AUSTRALIAN
Medicine
The national news publication of the Australian Medical Association

Ebola – time for Australia to step up

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ISSUE 26.18 - SEPTEMBER 16 2014

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

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BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Of death and dying – the discussion we must have

As Australians, we now enjoy a longer life expectancy than any previous generation.

Nutrition, vaccination, public health measures and a world class system of medical care all play their part in this great outcome. Greater longevity, however, also has implications for the way in which Australians reach the end of their lives in the twenty first century.

As doctors, we understand and acknowledge that most of us will eventually succumb to the effects of chronic disease, and that medical care is as much about disease control and symptom relief as it is about prevention and cure.

How we care for our patients as they approach their death can be among the most difficult yet rewarding aspects of our professional lives. I have certainly found this to be the case in my own clinical work.

The AMA recently published its *Position Statement on End of Life Care and Advance Care Planning 2014*. The statement is an update of (now superseded) policy statements on the role of the medical practitioner in end of life care and advance care planning. The statement has undergone a major transformation, updating definitions and applying more contemporary terminology and clarifying policy positions.

> "A significant issue, however, concerns the often contentious and emotive matter of medical futility"

It addresses a range of issues relevant to end of life care, including decision-making capacity, cultural awareness, conscientious objection, palliative care, artificial nutrition and hydration, workforce, and advance care planning.

The statement strongly supports patients to make their own informed health care decisions, emphasising the importance of open, continuous communication and collaboration between the patient, the health care team led by their doctors, and, where appropriate, the patient's carers, family members and/or substitute decision-maker (SDM).

A significant issue, however, concerns the often contentious and emotive matter of medical futility. While the medical profession supports patients (or their SDMs, as relevant) in making informed decisions to withhold and/or withdraw life-sustaining treatments, doctors are generally not obliged to try to prolong life at all costs.

Indeed, the Medical Board of Australia, in its Code of Conduct, states that good medical practice involves:

> *3.12.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.*

In the (now superseded) Position Statement on the Role of the Medical Practitioner in End of Life Care 2007, we addressed medical futility as follows:

> *Medical practitioners are not obliged to give, nor patients to accept, futile or burdensome treatments or those treatments that will not offer a reasonable hope of benefit or enhance quality of life.*

Upon reviewing this position, the AMA agreed that the general principle still holds true, but that it did not recognise the subjective nature of futility – that what is futile to the doctor may not be futile to the patient (or their SDM).

The doctor contributes his or her clinical judgement to determine medical futility based on expertise in physiology, pathology and therapeutics. Indeed, the updated position statement defines medical futility in clinical terms as "treatment that gives no, or an extremely small, chance of meaningful prolongation of survival and, at best, can only briefly delay the inevitable death of the patient".

With this information in hand, the patient (or their SDM) decides whether or not the proposed treatment has the potential to meet their goals of care. Not all patients will feel the same way – the values and goals of care of individual patients will differ. For some, the chance of living for a few days, even in discomfort, may be meaningful if it provides them with an opportunity to spend time with a particular loved one or fulfil a similar, profound experience – for them, the treatment is not futile.

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Of death and dying – the discussion we must have

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While we may believe it is inappropriate for patients (or SDMs) to demand medically futile treatment, the patient's views should be elicited, taken into account (along with relevant legal and resource implications), and discussed with the patient (or SDM) before making a decision not to offer a particular treatment.

The updated policy on medical futility now states:

> *7.1 Doctors should understand the limits of medicine in prolonging life and recognise when efforts to prolong life may not benefit the patient. In end of life care, medically futile treatment can be considered to be treatment that gives no, or an extremely small, chance of meaningful prolongation of survival and, at best, can only briefly delay the inevitable death of the patient (cit).*
>
> *7.2 Whilst doctors are generally not obliged to provide treatments that are considered medically futile, where possible it is important that the doctor discuss their reasons for determining a treatment to be medically futile with the patient (and/or the SDM, carers, family members) before deciding the treatment should not be offered.*
>
> *7.3 In some cases, a treatment may not offer a benefit in terms of curing a patient's condition, or significantly extending life or improving quality of life, but it may benefit the patient in other ways. For example, a 'medically futile' treatment may briefly extend the life of the patient so he or she can achieve their wish of saying goodbye to a relative who is arriving shortly from overseas.*

This updated position reflects our commitment to respecting patients and supporting them in achieving their goals of care, where possible, at the end of life.

The AMA *Position Statement on End of Life Care and Advance Care Planning 2014* can be viewed at: https://ama.com.au/position-statement/position-statement-end-life-care-and-advance-care-planning-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

Australia must act on worst-ever Ebola outbreak

The worst Ebola outbreak on record is on the verge of becoming a major international public health crisis that demands a much greater response from the Australian Government, AMA President Associate Professor Brian Owler has said.

While fears that a Gold Coast man recently returned from Congo was infected with Ebola turned out to be unfounded, hundreds of new cases are being detected daily in west Africa.

By late last week the World Health Organisation reported at least 4293 people across five west African countries had been infected with the disease and 2296 had died – though the agency admitted this was likely an underestimate.

"The number of new cases is increasing exponentially," the WHO said, calling the situation a "dire emergency with ... unprecedented dimensions of human suffering".

Attempts to bring the outbreak under control have so far failed and countries at the centre of the crisis are struggling to cope.

Liberian Minister for National Defence Brownie Samukai told the United Nations Security Council his country was facing "a serious threat to its national existence. The deadly Ebola virus has caused a disruption of the normal functioning of our state".

A/Professor Owler said that the world was witnessing an "evolving international humanitarian crisis", and the response so far – including from Australia – had been totally inadequate.

"The AMA acknowledges the recent commitment of $1 million by the Australian Government, but it is clear now that much more needs to be provided," he said.

The WHO has already formally declared the Ebola outbreak a public health emergency of international concern, and late last month issued a worldwide 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 disease.

The AMA President said a priority for Australia should be to get skilled medical and health professionals, fully equipped with the equipment and medicines they need, on the ground in west Africa as soon as possible.

"We have doctors and nurses who would volunteer to do that work, which is not without its dangers, so we need to get them there, along with the equipment and other resources they need," he said.

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Australia must act on worst-ever Ebola outbreak

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A/Professor Owler said that while Australia and the international community had been quick to act on the threat posed by Islamic State in Syria and Iraq militants in Iraq, the response to the Ebola outbreak had been "terribly slow".

"If the Government can get military arms airlifted to northern Iraq at short notice, surely we can airlift medical arms and legs to West Africa just as quickly to save lives," he said. "We need medical supplies. We need resources. We need mobile hospitals and beds and we need support and organisation for our health care workers that I know will be willing to volunteer and go."

The Bill and Melinda Gates Foundation late last week donated $55 million to help combat the Ebola outbreak, which health authorities warn could eventually infect more than 20,000 people.

Director of the WHO's Department of Pandemic and Epidemic Diseases, Dr Sylvie Briand, admitted it was likely the outbreak was even more extensive than current figures suggested.

"We know that the numbers are under-estimated," Dr Briand told a news briefing in Geneva, as reported by Reuters. "We are currently working to estimate the under-estimation."

A/Professor Owler said the outbreak was currently "out of control", but backed assurances by Australian health authorities that it posed little threat to Australia.

Chief Medical Officer Professor Chris Baggoley said the risk of Ebola coming to Australia was "extremely low".

He said procedures were in place to ensure that anyone coming into the country with the disease would be quickly identified, tested, isolated and treated.

"The risk of sustained transmission of Ebola in Australia is negligible," Professor Baggoley said.

Adrian Rollins

COMMENT

Tracking the outbreak

One of the most important tools in bringing infectious diseases like Ebola under control is to identify people who been in contact with an infected person and monitor them over a period of time.

But patient information systems in the countries at the centre of the Ebola outbreak – Liberia, Sierra Leone and Guinea – were already rudimentary even before the disease struck, and have so far not proven to be up to the task.

In Sierra Leone, for example, only around a third of contacts identified in the database maintained by the Ministry for Health have a clearly identifiable address.

In its 12 September situation report, the World Health Organisation warned "the capacity for contact tracing in Guinea, Liberia, and Sierra Leone is under extreme pressure, and needs to be further assessed; particularly in areas facing a surge in cases".

While authorities struggle to track the infection, there is no sign yet of the disease slowing in its spread.

As at 7 September, 48 per cent of all cases in the three countries had occurred in the previous 21 days – including almost 60 per cent in Liberia.

"Transmission is continuing in urban areas, with the surge in Liberia being driven primarily by a sharp increase in the number of cases reported in the capital, Monrovia," the WHO said.

Adrian Rollins

COMMENT

Of death and dying

The AMA has called for an end to the taboo on talk about death, urging that there be frank and open discussion about end of life care, futile treatments, advance care planning, dying and bereavement.

As a Senate committee holds hearings on proposed Dying with Dignity legislation, the AMA has released an updated policy statement on end of life care that broaches complex and highly emotive issues around how to care for terminally ill patients, including the right to refuse treatment and the pressure to prolong life at any cost.

AMA Vice President and emergency physician Dr Stephen Parnis said caring for people approaching the end of their life was at once one of the most difficult and yet rewarding aspects of being a doctor.

But Dr Parnis said effective, on-going communication between doctors, patients, families and carers was key to making a patient's final days as comfortable, calm and stress-free as possible.

"As doctors, we understand and acknowledge that most of us will eventually succumb to the effects of chronic disease, and that medical care is as much about disease control and symptom relief as it is about prevention and cure," he said. "How we care for our patients as they approach their death can be among the most difficult yet rewarding aspects of our professional lives."

The AMA Vice President said good communication between the patient, their family, carers and the health care team throughout the course of an illness helped "alleviate fear, confusion, and guilt over the patient's condition, assist with decision-making, and reduce the potential for conflict over the patient's care".

Medical practitioners caring for the terminally ill can be confronted with major ethical, moral and legal dilemmas.

In its submission to the Senate inquiry into the *Exposure Draft of the Medical Services (Dying with Dignity) Bill 2014*, the AMA said it opposed making it legal for doctors to prescribe and administer an end of life substance.

"We believe that doctors should not be involved in interventions that have as their primary intention the ending of a person's life," the AMA submission said, adding that activities like euthanasia and assisted suicide breached the fundamental ethical principles underpinning medical practice.

The AMA said it was consistent with good medical practice for doctors not to initiate or continue life-prolonging measures, or to provide treatments that had as their primary purpose the alleviation of symptoms, but which may have the secondary consequence of hastening death.

"Withholding and/or withdrawing life-sustaining treatment allows the course of the person's illness to progress naturally, which may result in death," it said. "In addition, the administration of treatment to relieve symptoms which may have the secondary consequence of hastening death is undertaken with the primary intent to relieve the patient of distressing symptoms.

"It is important that these practices, which are ethically acceptable…are not confused with activities that constitute euthanasia or physician-assisted suicide."

The issue can also be a legal minefield.

A study published in the *Medical Journal of Australia* last month found "critical gaps" in the legal knowledge of doctors that could expose them criminal charges including murder, manslaughter and assault.

The survey of 867 doctors found that, on average, they correctly answered just three out of eight questions about laws regarding end of life care.

The researchers said that doctors could run foul of the law for withholding or withdrawing treatment, as well as for providing life-sustaining treatment against a patient's wishes.

Dr Parnis said it was important that patients prepare advance care plans to inform doctors, families, and carers about their preferences in the event they lose decision-making capacity.

"An advance care plan is a process of ongoing reflection, discussion, and communication of health care preferences that may result in oral or written directives, such as an advance care directive," he said. "Legally competent patients have the right to make health care decisions, including the right to refuse interventions such as life-sustaining treatment."

He said patients with limited or impaired capacity should be encouraged and supported to participate in treatment decisions, consistent with their level of capacity at the time.

Adrian Rollins

COMMENT

Myths around doctor fees exploded

Doctors have largely shielded their patients from increases in the cost of health care by absorbing cuts in Government and insurer rebates for medical services rather than passing them on to consumers, busting the greedy doctor myth, the AMA has said.

AMA President Associate Professor Brian Owler has told a Senate inquiry that the vast majority of health services are provided at no cost to patients, even though Government and private health fund contributions to the cost of care have become increasingly inadequate.

Seeking to explode myths around doctor fees and the cost of medical care, A/Professor Owler told the Senate Community Affairs References Committee the widespread view that all out-of-pocket costs were caused by doctors, and that greedy practitioners were pushing up their fees faster than other health costs, was false.

"The vast majority of health care provided in Australia is provided at no cost to the patient," the AMA President told the inquiry, citing as evidence Medicare data showing 81.1 per cent of GP consultations in 2012-13 were bulk billed, while almost 90 per cent of in-hospital medical services were charged at the level of private health insurer benefits.

The AMA acknowledged that where patients are charged out-of-pocket costs, the fees they face are higher than a decade ago – the average charge for a GP visit climbed from $12.46 to $28.58 in the 10 years to 2012-13.

But A/Professor Owler said the data showed that patients were no more likely now than they were a decade ago to face out-of-pocket costs – in 2001-02, 17.5 of medical services involved out-of-pocket expenses, compared with 17.3 per cent in 2011-12.

He said this had only been achieved by doctors making up shortfalls in Government rebates and health insurer benefits themselves, rather than forcing their patients to make up the difference – a fact that has gone unacknowledged by governments and unnoticed by patients.

"The high rates of schedule fee observance by medical practitioners is rarely, if ever, acknowledged, let alone applauded, by Government or private health insurers," the AMA's submission to the inquiry said. "Instead, consumers are led to believe that schedules reflect appropriate fees, and out-of-pocket costs are blamed on 'doctors charging too much'."

The Association said health insurers had fuelled consumer misunderstanding by structuring policies that drive up out-of-pocket costs by precluding patient co-payments in order to qualify for no gap benefits, by only paying 25 per cent of the Medicare schedule fee, and by increasingly offering products that include out-of-pocket charges.

"These factors all contribute to the perception that there is a problem with out-of-pocket costs for medical services, when in fact they are decreasing as a percentage of services provided," the AMA submission said.

By far the most common source of out-of-pocket costs for patients is medicines not covered by the PBS.

Figures compiled by the Australian Institute of Health and Welfare show that in 2011-12, patients spent more than $8 billion (32.5 per cent of all out-of-pocket expenditure) on such medications, followed by $4.7 billion (19.1 per cent) for dental services and $2.9 billion (11.9 per cent) on medical care.

Not only do medicines and pharmaceuticals account for the lion's share of patient out-of-pocket costs, they have been instrumental in its growth. According to the AIHW, their share of overall out-of-pocket spending more than doubled between the mid-1980s to 2011-12, from 19.5 to 39.3 per cent. During the same period, the share of such spending attributable to doctors, dentists and other health practitioners slumped from 64.1 per cent to less than 39 per cent.

In its report, the Senate committee warned that care should be exercised in comparing out-of-pocket costs between countries, but analysis suggests Australian patients face higher charges than those in most other developed countries.

Out-of-pocket costs as a proportion of total household spending reached 3.2 per cent in Australia in 2010, compared with an average across Organisation of Economic Cooperation and Development countries of 2.9 per cent. When out-of-pocket spending was considered in terms of GDP per capita, Australia ranked just second, behind Switzerland.

Professor Stephen Jan, of the George Institute for Global Health, said this was due in part to the fact that a significant number of medical services are not covered by Medicare or private health funds.

A/Professor Owler and others who appeared before the inquiry said evidence that out-of-pocket expenses helped deter people from seeking medical treatment underlined concerns that the Federal Government's proposed $7 co-

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Myths around doctor fees exploded

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payment for GP, pathology and diagnostic imaging services would exacerbate health problems caused by deferred or foregone treatment, ultimately adding to the nation's health bill.

In its submission, the AMA cited research showing 6 per cent of Australians had delayed or avoided seeing their doctor because of cost, and studies have found that when out-of-pocket expenses for prescription medicines go up, more patients stop taking them.

In an echo of AMA fears the Government's co-payment model will hurt the sickest the hardest and ultimately cost the country even more, the Committee expressed concern that, even before the $7 co-payment was introduced, patients – particularly the vulnerable – were already deferring seeing their doctor or getting a prescription filled because of cost.

The AMA condemned a suite of health policy changes outlined in the Budget, including a $5 cut to GP rebates, increases to the PBS co-payment and watered down safety nets.

"These Budget measures are driven by ideology," the Association said. "They make no attempt to refine and shape the health care system to position it to deal with future challenges.

"Structural changes of this magnitude, without any long-term forecasting and analysis of their impact, subject the health of Australians and the Australian health care system to enormous risk."

Adrian Rollins

COMMENT

Greed of few tarnish the reputation of all

Doctors have voiced concern that a handful of practitioners charging excessive fees are flouting ethical standards and tarnishing the reputation of the medical profession.

At a forum on fees convened by the AMA early this month, representatives from more than 15 medical colleges and specialist societies engaged in a frank discussion about the damage to the public standing of doctors being caused by a small number of high profile incidents where doctors have charged fees well in excess of their peers.

AMA President Associate Professor Brian Owler, who chaired the forum at AMA House, said the vast majority of privately insured medical services were provided at no cost to the patients – 89.7 per cent did not involve out-of-pocket expenses, while the size of gap payments was known in a further 3.5 per cent of cases.

But A/Professor Owler said there was "a significant element of perception" in the public mind that doctors and surgeons in particular charged excessive fees, fed by occasional media reports of patients hit with what appeared to be very large medical bills.

Royal Australasian College of Surgeons President, Professor Michael Grigg, who attended the forum, said the medical profession could not afford to ignore the issue.

Professor Grigg told the forum that although surgeons were well regarded by the public, a majority thought the fees they charged were unreasonable – a perception fed by occasional reports of massive medical bills.

Medicare figures presented to the meeting highlighted the extent to which the problem was caused by a small minority of practitioners, showing that, for example, the average fee charged for a hip replacement was $2001, that 95 per cent of all fees charged were $4194 or less, but that a very small number of doctors were charging fees close to $10,000.

The forum discussed concerns that the activities of a small minority of practitioners undermined public confidence in the ability of the medical profession to regulate itself, to the possible detriment of the majority of doctors and future patient care. It considered how the profession could best respond to the issue.

Professor Grigg told the forum that the College considered those who charged fees seen as manifestly excessive were in breach of the profession's code of ethics, and faced possible expulsion.

Among issues discussed by those at the forum included the challenge of defining acceptable and excessive fees, and how to better inform both GPs and the general public about charges for procedures and treatment without falling foul of competition laws.

The forum agreed that measures to encourage more responsible fees should not compromise the ability of individual practitioners to charge what they considered to be fair and reasonable to meet the costs of running a medical practice and providing high quality care.

A/Professor Owler said the profession needed to address the issue of excessive charges if it was to maintain public confidence in the medical profession.

Adrian Rollins

COMMENT

Pharmacists told to stop pushing bad medicine

The AMA has accused the Pharmacy Guild of reviving the idea of chemist health checks as a ploy to strengthen its bargaining position ahead of crucial talks with the Federal Government.

As negotiations over the next five-year Community Pharmacy Agreement loom, the Guild has unveiled plans for a multi-million dollar advertising campaign spruiking the contribution of pharmacists and arguing that their range of services be expanded to include health checks, vaccinations and non-prescription treatments for minor ailments.

But AMA President Associate Professor Brian Owler condemned the Guild, accusing it of cynically using primary health care "as a bargaining chip in its efforts to secure the best possible deal for pharmacy owners – not patients – under the new Community Pharmacy Agreement".

The Guild has proposed that the Government should fund pharmacists to conduct cholesterol and blood pressure checks, administer vaccinations, and devise non-prescription treatments for minor ailments. It has previously suggested a fee of $50 for such services.

In an interview with *The Australian Financial Review*, Guild Chief Executive George Tambassis said: "[It's a good thing] if we're allowed to step up to do these extra services – we believe five years of education should able or allow us to do more things in our pharmacy that are remunerated by the Government and/or remunerated by the patient".

But A/Professor Owler said it was unacceptable for the Guild to propose that its members be able to offer services that, for strong clinical reasons, should be the preserve of general practitioners.

"This is a dangerous and irresponsible model of primary care," the AMA President said. "It fragments patient care, and undermines the important doctor-patient relationship."

He said it was likely the Guild would press the Government to include remuneration for pharmacist primary care services in forthcoming negotiations for the next Community Pharmacy Agreement.

The current agreement, worth $13.7 billion over five years, expires this year, and the stakes are high for both the Government and the Guild heading into negotiations for the next five-year deal.

The Government is pushing hard to contain spending across the board, while pharmacists have had their profit margins squeezed by the previous government's price disclosure reforms which saw the amount paid by taxpayers for medicines brought in line with the discounted prices manufacturers charge pharmacies.

Nationals Senator John Williams earlier this month spoke up for pharmacists, urging his Government colleagues to embrace a broader role for pharmacies, and to be fair in their negotiations with the Guild.

"Pharmacies need to broaden their horizons to survive," Senator Williams said. "I encourage my colleagues in Government to see that we do the right thing by our pharmacies in this new agreement."

But A/Professor Owler called on the Government to reject the Guild's plan.

"The Government would be foolish to consider handing over precious health funding to the Guild for an untested and unnecessary primary care experiment when huge cuts are being made to the mainstream health system," the AMA President said. "It would be completely unacceptable for the Government to seriously negotiate the Guild's proposal."

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Pharmacists told to stop pushing bad medicine

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He suggested, instead, that the Government could consider alternatives for the distribution of medicine, such as providing prescription services at supermarkets.

"We actually have the potential for other providers, such as Woolworths and Coles," A/Professor Owler said. "The case should be looked at in terms of what the best thing is for the patient. If the best thing is…being able to access medicines at a cheaper rate…then that's something I think needs to be considered."

He warned the Guild's scheme could end up costing the Government more, because patients diagnosed with a clinical condition in pharmacy health checks would have to be referred to doctor in any case.

A/Professor Owler said an assessment by the Medical Services Advisory Committee (MSAC) would confirm that GPs remain the most efficient and effective providers of primary health care and chronic disease management.

His call for an MSAC assessment was backed by the Consumers Health Forum, which said the AMA had raised "some important questions" about the best way to deliver primary health services.

Forum Chief Executive Officer Adam Stankevicius said MSAC's transparency made it the "appropriate place" to consider the Guild's plan, rather than secretive Community Pharmacy Agreement negotiations.

A/Professor Owler said pharmacists had a well-regarded role as a first port of call for everyday ailments, including providing over-the-counter medicines.

"But, as the saying goes, when pain persists, people [should] see their doctor," he said. "GPs and pharmacists work together at the local level in providing appropriate care for people. There is no need for pharmacies to take over the role of the local family doctor."

Unsurprisingly, the Guild rejected the AMA's criticisms, and accused it of being primarily concerned with protecting doctor interests.

"There is an overwhelming case for more and better use to be made of the infrastructure and expertise in Australia's 5400 pharmacies," a Guild spokesman told *Pharmacy News*. "No amount of tunnel-visioned turf protection by the AMA should prevent Australian health care consumers benefitting from a safe and sensible expansion of pharmacist services."

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Doctor Portal: the doctor's complete online resource

All the resources and information a busy practitioner needs is now just a click away following the launch of the AMA's Doctor Portal website.

Doctor Portal brings together all the tools and resources doctors look for on a daily basis – the GP Desktop Toolkit, the Find a Doctor feature, the CPD tracker, the Fees List, policy guidelines, position statements, practice advice and support – as well as access to AMA publications including the *Medical Journal of Australia* and *Australian Medicine*, all in one convenient location.

No more wasted time digging around through the entrails of the web to find the information you need – Doctor Portal is your one-stop information hub.

Not only does Doctor Portal give you ready access to the information and resources you need, it gives you a way to connect with colleagues near and far through public and private forums.

Click on the Doctor Portal link to check out these and other features:

- Content sharing – Doctor Portal allows you to securely share information and ideas with colleagues, providing public and private forums that only other registered medical professionals can access and participate in;
- Find a Doctor – locate practitioners using the Find a Doctor feature, which gives you access to Medical Directory of Australia information, including current practice contact details and a scalable map – perfect for when you are referring patients;
- All in one convenience: Doctor Portal features a refreshed MJA Bookshop, careers and jobs resources and the GP Desktop Toolkit, all at one site;
- Free access: Doctor Portal is a free service, and includes features exclusive to AMA members.

Doctor Portal is continually updated, ensuring that all information is current and you are never left out-of-date.

To explore all that Doctor Portal has to offer, visit: http://www.doctorportal.com.au/

Scheme offers a solution to rural doctor crisis

An innovative scheme that has boosted the recruitment and retention of doctors in remote communities in far western NSW, delivering significant improvements in health, should be rolled out nationally, according to the AMA.

The AMA said the Easy Entry, Gracious Exit scheme developed by the NSW Rural Doctors Network (RDN) has been a major success in attracting and retaining doctors in four communities – Walgett, Lightning Ridge, Brewarrina and Collarenebri – that have historically struggled with inadequate medical services and high practitioner turnover.

Under the program, Rural and Remote Medical Services (RaRMS) - a not-for-profit company set up by the RDN – takes responsibility for the administration of the practices, enabling medical practitioners to concentrate on their clinical duties.

One of the early beneficiaries was Dr Vlad Matic, who was the sole private GP and Visiting Medical Officer in Walgett in the late 1990s.

At the time his practice workload was onerous.

According to an appraisal by RDN, it was not unusual for Dr Matic to see 40 patients at his Walgett Doctors Surgery practice and then find a further 15 waiting to see him when he arrived at Walgett District Hospital at 6pm.

In an interview with *Australian Doctor* in 2009, Dr Matic said the heavy workload meant he had no time for preventive care.

"I realised that I would never be able to fix the health outcomes in the town," he told *Australian Doctor*. We needed to entice more health workers, especially doctors, to come and work here."

In 2002, RaRMS assumed responsibility to operate Walgett Doctors Surgery and engaged Dr Matic. By early 2003, Walgett's medical workforce had been expanded to two resident GP/VMOs engaged by RaRMS (supported by a fly-in GP/VMO for two months a year) and a resident GP at Walgett Aboriginal Medical Services, freeing up Dr Matic to undertake public health work.

This experience has been replicated in the other communities where RaRMS has assumed responsibility for practice administration work such as securing locums, ensuring the continuity and security of medical records, employing staff, securing surgery space, managing the purchase and maintenance of IT, medical equipment and consumables, engaging and paying utilities.

In return, doctors pay a service fee to the managing entity.

Relieved of these administrative tasks, doctors have been able to concentrate on treating patients and working to improve health outcomes, improving job satisfaction and reducing burnout, with the result that the doctor retention rate in these towns has risen to an average of five years – a vast improvement on experiences such as that in Brewarrina where, in a 20-month period a succession of 22 locums went through the town.

In its appraisal, RaRMS said the Easy Entry, Gracious Exit model had resulted in "greater reliability of general practice and VMO services, and less community anxiety about whether medical attention will be available when required".

In addition, the scheme boosted local employment, particularly for practice nurses in Walgett, Lightning Ridge and Brewarrina.

AMA President Associate Professor Brian Owler said the Easy Entry, Gracious Exit model had the potential to ease the doctor shortage in many rural and remote communities across the country.

"It involves adopting a 'walk-in, walk-out' approach that enables GPs to work as clinicians without having to become small business owners and managers," A/ Professor Owler said.

"This model removes many of the obstacles that prevent doctors from establishing or maintaining a country practice for the long term. It allows them to stick to their core business – looking after patients."

A/Professor Owler said the model ensured a far better experience for practitioners, boosting the chances they would stay.

"Once the doctors arrive in these towns they often find that, while free to leave at any time, the support, financial arrangements, and the interesting medicine is so attractive that they readily remain for a reasonable period," he said.

In a Position Statement on the model, the AMA said experience in had shown it ensured continuity of patient medical records and practice management independent of doctor turnover, fostered stability in the professional and clinical working environment, improved relations with the local Area Health Service, encouraged a significant expansion in Medicare services, and eliminated the regular crises caused when doctors were ill or took leave.

"The key objective is to ensure the continuity of the practice or practice management structure, rather than the continuity of the individual doctor," the Position Statement said.

The AMA Position Statement on the "*Easy Entry, Gracious Exit" Model for Provision of Medical Services in Small Rural and Remote Towns* can be viewed at https://ama.com.au/position-statement/easy-entry-gracious-exit-model-provision-medical-services-small-rural-and-remote

Adrian Rollins

COMMENT

Give rural junior doctors the training opportunities they need, where they need them: AMA

Governments nationwide have been urged to work together to create a rich network of rural training opportunities for junior doctors to help boost the medical workforce in country areas.

Concerns are mounting that the health of Australians living in rural and regional areas will slip further behind that of city dwellers as the rural medical workforce ages and access to health services becomes increasingly difficult.

The extent of the problem has been underlined by figures showing that, in 2012, there were 394 doctors for every 100,000 people living in the major cities, compared with just 222 per 100,000 in remote and very remote areas.

In its *Position Statement on Regional Training Networks*, released early this month, the AMA has proposed that governments collaborate to develop regional training networks (RTNs) which will provide quality opportunities for junior doctors to advance their training in country areas, increasing the likelihood that they will stay on and practice in rural communities.

Most efforts to boost practitioner numbers outside the cities focus on the creation of medical schools in regional centres or enticing doctors already established in practice to uproot their lives and move to the country.

But AMA President Associate Professor Brian Owler said evidence showed that one of the most effective ways to bolster the rural medical workforce was to help trainee doctors already living and working in country areas to complete their training there.

"Many medical students have positive training experiences in rural areas, but prevocational and specialist medical training often requires a return to metropolitan centres," A/Professor Owler said. "At this point in their lives, trainees develop personal and professional networks that are important to their future life and career path, and many are less likely to return to practise in rural areas.

"RTNs would enable junior doctors to spend a significant amount of their training in rural and regional areas, only returning to the city to gain specific skills."

A/Professor Owler said the idea made sense because of the increasing pressure on vocational training places caused by recent rapid growth in the number of medical school graduates.

He said investment had already been made in training medical students in regional centres, so it was only logical to give these graduates local prevocational and specialist training opportunities as well.

"We currently recruit almost a quarter of medical students with rural backgrounds, and almost a quarter of Australian medical students go through rural clinical schools," A/Professor Owler said. "We have the graduates - now we need effective training pathways to convert into them into a well-distributed workforce for the future."

In its Position Statement, the AMA said that building and maintaining a critical mass of doctors within a region was important, not only to improve the viability of practices but also to enhance professional development and increase training opportunities.

It said that to work effectively, RTNs must have flexible entry and exit points, and the support provided to junior doctors rotating from metropolitan to country areas – such as housing support and transport and relocation payments – should also be extended to those rotating from rural to metro areas.

A/Professor Owler said the creation of RTNs should be part of a comprehensive set of policies to address regional and rural medical workforce shortages.

"The development of RTNs would help to promote careers in regional and rural centres and improve patient access to medical care," he said. "If doctors have a good training experience in a rural area, they are more likely to stay."

The AMA held up the South West Victorian Regional Hub established by the Royal Australasian College of Surgeons as an example of an RTN.

Through the Hub, junior doctors get general surgery placements in regional hospitals in Geelong, Ballarat, Warrnambool and Hamilton, and partnerships have been established with Melbourne's St Vincent's and Alfred hospitals to provide further specialised rotations.

The AMA Position Statement can be viewed at https://ama.com.au/position-statement/regional-training-networks-2014

Adrian Rollins

COMMENT

Round-the-clock GP care needs right incentives

The Federal Government has been urged to reinstate direct incentive payments to support general practices providing after-hours services.

The AMA has told Professor Claire Jackson, who is heading a Government-appointed review of after-hours primary health care, that recent reforms to the provision of after-hours services have been a failure and there should be a return to incentive and targeted funding to assist GPs in providing such a vital service.

Health Minister Peter Dutton has commissioned the review amid widespread dissatisfaction within the medical profession about the previous Labor Government's decision to hand responsibility for contracting and coordinating after-hours GP services to Medicare Locals.

Chair of the AMA Council of General Practice Dr Brian Morton said recently that the botched handling of after-hours services by Medicare Locals had not only increased red tape and compliance costs, but had discouraged many GPs previously committed to providing after-hours care for their patients.

Presenting the AMA's submission to Professor Jackson, AMA President Associate Professor Brian Owler said the review was an important opportunity to undo recent policy failures and develop ways to strengthen and support the role of GPs in providing round-the-clock care for their patients.

"Cutting the direct PIP payments to general practices was a big mistake," A/Professor Owler said. "It created a clumsy new layer of bureaucracy with Medicare Locals responsible for channelling the funding to after-hours service providers.

"Australia cannot afford to repeat the failed Medicare Local experiment with after-hours incentives, otherwise we will go down the same track as the UK, where general practice has largely walked away from responsibility for after-hours care," he said.

The Government, which is focussed on holding down health spending, has specifically excluded the adequacy of Medicare rebates for after-hours consultations from the review's terms of reference – a serious limitation in the view of the AMA President, who lamented that "the MBS does not adequately reflect the skills, responsibility and costs associated with after-hours services, and there remains a very strong case for the relevant items to be better funded".

Before the previous Labor Government handed responsibility for after-hours care to Medicare Locals, such services were supported by payments through the Practice Incentive Program (PIP), and the AMA believes the system should be reinstated – with possible modifications to fill service gaps and address current Government concerns about the arrangement under which practices were used to funnel payments to medical deputising services (MDS's).

"The AMA believes that the previous PIP model supported the provision of after-hours coverage to most of the Australian population," A/Professor Owler said. "PIP should be restored, appropriately funded, [and] targeted funding should be made available to address identified gaps in service."

At a recent meeting, United General Practice Australia – which includes the AMA and six other peak GP groups – warned the Government that simply transferring responsibility for contracting and coordinating after-hours care from Medicare Locals to the primary health networks being set up to replace them could exacerbate existing problems with access.

"There [is] a real danger that, should the current or similar arrangement continue under PHNs, more general practices will decide there is too much red tape and funding uncertainty for them to continue to provide an after-hours service," UGPA said.

A/Professor Owler said many GPs continued to personally provide after-hours care to their patients, but changes in the composition of the GP workforce and the increasingly poor financial return for providing such services meant many practices were making alternative arrangements.

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Round-the-clock GP care needs right incentives

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He said practices were increasingly using MDS's or collaborating with other practices to ensure their patients had access to after-hours services – raising issues about continuity of care and communications between practitioners about matters such as medical history and treatment.

In its submission, the AMA proposed a set of principles to address current concerns and which should form the basis of future after-hours arrangements.

These include a proper level of funding for those GPs and practices that provide genuine after-hours services (defined as between 6pm and 8am on weekdays, between 8am on Saturdays and 8am on Mondays and 24 hours from 8am on public holidays).

Where practices do not provide after-hours services, the AMA said they must have arrangements in place for the on-call GP, contracted MDS or collaborative partner to be alerted to the medical history and clinical needs of at-risk patients, known drug seekers or patients with threatening psychiatric conditions.

To support coordination of care, the report of after-hours treating doctors should be provided promptly to a patient's usual GP.

To ensure after-hours services are complementary to, rather than competing with, existing providers, the AMA said they must focus on genuinely urgent cases and, where clinically appropriate, encourage patients to seek treatment during normal hours.

To protect quality of care, doctors providing after-hours services should be appropriately qualified, and MDS's should be fully accredited by the Royal Australian College of General Practitioners.

A/Professor Owler said the review should consider the need for as higher rebate for after-hours services in rural and remote areas to reflect the higher cost of attracting and retaining staff and operating facilities.

He suggested that video consultations, where clinically appropriate, could be used more extensively to provide after-hours care in rural and remote areas, for patients in aged care, and other settings, but would need to be supported by appropriate funding.

But the AMA President warned that after-hours helplines were no substitute for the service offered by GPs.

"There is a paucity of independent evidence about their cost effectiveness, and good evidence that they are ineffective in managing demand for emergency department services," he said.

Adrian Rollins

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

Support for research at expense of health care draws ire

A group of business leaders and research organisations have been criticised for appearing to throw unequivocal support behind the Federal Government's controversial plans to boost medical research funding through cuts to primary health care and medical training.

As the Government continues to flounder in its attempts to secure Senate support for key Budget measures including a $7 co-payment for GP, pathology and diagnostic imaging services, the Medical Research Future Fund Action Group has been formed to publicly back plans to funnel $3.5 billion of savings from a $5 cut to Medicare rebates and other health budget measures into medical research.

The Group emerged after Treasurer Joe Hockey complained that the business community was not doing enough to publicly back the Government's Budget strategy.

In a statement issued on 31 August, the Group declared that "the increase in medical research expenditure that will flow from the MRFF will underpin Australia's future as a world leader in the health industry".

The Group is chaired by Goldman Sachs Vice Chairman Alastair Lucas - who is also Burnet Institute Chairman – and includes UBS Australia chief executive Matthew Grounds, who also chairs the Victor Chang Cardiac Research Institute, Research Australia Chair Professor Christine Bennett, the Australian Society for Medical Research and the Group of Eight Universities.

Mr Lucas told Channel Nine, "I think it's really important for business leaders to come out and speak out about the economic benefits [of the Fund], because you can argue they are just as important as the health benefits".

But AMA President Associate Professor Brian Owler said he was "surprised" by the tone of the Group's endorsement of the Fund.

"While there is no doubt that the concept of such a fund is generally supported within the health and research community, the people I have spoken with are very concerned at the decision to establish the MRFF through large cuts to frontline health services and medical training," A/Professor Owler said.

'These cuts are wide ranging [and] will place greater pressure on the health system and make it more difficult for the community to access health care, resulting in a significant social and economic cost to the community through poorer health outcomes."

The AMA President said he found it "difficult to believe" that members of the Group would support the idea that funding for medical research should come "at the expense of essential programs and services that are already keeping the community healthy".

So far, the Group's public support for the MRFF appears to have made little difference to the political deadlock surrounding the Government's proposed co-payment.

In a departure from the defiant tone of recent comments on Budget negotiations, Health Minister Peter Dutton admitted last week that the Fund, originally intended to reach $20 billion, might end up being a fraction of this size if the co-payment is rejected by the Senate.

"The medical research future fund without the co-payment will be much smaller, no doubt about that," Mr Dutton said in an interview on Channel Nine. "The medical research future fund will go ahead, regardless of what happens in the Senate, but it will be much smaller. If the co-payment falls over, then that is going to be a big blow to the medical research future fund."

Under Government plans, the co-payment was the biggest source of funding for the research Fund, which would also be supplemented by savings from three other areas including medical training.

The MRFF Action Group has revealed that Mr Lucas was diagnosed with brain cancer little more than a week after helping launch the organisation. He will step back from day-to-day involvement while he gets treatment, but will continue to serve as Chair. The AMA wishes him a speedy recovery.

Adrian Rollins

COMMENT

Axe GP program if you must, but at least keep rebate: AMA plea

The AMA has called on the Federal Government to maintain full rebate access for prevocational GP trainees in light of its decision to axe a well-regarded placement program for junior doctors interested in general practice as a career.

AMA President Associate Professor Brian Owler has written to Health Minister Peter Dutton urging him to continue to provide access to A1 Medicare rebates for GP trainees even after the Prevocational General Practice Placements Program (PGPPP) is wound up on 1 December.

"PGPPP is a valuable program for many reasons," A/Professor Owler said. "It supports efforts to deliver more training and care in the community, supplementing the traditional hospital-based approach to medical training."

The Program is administered by General Practice Education and Training, and the Government announced in its May Budget that both would be wound up as part of wholesale cuts to GP training which would save the Commonwealth $115.4 million over four years.

The AMA has expressed deep concern over the changes.

In his speech to the National Press Club in July, A/Professor Owler said the loss of the PGPPP would "hit hard" while the abolition of GPET and its absorption into the Health Department would, combined with an overhaul of regional training providers, put the integrity of GP training at risk.

The AMA President witnessed the benefits of the PGPPP program first hand during a recent visit to Aboriginal community controlled health centres in the Northern Territory.

He met with junior doctors who, through the PGPPP, had been given the opportunity to work in clinics operated by the Central Australian Aboriginal Congress.

A/Professor Owler said the program not only helped broaden the experience of trainee doctors but, through careful targeting, "has also boosted access to GP services in rural and remote communities".

Several State and Territory governments are understood to be considering stepping in to fund a number of PGPPP-style places, particularly in rural and remote areas.

But A/Professor Owler warned such efforts were unlikely to be successful if the entitlement given to PGPPP trainees to deliver Medicare-funded services at the A1 rebate level was lost.

He urged Mr Dutton to consider supporting State and Territory efforts by extending this entitlement beyond the closure of the PGPPP program.

"The costs of maintaining access to A1 Medicare rebates would be negligible in the context of overall Medicare spending…[but] is essential to encouraging the involvement of practices [and] ensuring that patients are treated equally, regardless of whether they see a prevocational trainee, GP trainee or fully qualified GP," the AMA President wrote.

The alternative, a return to a situation in which prevocational medical training is delivered solely in hospitals, is "not in step with the direction of modern medical education," he said.

Adrian Rollins

COMMENT

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.

Health problems don't stop at the border

Cross-border health issues and the social determinants of health should be on the agenda of the G20 summit of national leaders, according to AMA President Associate Professor Brian Owler.

In a major speech to the Global Health Conference organised by the Australian Medical Students Association, A/Professor Owler said there was growing realisation that many health issues, such as climate change, infectious diseases, food safety, and obesity, required coordinated cross-border action.

"What someone does in another country affects our health here in this country," he said. "Another country's social policy, its economic policy, its agricultural policy, its health policy – all have real ramifications for everyone else."

A/Professor Owler said that "you don't require a passport" to witness the challenges of global health.

He said the significance for health of social determinants such as the quality of housing, opportunities for education and employment, and the scale of economic activity, was all too apparent among Indigenous Australians, whose health and life expectancy lag well behind that of other Australians.

The AMA, A/Professor Owler said, had two roles – to advocate and shape policies to improve global health, such as its work to educate the community on the health threats of climate change, obesity, alcohol and tobacco and, secondly, to facilitate opportunities for those embarking on a medical career, or seeking to take it in a new direction, to train and work in global health.

"Junior doctors and specialty trainees are increasingly looking for global health-related learning and networking opportunities," he told the conference. "Enabling junior doctors to have meaningful and rewarding experiences in developing countries can lead to a lifelong commitment to global health practice and advocacy that benefits both resource-rich and poor partners alike."

Those seeking training opportunities abroad, particularly doctors in training, faced a number of barriers, A/Professor Owler said, including a lack of recognition from education providers, uncertain supervision arrangements, inadequate preparation, cost and loss of income, and personal security.

But the AMA National Conference in May heard of several initiatives, some involving medical colleges including the Australasian College for Emergency Medicine and the Royal Australasian College of Physicians, to address these issues.

A/Professor Owler said colleges struggling with the issue could also consider entering into partnership with organisations such as Australian Volunteers International, which had experience placing and supporting people in projects in many different countries.

"I think that we have a tremendous opportunity in Australia to train doctors who are equipped to engage in regional health challenges in a global context, who can form global health partnerships, and meet our increasingly diverse future health challenges," he said.

Adrian Rollins

COMMENT

INFORMATION FOR MEMBERS

Qantas Club – AMA member rates – fee rise

Qantas has increased its Qantas Club membership fees for AMA members.

The new rates are listed below.

AMA Member Rates (GST inclusive)

- Joining Fee: $240 - save $140
- 1 Year Membership: $390.60 - save $119.30
- 2 Year Membership: $697.50 - save $227.50

Partner Rates(GST inclusive)

- Partner Joining Fee: $200
- Partner 1 Year Membership Fee: $340
- Partner 2 Year Membership Fee: $600

These are special rates provided for AMA members and their partners.

If you have any questions about this offer, please do not hesitate to contact AMA Member Services at memberservice@ama.com.au or phone 1300 133 655.

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

Treat 'richer before poorer', *Adelaide Advertiser*, 29 August 2014

One of Australia's largest health insurers wants privately insured patients to be given priority access in hospital emergency departments over sicker, uninsured patients. AMA President A/Professor Brian Owler said doctors think clinical need is the only legitimate way to prioritise patients.

Worst booze spots named, *Northern Territory News*, 30 August 2014

More than 700,000 Australians are bingeing on at least 11drinks a session on a weekly basis, and it is becoming an increasingly middle-class problem. AMA Vice President Dr Stephen Parnis said people drinking 11 drinks a day often present with delirium tremens – body tremors, hallucinations, agitation and delirium.

Virus vaccine subsidy refused, *Sunday Tasmanian*, 31 August 2014

Parents will face a $500 bill if they want to protect their children from the deadly meningococcal B virus after subsidies for a new vaccine were rejected for a second time. Former AMA President Dr Steve Hambleton has argued against the vaccine being subsidised unless it becomes much more cost effective.

Abbott's GP tax policy is enough to make anyone feel sick, *Hobart Mercury*, 10 September 2014

Tasmanians will be the biggest losers from Federal Government plans to slug sick people with a $7 tax when they see the doctor. AMA President A/Professor Brian Owler said Tasmania had a higher burden of chronic disease than the rest of the country. He said the proposed co-payment would discourage preventive health care and chronic disease management – two interventions needed more in Tasmania than most other areas of the country.

Let's get sincere with beer, *Adelaide Advertiser*, 11 September 2014

The head of one of Australia's biggest brewers said beer had an image problem and its nutritional aspects should be promoted. But AMA President A/Professor Brian Owler said the focus really needed to be on changing Australia's binge drinking culture rather than on the nutritional make-up of alcohol.

Send doctors to treat Ebola: AMA, *Courier Mail*, 11 September 2014

Australia should consider a military response to help control the Ebola outbreak in west Africa in the same way it was using the military to fly arms and supplies into northern Iraq. AMA President A/Prof Brian Owler said the World Health Organisation is about to ask Australia for more assistance.

Radio

A/Professor Brian Owler, 2UE Sydney, 29 August 2014

AMA President A/Professor Brian Owler condemned comments by Medibank Private CEO George Savvides that health fund members should get preferential treatment in public hospital emergency departments. A/Professor Owler warned Australia was heading down the path of US-style managed care, where private health insurers have a big say in the care provided to patients.

A/Professor Brian Owler, ABC North Queensland, 5 September 2014

AMA President A/Prof Brian Owler talked about promising results from an initiative to get more GPs working in rural areas. A/Professor Owler said there had been a good response to the Easy Entry, Gracious Exit model, and the AMA Rural Health Committee was looking to develop it further.

Dr Stephen Parnis, 2UE Sydney, 7 September 2014

AMA Vice President Dr Stephen Parnis talked about the Federal Government's budget. Dr Parnis said AMA valued access to health care and health care quality, and current Medicare rebates did not reflect the value of the service medical practitioners were providing.

A/Professor Brian Owler, ABC New England, 8 September 2014

AMA President A/Prof Brian Owler discussed the AMA's push to bring doctors to rural towns to set up general practices. A/Professor Owler said they have looked at a range of solutions around the shortage of medical staff in rural Australia and the Easy Entry, Gracious Exit program had proven to be effective.

Dr Parnis, ABC South East SA, 8 September 2014

AMA Vice President Dr Stephen Parnis discussed regional training networks and how they should be developed to encourage young doctors to pursue careers outside of capital cities. Dr Parnis said they could build on existing rural medical schools to increase training opportunities outside metropolitan areas.

Dr Brian Morton, 2SER FM, 9 September 2014

AMA Chair of General Practice Dr Brian Morton talked about a Pharmacy Guild of Australia proposal that pharmacists could conduct tests for blood pressure and cholesterol. Dr Morton said Australia has one of the best primary health care systems in the world, with some of the best health outcomes among developed countries, and would undermine this if pharmacists were allowed to provide services they were not trained for.

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AMA IN THE NEWS

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A/Professor Brian Owler, ABC NewsRadio, 10 September 2014

AMA President Associate Professor Brian Owler talked about the AMA's call for the Federal Government to make a much greater contribution to the international effort to stop the spread of the Ebola virus. A/Professor Owler said the world was witnessing an evolving humanitarian crisis in west Africa. More than two thousand people have already died from the disease, and without more resources tens of thousands more could perish, A/Professor Owler warned.

Television

Dr Stephen Parnis, ABC Adelaide, 8 September 2014

AMA Vice President Dr Stephen Parnis talked about new research showing parents who supply children with small amounts of alcohol in the belief it will foster safe drinking habits are making them three times more likely to drink in their teens. Dr Parnis said public health messages needed to change.

A/Professor Brian Owler, Channel 9 Melbourne, 10 September 2014

AMA President Brian Owler discussed the AMA's call for the Federal Government to assist the World Health Organisation in tackling the deadly Ebola outbreak in west Africa. A/Professor Owler said the humanitarian crisis was evolving and urgent assistance must be provided.

COMMENT

INFORMATION FOR MEMBERS

Criminal history checks

Members will know that when they renew their medical registration in September each year they have to make a declaration about their criminal history. At the same time, they are authorising the Medical Board to obtain a written report on their criminal history (e.g. a CrimTrac agency report).

Different jurisdictions have different laws prescribing what constitutes a criminal offence. Members may have had their renewal delayed if they have not declared an offence that is minor but which nevertheless constitutes a criminal offence in their State.

Criminal history checks are an integral part of the assessment of a medical practitioner's suitability to practice medicine in Australia.

A criminal history includes:

- every criminal charge made against a person for an offence;
- every conviction (including spent convictions); and
- any plea of guilty or finding of guilt by a criminal court, whether or not a conviction is recorded for the offence. Any criminal matter that goes before the courts, no matter how minor (even a challenge to a traffic infringement), is relevant to a criminal history declaration and will show up on a CrimTrac agency report.

Civil matters such as contract disputes or debt matters do not form part of your criminal history.

When you apply to renew your registration, you are only required to declare any change to your criminal history during the preceding year of registration.

If your criminal history has changed in any way over the preceding year, you must tick 'Yes' on the renewal form, and provide details of the offence.

When the Australian Health Practitioners Regulation Agency (AHPRA) processes your renewal application, a 'Yes' response will prompt them to obtain a report from CrimTrac to verify the details of your criminal history. AHPRA will then conduct an assessment of the information, and a decision will be made about whether the offence is relevant to your practise.

The factors the Board will consider in deciding whether a health practitioner's criminal history is relevant to the practise of their profession are set out in the Criminal History Registration Standard, which is available on the Medical Board of Australia website.

To reconcile the variation between jurisdictions about what constitutes a criminal offence, the Medical Board recently authorised AHPRA to make direct assessments when a criminal history shows a minor offence and there is no demonstrable connection with the profession. Minor offences include (but are not limited to) low level speeding, failure to wear a seatbelt, driving while unlicensed, driving an unlicensed or unregistered vehicle, parking offences, public nuisance, trespass and fishing offences.

The risk of failing to declare your criminal history is that it will subsequently show up on a CrimTrac report during one of AHPRA's regular audits, triggering an investigation into a false declaration.

Medical practitioners who have been found to have made false declarations will be asked to submit a written explanation to the Medical Board. The Board will then decide how to deal with the practitioner, including the relevance of the criminal history to the practice of medicine.

We remind members it is important to declare your criminal history on the registration form, no matter how minor the offence.

You will not normally incur any delays to your registration renewal, as you will continue to be registered while AHPRA makes an assessment, and you will also be protected from inadvertently making a false declaration.

AMA IN ACTION

There has been no let-up in the vigorous pace of the AMA's health policy advocacy, with Association officials working to advance public health and protect member interests on a number of fronts simultaneously.

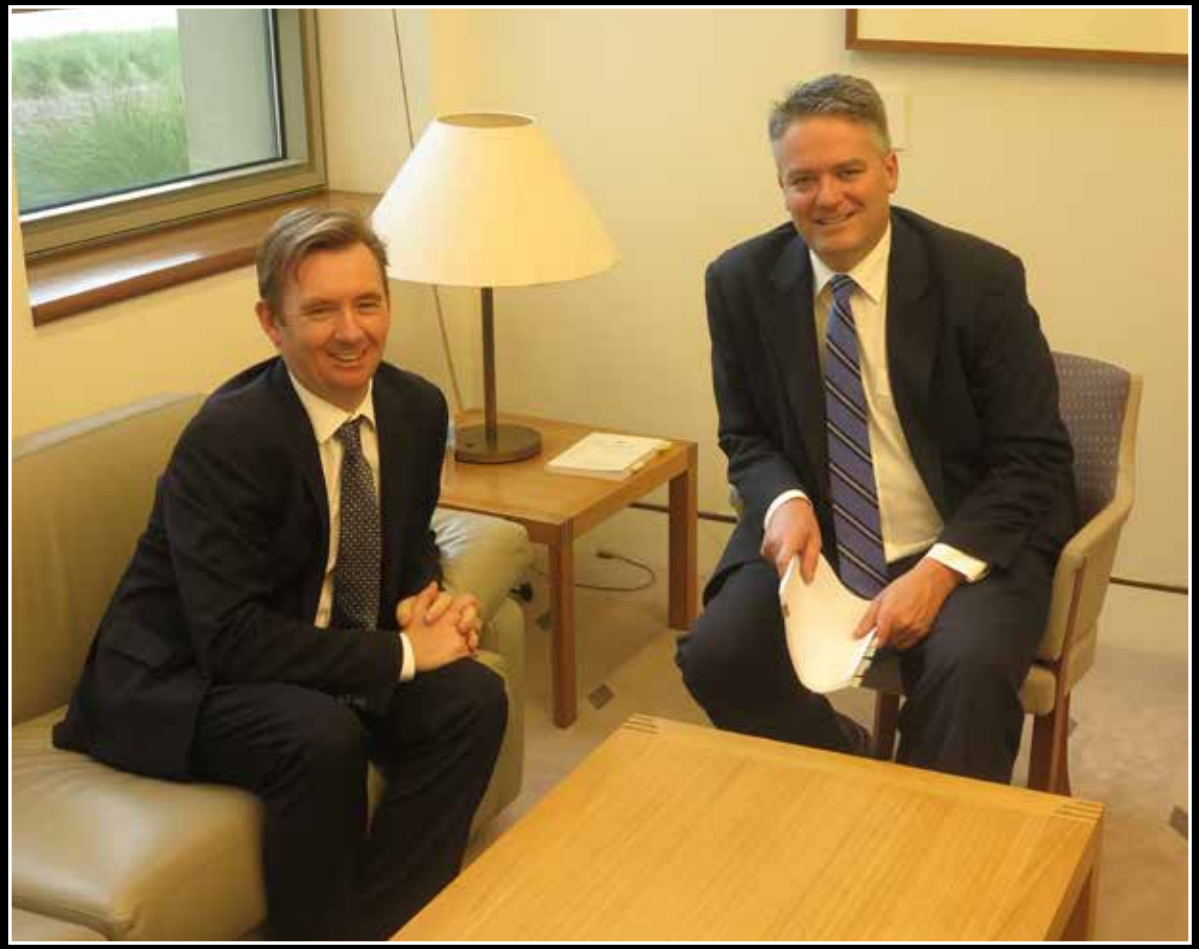
President Associate Professor Brian Owler met with Finance Minister Mathias Cormann as part of the AMA's efforts to convince the Government to dump its flawed $7 co-payment plan and associated $5 Medicare rebate cut.

The President also attended the Australian Medical Students' Association's Global Health Conference, where he delivered a major speech urging the creation of greater training opportunities for medical graduates interested in global health practise.

The AMA hosted a workshop involving 15 medical colleges and specialist societies to discuss excessive fees, and A/Professor Owler also met with officials from the National Aboriginal Community Controlled Health Organisation, and held a major media conference at Parliament House at which he called on the Federal Government to substantially increase its response to the Ebola virus outbreak in west Africa that has so far claimed more than 2000 lives.

Adrian Rollins

COMMENT



The AMA has a plan: AMA President Associate Professor Brian Owler (L) talks with Finance Minister Mathias Cormann about the AMA's co-payment proposal at Parliament House, Canberra.

Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
Dr Will Milford	AMA Member	AMC Specialist Education Accreditation Committee	13/8/2014
Dr Lawrie Bolt	AMA Member	PCEHR Pathology consultation workshop	8/8/2014
Dr Chris Moy	AMA Member	NeHTA (National E-Health Transition Authority) Clinical Usability Program (CUP) Steering Committee	4/9/2014
		PCEHR Pathology consultation workshop	8/8/2014
		PCEHR Diagnostic Imaging consultation workshop	6/8/2014
Dr James Churchill	AMA Chair of Doctors in Training	Australian Commission on Safety and Quality in Health Care: Health Service Medication Expert Advisory Group	25/07/2014
A/Prof John Gullotta	AMA NSW Member	PBS Authority medicines review reference group	19/9/2014
Dr Pryor	AMA VIC Member	MSAC (Medical Services Advisory Committee) Review Working Group for Inguinal Hernia	19/8/2014
Dr David Rivett	AMA Member	IHPA Small Rural Hospitals Working Group	18/8/2014
Ms Anne Trimmer	AMA Secretary General	Working Group for Cosmetic Services	5/8/2014
Dr Ian Millar	AMA Member	Standards Australia Diving Committee - developing a new version of the Australia and New Zealand occupational diving standard	29/08/14 and 30/07/14

GENERAL PRACTICE

Bring pharmacists into general practice

BY DR BRIAN MORTON

As it gears up for negotiations with the Federal Government on the 6th Community Pharmacy Agreement, the Pharmacy Guild of Australia is trying to expand the role of pharmacists in primary care to further the financial interests of pharmacy owners.

The Guild is proposing that the Government fund pharmacies to provide cholesterol and blood pressure checks, vaccinations, and to devise non-prescription treatments for minor ailments. It is apparently planning a multimillion dollar advertising campaign to promote its case.

AMA President Associate Professor Brian Owler has branded the Guild's plan as dangerous and irresponsible because it will fragment patient care and undermine the doctor-patient relationship. I wholeheartedly agree.

General practice is the home for high quality patient care and advice, and if pharmacists want to use their skill set to assist GPs in the care of patients, then they should do so as part of a GP-led multidisciplinary health care team.

The AMA is working in collaboration with the Pharmaceutical Society of Australia (PSA) on a proposal to integrate non-dispensing pharmacists into general practice.

"The AMA is working in collaboration with the Pharmaceutical Society of Australia (PSA) on a proposal to integrate non-dispensing pharmacists into general practice"

Both organisations think that such an arrangement would improve use of medicines, reduce adverse drug events and better coordinate care. It could also save the health system money by helping patients improve the management of their medication and make better use of medicines – potentially reducing the 190,000 hospital admissions caused each year by adverse drug events.

I agree with the thrust of recent comments made by the PSA's National President Grant Kardachi that we need to have a mature and evidence–informed discussion about how the expertise of pharmacists can be better used for the benefit of patients, and of the health system in general.

However, while the PSA says that pharmacists don't want to take over the role of doctors, the Guild certainly seems to want funding for providing services that are traditionally part of the ongoing preventive care undertaken by GPs.

I'm not sure why any government would fund programs that fragment patient care. Why fund pharmacists to provide ad-hoc cholesterol and blood pressure checks outside of general practice?

Supporting the integration of care and health services through the patient's family doctor is a far wiser way to spend scarce health dollars. Only the family doctor is trained to treat the whole person, interpreting results in the context of a person's full medical history and treatment regime.

The key to quality preventive care is the comprehensive training and diagnostic skills of GPs, coupled with the GP-led integration of medical and health services, the ongoing monitoring of patient risk factors, access to a patient's medical history and clinical record, and the trusted relationship patients have with their family doctor.

With more pharmacists than pharmacy jobs, and increasing numbers of pharmacists wanting more from their work, there is a real opportunity to make the best use of their skills within general practice.

This is worth further discussion, but it should be based on the best interests of patients and not the bottom line of pharmacy owners.

COMMENT

Why medical students want to change the world

BY KUNAL LUTHRA, VICE PRESIDENT (EXTERNAL), AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION. KUNAL IS A 5TH YEAR MEDICINE STUDENT AT MONASH UNIVERSITY.

In July 2012, at a Council meeting of the Australian Medical Students' Association, representatives from each of Australia's 20 medical schools adopted a policy statement on the shape of medical curricula in the twenty first century.

They proposed that medical curricula should include a focus on "developing leadership attributes" that would produce a generation of medical "change agents". They said that graduating medical students should be equipped with the skills to advocate for social conditions consistent with "the rights and dignity" of individuals and communities.

The primary message of the policy statement was clear: health does not begin or end in the consulting room. The ambition was to foster a generation of medical graduates who would respond to the health needs of their patients at an individual level, but also at the broader systems level. It meant that, in addition to anatomy and physiology, medical students should also learn about the social determinants of health and how to transform them.

Medical students are driven by the desire that drove them to medicine in the first place: to help people.

Learning about diagnosis and treatment certainly facilitates that, as does the ability to connect with and support patients while managing their ailments.

But for many, a deeper desire exists. They do not want to be just part of a health care system that churns out competent doctors into well-defined training pathways – they want to shape that system.

This has manifested in a significant and growing interest in global health and public health issues among medical students.

This interest has been reflected in the significant expansion of the Global Health Conferences that have been organised by AMSA in recent years.

The most recent conference, held in Sydney earlier this month, was an incredible and inspiring student-run event that attracted a distinguished list of speakers – even a Nobel laureate.

The conference created space for discussion and action on issues ranging from climate change to free trade agreements, while more than 500 students have signed up to AMSA's refugee and asylum seeker health campaign, ready to stand up for the health concerns of vulnerable individuals forsaken by successive governments.

Medical students around the country have been active on a range of issues this year, including internships and student numbers, refugee health, university fees, Indigenous health, the rural workforce maldistribution and much else, lobbying MPs and posting on social media.

They mobilised to voice their objections to measures in the Federal Budget that threatened equitable access to medical education, the provision of internships for current graduates, and access to health care for many Australians.

Monash University medical students have drafted a policy document on universal health coverage, proclaiming that "all people should have access to the acceptable quality of evidence-based health care that is required to maintain their health and wellbeing".

South Australian students have arranged meetings with the SA Health Department and both State and Federal MPs to highlight the affect the Federal Budget will have on the number of medical internships in the State.

AMSA has been vigorous in its opposition to plans to deregulate university fees, and will continue to push against such ill-considered reforms in the coming weeks.

Why do medical students want to change the world?

We are a diverse, opinionated group of individuals – there are as many differences as similarities.

But we share in common a desire to improve the health of individuals and communities.

Medical education should harness this, so that our inspiration turns into action.

AMSA's Medical Curricula for the 21st century policy statement can be viewed at: http://media.amsa.org.au.s3.amazonaws.com/policy/2012/Reformat/2012_reformat_medical_curricula_21st_century.pdf

Follow AMSA on Twitter @yourAMSA

COMMENT

RURAL HEALTH

Rural alarm bells

BY DR DAVID RIVETT

Two matters of concern to all rural Australians are the cutbacks to university funding announced in the Budget, and the National Party pushing its election promise to enhance rural mental health services to one side.

Every solution to the rural medical workforce shortage has a common key component - to train students with a rural background in rural and regional Australia, so they do not lose their connection with the bush and willingly return to serve their communities.

The Government's 20 per cent cut to university funding, to be offset by deregulating university fees, certainly won't help this happen.

As fees soar, the number of talented rural students able to access medical training will fall, given that they are already burdened by substantial expenses due to living away from home. Ivy-league urban centres of excellence will no doubt charge bigger fees than rural universities, and use some of the "cream" to fund scholarships for rural students to get their required quotas. However, one doubts if rural campuses will have matching funds to compete.

So, more students will go to inner urban areas to study and, no doubt, more will choose more lucrative inner urban procedural sub-specialties as a career to offset their greater accrued educational debt.

Hopefully, the Government will put some safeguards in place to prevent this happening but, as yet, none have been proposed.

> "It would have been a worthy Government initiative of more bang for one's buck than the Coalition's proposed 'Rolls Royce' paid maternal leave scheme"

Rural Australia has higher rates of depression and suicide than urban areas.

The causes for this are many, though a dearth of employment opportunities and higher alcohol use figure prominently.

Before the Federal election, the Nationals promised to target the issue with education and media campaigns. Sadly, this has been shelved. It would have been a worthy Government initiative of more bang for one's buck than the Coalition's proposed 'Rolls Royce' paid maternal leave scheme.

Personally, I doubt we will see any meaningful rural health policies out of the Coalition until much closer to the next election.

Even the almost-completed review of the current geographic delineation of remoteness/rurality, which is key to making the best use of taxpayer incentives to encourage rural practice has, almost a year after the Coalition's election, not seen the light of day.

The AMA's annual Parliamentary Dinner at Parliament House [on 27 August] was an opportunity to speak to Senator Fiona Nash about low-cost initiatives to enhance rural care, such as getting the Council of Australian Governments to embrace telehealth as a core component of rural care. Were all urban tertiary centres to routinely offer telehealth as an option, where clinically appropriate, it would reduce the need of patients in remote and isolated areas to travel so much for health care.

The Dinner was also a chance to encourage RACGP President Dr Liz Marles to work hard to try and find common ground between her College and the ACCRM to assume control of GP training when GPET is no more, for this is not a role for corporates nor the Health Department.

‘Mother’s little helper’ no more

Supplies of the mild tranquiliser made famous by the Rolling Stones as ‘mother’s little helper’ are drying up.

Pharmaceutical giant Roche has announced that, after being on pharmacy shelves for more than four decades, it has discontinued the supply of Valium (diazepam) in Australia, citing intense competition from generics.

The company said all its two and five milligram stocks of the drug were depleted and were no longer available.

“The decision has been made based on the number of generic diazepam alternative available,” Roche’s Group Brand Manager – BioTherapeutics, Paula Napier, said in a statement.

The discontinuation of Valium marks the closure of an important chapter in the treatment of anxiety, as well as a major driving force in Roche’s development as a major pharmaceutical manufacturer.

During the 1960s benzodiazepines gained rapidly in popularity because they were far more effective, and much safer, alternative to the barbiturates then in widespread use.

Diazepam became the top-selling drug in the United States during the 1970s, with sales peaking at 2.3 billion tablets in 1978. Its success underpinned Roche’s emergence as a global drug manufacturer.

Ms Napier said Roche had axed supplies of Valium to free up resources for other areas of research.

“Roche is committed to the research and development of new treatments, particularly in therapy areas of significant unmet medical need,” she said. “As a consequence, we regularly review our portfolio to ensure our investment is prioritised into these areas.”

Adrian Rollins

COMMENT

Patients lose out in blue over genes

The Federal Court has upheld a private company’s claim to own the patent for the mutation of a human gene, fuelling fears life-saving diagnostic tests will be put out of the financial reach of many patients.

In a decision that stunned health campaigners, the full bench of the Federal Court early this month unanimously dismissed an attempt by lawyers acting for cancer survivor Yvonne D’Arcy to strip US company Myriad Genetics of its patent on a mutation of the BRCA1 gene, which forms the basis of common test for breast cancer.

Announcing its ruling, the full bench backed the original judgement of Justice John Nicholas that the process of isolating a gene from the body was an invention rather than a naturally occurring thing, and so could be patented.

The decision stands at odds with a ruling of the US Supreme Court last year that invalidated the Myriad patents, and has reignited concerns the patients could face much higher test costs.

“Australian women were only protected from an attempted commercial monopoly over the BRCA1 and BRCA2 tests in 2008 because the company that threatened to take those tests away withdrew its patent claims voluntarily,” said Cancer Council Australia Director of Advocacy Paul Grogan. “There was nothing in the law to protect consumers from the monopolisation of those diagnostic tests, and there still isn’t.”

The law firm acting for Ms D’Arcy, Maurice Blackburn, has flagged a possible appeal to the High Court, but legal experts said the decision appeared correct under the law, meaning any change would have to be through legislation.

Mr Grogan said the Federal Court decision meant there was now a “strong case” to change the law.

“The patents system should reward innovation and help deliver affordable health care, not stymie research and increase costs by allowing commercial entities to control the use of human genetic material,” he said.

Adrian Rollins

COMMENT

McDonald's home delivers Mac-attack as sales slump

Fast food giant McDonald's has instituted expanded a trial of its home delivery service in an attempt to shore up its bottom line amid slumping sales.

In an encouraging sign for public health advocates, McDonald's reported that its Australian sales plunged 7.3 per cent in the June quarter following a similar decline in the first three months of the year, contributing to a 2.5 per cent fall in sales globally in June and July – the company's worst performance more than 11 years.

The company's Chief Executive Don Thompson identified Australia as a key market where it was trying to stabilise sales.

While food scares in China and fierce competition in the United States weighed heavily on the poor global result, observers think the fast food giant is also feeling pressure from a change in consumer habits toward healthier and fresher foods.

McDonald's has long been associated with food laden with fat, sugar and salt, and in recent years has tried to change its image by offering salads and expanding the range of products on offer.

But many of its menu changes have elicited only a muted response from consumers, and it recently turned to home delivery as a way to boost sales.

In a statement to the *Sydney Morning Herald*, McDonald's said that "our customers have often said they like the idea of Macca's delivery, so we're currently trialling it in a number of our restaurants."

But health advocates have raised concerns about the move.

AMA Queensland President Dr Shaun Rudd warned that the home delivery service was only likely to add to the nation's obesity problem.

"I think, unfortunately, they'll sell more food, and that means there's going to be more burgers and more fires eaten by the population there, and they are already extremely overweight," Dr Rudd told the *Sydney Morning Herald*.

McDonald's began a trial of its home delivery service in the North Paramatta area – where the adult overweight and obesity rate is estimated to be around 60 per cent - last November and, following its success, has expanded the pilot to six other restaurants in Sydney. Trials in Victoria, Queensland and Western Australia were due to begin last month.

Melbourne University Public Health Professor Rob Moodie told *Business Insider* McDonald's was targeting poorer areas to kae the most sales.

"It's their job to make money. They have no allegiance to the Australian population," Professor Moodie said. "I don't know if McDonald's has any sense of responsibility full stop. They've never made any attempts to be involved in good health. [Home delivery] just makes it that much easier for people to eat nutrition-poor food."

Adrian Rollins

COMMENT

Health on the hill

Political news from the nation's capital

Concerns private sector will turn a deaf ear to need

Parents of hearing-impaired children have voiced alarm that the Government agency tasked with providing publicly-funded hearing services might be privatised.

Finance Minister Mathias Cormann has appointed PricewaterhouseCoopers to conduct a scoping study into the possible sell-off of Australian Hearing, which provides taxpayer-funded hearing assessments, hearing device fittings and counselling and rehabilitation programs for children with permanent and long-term hearing loss as well as adult concession card holders, veterans and Indigenous peoples, through more than 490 centres nationwide.

Australian Hearing received $56 million in the 2012-13 Budget to provide services.

While the Government insists no decision has been made to privatise the statutory authority, parent groups are concerned the terms of reference set by the Finance Minister for the study predispose it to recommend the agency's sale.

The terms include "the identification of options for continued ownership [and] for a potential sale", including the minimisation of any residual risks and liabilities for the Commonwealth and the maximisation of benefits to the Government.

In a statement, three parent groups, Parents of Deaf Children, Aussie Deaf Kids and Canberra Deaf Children's Association, have warned that "it is of considerable concern that the objectives [of the study] leave little doubt as to the preferred outcome – to sell Australian Hearing in order to maximise financial benefit to the Government".

The groups have prepared a joint submission in which they argue against any sell-off on the grounds that it is likely to result in a diminution of services.

Aussie Deaf Kids founder Ann Porter said the system was built around the fact that children suffering hearing loss could access Australian Hearing services, regardless of where they lived and their family's financial position.

"It is naïve to believe that a private provider could deliver this diverse level of service to Australian children with hearing loss, given Australian Hearing's buying power, and the high cost and low returns of providing these services, especially in regional and remote locations," Parents of Deaf Children President Leonie Jackson said.

In announcing the scoping study, the Government noted that current arrangements meant Australian Hearing was simultaneously responsible to two departments. It is contracted by Health to deliver hearing services through a voucher program and a community service obligation, while being accountable to Human Services for its financial performance.

"These arrangements sometimes create conflicting pressure for AHS when trying to balance commercial drivers," the Finance Department said.

As reported in the *Sydney Morning Herald*, in June Health Minister Peter Dutton told Parliament the scoping study had been commissioned to "make sure that we are getting money away from bureaucratic services and back to front-line services".

Adrian Rollins

COMMENT

Frontline care could be casualty of co-payment deals

The AMA has raised concerns that patients and primary health care services could be short-changed in any horse trading done by the Federal Government to secure Senate support for its controversial health cuts.

AMA President Associate Professor Brian Owler warned that even if the Government's plan for a $7 co-payment for GP, pathology and diagnostic imaging services was knocked back by the Senate, it might still receive backing for its $5 cut to Medicare rebates, leaving both patients and doctors worse off.

"What we are concerned about is the potential trade-offs and deals that might be done that might mean that we do not have a co-payment, but are still stuck with a cut to the Medicare rebate," A/Professor Owler said. "That would mean patients are worse off [and] that there is no support for GPs or investment in general practice."

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Health on the hill

Political news from the nation's capital

... FROM P30

The Government has so far held firm to its co-payment plan. Health Minister Peter Dutton has insisted that he will not compromise on the proposal.

But Mr Dutton and other senior ministers have to this point failed to convince key minor party and cross-bench senators to back the idea. Palmer United Party leader Clive Palmer has declared it a "dead duck", and only Liberal Democratic Party Senator David Leyonhjelm has come out in its support.

The AMA has continued to meet with senior Government ministers to discuss its alternative proposal for a $6.15 co-payment, with exemptions for concession card holders and children younger than 16 years and no cut to the Medicare rebate.

Mr Dutton quickly dismissed the AMA plan as a "cash grab" by doctors, but A/Professor Owler said the Association was continuing to talk about its proposal with other minsters, including at a meeting with Finance Minister Mathias Cormann earlier this month.

"We had a very good discussion about the details of the plan [with Senator Cormann]," he said. "When you actually look at the plan and go through the details, [there is] protection for vulnerable patients but [it] actually meets a number of the Government's other objectives."

The Government has complained that the AMA's plan would rip $3.5 billion from the proposed Medical Research Future Fund, but A/Professor Owler he had become cynical about the plan.

"The MRFF is being used as a vehicle that allows the Government to cut funding to frontline services but still say it has not cut the overall health budget," he said.

Adrian Rollins

COMMENT

Former immigration chief takes top health job

The bureaucrat charged with implementing Australia's controversial hardline refugee policy has been appointed to head the Commonwealth Health Department.

The Federal Government has announced that Martin Bowles, who has led the Department of Immigration and Border Protection since January 2013, will succeed Jane Halton as Health Department Secretary.

Since joining the Federal public service in 2003, Mr Bowles has worked in the education, defence, climate change and immigration portfolios.

But before that, he had been an experienced bureaucrat in the New South Wales health system, including stints with the Richmond Health Service, the Central Regional Health Authority, the Northern Rivers Health Service, Prince of Wales Hospitals, Sydney.

Immediately prior to joining the federal public service, he was Chief Executive Officer of the Wentworth Area Health Service.

Adrian Rollins

COMMENT

Members-only treatment in Medibank float

The Federal Government is considering a proposal to give Medibank Private's four million policyholders incentives to purchase shares in the insurer when it is floated on the market.

The Australian Financial Review has reported that Finance Minister Mathias Cormann has approved plans for the float to include a special offer to policyholders separate from the general public offer and an offer to broker firms.

The share offer will go public at the end of this month, when prospective investors will be able to register their interest, Senator Cormann told ABC radio.

"By the end of October, people will be able to receive the Medibank Private share offer prospectus," he said. "That prospectus will include all of the specific detail about the structure of the sale, including the issues relating to Medibank customers."

The timing means the company could be listed on the Australian Securities Exchange by the end of the year.

The AMA has warned that the sell-off could result in higher health insurance premiums.

But Senator Cormann was dismissive of these concerns.

"The ownership structure of Medibank Private is completely irrelevant when it comes to the setting of premiums," the Minister told ABC radio's *PM* program. "That is because, number one, Medibank Private will continue to operate in a highly competitive market and will have to be mindful of, obviously, competition from other private health funds when it sets pricing, and number two, premium setting is highly regulated in Australia and, of course, there is a process there which ensures that premium increases are appropriate and that process will not change."

The Government approved an average annual premium increase of 6.2 per cent on 1 April, but analysis by financial services firm Canstar has found that in some states the average increase has been much higher.

Canstar reported that in New South Wales and Victoria average premiums for hospital cover have risen by 9.2 per cent, by 8.84 per cent in Queensland and 8.42 per cent in the Northern Territory.

Adrian Rollins

COMMENT

OPINION

BY SIMON HOYLE, EDITOR, *PROFESSIONAL PLANNER*

Why promoting the public interest will win the public's trust

This article was first published by Professional Planner on 1 September, 2014, and can be viewed at: http://www.professionalplanner.com.au/featured-posts/2014/09/01/why-promoting-the-public-interest-will-win-the-publics-trust-30175/

A week or so ago the President of the Australian Medical Association (AMA), Associate Professor Brian Owler, was interviewed on ABC radio – and other places – about the AMA's proposed amendments to the government's $7 co-payment for visits to a general practitioner.

Owler spoke knowledgeably, at length and passionately about the need to ensure Australia did not follow the US into a "two-tier" healthcare system, and why the most disadvantaged in our community need to be protected from measures that could adversely affect their standard of heath.

At least in the interview I heard, Owler did not once speak about the impact that the co-payment would have on the practices of his members. He didn't mention the increased red tape that the co-payment would create.

It was a near-textbook example of how a professional association speaks on an issue, even when that issue has a potentially significant effect on its own members.

Placing the public interest first, and speaking about that, is second nature to a professional association like the AMA. And for that reason, among others, it's why governments and regulators alike treat associations such as the AMA seriously, and involve them in the formulation and implementation of public policy.

The impact of a policy may or may not be in the interests of the association's members, but that is not the association's first priority. The AMA's first concern is that the healthcare needs of all Australians continue to be met, without favour and without discrimination based on an individual's ability to pay. Of course, in doing that, the interests of the AMA's members are advanced. But they're advanced in the context of what's good for the public interest, not what's good for the self-interest of doctors.

Interestingly, the interview with Owler was followed by interviews with other players in the healthcare system, all of whom spoke about the impact of the proposed co-payment on their members (that is, healthcare workers and professionals) and on the businesses their members own and operate. And they also complained about the "preferential treatment" they perceive the government is giving to the AMA in the debate.

We'll see how seriously policymakers treat associations when the Parliamentary Joint Committee on Corporations and Financial services inquiry into financial planning standards gets underway for real. The committee is accepting submissions until Friday this week; thereafter there will be a series of hearings, and a report published before the end of the calendar year.

It's not always easy, when an association's members perceive that the public interest is contrary to their own. But that is, at the end of the day, a terribly short-sighted view. At the end of the day, good public policy is good for everyone.

"Preferential treatment" of professional associations shouldn't come as a surprise to anyone; it's one of the privileges often granted to true professions. Good public policy is good public policy. It puts the public interest first; it puts the interests of consumers after that; and it puts the concerns of special-interest groups next – and let's face it, all associations, including professional associations, are really only highly polished special-interest groups.

That's why any association representing a membership that stands primarily to protect and advance the public interest will always get a good hearing in Canberra and will always stand a reasonable chance of influencing the direction of government policy.

Article printed from Professional Planner: http://www.professionalplanner.com.au

URL to article: http://www.professionalplanner.com.au/featured-posts/2014/09/01/why-promoting-the-public-interest-will-win-the-publics-trust-30175/

COMMENT

Life online, where even car tyres are for sale

BY **DR CLIVE FRASER**

The internet has revolutionised so much of the world around us. It makes you wonder how we read the news, booked an airline ticket, sent a letter or even met before the World Wide Web came along.

How did we keep ourselves occupied before we had Wikipedia, Facebook, Twitter, Instagram, Snapchat and YouTube?

And who was it who decided to place a capital letter inside so many techno neologisms?

While online dating seemed like a mecca for stalkers and an unorthodox way to meet not that long ago, my younger colleagues assure me that it's now very much the norm.

The logical consequence of all that data traffic is the gradual decline of the traditional means of performing many tasks.

The most obvious evidence of this is the gradual extinction of newsagencies.

For years they were protected businesses, with a monopoly on the sale of newspapers in their local area.

Just like the "Rivers of Gold" that flowed from their classified ad columns.

But that monopoly is worthless when people stop buying newspapers, when no one sends cards anymore and people search for unique cars online rather than in a printed magazine.

I'm predicting that the real world will be completely replaced by the virtual world sometime before Christmas.

I've just discovered that the latest retail transaction to go online is the purchase of car tyres.

Until recently, I'd entrusted all advice on tyre purchases to a beloved local guy called Dave who'd watched my family grow up, and who always knew exactly the right rubber to put between myself and the road.

I never bothered to shop around because I knew that Dave would look after me with the best price and the best advice.

But a colleague with a Range Rover started looking for a cheaper price online after discovering that his 20-inch tyres were around $700 a piece.

Those 20-inch rims meant a very low profile configuration that also made the tyres rather prone to damage on kerbs.

Somewhat relieved to have finally worn out a set after 45,000 kilometres, he made the familiar telephone call to his local tyre guy and was pleasantly surprised by a quote of $578 each for Pirelli PZero 245/45R20 99Z tyres (that is, $2312 for a set of four).

Not exactly expecting to find a better price at another outlet, and denying that he was back on

the dating websites, he nonetheless searched online and found a site selling car tyres.

Searching both according to the make and model of his car and, alternately, according to tyre size, he was given a quote of $311 for exactly the same Pirelli tyre, fitted and balanced!

That's $1244 for four tyres, providing a saving of $1068 on a full set.

Checking twice in disbelief to be sure, he then ordered and paid for his tyres online, and had the option of having them fitted at any one of 1000 locations in Australia - most of them new car dealerships which, reassuringly, are still made of bricks and mortar.

But, as fate would have it, his fitting location was back at the same dealer he'd obtained the original $578 quote from.

So would I buy my next set of tyres online?

Absolutely.

Sorry Dave.

PS There is an additional $10 freight charge per tyre for non-metropolitan delivery.

Safe motoring,

Doctor Clive Fraser
doctorclivefraser@hotmail.com

COMMENT