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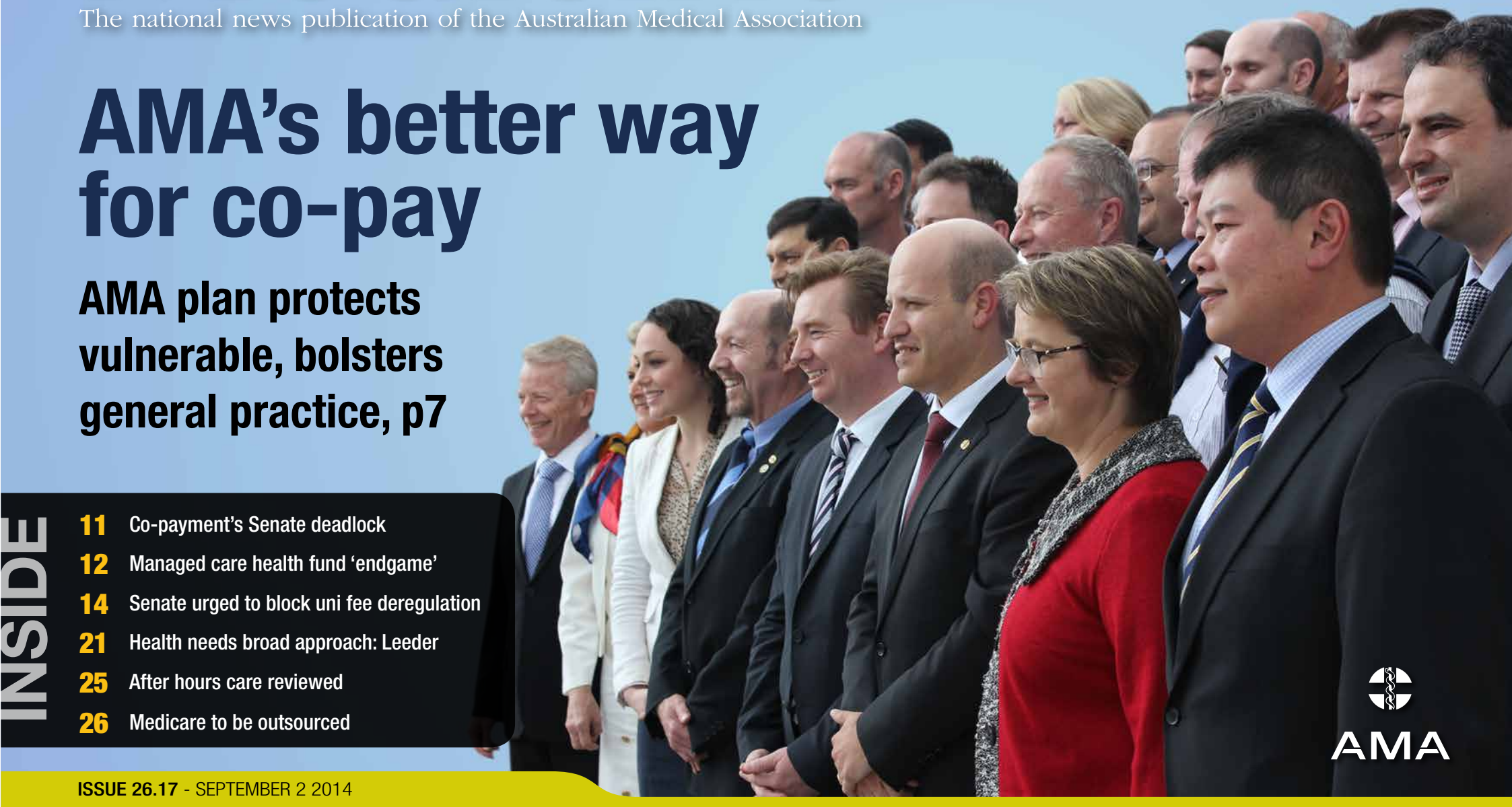
AMA's better way for co-pay

AMA plan protects vulnerable, bolsters general practice, p7



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AMA

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In this issue

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Cover: AMA Federal Council Members set a program of work at their first meeting in Canberra under new AMA constitutional arrangements.

AMA LEADERSHIP TEAM

President
Associate Professor
Brian Owler

Vice President
Dr Stephen Parnis

PRESIDENT'S MESSAGE

BY AMA PRESIDENT ASSOCIATE PROFESSOR BRIAN OWLER

> "For a one per cent reduction in GP visits, a $7 co-payment on all patients seems like a very significant impost on society for a very, very modest return. It simply does not make sense"

Strengthening general practice

The Government's Budget proposal for a general practice co-payment has been universally condemned since it was announced, and deservedly so. It is bad health policy.

At the request of the Prime Minister, the AMA developed an alternative co-payment model. Late last month, we released that proposal. It aims to protect vulnerable groups in our community while suggesting that, where people can afford to contribute, they should do so.

The AMA proposes a co-payment of $6.15 for concession card holders and those under 16 years of age, which would be paid for by the Government, and not from their own pocket. Only non-concession patients over 16 years of age would be asked to make a co-payment of at least $6.15. This amount was chosen on the basis that it is the current GP bulk billing incentive. The amount would be indexed.

The Government has argued that the co-payment should be a price signal to reduce unnecessary visits to the doctor. However, as the Government itself has modeled, this is likely to lead to just a 1 per cent reduction in GP visits in its first year, an outcome that underlines the confused thinking behind the co-payment proposal.

A $7 co-payment on all patients seems like a very significant impost on society for a very, very modest return. It simply does not make sense.

What has become clear is that the Government's $7 co-payment proposal is nothing more than an attempt to make the Budget bottom line 'look better'.

The pre-election commitment to not cut health was always going to be a problem for the Government.

So, taking $20 billion dollars out of health by 2020 and putting it into the Medical Research Future Fund (MRFF) allows the Government to say that the money has been kept in health. It also, as the Finance Minister has finally articulated, means that the Government can make debt look better because the MRFF will offset debt. Ingenious!

That is also the reason that the Government can't accept the AMA's proposal.

As the AMA has repeatedly said, we cannot accept a cut to the Medicare rebate. Consequently, our alternative co-payment proposal does not save the Government the $3.5 billion it has budgeted to come from the cut to Medicare rebates. Instead, it provides for only a very modest saving.

For the Opposition, this is an opportunity to capitalise on the Government's intentions for Medicare – real or perceived. The Opposition has stated that it will never support any GP co-payment. It has attacked the Government for trying to get rid of our universal health system. However, they ignore the fact that almost 20 per cent of GP services are not bulk billed and instead attract a significant co-payment.

For many people, the concept of universality means that everyone has access to health care using Medicare bulk billing. However, universal access to care is not the same as access that is free of charge.

The AMA agrees that there is a role for free medical care for some patients in our society, particularly those for whom any sort of financial barrier to care would deny or deter them from accessing health care. We know that almost 6 per cent of adults already state that this is the case.

So, why has the AMA suggested a co-payment for patients who can afford to contribute?

It is because if we continue to encourage a bulk billing culture in general practice for all patients, the quality of general practice will suffer. Today, bulk billing relies on a Medicare rebate whose value has, in real terms, continually dwindled.

Competitive pressures mean that GP consultation times are becoming shorter and doctors can only treat a single health issue at a time.

The long-term sustainability of our health care system hinges on the ability of general practice to focus on prevention and manage chronic disease.

Managing the burden of chronic disease is the greatest challenge for Australia's health care system. A modest co-payment for those who can afford to contribute will encourage the sort of quality general practice that we need to see, and which is so important in keeping patients well and out of more expensive hospital care.

It's an easy shot to paint the AMA and its members as only being interested in a 'cash grab', as the Health Minister has done. In fact, the AMA has led the debate in relation to concerns about vulnerable patients in our community. The AMA has been

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Strengthening general practice

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consistent in its support for some co-payments, but also in its strong opposition to the Government's co-payment proposal.

For many GPs, particularly those in suburban small practices or in regional areas, their practices grapple with how to provide quality and comprehensive care for their patients in a competitive environment. If they don't bulk bill, their patients go up the road to the bulk billing clinic or they only attend when they have a serious problem that needs a longer consultation. This is why the AMA wants significant new investment in general practice.

While the AMA's proposal does result in an increase of funding for general practice of $580 million over three years (compared with the Government's Budget 'windfall' of $480 million), it also protects vulnerable patients and children - and also excludes out of clinic services such as visits to residential aged care facilities.

This investment is not a pay rise for GPs. It is an investment in more staff and better facilities in general practice to further improve the quality of care and meet growing demand for GP services.

If practices are to gear up for the introduction of a co-payment next July, they will need information and plenty of notice. The Government needs to put its model to Parliament for scrutiny and debate sooner rather than later.

If the Government's co-payment is to be ditched completely, we will need an alternative plan to strengthen general practice.

The AMA's proposal does not make the Government's debt level 'look better'. Rather, the AMA's proposal is about sustaining the health care system through investing in general practice, while maintaining access to affordable health care for everyone.

This is a plan for a universal health care system that will serve the for community much longer than the stressed current model.

This article was originally published in Fairfax newspapers – The Age, The Sydney Morning Herald, and The Canberra Times - on 28 August 2014

COMMENT

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

SECRETARY GENERAL'S REPORT

BY AMA SECRETARY GENERAL ANNE TRIMMER

Nation's diverse health needs underline high stakes in getting health policy right

Over the past couple of weeks I have been travelling with AMA President Associate Professor Brian Owler visiting members in different parts of Australia and hearing about their working lives, daily challenges and experiences as doctors.

These visits highlight the many differences in members' practices, and in the needs of their patients. They also highlighted the commitment invested by doctors in ensuring the right care is given when needed. The settings were as diverse as Amoonguna near Alice Springs and Bathurst Island north of Darwin.

I was very impressed with the energy of the trainee doctors we met in the Northern Territory.

Many of the trainees had spent time working in Indigenous health centres in different communities. They reflected on the changes in training for GP registrars as a result of the Budget and the possible impact on the GP pipeline into some of the tougher areas. Many said that they would not have gone down the general practice path if they have not had the chance of being part of it in the pre-vocational period. We need to ensure that these opportunities remain, even if in a different form.

Public health issues were at the fore in many of our discussions – from management of chronic disease to the impact of misuse of alcohol.

Public health experts pointed out that the life expectancy gap will be addressed from a health perspective in line with the Close the Gap initiatives, but that the social determinants of health will be the factors that impede achieving the targets – housing and employment.

Work is underway on shaping the National Alcohol Summit which the AMA will host in late October at Parliament House in Canberra.

The Summit will address multiple domains which look in detail at the impact of alcohol misuse – domestic violence, in association with sport, by teenagers, in Indigenous communities, and street violence.

The objective is to agree on a National Alcohol Strategy to replace the now defunct plan developed some years ago.

Last week, the AMA hosted its annual Parliamentary Dinner. It provided an opportunity for members of Federal Council, the State AMA CEOs, and colleagues from other health-related interest groups to meet with politicians from all political persuasions.

The dinner was addressed by A/Professor Owler, Minister for Health Peter Dutton, Shadow Minister for Health Catherine King and Greens health spokesman Senator Richard Di Natale.

The stakes are high in this session of Parliament, with the Government keen to get its Budget measures through.

> "The settings were as diverse as Amoonguna near Alice Springs and Bathurst Island north of Darwin"

For those commentators willing to consider the detail, the AMA's proposal for an alternative approach to the co-payment has attracted some thoughtful responses.

The AMA Board spent two days at the end of the month in a strategic planning meeting to set the direction of the company for the coming period.

The decisions taken at the meeting will help determine priorities for investment and activity on behalf of AMA's members, and opportunities to grow membership for the future.

I will report more in a future column.

COMMENT

$6.15 co-payment an investment in quality care: AMA

AMA President A/Professor Brian Owler and AMA Council of General Practice Chair Dr Brian Morton present the AMA's alternative GP co-payment proposal to the national media. AMA House, Canberra, 21 August

Children and concession card holders would be exempted from paying a co-payment for GP services under an alternative model put by the AMA to the Federal Government and publicly released late last month.

In a plan designed to protect vulnerable patients while injecting much-needed funds into general practice and putting a value on quality primary health care, the AMA has proposed that a $6.15 co-payment apply to most GP services, with Government paying the fee on behalf of children younger than 16 years and concession card holders.

Under the AMA's plan, the co-payment would not apply to residential aged care and home visits, chronic disease management services, health assessments and mental health treatment items, while child immunisation would be covered under the blanket exemption from the co-payment for children younger than 16 years.

In addition, the AMA has called for a two-year delay on the Government's proposal to impose co-payments for pathology and diagnostic imaging services, pending detailed consultations and assessments with professional and consumer groups.

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AMA co-payment: how it would work

- no cut to Medicare rebate
- practitioners free to set own fee
- $6.15 co-payment would apply to most GP services
- Govt would pay co-payment on behalf of children younger than 16 years and concession card holders
- co-payment would not apply to:
  - > residential aged care and home visits
  - > chronic disease management services
  - > health assessments
  - > mental health treatment items
- two-year delay on co-payment for pathology and diagnostic imaging services, pending consultation and review
- the inclusion of the co-payment in Medicare Safety Net calculations
- A1 rebates for general patients linked to the application of the co-payment

COMMENT

$6.15 co-payment an investment in quality care: AMA

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AMA President Associate Professor Brian Owler said the Association's model, which was presented to the Government in late July, was underpinned by two important principles – protecting vulnerable patients and supporting quality general practice.

A/Professor Owler said the Government's $7 co-payment plan had failed dismally on both counts – it would fall disproportionately heavily on the sickest and most vulnerable, and the $5 cut to Medicare rebates it involved would make many general practices, particularly those in disadvantaged areas, unviable.

The Government has failed to articulate and clear and internally-consistent rationale for its proposed $7 co-payment, which would apply to all GP, pathology and diagnostic imaging patients.

The plan has been alternately presented by the Government as a way to ration access to health care by sending a 'price signal' to patients, as a means to support medical research (co-payment revenue is to be directed to a Medical Research Future Fund) and as a way to improve Commonwealth finances by helping defray the rising cost of Medicare.

But A/Professor Owler said the AMA proposal would provide the Government with only modest savings, of around $66 million – a fraction of the $3.5 billion claimed by the Government under its proposal.

Instead, he said, through its co-payment model, the AMA sought to address what it saw as a secular decline in support for general practice that was undercutting quality health care and would eventually increase the incidence and severity of preventable disease and exacerbate the pressure on the health system.

At the heart of these concerns is the long-term deterioration in the value of Medicare rebates for GP services.

A/Professor Owler said Medicare rebates had increased by an average 2.48 per cent a year in the past 30 years, completely outstripped by growth in the costs of providing quality medical care such as rents, training, staff costs, insurance, and equipment, and had been frozen for the past two years.

He said the erosion in the value of Medicare rebates had been exacerbated by the surge in bulk billing, to the extent that more than four out of every five patients seen by the nation's GPs are bulk billed.

"The Medicare Benefit Schedule does not represent the true quality of quality primary health care," the AMA President said. "It does not value the vital role of general practice in the health system."

Under the AMA proposal, GPs would receive the $6.15 co-payment, injecting an extra $580 million into general practice, according to Government modelling.

A/Professor Owler said the much-needed injection of funds could relieve some of the competitive pressure on GPs to bulk bill and cut consultation times.

"If we continue to go down the path that we are, with 81 or 82 per cent of GP services being bulk billed, then what will happen is that we have this competition where the bulk billing signs do go up, and people are forced to bulk bill on the basis of competition," he said.

"At the end of the day, that's a bad thing for patients, because [it means] those practices are essentially just bulk billing and they have to adjust, eventually, the amount of time that they spend with patients, [which means] they can't do the prevention, [the] chronic disease management.

"What we want to do is actually give them a break from that bulk billing competition, allow them to actually charge a fee that recognises more of the services that they are providing, and actually allows them to do the important work of prevention and chronic disease management that actually we want our GPs to do for the sustainability of the health care system."

In its model, the AMA has effectively re-badged the $6.15 bulk billing incentive for metropolitan GP services ($9.25 in rural and regional areas) as a direct co-payment to GPs.

The AMA proposal includes a hefty incentive for GPs to charge the co-payment.

Where they charge the schedule fee plus the co-payment, GPs will receive the full A1 schedule rebate (currently $37.05 for a level B consultation), plus the co-payment (for a total payment of $43.20).

But if a GP decides to waive or reduce the co-payment, they would only be eligible for the A2 level schedule rebate

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$6.15 co-payment an investment in quality care: AMA

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(currently $21 for a level B consultation), meaning they would receive just $26.15 – a stiff $17.05 financial penalty.

A/Professor Owler said that there would inevitably be patients who were older than 16 years and did not hold a concession card but who had a reduced capacity to pay, such as low income families or those with complex and chronic conditions. He said people in these circumstances were known to their GP, and under the AMA model the family doctor would continue to look after them as happened under current arrangements.

The AMA President said the AMA was open to suggestions on ways to improve its co-payment model, not least from the Indigenous community.

"The AMA model is an attempt to support quality general practice," he said. "It aims to allow GPs the opportunities to spend more time with patients to provide preventative health care and chronic disease management, and to place a value on the valuable service they provide.

"The focus is on the quality of the services, and this benefits the GP, the patient, and the broader health system.

"The AMA model is all about maximising the benefits of high-quality primary care and general practice, keeping people well, keeping people out of more expensive hospital care."

Adrian Rollins

COMMENT

Grassroots lobbyist

A rural voice: Kempsey GP Dr Colin Farquharson at AMA House, Canberra late last month

AMA member, Dr Colin Farquharson, a GP from Kempsey, NSW, was visiting Canberra recently and paid a visit to AMA House.

Dr Farquharson has been in regular contact with the Federal AMA since the May Budget to share his thoughts on the terrible impact the Government's proposed GP co-payment model would have on his practice and his patients.

Colin has become a busy grassroots lobbyist on the issue by raising his concerns with local Coalition politicians, including the Assistant Minister for Employment and Member for Cowper, the Hon Luke Hartsuyker MP, and the Member for Lyne, Dr David Gillespie MP.

He says that many of his patients are elderly, poor, or Indigenous, and that they would be hit hardest by the proposed co-payment.

Colin also does visits to residential aged care patients, and says collecting the co-payment would be unworkable and totally inappropriate.

Dr Farquharson and his rural practice exemplify the need for the AMA's ongoing campaign against the Government's proposals.

COMMENT

AMA's co-payment proposal: the reaction

Prime Minister Tony Abbott:

The system is becoming unsustainable. It is vital that we try to ensure that there are sensible price signals in the system. And if it's right and proper to have a modest co-payment for the PBS, why not have a modest co-payment for Medicare?

Treasurer Joe Hockey:

I am glad that they [the AMA] do support the concept of the co-payment. I think that is hugely important. If we want to have a sustainable Medicare system we are asking Australians to make a contribution along the way because, ultimately, nothing can be for free.

Health Minister Peter Dutton:

The current proposal put forward by the AMA with regards to the $7 co-pay will result in a windfall for doctors while wiping out 97 per cent of the Government's estimated savings.

Opposition leader Bill Shorten:

Labor will not accept Tony Abbott's GP tax in any form.

Palmer United Party leader Clive Palmer:

Who cares [about the AMA proposal]? We won't accept any co-pay, doesn't matter what they say.

Royal Australian College of General Practitioners:

The AMA's alternate model is on the right track, however [the RACGP] is still concerned about the risks posed to vulnerable populations.

Mental Health Australia CEO Frank Quinlan:

AMA's proposal to exempt people treated under mental illness Medicare items from GP co payments "is an important first step in encouraging people concerned about their mental health to see a GP, but protections must go further".

Australian Healthcare and Hospitals Association:

The co-payment policy proposal released by the AMA goes some way to addressing the inequities of the Government's policy, but it still falls a long way short.

Consumers Health Forum CEO Adam Stankevicius:

A co-payment would erect a barrier to primary health care for many thousands of families and individuals who would not qualify for concessions. The Federal Government, and now the AMA, are proposing a new impost on health consumers before investigating other ways to make health care in Australia more cost effective.

COMMENT

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

Co-payment faces Senate deadlock

The Federal Government's ambition to introduce a $7 co-payment for GP, pathology and diagnostic imaging services is faltering as opposition to the plan hardens among balance-of-power senators.

The efforts of senior Government ministers including Treasurer Joe Hockey and Health Minister Peter Dutton to use Parliament's winter recess to lobby key crossbench senators to back the co-payment proposal have so far proven fruitless.

Billionaire miner Clive Palmer, leader of the Palmer United Party – which controls three crucial Senate votes – last week declared the Government's co-payment plan "dead".

"The co-payment is dead. We won't be supporting it. It's over, finished," the PUP leader said, adding there would be no compromise deal with the Government to secure its passage. "We're not going to have a co-payment of even one cent. There'll be none. Isn't that good?"

Other key cross bench senators, including Democratic Labor Party Senator John Madigan and independent South Australian Senator Nick Xenophon, have also voiced their opposition to the co-payment. So far, only Liberal Democratic Party Senator David Leyonhjelm has publicly backed a co-payment of some form, while both Labor and the Australian Greens remain implacably opposed to the idea.

But the Government has so far refused to concede that its proposal is in deep trouble.

Mr Dutton has insisted that key senators are much more receptive to the proposal in private than they are in public.

"People will position publicly on these issues," he said.

"The difficulty for us is that we're not commenting on private discussions. All I can say is that privately we've had productive discussions with many of the senators."

The Government is delaying putting legislation for the co-payment to a vote in the Senate as it seeks to marshal the numbers it needs to secure passage of the controversial proposal.

Mr Dutton and other senior Government figures including Finance Minister Mathias Cormann, have suggested that there is no urgency to vote on the legislation, given that the measure is not to due to come into effect until mid-2015.

But pressure is mounting on the Government to end the uncertainty about this and other Budget measures amid warnings delays in resolving the Budget are sapping business and consumer confidence and deterring investment.

The uncertainty is also causing confusion and distress for patients, with reports that some GP clinics have been forced to send text messages to their patients to reassure them that no co-payments have yet been introduced.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Parkinson's Seminar

During September, Parkinson's Victoria will host an Australian-first "Living Well" seminar addressing the long-term challenges for those who have been living with the condition for more than seven years.

The two-day educational event will bring together health care professionals and those affected by Parkinson's from across Australia to learn, share and discuss treatment options, care challenges and lifestyle choices.

The seminar runs from 11 to 12 September, and is being held as part of Parkinson's Awareness Week. It will feature presentations from medical experts including Professor Malcolm Horne, Dr Andrew Evans, Dr Wesley Thevathasan, Dr Luke and Mary Jones.

Health care professionals will receive important information about the latest treatment advances including deep brain stimulation and a multidisciplinary team approach to caring for long-term sufferers.

For more information, go to: http://www.parkinsonsvic.org.au/documents/LivingWellregistrationflyerPLWP.pdf

Managed care is health fund endgame: Owler

US-style managed care was "clearly the endgame" for private health insurers pushing for a greater role in the provision of primary care, AMA President Associate Professor Brian Owler has warned.

Giving evidence to a Senate committee inquiry, A/Professor Owler accused Medibank Private of circumventing laws prohibiting insurers from providing cover for Medicare services and seeking to secure preferential access to GP care for its members.

"Anyone who thinks that managed care is not the endgame of some of the private health insurers needs to open their eyes, because that is clearly the endgame," he told the Community Affairs Legislation Committee at a hearing on 20 August.

Earlier, the inquiry heard details of a deal between Medibank Private and 26 GP clinics and 145 GPs in south-east Queensland under which the fund's members a guaranteed to be bulk billed, get a same-day GP appointment if they call before 10am and get after-hours GP visits with a maximum waiting time of three hours. In exchange, Medibank contributes to practice administration costs.

Other funds are looking at similar arrangements. Insurer NIB is about to pilot a program under which GPs would be compensated for providing services such as disease management, home-based care and advance care plans for its members, while HCF said it was watching the Medibank trial with interest.

In testimony to the Committee, Medibank's Manager of Government and Regulatory Affairs, James Connors, denied its arrangement, known as GP Access, compromised the universality of Medicare.

"There is no agreement between us and the doctors that provide the GP Access service to provide preferential access," Mr Connors said.

But A/Professor Owler dismissed the insurer's denials, and told the inquiry GP Access had "basically been set up to circumvent the legislation".

"It is a commercial arrangement," he said. "[Medibank are] paying an administrative fee to the practice for their patients to be seen without an extra charge, and with priority appointments.

"It is circumventing the legislation and basically allows the private health insurer to cover the gap or any private billing that takes place in general practice."

The AMA President said the arrangement was unacceptable because "if you rolled that out with multiple insurers and multiple practices, then you would have real problems with equity of access, and those without private health insurance would not get access".

Hi warnings were backed by officials from the Australian Dental Association, who cautioned that clinical autonomy would be undermined if health funds were allowed to continue to enter into preferred provider arrangements.

ADA Chief Executive Robert Boyd-Boland said dentists routinely dealt with the private health insurance industry, and much could be learned from their experiences.

He told the Senate Committee that, in their relentless search for increased profits, many health funds sought to limit patient choice of dentist; impose restrictive business rules and policies that seek to dictate the nature of treatment allowed; increase out-of-pocket expenses; and artificially inflate the cost of services from non-preferred providers.

> "Anyone who thinks that managed care is not the endgame of some of the private health insurers needs to open their eyes, because that is clearly the endgame"

GP Access is just one of a number of initiatives taken by Medibank to expand its range of operations and commercial offerings, though the corporation has denied any suggestion of a link between these activities and the fund's looming privatisation.

But A/Professor Owler said the insurer was working towards instituting managed care arrangements to bolster its bottom line.

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Managed care is health fund endgame: Owler

... FROM P12

"We have Medibank Private entering into arrangements to circumvent legislation with a particular GP group; we have this extension into chronic disease management; we have the Medibank Defence Solutions in the contract with the defence forces, and we have Medibank Private actually introducing, unilaterally, a program where they have a pre-approval process for what they have said are procedures that have a cosmetic component," he said.

Greens Senator Richard Di Natale has proposed amendments the Private Health Insurance Act that would effectively block private insurers from being involved in the provision of GP services, and A/Professor Owler said the AMA supported the intent of the law change.

He told the Committee that although the AMA thought there might be a role for private funds in primary care, it would only be to provide targeted funding for chronic disease management and prevention services for the 4 per cent of patients who were regularly showing up in hospital.

But the Federal Government is yet to respond to the medical profession's concerns, and Health Minister Peter Dutton has instead flagged interest in greater private sector involvement in the provision of primary care.

The Health Minister said it was "crazy" that often the first insurers knew about the health of their members was when they received a claim for hospital services.

"I think it is perfectly sensible for insurers who desire to be involved in process earlier to invest money in a preventive way, to perhaps help people going to see a paediatrician, a dietician or a psychologist about lifestyle and ways they can improve their health outcomes," Mr Dutton said. "That ultimately results in savings for the taxpayers, for the insurer, but better health outcomes for the insured."

He said the trials being conducted by Medibank Private were a promising sign of what might be done.

"If we have got a willing doctor, a willing insurer, a willing patient, I think we should give the trials the benefit of time and experience, to see what recommendations come out of that, because if we can keep people out of hospital, out of emergency departments, out of ambulances at two o'clock in the morning, then that is much better for patients, and much better for the Australian taxpayer as well."

Adrian Rollins

COMMENT

GAMSAT, single interview has AMA support

The AMA has called on the competition watchdog to remain vigilant that the selection processes used for graduate-entry medical schools, particularly single interview screening, are operating fairly.

The Australian National University and the Graduate Australian Medical Schools Admissions Test Consortium (GAMSAT) have applied for renewed authority from the Australian Competition and Consumer Commission for the use of the common test and the single interview process for graduate applicants.

The GAMSAT test, developed by the Australian Council for Educational Research in conjunction with the Consortium, is designed to assess the capacity of applicants to undertake "high-level intellectual studies in the medical and health professional programs".

In addition, applicants undergo a single test at their preferred institution, the score from which may be passed on lower preference schools if their application is unsuccessful.

In a letter to the ACCC, AMA President Associate Professor Brian Owler said the Association supported the application from the ANU and the GAMSAT Consortium for a new authorisation following the expiry of the authorisation granted in 2009.

A/Professor Owler said the Consortium's assessment was that the single interview process did not add to the risk that an applicant was unsuccessful – a conclusion supported by the fact that there had been "very few" appeals lodged.

But he asked the competition watchdog to monitor the arrangements closely to ensure they did not lead to any unintended outcomes.

"The AMA would encourage the ACCC to remain vigilant with respect to the single interview process by ensuring that the Consortium provides publicly accessible information about its operation so that it remains transparent, and we continue to see the most meritorious students gain entry to medical school," A/Professor Owler wrote.

Adrian Rollins

COMMENT

AMA raises concerns over university deregulation push

Australian Medical Association President Associate Professor Brian Owler has written to crucial crossbench senators urging them to oppose the Federal Government's push to deregulate university fees and reduce subsidies for Commonwealth Supported Places.

The AMA holds several concerns about the impact of these budget policy changes on medicine. As a much sought after qualification, there is a significant risk of an explosion in costs for a medical degree under the proposed university overhaul.

In his letter, A/Professor Owler said there was good evidence that high fee levels and the prospect of significant debt deters people from lower socio-economic backgrounds from entering university.

"We also know, in relation to medicine, that a high level of student debt is an important factor in career choice – driving people towards better remunerated areas of practice and away from less well paid specialities like general practice," he added.

Senators have been warned that under the Government's plans, the cost of studying medicine for local students could match fees charged for international students – such as the $264,400 charged by the University of Sydney for its four-year Doctor of Medicine program.

The AMA has indicated a willingness to discuss a more balanced set of reforms with the Government to address the medical profession's concerns.

A/Prof Owler said the AMA would keep senators informed on any progress made on the issue in discussions with the Government. But he stressed that, unless there were meaningful changes to the Government's proposals, they should be opposed.

Odette Visser

COMMENT

Medibank boss in damage control over patient priority views

Medibank Private boss George Savvides has been forced into damage control after AMA President Associate Professor Brian Owler revealed he had argued that patients with private health insurance should get priority treatment in public hospital emergency departments.

In a major addresss to federal parliamentarians last week, A/Professor Owler recounted comments made by Mr Savvides in a speech to an AMA forum in March in which the Medibank chief talked about preferential treatment for the privately insured.

"Among a number of other topics, he tried to tell us that they [Medibank Private] wanted patients with private insurance in a public hospital emergency department to receive priority," the AMA President recalled.

"His question was: 'If your son breaks his arm and goes to the emergency department, and you have private health insurance, why shouldn't little Johnny get priority?'

"Well, to his surprise, that was not well received."

Instead, A/Professor Owler said, the view of doctors was that patients should be treated according to clinical urgency rather than insurance status.

"Our emergency department doctors are not going to make a more deserving patient wait because little Johnny's parents have private insurance.

"Now, our speaker was a little taken aback by the rejection [in the room], but also by the strength of the rejection."

A Medibank spokeswoman told *Guardian Australia* that Mr Savvides' comments had been taken out of context.

"[Mr Savvides'] comments were misrepresented," she said. "He doesn't agree with those comments."

The insurer also issued a statement in which it said Medibank "does not believe that private health insurance members should get priority in emergency departments".

"We expect people in most need of emergency treatment, regardless of their personal circumstances, should be given priority."

But A/Professor Owler stood his ground and vigorously denied claims he had misrepresented Mr Savvides' comments, which he said had been heard both 30 other doctors also in the audience at the March function.

"He was standing at the podium speaking when he said those comments," the AMA President said.

"Perhaps his comments don't represent Medibank's official position, but I was just reiterating the comments he made during his speech.

"If he doesn't believe it, then he shouldn't have said it, but I know that's what was said and so do the other doctors present."

Adrian Rollins

COMMENT

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

Proposal means few will have to pay fee, *Northern Territory News*, 15 August 2014

Very few patients will pay the $7 GP fee and the Government will make almost no savings under the AMA proposal being considered seriously by the Government. The AMA would like pensioners, nursing home patients, Indigenous Australians, and the chronically ill to be exempt from the co-payment.

Medicare fee jeopardises Aborigines, *The Age*, 15 August 2014

Health leaders have warned the Abbott Government's proposed $7 Medicare fee could widen the gap in life expectancy between Indigenous and non-Indigenous Australians. AMA President A/Professor Brian Owler said the proposed fee was in effect a cut to Indigenous health funding.

Fee disaster in regions, *Courier Mail*, 15 August 2014

Implementing the Federal Government's $7 GP co-payment proposal would be disastrous for Indigenous health care. AMA President A/Professor Brian Owler has been touring the Northern Territory and said GP co-payments were the key issue raised with him.

Split bills key to Budget, *Sunday Times*, 17 August 2014

Health Minister Peter Dutton is in talks with the AMA to offer greater concessions on the $7 GP co-payment for vulnerable Australians, but has ruled out blanket exemptions for pensioners.

Call to link medicine to overseas prices, *Weekend Australian*, 16 August 2014

The Government could save $580 million a year by bench-marking the cost of drugs in Australia to international prices, eliminating the need to increase the co-payment on medicines, according to some analysts. The AMA argues the financial costs that arise from patients skipping medicines and other treatments go well beyond the health system.

$20b medical fund at risk if $7 co-payment is rejected, *Australian Financial Review*, 18 August 2014

A $20 billion government medical research fund meant to find cures for diseases may become the victim of a political compromise over the Government's $7 doctor and pathology charge. AMA President A/Professor Brian Owler said the fund should never have been linked to the controversial charge.

Outrage mounts over lack of GP fee details, *Northern Territory News*, 18 August 2014

Pressure is mounting on the Federal Government to release details of its planned changes to the controversial $7 GP fee as doctor's groups and consumer demand answers. AMA President A/Professor Brian Owler said the AMA is arguing for pensioners, nursing home residents, Indigenous Australians and the chronically ill to be exempted from the GP co-payment.

$7 GP fee deal waits on AMA's proposal, *Courier Mail*, 20 August 2014

Federal health beancounters met with the doctors' union in further signs the Government is closer to negotiating a deal on its $7 GP co-payment. It is understood the AMA has urged Mr Dutton to exempt pensioners, the chronically ill, Indigenous patients and nursing home residents from the co-payment.

Doctors want half exempt from fee, *Adelaide Advertiser*, 21 August 2014

Almost half the population would be exempt from the $7 GP co-payment under an AMA compromise. AMA President A/Professor Brian Owler admits the Government will make virtually no savings if it adopts the plan.

GP clinic scheme under fire, *The Age*, 21 August 2014

Private health insurance customers are being given preferential treatment at certain GP clinics in a trial that poses a threat to universal health care. AMA President A/Professor Brian Owler told a Senate hearing the scheme was s step towards the managed care system that exists in the US.

MORE P16

AMA IN THE NEWS

... FROM P15

Healthcare AMA plan rejected, *Sydney Morning Herald*, 22 August 2014

Prime Minister Tony Abbott has rejected a proposal by doctors to exempt pensioners from a $7 GP fee, but has left open the possibility of negotiating whether children's visits were charged. Health Minister Peter Dutton thanked the AMA for their honesty in publicly and privately supporting a co-payment in principle.

Shop for a low-cost surgeon, *Adelaide Advertiser*, 23 August 2014

Patients will soon be able to shop for a surgeon, as a health fund makes public which specialist don't charge a gap. Terry Barnes is calling on the Government and the AMA to ensure doctor fees are capped at the level of the AMA fee.

We must discourage our bulk-billing culture, *The Age,* 28 August 2014

A $7 co-payment on all patients, for such a tiny return, does not make sense. AMA President A/Professor Brian Owler said the rationale behind the general practice co-payment proposal is confused.

Radio

A/Professor Brian Owler, ABC Riverland SA, 15 August 2014

AMA President A/Professor Brian Owler talked about the proposal put forward by the AMA to the Federal Government to change its GP co-payment plan. A/Professor Owler said that under the AMA plan concession card holders, children younger than 16 years, nursing home residents and patients will mental and chronic illnesses would be exempted from the co-payment.

A/Professor Brian Owler, 666 ABC Canberra, 21 August 2014

AMA President A/Prof Brian Owler talked about the Budget and the $7 GP co-payment. A/Professor Owler said the AMA is concerned about people in aged care, the unemployed, people with a disability, and those living in remote areas.

A/Professor Brian Owler, 2UE Sydney, 21 August 2014

AMA President A/Prof Brian Owler discussed the $7 GP co-payment released in the Abbott Government Budget. A/Professor Owler said the proposal does not protect vulnerable patients, does not have proper safeguards, and goes against prevention and chronic disease management health policy.

A/Professor Brian Owler, 2HD Newcastle, 22 August 2014

AMA President Associate Professor Brian Owler talked about the AMA's alternative model for the GP co-payment. A/Professor Owler said a co-payment for those who can afford it is important because if they continue to be bulk billed, quality of care will suffer.

A/Professor Owler, 2GB Sydney, 26 August 2014

AMA President A/Professor Owler discussed the GP co-payment. A/Professor Owler said the AMA's alternative GP co-payment model exempts concession card holders and patients under 16 years, and the $6.15 was essentially the bulk billing incentive that already exists.

Television

A/Professor Brian Owler, Channel 9 Perth, 18 August 2014

AMA President Brian Owler talked about patients being slugged with medical costs much higher than are covered by Medicare. A/Professor Owler said the MBS has never kept pace with inflation.

Dr Brian Morton, ABC Sydney, 20 August 2014

AMA Chair of General Practice Dr Brian Morton talked about private health insurers moving into general practice and their claims that it will help keep their customers healthy and thus cut hospital cuts. Dr Morton said urgent cases should always get priority, regardless of insurance status.

A/Professor Brian Owler, Sky News Sydney, 21 August 2014

AMA President Associate Professor Brian Owler talked about the AMA's alternative plan for the GP co-payment. A/Professor Owler said the AMA co-payment includes no cut to the Medicare rebate, a $6.15 co-payment for standard consultations, and with concession card holders and those aged under 16 exempt.

A/Professor Brian Owler, WIN Canberra, 22 August 2014

AMA President A/Professor Brian Owler discussed the AMA signing off on their alternative GP co-payment plan. A/Professor Owler said the AMA suggested changing the tax from $7 per visit, to $6.15 and providing an exemption for children and pensioners.

COMMENT

AMA IN ACTION

The AMA played host to more than 160 guests including Federal Government ministers, senior members of the Opposition, senators, senior public servants and doctors from across the country at its annual Parliamentary Dinner on 27 August.

AMA President Associate Professor Brian Owler, Health Minister Peter Dutton, Shadow Health Minister Catherine King and Australian Greens health spokesman Dr Richard Di Natale delivered speches to an audience that included members of the newly-constituted AMA Federal Council as well as prominent and senior politicians including Assistant Health Minister Fiona Nash, Speaker Bronwyn Bishop, Assistant Employment Minister Luke Hartsuyker, former Immigration Minister Philip Ruddock, Queensland MP Bob Katter, former Labor ministers Brendan O'Connor, Richard Marles, Jan McLucas, Warren Snowden, Kelvin Thomson and Alan Griffin, Greens leader Christine Milne and her Senate colleague Sarah Hanson-Young.

Earlier that day, the AMA Federal Council convened at the offices of the Federal AMA for the first time under the revised constitutional arrangements approved at the AMA National Conference in May. The Council discussed organisational issues and a future work program, while the AMA Limited Board convened for a two-day strategy meeting.

Amid all this activity, Chair of the the AMA Council of Doctors in Training, Dr James Churchill, very bravely accepted an Ice Bucket Challenge from Australian Medical Students Association President Jessica Dean and, before a dozen witnesses, was doused with litres of frigid water on the steps of AMA House – not an undertaking to be taken lightly on a winter's day in Canberra.

A week earlier, national media descended on the AMA for a media conference at which A/Professor Owler and Chair of the AMA Council of General Practice Dr Brian Morton released the AMA's proposal for a GP co-payment - an event that drew live television coverage and attracted attention from newspapers and radio stations nationwide.

Adrian Rollins

COMMENT

AMA President Associate Professor Brian Owler catches up with Health Minister Peter Dutton at the annual AMA Parliamentary Dinner at the Great Hall, Parliament House, during a week of tense negotiations over the passage of Budget measures through the Senate.

SEPTEMBER HEALTH EVENTS

The dates and events listed are major awareness days, conferences, weeks and months related to health. If you know of an upcoming national health event please email the details to ausmed@ama.com.au

Sun	Mon	Tue	Wed	Thur	Fri	Sat
31	**1** International Prostate Cancer Awareness Month Childhood Cancer Awareness Month Blue September National Gold Bow Day National Jean Hailes Women's Health Week National Asthma Awareness Week National Parkinson's Awareness Week National Light the Night	**2**	**3**	**4**	**5**	**6**
7	**8** National Stroke Week National Eczema Awareness Week National Idiopathic Hypersomnia Awareness Week World Physiotherapy Day	**9** International Foetal Alcohol Spectrum Disorder Awareness Day	**10**	**11** National R U OK? Day	**12** National White Balloon Day National Walking with Wellness Week	**13** World First Aid Day
14 SA and WA Parkinson's Walk in the Park	**15** World Lymphoma Awareness Day National Firefighters Cancer Awareness Day World Mitochondrial Disease Awareness Week National Headache and Migraine Week	**16**	**17**	**18**	**19**	**20**
21 World Alzheimer's Day World Stay in Bed Day	**22** World CML Day	**23**	**24**	**25**	**26**	**27**
28	**29** National Sleep Awareness Week	**30**	1	2	3	4

Lyme disease: the jury is still out

A national panel of medical experts has failed to resolve the controversy around claims Lyme disease is endemic to Australia, finding there was no conclusive evidence that Lyme disease-causing bacteria are present in Australian ticks.

In a result unlikely to douse claims Australia has Lyme disease, the Clinical Advisory Committee on Lyme Disease, convened by the Health Department, has concluded its work without being able to conclusively establish whether or not there is a local version of the debilitating North American ailment.

A progress report issued by the nation's Chief Medical Officer, Professor Chris Baggoley, stated that "the conclusive finding of a bacterium that could cause Lyme disease-like syndrome in Australia has yet to be made".

Great controversy surrounds the disease, which causes flu-like symptoms with associated fatigue, muscle pain and various neurological symptoms.

Several medical practitioners claim to have diagnosed the illness in patients who have never travelled to areas overseas where it is endemic, but positive laboratory tests have been disputed and its endemic presence in Australia is yet to be officially verified.

The Clinical Advisory Committee, established by Professor Baggoley in late 2012 following a request from the NSW Chief Health Officer Dr Kerry Chant has, in conjunction with the Health Department, outlined a program of research it hopes will shed further light on the issue.

In his progress report, Professor Baggoley provided a reassuring message for those convinced Lyme disease, or something like it, is present in Australia.

> "... the failure to identify an indigenous cause for Lyme-like syndrome was hampering efforts to develop an appropriate diagnostic test"

He said that, even though the Committee concluded its work on 15 July, "the Department's interest in an Australian Lyme disease-like syndrome will be maintained".

Research is being pursued in a number of areas, including continued attempts to determine if Lyme disease-causing *Borrelia* bacteria are present in Australian ticks, whether it might be present in other vectors including flies, sand flies and mites, determining the best laboratory test for the disease, and the appropriate form of treatment.

Professor Baggoley said the failure to identify an indigenous cause for Lyme-like syndrome was hampering efforts to develop an appropriate diagnostic test.

"The most appropriate laboratory testing algorithm has yet to be agreed," he reported. "Doubts around the sensitivity and specificity of diagnostic tests available in Australia hinder the exploration of a potential Borrelia infection in Australian patients with no relevant travel history."

The issue was further complicated by a lack of consensus around Lyme disease diagnosis, the Chief Medical Officer said, noting that although clinical presentation was a common basis for diagnosis there was no agreed case definition.

These issues had to be resolved in order to determine the most appropriate treatment, he added.

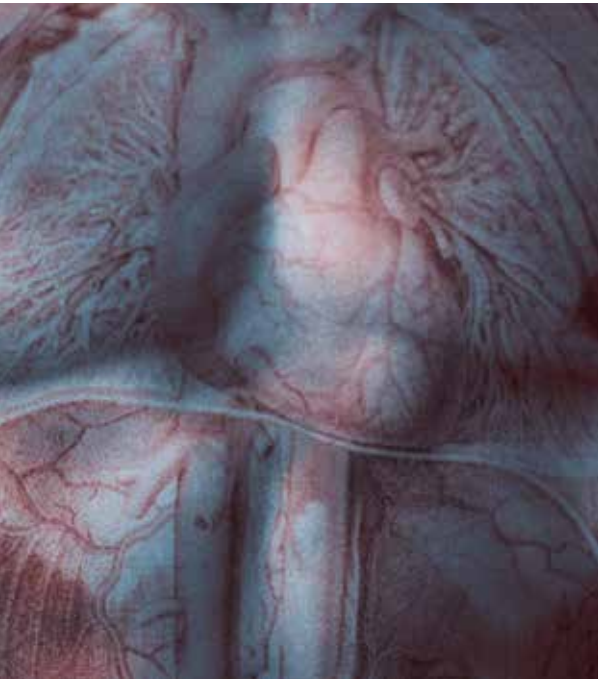
"Treatment of acute Lyme disease acquired from overseas endemic areas is generally agreed, and would comprise a short course of antibiotics, such as doxycycline," Professor Baggoley said. "[But] the treatment for 'chronic' Lyme disease is more contentious, and the existence of this form of the disease is strongly disputed."

The Health Department has established a Lyme disease website (http://www.health.gov.au/lyme-disease), which includes advice and assessments of the disease, as well as details of the research program mapped out by the Department and Committee and links to other reports and information.

Adrian Rollins

COMMENT

Irregular heartbeat raises stroke risk



Thousands of Australians are unaware that they suffer a condition that substantially increases their risk of having a stroke.

The National Stroke Foundation has warned that more than 400,000 Australians living with atrial fibrillation (AF) – a condition that involves an irregular heartbeat - are up to five times more likely to have a stroke.

To help increase understanding of the danger posed by AF, and to provide some reassurance to sufferers, the Foundation has developed a free booklet for those with AF and their families.

AF affects the heart, making it beat faster and out of rhythm. Those with the condition may experience a 'pounding' or 'fluttering' heartbeat known as heart palpitations, while some may experience symptoms such as an irregular pulse, dizziness, tiredness, shortness of breath or chest pain, or may feel faint or light headed.

The new patient resource, *Living with atrial fibrillation*, explains in simple and easily understood terms what AF is and how it affects patients' lives. It includes personal stories of patients, among them active and regular gym user Barry Prater, who was diagnosed with non-valvular atrial fibrillation in 2012. Less than a year later he suffered a stroke.

"I had no idea what a normal heart rate was," Barry warns. "I thought my low heart rate was simply a sign of being fit. After exercise, however, it would sky rocket. My body was trying to tell me something. After my diagnosis, I struggled to find information about AF written by patients."

National Stroke Foundation Chief Executive Officer Dr Erin Lalor said the new booklet will help patients and their families to understand the effects of AF, particularly the risk of stroke, which can be reduced if the condition is carefully managed.

"People with AF who don't know a lot about it, those who have experienced AF-type symptoms or may be at risk, should speak to their doctor and find out more. Being diagnosed with AF can be a frightening experience. However, patients report a significantly improved quality of life when their AF is appropriately managed," Dr Lalor said.

The *Living with atrial fibrillation* booklet is available from www.morethanmedication.com.au or from the National Stroke Foundation on 1800 STROKE (1800 787 653) or www.strokefoundation.com.au

Odette Visser

COMMENT

PUBLIC HEALTH OPINION

Stepping outside of health to be healthy

BY PROFESSOR STEPHEN LEEDER

> “It is theoretically possible for a health-conscious person to go into a pub with his mates carrying a bag of carrots to eat while they drink”

I understand that AMA President Associate Professor Brian Owler, during his recent visit to the Northern Territory, had impressed upon him by health policy managers just how critical progress in the provision of mainstream medical and public health services has been to reducing rates of low birthweight babies and encouraging increments in life expectancy. That is good news.

A/Professor Owler’s informants, however, went on to say that future gains in health would probably come more from outside health, including through action in portfolios such as education and transport, private sector activity that would improve food quality and security, and through economic uplift and reduced unemployment.

A/Professor Owler, a neurosurgeon who appears on billboards in NSW urging people to drive safely and without excess speed to keep their brains intact, knows very well what the health people in NT were talking about. There is a dimension to health that leads us not only out of the ward, but out of the Health Department and the health portfolio into the tough real world beyond. Paradoxically, the better we become at administering medical care and achieving low tobacco smoking rates and 95 per cent immunization rates, the less there is that we, in health and medicine, can do directly to achieve a preventive goal. The architects and engineers of our fate are elsewhere.

Take diabetes as an example. Think about the way in which the availability of high-quality, affordable food varies among suburbs according to economic status. Tired workers in Sydney’s western suburbs retuning late after a full day’s work in the city centre may easily settle for high-fat, high-calorie food because they do not have the time or energy to prepare more nutritious meals. Takeaway food stores abound, as do liquor outlets. Fresh food stores do not.

The design of new suburbs, and the redesign of old ones, is a mixture of private and public enterprise. Planning authorities need to be aware that their decisions will influence the health of people - and not merely (though importantly) in relation to sanitation and clean water.

The structure of Government, with its multiple departments, is robust and has served us well in health, and there are many positive examples of interdepartmental activity at both State/Territory and federal level, often involving health and education. In South Australia, an active program of ‘health in all policies’ has sought to inculcate an awareness of health consequences, especially for non-communicable diseases, of what is decided in portfolios other than Health. It is a tough job to establish a common language across different government departments.

It is true that the buck for health decisions ultimately stops with the individual. He or she decides what they will eat and drink, and how much exercise they will take. But 40 years ago the English epidemiologist Geoffrey Rose made a compelling point. It is theoretically possible for a health-conscious person to go into a pub with his mates carrying a bag of carrots to eat while they drink. But it is a big ask, and not many of us have the willpower to that extent.

Even before Rose, people were drawing compelling links between social and economic circumstances and health.

More than 60 years ago a young doctor in Johannesburg, Mervyn Susser, began asking some very pointed questions about rates of disease and illness afflicting black South Africans.

As he later recalled, at the time medical schools only taught about illnesses afflicting white people – “what happened in the black population was a foreign land”.

His questioning mind eventually led Dr Susser – along with his equally committed wife Dr Zena Stein – to become giants in the field of epidemiology, helping establish proven methods for studying and treating disease.

As he put it, it was about improving public health “from the ground up”, determining who had diseases, and asking why.

Sadly, Dr Susser died on 14 August, aged 92, but his legacy is a much keener understanding of the importance of a multifaceted approach to studying and tackling disease.

We need, as a profession, to reflect on how our advocacy to those who determine our environment might be conducted.

Individual choice is conditioned by the environment. A person living in sub-Saharan Africa in poverty is in no position to make lifestyle choices, and nor are many of our people, to a lesser degree, in Australia today.

If we wish to carry the preventive agenda forward, we need to follow the lead of the Victorian Traffic Authority and the AMA President and make our messages about improved environments clearly heard. Health is everyone’s business and, as our colleagues in the NT tell us, the next steps are to be taken outside our immediate domain.

GENERAL PRACTICE

After-hours primary health services up for review

BY DR BRIAN MORTON

> "... the AMA is still waiting on a full and clear statement from Department of Health and the Department of Human Services, which has been promised"

The AMA has welcomed the Government's recently announced independent review of after-hours primary health care services. The review will be headed by Professor Claire Jackson, with recommendations to be provided to the Government by 31 October 2014.

This latest review was one of the recommendations to Government following Professor John Horvath's Review of Medicare Locals to assess their performance and effectiveness. Among other things, he recommended that the Government should "review the current Medicare Locals' after-hours program to determine how it can be effectively administered".

The AMA, in its Submission to the Review of Medicare Locals, highlighted the ineffectiveness of Medicare Locals in implementing after-hours funding arrangements, leaving a number of GPs previously committed to after-hours care disenfranchised, and adding to the red tape and compliance costs for general practice.

The AMA supported a restoration of after-hours funding via the Practice Incentive Payment program, with supplementary programs developed to target identified gaps in service delivery at the local level.

The review is focusing on the key principles for after-hours primary health care services, including the role of GPs and general practices in delivering after-hours services, and delivery challenges in rural and remote regions.

There will be opportunity to comment on the PIP after-hours incentive and on the role played by MLs in funding after hours care, as well as the after-hours GP helpline and the potential use of video conferencing to provide after-hours care. It is also looking at possible funding alternatives for rural and remote regions.

The AMA is preparing a submission to the *Review of After-Hours Service Delivery*, working with both the AMA Council of General Practice and the AMA Rural Medical Committee.

Comments received to date from member representatives to date highlight the need for funding to be directed to those GPs and practices that are providing a genuine after-hours service to their patients.

Also, given the poor remuneration for after-hours services and the disparity in service accessibility, a single solution is unlikely to address the barriers to the provision of after-hours services and provide appropriate patient access.

The AMA's Position Statement on *Out-of-Hours Primary Medical Care* outlines what we think an after-hours primary care model should look like. Among others things, it would need to:

- provide appropriate remuneration for the provision of clinically required services;
- ensure continuity of care;
- be driven by well-defined clinical need;
- be locally appropriate and conform to appropriate professional standards; and
- prove its effectiveness.

The AMA has also met with Professor Jackson in the lead up to the provision of our submission.

Because the timeline for the review is so short, any AMA members who would like to contribute comments or ideas should contact the AMA immediately to ensure their views can be considered.

COMMENT

Clinical academic pathways: reorienting our approach to research for doctors in training

BY DR CHLOE ABBOTT, AMA COUNCIL OF DOCTORS IN TRAINING, ACT REPRESENTATIVE; CHAIR OF ACT DOCTORS IN TRAINING FORUM

> "There are a number of attractive options for improving the integration of clinical academic pathways into the Australian medical training system"

Numerous doctors, in both their prevocational and vocational training years, express a desire to incorporate academic research into their expertise as a medical practitioner. Motivations for this range from satisfying professional requirements to wishing to pursue a full-time career in medical research.

However, these doctors face a dilemma regarding how and when are they can pursue these opportunities.

A lack of coordinated clinical academic pathways that would allow doctors to complete clinical obligations while also undertaking the requirements of research is a major issue for those in the prevocational and vocational workforce.

This has manifested in a decline in the number of academic positions in the past decade, as many doctors veer away from the field because of the perceived or actual disadvantage involved in sacrificing clinical experience for academic research.

At the same time, doctors are faced with the issue of higher education requirements to secure training positions, or employment after their training completion.

As competition for places has intensified, academic research experience has become an increasingly significant point of difference for trainees, but this is yet to be reflected in many pathways currently available in Australia. Instead, trainees are burdened with meeting their clinical training requirements while simultaneously attempting to pursue academic research, often leaving them in difficult financial circumstances - the remuneration of these endeavours is significantly less than a full time medical trainee income.

Australia is not alone in what has been labelled an "academic medicine crisis".

As early as 2005, the International Campaign to Revitalise Academic Medicine was warning that academic medicine was at risk of "failing to realise its potential and global responsibility due to lack of both infrastructure and structural change required to capitalise on investments in this field".

In a report published by the Milband Fund, the Campaign identified a number of barriers to the development of academic medicine through to mid-2025, and discussed a number of potential solutions to reviving the clinical academic workforce.

The AMA Council of Doctors in Training is currently working with universities, medical colleges and the Medical Deans Australia and New Zealand (MDANZ) to support existing pathways to academic medicine and provide direction for the development of programs that would enable trainees to meet vocational requirements and academic pursuits simultaneously, without financial or employment disadvantage.

There are a number of attractive options for improving the integration of clinical academic pathways into the Australian medical training system.

The successful implementation of the UK Academic Foundation Program, which has fostered the development of an optional pathway which incorporates academic research in the first two years of a medical career, provides a potential model for Australia, particularly given the growth in medical graduate numbers and the limited opportunities to expand training places.

Ways of formally integrating research opportunities into vocational training and strengthening the linkages between undergraduate, prevocational and vocational research pathways, must be examined.

As we delve into the challenges facing the Australian health system, including ballooning health care costs associated with an aging population, it is obvious that competition for funding will intensify.

Just as workforce planning is beginning to focus on population demand, research concerned with the biggest and most costly health conditions should be fostered, both for its potential to improve patient care and to reduce health care costs.

*For more information, see the **AMA Position Statement on Clinical Academic Pathways in Medicine (2013)** at: https://ama.com.au/position-statement/clinical-academic-pathways-medicine-2013*

Health on the hill

Political news from the nation's capital

NDIS costs up, but quicker to help

The average cost of care for those participating in the National Disability Insurance Scheme is rising, but the time taken to determine eligibility and start receiving support is falling, according to a progress report on its first trial year.

In its latest assessment of the sustainability of the Scheme, the National Disability Insurance Agency reported that, as at 30 June, 8585 eligible participants had enrolled in the scheme – 91 per cent of what had been anticipated at this stage – and of these, 7316 had current approved and funded care plans.

The Agency found that the average annualised cost of care packages was $34,600 a year, a $2400 increase since March, though it said the figure was skewed by a small number of people with very expensive care plans.

It reported that, of 5148 people in NSW and Victoria receiving support through the NDIS, 3346 (65 per cent) had approved care packages that cost less than $30,000 a year, while around 500 required care packages worth $100,000 or more a year.

In all, support for those with packages worth $30,000 or less accounted for just 18 per cent of funds committed under the scheme.

Adding to the imbalance, so far there have been fewer low cost participants than had been expected, and more at the mid-range.

"Therefore, the overall annualised average package cost is driven by a small number of participants with high cost plans," the Agency said. "Understanding this distribution is key to monitoring the Scheme, and much more relevant than the annualised package cost."

In a sign that the Agency's performance is rapidly improving, the average time taken to determine eligibility to participate in the NDIS participant's eligibility has been more than halved, from 29.7 days in the first six months of the Scheme to 13.3 days in the second six months.

Applicants now face an average wait of 94 days to begin receiving services, a week less than six months ago.

Overall, the Agency found the Scheme in its cost and implementation was broadly on track, so far allaying concerns of an unexpected budget blow-out.

The Scheme is being trialled in a number of locations across the country prior to its full national roll-out.

As at 1 July it was being offered to people with disabilities in the following locations:

South Australia: children aged 13 years and younger;

Tasmania: people aged between 15 and 24 years;

Victoria: people 65 years or younger living in the City of Greater Geelong, Colac-Otway Shire, Borough of Queenscliffe and Surf Coast Shire;

New South Wales: people 65 years or younger living in the local government areas of Newcastle and Lake Macquarie;

Australian Capital Territory: staged intake of all eligible residents up to the age of 65 years;

Western Australia: people 65 years or younger living in the local government areas of Swan, Kalamunda and Mundaring; and

Northern Territory: people 65 years or younger living in the Barkly region around Tennant Creek.

The assessment of those participating the scheme has so far been largely positive.

Asked to rate their satisfaction between -2 (extremely dissatisfied) and +2 (extremely satisfied), those surveyed by the Agency reported an average score of 1.66, a level consistent with the last survey conducted in March.

There has been some nervousness that the Federal Government might look to scale back its commitment to the NDIS, but Assistant Minister for Social Services, Senator Mitch Fifield, said the Commonwealth remained "firmly committed" to the Scheme and its full national roll-out and paid tribute to the "herculean effort" of Agency staff to get the trial sites up and running.

"The Commonwealth remains firmly committed to the NDIS and is working closely with our state and territory counterparts and the NDIA to deliver the full national rollout of the National Disability Insurance Scheme," the Minister said, adding that the Government was closely monitoring the Agency's performance.

"It is important that the NDIA be a continually learning organisation that can listen to feedback and make adjustments as necessary," he said. "It is to be expected that there would be important lessons to be learned following the first year of the operation of the trial sites. This is how we will ensure that the Scheme can be the best that it can be."

Shadow Minister for Disability Reform Claire Moore said the Scheme's performance so far was a credit to Agency staff and service providers, and said Labor would hold Prime

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Minister Tony Abbott to his promise to deliver the NDIS in full and on time.

The Agency has urged medical practitioners to help in implementing the NDIS by assisting patients with a disability assess their eligibility for assistance.

"The NDIS is designed to support thousands of people with a significant and permanent disability that affects their ability to take part in everyday activities," the Agency said. "People with a disability that significantly affects their communication, mobility, self-care or self-management may be eligible. The NDIS also covers people for whom there is good evidence early intervention would substantially reduce the impact of the disability."

The Agency has asked doctors to direct patients to the online self-assessment tool, My Access Checker, which is at ndis.gov.au/my-access-checker.

The Checker helps people with permanent and significant disability assess whether they may be eligible for assistance from the NDIS. The process may involve health professionals providing information about their patient's diagnosis, treatment, the duration of their impairment and the impact their disability has on their ability to perform daily tasks.

For more information about the NDIS, visit ndis.gov.au or call 1800 800 110.

Adrian Rollins

COMMENT

Insurers could dig further into primary care with after-hours review

Hopes for an overhaul of Medicare rebates for after-hours care have been dealt a blow after they were excluded from a review of after-hours primary health care services commissioned by the Federal Government.

Health Minister Peter Dutton ruled out after-hours Medicare Benefits Schedule items from being included in the review, to be headed by former Royal Australian College of General Practitioners President Professor Claire Jackson.

Instead, it is likely to include suggestions for greater private sector involvement in the provision of after-hours care – a potentially contentious area given grave concerns held by the AMA about the push by private health funds into primary care.

The review's terms of reference, unveiled by the Minister, include looking at "opportunities for improved engagement with the private sector".

"The Government is committed to fixing Australia's health system and to improving frontline services to meet community needs, including after-hours services," Mr Dutton said. "Professor Jackson will provide advice to the Government on the most appropriate and effective delivery mechanisms to support ongoing after-hours primary health care service provision nationally."

The review has also been directed to look at policy setting required to generate "innovative solutions".

The Minster has set Professor Jackson a tight deadline for the review, asking her to report back with recommendations by 31 October.

AMA President Associate Professor Brian Owler has voiced major fears about the potential for increased private sector involvement in general practice to open the way to US-style managed care.

The AMA has been watching with concern a trial arrangement between Medicare Private and primary health provider IPN under which the insurer contributes to practice administrative costs in return for privileges for its members, including a guaranteed GP appointment within 24 hours.

In a major speech to the National Press Club in July, A/ Professor Owler warned that "the stage is being set for a US-style managed care system in both the primary care and hospital settings [and] I am concerned that the Government is also looking towards such a system."

Professor Jackson's inquiry comes against a turbulent backdrop for general practice. Not only is the Medicare Local scheme to be scrapped and replaced with Primary Health Networks, but Government plans for the introduction of a $7 co-payment for GP services remains in political limbo and the speciality is still trying to absorb the implications of wholesale changes to GP training arrangements, including the abolition of General Practice Education and Training and the absorption of its functions within the Health Department.

The Government has identified arrangements for the provision of after-hours GP services as one of its biggest concerns.

Under the Labor Government, Medicare Locals were given responsibility for contracting and coordinating after-hours GP services within their catchment areas.

But the process has been dogged by problems and complaints, and former Chief Medical Officer Professor John Horvath recommended in his report on the on the flawed

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Medicare Locals scheme that the provision of after-hours primary health care services be reviewed.

AMA is preparing a submission to the Jackson review.

Mr Dutton said current arrangements for after-hours services would be maintained until the end of Medicare Locals on 30 June next year, and "new funding arrangements will be transitioned from 1 July 2015 to ensure continuity of after-hour service provision".

Questions and comments regarding the Jackson review can be sent to afterhoursreview@health.gov.au

COMMENT

Adrian Rollins

Medicare: coming to a post office near you?

Details of patient consultation items and Medicare rebate claims could end up in the hands of private corporations under Federal Government plans to outsource Medicare and Pharmaceutical Benefits Scheme claims and payment processes.

The Health Department has called for expressions of interest from the private sector to take over the management and processing of Medicare and PBS claims from the Department of Human Services.

Health Minister Peter Dutton said it made good sense to explore the possibility the private sector could provide the service more cheaply and efficiently.

"The current IT systems that manage the claims and payments processes are dated and in need of a substantial upgrade," Mr Dutton said. "In these circumstances, it is good process to review and test existing and alternative systems."

Medicare offices are not included in the plan, and would be expected to continue to provide face-to-face services for clients.

But Mr Dutton said private companies already provided data services to the Government, and the "commercial sector may be able to provide a better service to Australians at a lower cost to the taxpayer".

Australia Post is considered by some to be one of the frontrunners in providing the outsourced service, which involves a massive undertaking.

The successful bidder would have to be capable of processing around 630 million transactions a year, involving claims worth around $31.5 billion.

The idea to outsource the processing of Medicare and PBS claims was presented by Australia Post to the Commission of Audit, and Chief Executive Ahmed Fahour told *The Australian Financial Review* his organisation was "uniquely positioned" to provide the service.

Already, Australia Post has struck a deal with DHS to provide a digital postal services for agencies including Medicare and Centrelink.

Adding to suspicions that Australia Post is a frontrunner for the possible contract, the window for submitting expressions of interest was very narrow given the potential size of task. The notification was made public on 8 August, and bidders were given just two weeks to lodge their proposals.

The prospect that private organisations will process Medicare and PBS data has some to raise privacy concerns.

Shadow Health Minister Catherine King said she was "extremely concerned" about the implications of the plan for data security and jobs.

"People receiving healthcare and targeted government support… shouldn't have to stand in line at Australia Post, at some private company's shopfront or spend hours on hold to some international call-centre, just to lodge a claim or hand in a form," Ms King said. "They also shouldn't have to worry about their most sensitive medical and financial details being handed over to a private company."

The Consumers Health Forum said any move to outsource the processing of Medicare and PBS claims must involve rigorous safeguards to protect patient privacy and interests.

COMMENT

Adrian Rollins

Anderson's fresh attack at boundaries of knowledge

Eminent medical researcher Professor Warwick Anderson will head a global, interdisciplinary collaboration pushing at the boundaries of life sciences knowledge from next year.

Professor Anderson, who has led the National Health and Medical Research Council for the past nine years, has accepted an offer to become the next Secretary General of the International Human Frontier Science Program Organisation.

In the position, which he assumes next July, Professor Anderson will pilot the collaboration through the next phase

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of its work supporting fundamental research into the complex mechanisms of living organisms.

Since its inception in 1987, the Program has used collaborative research grants and postdoctoral fellowship programs to help fund more than 6000 research projects involving scientists from more than 70 countries.

Program President, Professor Nobutaka Hirokawa, said Professor Anderson was "exceptionally qualified" for his new position.

"His experience guarantees the continuity of HFSPO's standing in the global scientific community and, at the same time, it is a recognition of the increasing scientific strength of the Asia Pacific region," Professor Hirokawa said.

Australia is among 14 countries and regions that contribute to te program, including Canada, France, Germany, India, Italy, Japan, Republic of Korea, Norway, New Zealand, Singapore, Switzerland the United Kingdom, the United States of America and the European Union.

Health Minister Peter Dutton paid tribute to Professor Anderson's work, particularly his time as head of the NHMRC – a position he was appointed to in mid-2006 by the-then Health Minister, Tony Abbott.

"Since that time, Australia has become a world leader in the field of health and medical research, and Professor Anderson has played a key role guiding some of our most gifted researchers in a diverse range of fields and pursuits," Mr Dutton said. "Professor Anderson leaves Australian research in much better shape than he found it, and does so with the respect and admiration of his peers."

Professor Anderson will continue with the NHMRC until he takes his position with HFSPO.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Cambodian Children's Trust

The Cambodian Children's Trust, which works to support families and children in the city of Battambang, is looking to expand its Medical Advisory Panel as it grows its family support base.

Panel members are expected to liaise on an occasional basis with the Trust's well-trained nurse manager by phone, email or Skype, as needed. They will also have opportunities to conduct clinics when in Battambang (about six hours north west from Phnom Penh).

The Trust is seeking candidates with a diverse range of skills, including all-rounder GPs experienced in emergency, obstetrics and gynaecology and anaesthetics, as well as practitioners trained in tropical medicine, public health, infectious disease, paediatrics, psychiatry, cardiology, endocrinology and dermatology.

The Trust is run by former NSW Young Australian of the Year Tara Winkler. More information can be found on the Trust's website, http://www.cambodianchildrenstrust.org/about/meet-the-team/

INFORMATION FOR MEMBERS

Palliative Care

Palliative Care Australia is seeking feedback on its latest draft of industry standards.

PCA President Professor Patsy Yates said the process had been driven by the palliative care sector, which was calling for the standards to be updated to "clearly articulate and promote a vision for compassionate and appropriate end of life care across all settings".

Australia's ageing population will place increasingly heavy demand on the palliative care sector in the coming years. The industry body is aiming to ensure the standards reflect current practice while remaining relevant in the future.

Individuals and groups can offer their contributions on National Palliative Care Australia website until 26 September 2014.

Doctors, nurses worldwide called to help tackle deadly Ebola outbreak

The World Health Organisation has launched an international appeal for doctors and nurses, particularly those experienced in infection prevention and control, to join health teams being sent to West Africa to help control the worst Ebola virus outbreak on record.

As the death toll from the disease has jumped to more than 1500 people, the WHO is helping coordinate international efforts to treat the deadly infection and combat its spread, and has specifically called for specialists in infection control and prevention to support the work of medical teams on the ground.

The appeal came as the Federal Government announced it was providing the WHO with $1 million to help fund efforts to combat the outbreak.

Foreign Minister Julie Bishop said that although there have been no cases of Ebola in Australia and the risk of its spreading here was low, the nation was responding to the WHO's declaration that the outbreak constituted an international public health emergency.

The WHO has reported that, as at 29 August, there had been 3052 confirmed, probable or suspected cases of the infection in West Africa, resulting in 1546 deaths. In a more promising development for health authorities, the current outbreak of the disease has not proved as deadly as in the past, with a survival rate of 47 per cent survival rate – well down from a mortality rate of 90 per cent in previous outbreaks.

But, underlining the urgency of its worldwide appeal for health workers to join the international effort to control the outbreak, the WHO said there had been an "unprecedented" number of doctors, nurses and other health staff infected with the deadly disease.

By the end of August, more than 240 health workers had contracted Ebola, and more than half had died, the WHO said.

"Ebola has taken the lives of prominent doctors in Sierra Leone and Liberia, depriving these countries not only of experienced and dedicated medical care, but also of inspiring national heroes," the UN agency said.

It said the disease's heavy toll of health workers was due to a number of factors including a shortage of personal protective equipment, a paucity of qualified medical staff, the dedication of doctors and nurses to work in isolation wards for far longer than is considered safe, and a lack of knowledge in proper infection prevention and control techniques.

The fact that the disease has spread to cities is also significant, leading to "vastly increased opportunities for undiagnosed cases to have contact with hospital staff. Neither doctors nor the public are familiar with the disease…[and] doctors and nurses may see no reason to suspect Ebola and see no need to take protective measures".

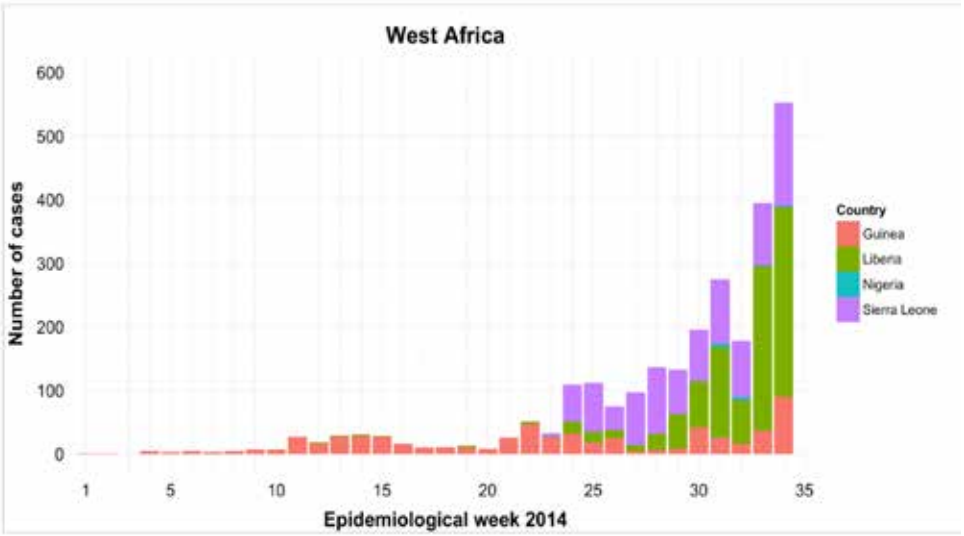
Just such a scenario has played out in Senegal, where a visiting Guinean student suffering what was thought to be malaria sought treatment in a Dakar hospital. It was subsequently confirmed that he was infected with Ebola, sparking an emergency effort by health authorities to track everyone he had been in contact with.

Rates of infection in the outbreak continue to climb, with estimates that ultimately up to 20,000 people will become infected – meaning, at current fatality rates, that more than 10,000 people could be killed – making it the deadliest Ebola infection on record.

Adrian Rollins

COMMENT

Combined epidemiological curves



Source: WHO Ebola Response Roadmap Situation Report 1, 29 August

OPINION

BY PROFESSOR STEPHEN DUCKETT, DIRECTOR, HEALTH PROGRAM AT GRATTAN INSTITUTE

Australian health care: where do we stand internationally?

This article was first published by The Conversation on 1 September, 2014, and can be viewed at: http://goo.gl/80wv4H

There is an old joke about one fish asking another about the state of the water and the other answering "what's water?" When you're immersed in something and that is your daily experience, you are not able to step outside it – all you see is what you know.

But with all the talk about Australia's health system being unsustainable, it's useful to step back and look at the Australian health system in an international context.

So, how do we perform against our peers? The short answer is pretty well.

Comparing inputs and outcomes

Much of the sustainability talk is about costs, and only about costs. Costs are important, but any reasonable comparison of Australia's standing also takes into account what we get for the spending. Measuring costs is (relatively) easy. We can compare cost per head spent on health care (standardised across countries into a common monetary unit) or costs as a share of gross domestic product (GDP).

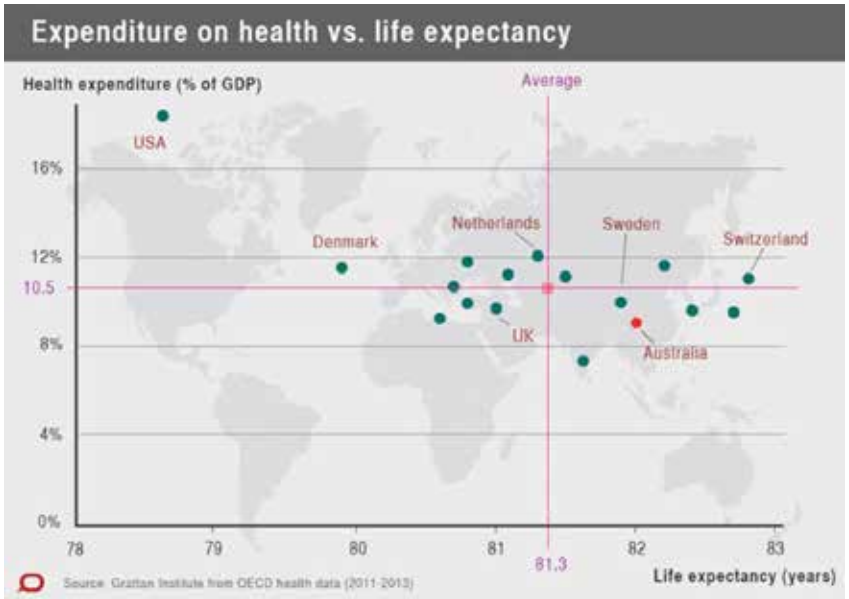
Measuring the benefit side is a bit trickier. The most common comparisons of outcomes are mortality-based measures, partly because measurement is definitive. There are choices here too. Life expectancy and a measure of "early deaths" (deaths before age 70) known as "potential years of life lost" are the two most common.

Using these mortality-based measures to compare health systems has a number of weaknesses. It assumes that the most important contribution of the health system is delaying death, ignoring quality of life. They also assume that the health system is the most important contributor to life expectancy, ignoring broader socioeconomic and environmental factors such as clean water, employment and good nutrition.

Despite these weaknesses, the measures are commonly used, readily available for comparable countries and they're the best we've got.

Better than average

The graph below shows where Australia sits compared to similar OECD countries (countries within 25% of Australian GDP). Countries which are better than the OECD average on life expectancy are on the right hand side. Countries that spend a smaller share of GDP on health care are on the lower part of the graph.



Life expectancy and health expenditure of selected countries, latest year (2011-2013) Grattan Institute/OECD

Australia is in the good quadrant: better than average life expectancy, lower than average share of GDP. The stand-out poor-performing country is the United States, with high costs and poor outcomes.

So we're OK now, but are we going downhill?

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Australian health care: where do we stand internationally?

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The graph above shows data for the most recent year available. Australia's historic trends are also good. In 2001, Australia spent 8.2% of GDP on health; ten years later GDP share had increased to 9.1%. Over the same period, the comparable country average had increased faster – from 8.8% to 10.3%.

Our life expectancy improvements essentially mirrored other comparable countries.

This suggests that in addition to being in a good position now, the trend in both inputs and outcomes over the past decade has been a healthy one, comparably.

No cause to be complacent

Australia is performing well against our peers, and has done so over the past few decades. But current life expectancy is the product of past policies. And past good performance doesn't guarantee we are well positioned for changing health-care needs.

Equity concerns

It's important to remember that the data above are country averages. In Australia's case, the average masks very poor performance for our Indigenous populations whose average life expectancy is around ten years shorter than non-Indigenous Australians. Poorer Australians also have worse health outcomes.

There are other equity issues as well. A Grattan Institute submission to a recent Senate Committee inquiry showed that some households face very high levels of out-of-pocket costs. Australian Bureau of Statistics surveys show people are already deferring care because of high out-of-pocket costs.

Access to care for people in rural and remote Australia is much worse than in metropolitan areas, causing problems not only in term of health status but also in increased cost of care.

Future care needs

Repositioning the health system to address the challenges of chronic disease is hard. It seems obvious that a system that pays doctors for seeing patients again and again is probably not suitable to encourage continuity of care and looking after a person for an ongoing illness.

Unfortunately, getting beyond that simplistic statement is complex. The evidence on the best way to pay doctors is quite weak and so moving forward on better payment systems will require experimentation to identify what works in the Australian context.

Structural changes, to improve seamlessness of care to ensure that a person with chronic illnesses has access to all the professional skills needed, will also be required.

Prune waste

Science advances, and with it come new treatments and new demands for funding. The increasing prevalence of chronic illness creates another set of pressures on health spending.

There are a number of potential responses to the challenge of increased costs. The worst is to panic and adopt draconian "quick fixes" which aren't fixes at all. The $7 co-payment proposal, which shifts costs rather than saves them, is an example of this approach.

The alternate pathway is to attack waste in the health system: there are inefficiencies in hospitals, in the way we use our highly skilled health professionals and in how we pay for pharmaceuticals. Billions of dollars can be freed up in these areas.

Pruning waste is hard as every dollar of health spending is a dollar of someone's income, profits or revenue. Rent seekers will be out in force to defend the status quo. Paraphrasing another famous saying, political leadership was never meant to be easy but nevertheless, Operation Eliminate Healthcare Waste should surely be a political priority.

Where to from here?

Australia is not alone in facing these challenges: the changing health-care profile is a universal phenomenon. Other countries are addressing these issues and we can potentially learn from those experiences. *The Conversation* will be publishing five "country studies" over the next week to explore these international lessons.

COMMENT