

The scholarship was established in 1995 with a contribution from the Commonwealth Government.

Adrian Rollins

COMMENT

Caring for those on the fringe

A Turkish-born GP who has broken down barriers to the treatment of socially isolated and marginalised communities in rural Victoria has won the AMA Excellence in Healthcare Award for 2014.

Dr Mehdi Sanati Pour, who works as a GP in Mildura, has been recognised for his extraordinary work in overcoming cultural, social and linguistic barriers to provide specialist care, especially mental health services, for many unwilling or unable to access mainstream health services in the Sunraysia region.

Presenting the Award at the AMA National Conference, outgoing AMA President Dr Hambleton said Dr Sanati Pour had, in the

best traditions of the medical profession, strived to ensure quality health care was provided for all in his community, including many groups that often fall through the cracks of the health system.

Dr Sanati Pour, who trained in and practised medicine in Turkey before migrating to Australia, began working in the Victorian public hospital system in 2005. In 2008, he moved to Mildura where he undertook GP training and joined a busy local practice.

Dr Hambleton said that during his training in Mildura, Dr Sanati Pour realised there was a shortage of specialised services in rural and regional areas, particularly for culturally and linguistically diverse groups.

"Dr Sanati Pour saw how differences in language and culture can throw up big barriers that hamper access to medical services, and he has taken it upon himself to try and bridge these gaps in health care."

Among his initiatives, Dr Sanati Pour has organised health workshops and assessments for the local Turkish community; after-hours Pap smear sessions, run by a female Pap smear nurse, to provide screening and health information for women in full-time work and those for whom cultural and religious



Dr Mahdi Sanati Pour accepts his award

issues preclude regular health checks by male GPs; as well as a weekly refugee health clinics where recent arrivals are given comprehensive health assessments, including of their mental health.

"This award recognises and acknowledges Dr Sanati Pour's tireless efforts to achieve the best possible health outcomes for the Sunraysia community, particularly for those who – for reasons of culture, language and social isolation – might otherwise not get the care they need," Dr Hambleton said.

"He is truly a worthy winner of the AMA Excellence in Healthcare Award."

Adrian Rollins

COMMENT



A year of achievement, state by state

Getting governments to admit they were wrong and convincing them to change course is never easy, but State and Federal AMAs who managed to achieve just such feats were feted in a ceremony at the AMA National Conference.

Outgoing AMA President Dr Steve Hambleton presented a string of awards recognising the outstanding success of AMA organisations around the nation in saving governments from themselves and lobbying for better outcomes for their patients and communities.

The details of the awards were:

Best Lobby Campaign 2014 – AMA South Australia

**‘Co-location of the Women’s and Children’s Hospital
with the new Royal Adelaide Hospital’**



AMA South Australia President Dr Patricia Montanaro accepts the Best Lobby Campaign Award

The relentless and strategic efforts of AMA South Australia resulted in the State Government and Opposition changing their respective policies and locking in support for the co-location of the Women’s and Children’s Hospital with the new Royal Adelaide Hospital.

Dr Hambleton said it was a very significant outcome, achieved by AMA South Australia through its insistence that clinical outcomes be accorded the same importance as efficiency in assessing the co-location plans. The co-location of the two services will ensure that women facing pregnancy and birthing complications will receive the best possible health care.

AMA South Australia lobbying helped convince the SA Government to overcome its long-held reluctance and commit to invest \$600 million in the project.

The judges were impressed with the effectiveness of AMA South Australia’s campaign, which centred on demands for a better functioning hospital system.

Best Public Health Campaign 2014 – AMA New South Wales

‘Alcohol-related Violence’



AMA WA President Dr Richard Choong accepts the National Advocacy Award

AMA New South Wales showed great leadership and resourcefulness in creating the ‘Alcohol-related Violence’ campaign.

Conducted amid a spate of violent assaults linked to drinking, the campaign effectively highlighted the serious health consequences of the nation’s drinking culture.

The campaign’s blunt but carefully worded messages hit the mark, and continued to be heard even amid NSW’s tragic toll of alcohol-fuelled deaths and injuries.

The campaign was characterised by close collaboration with other concerned organisations, which was a great strategy to extend its reach and change attitudes.



A year of achievement, state by state ... FROM P52

Best State Publication 2014 – AMA New South Wales

‘The NSW Doctor’



AMAQ President-Elect Dr Shaun Rudd accepts the New Media Award

The Best State Publication prize was awarded to *The NSW Doctor* for the quality of its research and the variety of issues covered in every edition. Government decisions and election commitments that affect the medical profession were thoroughly examined, leaving readers confident they were fully informed.

One judge remarked that, “[The NSW Doctor] covered

a wide range of issues of appeal to all sections of the medical profession, including doctors in training, mental health, Alzheimer’s disease, and an interesting piece on health care in Western Sydney.”

Feature articles were characterized by great attention to detail, and regular interviews with leading personalities such as Ita Buttrose were well written and informative.

National Advocacy Award 2014 – AMA Western Australia

‘Campaign against Curtin University Medical School’

AMA Western Australia took a lone and courageous stand when it decided to oppose plans for a new medical school at Curtin University, which had backing from within the WA Government as well as other medical professions.

The advocacy effort undertaken by AMA Western Australia was diligent and persistent. AMA Western Australia was effective and made sure that its messages could not be ignored. Adding to its effectiveness, AMA WA engaged in public debate in a manner that upheld its dignity and status.

Most Innovative Use of Website or New Media 2014 – AMA Queensland

‘AMAQ Website’

The new Health Vision Blog site developed by AMAQ has made a space for the medical community to converse and



AMA NSW President Dr Saxon Smith accepts the Best State Publication Award

share views on important health care challenges. Blog contributors have written about end-of-life care, workforce and training, public and preventive health, creating a unified health system, and reprioritising care in response to changing demands.

The space provided for feedback and discussion is highly valued by users, and is a source of great insight for AMA Queensland in helping it to keep up with issues of importance to the medical profession.

The AMA Queensland last year also launched a user friendly website. The new look website is fresh, vibrant, and easy to navigate.

Adrian Rollins





Study of shortcomings in care wins \$10,000 prize

A study of the rates of guideline-recommended investigations and therapies for acute coronary syndrome (ACS) was awarded the annual MJA/MDA National Prize for Excellence in Medical Research at the AMA National Conference.

The paper, published in the *Medical Journal of Australia*, was entitled “*Acute coronary syndrome care across Australia and New Zealand: the SNAPSHOT ACS study*”, and looked at variations in the care of patients with acute coronary syndrome despite the presence of well-developed clinical guidelines.

Using data from local registries in Australia and New Zealand, the researchers found there was incomplete implementation of evidence-based guideline recommendations, with variations in care appearing to correlate with differences in clinical outcomes.

Geographical challenges, patient characteristics (including cultural diversity), health workforce and the health policy environment were identified as likely factors contributing to the uneven application of the guidelines.

This study set out to measure rates of guideline-recommended interventions and in-hospital clinical ACS events using public records and health network data from 478 sites and 4398 patients with suspected or confirmed ACS across Australia and New Zealand.



Dr Dereck Chew accepts the MJA-MDA Award from Dr Steve Hambleton and Dr Rosanna Capoolingua

Of the 1436 patients with myocardial infarction (MI), 1019 (71 per cent) were treated with angiography, 610 (43 per cent) with percutaneous coronary intervention, and 116 (8 per cent) with coronary artery bypass grafting.

The in-hospital mortality rate was 4.5 per cent, and the recurrent MI rate was 5.1 per cent.

After adjusting for patient risk and other variables, significant variations in care and outcomes by hospital classification and jurisdiction were evident.

The authors identified variations in the application of the ACS evidence base and varying rates of in-hospital clinical events.

They concluded that “a focus on integrated clinical service delivery may provide greater translation of evidence to practice and improve ACS outcomes in Australia and New Zealand”.

The judges from the *MJA*'s Editorial Advisory Committee recognised that this research, conducted with robust and transparent methodology in a difficult real-world setting, contributes to the very important endeavour of improving the health of patients with suspected and confirmed acute coronary syndrome.

The prize was \$10,000.





New members of the AMA Roll of Fellows

Two former State AMA Presidents and a leading GP advocate were inducted into the AMA Roll of Fellows at the AMA National Conference.

In a formal ceremony highlighting the outstanding contribution they had each made to the AMA and medical profession, former AMA Queensland President, **Dr Alex Markwell**, former AMA Victoria President, Dr Stephen Parnis and leading GP advocate **Dr Stephen Wilson**, were added to the Roll of Fellows by outgoing AMA President Dr Steve Hambleton.

"The new Fellows have all excelled in their medical careers, across many specialties," Dr Hambleton said. "At the same time, they have dedicated themselves to working to improve conditions for doctors, and to make the Australian health system work more effectively for patients and communities."

The following are excerpts from their citations:

Dr Alex Markwell

Ever since graduating from the University of Queensland in 2002, there have been two enduring threads running through Dr Markwell's work and activities – a commitment to the well-being of her patients and the broader community, and a determination to improve the lot of the medical profession.

As President of AMA Queensland in 2012 and 2013, the emergency physician was a tireless champion of policies to improve well-being, including by enhancing health literacy and tackling the social determinants

of health to reduce the burden of preventable disease, most notably trauma-related injury and death, and lifestyle-related conditions such as type 2 diabetes.

Dr Markwell has also been a consistent and effective advocate for improved medical education, including as Chair of AMA Queensland's Council of Residents and Registrars, and later as Chair of the Federal AMA Council of Doctors in Training. She has fought hard on behalf of junior doctors to increase clinical training capacity, improve work hours, and safeguard doctor health. This commitment has also carried



Dr Steve Hambleton with AMA Role of Fellows inductees, Dr Alex Markwell, Dr Stephen Parnis and Dr Stephen Wilson

through to her work as a Senior Lecturer at the University of Queensland.

In recognition of her selfless and tireless efforts, which embody the AMA's ethos of integrity and care for both patients and members, Dr Markwell has been appointed the inaugural Ambassador for the AMAQ Foundation.

Dr Stephen Parnis, MBBS DipSurgAnay FACEM

Throughout an interesting and varied medical career that has taken him across the country and across the world, Dr Parnis has had a keen and abiding interest in medical education and training.



New members of the AMA Roll of Fellows

... FROM P55

Through more than a decade of activism, the emergency physician - who recently completed a two-year term as AMA Victoria President - has been at the centre of big issues that have shaped and, at times, threatened to derail, medical education.

As current Chair of the AMA Council of Salaried Doctors, an Australian Salaried Medical Officer Federation Councillor, a long-serving Chair of the AMA Victoria Industrial Relations Subcommittee and a member of the Medical Training Review Panel of Australia, Dr Parnis helped see off Federal Government plans to cap tax deductions for self-education expenses (the successful 'Scrap the Cap' campaign), helped medical trainees win representation in medical Colleges, and led the successful negotiation of ground-breaking enterprise agreements for doctors in training and medical specialists in Victoria.

Important as this work has been, Dr Parnis has also thrown himself into promoting public health. He is a vigorous and resilient advocate who has been at the forefront of AMA Victoria efforts to reduce the harm caused by smoking

and alcohol, stamp out attacks on health workers and improve end of life care.

Dr Stephen Wilson

General practice can have few more passionate and effective advocates than Dr Wilson.

The Perth-based GP, who has been in practice for almost 30 years, is active at all levels of the AMA and Government advancing the interests of general practitioners and their patients.

The former AMA WA Vice President is a long-serving Chair of the AMA WA General Practice Council, and since 2008 has also been an important member of the Federal AMA Council of General Practice.

Dr Wilson's keen sense of justice and fairness has led him to practise in less affluent communities where the need for his services has been greatest, and he has been a prominent critic of policies that increase health costs.

In keeping with his concern about access to health care, Dr Wilson has long pushed for GP shortages in regional areas to be addressed, and is a knowledgeable advocate for better use of information technology in providing health care.

Adrian Rollins



INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

The AMA Council of General Practice has developed a resource that brings together in one place all the forms, guidelines, practice tools, information and resources used by general practitioners in their daily work.

The GP Desktop Practice Support Toolkit, which is free to members, has links to around 300 commonly used administrative and diagnostic tools, saving GPs time spent fishing around trying to locate them.

The Toolkit can be downloaded from the AMA website (<http://ama.com.au/node/7733>) to a GP's desktop computer as a separate file, and is not linked to vendor-specific practice management software.

The Toolkit is divided into five categories, presented as easy to use tabs, including:

- online practice tools that can be accessed and/or completed online;

- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

In addition, there is a State/Territory tab, with information and forms specific to each jurisdiction, such as WorkCover and S8 prescribing.

The information and links in the Toolkit will be regularly updated, and its scope will be expanded as new information and resources become available.

Members are invited to suggest additional information, tools and resources to be added to the Toolkit. Please send suggestions, including any links, to generalpractice@ama.com.au



Social functions - Image Gallery

Click on the links below to load galleries

Gala Dinner



Canberra's National Arboretum was the spectacular venue for the Gala Dinner, held on Saturday, 24 May. At the dinner, World Medical Association Chair of Council, and former AMA President, Dr Mukesh Haikerwal was presented with the AMA's highest honour, the Gold Medal.

Leadership Dinner



Australian War Memorial Director and former AMA President Dr Brendan Nelson was the guest speaker at the annual Leadership development Dinner. The dinner, organised and hosted by the AMA Council of Doctors in Training, was held on Friday, 23 May at the Australian War Memorial.

Cocktail Function



More than 100 delegates attended the President's Welcome Reception at Canberra's National Convention Centre on Friday, 23 May. At the reception, outgoing AMA President Dr Steve Hambleton presented a string of awards including National Tobacco Scoreboard Achievement Award, the AMA/ACOSH Dirty Ashtray Award, the AMA Woman in Medicine Award, the AMA Excellence in Healthcare Award and the AMA Media Awards.



BY PROFESSOR
STEPHEN LEEDER

The budget war

Dust from the explosion of the Budget bomb has yet to settle. It is hard to see what buildings remain and what the final body count will be.

Co-payments for bulk-billed consultations will preferentially affect those least able to pay - the less well-off and the self-funded retiree struggling with the costs of diabetes and heart disease. Co-payments are the biggest bomb craters immediately visible that distress and upset just about everyone.

As in war, logic and truth were early casualties. We were told for months before the Budget that the health system was unsustainable, yet the evidence suggests otherwise.

The argument was economic, meaning that we are running out of money, which is nonsense. The determination of sustainability is political - as a rich society we can sustain what we want to sustain, be it war or peace. We can buy jet fighters, detention camps or hospitals at will.

Co-payments were touted as a way to make us all pay more at the point of use of health care and so rescue health care from bankruptcy. But in general practice? This is not where the big costs are. Co-payments were dropped from the sky.

Smart bombs at that - not blitzing the wealthy but those who are bulk billed - served by the least politically powerful medical craft group. Massive opportunities for efficiency savings in hospitals and the pharmaceutical supply

line were ignored, presumably because they would require intelligent analysis, political effort, recruitment of the medical profession to formulate policies, and guts.

Then, miraculously, when the budget was released like a missile from a drone, the sustainability of health care was no longer a reason for attack. Instead, (taking a page from the Gospel of Bush and Blair, like the missing weapons of mass destruction in Iraq), the unfindable unsustainability crisis did not deter those with their fingers on the buttons.

Co-payments, now rebadged as a revenue stream to fund a Medical Research Future Fund that the College of Physicians - perhaps with irony or perhaps not - termed "visionary", were fired off to the amusement of the Prime Minister sitting listening to Budget. Funny weird, yes, but not funny funny.

The Medical Research Future Fund will support research decades hence that, the Treasurer believes, will enable us to cure diseases such as dementia and the degenerative disorders that are now epidemic worldwide. Oddly, the fact that these diseases can be prevented was not only dismissed, but the money for preventive programs - and a national agency designed to deal with the forces such as food, alcohol, tobacco and urban design that cause these problems - was removed, much to the delight of the brewers and the food industry. Too much prevention would mess with the profits

of these corporations and diminish the market for pharmaceutical cures for the diseases researched in coming decades with money from the research fund.

The lack of logic and policy manifest by the recent health budget is not just breathtaking. It is asphyxiating.

“ The jumble of ideas is haphazard, insensitive to (one must charitably assume) unintended but fully predictable side effects, and disingenuous in its use of erroneous scare tactics about sustainability ”

The jumble of ideas is haphazard, insensitive to (one must charitably assume) unintended but fully predictable side effects, and disingenuous in its use of erroneous scare tactics about sustainability.

Strong resistance to its more ethically objectionable elements, of which the co-payment is paramount, is surely justified. We deserve much better than this.

This Budget is a disastrous beginning for the new government.



BY DR BRIAN MORTON

\$7 MBS co-pay fails to pass the means test

There has been so much focus on the \$7 co-payment measure announced in the May Budget that the community seems largely unaware that the Government is also proposing that Medicare rebates for GP attendances, along with rebates for pathology and diagnostic imaging services, will be cut by \$5. Every other MBS item will have also effectively be cut because of the freeze on indexation.

I'm not quite sure how Health Minister Peter Dutton thinks he is strengthening general practice. The Government is simply withdrawing significant support for patients to access frontline care and shifting more costs on to them.

In addition, the Government seems to have given little thought to the costs that will be imposed on practices as they endeavour to collect the \$7 co-payment.

GPs visiting residential aged care facilities will be expected to collect \$7 from each patient they see. Some practices will require more equipment, a larger reception desk, and more staff to process payments, manage bad debts and do the banking. There will be additional processing costs with EFTPOS fees and transaction costs. It will mean having to run a cash float and all the additional security concerns, cost and headaches that go along with that.

For one period of illness there will be multiple \$7 co-payments that have to be collected. This

will be particularly difficult for pathologists, as they rarely see the patient. If GPs are expected to collect the \$7 on their behalf, that will only add to the administrative burden for practices.

With this proposal, the Government is asking all patients to contribute to their health costs.

If patients cannot afford this, the Government seems to think that GPs should act as some sort of de facto safety net. From 1 July next year, every time we waive the MBS co-payment we will be taking at least a \$5 cut in our pay for the service – if a patient holds a concession card or is younger than 16 years the hit to income will be \$13 to \$16.10.

The Government is also going to exclude the \$7 paid out-of-pocket from counting towards the new Medicare Safety Net! The Government's revised Medicare and Pharmaceutical Benefit Scheme safety nets will do less to catch those with large health care costs.

While the thresholds for the Medicare Safety Net will be reduced and streamlined, the proportion of out-of-pocket expenses that count, and the benefits payable, will be decreased. When it comes to medication, the thresholds are also set to be increased every year.

Patients with concession cards or children younger than 16 years will be expected to pay \$70 out-of-pocket before the MBS co-payment

will be waived. The Government appears to have given little thought to the needs of families or the pressure this will put on lower socio-economic groups.

This situation becomes even worse when several family members are sick at one time, or they need to make multiple visits, undergo numerous tests, and get several prescriptions, all in a couple of days. For people on benefits, cash flow will be a real problem.

“ If the Government hopes to get its co-payment measure through the Senate it is going to have to construct a better model. One that supports our sickest and most vulnerable, and the practitioners who care for them ”

If the Government hopes to get its co-payment measure through the Senate it is going to have to construct a better model. One that supports our sickest and most vulnerable, and the practitioners who care for them.

The AMA stands ready to assist the Government to get this right, to make sure there is better support for our vulnerable patients and for those who are at the frontline of their medical care.



BY DR JAMES CHURCHILL

“ These decisions reek of shortsighted cost shifting, as the Federal Government looks to vacate the prevocational space ”

Sweeping Budget changes dramatically alter training landscape

In recent weeks, much has been said of the 2014 Federal Budget and its impact on patients and doctors.

Between a \$7 co-payment for each GP, radiology and pathology service, Medicare rebate cuts and few protections for the vulnerable, only a hostile Senate currently stands in the way of the Coalition Government's vision for a wholesale change to a user-pays health system.

This move to shift more costs on to patients comes at a time that health systems around the world, most notably the United States, have embraced the need for equitable access to health care for all, particularly those who cannot afford it.

After the dust has settled, however, it's clear that the Budget has also made a number of changes to the landscape of medical training. Health Workforce Australia, created by the nation's Health Ministers in 2009 to formulate a National Training Plan for Australia's medical workforce, will be dissolved, with its functions transferred to the Commonwealth Department of Health.

While the Government is promising that a commitment has been made to continue essential projects, including the National Medical Training Advisory Network, the challenge during

the coming months will be to ensure that workforce planning expertise is retained and no momentum lost during the move from Adelaide to Canberra.

General Practice Education and Training is also being absorbed by the Department of Health, a significant shake-up for GP training, along with a proposal for future competitive tender processes for general practice training providers.

The Confederation of Postgraduate Medical Education Councils was also singled out for a complete cut in its federal funding; nobody has been identified to pick up the CPMEC's good work in the prevocational space.

The only good news from the Budget was the creation of an additional 300 GP training places - funded, however, by cutting the valuable Prevocational General Practice Placements Program (PGPPP), which had provided up to 975 rotations for junior doctors to gain experience in general practice.

Notably, in South Australia, PGPPP had been providing required Emergency Medicine core rotations for 23 internship places, which will be cut unless additional public hospital ED rotations can be urgently found.

The consequences for later stages of training are even more significant, as the loss of these rotations threaten hundreds of prevocational posts around the country.

These decisions reek of shortsighted cost shifting, as the Federal Government looks to vacate the prevocational space.

At the same time the Federal Government expects its State and Territory counterparts to fill shortfalls in training funding it has created, it has abandoned the National Health Partnership Agreements, resulting in a reduction in growth funding for the states.

Unfortunately, the education Budget papers contained perhaps the most dangerous paradigm shift for medical education.

With an average 20 per cent cut to federal funding for each university place, lower indexation arrangements and the deregulation of student fees, universities are likely to soon be charging students hundreds of thousands of dollars for a limited number of medical places.

The effect will be a higher education system in which a medical degree will soon be completely out of reach for those not fortunate enough to have chosen rich parents.

While scholarship programs are welcome, international experience demonstrates that the prospect of high postgraduate debts deters students from poor backgrounds and can drive graduates away from less-well-remunerated specialties, such as general practice.

All in all, it's clear that the AMA Council of Doctors-in-Training has much to work on in the coming weeks and months.



BY DR STEPHEN PARNIS

Salaried doctors an essential voice in the AMA

This is my final article as Chair of the Council of Salaried Doctors. I have served on the Council for five years, including three as Chair, and believe now is the appropriate time for me to relinquish this role.

The necessary reorganization of membership records to reflect salaried doctor membership is now taking place, which delays the election of my successor. In the interim, Dr Barbara Bauert – the Northern Territory Representative on AMACSD – has kindly agreed to Chair AMACSD and represent Salaried Doctors on Federal Council.

My time with AMACSD has been thoroughly satisfying – and turbulent. In my years on the Council, we have contended with many challenging issues affecting the Australian health system.

I have written about many of these issues in *Australian Medicine* in recent years.

Of course, these articles have only touched the surface of the myriad number of issues that affect salaried doctors and their patients. To varying degrees, these issues have had a direct impact on clinical standards, working conditions, training opportunities and patient access to medical care.

In recent times, these articles have focussed on:

- palliative care and the need to better address end-of-life decisions;
- revalidation as a discussion initiated by the Medical Board, but no real details yet to be considered;
- funding cuts at both State and Federal levels, with inevitable implications for access;
- medical registration and the problems experienced with AHPRA and the 2010 national system;
- generalism as a necessary medical skill set, given the complexity of contemporary patient presentations;
- rights of private practice – a complex, long-standing, and invaluable part of public hospital work;
- clinical governance as a mechanism for improved standards of care;
- workforce issues and the challenges of training today's junior doctors through to independent practice;
- safety in the medical workplace;
- supervision of trainees as an essential part of medical education; and

- the Queensland contracts dispute – the harm that has been caused, the remedies that are being applied, and the lessons to be learned.

There is nothing minor about any of these issues.

What is clear is that, while we have a system of health care that is among the best in the world, its future is far from guaranteed.

“What is clear is that, while we have a system of health care that is among the best in the world, its future is far from guaranteed”

Providing insufficient resources will inevitably harm our ability to provide the care we expect to give, and that Australians rightly expect to receive.

One of the principal roles of the AMA is to support, represent and defend doctors and others who work to maintain our health system in the face of harsh criticism, dramatic funding cuts, personal risk, mounting workloads and responsibility, and an increasingly complex and difficult industrial landscape.

The current situation in Queensland merits special mention. We have consistently called for a less belligerent approach from the Newman Government, and an acknowledgment that the

Salaried doctors an essential voice in the AMA

... FROM P61

vilification of the medical profession in Queensland was utterly misguided. The resolution achieved in recent weeks is not perfect, but it is a much better outcome compared with what could have occurred.

I remain concerned about a broad trend away from collective bargaining, largely based on ideological motives. This is something we must monitor carefully in coming years.

We must also recognise that the issues played out in Queensland have the potential to resonate through all health systems around the country.

The dispute also demonstrated that the combined advocacy of the AMA and Australian Salaried Medical Officers Federation – working closely together, as we absolutely must – can genuinely protect the interests of doctors and the health system in which they work.

Within the AMA, the Council of Salaried Doctors has been determined to deal with the question of salaried doctor representative numbers in the AMA. This issue has been on our agenda for some years, and we consider the current constitutional reform process as the ideal time to obtain clarity around the salaried doctor membership category.

If the Queensland contracts dispute has demonstrated anything, it is that the interests and impact of salaried doctors are an essential part of the collective voice of the AMA.

As I hand over the reins to Dr Bauert, I take this opportunity to thank everyone who has been involved in the Council of Salaried Doctors for their help, support and good judgment. The importance of what we do should never be underestimated.



INFORMATION FOR MEMBERS

Medical claims for diagnostic imaging and pathology provided to patients in public hospital emergency departments

Diagnostic imaging and pathologist specialist members should be aware they are legally responsible for all services claimed under Medicare that are billed under their provider number or in their name, even if the billing was done by hospital administration.

Pathology and diagnostic imaging services for patients in public hospital emergency departments are covered by Australian Government funding arrangements and are not eligible for Medicare benefits.

Emergency patients are to be treated as public patients until a clinical decision to admit has been made and the patient has elected to be admitted as a private patient.

More information about this is available from the Medicare website: <https://www.medicareaustralia.gov.au/provider/business/audits/public-hospital-emergency-depts.jsp>

The AMA provides the following advice to members about the use of provider numbers in public hospitals:

- where medical services claimed against Medicare are being rendered

in public hospitals under a medical practitioner's name and billing provider number, the practitioner must be made fully aware of, and be prepared to accept responsibility for, that billing;

- where services claimed are being rendered in a public hospital, medical practitioners should seek a written guarantee from the hospital that the arrangement is not in breach of the relevant Australian Health Care Agreement; and
- public hospitals must provide doctors with full records of all medical accounts raised in their name.

If you believe your provider number may have been used in ways that contravene the relevant provisions in the Health Insurance Act, the AMA recommends you contact your State AMA Office. As this issue affects employment contracts, State AMAs will be able to coordinate representation for affected members.

The AMA will keep abreast of Medicare compliance matters through its participation on the DHS Compliance Working Group.



BY DR DAVID RIVETT

One Term Tony?

Considering there was no genuine consultation with doctor representative groups, and no sound input from the medical coalface, regarding proposed changes to health care financing, this was indeed an “enlightened” Federal Budget.

The litmus test for me was to see if our ‘brave’ new government embraced the deregulation of pharmacy advised by the National Commission of Audit. They did not, so I will not use the word brave in regard to this Budget again.

Though, thankfully, it is hard to picture many of the proposed Budget changes getting through the Senate in their current form, it is worth having a look at them in detail.

The first is to apply a GP tax, imposed on those who actually use health care most frequently: the aged; those stricken with cancer; children; chronic disease sufferers; residential aged care facility residents; the Indigenous; plus those who want to embrace preventative care.

In brief, it will most heavily on those most often unable to pay, and also penalises those most prepared to seek help to stay healthy (and thus reduce downstream tertiary care costs where the big dollars go). The wealthy, who could and should make co-payments, are not targeted.

Such a simplistic policy smacks of a philosophy which is un-Australian. Aussies are generous people. We care. We are not a nation of bean-counters. We value mateship, not elitism. We value caring more than costing. We are proud of our current universal access to quality health care.

Encouraging preventative health care, not discouraging it, is where the savings lie.

The \$2 “bonus” for GPs is no such thing. It will be eaten up by tax collection administration costs.

Secondly, the Budget slashes public hospital funding for the states.

Indeed, if we pursue this line of thought that less is more then, rather than embracing as heroes those citizens shaking collection cans at the roadside to support their local children’s hospital or other hospitals, perhaps we should denigrate them.

But let us get focussed.

Apparently, in the eyes of this removed-from-reality Budget, it makes economic sense to let the ill perish with minimal care. Perhaps charities focussed on expanding health care should be banned, and the seriously ill and poor not offered care but be publicly belittled and expeditiously removed. Such thinking is immoral and unsound nonsense.

Thirdly, the Budget freezes Medicare rebates for specialist consultations.

Specialists are already being hit with the Budget bail-out tax levy. Now those compassionate enough to bulk bill will see their incomes slide. Patient gaps will grow, resulting in less private care, and more demand for public care.

What is the philosophy underlying these changes? Is it stupidity? Or worse, does it reflect

a desire to see persecution of the unwell who seek taxpayer-funded care?

It certainly embraces use of barriers to the access of care, which in turn creates cost shifting to the states via public hospitals.

Fourth, the Budget applies harsh new eligibility criteria for youth unemployment benefits.

As a wealthy society with no real budgetary crisis, we do not want or need the divide between rich and poor to be accentuated.

We do not want the young unemployed persecuted and denied support.

We must realise that if we do cut this support, we will force some into crime and extremism, and many others will suffer worse mental health outcomes.

These are not attractive outcomes for society. Why cannot our elected representatives realise this?

What are the options?

These are clear.

If we must choose enforced medical co-payments, providing we seriously believe there is a fiscal crisis facing Australia, then for heaven’s sake, let’s have payments confined to those who can afford them.

That is, let them be targeted, not just applied as a blanket thrown over all and suffocating the most needy.

Secondly, cost-shifting between the states and the Commonwealth must end.

It all too often pervades and perverts policy. Perhaps a single funder of health care is the only way to be rid of it.



BY AMSA PRESIDENT
JESSICA DEAN

“For many current doctors, medical education was heavily subsidised or even free. I wonder if, had you had your time again, what would have been your debt threshold? How much would be too much?”

How much would you pay to become a doctor?

Following the release of the Federal Budget, a big question high school students around the country are asking is, “how much would you pay to study medicine?”

Currently, the student contribution to medical education costs are capped at \$9792 a year. This amount means medical graduates are left with a manageable HECS debt on completion of their degree.

But this picture is set to change.

In its Budget, the Government announced it would cut its contribution to course fees by 20 per cent, while the interest rate on student loans would go up. Furthermore, tertiary education fees are to be deregulated.

If market forces are applied, universities will be able to set their own prices. For courses such as medicine, high demand and the low supply of places will mean that course fees have the potential to skyrocket. The Grattan Institute estimates that medicine course fees could rise by as much as 270 per cent, pushing the annual cost to \$37,000 and putting the total bill for a medical degree at \$180,000.

In 2008, the Australian Government placed a legislative ban on undergraduate full-fee domestic places. Postgraduate courses, such as at the University of Melbourne, were exempt from

this ban. It is already the experience of medical students that the admission thresholds of postgraduate full-fee places are lower than that of equivalent Commonwealth Supported Places, due to financial barriers to access.

Medical school entrance should be a meritocracy, not a socioeconomic hierarchy.

For many high school students, a potential \$180,000 debt may lead them to question medicine as a career option.

If they do manage to find or borrow the money, the outlay and debt may significantly affect their future choices. There are already stories of parents mortgaging homes to fund their children’s medical education. Students struggle financially though medical school already. Long contact hours and huge workloads mean it is very difficult to maintain part-time employment while studying medicine. Combine this with inadequate income support programs, and the result for many is life below the Henderson poverty line.

Pushing up the cost of a medical degree could also exacerbate imbalances in the medical workforce.

The potential for heavy course debts to influence specialty choices is concerning. Studies have shown that increased debts from medical school

influences graduates to favour higher paid specialty pathways, and away from fields where there may be greater community need.

Beyond the inequity, this political move may lead to a sacrifice in the quality of medical school admissions.

The 2008 Bradley Review of Education found that rural, remote, Aboriginal and Torres Strait Islander students, as well as students from low socioeconomic backgrounds, already face significant barriers to tertiary education.

If we want a representative workforce, we need to work to remove such obstacles to access.

Following the Review, the-then Government committed to the goal that 45 per cent of people aged 25 to 34 years would hold a bachelor’s degree or higher by the year 2025. The changes in this Budget are likely to significantly hamper efforts to reach this goal.

For many current doctors, medical education was heavily subsidised or even free. I wonder if, had you had your time again, what would have been your debt threshold? How much would be too much?

For more information, please see AMSA’s Official Policy homepage at: <https://www.amsa.org.au/advocacy/official-policy/>

Jessica Dean is the President of the Australian Medical Students’ Association. Jessica is a 6th year Medicine/Law student at Monash University. She is currently completing an Honours Project in Bioethics at The Alfred. Follow on Twitter @AMSAPresident or @yourAMSA



BY DR ELIZABETH FEENEY

“The AMA will continue to advocate for the rights of doctors working in areas of armed conflict to carry out their ethical duties to patients and others, to care for the sick and injured impartially, without fear of prosecution or punishment.”

Honouring courageous colleagues, past and present

At this year's AMA National Conference, we had the unique opportunity to show our support for colleagues, both past and present, who demonstrate exceptional service as medical practitioners while working in areas of armed conflict.

One of the most moving moments from this year's AMA National Conference came when the President's Award was presented to the family of Dr Bernard Hazelden Quin.

Dr Quin was killed in Nauru in 1943, executed by Japanese troops along with four other Australians, in retaliation for the United States' bombing of the island.

Dr Quin originally went to Nauru with his family, his wife and five young children, to work as an Australian Government Medical Officer to care for the Australian troops as well as the local Nauran population. Dr Quin left Nauru with his family in 1941 but returned by himself on request from the Australian Government to continue to provide

medical care. Australian troops withdrew after the Japanese began bombing the island at the end of 1941; however, Dr Quin chose to stay and continue to care for the local Naurans.

Dr Quin's professionalism and dedication to the Nauran people led him to make a truly courageous decision to stay, to not abandon them, and for that decision he paid with his life.

In honouring Dr Quin with the President's Award, the AMA paid tribute to those colleagues working in areas of armed conflict who have put the needs of their patients above their own and have never been formally recognised for their sacrifice.

While the President's Award was the opportunity to honour our colleagues from the past, the AMA continues its support for doctors working overseas today in areas of armed conflict.

National Conference delegates endorsed a resolution in support of members of the Turkish Medical Association who face legal action for providing emergency medical care

to demonstrators at protests in Istanbul last year. We have highlighted this issue through the media, and will raise it with the Australian Government.

The AMA has raised similar concerns in the past in relation to colleagues in Bahrain and Syria, we have publicly supported the Australian Red Cross and International Committee of the Red Cross (ICRC) 'Global Life & Death' campaign, and we have formally adopted the adopted the World Medical Association's *Regulations in Times of Armed Conflict and Other Situations of Violence, Declaration of Seoul on Professional Autonomy and Clinical Independence, Declaration of Geneva, and the Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*.

The AMA will continue to advocate for the rights of doctors working in areas of armed conflict to carry out their ethical duties to patients and others, to care for the sick and injured impartially, without fear of prosecution or punishment.

We will continue to campaign for governments to protect doctors and other health care workers so that they may undertake their professional duties in relative safety. Through our advocacy, we honour our colleagues, both past and present, who have placed themselves at great personal risk to care for others during conflicts throughout the world.

COMMENT



BY DR RICHARD KIDD

Telehealth could be the answer for better aged care

One of the key challenges for our ageing population is access to medical services.

The current model for aged care patients with limited mobility imposes big demands for time on clinicians, who are frequently required to leave their surgeries and travel to see their patients.

When access to medical services is inadequate, health outcomes are poorer and there are increased visits to hospital emergency departments.

The recent Commission of Audit report recognised that Australia's health system is not equipped to face future challenges posed by our ageing population, and recommended the Government explore opportunities to improve efficiency in health care delivery and effectiveness.

One option for achieving just this is through greater use of telehealth.

In 2013 the Federal Government, through its \$20.6 million *Telehealth Pilots Program*, funded several pilot projects to investigate the potential for improved health care delivery through telehealth.

Of particular interest to the AMA Committee for Healthy Ageing is the \$2.5 million project, led

by Flinders University, which is investigating the effectiveness of online technologies to support aged and palliative care patients in South Australia.

The Flinders University project aims to demonstrate increased access to team care and specialist clinical services, and fewer unnecessary hospital admissions.

At conclusion, the project will evaluate a technologically enhanced model of providing care, and propose costing and governance arrangements to support ongoing operation.

In the Flinders University study, 145 palliative and aged care patients have been given a mobile tablet configured with simple access buttons. The tablet is their portal for access to medical care in the comfort of their own home.

The University has reported solid progress since services began operating in mid-2013. Patients reported feeling more connected to their clinician when using videoconferencing than using the telephone. In turn, the technology enables health care providers to review more patients, and in a way that is more targeted to assessment scores. They can also monitor patients in real time, without the delays associated with travel time.

The key challenges to the use of telehealth in

Australia lie in the technology. Start-up costs, transmission quality and data security are all hurdles.

To address these problems, the *Telehealth Financial Incentives Program* offered incentives to eligible health professionals and aged care services to encourage investment in video technology to enable consultations with specialists, consultant physicians and consultant psychiatrists. More than 3000 specialist providers took up the incentive during its four years of operation.

“ The key challenges to the use of telehealth in Australia lie in the technology. Start-up costs, transmission quality and data security are all hurdles ”

We are all looking for a better health care delivery model for ageing Australians, and improved opportunities to coordinate care across providers.

The early signs are that telehealth technology has potential to offer an efficient and effective solution. It is hoped a successful Flinders University telehealth trial will provide the foundation for wider telehealth service development and implementation to support our care for our older patients.

ABC dumps controversial statins program

Doctors complain they are still dealing with the fallout from an ABC program that made controversial claims about the safety of statins before being pulled by the national broadcaster for breaching standards of impartiality.

GPs have reported they are still encountering patients who unilaterally decided to stop taking statins after viewing or hearing about claims made on the ABC science program *Catalyst* that statins were overprescribed and their benefits exaggerated.

The first episode of the two-part series 'Heart of the Matter', broadcast in October last year, gave prominence to unorthodox views questioning the value of diets low in saturated and trans fats, while the second episode emphasised the views of researchers who claimed statins caused significant side effects - claims that have subsequently been withdrawn - that outweighed their benefits.

The ABC launched an internal

investigation into the program after being deluged with complaints by organisations such as the National Heart Foundation as well as individual medical practitioners and its own resident health expert Dr Norman Swan.

The investigation, finalised last month, found that the second episode of the program breached the broadcaster's rules for impartiality, while the first episode presented information in a way that underplayed and undermined mainstream medical advice about the health benefits of low saturated fat diets.

In its report, the ABC's Independent Audience and Consumer Affairs Unit said there was "an inherent danger when any program present criticisms of medical practices or advice, that people will act without consulting experts or fully considering the consequences".

It said the *Catalyst* program had omitted important information and had slanted the way competing views and conflicting

information was presented.

"In our judgement, the quality of [episode one] would have been enhanced if it had more clearly communicated why the National Heart Foundation hold their views," the report said. "Little substantive evidence was presented to support their perspective, and the strength of evidence

that was referred to was doubted in the narration and directly challenged – and often emphatically rejected – by other contributors.

"Although the program did not explicitly endorse the unorthodox view, the language used by the reporter tended to add weight to the contrarian argument."



ABC dumps controversial statins program

... FROM P67

The report was more damning about the second episode, which called into question the benefits of taking statins.

"Flaws with the program's presentation did result in a finding that editorial standards had been breached," the investigation found. "The program's treatment of use of statins in secondary prevention focused solely on mortality benefits in a way that reinforced the view that statins were overprescribed, and their benefits exaggerated."

ABC Managing Director Mark Scott said that, as a result of the investigation, both programs had been removed from the ABC website, and a note had been added to the *Catalyst* website reinforcing advice that viewers should not make changes to their medication without seeking appropriate medical advice.

But Mr Scott defended the broadcaster's decision to investigate the use of statins.

"The *Catalyst* programs were very engaging, attracted large audiences and clearly touched on an issue of importance to many Australians," he said. "The link between statins and heart disease is a matter warranting investigation and coverage on our programs."

But the shadow over the *Catalyst* series has deepened after one of the researchers featured calling into question the use of statins has subsequently withdrawn a key claim, and his findings are the subject of an investigation by the *British Medical Journal*, where they first appeared.

Dr John Abramson from Harvard Medical School and British cardiologist Dr Aseem Malhotra have withdrawn statements made in their papers after figures used as the basis of the claims were found to be incorrect.

The authors cited data from an uncontrolled observational study that indicated almost 18 per cent of patients taking statins suffer side effects, but inflated the findings.

"The side effects of statins – including muscle symptoms, increased risk of diabetes (especially in women), liver inflammation, cataracts, decreased energy, sexual dysfunction and exertional fatigue – occur in approximately 20 per cent of people treated with statins," Dr Abramson and his colleagues wrote in their conclusion.

This figure was subsequently repeated in an article by Dr Malhotra published in the same edition of the *BMJ*.

But, in an editorial published on 15 May, *BMJ* Editor in Chief Dr Fiona Godlee wrote that "this [20 per cent] figure is incorrect".

Dr Godlee said the statements by Dr Abramson and Dr Malhotra "did not reflect necessary caveats and did not take sufficient account of the uncontrolled nature of [the] data".

Furthermore, "during the revision process, the authors placed more certainty on the 18 per cent figure in their conclusions, and this was rounded up to 'nearly 20 per cent' in a summary box".

“ The authors cited data from an uncontrolled observational study that indicated almost 18 per cent of patients taking statins suffer side effects, but inflated the findings ”

Dr Abramson appeared on the *Catalyst* program and claimed that statin manufacturers distorted evidence about the side effects of using their medicine.

The researcher who blew the whistle on the error, Oxford University Professor of Medicine Rory Collins, believes the withdrawal of the statements does not go far enough, and has pushed for the papers to be retracted.

Dr Godlee has questioned whether a retraction is justified given the incorrect statements were secondary to the primary focus of each article, but has referred the matter to be assessed by an independent panel.

Adrian Rollins

COMMENT

Major study proves vaccination-autism link a myth

Anti-immunisation campaigners are continuing to peddle misinformation despite the results of a comprehensive international review that found no evidence of a link between vaccination and autism.

The organisers of a Sunshine Coast health expo have been heavily criticised for inviting the founder of the Australian Vaccination-skeptics Network (AVN), Meryl Dorey, to speak at their event, particularly given the widespread alarm the group has caused by spreading falsehoods about the safety of vaccines.

The NSW Health Care Complaints Commission has issued a public warning following an investigation into claims made by the AVN.

In a statement released on 30 April, the Commission reported that the AVN “does not provide reliable information in relation to certain vaccines and vaccination more generally. The Commission considers that AVN’s dissemination of misleading, misrepresented and incorrect information about vaccination engenders fear and alarm and is likely to detrimentally affect the clinical management or care of its readers”.

The warning came as Sydney University researchers release the findings of a study into claims made by many anti-vaccination campaigners that immunisation is linked to autism.

The systematic international review found that there was no evidence of a link between childhood vaccinations

and the development of autism or autism spectrum disorders (ASDs).

The research, based on examination of five cohort studies involving more than 1.25 million children and five case-controlled studies involving more than 9920 children, found there was 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.

Senior author Professor Guy Eslick from the Sydney Medical School said these vaccines were those most commonly cited by anti-vaccination groups as posing an autism risk.

Professor Eslick said that, until now, there had never been a quantitative data analysis of any relationship between autism, ASDs and vaccination.

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

Professor Eslick said the finding was significant because of the reluctance of a small but significant proportion of parents to vaccinate their children because of fears it can lead to autism.

Concerns of a link between vaccination and autism spring from a study, since discredited, published in *The Lancet* in 1998, that claimed to have established such an association,

The National Health Performance Authority’s *Health Communities: Immunisation rates for children in 2012-13* report showed around 75,000 children five years or younger were not fully immunised last financial year, and in pockets of the population immunisation rates were well below the level required to achieve herd immunity. In particular, in North Coast NSW among one- and two-year-olds and Eastern Sydney for five-year-olds, at 86.1 per cent, 89 per cent and 86.2 per cent respectively.

Significantly, about 15,000 of these children had parents who had lodged conscientious objections to vaccination.

The results echo Council of Australian Governments Reform Council figures showing worrying gaps in immunisation in some areas that threaten to undermine protection against infection. According to the Council, in parts of NSW vaccination rates among children aged between 12 and 15 months have slipped as low as 81.1 per cent, while in South Australia, just 77.1 per cent of Indigenous children in the same age group are fully immunised.

Professor Eslick said this was particularly concerning because of serious outbreaks of measles, whooping cough and other vaccine-preventable diseases both within Australia and abroad.

“The increase in parents deciding not to vaccinate their children has substantially decreased herd immunity, increasing the risk of catching potentially more serious infectious diseases,” he said. “The risks incurred by not immunising a child is increasing substantially.”

Professor Eslick’s research was published in the journal *Vaccine*.

Adrian Rollins

COMMENT



Health on the hill

Political news from the nation's capital

Govt considers opt-out clause in e-health overhaul

Patients may be required to actively opt-out of having an e-health record under changes being considered by the Federal Government as part of an overhaul of the troubled Personally Controlled Electronic Health Record scheme.

The Federal Government is considering the recommendations of a review it commissioned into the PCEHR, including suggestions it be turned into an opt-out scheme, be re-named MyHR, and include arrangements to make it clear when patients change or withhold information.

The PCEHR, which was commissioned in mid-2012, has met resistance from the medical profession and has failed to elicit widespread interest among patients because of a series of perceived shortcomings.

Doctors, in particular, have been reluctant to use the system because of its limited clinical utility, the additional burden of establishing and maintaining electronic patient records, and unresolved medico-legal issues.

In the early part of this year, little more than one million people had registered for an electronic health record, and a handful of medical practices accounted for a large proportion of the records that had been created.

Former AMA President Dr Steve Hambleton was part of a three-member panel commissioned by Health Minister Peter Dutton to review the PCEHR. The results of the review, which was completed last December, were released by the Government last month.

Among the review's 38 recommendations, it proposed that participation in the My Health Record (MyHR) system – as it would become – should become an opt-out arrangement from the beginning of next year.

This has been seen as a critical change that would immediately make electronic health records more clinically useful, because knowing every patient had a record would encourage doctors to use the system.

One of the criticisms of the PCEHR was the extent to which patients had control of what appeared in the record, particularly their ability to remove or shield information.

This arrangement undermined the clinical usefulness of the e-health record for doctors, because they could not be confident that it contained all relevant medical information.

To help address this, the review recommended there be a requirement that copies of Medicare items for health assessments, comprehensive assessments, mental health care plans,

medication management reviews and chronic disease planning items be uploaded to the MyHR, and to add a flag to alert clinicians if a patient had restricted access to or deleted a document from the record.

The review also recommended that the National E-Health Transition Authority be dissolved and replaced by the Australian Commission for Electronic Health, which would be advised by committees that included clinicians.

The Federal Government has committed \$140 million to continue the roll-out of the PCEHR while it considers the findings of the review.

Mr Dutton said the review had provided “crucial advice” on how the PCEHR could be improved, indicating that the existing system was likely to be overhauled.

“The Abbott Government fully supports the concept of a national e-health record system, but it needs to be effective, functional and easy for all Australians to use, while being clinically relevant to our doctors, nurses and other frontline health care providers,” the Minister said. “It’s clear many of the existing problems with the PCEHR system stem from the rushed early implementation.”

Adrian Rollins



WINE

Cat's urine or quaffing delight – the wine that divides the world

BY DR MICHAEL RYAN

The discussion of acid in wine can Asking drinkers' opinions on a foundation grape like Sauvignon Blanc (SB) is like asking State of Origin fans to clap when the opposition scores a try. It polarizes a room.

Aromatic, sharp, crisp and zesty are some of the more measured descriptions it attracts. Less flattering, some have characterized it as like "feline urine passing through a Juniper bush".

There is no doubt it's flavor is pronounced. Aromas of the green spectrum abound, such as grass, gooseberries and nettles. Sometimes it has passion fruit and lychee notes, with a hint of flintiness or minerality (wine nerds note: this is caused by methoxypyrazines and thiols present in the wine).

Sauvignon Blanc probably originated in the Loire Valley of France, rather than Bordeaux, as previously thought.

DNA studies show that it is the progeny of Savagnin, a wild type of vine with a long history, and

its ancestry probably includes Pinot. In turn it, along with Cabernet Franc, is a parent of Cabernet Sauvignon.

Sauvignon Blanc is a widely planted variety found all around the world, though it appreciates cooler climates. It is the third-most planted white in France, after Ugni Blanc and Chardonnay. The Loire Valley is its home, with Sancerre and Pouilly-Fume being regions of significance. If the wine is exposed to oak, it is termed Fume Blanc – a term coined in California. In Bordeaux, it is often blended with a close relation, Semillon.

I've also heard it referred to as the accountant's wine, the reason being it is picked, quickly fermented in stainless steel, has no oak exposure and can be bottled early and released within four to six months of picking. Hence, getting the cash flow started.

New Zealand Sauvignon Blanc remains the darling of whites in the New World of wine.

Strong passion fruit and tropical aromas are evident, with tight bucket loads of acid. It remains the country's chief wine export, making up 70 per cent of all varieties sold by New Zealand on international markets.

All regions of New Zealand except around Auckland are renowned for producing SB – the sole exception being Auckland's Kumea Estate. Marlborough is the most prolific area, with multiple recognized sub-regions.

Australia produces more herbal, grassy styles of SB, though Tasmanian SBs understandably produce aromas similar to those in NZ vintages. The Adelaide hills, Western Australia, Coonawarra and the Limestone Coast are all major SB producing areas, and it finds its way into the Semillon blends that are prolific in Western Australia.

Chile produces more earthy SB wines. It is believed that a lot of these wines are actually descended from Sauvignonasse grapes – the genetic bastardry rolls on. South Africa's SBs are somewhat grassy and tropical. California, Oregon and even Mexico make some SB. Russia, Ukraine and Romania have some plantings. Austria and Switzerland also grow SB.

WINES TASTED

- 1. Neederberg Winemakers Reserve 2012 Sauvignon Blanc, South Africa** - the colour is light lime. The nose exhibits zesty lime and green pea fragrances, with floral herbal notes. Palate is juicy and forward with subtle acidity. Overall, enjoyable and sitting somewhere between Australian and NZ styles.
- 2. Cono Sur Especial 2012 Valle de Casablanca Sauvignon Blanc, Chile** - The palate has generous fruit and mild acidity with a funky, earthy taste. Very pleasant but idiosyncratic.
- 3. Middle Earth Nelson 2013 Sauvignon Blanc, New Zealand** - a slightly deeper green/yellow colour. The nose has classic New Zealand gooseberry and passion fruit aromas, with flinty minerality. The palate has generous fruit with acids complimenting the overall mouth feel. Moderate sweetness and structure make this wine a little more complex than Marlborough SBs.
- 4. Shaw and Smith Adelaide Hills 2013** - ale green in colour, with grassy floral notes on the nose. The wine maker tells me there is a hint of grapefruit present. Certainly, some passionfruit aromas are present. This is bone dry on the palate, with lip-smacking crispness. It is a very good representative of what Australian SB is like.
- 5. Cloudy Bay Te Koko 2010 Marlborough Sauvignon Blanc** - a deep yellow colour, with a tinge of green. There are complex lemon herbal aromas with mandarin and spices like ginger. On the palate it is a full, rich wine with subdued acidity. Overall, a lush complex version of a NZ SB. This wine is made with wild yeast ferment and some lees contact. Some bottle age adds to the complexity. My personal favorite of the SBs.

COMMENT