AMA

MORE THAN JUST A UNION

A HISTORY OF THE AMA

Celebrating **50 years** of the
Australian Medical Association







50 YEARS

AMA

CELEBRATING 50 YEARS

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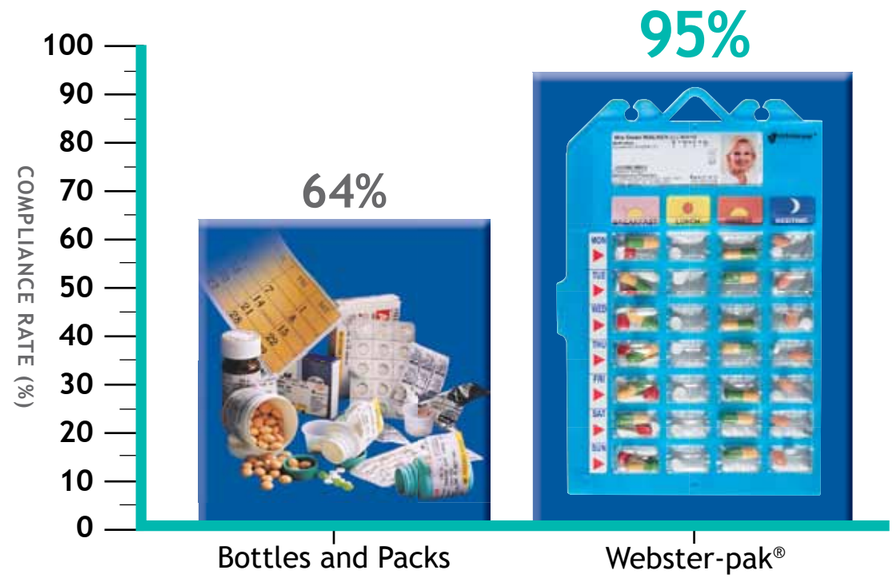

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References: 1. Managing medications made easier. (2010, Spring). VA Research Today, pp 54-57. 2. Valenstein et al. Using A Pharmacy-Based Intervention To Improve Antipsychotic Adherence Among Patients With Serious Mental Illness. Schizophrenia Bulletin 2009; pp 8-9.

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Message to the Federal office of the Australian Medical Association From the National E-Health Transition Authority: (NEHTA)

It is with great pride that I write to congratulate the AMA on achieving its first 50 years as the peak National representative group for all of Australia's Medical Practitioners.

The AMA has had a core and key role in promoting for the health, healthcare and wellbeing of the citizens of Australia and in the Public Health of the Nation.

The role of Doctors in the health of the Nation has never been in doubt and the representative role of the AMA has paid many dividends for the people who entrust their care to the profession - patients.

The AMA has championed research, innovation and new technology into daily practice based upon the principles of Safety and Quality and the phrase which drives medicine: **"Primum non nocere"**: first do no harm.

The medical profession has embraced the use of technology in the health sector: eHealth. The AMA has a proud record of championing electronic transactions in the commercial side of practice through Medicare scheme and private health funds. With the drive of the profession, and in partnership, the very successful GP Computing group (hosted for some years in the AMA Federal Office) was a key driver to prosecute the case for health IT in Australia's General Practices. This has been so successful that the 98% of GPs who use IT for Clinical purposes stand out as a beacon for other Medical Practitioners in Australia and something to herald internationally.

Now with the dawn of the new connected healthcare system in Australia deploying IT in the health sector (eHealth), the Doctors of Australia stand at the vanguard of the deployment of the Personally Controlled Electronic Health Record (PCEHR) – the eHealth Record. The AMA has been a key stakeholder and partner in this effort publishing the "AMA Guide to Medical Practitioners on the use of the Personally Controlled Electronic Health Record System". This acknowledges the need for Clinical Leadership, the key role of the medical profession and the drive for safety, quality and utility.

NEHTA has welcomed the good working relationship with the AMA and values the clear and frank discourse that has been the hallmark of the Doctor's Peak Body.

Congratulations! Onwards to the Centenary!

Mukesh Haikerwal AO,
Head of Clinical Leadership, Engagement & Clinical Safety, NEHTA.

Chair of the Council of the World Medical Association. 19th President, AMA

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Her Excellency Ms Quentin Bryce AC
Governor-General of the Commonwealth of Australia

Message from Her Excellency Ms Quentin Bryce, AC CVO
Governor-General of the Commonwealth of Australia

to mark fifty years of the Australian Medical Association

On the occasion of its fiftieth anniversary, I offer my warm congratulations to the Australian Medical Association.

In the five decades since various branches of the British Medical Association formally merged in 1962, the AMA has consolidated its position as the peak membership body representing medical practitioners and medical students across Australia.

Under the leadership of prominent Australians – from first President Dr Lindsay Thompson through to Dr Brendan Nelson, Professor Kerryn Phelps, Dr Mukesh Haikerwal and many more – the AMA has demonstrated an unwavering commitment to improving patient care and to supporting the wider medical profession. It's motto – '*pro genere human concordes*' – or 'united for humanity' – rings true.

Today, with Dr Steve Hambleton as its President, the AMA continues to shine. On behalf of our community, I thank you for the contribution you continue to make across Australia's health sector.

Quentin Bryce
13-6-2012

Government House Canberra ACT 2600 Australia
Telephone +61(2) 6283 3525 Facsimile +61(2) 6283 3595

PRIME MINISTER
CANBERRA

MESSAGE FROM PRIME MINISTER JULIA GILLARD

AUSTRALIAN MEDICAL ASSOCIATION
FIFTIETH ANNIVERSARY

I am pleased to congratulate the Australian Medical Association on its fiftieth anniversary.

Since the Australian branches of the British Medical Association merged in 1962, the AMA has grown into one of our largest professional associations with thousands of medical practitioners and students as members.

All Australians can be proud of the exceptionally high standard of our nation's medical profession and the longstanding institutional arrangements such as Medicare and the PBS that enable accessible, high quality health care for our whole community.

Doctors are among the most respected figures in our society, and the AMA has been a robust and consistent voice for the profession in years of incredible change and expansion for the medical system.

I pay tribute to the AMA's significant contribution to the development of public policy in Australia, in particular its unwavering support for efforts to tackle smoking and alcohol abuse.

I congratulate the AMA and its leaders, past and present, on this landmark anniversary, and look forward to continuing our work together for the nation's benefit and for the good of humanity.

The Honourable Julia Gillard
Prime Minister of Australia

AMA

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T: 61 2 6270 5400
F: 61 2 6270 5499
E: info@ama.com.au
W: www.ama.com.au
42 Marcus St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

More Than Just a Union

AMA President Dr Steve Hambleton

Welcome to a very important AMA publication – a history of the AMA. Note that we are calling it *a* history, not *the* history. There is good reason for this.

The researcher and author of this history, Dominic Nagle, has spent many months piecing together fragments of the AMA past from many sources to create a seamless narrative. The source material has been patchy in places – poor or incomplete record keeping, lost files, missing files, and fading memories. On the other hand, some Branches of the AMA (formerly the BMA) have kept excellent files and archives.

The National Library of Australia was another handy resource.

But this history is based on the records, recollections, and resources of some. Others will have different memories or different slants on what happened in AMA history, from long ago to more recent events.

The Federal AMA is 50 years old this year, but the history of the AMA under other names goes back much further. We provide you with some of that pre-history.

The history of medical organisation in Australia actually dates back to the early 1800s with groups of doctors banding together under various names and for various objectives.

It wasn't until 1880, however, that branches of the British Medical Association (BMA) were formally recognised in New South Wales and South Australia. Others soon followed. But it wasn't until 1962 that the Federal AMA as we know it was born.

This publication includes some personal recollections from previous AMA presidents.

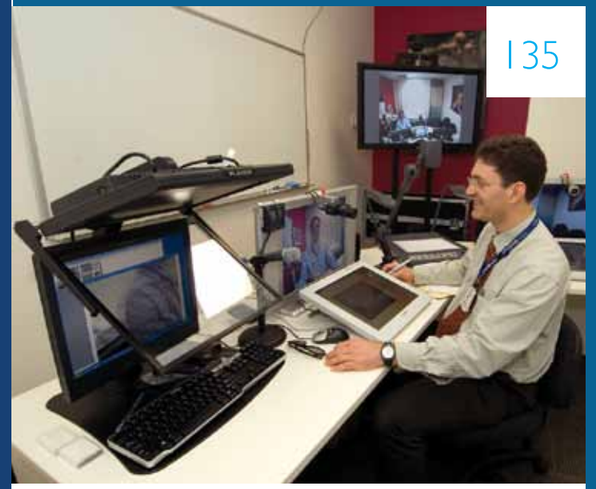
We also feature contributions on some of the big health issues from some of the most respected people in their respective fields of health and medicine in Australia.

This particular AMA history does not end here. It is the beginning. It is a living history. It will be posted on the AMA website and we invite you to provide comment. We invite you to add your version of events or add episodes of AMA history that we may have missed. We want you to build on this history, round it out, fill in the gaps.

As it stands, this is a fascinating account of the role that the AMA has played on the medico-political stage in Australia. I commend it to you.

The Federal Council and I thank Dominic Nagle and all who have assisted him in completing this monumental task.

Dr Steve Hambleton
President



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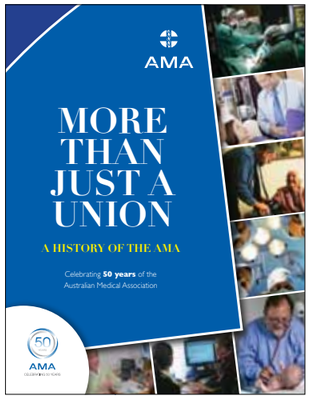

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Asia-Pacific Headquarters
Level 15, Tower 2, Grafton Street, Bondi Junction, NSW 2022, Australia
Tel: +61 2 8063-4800
Fax: +61 2 8580-5047

Publishers
Ross W. Jobson, Peter Antell

General Manager
Lloyd Millett, lloyd.millett@faircount.com.au

General Manager Sales & Business Development
David Sanis, david.sanis@faircount.com.au

Sales Manager
Gary Mason, gary.mason@faircount.com.au

Advertising Account Executives
Alan Batt, Angela Lyos

Editor
Tara Sena-Becker

Editorial Assistant and Picture Researcher
Deborah Singerman

Art Director
Scott Ware, scott.ware@faircount.com.au

Production Coordinator
Lisa Omagari

Chief Information Officer
John Madden

Printing and Origination
GEON

This history of the AMA could not have been written without the help of Debbie Robson, guardian of the AMA's records. Thanks are also deserved by Kirsty Waterford, John Flannery and Geraldine Kurukchi for their help and support. The AMA is grateful to Geoff Pryor, Bill Mitchell, David Rowe and Ian Sharpe for the use of their cartoons.

MORE THAN JUST A UNION

A history of the Australian Medical Association

IN THE BEGINNING …

Medical organisation in Australia began very shortly after that in England and it was meant to deal with much the same set of circumstances as those in the old country.

In England, the Provincial Medical and Surgical Association had been founded in 1832 in the rural area of Worcestershire, primarily through the efforts of Dr Charles Hastings of the Worcester Infirmary and a group of supporters, with four basic and seriously difficult objectives.

As its name implies, one reason for beginning this "Great Experiment" was to resist what was considered to be the overweening influence on the profession of its practitioners in the great medical centres such as London, Edinburgh and Glasgow. Another was the need to unite and represent the physicians, surgeons and other medical practitioners and defend their interests from those of the apothecaries, barbers, blood-letters and all the other disparate groups who had attached themselves to medicine in those days. Associated with that was the need to establish and impose on its members a rule of ethics that would end the quackery, in-fighting, poaching, urging, jobbing, secret commissions and other practices that had disfigured the profession to that point. Finally, through activities such as meetings, discussion and publication of papers, the new association set out to raise the standards of medical science and practice and to encourage scientific study.

Most significantly for the profession in Australia as well as in Britain, the association adopted Dr Hastings' strongly-held (though not at first universally-supported) view that, if the new association were to achieve all these objectives, especially that concerning health standards, it needed to act politically.

Considering the task it had set itself, it is not hard to understand why it took almost 25 years for the association to establish its national credentials, taking up the title British Medical Association (BMA) from another group that had expired along the way.

The new organisation and its members had achieved much in that time. They had persuaded Parliaments to establish the General Medical Council and the Medical Register and impose professional and ethical standards on medical practitioners in a legislative environment familiar to us today. They had driven the great sanitary and other public health reforms that had been achieved in Victorian Britain, ensured the paramountcy of health and safety in the new factory legislation and helped reform the medical education system (including training for nurses and midwives).

These achievements had been hard won. As Dr Hastings had discovered, doctors proved notoriously hard to organise. But, in the process, members of the new association also gained great advantages for their profession. Through organisation, cooperation and collegiality, the new body had developed into a national force for great public good. By tackling the quacks and chancers who had so discredited medicine, it had also resurrected and cemented the reputation of a profession that had gone through hard times.

Medical professionals in the new colony, some of them themselves members of the BMA, watched all this with great interest, and an ambition to repeat it in Australia. It was recognised that the physical and social conditions in early Australia were harder than any known in England and that what health systems existed here were different in each settlement. Moreover, the BMA experience showed that any effort to extend the BMA's achievements to Australia would almost certainly run into the English difficulty of organisation among doctors. Though the Australian environment and society were so vastly different, doctors in the new colony did share one condition with their English counterparts, one that had so complicated efforts to organise in England: an extremely competitive professional culture.

So, for years after European settlement in Australia, doctors had formed groups that came and fought and went – flaming and dying out. Even as late as 1847, the first medical journal published in Australia, *The Australian Medical Journal*, had cause to complain in a tetchy editorial that:

"there is not any portion of the community so completely disunited, so thoroughly disorganised. So notorious is it that the squabbles of the doctors have become a standing jest to the non-medical public, much of our liberality to whom proceeds from our illiberality towards each other, and who, while it reaps a rich harvest of benefits in innumerable ways consequent on our constant endeavour to outbid each other for its favours, laughs in our face and sets us down for a set of nincompoops".

Nearly a generation later, things had still not got much better. In 1870, *The New South Wales Medical Gazette* (itself, as it turned out, only a temporary phenomenon, a casualty of the disharmony) described what it called "the mischievous state of medical ethics by the establishment of medical societies". Many attempts had been made to remedy this, it said, but they had failed:

"through the restrictions enforced by their rules and by-laws … The want is felt in every town or district of town or country of a society founded on the broadest possible base both as to admission of members and subjects for discussion."

The history of early medical organisation in Victoria and New South Wales provides spectacular examples of this.

VICTORIA

Surgeon George Bass, Matthew Flinders' close friend, had visited what became Victoria when he landed in Western Port Bay in 1798 but it was not until settlement in the 1830s that doctors began their work in what was then known as the Port Phillip District.

The Medical Register was extended from New South Wales to the Port Phillip District in 1838. The medical community there at the time was led by Dr Barry Cotter (later Government Medical Officer) who had come over from Tasmania. There were some formidable personalities practising medicine in the area at the time, but they often had other interests and activities that were apparently more important: politics, for example, the acquisition of land and the accumulation of fortune. There appeared to be little attempt among them at professional organisation or even professional cooperation. Dr (later Sir) James Palmer, for example, was the first President of the Victorian Legislative Council and third Lord Mayor of Melbourne. Dr William Haines was the first Premier of Victoria. Dr Alexander Thomson came from farming in Tasmania not only to medicine in the new settlement but also to banking, politics and even preaching before becoming the first Mayor of Geelong. Years elapsed before attempts by doctors in Victoria to organise themselves were recorded.

By 1844, the Medical Board had listed in the *Government Gazette* 35 "gentlemen [who had] submitted the necessary testimonials of qualification" to practise in the Port Phillip District. But it was two years before 12 of them formed a Port Phillip Medical Association (PPMA). The 12 included such (eventually) prominent characters as Dr Patrick Cussen, the first to perform surgery in the new settlement, later President of the Port Phillip Medical Board, Colonial Surgeon and the person most responsible for founding Melbourne's first general hospital. Dr Daniel Thomas was a pioneer in the use of ether anaesthesia in Victoria. (He was also the brother-in-law of Dr Farquhar McCrae, later a particularly disruptive influence in New South Wales). Drs David Wilkie and Godfrey Howitt were office-bearers in the Philosophical Institute of Victoria (later the Royal Society of Victoria), then the colony's most influential body of people eminent in the sciences, including medicine. Dr William Gilbee was a pioneer in Australia in Lister's New Method as a surgeon at the Melbourne Hospital and a council member of the Royal Society. He had also been a gold prospector in California and was on the Burke and Wills Exploration Committee.

The association's objectives were to develop a code of ethics, meet to discuss scientific papers, set up a library and publish a journal. Its members were reported at the time to enjoy "capital dinners and first-rate social and intellectual evenings", but disputes began within a couple of years over such issues as the composition of a code of ethics, alleged breaches of professional etiquette and fee schedules (based at the time on fees set by Scottish doctors almost 20 years earlier). A journal was published but it lasted only six months. Meeting attendances dwindled. Members began to drop out. By 1851, the PPMA was disbanded, the minutes of a special (and final) general meeting called in November that year noting: "society dissolved, sold books, cleared up".

Six months later, in 1852, some of its members went on to organise a Victoria Medical Association (VMA). Dr Wilkie was elected President. The VMA quickly became involved in tackling the great sanitation and other preventive health problems facing Melbourne at the time and influencing legislation to deal with them. Within months, perhaps because the VMA was spending so much time and activity on these great public health issues rather than organisation, doctors on the staff of the Melbourne Hospital, led by Dr William McCrea who became Colonial Surgeon the following year, organised a rival Medical-Chirurgical Association of Victoria.

By now, the discovery of gold had spawned new settlements outside the Port Phillip District. The settlers there soon needed proper health care (among other kinds of support), especially as quacks of all kinds had joined the long list of 'entrepreneurs' commonly attracted by gold rushes, and doctors soon began to form associations to enforce ethical medical standards in the goldfields. A Castlemaine Medical Association was formed in 1853, a Mt Alexander Medical Association and a Bendigo District Medical Association in 1854 and a Ballarat Medical-Chirurgical Society in 1855. In Melbourne that same year, more reorganisation was happening: the VMA was amalgamated with the Medico-Chirurgical Society of Victoria, the new group now called the Medical Society of Victoria (MSV).

As all this medical organisation was gaining ground and covering more territory, standards of practice were improving in the colony, thanks to the great advances being made in the medical sciences, in medical education and in medical instrumentation. But all these developments did little to discourage the almost traditional disharmony among the organisations and their members and supporters.

From the 1850s and for the next 20 years, the rivalry among the various Victorian associations and their organs and among individual members was astonishingly virulent, easily out-performing the behaviour of members of the profession in England that had brought about Dr Hastings' reforms and his founding of what became the BMA. Doctors attacked each other publicly with extravagant and often libellous allegations of misdiagnoses, maltreatments, advertising of services, discounts on fees and support for such horrors as homeopathy. The tone of the discourse can be seen in an 1872 obituary in one of the contending journals, which reported of a Dr Mackenzie barely cold in his grave that "he had good abilities and excellent opportunities. He failed to use the former and he wasted the latter. His life and death alike are warnings". Already, by 1860, *The Lancet* was horrified by the "very disunited state" of the profession in Melbourne which had "certainly become famous in the annals of social medical warfare".

The MSV had begun well. Its members included some of the more notable and influential practitioners in Victoria. Its finances were healthy. Well attended meetings heard and discussed papers on a range of professional topics such as obstetrics, sanitation, cardiac and other diseases and infectious disease. It started a library, run by Dr James Neild, then Honorary Secretary of the Society and one of Melbourne's most eminent doctors. It published an admired journal, *The Australian Medical Journal*, edited by Dr Neild. It was heavily involved in the creation of a medical school in The University of Melbourne. It lobbied successfully for legislation on medical registration.

It could not stop the bickering, however. It was not long before members began to attack each other internally and in the public prints: over whether treatments were justified or not, allegations of misdiagnosis, advertising doctors' services and other breaches of professional etiquette, discounted fees, membership applications and the worth of medical evidence at coronial inquiries. Even Dr George Halford, an early member of the MSV, Professor of Physiology at The University of Melbourne, founder of the first medical school in Australia, and arguably the most eminent doctor in his day in Victoria, had to deal with charges by his own colleagues that he had been advertising his services. There was a nasty falling out between the Society and Dr McCrae, a founding member (but by then head of the Board of Health), because it resisted a measure that would have allowed lay people to vaccinate patients. Members were becoming discouraged. Some, not appreciating the candid way all the dissension was reported in the journal, mounted formal complaints against Dr Neild. Subscriptions began to fall.

In 1868, the MSV was challenged by a Medical Association of Victoria (MAV). The new association published its own journal, The *Australian Medical Gazette*, as a rival to *The Australian Medical Journal* which, it said, favoured ("sought the welfare") of a privileged few among the doctors in the State. It accused the MSV of "monstrously outrageous and hostile conduct … towards the great body of the profession". In any case, the MAV said, the MSV represented only a minority of the doctors then practising in Victoria.

But the appearance of a rival organisation still did not seem to concentrate minds in the MSV. The dissension was still going on well into the late 1870s. At this point, it generated an incident that radically changed the course of medical organisation in Victoria and beyond. The incident illustrates the often choleric nature of relations between doctors in those days.

Briefly, a court heard a suit during 1879 by a surgeon member of the MSV against a patient who had not paid his bill for an operation. Two doctors called by the patient in his defence testified that the procedure had been unnecessary. One of the doctors was a member of the MSV. The two MSV members had already appeared on opposite sides in an earlier court case. The surgeon/MSV member complained to the MSV committee that the defence witness/MSV member was guilty of unprofessional conduct in alleging that the procedure had been unnecessary. The committee dismissed the complaint, though its judgment also said that doctors ought to be circumspect when giving evidence against a colleague. The matter did not end

From the 1850s and for the next 20 years, the rivalry among the various Victorian associations and their organs and among individual members was astonishingly virulent, easily out-performing the behaviour of members of the profession in England that had brought about Dr Hastings' reforms and his founding of what became the BMA.

there. The complainant was dissatisfied with the committee's decision; the other side was upset that the decision had been so equivocal.

Then the defence witness complained about the way the matter had been reported in Dr Neild's journal. A special meeting of the society was called to hear the complaint. Dr Neild resigned, furious at being accused of partiality and personal animus against the complainant. Refusing all blandishments to change his mind, he then joined with professional colleagues, dissatisfied and disheartened by years of disharmony, in discussing setting up their own organisation.

Things moved rapidly because the idea of an alternative organisation had already been discussed for some time by MSV members who were distressed by all the unrest. A meeting at Dr Neild's house was attended by some of Victoria's leading doctors such as Drs Wilkie and Gilbee, who had already discussed the possibility of a rival organisation, perhaps a branch of the BMA. Also attending was a Dr Louis Henry, newly arrived from England. Dr Henry's application to join the MSV had been refused despite it being noted that "against him there was personally no cause for complaint" and though his medical qualifications were judged excellent. The reason, it is thought, was because of the suspicion that Dr Henry was organising for the BMA in Australia. The suspicion was well-based: he had returned from England, via South Australia and New South Wales, on a mission authorised by the BMA to establish branches in Victoria and elsewhere in Australia.

In a letter to doctors in Victoria, Dr Henry pointed out the advantages of being part of an organisation which then had nearly 9,000 members in Britain and which had considerable advantages "in respect to social power, scientific progress, and moral advancement", plus, for its members, "the advantage of mutual communication and support, through the columns of the *British Medical Journal*". The *BMJ* was free to BMA members, Dr Henry said, and "always open, not only to the publication of the reports of proceedings of the Meetings of Branches, but to original papers of all kinds".

Out of the meeting at Dr Neild's house grew a branch of the BMA, with Drs Neild and Henry as its prime movers and Dr Gilbee as President. Most of its 30 founding members were members also of the MSV. The aim was that the new body would co-exist with the older one: the MSV would continue to concentrate on medical science matters and the BMA would handle ethical and medico-political matters. Sweetness and light did not last long, however.

The MSV did consent to the BMA using its premises, and the two organisations agitated together on such issues as improvements to Melbourne Hospital and better administration of hospitals generally, infectious disease control and public health, medical education and legislation to deal with medical quackery and the activities of friendly societies. But rival views on ethics and other issues were soon reported.

Various tentative moves towards amalgamation were thwarted by both sides. The grumblings were not helped when Dr William Cutts, then President of the BMA (and described by contemporaries as normally "kind, tolerant and friendly"), was deeply offended when his offer to the MSV journal of a report on BMA activities was rejected because most of it had already appeared in the public prints. "It seemed scarcely becoming," the rejection slip said, "that a medical organisation should send accounts of its meetings to a professional journal in the form of long columns clipped from a lay newspaper."

Worse, in 1900, hostilities broke out, among MSV members, but with results that threatened relations with their BMA colleagues. As so often before, they involved allegations that a member had behaved unprofessionally in helping promote a medical product. The MSV Council found against the member and decided to expel him. Enough of his colleagues rebelled that the Council failed to get the 75per cent support from members that its decision required. The Council resigned. Terms of a proposed compromise between both sides were rejected.

It took more than five years and all the peacemaking skills of Dr (later Sir) George Syme, Vice-President of the MSV, and Dr (later Sir) Harry Brookes Allen, Honorary Secretary, for the two sides to come back together. It was not until late in 1906 that MSV and BMA members decided on formal amalgamation. In the amalgamation agreement, all members of both organisations would become members of the BMA. All offices would become vacant. A new branch council would be elected by MSV and BMA members in a joint meeting. There would be one set of rules. Members of one organisation would automatically become members of the other. All funds, real estate and other property such as libraries would be shared, though the MSV would retain formal title to its hall because it needed a new deed of trust for ownership to become joint.

So was born a Victorian branch of the BMA. Dr Augustus Kenny, a prominent ophthalmic and aural surgeon, was an early two-term President. His influence on Victorian medical affairs has been described as profound. Though relatively young – he was born in 1863 – he had not been only involved in the medical, civic and religious life of Melbourne but he had also been an energetic supporter of the concept of a medical organisation that would promote the interests and ideals of the profession nationally. It was this strong view that led him also to exert great influence on the extension of the BMA to Queensland later.

CHANGE IN THE AIR

On assumption of the Presidency in May 1982, I was deeply conscious of the new Labor Government's health plans, to be called Medicare, and the ongoing continuum of problems dating back to the introduction of Medibank which had, in 1973, been fiercely opposed by the AMA.

Then it had been difficult for the AMA to engage in meaningful discussions with the Labor Government because of the stated non-negotiatability of many of its plans. On this occasion, the AMA resolved to minimise, and indeed remove, government interference in the practice of medicine. Much was achieved but the greater control of medicine remained the Government's frequently stated objective.

At a broader level, the Government unsuccessfully sought to control the incomes of all the professions by persuading professional bodies to submit their fees for determination by the Australian Conciliation and Arbitration Commission. The AMA was heavily involved in this issue through the Australian Council of Professions – unity is strength, a lesson that individual doctors and groups of doctors tend to forget.

The major activity in 1984 was the fight against the onerous provisions of Section 17 of the Health Insurance Act introduced with Medicare. Section 17 gave the Minister the power to impose any controls he chose on the private practice of medicine in public hospitals, including control of fees.

Following many negotiations, we received the report of the Penington Inquiry, which showed that the Government had acted in haste on wrong information when it provoked Australia's first doctors' strike.

While the report was being considered at many meetings, the New South Wales hospitals dispute erupted. I was asked by the NSW Branch and the Senior Royal Clinical Colleges to intervene. This led onto a period of frenetic activity, which was to last almost to the end of my Presidency in 1985.

The peace package announced in early April 1985 addressed many of the problems arising from the dispute. Most commentators saw it as a major victory for the AMA and for the profession. The major concession was undoubtedly the complete retraction by the Federal Government of the amendments to Section 17 of the Health Insurance Act.

Other concessions included choice of modified fee-for-service for visiting doctors at metropolitan district and country hospitals, withdrawal of the Commonwealth from regulation of private hospitals, and an improved private hospital insurance package.

Some dissident members of the Association, whose real agenda seemed to be the fall of the Hawke Labor Government, called for an extraordinary general meeting to consider a motion of no confidence in me. It was held in Canberra on 11 May. The motion was defeated on proxy votes by 7232 votes to 1196 – 86 per cent of the votes were cast in my favour. After the meeting, I issued the following statement:

Today's vote not only vindicates me personally but also preserves the honour, stability and credibility of the Association. This is of great importance to all doctors. The AMA is and will continue to be the only effective representative body of the medical profession.

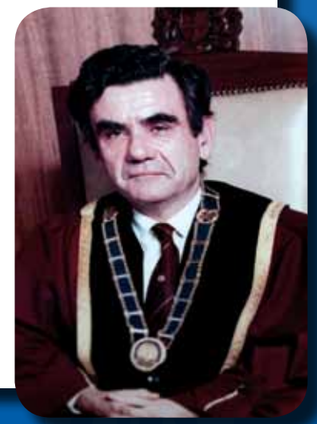
My ongoing thanks remain for the support of the members of Federal Council and our excellent staff, led by the Secretary General, Dr George Repin.

As Chairman of the Constitution Committee of Federal Council, I had long recognised the need for the AMA to adapt its structure and function to meet demands placed upon it. Fortunately, constitutional change occurred under my successor as President, Dr Trevor Pickering, but not without vigorous opposition. This has allowed the Association to continue to represent the profession as a whole in an effective manner. The profession needs an effective unified national body.

Looking at the profession today, I see increasing bureaucracy and unnecessary red tape. As a true profession, we seem in danger of losing our sustaining ideals and of becoming a series of fragmented disciplines that are prisoners of the technology that increasingly separates us.

We need to re-commit to ethics and quality of service. Remember the words of a former editor of *The Lancet*, Sir Theodore Fox: "the human race does not need a doctor, whereas human beings do".

I greatly enjoyed my term as President despite the stresses and strains, especially on my family and patients.



Dr Lindsay Thompson: AMA President 1982-85

NEW SOUTH WALES

In early New South Wales, medical organisation had taken place in the same disputatious atmosphere as that which developed in Victoria, though it no doubt also reflected the broader raucous political and social environment of the new colony. Among the larger-than-life characters who had arrived with the First Fleet were 10 doctors, led by Surgeon General John White and including such well-known mettlesome figures as William Bland, D'Arcy Wentworth and William Redfern.

Among their other activities, these three were heavily involved in the origins of a hospital system as well as the medical life of the colony. Dr Wentworth was one of the contractors involved in building the Rum Hospital in Sydney, later called the Sydney Infirmary and predecessor of what became Sydney Hospital. Dr Redfern was author of a report for the Government on the high rate of mortality among passengers on convict ships whose recommendations on health and hygiene were radical for their day. He was also a pioneer in reforming medical education in the colony. With Dr Bland, he was on the committee that ran a voluntary hospital in Sydney, set up by the Benevolent Society in 1821 "for the poor, blind, aged and infirm". Dr Bland ran a private practice in the city even during his time as Member of the Legislative Council.

All three were also active in the emancipist movement and local politics. Only Dr Bland was interested in medical organisation, Drs Wentworth and Redfern eventually concentrating on other activities, including building their fortunes.

Dr Bland had come out from Britain in 1814 as a convict, having killed a fellow naval officer in a duel; was pardoned and began medical practice in 1815; was imprisoned again in 1818 for 'divers libels' of Governor Macquarie; and resumed medical practice after serving 12 months in prison. Though he was heavily involved in the activities of the emancipists (and served two terms in the Legislative Council between 1843 and 1850), he also found time to be a founding member of a Medico-Chirurgical Association of Australia. This was formed in 1844 to:

"maintain and secure the dignity and the privileges of the medical and surgical profession in this colony; to procure the passing of an Act by the Colonial Legislature to effect these objects; also to put down quackery; and put an end to the mischief which now all too frequently results from the utter absence of any law to prevent the practising of unqualified persons".

But the Association did not long survive, despite the involvement in it of such eminences as Dr Bland.

Through all this time, standards of medical practice in New South Wales generally continued to be poor. It was not until 1838 that the Medical Register was introduced and that the Legislative Council enacted legislation to regulate doctors, though even then the hand of regulation was by no means heavy. The Act set up a medical board to examine the credentials of doctors who wished to be registered, but it did not actually prevent unqualified people from practising medicine. It provided for attendance with payment of medical witnesses at coronial inquiries, but it did not prevent coroners from calling on them even if they were unqualified. And, though some of the colony's medical professionals continued to try to organise professional associations to deal with this problem, they still continued to wage "social medical warfare" like their Melbourne counterparts.

The disruptive Dr Farquhar McCrae, for example, newly arrived from Victoria, mounted a crusade

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against Dr Bland in pamphlets and the public prints for alleged unethical conduct in the way a patient had been treated. A former cavalry officer with aristocratic connections and aristocratic arrogance, Dr McCrae was said to have considered Dr Bland with contempt not only because he was "a naval officer discharged in disgrace" but also because of his less than blue-blooded origins.

Another nasty and equally public controversy involved Dr Charles Nathan, a leading practitioner in Sydney, one of the original four consultants appointed to the Sydney Infirmary and later a member of the Senate of The University of Sydney. Dr Nathan's problem basically was that he worked with a Dr John Belisario on pioneering anaesthetic techniques, Dr Belisario having been trained as a mere dentist (though he was also a member of the Royal Society, the Linnaeus Society and a corresponding member of the Academy of Natural Sciences in Philadelphia).

In 1846, Dr Bland is recorded as becoming a trustee of an Australian Medical Subscription Library in Sydney which operated until 1860. It was then taken over by an Australian Medical Association that had been established only two years earlier.

In 1850, a Dr Henry Grattan Douglass led activities to organise and improve the performance of medical practitioners through a group to advance science that eventually became known as the Australian Philosophical Society, later called the Philosophical Society of New South Wales and later still the Royal Society of New South Wales. Dr Douglass was the first secretary of the organisation. Its first meeting was said to have attracted 60 doctors, though minutes do not appear to have been kept. Another prominent member of the group was Dr Charles Nicholson, later Chancellor of The University of Sydney. Dr Nicholson did not involve himself in efforts at medical organisation in NSW before he returned to England in 1862, but he was instrumental in establishing a medical section in the Royal Society.

The first signs of the original Australian Medical Association appeared in Sydney in 1858, when Dr James Robertson, newly arrived from England, canvassed fellow practitioners with a proposal for what he called "conversational meetings", the hope and objective being that "out of these will arise the much-to-be-wished-for society". There had been obstacles previously to the formation of an association, he said, but he hoped, "if the preliminary difficulty of having a few meetings experimentally can be got over, that a society may be formed in Sydney in such a manner as to ensure unity of action and permanence".

Reports put attendance at the first of these meetings (held at Dr Ferguson's house) at between 40 and 87. Some of those attending were reported as having travelled all the way from Queensland for the meeting. Discussion centred on a paper on scarlatina. Later that year, a special meeting appointed a committee to draw up bylaws for the new organisation. Three months after that, the first council was appointed. Next, a code of ethics was drawn up. It was based largely on the one that the American Medical Association had adopted in 1847 (though that did not help when the inevitable argument started). Still, by 1860, the association was encouraged enough to report that "the spirit manifested by the Fellows leads the Council to indulge the highest hopes for the usefulness of the association both in its professional and ethical character".

Dr Bland was elected the association's first president. More meetings followed, said to be well attended. The new association had the respect and authority to be consulted in the drafting of medical legislation for the colony. But the old disputation soon re-appeared. There were personal and professional disagreements. One of the more serious concerned the inclusion in the association's code of ethics of a stipulation (imported from the United States) that members wanting to publish an article in a non-professional journal needed the association's permission. Unfortunately, there being no scientific journal, papers read at meetings were also being reported in the lay media. The argument about this was settled to some limited extent by an invitation to members from the editor to publish in the *Australian Medical Journal* in Melbourne – limited, because Dr Bland seems to have been the only member to accept.

More seriously, though its members were disagreeing among themselves with some vigour, most of them were not putting much energy into the association that the association was quickly and badly needing.

In its first 12 months, the new body was reported to have attracted 111 members. But it was very locally-oriented. Members made little attempt to recruit colleagues outside the Sydney area. Meetings began to lapse quite quickly. Attendances were falling to the point that the quorum for Council meetings had to be cut. The association lost much of its drive when Dr Robertson died in 1863. Only five years after that, the records showed that only six members had paid their subscriptions. Often there were not enough members to attend meetings even to elect officers. A special meeting was convened in 1868 to analyse what had happened and to arrest the decline. But decline continued, and the association was wound up the following year. Foundation member Dr Frederick Milford complained later that his colleagues had tried "all the means in their power to procure the attendance of Fellows and to beat up for recruits, but their efforts were not met with success".

He, Dr Nathan and others continued to try without much support or success to resurrect the organisation in one form or another - a medical practitioners association, for example,

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The *British Medical Journal* was considered an important advantage of membership but subscriptions sent from the Sydney branch were ignored. So too were applications for membership. Complaints and other correspondence went unanswered.

and another group formed out of the foundation of a medical school at The University of Sydney.

On the other hand, medical life generally in the colony continued to expand. A specifically medical section of the Royal Society had been set up in 1876 by Dr Nicholson and supported by such leaders of the profession as Sir Normal MacLaurin and Sir Philip Sydney Jones, later President of the NSW branch of the BMA. A medical school, established at The University of Sydney, was associated with an extended Sydney Hospital and a new hospital in the city, Royal Prince Alfred. But the profession remained as disorganised as at any time since the turn of the century.

This was the situation, in 1880, when Dr Henry arrived in New South Wales. His mission probably originated in part from an appeal made 12 months earlier to BMA HQ in London by doctors in Sydney. The doctors complained that they had been "subjected to 20 years of turbulence in the field of medical organisation" and asked for details about how to form a branch of the BMA. Dr Henry wrote to the doctors that he had brought with him a commission from the BMA in England enabling him ("as the accredited agent and correspondent for the BMA in Australia") to authorise the formation of a BMA branch in the colony.

Early in February that year - without waiting for a response from the BMA but armed with Dr Henry's advice - eight doctors met at Dr Milford's house to try to organise a BMA branch in New South Wales. When the BMA finally replied to the Sydney doctors' request made in 1879, it announced that its Council had given formal recognition to both the NSW and SA branches on the same day – 7 July 1880.

So far, so good. Like all the other branches of the BMA, the branch in New South Wales subscribed to the guiding objectives and strategy for action set out for the organisation in England by Dr Hastings: to unite medical practitioners, to advance the medical sciences and – through political activity – to improve and defend medical standards. As a newcomer to the organisation, it looked forward to advice and support from its English parent. But there it hit its first great problem: the English parent's system seemed not to be working at all well.

Service was limited. Head Office often failed to list its new members out in the colony. The *British Medical Journal* was considered an important advantage of membership but subscriptions sent from the Sydney branch were ignored. So too were applications for membership. Complaints and other correspondence went unanswered. The new branch in Victoria had similar complaints. With their branches' blessing and support, members in Victoria and New South Wales travelling in England detoured to head office in London to complain to Mr Francis Fowke, Secretary of the BMA, himself. Members were resigning. Some were discussing the possibility of breaking away from the BMA. One meeting in New South Wales actually voted for independence, though the vote was nullified on constitutional grounds.

Things only settled down when Mr Fowke informed the NSW branch that he had investigated the problem and discovered its source. It was that a clerk at Head Office, apparently suffering from a condition described as "cerebral softening", had been burying the missing material in his filing system - unanswered and forgotten. Mr Fowke explained that the man had been encouraged to retire and asked that the NSW branch take no further action. The branch agreed. Normal service was resumed. The problem was solved.

QUEENSLAND

The penal colony established at Moreton Bay in 1825 for the more obstreperous of the NSW convicts was officially closed down 14 years later, at which point land became available for permanent civilian settlement. Doctors very quickly became active and prominent in the new community. By 1862, when Queensland's first medical register was compiled, 23 doctors were practising there, though (as in the earlier colonies) their status was often as much the result of their activities in agriculture, business, science, the law and politics as in medicine. And (as in the earlier colonies) their progress towards cooperation was often interrupted by disagreement and dissension.

Leaders of the profession earlier on in the new colony included Dr Joseph Bancroft, a founding member of the Queensland Medical Society (QMS), house surgeon at Brisbane Hospital and a pioneer in research into then common diseases such as Hansen's disease and filiariasis. Dr Bancroft was also, as a botanist, a collaborator in wheat-growing experiments with William Farrer. Dr David Ballow was Colonial Surgeon, a magistrate and a well-known cotton farmer. Dr William Hobbs was a member of the Medical Board of Queensland, an executive member of the Legislative Council and a promoter of the medicinal virtues of dugong oil over cod liver oil. Another doctor-member of the Legislative Council was Dr Kevin Izod O'Doherty, who had been transported for his participation in the Young Ireland movement. Dr O'Doherty was a successful physician in Brisbane, a fierce opponent of bringing Pacific Islanders over to work in the Queensland canefields and an architect of sound health legislation before returning to Ireland and representing an Irish constituency in the British House of Commons. Dr Kearsey Cannan was founding president of the QMS. He was not, as has been said, the first doctor in private practice in Queensland but he was certainly so in Brisbane.

A Philosophical Society was founded in 1859, mainly for scholarly discussion about the natural history of Queensland, the climate and its ramifications and other local scientific issues, but with doctors among its members, including Dr Bancroft.

It was not until 1871 that the QMS was established as a purely medical organisation. Dr Cannan was President; Dr Bancroft was Secretary. Its objective

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(among other things) was to be a tribunal for resolving misunderstandings between "radical gentlemen". This was in effect an invitation to members to suffer much grief later - as the experience of other, earlier medical organisations had demonstrated - because nothing seemed to encourage disagreement and even secessionist tendencies in these organisations more than establishing rules of behaviour that members then had to enforce on their colleagues.

The QMS had achieved much in its early years, all the same, especially in defence of medical standards, and was planning Queensland's first medical school. Then, as Dr Bancroft put it, "the evil genius that presides over ethics again interferes". The evil genius was the aura of disharmony that seemed to settle on medical organisations that tried to arbitrate between disagreements over rules among their members - rules governing not only medical ethics and standards but also, in those early days, the relationship and the boundaries between doctors and chemists. The argument within the QMS was every bit as vituperative as that within its colleague organisations elsewhere. So, before the end of its first 10 years, members and other doctors in Queensland were beginning to look around for a better behaved, more fit-for-purpose alternative.

So, in 1882, the Medical Society of Queensland (MSQ) came into being. It had 27 members originally, including Dr William Taylor, an ophthalmologist member of the Medical Board and an MP. Dr O'Doherty was President. The MSQ followed the QMS in being a strenuous champion of medical qualifications and standards, especially through legislation. But, again, though the records are sketchy, it seems to have spent what time was given to it in equally vigorous disagreement over another issue that had bedevilled medical organisations elsewhere: the doctor-chemist relationship.

In 1886, Dr Taylor and colleagues decided to calm things down. Dr O'Doherty by then had returned to Ireland and Dr Bancroft, who was recognised as the head of the medical profession in Queensland, had succeeded him as President. To try to head off the all-too-usual dissension, members ruled that their discussions should be limited to scientific issues and that matters such as ethics and legislation should not "for the present" be discussed at general meetings unless they had been resolved beforehand by a committee "duly appointed for the purpose".

Meanwhile, medical organisations were being formed throughout the settled areas of the colony: in Townsville, Maryborough, Rockhampton and Ipswich. The QMS had formed a Queensland Medico-Ethical Association to be involved in what could be called non-scientific issues such as fee-setting, the impact on the profession of friendly societies and contract practice.

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But, by the end of the 1880s, even the MSQ was thought to be running out of steam, despite the involvement in it of some of Brisbane's medical establishment. Dr Bancroft died in 1894, which was a huge loss, and the MSQ was already being described by an observer as "not altogether a happy family", with quarrels still raging "on a somewhat Homeric scale". The situation was ripe for the intervention of Dr Kenny of Melbourne.

In 1894, supported by senior members of the Brisbane medical establishment, Dr Kenny visited Queensland to urge that doctors there follow the lead of their Victorian colleagues and form a Queensland branch of the BMA. It was an idea whose time had come. Members of the Brisbane medical elite were already supportive. Some of them were already members.

So the Queensland branch of the BMA came into being, its officeholders including influential members of the QMS. Its first President was Dr Taylor. Its first Secretary was Dr Peter Bancroft, President of the QMS (and nephew of Dr Joseph Bancroft). Surgeon Dr John Thomson, President of the Queensland Medico-Ethical Association, later became President of the Queensland branch of the BMA. The two organisations co-existed more or less in amity for the next six years, until they amalgamated formally in 1900.

SOUTH AUSTRALIA

Historians have labelled South Australia as the Paradise of Dissent. Certainly, there was much public argument involving doctors early in the history of the colony over the state of the first hospitals there. Dr (later Sir) Joseph Verco, arguably South Australia's most eminent physician in those days (and later a founding member of the state branch of the BMA), was reported to have complained that a gap had grown between "sedate seniors" among the colony's doctors in the early days who were more concerned with "petty disputes about medical etiquette and punctilio" and "ardent juniors" who wanted "a rather more scientific kind of meeting to read papers and discuss cases and specimens". This generation gap was said to be the reason for the failure of an early attempt at organisation (the South Australian Medical Association) that survived no longer than five years. But, in comparison with attempts at medical organisation in the settlements in the east, that in South Australia was comparatively benign.

In 1834 (two years, that is, before the colony was proclaimed and the first immigrant vessels arrived there), a South Australian Literary and Scientific Association had been established "for the Cultivation and Diffusion of Useful Knowledge". It set up a library, organised lectures and arranged "periodical meetings for conversation". By 1853, it had morphed into the Philosophical Society of South Australia and then, in 1880, into the Royal Society of South Australia. During this period, leading doctors in the colony had featured prominently in its activities. They included Dr Verco and Dr William Gosse (later both founding members of the BMA) and Dr George Mayo, later President of the Medical Board. Dr (later Sir) Edward Stirling, who helped set up the medical school at The University of Adelaide (and led the campaign to allow women to study at the university) was another active member.

Dr Handasyde Duncan, who became the colony's first Health Officer in the late 1840s, is said to have helped set up a medical organisation around this time but its records have been lost. In 1872, the South Australian Medical Association was founded, with Dr Gosse as its first President. But its records also have been

Historians have labelled South Australia as the Paradise of Dissent. Certainly, there was much public argument involving doctors early in the history of the colony over the state of the first hospitals there.

lost – though it has been reported to have held some meetings in its first year – and it is said to have been wound up in 1881.

Meanwhile, another generation gap had opened up. Adelaide had attracted a group of younger, mainly Australian-born doctors during the 1870s (many of them on the staff of the Royal Adelaide Hospital) who had become disenchanted by what they considered to be a lack of scientific interest among their older colleagues. They joined with Dr Gosse and like-minded and locally well-known physicians such as Dr Thomas Corbin, Dr John Davies Thomas and Dr William Hayward in trying to establish an active and better organised professional body in South Australia. In 1879, their ambitions and ideas came to fruition when Dr Henry, still in Melbourne, issued his invitation from the BMA to form a branch in South Australia. The deed was done in June of that year. The first branch of the BMA was established, though the SA move was not immediately ratified by the parent body in London until 1880.

Dr Corbin, who moved the formal motion to establish the branch, was Secretary. The President of the Council was Dr Gosse (said by Dr Hayward to be universally respected "at a time when the brotherhood of man was not conspicuous among the members of the medical profession"). Over the next five years, the new branch had recruited about 80 members and it began to publish reports of its proceedings. It had helped found a medical school in The University of Adelaide in 1885. It organised the first Intercolonial Medical Congress in 1887, which coincided with the South Australian Jubilee Exhibition. Congresses followed in Melbourne in 1889, in Sydney in 1892 and in Dunedin in New Zealand in 1896. Moreover, the SA branch was a prime actor in the development later of BMA branches into a national organisation.

The path ahead was not always smooth, however. In the 1880s and 1890s, the branch had developed enough muscle and organising ability to take on the State Government over staffing issues at the Adelaide Hospital in a dispute that had poor consequences for the organisation. The branch decided to boycott the hospital. All its members on the honorary staff resigned. The medical school almost completely shut down. It did not help that Premier Charles Kingston was widely suspected by doctors of having homeopathic sympathies. Relations with the Government were not entirely restored for 15 or so years.

Looking back on the dispute, Dr Verco and other leading members of the BMA branch were reported to have considered that it could have been handled more wisely. All the same, the BMA had shown itself as an organisation of some influence and, eventually, a force to be consulted in health policy and legislation.

And it was the BMA branch in South Australia that was the wellspring for the evolution to national organisation. In 1911, at the instigation of Dr Hayward, the members resolved that a Federal Committee of the BMA should be formed that would represent the interests of the state organisations in the developing national-level issues such as the Commonwealth's ideas for a national health system, operation of hospitals and national health insurance.

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SEARCH FOR UNITY

Presidency of the AMA led me to valued friendships and down paths that proved challenging.

The major challenge was to review the Articles of Association of the AMA (adopted in 1962) and render them relevant to the changing needs of the profession and the community. My Presidency began in the wake of the New South Wales hospitals' dispute and the disunity within the profession that followed.

The Hawke Labor Government introduced Medicare in February 1984 with the inherent threat of nationalisation of medicine included in the legislation that granted the Minister unfettered power over doctors' fees in hospitals. The dispute was eventually resolved to the AMA's satisfaction in early 1985 but it clearly demonstrated the increasing importance of the rapidly expanding specialty groups and the need for them to have a voice in decision-making at a political level.

This had to be acknowledged within the AMA structure. Although deficiencies in its constitution had been recognised for some years, the branches remained implacably resistant to any dilution of their powers. The state branches then exerted almost total control over the Federal AMA where there was no craft group representation.

My three-year term was largely consumed by a search for unity within the profession, a search that led eventually to a successful major review of its outdated constitution. Sir Robert Cotton, a distinguished businessman, politician and diplomat, agreed to undertake a review and present a report on the structure, function and constitution of the AMA.

The 200-page Cotton Report was delivered in March 1987. Recommendation 2 was critical. It stated "that the AMA becomes a national organisation and the autonomy of the Branches be removed".

An intensive, exhaustive exercise followed to explain and discuss the report's recommendations to all members of the profession. This process strongly reinforced the need for closer involvement of the expanding specialist groups, especially the Royal Clinical Colleges, which proved vital in the subsequent successful creation of a far-reaching blueprint for the future. Regrettably, but understandably, it was not achieved without bitterness, anger and frustration within some sections of the profession.

Bulk billing and its inherent temptations, fraudulent billing and alleged overservicing of patients appeared with the introduction of Medicare. The setting up of fair monitoring systems and the collection of meaningful data remains a problem for the Association 25 years later.

From the outset, the AMA has advocated early professional involvement in the review process. Public challenges by government over alleged excessive medical fees and incomes occurred on a regular basis. It was the time of 'national wage restraint'. Although the attacks were largely based on the misuse and distortion of data, responding to them required a lot of attention.

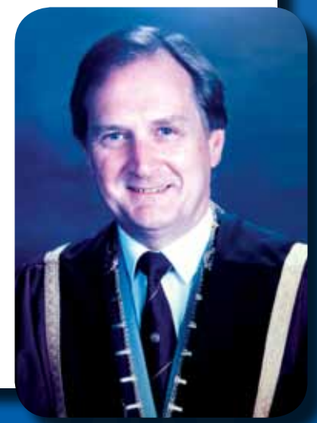
It was a volatile time. Confrontation with government over fees and Medicare benefits led to the AMA withdrawing from future participation in annual enquiries into fees for Medicare benefit purposes. Subsequently, because of undue obstruction by departmental representatives on the Medicare Benefits Schedule Revision Committee, the AMA also withdrew its participation from that body.

Fees were again in the news in late 1987 when the Chairman of the Government's Price Watch Committee launched an outrageous attack on alleged overcharging by doctors, an attack which lasted several months. In the end, the AMA succeeded in protecting the interests of doctors and patients.

Quality assurance was in its relative infancy in Australia, although the AMA was in the forefront of international activity. The AMA/ACHS Peer Review Resource Centre was established in 1979 with seeding funding from the government. When that funding ceased in 1986, so did the Resource Centre. The AMA took over responsibility for the further expansion and consolidation of clinical review activity, while the Australian Council on Healthcare (or Hospital as it was then) Standards was responsible for continuing education in peer review.

Looking back, one recalls the difficulties and intense resistance generated by the introduction of the concept. Yet, against strong initial opposition, it is now a principle embraced by all professions and disciplines. Diagnosis-related groups were introduced in 1986 as the basis for hospital funding.

I wish to pay tribute to the members of my Executive, Federal Council and members of the Secretariat. Their support, loyalty and advice were essential in carrying out my duties. I thank them sincerely.



Dr Trevor G Pickering: AMA President 1985-88

TASMANIA

Doctors were members of both groups of new settlers who arrived in Tasmania in 1804: in the south, under Col David Collins on the site of the future Hobart (succeeding the original Bowen expedition of 1803); in the north, under Col William Paterson on the site of the future Launceston. Though they were allowed to practise privately, the nature of the settlements – with such a high proportion of the population being convicts and military as well as bondmen – meant that doctors there were basically in government service.

There was another difference between them and their colleagues on the mainland: they did not spend so much time and effort in internecine warfare but reserved any bellicosity for a long campaign against the Government over hospital policy – a campaign that occurred during and after the BMA's taking over medical organisation on the island. As in the other settlements, however, many doctors in early Tasmania, being also prominent in the general society, pursued other than medical interests.

Dr James Scott, who was Colonial Surgeon in the southern (Hobart) area of the island, was also a banker, property owner and magistrate. Dr (later Sir) James Agnew, Colonial Surgeon in Hobart, became Premier in 1886. Dr (later Sir) Robert Officer, Surgeon Superintendent of the New Norfolk Hospital, was also Speaker of the House of Assembly. Dr Henry Butler was a Minister in the Wilson Government in 1869 and, in 1877, Speaker of the House of Assembly. Dr William Crowther, having taken over his father's practice in Hobart, was a successful surgeon and was appointed to the Tasmanian Court of Medical Examiners. (He was also suspected of being involved in the mutilation for scientific purposes of William Lanney, known as the last Aboriginal male in Tasmania, and so suspended for a time from his role as honorary medical officer at Hobart General Hospital.) But, as well as interests in sawmilling and whaling, he was also Premier in 1878 and 1879. Dr Crowther's son Edward, President of the Court of Medical Examiners like his father and honorary surgeon at Hobart General, was also a member of Parliament and an (unsuccessful) speculator in minerals prospecting and mining. Dr Edward Bedford, medical officer at the subscription hospital he founded in Hobart "for the labouring classes", was a well-known botanist and a founder member of the Royal Society of Tasmania – though not so much as a doctor as a natural scientist, a colleague of such eminent scientists as the ornithologist John Gould, the geologist Joseph Jukes and the botanists Paul Strzelecki and Joseph Hooker.

Probably because of the involvement by all these medical men in all these non-medical activities, there is little evidence of concerted attempt at medical organisation in the new settlement.

It is thought that Dr Henry tried to extend his recruiting activities from Victoria and New South Wales about 1880 but, if he did, nothing seems to have come of it. Later in the 1880s, a group of doctors did form a committee to establish a BMA branch on the island because a medical society was "urgently needed" (as the *Australasian Medical Gazette* reported at the time). But there is no record of it making any progress. It was not until 1896 that Dr Agnew formed a medical section of the Royal Society to pursue medico-political interests, such as government health and hospital services and dealing with such menaces as chemists, quacks and homeopaths. The section had to make do as a medical organisation (though without any protective or other normal benefits) until a Tasmanian branch of the BMA was formally established 15 years later.

In 1897, a group of Launceston doctors formed a sub-branch in Launceston of the Victorian branch of the BMA. It was said to be "virtually defunct" by 1904. But its members were active enough in 1898 to start a fierce struggle with the Government over the Launceston General Hospital, which had been redeveloped the year before from the original 1863 institution. To some extent, it won. It was a victory, however, that caused the association much aggravation later.

The Launceston General Hospital of 1897 had replaced two earlier hospitals. One of them – the Cornwall Hospital – was a subscriber-based institution. The BMA sub-branch wanted the new hospital to be on the same subscription basis as that of the Cornwall, thus taking care of what was termed "the sick poor". It also wanted the honorary staff to be given superior status to that of the surgeon superintendent, a position established in the military-style hospital system adopted in the first days of settlement and continued since. The Government insisted that the post remain senior. The BMA sub-branch, having unsuccessfully tried to get the position abolished by the hospital board, extended its campaign to the Parliament and in the public prints.

Eventually, after a Parliamentary Select Committee had intervened in the dispute, the Government agreed that the status of the post should be equal to that of the honoraries. The result was that the first Surgeon Superintendent at the new hospital was the eminent surgeon and pioneer of intravenous fluid replacement Dr (later Sir) John Ramsay, administering what was described later as "a community hospital in the full sense of the word".

But there was another problem. Dr Ramsay had had such an outstandingly popular private practice that well-off Launcestonians were happy and ready to pay for hospital treatment by him, jumping the queue ahead of the less well-off whom the Cornwall had originally serviced. Patients who could have afforded treatment by a doctor in private practice outside the hospital were receiving it instead inside the hospital, more cheaply and often even free. The doctors in private practice were incensed by this unfair competition.

The sub-branch argued that Dr Ramsay be prohibited from working in private practice while he was employed as Surgeon Superintendent. It even managed, after nearly 10 years of agitation, to get Parliament to put this into legislation. Dr Ramsay resigned in 1912, which did bring some relief from the unrest, but the 'unfair competition' problem did not go away. His successor, Dr Herbert Sweetnam, was just as popular with patients as Dr Ramsay had been, and his appointment had the same effect.

So the struggle continued. Worse, it spread. Though a Tasmanian-wide branch of the BMA was formed in 1911, doctors in Launceston and Hobart had continued to practise effectively as separate groups. (A formal decision to establish separate Northern and Southern Divisions of the BMA was not taken until 1925.) In 1917, Dr Sweetnam was still Surgeon Superintendent at the Launceston Hospital and, in the view of the doctors there, still a cause of unfair competition. The problem survived in the north. It was about to go south.

The Hobart Hospital had already gone through a controversy of its own over the rights to practise privately of a medical staff employed by a basically military hospital. This dispute had been settled more or less amicably. And, though it still had a surgeon superintendent position officially superior to that of the honoraries, the hospital in Hobart was not by and large suffering the travails of the hospital in Launceston. But, in 1917, the Launceston doctors asked their Hobart colleagues to join them in asking the BMA branch to take up their case as a matter of principle. This meant that the status of the surgeon superintendent position in Hobart would be roped in with the dispute over the position in Launceston. But the Hobart colleagues agreed. The BMA decided that, until the Government gave it an assurance that patients should be means-tested (that is, they would not be admitted if they could afford their own treatment), honorary staff from both hospitals should be withdrawn. The Government refused. The medical staff resigned.

The result was catastrophic for the BMA, north and south. It was excluded from both Hobart and Launceston hospitals, in the case of Launceston until 1925 and Hobart until 1930. It took years for relations between the BMA and the Government to improve – a situation immensely complicated by the Ratten case.

Dr Victor Ratten had studied medicine in the United States and, in 1907, came to practise in Tasmania where, as a JP, health officer to the local council, an officer in the Royal Australian Army Medical Corps and a successful surgeon, he was reported to have become a popular and respectable figure in the society. But the BMA questioned his qualifications and sought to have him deregistered. Dr Ratten had allegedly qualified at Harvey Medical College in Chicago – 'allegedly' because, though his diploma was dated 1907, the college appeared to have closed down in 1905.

The Government disagreed with the BMA's demand. Not only that, it pointedly made him Surgeon Superintendent at the Hobart hospital. The BMA continued to question Dr Ratten's qualifications. A Royal Commission was set up to investigate them. It decided that they were valid, though it refused to pursue evidence to the contrary from Chicago. The Medical Council considered appealing the Commission decision in the High Court. The Government sacked the Council, appointing replacements who it thought were Ratten sympathisers. But the replacement members refused to play the Government's game, proceeding to investigate Dr Ratten and even discussing whether or not to take the case to the Supreme Court. The Government

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responded by pushing through what is known as the *Ratten Doubt Revocation Act*, extraordinary (if not unique) legislation that in effect prevented the Council from seeking to deregister a doctor whose qualifications were fraudulent if the fraud had happened more than seven years previously.

Dr Ratten remained in charge at Royal Hobart until well into the 1930s – according to reports, with two other doctors to do the rounds and the matron to give the odd anaesthetic.

The BMA did agree to the honoraries' return in 1930. Moreover, it seemed in 1937 as though it regained its influence in government circles when the head of the Health Department invited the branch Council to help design and take part in a government program to establish health and medical services in rural and remote areas of the State. The BMA, having consulted members and others about how the idea could work in practice and how doctors could work with it, responded with its version of the program. But peace between it and the Government had not yet been restored.

The State Government by then was led by Albert Ogilvie, a pugnacious character with a special interest in health policy. His response to the BMA plan was his own proposal for a state-funded system of medical services administered by the Department of Health and staffed by doctors paid by the Government. The BMA was naturally alarmed by this. It was also concerned by the Government's proposal that the services provided by the new system be free to all, rich and poor alike. Premier Ogilvie returned from a visit to London with a threat that, if doctors in Tasmania would not cooperate with his planned new system, he would find doctors who would in England or elsewhere in Europe.

The then Secretary of the Federal Council of the BMA, Dr John Hunter, visited the Tasmanian branch to investigate the problem, at the invitation of local members. In a report later to the Federal Council, he made it clear that the situation in the State had serious ramifications not only for local doctors but also for the profession nationally, because "there is no doubt that what is happening in Tasmania will be watched with a good deal of interest by other governments in other States". By then, a compromise solution to the disagreement had been reached in which doctors would work in the new system, paid jointly by the Government and the local municipality, but with the right to practise privately after normal working hours. The BMA helped draw up the compromise, having accepted that continuing war with the Government was not a great idea and that a better one was to concentrate on getting improved terms for doctors in the new system.

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WESTERN AUSTRALIA

Probably the first doctor to work in the new colony was Dr Isaac Scott Nind. He was the surgeon with the Lockyer expedition of 1826 to the King George Sound area, though he was less well known for his work as a doctor than for his vocabulary of words and placenames of the Nyungar people and his anthropological research for the Royal Geographical Society in London. Dr Nind left the colony after only a few years, in any case, returning to practise in New South Wales where he died in 1868.

In the first 40 to 50 years of the new society, doctors (as in all the other settlements) were prominent not just in medicine but also in exploration, public service and private commerce.

Governor John Hampton was a doctor, though not a practising one, being exclusively involved in improving the fragile local economy and managing the convict system in his three years of office. The first doctor in private practice in the new colony is said to have been a Dr Thomas Harrison who worked in the Fremantle area. Dr Alexander Collie explored the Cockburn Sound area with the Preston expedition in 1829 and then practised in the Albany area before coming to Perth where he established the first hospital tent and became Colonial Surgeon. Dr Thomas Lovegrove practised at Bunbury and became Resident Medical Officer there before his appointment as Government Resident and Warden in the Kimberley goldfields. He was also Acting Colonial Surgeon for about a year in the absence in England of Dr Alfred Waylen. Dr Waylen's doctorate in medicine from St Andrews University in Scotland was the first medical qualification granted to a West Australian-born person. He practised at Guildford before his 30-odd years in government service as Colonial Surgeon, member of the Medical Board, chairman of the Aborigines Protection Board and Superintendent of Vaccination. Acting Colonial Surgeon Dr William Milligan, who in Perth's early days offered his services out of a tent near Barrack Street and later in a former stables, was one of the leading citizens depicted along with Governor Stirling and Captain Fremantle in George Pitt Morison's famous painting, The Foundation of Perth. Dr Charles Simmons also treated the sick among the first white settlers out of a marquee on Garden Island.

Conditions were especially hard in Perth in those days; it was far from being the progressive city envisaged by

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Governor Stirling. The first permanent hospital building did not open until the mid-1850s. At the beginning of the 1830s, when the population was still only about 1,500, nearly everybody was still living and working in tents and other makeshift accommodation. (Even in Stirling's official residence, the leaks were so bad when it rained that letters had to be written under an umbrella.) The tents in which the first doctors treated their patients (and even the loftiest families lived) were surrounded by deep ditches to keep out snakes and "unfamiliar animals".

There was a major difference between the environment in which doctors practised in the new colony and that in the settlements elsewhere in

Australia: the absence of the traditional discord. Harmony was not disrupted until much later, when the local newspaper was used to air criticisms of the way patients were treated in the smallpox and typhoid epidemics in the early 1890s. At the centre of it was the cantankerous English-born Dr Edward Haynes, who had already had the odd clash with Perth colleagues. Dr Haynes, citing his record in England of dealing with epidemics, had asked the Board of Health to appoint him medical officer (salary £200) in charge of a smallpox epidemic in Perth in 1893. Whether or not the Board had in mind Dr Haynes' disputatious reputation, it appointed instead Dr Michael O'Connor, a young up-and-coming Western-Australian-born doctor who was already helping to deal with the epidemic. Dr Haynes was not pleased.

The Board already had its internal problems in dealing with the epidemic. Mr William Traylen, a lay Board member who was also on Perth City Council, was leading a noisy public campaign against the Board's compulsory vaccination policy and for the use as an alternative treatment a medicine composed of cream of tartar dissolved in water. Then, when the Board set up an emergency infectious diseases hospital at Subiaco, Dr Haynes set up his own nearby with his own method of treatment. He claimed to be persecuted when, after he had been called out to a patient with smallpox symptoms, the police refused to let him breach the quarantine regulations by entering the patient's house and he was left out in the street shouting out his instructions to the patient's family. Dr Haynes did work with Dr Waylen and other colleagues in a free vaccination campaign at Perth Town Hall, but his criticisms of the Board's handling of the epidemic did not stop. The dispute degenerated again when Dr Haynes interrupted a public inquiry into a smallpox fatality and had to be reprimanded for interfering with witnesses. He ran out of friends finally when it was discovered that he had sent a telegram to the colonial government in Sydney calling for it to intervene in handling the epidemic because the local authorities were incompetent and then when he scandalised his colleagues by getting the *Australasian Medical Gazette* to publish his version of the way the epidemic was handled.

All this did not go down well in what was then a small and isolated society, and at a time when secession was in the air. Nor did it later that year, when his view of the Board of Health fuelled a brutal offensive against it in the Parliament. Whatever their reason, his fellow doctors rejected him some years later when honoraries were up for election to the Perth Hospital and, 10 years after that, some members of the newly-formed branch of the BMA even tried to expel him for his "scandalous publications".

The Haynes incident is recorded at some length because it almost certainly influenced – if not delayed – the development of medical organisation later in the colony.

Already, by the mid-1850s, doctors in Western Australia had been discussing their need to organise, though the matter had not gone much further than that. Nothing much had changed until the Victorian branch of the BMA, reportedly encouraged by the Victorian Government Botanist Baron Ferdinand von Mueller, sent a request to the South Australian branch in 1886 to help round up support among doctors in Western Australia for an organisation for medical professionals.

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The Baron had no medical qualifications (he was trained as a botanist and chemist). But he had a number of medical contacts in Western Australia and elsewhere because of his research into the medical qualities of the flora he had discovered while with the Gregory North Australian Exploring Expedition in 1855. But, despite the Baron's influence and contacts, the Victorian-South Australian initiative petered out.

A Medical Union operated at Coolgardie on the goldfields for a while but it was very localised and attracted few members. The issue of organisation was not resurrected until 1895, in Victoria rather than Western Australia and – unfortunately, because by then he was running so short of people who wanted to have any dealings with him – via an initiative of the unpopular Dr Haynes who had written in the *Australasian Medical Gazette* that doctors needed to form an organisation in Western Australia to protect their interests.

Still, the Victorians maintained interest, encouraged by contact from a Dr George McWilliams offering the Victorian branch his support. The Victorians were encouraged. Dr McWilliams, though young, was a prominent (and very busy) Perth character: head of out-patients at Perth Hospital, founder-president of the St John's Ambulance Society, head of an organisation that looked after poor sick children, president of the Perth Cycling Club and honorary surgeon to the Western Australian Turf Club. But, perhaps because he had so many other things to do, Dr McWilliams was missing in action when a group of his colleagues formed a WA Medical Association in 1897 and the new group languished. It was not until a year after that that another group of doctors met in the Perth Hospital boardroom to discuss forming a branch of the BMA in Western Australia. This time, the notion of organisation was about to take off.

The prime movers were relatively new to Australia and very possibly had witnessed what an active and committed organisation like the BMA had achieved in the UK. Dr Herbert Horrocks had only recently arrived from England, though he had already been appointed to the Dental Board. His co-actors were the Stewarts. Dr Mitchell Stewart and his brother Fergusson had arrived from Scotland in the late 1880s and their sister Roberta in 1896, and the three of them had a group practice at Guildford. Their initiative led to 27 doctors setting up a branch of the BMA in Perth. Dr Waylen was elected President. Dr Mitchell Stewart was on the Council. His sister Roberta was an active and influential member.

In fact, Roberta, the first woman to practise medicine in Perth, came to have an enormous influence on the health system and the society of Western Australia as a whole until she died aged nearly 90 in 1961. In 1898, she married Martin Jull, with whom she had one child, the writer-historian Henrietta Drake-Brockman. With Edith Cowan and others, Dr Jull was heavily involved in social reform, especially (as a foundation member of the Children's Protection Society) in activities aimed at reducing the high rate of infant mortality in Perth and rural areas of the State. She was a member of Convocation and the Senate of the new University of Western Australia and the first medical officer of schools in the Public Health Department.

Dr Jull and her brothers had much to do with the mark that the new BMA branch was quickly making on development of the WA health system, particularly in helping develop programs to reduce infant mortality. New regulation had been drawn up to deal with infectious diseases, enforced by a Central Board of Health. A Principal Medical Officer had been appointed to control standards in the goldfields hospitals, where conditions were atrocious. The BMA was being consulted on a range of matters, including school health and food safety.

In 1911, when the branch was finally incorporated, a report to the Council had complained that most of its work was still being done by only "a willing few" and that the others displayed what could only be described as "enthusiastic apathy". Dr Jull herself had suggested that so much administrative work had had to be done by the Council and the honorary secretary that the new branch needed to employ clerical staff, part-time to start with. But the branch had achieved a huge amount in its first years.

It had developed a code of ethics, supervised by a committee, and prepared a paper on ethics and medico-politics for the Australasian Medical Congress. It had prepared ideas for a doctors' organisation at the national level, such as a federated BMA. A committee had drawn up fair contracts for members who worked for friendly societies. It had worked with the Government on a system of medical inspection of schools, legislation to deal with workers' compensation and the operations of midwives and the appointment of a Commissioner of Public Health to replace the Central Board of Health and with much greater powers. It had helped set up a maternity hospital in Perth.

With the developments in Perth, medical organisation had now been accomplished over most of the country, but there was little evidence of cooperation among the different branches in the different jurisdictions. In the new Commonwealth, and especially in the aftermath of World War I, a national government began considering ideas for the structure and elements of a national health service. The new organisation, operating as separate entities in different systems and often with different agendas, had to prepare itself for these developments, especially for their ramifications for its members.

ONE VOICE

MOVING TO NATIONAL ORGANISATION

For some years in the late 19th century, support for the idea of a more coordinated national structure had been growing among BMA members. Federation and the debate preceding gave it strength. This was not just because the process that led to the birth of the Commonwealth of Australia let loose a broad and proud national sentiment. The Constitution, which defined which level of government was responsible for which areas of responsibility in the new Australia, made it clear that the medical profession would now have a national level of government with which to deal on health and medical issues.

Quarantine was one such issue. Doctors in the pre-Federation colonies had long been agitating for a national quarantine system that could deal with the epidemics of smallpox and cholera that had come ashore from foreign ships from time to time, as in the Perth smallpox epidemic of the 1890s. In the mid-1880s, the NSW branch of the BMA had formally resolved to press for uniform, nationwide legislation that would enforce health inspection of all ships calling into Australia, especially in the north and west of the country. They would have been encouraged by the decision of the first Federal Council of Australia in 1883 (forerunner of the Federation Conventions of the 1890s) to discuss quarantine as one of the fields for action by the proposed national government.

Responsibility for quarantine was one of the powers given to the Commonwealth Government in S.51 of the Constitution. So were powers covering pharmaceutical, sickness and hospital benefits and invalid pensions. Significantly for the BMA and future medical organisation, the Constitution gave power to the Commonwealth to legislate for medical and dental services "(but not so as to authorise any form of civil conscription)".

Thus the profession was drawn into national health policies and activities. And, as the new era began, it seemed urgent and inevitable that the disorganised and even ramshackle structures and institutions at state level overseeing health and medical practice also needed to be rationalised: for example, hospitals, professional registration, medical education, public health and occupational health. Commonwealth governments were now contemplating a national health service. From its very limited role in quarantine, and (especially after World War I) having responsibility for the new pension and repatriation schemes, the Commonwealth was becoming ever more active in providing, administering and paying for health and medical services. A Commonwealth Health Department would soon replace the Department of Customs and Excise (which had covered the issue of quarantine) as the department to administer national health policy. Dr John Cumpston, a prominent official in the Victorian branch of the BMA (and, later, Commonwealth Director of Quarantine before becoming founding Director-General of Health between 1921 and 1945), later noted that the framers of the Constitution "could hardly have visualised that Federation, in practice, would inevitably involve the penetration of Commonwealth authority into the intimate daily life and social relationships of every individual person in the nation".

Within the medical profession, however, debate had long been going on about the ways in which it should and could respond to all this. Not everybody agreed with what was happening. Members were reported to be discouraged about the ideas about amalgamation or other forms of national integration by the turbulence in Victoria when the MSV and BMA were getting together – though the two organisations would be fairly amicably amalgamated shortly. Colleagues in both South Australia and New South Wales were reported in 1902 to be opposed to any moves towards national organisation, not just because of failure "to distinguish between federation and an Australian Medical Association", but also because of "the parochial spirit which views with distrust any suggestion of change coming from an outside source". Members in various States were said to prefer reorganisation into a discrete Australian or Australasian Medical Association rather than federation with the BMA.

Still, the pressure for "one voice" was growing and spreading, the need increasingly recognised among the branches "to have a body which could speak with one voice on matters of a national medical character," to quote Dr Charles Ross-Smith (Secretary General of the AMA from 1963 to 1966) in his seminal article in 1962 in *The Medical Journal of Australia*, "The Evolution of a National Medical Association in Australia".

In 1901, the MSV had kicked off the process by approving the recommendation by a committee that:

LET THE BATTLE COMMENCE

These were tough years to be AMA President. The previous decade had seen the Labor governments in New South Wales and Canberra aggressively pursue, with intent to destroy, the independence of the medical profession.

Then-premier, Neville Wran, had told me at our first meeting, "Doctor Shepherd, you represent the last independent group in society. As such I will move to control you."

In a pincer movement, Neil Blewett was in Canberra using federal legislation to restrict our right to treat private patients in public hospitals as he simultaneously sought to bring general practice to its knees with bulk billing. Governments started funding rampant medical consumerism. This emergent group of predators considered patients as 'clients' and professional standards as the domain of their relentless activism. Our profession had given our nation the highest standard of care in the world, yet we were besieged as the enemy in some kind of class war.

We had to fight. The AMA had been captured by a group for whom negotiation was little more than appeasement. They regarded the AMA office as a reward for years on committees and councils rather than fighting on behalf of the profession.

Through three hard years, first, I had to reshape the AMA itself – the Secretariat, Branches (Victoria especially), build a team of people prepared to energetically bleed for the cause, and professionalise the AMA to be a fearless and respected voice for the medical profession. None of this was easy.

The Australian Doctors Fund, established in 1988, was an essential complement to the AMA, focusing as it did on issues as diverse as the decriminalisation of healthcare, the looming crisis of medical immigration, AIDS and road trauma. It would later support the courage of plastic surgeon, Cholm Williams, in his legal battle to have patient records remain the property of the doctor.

My critics forget that we were dealing with a government that had withdrawn all support for private health care, telling Australians that Medicare was all they needed. Senior members of the same government readily used the private hospitals I had worked so hard to defend and for which access to the poor was diminishing thanks to government policy.

Then-health minister, Brian Howe, finally offered a Medicare co-payment in 1991. At first we thought we had finally broken through. With Bob Hawke's support, Howe announced there would be a patient co-payment. However, on closer examination, he was actually planning to cut the Medicare benefit for patients who paid their fees and shift half a billion dollars a year out of health to play with cities. We said no. Paul Keating used it to knock off Bob Hawke.

Sir William Keyes was the Keating government's head of the Office of Overseas Skills Recognition. He told the AMA National Conference in 1992 that any overseas doctor should be allowed into Australia. When challenged if that might, for example, extend to a Pakistan-trained neurosurgeon, he replied "yes, the market should be allowed to sort it out".

In October 1992, Brian Howe had told us not to bother telling him what the government should do. He said that if we wanted to change what the government was doing, we would have to change the government.

Although I was not often inclined to take Howe's advice, I did on this occasion.

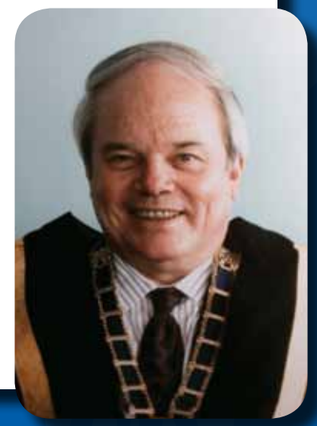
We worked tirelessly in support of John Hewson's Fightback! His health policy restricted bulk billing to pensioners and the unemployed while allowing private health insurance for outpatient services up to 85 per cent of the AMA fee. Families would get means-tested assistance to buy private health insurance. I took the view that if you were not prepared to fight for that then the AMA should pack up its tent and go home.

I battled corporatisation of health care and the profit motive of those who wanted to bring our younger colleagues to servitude in medical emporia. Rural doctors were a major focus, until then receiving scant regard from Canberra politicians and bureaucrats who considered them their masters.

Amid all of this, we fought tobacco companies to get them out of sport and off television. Although Jeff Fenech was a mate and patient, we argued the case to better regulate boxing.

Fred Hollows was another mate who put his heart and soul into Aboriginal blindness. Inspired by this and the neglect of the Government, I asked Gordon Briscoe to address the Federal Council in 1992. That started us on the journey of Aboriginal health.

I felt that by the time my three years ended in 1993 that I had played a role in building the AMA into a modern effective organisation. It would – and should – be one to be feared and respected.



Dr Bruce D Shepherd: AMA President 1990-93

"the time is opportune for formation of an Australasian Medical Association with the following objects:

- *the control and management of congresses;*
- *the establishment of an Australian Medical Journal*
- *the direction of medical polity;*
- *medical defence.*

The 'ardent juniors' in South Australia had been for some time energetically promoting the concept of an inter-colonial congress as a means of encouraging cross-border collegiality and exchange of information about progress in medical science. Such congresses would in practice add to the attractiveness of an organisation that would be more effective than a group of separate bodies with not much more than accidental and desultory contact. Twenty years previously, the maladministration problem at Head Office in London had stimulated the idea of an independent Australian association among members in New South Wales and Victoria. Among the activities that led finally to the formation of a branch in Western Australia was work on proposals for a federated BMA. Several of the medical journals that had been published over the preceding decades had advocated federation or national organisation. Their campaigns were reported to be well received by members frustrated because the *British Medical Journal,* which they received as part of their membership, for all its great value in keeping doctors up to date with the galloping medical advances of the day, was no great help in their understanding and dealing with exclusively Australian conditions. National organisations had already evolved in other English-speaking Dominions such as Canada and South Africa.

Shortly before the Inter-Colonial Congress in 1911, Dr Hayward convinced the SA branch, as the first in Australia, to agree to take the lead in moves towards union of all the BMA branches in the country. The branch proposed that a permanent federal committee be created to draw up a process which would make sure that the profession was prepared any time any government in Australia proposed any legislation that affected it. The Australian branches agreed. In 1912, very shortly after the final Australian branch of the BMA had been formed in Tasmania, a Federal Committee of the BMA was established, comprising two representatives of each branch, chosen annually.

All this agreement came with conditions that could have limited – and, later, certainly did limit – the work of the Committee. None of the branches had ceded actual powers to it. It could not initiate matters. The original concept was that it should be an Australasian committee, and New Zealand representatives attended the first couple of meetings of the committee. Later, however, the New Zealand branch opted out because "while the New Zealand branch is fully alive to the advantages of such a federation as applicable to Australia; owing to our geographical position and the different interests and conditions and also the difficulties in the way of obtaining direct and satisfactory representation on the Committee, this branch cannot see its way to join the Federation".

The constitution of the committee was drawn up by Dr Robert Todd, a lawyer as well as a doctor and secretary of the NSW branch. It stipulated that the Committee would act as a medium for negotiating on behalf of the branches in Australia on "matters common to such branches", and to represent Australian members of the BMA in dealings with Commonwealth and State governments on "any matter affecting the relations between the government and the medical profession". Dr Ross-Smith described the committee as "an advisory

Shortly before the Inter-Colonial Congress in 1911, Dr Hayward convinced the SA branch, as the first in Australia, to agree to take the lead in moves towards union of all the BMA branches in the country.

body to the branches in medical or political matters of a national character".

Finally, both the Committee and its constitution had to be approved by the parent organisation in Britain, a slow process (first) because the BMA constitution had to be amended to accommodate them, and (second) because they needed to be approved by the BMA branches before they could be considered by the BMA Parent Council. Luckily, the Australian application was formally approved during the BMA Annual Representative Meeting in July 1912. (Luckily, because the application managed to squeak through in the last few minutes of the last session of the last day of a conference otherwise distracted by uproar throughout because of the Lloyd George Government's proposal to legislate for national health insurance in the UK.)

Despite all these potential hurdles, the Committee quickly got down to work. Its first meeting was held in Melbourne in May. It was chaired by Dr Hayward in an atmosphere of agitated discussion in the profession concerning its fears that the Commonwealth Government intended to introduce a national health insurance scheme and to nationalise hospitals. It passed a resolution that sought to enable the Australian branches to deal with these Australian challenges, proposing that the constitution of the British parent body be altered to provide that an Australian Council be established, its members to be elected by Australian members of the BMA, which would administer the affairs of the BMA in Australia, though not in such a way as to affect the BMA outside Australia. The Australian Council was not established until 1933. Much work had needed to be done on such delicate matters as getting the state branches to agree to its constitution and remit among the Australian branches and getting the BMA Parent Council to accept the autonomy that the Committee had in mind.

In 1916, Dr Hayward and Dr Donald Cameron from Queensland travelled to the UK to press the issue on the parent organisation. Their mission was followed six years later by another by Dr Todd. The urgency of the issue had been enforced by the great influenza epidemic of 1917-18, when federal officials had no one doctors' organisation to consult on quarantine activities and so had been forced to consult the six state branches separately.

It was following these "eminently successful efforts", as Dr Ross-Smith has described them, that the BMA Parent Council formally got around to agreeing to the Australian proposition in 1923. There was now a charter from the BMA by which the Federal Committee could be converted into a Federal Council and, from then on, authority by which the branches could form the Council, define its powers, functions and responsibilities and cede their own executive powers to a Council. Discussion continued, but not much action. The Victorian branch did resolve in 1927 that the time was right for a Federal Council with executive powers. But it was not until 1930 that draft proposals for a Council were published in the *MJA*, which reported that "the Federal Council which takes the place of the Federal Committee will have wider powers". When it came to defining and agreeing to those wider powers, however, there was much devil to be exorcised in the detail.

The Federal Committee had been a significant step in the evolution of a national structure for the association. As a national health policy was being created, it had wrung from Prime Minister Cook his important concession on consultation. It had helped solve the longstanding problem of doctors servicing the friendly societies.

FRIENDLY SOCIETIES

One matter that had grown from a state-sized irritation to a nation-sized problem concerned contracts between doctors and the friendly societies that governed terms and conditions – capitation rates, for example – for the very many doctors providing medical services to society members.

Friendly societies were extremely popular throughout most of the 19th and well into the 20th century. Among their other services, they provided health coverage for (often less well-off) members and their families for discounted rates determined annually between doctors and societies. About the time that BMA branches were being formed in the States, about a third of all doctors were thought to be involved in these arrangements. By the time World War I was declared, the number of participating doctors had risen to 50 per cent or more – almost all the doctors in South Australia, according to some reports. The reason for the popularity of these arrangements was that the annual capitation rates very often represented steady annual income for the doctors. But, in the pre-war period, as the societies grew and became more commercially sophisticated, they became more inclined to press down on capitation rates. Not only that, but it was strongly suspected that societies were fiddling their members' income levels so as to force rates down. Doctors and their organisations became alarmed at, in effect, being forced to act as sweated labour for the societies.

The issue was on the agenda for the first meeting of the new branch in South Australia. Doctors in New South Wales published black lists of the worst offenders and even the doctors who continued to provide services to them. Some doctors in Queensland wanted strike action, but the BMA branch there refused to countenance it. Negotiations between the BMA branches and the societies were going nowhere. Shortly before the Federal Committee was formed, the NSW branch designed a

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The Federal Committee took up the running, using the NSW model as a basis for agreement. By the time war was declared in 1914, the societies had agreed to the BMA's terms in New South Wales, Queensland and Western Australia.

model contract that specified minimum rates, income ceilings for society members receiving medical benefits and extra fees for specific services.

The Federal Committee took up the running, using the NSW model as a basis for agreement. By the time war was declared in 1914, the societies had agreed to the BMA's terms in New South Wales, Queensland and Western Australia. But in Victoria and South Australia agreement was not reached until after the war, when government at the national level was well ahead with its thinking on a national health insurance scheme – a deeply concerning prospect for doctors in Australia. They had heard all about the uproar in the UK a few years earlier about the compulsory scheme established by the Lloyd George Government, a scheme so contentious that the argument over it led eventually to reform of the House of Lords.

FEDERAL COUNCIL

Despite its achievements so far it was clear that, for a number of reasons, there were severe limitations on the Federal Committee's capacity to exert BMA influence on the process in which, following World War I, national government inexorably increased its power over health policy.

The powers that the Federal Committee had been given meant that it was not much more than a kind of way station on the way to an effective national structure. No branch had actually agreed to cede to the new body any of its powers. The Committee was unable to initiate any matters, only to coordinate those sent to it by the branches, coordinate them and then send them back to the branches for action. Its constitution ensured that it was but a medium for negotiations involving the branches. As Dr Ross-Smith noted in his history, it was an "advisory body to the branches in medical or political matters of a national character". As the *MJA* recorded at the time, "the chief handicap of the Federal Committee was that it had no power to initiate new movements or to institute reforms; it dealt only with matters brought to it by the branches". The new Federal Council, it went on to say, would deal with "large questions affecting the whole of Australia".

The new body was finally incorporated in May 1933. It had taken more than four years to get the branches to agree on the form of the constitution of the Council. Three prime objectives were agreed: "to promote in Australia the medical and allied sciences, to maintain the honour of the medical profession, and to promote and maintain the interests of the profession." Its constitution provided that it "may consider any matter affecting the medical profession in Australia, and may act in connection therewith on behalf of the branches collectively". But, when the constitution was examined closely, it was found not to show any attempt at specifying the powers of the Council. It could "consider" but how could it "act"? Some limitations on its powers were defined, on the other hand: it could not enforce decisions on the branches, for example, and the branches (or a majority of branches) reserved the right to approve matters.

Nonetheless, expectations of the new Council were high. Dr Mervyn Archdall, the new editor of the *MJA*, greeted it as "a corporate body with power to initiate and to carry into effect measures advantageous to the Branches. The days of tedious reference to the Branches on matters of all kinds, the days of slow machinery are, or should be, done". It would not be long before cold water would be thrown on that idea.

Actually setting up the Council was not all smooth either.

It had very little in the way of financial support. Its funds, which came from a quite small annual increase in members' subscriptions, was reported barely to cover the costs of its two meetings a month. The funding problem was alleviated to an extent by supplementary grants from the branches, and even a subvention of £1,000 a year over three years from the BMA Parent Council in England. The problem was still grave enough that it was decided to limit membership of the Council to 12 members. (Later, after the debate over the powers of the Council vis-à-vis the branches had reached a critical juncture and, when mollification of the branches was badly needed, membership was increased to 15: four from New South Wales, three from Victoria and two each from the other four States. It then represented more accurately the numerical strength of the branches.) Dr John Hunter, though continuing as Medical Secretary of the NSW branch, had been acting also as Secretary of the Council. Dr Hunter's brother Hugh was appointed his assistant three years later as the workload built up. Though it was appreciated that impending Commonwealth legislation meant even more work, there were no funds for a full-time Council secretariat, the Federal Secretary having to share office and staff with the NSW branch.

The Council quickly exerted influence on developing health policy, however, despite these difficulties. It drew up proposals for a policy of integrating hospitals in a national system for the 1934 Congress, following up on the ideas being promulgated in Australia by Professor Errol Meyers of Queensland and in the UK by the BMA proselytising pamphlet *A General Medical Service for the Nation* in 1930. In 1935, the Federal Council suggested (and put to Commonwealth and State governments) proposals for a national health insurance system. It was in consultation with the Commonwealth Government on an independent national medical research organisation, as the Federal Committee had proposed in 1912, which led to the creation of the National Health and Medical Research Council.

Although the new structure was "in some ways cumbersome and slow," as Dr Ross-Smith says in his account, it "stood the test of time. Negotiations with the Commonwealth Government Health Department formed a major part of the Council's activity . . . owing to the rapid growth of the National Health Service in Australia. Negotiating on behalf of the profession with other Commonwealth Government departments, such as those of repatriation and social services, was also a major function of the Federal Council".

There was much to be negotiated. "Matters of a national character" had grown spectacularly in numbers and scope since Federation. So had their impact on the medical profession. Immediate matters included the status of doctors in the Government's plans – shortly to be revealed – for a national health insurance scheme.

HEALTH INSURANCE

The first sign of a national health insurance scheme in Australia had come in 1909. Its development needs consideration in some detail because it led to huge challenges to the structure and authority of the BMA in Australia and, as a result, to the evolution of the association into an autonomous Australian organisation.

The Commonwealth Government asked Sir George Knibbs, the Commonwealth Statistician, to take advantage of his attending the International Congress on Life Insurance in Austria in 1909 to detour to Britain to investigate the Lloyd George proposal and a similar scheme that had been proposed in Germany. There was broad agreement between both sides of national politics that a scheme was necessary, but disagreement over whether it should be compulsory or not. Sir George came back with a recommendation for a scheme similar to that being proposed by Lloyd George in Britain. The BMA was not enthused, but there were no more developments for the next 15 years, everybody's minds being concentrated on the war and post-war recovery. In any case, Prime Minister Cook had promised a Federal Committee deputation in 1913, shortly after he took office, that no national health insurance scheme would be set up without the BMA being consulted.

In 1924, the Bruce-Page Government appointed a Royal Commission to enquire into national insurance. It reported the following year with a recommendation for a national insurance fund that would pay sickness, maternity, invalid and superannuation benefits. It was not until 1928 that the Government responded to the Royal Commission with legislation that agreed in general with a fund but, even then, it was not enacted at the time, partly because of a faltering economy. Governments came and went over the next seven years as they struggled to deal with the Great Depression and its aftermath but, at three elections between 1929 and 1934, the major parties agreed in principle that a national health insurance scheme was needed.

In February 1935, the Federal Council had adopted a motion by Sir Henry Newland that a sub-committee be formed to draft "a complete scheme of national insurance applicable to Australian conditions". Its members were Sir Henry, his South Australian colleague Dr Bronte Smeaton and Dr Geoffrey Newman-Morris of Victoria. Sir Henry tabled the sub-committee's report at a Council meeting in August that year. It had found it impossible to draw up a complete scheme, he said, and therefore its report was "of an informative nature" only. At the Council's next meeting, in March 1936, it

was reported that the matter had been discussed at branch level and that the Queensland Branch had dissociated itself from "certain clauses" in the sub-committee report. The Council resolved that no further action was needed at the time. But the insurance issue came up again when it met next, in August 1936, in the context of discussion about general principles that should underlie any federal or state medical service. The Council included among these principles the establishment of a Commonwealth Insurance Department, that an insurance scheme should cover "all below a certain [income] limit, against all sickness", that there should be free choice of doctor, that payment of GPs should be by capitation fees and that the medical profession should be represented adequately in the scheme's quality and administration.

After the 1937 election, the Lyons Government renewed active interest in the idea, bringing out to Australia a British health official, Sir Walter Kinnear, in 1938 to advise it on what such a scheme might include. His advice was that the Government should set up a scheme similar to that which then operated in Britain. This was a revision of the detested Lloyd George scheme. It would cover everybody earning up to £365 a year, the costs to be shared by the government, employers and employees. It would exclude unemployed and self-employed people and dependants of wage-earners.

The Federal Council agreed on its response to Kinnear at a meeting in August that year. It favoured (among other things) an annual income limit of £365, a capitation rate of £1 a year if medical benefit was available to the insured person only and £2 a year if it was available to the insured person plus dependants, 1,500 as a maximum number of insured persons on the list of a medical practitioner and a maternity benefit scheme "on a compulsory and contributory basis" to replace the current maternity bonus scheme, which would have a material effect on lessening maternal morbidity and mortality in Australia.

At its next meeting, in February 1938, the Council agreed, "after a full discussion", with a motion by the President, Sir Henry Newland, that "in view of the imminence of the introduction of a National Health Insurance Bill into the Commonwealth Parliament", an executive committee be formed "with full power to act for the Council", which "could, in an emergency, be consulted by the Government". The new committee comprised representatives from all the States. Later in that meeting, Dr Hunter reported that some branch councils held different views from those of the Federal Council, including on the annual income limit and terms of service. Having discussed this, the Council resolved that "the whole matter of National Health Insurance be left in the hands of the Executive Committee". The decision would have consequences. It raised the question what power the Council had to make decisions on behalf of members, especially one that would have material effect on their incomes. As the history of medical organisation in Australia had consistently shown, doctors were not easily corralled.

Some months later, in line with Prime Minister Cook's promise in 1913, the Government invited the BMA to discuss the Kinnear scheme with officials. The Executive Committee accepted the invitation. Though the discussions were to be confidential, details leaked that suggested that terms had been agreed on such matters as capitation fees, fees for after-hours calls and other services. The leaks were inaccurate. The Council had favoured fee levels and other bread-and-butter matters in developing its response to Kinnear (as reported above) but it had not reached any agreement on them with the Government. Indeed, it was still insisting as late as March 1939 in a meeting with Treasurer Casey that the Government should provide "such actuarial calculations as may assist our deliberations" on these bread-and-butter matters.

Nevertheless, members reacted with fury, the leaks coming "like a thunderbolt", according to a report in the *MJA*. They complained that they had not been consulted, that the Federal Council was exercising plenary powers that it did not have, that the discussions

Nevertheless, members reacted with fury, the leaks coming "like a thunderbolt", according to a report in the *MJA*.

SETTING THE AGENDA

Four months after Bruce Shepherd placed the chains of office on my shoulders at the 1993 AMA National Conference, I gave my first address as president to the National Press Club in Canberra.

I had thought long and hard about what to say, the direction in which the Association needed to go, and my own beliefs about what had to be done.

And so I laid out the agenda – the critical importance of an independent medical profession, the consequences to health care and its financing of universal bulk billing, and the crucial role played by private healthcare and insurance to an effectively functioning hospital sector.

But in addition to these core issues, I laid out an AMA agenda in Aboriginal health, environmental health, the human and health effects of unemployment, discrimination against women in the profession, illicit drug use, immunisation, youth suicide, euthanasia and gay law reform, among others. The AMA would be a voice for those with neither power nor influence, reflecting in what it said and did the profession's commitment to an ethic of service to others. In leading the Association, I would not be 'safe'.

That day I also held to the cameras a packet of Winfield cigarettes in one hand and Ratsak in the other. I asked why the warning on one killer of Australians was a barely legible note about its impact on fitness, while the other, in 'black on gold', told its consumers exactly what it did – "kills rats and mice". Hours later, then health minister Graham Richardson rang to concede that the Commonwealth would finally move on explicit health warnings on tobacco products.

There were hundreds of calls to the Canberra office that day of support and of membership enquiries. Bruce Shepherd rang and simply said, "great job mate, I'm proud of you".

This was a period of immense change and transformation for the Association.

Among the many changes were the AMA-led development of the Professional Services Review, bedding down the nascent Divisions of General Practice, establishing the AMA Council of General Practice, the move to commence the Relative Value Study, and agreement on the concept of 'informed financial consent' prior to surgery. We also convinced the new Health Minister, Graham Richardson, of the need for government to encourage private health insurance. Richardson famously called on then Prime Minister, Paul Keating, to take out private health insurance.

The AMA employed its first Indigenous health adviser, successfully campaigned for responsibility for Aboriginal health to be removed from the Aboriginal and Torres Strait Islander Commission and placed into the Health Department, seeded establishment of the Indigenous Doctors' Association, facilitated changes to medical education to increase and support increased numbers of Indigenous students, campaigned for increased resourcing of Aboriginal Community Controlled Health Organisations, and encouraged support for specialist services in Indigenous Australia. The first Indigenous artwork for the AMA was commissioned but, most importantly, Aboriginal health was made a mainstream health issue by the AMA.

I made numerous trips to remote areas of the nation with colleagues and politicians to show middle Australia the existential despair, disease and premature death occuring in much of Indigenous Australia. It would not be until 2007 that a government would declare the national state of emergency that the AMA had called for in 1994.

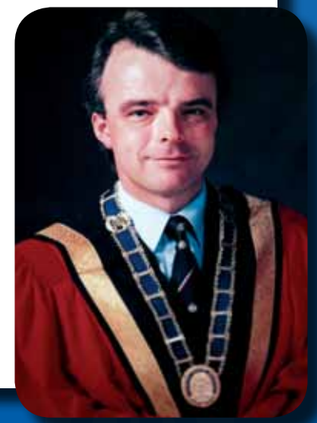
A great deal of effort was invested in tobacco control. In addition to explicit health warnings on cigarette packets, the prohibition of tobacco sponsorship of sport and early bans on smoking in public places, in 1994 we did something that has literally changed the world.

In 1994, I successfully moved on behalf of the AMA that the World Conference on Tobacco and Health in Paris adopt a resolution calling for a United Nations strategy on tobacco control. This was subsequently embraced by the UN as the Framework Convention on Tobacco Control, the global template for action on tobacco control.

My young family sacrificed much to allow me to serve the AMA. We lived in Hobart and I literally spent half the year on the mainland. I juggled GP locums and many nights doing house calls in the satellite suburbs of the city with the leadership of the AMA, on many occasions having little or no sleep. I did not appreciate just how hard – or rewarding – those two years were, until it all finished in May 1995.

To Bruce Shepherd, David Weedon, Priscilla Kincaid-Smith, Ross Glasson and many others, I owe a debt that can never be repaid. But the great sense of privilege and pride I felt in leading and representing the medical profession will never leave me.

The only medical organisation in Canberra that counts – really counts – is the AMA. Its influence and respect relies entirely on the strength of membership, quality of leadership and, above all, a commitment to the nation's best interests and health transcending all else.



Dr Brendan Nelson: AMA President 1993-95

had not covered the very principles of the proposed scheme. Members feared that the agreement meant for all practical purposes that they would be public servants. According to the Council's annual report for 1939, in December 1938 it distributed a pledge among members that they would not apply for or accept service in the scheme until terms and conditions were accepted by a majority of BMA members. Nearly 77 per cent of these pledges were signed and returned. Doctors assailed members of Parliament with protests.

Treasurer Casey was reported as being worried that the doctors' opposition was "seriously embarrassing" the Government. Unless the problem was resolved, the part of the proposed scheme governing medical benefits would be unworkable. In July, the Government therefore was considering appointed another inquiry to clarify the medical benefits proposals. But, eventually, despite Dr Page's enthusiasm for it, the whole idea of a health insurance scheme was dropped by the Government, lost when disagreement over it between Dr Page and the then Mr Robert Menzies led to the UAP-CP governing coalition breaking up.

A difficulty for the federal leadership of the BMA throughout this episode – and for the BMA as a whole – was that, in all the time that the notion of a national health insurance scheme had been debated, it had not developed a clear BMA policy for it. A basic reason for that was that – though the leadership had long realised that a national scheme was inevitable, though it had prepared for it with its efforts to solve the problem with the friendly societies, though it had discussed it with the branches, and though it had appealed to branch members for interest in and ideas for it – the profession in general had not responded and it had not been able to get a policy through the association's structures.

FEDERAL POWER QUESTIONED

The insurance episode demonstrated that, if Federal Council was to support and defend the interests of the association as national government intruded more and more into health policy and delivery, it needed to do so with the full and early involvement and formal consent of the branches, and their members who would be the ones asked to deliver that policy. It was just as well: national health policy was set to evolve seriously and rapidly. But another, difficulty, even more serious, that had been shown up by the insurance episode was that there was ambiguity leading to misunderstanding about the precise boundaries between the powers of the Federal Council and those of the branches. The latter difficulty had to be sorted out before the former caused even more problems in the great changes ahead.

The BMA faced the dilemma that the Government assumed that the leadership at the federal level had power that it really did not have. The Council's achievements were in the main the result of the influence it had, through its consultations with government, exerted on health policy. This was almost certainly why the Federal Government was treating the Council as the body that spoke for the entire BMA on health and medical matters. But, as the insurance episode demonstrated, it was not so simple. The branches had given the Federal Council the authority to act for them, and – until the insurance episode – the working relationship between them had been basically cooperative and amicable. But the branches had not surrendered to the Council the powers that had been transferred to them from the BMA Parent Council. As the BMA was becoming more of an actor in and influence on national health policy, and expected to be so by an ever-more active Federal Government, this was a problem that could not be ignored or deferred. Federal Council asked Mr Frank Kitto QC, an expert on constitutional and equity law (and later a Justice of the High Court) for his advice on the powers of the organisation.

His advice when he reported in 1943 was not all that helpful. He recognised the difficulties inherent in the BMA constitution, which had not defined the relationship between the branches and federal bodies such as the Federal Council. The branches had given the Council authority to act for them, but they had not given up their powers, and the Council could not override them. As in the insurance episode, for reasons outside its control, the Council might have to reach decisions before it had had time to consult the branches and seek their agreement to these decisions. But, according to the constitution, the branches were in no way bound by them. They could accept Council's decisions or reject them as they saw fit.

Mr Kitto offered two possible remedies: amendment of the constitution of each branch or a request to the Parent BMA to a change in its own constitutional arrangements that would allow a central body such as Federal Council the power to override the branches. Neither seemed practical. The upheaval would have been enormous. Mr Kitto concluded that the way forward was a kind of gentleman's agreement in which the branches accepted a moral obligation informally to allow the Federal Council informally to take over some of the branches' powers. Given the pace

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and the implications of political change at the time, this was not going to hold up for too long.

A Labor Government intent on change was now putting greater pressure on the Council. In 1947, after it had been agreed that the number of branch representatives on the Council would be increased to represent their numerical strength, the Council reported that the branches had agreed to the principle that:

in respect of questions on which the Branch Councils have made decisions and reported such decisions to the Federal Council, the Federal Council's decisions, made after consideration of such reports, shall become the policy of all the Branches, and that the Federal Council shall have the power to state these decisions to all interested bodies as the Association policy.

The change did not come too soon.

NATIONAL HEALTH

In Britain, the 1942 Beveridge Report on social security had included a recommendation for a national health service which gained almost universal support, including from the BMA. A national health service had already been set up in New Zealand.

In Australia, World War II had become a powerful pressure point for change. Doctors were needed for services to the armed forces; those left behind were overworked. The divide between city and country and between regions constituted a challenge to the quality and quantity of medical and hospital services that breathed life into ideas for more coordinated, if not national, health services. Despite the peacemaking work of the Federal Committee, differences over contract practice still irritated relations in various areas between doctors and the friendly societies. Neither Government nor Opposition was satisfied with the state of the legislation governing national health insurance. Even the first Menzies Government was considering systemic change: Commonwealth Health Minister Frederick Stewart had asked the National Health and Medical Research Council (NHMRC) in May 1941 to report on the most effective way towards "the preservation and protection of the health of the people of Australia". The Government's reason for asking the NHMRC to produce the report was that it considered it the only organisation at the federal level that represented a wide enough range of medical interests. Thus, it ignored both the range of medical interests represented by the Federal Council and the BMA's position that the NHMRC should be a purely research and not a policymaking institution.

Federal Council had accepted the creation of the NHMRC with some qualms in the first place. In 1926, the Bruce-Page Government had established a Federal Health Council, which Sir Earle Page, a BMA member and a Minister in the Government, said would help develop a national health policy. The BMA asked to be represented on the Council; the request was ignored. In 1935, when the Lyons Government proposed a Medical Research Council, the BMA insisted that it should confine itself to research matters and not get involved in medico-politics. It also argued that it should not comprise just bureaucrats, except perhaps Dr Cumpston. Dr Page appeared to support the BMA position on this but the Government finally nominated for the NHMRC two officials from the Commonwealth (including Dr Cumpston as chair) and six from the States - but only one representative of the BMA, though some other officials than Dr Cumpston were BMA members. The NHMRC also replaced the Federal Health Council. Federal Council accepted all this with reluctance, and nominated Dr John Newman-Morris, former President of the Victorian branch of the BMA and therefore a person of some weight, as the association's representative on the NHMRC.

Reform was in the air: the NHMRC inquiry would have serious ramifications for medical professionals and their organisation.

In Australia, World War II had become a powerful pressure point for change. Doctors were needed for services to the armed forces; those left behind were overworked.

Its report was published in July, only two months after it had begun its work and only days before the Menzies Government gave way to the Curtin Government. It disagreed strongly with the insurance legislation, especially the capitation method of payments, which it said would be unacceptable to any professions or trades. It criticised fee-for-service in private practice as impractical. Instead, it offered a "tentative" discussion paper (*Outline of a Possible Scheme for a Salaried Medical Service*) that canvassed the idea of salaried doctors providing uniform hospital and medical services in a system of regional health districts, with health centres to service major populated areas. The Commonwealth Department of Health would administer the scheme, which suggested that control of the scheme would be exercised by the Commonwealth, though the paper did not deal with any constitutional complications arising from that. The scheme would be paid for out of taxation. Finally, the paper recommended that the idea receive "critical and dispassionate examination in consultation with the medical profession".

The NHMRC would have given the paper unanimous approval but for the dissent of one member: Dr Newman-Morris of the BMA, who was unable formally to support any changes to the health system that had not been approved by Federal Council.

The NHMRC report did not seem to go anywhere at first, but it amplified ideas about health policy that were well-known to be already circulating among politicians who had decided that post-WWII arrangements would include a radically new health and hospital system.

So the Federal Council responded immediately to the NHMRC report by issuing far-reaching (if not radical) proposals of its own for a health system; radical at the time because they challenged the current verities. A "proper administrative organisation" was needed to bring together and incorporate all aspects of medical practice into any system of social reform, it said. Private practice and private hospitals should be retained in the district-based health system envisaged by the NHMRC. But the BMA went further. Health was or should be one of a range of social issues, it said. Existing social conditions now meant that "the care of personal health is a social duty and not an individual responsibility". Medical practice had developed areas of specialised work that had resulted in a complex of uncoordinated activities, all acting for individual health care and all becoming increasingly divorced from the principle that should govern prevention of disease.

There was no great outbreak of public debate or controversy following publication of either the NHMRC discussion or the Federal Council's response. There was a world war going on, after all. But the Government had now been offered – perhaps even confronted by – an alternative health policy, seriously different from present arrangements and very probably unanticipated in any current government thinking. Whatever the reason, it very quickly headed off any discussion by appointing a Joint Commonwealth Parliamentary Committee on Social Security, with equal representation by the Government and Opposition, which would bring forward recommendations to improve social conditions generally, not just health.

The Committee, though it was set up by the Menzies Government, was retained by the successor Curtin Government. Between 1943 and 1946 it produced not one but nine separate reports, though only the last four concerned health. This constant drip-feed of reports produced widely varied aspects of policy for a national health system for everybody involved to consider. They included proposals for a Ministry of Social Services that would be responsible for medical and health services as well as social services generally. A universal health service should be established, with salaried doctors staffing hospitals. The service would be funded either out of taxation or via a compulsory insurance scheme. A Commonwealth Health Commission, with BMA representation, would implement and run the scheme. The Committee acknowledged that there were constitutional complications with these proposals but it thought that they could be overcome through Commonwealth-State cooperation. Not all these ideas touched ground, but they and others were coming thick and fast.

REMUNERATION

One of the Parliamentary Committee's primary interests was doctors' remuneration. In its final report, it agreed with the NHMRC in opposing the 1938 health insurance legislation. Its cover was restricted, the Committee said, the benefits that it proposed were limited, and there were inherent disadvantages in the proposed method of payment. But it came down against both fee-for-service and capitation.

The Committee said that its investigations had been helped by advice from leading doctors. It had had the help of advice from a medical planning committee that had included distinguished members of the medical profession as well as politicians. Throughout its investigations, the Committee had had the cooperation of the profession, it said, and good relations with the BMA at federal and branch levels. Even if it were well-founded, this sunny frame of mind would not long survive.

From the individual member level upwards, there was a flurry of debate within the BMA as a response to the proposals of the NHMRC and Joint Committee reports, not only as they concerned doctors' remuneration but also over their potential constitutional limitations.

The Council was thought to be only implicitly supporting a fee-for-service system by at first rejecting just capitation and salaried service. Later, however, it made its support for a fee-for-service system explicit by adopting the position that it was the only acceptable one for medical services.

The Committee's proposal for a salaried medical service had found favour with some doctors in Victoria who had already canvassed the idea beforehand. Debate in the Queensland branch is reported to have produced support for three suggested remuneration schemes. Capitation had been supported by two members of the Federal Council in giving evidence to the Committee.

The Council was thought to be only implicitly supporting a fee-for-service system by at first rejecting just capitation and salaried service. Later, however, it made its support for a fee-for-service system explicit by adopting the position that it was the only acceptable one for medical services. It also canvassed ideas for a statutory body containing BMA representatives and reporting to the Department of Health to operate the health system, rather than the Health Commission envisaged by the Committee.

UPHEAVAL IN THE GOVERNMENT

While the Joint Committee had been chugging along, tumultuous political events had been taking place, not over health especially, but with serious ramifications for the health system and the medical profession. After the period 1941 to 1943, during which governments came and fell, John Curtin had succeeded Mr Menzies after a general election campaign in which a national health system provided free at point of delivery by salaried doctors was formally and specifically included in Labor's election policy. Senator James Fraser, who had become Minister for Health, emphasised the point (inflaming the BMA,

While the Joint Committee had been chugging along, tumultuous political events had been taking place, not over health especially, but with serious ramifications for the health system and the medical profession.

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its members and doctors generally) by going out of his way to confirm that doctors would staff a salaried medical service in the new system.

This, as the *MJA* said at the time, was tantamount to the Government's saying that "whether you like it or not, we intend to put our ideas into practice and we are training our own men to work for us". The Government wanted consultation on its national health policy. The BMA refused. Sir Henry Newland, President of Federal Council, labelled the consultation that the Government had in mind as an "indulgence in professional euthanasia".

So, for the first time since Federation, national government and the medical profession were at absolute loggerheads, two competing forces facing each other with different primary objectives and interests arising from different value systems. Casualties were not going to be light.

PHARMACEUTICAL BENEFITS SCHEME

The first clash between them subsumed whatever debate had been taking place over the NHMRC and Joint Committee reports, and it had profoundly significant consequences, setting off huge problems for the Government that it never resolved before it was defeated six years later.

It was fought over the Pharmaceutical Benefits Scheme. This proposed that medicines would be provided free at the point of service on a doctor's prescription. It also proposed a number of close instructions for doctors using the scheme, including that they must use the prescription forms provided by the Government. The Government was reported to be confident that the legislation it would present to set up the scheme would not have any constitutional problems.

The BMA did not disagree in principle with provision of free prescribed medicines but it maintained that it was not the Government's responsibility to decide which medicines should be included on free lists or how doctors should write out prescriptions. Sir Henry Newland said that the scheme would inhibit doctors in prescribing what they judged to be the most suitable medication for their patients. The BMA also challenged the advice by Attorney-General Bert Evatt that the legislation was constitutionally sound. Notwithstanding the BMA's reaction and advice, the enabling legislation was passed by the Parliament in April 1944.

It was immediately rejected by Federal Council. The arrangements for it had been clearly well organised before the doctors who would run the scheme, or indeed anybody outside the Government, had seen any of its detail. The formulary of medicines for which it provided was discriminatory. Doctors would not be able to prescribe medicines that were the most suitable for their patients. Not only that but it was also identified as the Labor Party's first legislated step towards a socialised and nationalised health service, as foreshadowed by Senator Fraser.

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Federal Council instructed members not to cooperate with the scheme. It refused the Government's request for the names of doctors who could join the committee that was proposed to advise on the medicines that should go on the list. And, when the enabling legislation was proclaimed in 1945, the BMA responded in the courts. On behalf of the Victorian branch, the Attorney-General of that State launched action in the High Court that challenged the constitutionality of the legislation. In November that year, the High Court decided Dr Evatt was wrong and the BMA right: that the legislation, which sought to introduce a scheme of subsidised medications, was unconstitutional because it was not supported by Sec.51 of the Constitution, the section that gave the Commonwealth power to legislate only for invalid and old age pensions. Not only was the constitutionality of the PBS legislation in doubt but now also that covering other social policies such as child endowment. This was getting messy.

The Government (by now led by Mr Chifley) mounted a referendum the following year to gain approval for a change to Sec.51 so that it could provide pharmaceutical, sickness and hospital benefits and medical and dental services plus maternity allowances, widows' pensions and child endowment. Not surprisingly for a proposal that guaranteed support for mothers, widows and their children, the referendum was strongly supported. The Constitution now allowed the Government to proceed with a pharmaceutical benefit. But it also retained the clause in Sec.51 that it could not do this so "as to authorise any form of civil conscription". That clause was soon to cause the Government much grief.

With the referendum result behind it, the Government introduced legislation in 1948 to implement the PBS with amendments to deal with clauses in the original Act that the High Court had criticised. In the BMA's judgment, the 1948 legislation was in practice no better than the 1945 one, and it decided to launch a national campaign against it.

Doctors were instructed not to cooperate with the scheme and return their formularies to the Government without opening them. The campaign was effective: it was reported that about 98 per cent of all doctors complied with

the BMA's instructions. Moreover, the association issued yet another legal challenge as soon as the legislation was proclaimed, on the ground that the Government's instructions to doctors under the legislation amounted to civil conscription and therefore was in breach of the Constitution. This too was upheld by the High Court.

It was now 1949. An election was due. Time had run out. The Government did not have time to put up any more amendments to the PBS legislation that would satisfy the High Court and the BMA.

While the struggle over the PBS was taking place, the Government had moved on another aspect of health policy. This was its proposal, also opposed by the BMA, to legislate for a hospital subsidy scheme and negotiate it with the States. The subsidy proposed would be paid on condition that each state government would abandon means testing of public hospital patients. A similar subsidy would be paid to private hospitals for patients who had taken out private health insurance.

Though the BMA at the federal level opposed the scheme, some state branches accepted that it as relatively inoffensive in practice. New South Wales (with Federal Council support) set up a Medical Benefit Fund to head off any attempt to use the subsidy scheme to introduce a salaried medical service sessional payments. Something like 1,000 doctors in New South Wales each donated £10 to establish the MBF. The Fund was open to public subscription. Subscribers were offered reimbursement of expenses for treatment by doctors on a fee-for-service basis. This became the basis for the national insurance scheme established by the Menzies Government in the early 1950s.

The matter rested at that point. An election was called in December 1949.

PEACE BREAKS OUT

Peace between the BMA and the Commonwealth was restored when the Chifley Government lost the 1949 election and was succeeded by a government led by Mr Menzies and including as Health Ministers over the next decade BMA members Drs Earle Page and Don Cameron.

The relationship between government and the association quickly became less bellicose. Consultations took over from salvos. These consultations could be fairly lively, according to BMA officials who were present. They found that Dr Page could be "explosive" – described by colleagues as a "controlled tornado" – compared to Senator Nick McKenna, his much calmer predecessor in the Chifley Government. He had inherited Senator McKenna's advisers who, one BMA official has said, "were all very nice fellows, but unchangeable as the Bourbons". Nevertheless, the contacts led, especially in the first few years, to private practice being retained on a fee-for-service basis and government subsidies for the health funds to help defray patients' health and hospital costs, as the BMA had proposed in its "general principles" of 1941 and as Dr Page had promised in the 1949 election campaign. The BMA was invited to have representatives on the Pharmaceutical Benefits Advisory Committee and an enquiry into the Pensioner Medical Service.

With the BMA closely involved, the Government drew up the National Health Act, whose component parts were the PBS, the Pensioner Medical Scheme, the Medical Benefits

It was now 1949. An election was due. Time had run out. The Government did not have time to put up any more amendments to the PBS legislation that would satisfy the High Court and the BMA.

RELUCTANT CONDUCTOR

In the latter years of my term as Honorary Secretary of the Queensland branch, and as its President (1983-84), I had the opportunity to attend the Federal Assembly of the Australian Medical Association. The highlights of the meetings (for a newcomer) were the enforcement of strict rules of debate and the humour associated with the daily motion to "suspend so much of the standing orders that would allow smoking to occur" for the remainder of the afternoon.

In my early years as a delegate, I was surprised that this motion passed, let alone that it was even being considered. The ventilation in the venue, the Senate Room of the University of Sydney, was suboptimal, and as the meeting progressed the atmosphere became putrid. Eventually, after several years on Federal Assembly, I was pleased to be present when the motion was lost and smoking was outlawed by the Assembly.

After an absence of about 12 months from the federal scene, I was surprised to receive a call in 1988 from Dr Bruce Shepherd, who urged me to nominate for a position on the Federal Council as the pathology representative. I accepted, probably because of my susceptibility to flattery, rather than based on any real desire to start a 'career' in the federal arena.

Such was not to be. A few years later, I joined the Federal Executive. As Vice President from 1993-95, I watched in awe as Brendan Nelson as Vice President, and then President, captivated his audiences on numerous occasions, even cynical members of the medical profession. His handling of the press was truly amazing and I marvelled at his ability to think on his feet, and control all situations. This job was not for me, I remember thinking frequently.

All was to change. Brendan decided to throw his hat into the political ring by nominating as a candidate for the Liberal Party for the federal seat of Bradfield in 1995.

Nominations for the presidency of the AMA closed on the Friday, a day before the selection of the candidate in Bradfield. I agreed to nominate, along with Brendan, for the position of President of the AMA. If Brendan was unsuccessful the following day (for which I prayed), I would withdraw my nomination and he would continue on as a very effective AMA President. I thought I was reasonably safe, particularly when some sections of the media turned on the prospective Liberal Party candidate, for reasons that are probably best not canvassed here.

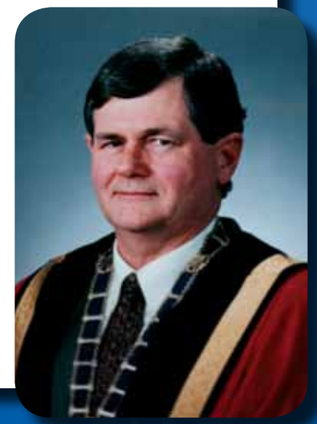
To my surprise and horror, I received a call from Bruce Shepherd at noon on the Saturday. He said he had "good news": Brendan had won preselection and I would be AMA President.

The reluctant President was soon filling very big shoes. I hated every second of the ensuing year, but tried not to show it. Only two incidents of that 'hell year' remain in my mind:

1) a visit to Kirribilli House to meet the Prime Minister of the time, Paul Keating. He was so different to his public image. I will always remember his informal manner, his politeness to a potential thorn in his side, and his frank assessment of all health ministers that he had encountered; and
2) becoming lost in Parliament House and the then health minister, Dr Carmen Lawrence, asking me if she could "show me the door" (in good humour).

I have a personal rule that I try to keep. Never return to an organisation that one has previously served. Accordingly, I will not be at the launch of this book, for which I apologise in advance. I broke that rule once in the AMA, and regret very much my brief return to chair an extraordinary meeting of the AMA. Each 'side', including me as chair, had legal advisers in attendance and the meeting achieved little, and soon was adjourned.

Hopefully, after serving for 23 years in AMA politics, I have learnt one thing – how to chair a meeting. It is like conducting an orchestra – if the wind instruments are too loud, it is essential to silence them; if the violins are too soft one needs to bring them in (to the discussion). There is no place for the beating of drums in an orchestra or meeting. My baton has now been laid to rest.



Dr David Weedon: AMA President 1995-96

The AMA Annual Report for 1966 recorded "its appreciation of the willingness of successive Ministers of Health to discuss with Federal Council important matters associated with the National Health Service and with medical planning in general.

Scheme and the Hospital Benefits Scheme, and whose structure and operation had (in the opinion of the BMA) been rendered simple, unobjectionable and compatible with private practice. Later, in the early 1960s, Health Minister Senator Wade set up a consultative committee, composed of BMA and government officials, to "simplify and speed up the settlement of matters of mutual concern" in the health system. Sir Cecil Colville, President of Federal Council (and later first President of the AMA), said that the committee "in no small measure contributes to the smooth running" of the health service.

Problems did arise from time to time, even in the era described by Sir Earle as one of cooperative partnership between the BMA, the Government and the health funds. There was still the odd disagreement: over the formulary lists and charges for prescriptions in the PBS, for example. The Government's response to the BMA pointing out anomalies in medical benefit schedules was not considered to be very helpful. The Government rejected a BMA request for representation on the Commonwealth Insurance Council and the need for an adequately representative Medical Benefits Advisory Committee. Changes to the means test under the Pensioner Medical Scheme in 1953 had its effect on the incomes of private practitioners, which had caused some disquiet among members. But, essentially, the era of cooperation – with health no longer such an acute area of contention between doctors and government or a vexed campaign issue in five federal elections – had resulted in a relationship that was deemed to be working reasonably.

The AMA Annual Report for 1966 recorded "its appreciation of the willingness of successive Ministers of Health to discuss with Federal Council important matters associated with the National Health Service and with medical planning in general. It is hopeful that such a happy relationship with the Commonwealth Government may continue." In the 1967 Annual Report, the AMA complimented the Government for the spirit of cooperation epitomised in "informal meetings, at which many problems are resolved before they grow into areas of conflict". But this cooperation was becoming less friendly. By the end of the 1960s, and especially by the time John Gorton had succeeded Harold Holt, the relationship was coming under pressure, and it would lead to much dissension between the profession and the government and within the profession and its organisations.

Among the reasons for this was almost certainly the fact that, except for one brief year in 1963, none of the four Health Ministers had had Cabinet rank since Sir Earle Page had retired in 1956. So it can be argued that it was not all that high among the priorities of the later Menzies and successor governments. Harold Holt succeeded Sir Robert Menzies in 1966, John Gorton succeeded Harold Holt in 1968, William McMahon succeeded Gorton in 1971 and – in all that time, until the McMahon Government lost to the Whitlam Government in 1972 – Health remained a junior Ministry, though the health service itself was clearly showing wear and tear around the edges.

INDEPENDENCE

AN AUSTRALIAN ASSOCIATION

In the meantime, the association itself had been undergoing huge change. When the era of cooperation began in 1949, the profession was still represented by a loose confederation of basically autonomous branches of a British organisation. The powers and responsibilities of each level of the organisation in Australia were defined, limited and accepted only in a kind of gentleman's agreement. Over the preceding 40 or 50 years, the association and the profession at large had faced huge change in health policy in Australia and, most importantly, with the way in which government structures had developed in Australia to put this change into place. More change was on the way. From time to time since the 1890s, events such as the parent body's handling of matters in Australia had set off much talk among branches and members about whether or not a professional medical organisation was needed that could act and react more flexibly, more independently, than one that was but one branch among others of a parent body on the other side of the planet. By 1936, the ties between the parent BMA and its Australian branches were still close enough that the parent in London was putting £1,000 a year towards the secretariat and other expenses of the Federal Council in Australia.

In its eighth meeting in August 1937, a decision by the Council to reappoint Dr Hunter as General Secretary led to a general discussion about the organisation of the medical profession in Australia. This in turn led to the Council's deciding that Dr Newman-Morris, one of the two Victorian delegates, form a committee with Dr Hunter that would "draw up a proposal, for submission to the Branches, for the formation of an Australian Medical Association". In a draft proposal for the committee, the Council said that it had become increasingly apparent that the organisation of the profession in Australia "is impeded rather than assisted by reason of the fact that the work is carried on under the Memorandum and Articles of Association of the British Medical Association. This involves frequent reference of important matters for decision to London, and the transference of large funds which are required in Australia. The Federal Council therefore is of the opinion that the time has arrived to explore the possibility and desirability of forming an Australian Medical Association affiliated to the British Medical Association, and refers the matter to the Branch Councils for consideration." The Council resolved that Drs Morris and Hunter should outline a draft constitution of an AMA for a later meeting.

The next meeting of the Council was in February 1938. Delegates discussed the committee's report (which had also been circulated to all the branches). They decided that the Federal Council – "realising by experience the need of complete autonomy and powers for regulating the actions and promoting the interests of the organised profession in the Commonwealth" – should urge the BMA Central (parent) Council to consider amending the BMA's Memorandum and Articles of Association and by-laws "so as to give the organised profession in Australia full autonomy". They also resolved to authorise Dr Victor Hurley (who was going to the UK as a representative of the Victorian Branch to the 1938 BMA Annual Representative Meeting) to discuss the issue with officials of the parent body. His report on his discussions was tabled at the Council's meeting in December 1938. At that meeting, it was decided to ask the views of the branch councils about the desirability and extent of altering the Federal Council's Articles of Association "with a view to obtaining greater autonomy (for it), than at present possessed". The Council also resolved that it was "of opinion that, in order effectively to organise the BMA in Australia, the fullest possible executive powers be given to the Federal Council, and that the Branch Councils be requested to indicate if such executive power be desirable".

Finally, at a meeting in September 1959, the Council decided that "the time is now opportune to proceed with the formation of an Australian Medical Association, independent of but affiliated with the British Medical Association" and that its opinion "be forwarded with a request that the views of members be obtained". Its decision was circulated to the branches with a statement on five pros and two cons in forming such an autonomous body.

A HISTORY OF
THE AMA

Under the heading "Advantages", the statement listed that:

"Complete autonomy of the medical profession in Australia would result; decisions of procedure and action deemed advisable for the organised profession in Australia would lie with a body composed of Australian elements, fully equipped with the knowledge of local conditions and problems;

On the financial side, the present BMA overseas subscription would no longer need to be paid to the Parent Body, ie, an amount of approximately £25,000 would be retained in Australia. However, it is impossible to forecast at this stage the probable saving, if any, likely to accrue from this to the individual member, as undoubtedly in the setting up of a new association there are bound to be some initial and unforeseen expenses;

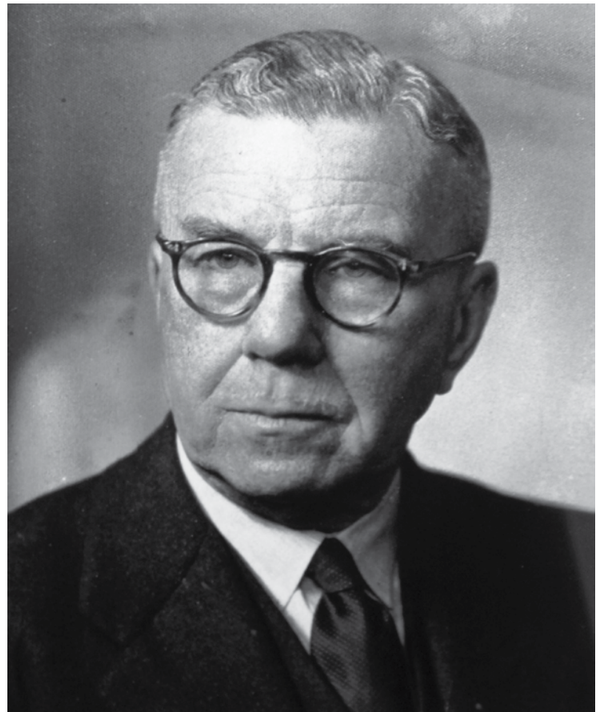
In the field of medico-political negotiations, it is believed that the importance of such negotiations in future will increase and although in the past the name of the British Medical Association has always carried with it the great prestige and high esteem it so rightly deserves, it is nevertheless felt that a purely Australian association, with the full representation of the Australian medical profession, would have an even stronger and greater part to play."

The disadvantages were that:

"The effect of disruption of the close and traditional ties which have existed with the British Medical Association for such a long period, and the very real sentiment attached thereto, needs to be carefully considered. However, as has been evidenced in the case of other medical associations of Commonwealth countries, particularly Canada and South Africa, close affinity and affiliation with the BMA has been shown to be possible and, in fact, none of the existing attachments of friendship and cooperation with the Parent Body needs to be lost;

Members of a Medical Association of Australia would no longer routinely receive the British Medical Journal but for those members in Australia still wishing to receive this Journal, a separate annual subscription of two guineas would provide same."

Dr (Sir) Cecil Colville, first Federal President of the AMA, 1962-64



Dr Ross-Smith has pointed out that the idea of a national association caught on with remarkable speed. The *MJA* reported in a November 1959 issue that it was "hastened by a rather more rapid (even startlingly sudden) appreciation of the fact that leaders of the Association in England had no objection to such a move and indeed considered it overdue". In fact, the Canadian Medical Association had been born as far back as 1867, the Medical Association of South Africa in 1947 and the associations in India and Pakistan in 1950.

With the branches' unanimous agreement, the Council decided in February 1960 to start straight away drawing up a constitution for the new national association. "A steering committee, composed of the four NSW representatives on the Council, was duly appointed for this purpose," Dr Ross-Smith says, "and the committee was directed by the Council, in formulating the constitution, to make every effort to maintain unity in all branches of the profession in Australia. This concept of unity of the profession was actively pursued, and not only the six BMA branches but, in addition, all nationally organised medical societies and organisations, totalling 30 in all, were consulted about the constitution. The splendid work of the steering committee culminated in a National Convention of representatives of branches, the Royal Colleges and other nationally organised medical bodies in Sydney, on November 26 and 27 1960 for the purpose of discussing a Draft Constitution.

"The Federal Council, having virtually received a vote of confidence at the Convention, proceeded immediately to finalise the Memorandum and Articles of Association, which was adopted in final form on June 10 1961," Dr Ross-Smith reports. The Australian Medical

Association was then duly registered in Canberra, ACT, on October 25 1961 and, from January 1 1962, it commenced to function, with the six former State BMA Branches becoming Branches of the Australian Medical Association."

Dr Ross-Smith says that a close link was retained between the AMA and the BMA, "as evidenced by the signing of an affiliation agreement, designed to work to the mutual advantage of members of both Associations", and that a large number of AMA members had shown their desire to keep in touch with the British colleagues and British medicine by continuing as overseas members of the BMA.

The first AGM of the new organisation took place in May 1962 at The University of Adelaide – fittingly, in the State that had played such a significant part in the history of medical organisation in Australia. Prime Minister Menzies opened the meeting, having been made the first honorary life member of the AMA. Sir Henry Newland, President of the old Federal Council, installed Dr Cecil Colville as the AMA's first President. Sir Douglas Robb, President of the parent BMA, presented Dr Colville with a gavel made from a mulberry tree in the garden of the BMA's then national office in London (in what had once been the home of Charles Dickens). The other first office bearers in the new AMA were: Vice-President Dr Angus Murray (NSW), Chair of the new Federal Assembly Dr LR Mallen (SA) and Treasurer Dr WF Simmons (NSW). The AGM concluded with a standing ovation for Dr John Hunter, who was retiring at the end of 1962 after 20 years as General Secretary of the Federal Council. Dr Hunter, Dr Colville said, "more than any single person, was responsible for the success of the fight … against the Chifley Government in its attempt to place a galling yoke of subservience on the necks of the members of the medical profession".

NEW ORGANISATION, NEW ISSUES

Before then, according to the *MJA* report of proceedings, Dr Colville had delivered his first Presidential address to the AGM, foreshadowing some of the great new issues that were heading for the agenda of the new organisation.

One was what he said was "the steady increase in the number of individuals whose treatment was the responsibility of some outside body", such as the Pensioner and Repatriation Medical Services, workers compensation and third-party insurance. There was little doubt that more and more members of the community would come to receive their medical requirements under these and similar arrangements, he said, and every such development represented a further inroad into ordinary private practice. In addition, capitation and salaried medical service, involving as they did the intrusion of a third party into every phase of the doctor-patient relationship, must inevitably lead to a deterioration in the standards of medical practice.

Dr Colville went on to warn that the fragmentation of the profession into specialities was an immediate problem for its unity. The AMA, to which practically every member of every one of the specialist groups belonged, would have a major part to play in this. Though it was obvious that scientific aspects of any given speciality could only be dealt with by certain members, the larger problems of a medico-political nature would be shared with all other members of the profession. It was hoped, he said, that all specialist bodies would accept the principle that dealing with such matters was the legitimate function of the AMA as a whole rather than of any separate group.

The new Federal Assembly of the AMA, comprising respresentatives of the branches, held its first meeting at the same time as the first AGM, also in Adelaide. It had been given significant authority in the new organisation, including the power to instruct Federal Council on matters of policy. It determined what the MJA described as two major items of policy. One such item concerned ethical conduct, on which the Assembly resolved that a condition of AMA membership was acceptance of the obligation "to observe the highest standard of professional integrity in the conduct of medical

practice". The other concerned the future of medical practice – soon to be the subject of fierce national debate. The Assembly resolved that "the present form of national health service with its system of government-subsidised voluntary health insurance is in the best interests of the community", that the AMA recognised that the system could be improved "by the removal of anomalies and the correction of some deficiencies" and that it would "strive constantly to bring about amendments to improve it". The Assembly went on to resolve "that a national health service based either on a capitation system or a salaried system is not in the best interests of the Australian community" and that the AMA would "oppose any attempts by a Government to introduce a salaried or capitation system of medical service".

So the new AMA and the Federal Assembly began life with very definite views already formed on some heavy future political issues.

These issues were not particularly salient in the six election campaigns that took place between when the era of cooperation with the Menzies Government began and 1966, when the Holt Government was returned to office. Certainly, for the first few years of the new AMA, the national health service agreed with the Government had been chugging along without much public controversy. A Commonwealth-AMA Standing Committee set up in 1963, with the Executive Committee of the Federal Council and the General Secretary representing the AMA on it, met regularly to deal (according to the AMA 1964 Annual Report) with "important matters which can be discussed in an informal manner between the Government and the AMA, prior to placing them officially before either body". The Minister often attended meetings of the Federal Council and there were frequent discussions between AMA officials, the Minister and departmental advisers.

Towards the middle of the 1960s, some of these "important matters" began to interrupt the even flow of events.

The AMA was advised that the 1965 Budget would make changes to the Pensioner Medical Service, one of whose effects would be to add more new pensioners to the scheme than the AMA had anticipated. The Budget created "prolonged dissent" among members, the 1966 Annual Report says, and the Federal Council asked its Executive Committee to investigate a satisfactory definition of the means test used in the scheme before completely reviewing AMA policy on the issue. In mid-1966, Health Minister Jim Forbes told the AMA that he was going to call a special meeting to consider establishing a General Medical Council (GMC), only to be told that the AMA had the year before set up a special ad hoc committee to look into the need (if any) of a GMC and its functions and role and that it was still awaiting the committee's report. The committee comprised representatives of the colleges and deans of faculties at three universities, as well as the AMA itself. Dr Forbes agreed to defer his special meeting until the AMA received the committee's report. Another issue raised with the Federal Council by Dr Forbes in 1966 concerned the costs of the PBS, which he said were rising at a higher rate than any other government expenditure, despite his Department's efforts to keep down the cost of individual drugs. He said that the increasing use of these drugs by private and pensioner patients had become a matter of great concern and that he would like the AMA to advise him if these costs were necessary. Again Dr Forbes went no further, having been told that it would help achieve economies in prescribing if his Department provided public lists of drugs according to therapeutic group and their cost. Mainly, though, in the first half at least of the 1960s, relations between the AMA and the Government continued on their amiable way.

VERITIES CHALLENGED

But, at the halfway mark in the 1960s, early signs began to emerge of a new public debate, stimulated almost certainly by the obvious struggle by various governments to keep a lid on the ever-rising costs of the health service, and even over whether or not it was as comprehensive or even as

effective as it should be. And the first of these signs were to be seen coming from within the ranks of the profession itself.

In 1964, two doctors in Melbourne produced critiques of the scheme that – though they were half-hidden in two minority publications – helped set off events that were to have important consequences for the entire health system. In brief, in a Fabian Society tract, Dr Moss Cass proposed a service very similar to that created by Aneurin Bevan in Britain, staffed by salaried doctors. Dr Hugo Gold proposed in the journal Dissent a compulsory insurance scheme with fees set by annual review and a cap on the gap between fee and benefit, very similar to provincial schemes that he had seen operating in Canada. Some perspicacious doctors did raise the alarm about these proposals in the *MJA* and the ideas of Drs Cass and Gold were noted by elements in the ALP. But both proposals – launched as they were in minority publications and taken up as they were by a political party considered almost permanently mired in opposition – drowned in the sea of political noise generated by the Vietnam War. They might have remained drowned but for two connected developments that were to throw the entire health system into confusion and controversy for years.

The first was the publication three years after the Cass and Gold proposals of a research paper in the learned journal *Australian Economic Review* by doctors Rob Scotton and John Deeble that proposed to turn the health system upside down. It recommended an insurance scheme providing, without means test, universal entitlement to benefits and covering all medical and public hospital services. Individual income tax concessions on health expenditure and contributions to voluntary health insurance organisations would be abolished. A health insurance fund would be financed out of a tax surcharge matched by Commonwealth subsidy and administered by a statutory Commonwealth Health Insurance Commission. Like the Cass and Gold ideas, the proposals by Scotton and Deeble at first attracted little debate outside the cognoscenti. But by then, the 1969 election was in view and the Opposition, with a new leader was interested in these newideas. Well before their proposals had been organised into an actual scheme in the *AER* article, Scotton and Deeble had had a long meeting to discuss them at Dr Cass's home with the new Opposition Leader, Gough Whitlam. The ALP had become heavily critical of a system which it saw as propping up an industry that – though it had an annual turnover of more than $1,350 million plus (in today's values) and though it was ostensibly private – was receiving a direct Commonwealth subsidy that provided more than a third of the benefits that it was paying out.

The second development added to the questions being raised about the health system. It arose from activity in the Senate, where the Government now lacked a majority. In April 1968, ALP Senators (with support from the Democratic Labor Party benches and against the wishes of the Government) successfully moved to set up a Senate Select Committee with a broad mandate: "to inquire into medical and hospital costs in Australia and, in particular, to examine the operation and administration of the medical and hospital benefit schemes, and to recommend such . . . measures by the Commonwealth as will . . . enable the provision of the optimum standards of medical and hospital care for all". The Federal Council understood this to include the Pensioner Medical Service, repatriation services "and the whole philosophy of National Health Services, including compulsory as opposed to voluntary health insurance, all aspects of the medical and hospital system and a voluntary health insurance scheme". The Select Committee, which was required to report back by the end of September 1969, was chaired by a government Senator and its other five members included two ALP Senators.

Before the Senate Select Committee could start its work – within 10 days – the Government moved to head it off with a committee of its own, chaired by Mr Justice Nimmo, with very limited riding instructions that virtually demanded (if anything) modification at most, rather than reform, of the system. It was to hear evidence only in private. Its mandate was narrow: the Government asked it to find answers and recommendations concerning specific questions on the "provision of adequate financial protection against the cost of illness in the context of both a voluntary health insurance scheme and the obligations at present accepted by the State Governments".

The committee took this to mean that the status quo had to be retained (ie, that the structure and composition of the health insurance industry were not to be touched and that the state governments would continue with the services that they provided and meet at least 50 per cent of public hospital costs). Its inquiry therefore lacked the scope seen in similar inquiries into health systems elsewhere in comparable countries: the report of the Canadian Royal Commission on Health Services in 1964, for example, or the Guilleband Committee report in 1956 into the cost of the National Health Service in the UK. Its existence might have pre-empted the work of the Senate Committee, but the way in which the Government had set it up and the constraints it had put on its scope promoted health as a political issue immediately before the 1969 election. In addition, when it did report, in March 1969, its findings did the Government no favours. It created problems also for the still-young AMA.

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NIMMO REPORT

Nimmo found much to dislike about the health insurance scheme in Australia and, given the limited riding instructions that it had been given by the Government, it had come back with a surprisingly broad report.

The existing scheme was too complex, it said, with bureaucratic red tape and duplication of services. The benefits received were too low and the contributions beyond the capacity of too many people. The gap between fee and benefit – already too great – was increasing. The percentage of people with no form of medical cover was as high as 17 per cent and of those with no hospital cover 15 per cent. Many families on low income with health insurance were insuring themselves at the lowest possible rate. There were too many funds; the funds were using too high a proportion – about one quarter – of contributions in their operating expenses, including on advertising and related activities. Many health services were not covered by the scheme, including nursing, dentistry, and optometry.

The Committee recommended that the system operate in a regional structure, in which the funds would be zoned by regions, with one organisation having exclusive access to its designated region. A list should be drawn up of common fees for all services, adjusted "at appropriate times on the basis of relevant economic indicators". Doctors should be required to inform patients of the cost of a course of treatment before they took it, and to tell them whether or not the charge conformed to an agreed common fee. The gap between cost and benefit should not exceed $1. Doctors should have to agree to charge these common fees if they wanted to be eligible to take part in the system. Hospitals should abolish the honorary system and employ only sessional or salaried medical staff. Though because of its limited mandate it resisted the Labor Party's clamour for a universal scheme, it did propose that special assistance should be provided for lower income families who not afford health insurance. There should be a much closer relationship between hospital and medical fees and contributors' benefit entitlements. The whole thing should be run by a National Health Insurance Commission, which would also be the disciplinary body to deal with any abuses of the system.

The AMA's immediate response to Nimmo was detailed and careful. The association said that it agreed with the general opinion expressed by the Committee, that the national health insurance scheme could be improved by rationalisation and simplification. But it thought that "some of the findings have been expressed in language which overstates the problems . . . Moreover, the Australian Medical Association expresses its surprise that there appears to have been no adequate study [by the Committee] of reasons for non-insurance and under-insurance."

It opposed several recommendations that had special importance for the medical profession. These included the proposed National Health Insurance Commission (preferring health insurance to continue to be administered by the Department of Health); that doctors agree to participate in the system if they wanted their fees to be eligible for medical benefit; that the service-benefit gap be limited to $1; and that standard ward accommodation be universally available regardless of means. It approved the Committee's recommendation that "there be established what are the

most common fees currently being charged in each State for all the medical services and procedures provided by medical practitioners". But it disagreed with the Committee's proposal that these fees should be adjusted "at appropriate times, on the basis of current economic indicators". Benefits for medical services should be adjusted instead "at appropriate times, on the basis of current medical fees", the AMA said, and it undertook "to base recommendations to its members for fee variations, on relevant economic indicators". It supported the gradual replacement of the honorary and concessional services system with sessional arrangements.

INSURANCE: SENATE COMMITTEE REPORTS

Six months later, in 1969, the Senate Committee tabled an interim report, with 36 separate groups of recommendations. It supported the existing voluntary health insurance system in general, but suggested that it needed a number of improvements. "Those concerned" should reach urgent agreement to establish tables of most common fees for all types of medical services that would be reviewed periodically, it said. Any variations in these tables should be "related to an index acceptable to the medical profession", the Commonwealth Government and the funds.

Higher benefits should be payable for services by specialists – specialist registers to be determined by federal and state governments – and the combined Commonwealth and fund benefit for both GP and specialist services should be 90 per cent of the most common accepted fee. The means test for outpatient treatment at public hospitals should be abolished, public hospitals should consider imposing charges for medical services on both inpatients and outpatients, these charges to be incorporated into the existing health insurance system. Public hospitals should replace the honorary system with sessional payment arrangements.

The two ALP minority members dissented. Their view was that the system was so haphazard and deficient that it was causing financial difficulty and hardship for many people. They said that the main fault with it and its high cost structure "have been caused by lack of cooperation on the part of Commonwealth and State governments and the Australian Medical Association, and by a self-interest on the part of the management of some of the large insurance funds". The entire system should be replaced by a universal health insurance system that reflected more effectively the capacity of patients to pay according to their financial abilities. The Government should provide more rigorous supervision over the funds, which were devoting an unduly high proportion of contributions on administration.

The Federal Council met the day after the Senate interim report was tabled. The AMA was thus ready to analyse it at its highest level.

It called the Committee's proposal that benefit for GP and specialist should be 90 per cent of the most common fee "completely unrealistic". The future stability of the Medical Benefit Scheme could hardly be based on the proposition "that doctors' fees should be stabilised in order to subsidise community health costs". The AMA believed that the preservation of satisfactory rebates to contributors required periodic revision of Commonwealth and fund benefits "related to justifiable customary medical charges for particular services". It had a particular problem with one Committee proposition: that charges for hospital inpatient and outpatient services could be expected to be lower than comparable services in private practice which would mean, with its idea of a benefit return of 90 per cent of the common fee, that charges for these services would be totally covered. The AMA must oppose this, the Executive Committee said; it would put hospitals in direct competition with private practice, "with a clear economic disadvantage to private practice patients". The Committee had proposed that the means test for eligibility for outpatient treatment at public hospitals be abolished, that public hospitals should consider fees for medical services provided by them for both outpatients and inpatients and that public hospital charges for treating both kinds of patients be covered by health insurance, with payment of Commonwealth and fund medical benefits. The AMA was strongly opposed to these ideas too. Patients should be means-tested for outpatient and inpatient services, it said. Visiting Medical Officers (VMOs) should be able to charge private and intermediate inpatients on a fee-for-service basis. Treatment for public ward patients and all outpatients (subject to means-testing) should be by full-time hospital and visiting staff. If the honorary system was terminated, as proposed by both the Committee and Nimmo, VMOs should paid on a sessional basis for public ward and outpatient services.

Most of the rest of the Committee's interim report was, if not entirely agreeable to the AMA, at least not drastically disagreeable. The AMA was relieved also that the Committee, by majority decision, had come down heavily in favour of voluntary health insurance as the basis of the National Health Service and that, though the two dissentients had disagreed with this, they had cooperated with the Committee's attempts to find improvements to the system.

(The Committee issued its final report in June 1970. It incorporated some changes dealing with the Pensioner Medical Service and insurance cover for low-income groups, but its recommendations were unchanged, and the Federal Council considered that the AMA need to make no further comment).

MEDICAL POLITICS

My pathway to the Presidency commenced on a fateful Thursday evening when I went home to have dinner with my family rather than attend a clinical staff meeting at Fremantle Hospital. In my absence, I was appointed the AMA hospital representative.

My eyes were opened to the world of medical politics. I found it useful and productive to work with like-minded doctors to contribute to the broad area of medical practice. It quickly became clear that the Government was not our friend but a serious competitor in directing the future of medicine.

The requisite training program to deal with awesome structures of government included a long period of training by Peter Jennings, a remarkable state AMA employee who spent his professional career representing our interests to government and other bodies.

The move into the Federal AMA was not straightforward given the lack of any direct flights between Perth and Canberra. I settled into a regular pattern of catching the midnight horror to Melbourne with the aid of Temazepam, one hour in the lounge to breakfast and shower, then a short hop to Canberra where I would usually be the first person to turn up for the morning meeting!

There was only one serious hiccup when I called the renowned Rohan Greenland to ask why he was not there to pick me up at the Canberra airport, only to be told that the meeting was at Sydney airport. Fortunately, the shuttle got me to that meeting on time as well.

I remember my sense of surprise when Brendan Nelson, our best known president, approached me at a social function and encouraged me to look towards a position as federal president. With his sudden elevation to serious political life, I was then elected to follow David Weedon and his environmentally focused term.

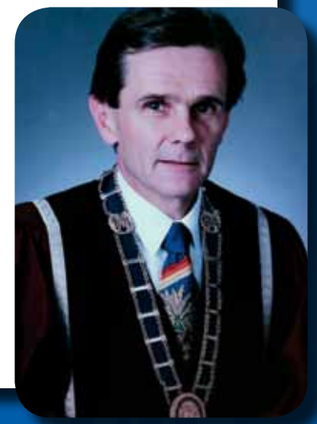
Not unexpectedly, the main issues during my terms involved conflict with government to the extent that the then health minister, Michael Wooldridge, eventually closed down communications.

The junior doctors had to deal with the provider number issue. They rightly perceived this as a setback for their career prospects and there was a broader concern within the profession that the restrictions on medical practice held by government would be used to conscript doctors to unattractive positions. Junior doctors were magnificent in responding to calls for industrial action and came close to defeating the legislation but were undermined at the last minute by the Australian Democrats. However, as a result of the strength of their protests, a series of governments since has trod warily in attempting to coerce Australian graduates. The Australian Democrats disappeared subsequent to that betrayal.

To my surprise, the other great issue that arose was the attempt by the health funds to introduce US-style managed care into the private hospital system. Fortunately, the surgeons had been well trained by Bruce Shepherd to protect their interests (and those of their patients). What started off as an offer of substantially higher payments in return for a degree of control over surgical practice by the health funds ended up being no more than higher payments from the health funds – not a bad outcome for the medical profession.

But my best moment came at a dinner with Michael Wooldridge and representatives of the private hospital industry. We took to him the concept of lifetime health cover whereby health insurance premiums would be steadily increased for late entrants to the system. To his credit, Michael introduced the proposal (despite advice that focus groups hated it). That single component of the changes to health insurance produced a 50 per cent increase in membership in private health funds and helped underwrite the future of our private hospitals and private surgical colleagues.

My period as president ended when I was defeated by my vice president, a general practitioner. To his credit, he organised a very successful campaign to recruit the eastern states' members of our electoral college. My disappointment at missing out on another year of travelling to Canberra once or twice a week was modest. I remain a proud supporter of the AMA and am especially pleased that we have had such a magnificent variety of federal presidents to add flavour and diversity to the organisation.



Dr Keith Woollard: AMA President 1996-98

1969 ELECTION

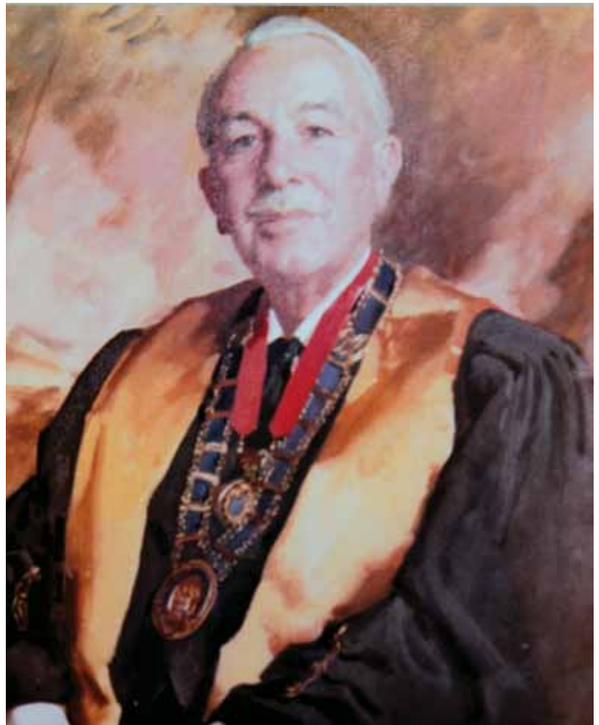
The Government did not respond formally to the reports of either the Nimmo or the Senate. In early August (ie, five months after the Nimmo report was published), Dr Forbes told the Executive Committee that the Government had not yet made firm decisions about it. Because it had not done so, it had not yet undertaken the comprehensive review of the Pensioner Medical Service that it had promised. On the other hand, the ALP's plans for drastic changes to the health system were quite clear. The Scotton and Deeble proposal had been energetically promoted for at least a year by Mr Whitlam and the ALP. In 1968, the new Opposition Leader had described it in detail at a well-reported meeting of Sydney doctors and in an article ("The Alternative Health Program") in *Australian Journal of Social Issues*. At its Federal Conference in 1969, the ALP had adopted the Scotton and Deeble plan as party platform at its Federal Conference in 1969. Rebadged as Medibank, it was at the core of the ALP's election policy. Moreover, two comprehensive inquiries had now encouraged a range of orthodox and unorthodox ideas to be aired on how the health system could or should evolve.

It was now just one month to the election. Health had become a highly contentious issue between a government grown tired and erratic after 20 unbroken years in office and a newly resurgent opposition. The energetic ALP campaign had the result that the polls were showing growing public interest in the ALP's policy of compulsory insurance. This sensitive state of affairs led AMA Federal President Sir Clarence Rieger to issue a "President's Message" in the *AMA Gazette* that emphasised that the AMA was firmly opposed to compulsory health insurance. "It is necessary to state this fact clearly and unequivocally at this time because health insurance is an issue in the coming election," Sir Clarence said. "The AMA has never joined in party politics as such, nor does it intend to do so. However, it is has a duty both to its members and to the public to make known its opinions on matters of health, even if these views have political implications . . . I would ask members of the profession to give this policy not merely their passive acquiescence but their active support."

In October, the Gorton Government was returned, but it was very close. The Liberal-Country Party coalition suffered a swing against it of 16 per cent; the ALP gained 18 per cent. Preferences from the Democratic Labor Party ensured that the Coalition had a seven-seat majority in a 125-seat House of Representatives, but the ALP had set itself up for the election scheduled for 1972. Five of the 67 members of the new Parliamentary Labor Party were GPs who obviously supported the ALP's policy. Health would remain contested. The first manifestations of this after the 1969 election were not a contest between the profession and the ALP but between the profession and the new Government. Indeed, 1970 - a year that the profession was entitled to believe would be one of cooperation – was described by the 1970 AMA Annual Report as one of "considerable ferment and unrest in the medico-political field", the result mainly of the Gorton Government's amendments to the *National Health Act*.

Armed with the information and ideas from the Nimmo and Senate reports, the Government introduced its amending legislation into Parliament in March. With a number of changes

Federal President Dr (Sir) Clarence Rieger



along the way, the legislation was passed in June. During this period, the annual report says, relations between the Federal Council, state branches and "various national medical organisations were subject to considerable strain and conflict. Consequently, discussions between the Australian Medical Association and the Commonwealth Government, and in particular the Commonwealth Department of Health, were at times most difficult". There were many such discussions. They involved at various times Sir Clarence and his successor Dr Roderick McDonald, the Executive Committee and colleagues with Minister Forbes, Director-General of Health Sir William Refshauge and various departmental officers. At one point, the annual report says, Sir Clarence, Dr McDonald and Secretary General Dr Edgar Thomson had to leave the Federal Assembly meeting in June for urgent talks "about the profession's cooperation with the revised Act" with Prime Minister Gorton and Minister Forbes.

"Without the degree of cooperation which has existed over the years between the Australian Medical Association and the Commonwealth Government," the annual report says, there may well have developed an impasse between the medical profession and the Government. "The Australian Medical Association believes that, despite its contentious features and some remaining weaknesses, the revised National Health Act is a great improvement, from the point of view of both the medical profession and the community in general." But, only a few pages on from this, the annual report goes to show that, whatever the community might have thought, the profession was not so convinced.

The period of "strain and conflict" was now over. Mr William McMahon, who had challenged and won the leadership of the Liberal Party from Mr Gorton and was now the Prime Minister, was thought to be better disposed towards the AMA and the medical profession.

DIFFERENTIAL FEES

The peace lasted until 1972, when another Federal election was in view. For most of the year, while the ALP was promoting its health policy for the coming election campaign, the AMA was distracted by a dispute with the Government over GP members' observance of most common fees. The dispute began in January, when Health Minister Kenneth Anderson announced that a growing number of doctors, especially in New South Wales, were not observing most common fees agreed with the Gorton Government a year earlier. In meetings with members of Federal Council, Senator Anderson said that he expected the Council to tell the Government how this problem should be solved. If Federal Council advised him that it was powerless to act, he said, the Government would have to consider its position.

At its next meeting, Federal Council decided to ask NSW Branch Council to "take all steps in its power" to obtain greater observance of most common fees by GPs. NSW Branch Council responded – "for the information of the Minister" – that, though it supported the concept of the most common fee as a guide to medical benefits, so long as 79 per cent of the fees for GP consultations were within 20c of the common fee or less, it was not willing to ask GP members to reduce their fees. Two weeks later, Prime Minister McMahon announced that a judicial review would determine "fair and reasonable" fees for consultations and home visits by NSW GPs until mid-1973. The AMA would then be asked to give firm assurances that there would be general observance of these determined fees. Senator Anderson added that, if there was not general observance, "other measures would be considered". Federal Council and NSW Branch Council formed a joint liaison committee to prepare a submission to the review. In May, Mr Justice Mason handed down his decision that the fee for GP surgery consultations should rise by 10c, plus another 10c for NSW GPs who had in effect lost income by charging the most common fee since 1971, and that the fee for home visits should rise by 40c. The Government accepted this determination, deciding that it would increase Commonwealth benefit to match the fee increase.

While the judicial review was underway, Federal Council had set out to consider the implications of a situation in which the Government expected it to control fees recommended by state branches when it had no power to do so. At a special meeting in May, it decided to solve the problem by asking members in a plebiscite to agree that it should have sole authority "to make recommendations on variations in the level of fees to members . . . that [its] recommendations be based on the advice of the Economic Advisory Committee and take into consideration recommendations from Branches and affiliated organisations".

This decision was rejected by the NSW Branch Council because it thought that it could prejudice the evidence being prepared for the judicial review. Unless the plebiscite were deferred, it said, the Branch would consider withdrawing from the AMA and conducting its own affairs. The Victorian Branch did not go this far in its response to Federal Council's decision, but it also asked for the plebiscite to be deferred. Federal Council nevertheless pressed on with it. The results of the plebiscite were given to it at its next meeting in April and the results were published in the *AMA Gazette* in May.

More than two thirds of members had voted and more than 72 per cent had voted "Yes".

Encouraged by this support, Federal Council resolved to ask the next meeting of the Federal Assembly in June to decide:

- *that the AMA informs the Federal Government that it can no longer recommend to its members to adhere to any fee except where that fee is determined by the AMA;*
- *that the AMA adopt a policy of uniform national fees for all items of service with provision for local variations to provide for difference in costs and conditions of service;*
- *that Federal Assembly gives full power to Federal Council to conduct all discussions with regard to fees on which rebates are based, including the level of these fees throughout Australia; and*
- *that Federal Assembly invest Federal Council with the sole authority and responsibility for making recommendations directly to members of the Association on fees to which rebates apply as well as the periodical fee variations. The Federal Council shall act on the advice of a full-time Fees Bureau to be established in the Federal Office, which would possess and have access to all the necessary relevant expertise and which would provide channels for full consultation in both directions with all the various groups, general practitioner and specialist, in the medical profession.*

The Fees Bureau was set up in the Federal Office and, at meetings between then and the end of the year, Federal Council designed the working relationship between the Bureau and the Economic Advisory Committee.

Federal Assembly agreed. The Fees Bureau was set up in the Federal Office and, at meetings between then and the end of the year, Federal Council designed the working relationship between the Bureau and the Economic Advisory Committee. At its meeting in December, Federal Council resolved that "a list of fees incorporating the present list of most common fees with alterations to correct anomalies, the eradication of inappropriate fees, subdivision of existing items, variations due to economic changes and a move towards national uniform fees be prepared by the end of February 1973, for implementation on July 1 1973".

MEDIBANK IN SIGHT

It was now well on into an election year. While the AMA was preoccupied with the fees dispute, the ALP was busily promoting the health policy first drawn up for the 1969 election and since developed and refined. Basically, Medibank (as it was now called) was to be a universal insurance scheme (ie, including pension recipients) in which all medical services would attract 85% benefit. On the grounds of efficiency and affordability, there would be only one fund. It would be managed by a Health Insurance Commission and financed by a levy on income tax, workers' compensation and third-party insurance. Benefits would be negotiated between the AMA and the HIC. Doctors would continue to charge fees for service. The favoured method of charging under an ALP Government would be bulk-billing but it would not be mandatory. The honorary and concessional system would be abolished and all public hospital medical services would be paid for on a sessional or salaried basis. Public hospitals would be financed through a 50-50 federal-state sharing arrangement. Medibank would be administered by a Department of Social Security. The Department of Health would be responsible for the PBS and the NHMRC and a new body, a Hospital and Health Services Commission, which would cooperate with the States on public health priorities and activities. Public hospitals and nursing homes would be modernised. Multi-disciplinary health centres would be set up in areas where doctors were thin on the ground. The whole thing was to be run by Mr Bill Hayden.

The ALP was not only promoting Medibank publicly; it was also working hard to attract support from the AMA and the medical profession generally, Mr Hayden being described in the Annual Report for 1971 as being "frank and friendly". He and Mr Whitlam explained Medibank and answered questions about it at meetings of AMA members organised by state branches. Mr Hayden pledged in a Fabian Society pamphlet that Medibank would not be a threat to the "longstanding traditional delivery system". It would be based "on fee for service private practice, he said, and he emphasised that the ALP shared the angst of GPs over the differential fees proposed in the Gorton health reforms. Mr Hayden repeated these points in discussion with members of Federal Council.

But the AMA remained guarded. It did not disagree that the existing system needed overhaul but it did not accept that it should be done away with altogether. Random sampling of members commissioned by the AMA found that a solid majority – close to 75 per cent – agreed with their leaders. Federal Council had organised a seminar as early as 1970 at which Drs Scotton and Deeble discussed the proposal with members. It had asked the Queensland branch to examine the particular implications for members of a salaried medical service.

By mid-1972, with all this information and the benefits of its own analysis, Federal Council had resolved that the AMO would oppose Medibank. The Federal Council formally restated its support for voluntary insurance, publishing its reasons in a special supplement to the *AMA Gazette*. Federal President Dr Keith Jones announced that Medibank was a disaster. Federal Council set up a group to devise plans (one each for the Coalition and the Opposition) for action for whichever party won the election. In the event, on 2 December, it was the ALP. The AMA now set itself for Medibank.

WHITLAM GOVERNMENT

Within weeks of the election, Mr Hayden (now Minister for Social Security) formed a Health Insurance Planning Committee to draw up a Green Paper on the proposed new health system. The committee comprised five government officials plus Dr Scotton, with Dr Deeble in the chair. The Government gave it three months to bring down recommendations on the principal elements, and the process and timetable for establishment of the system. It wanted the scheme basically to be the same as that which the ALP had been promulgating for two years. Added details were that public hospitals should provide free standard ward treatment for all, with medical care provided by staff doctors, plus free outpatient care – both without means test; retention of the $5 cap on the gap between fee and benefit; community health centres; and tax concessions to be continued on health insurance contributions and net hospital and medical expenses.

Federal Council called a meeting on 13 January of Branch Presidents and representatives of 15 affiliated organisations to discuss the situation, which was widely reported and interpreted (correctly, according to the 1973 Annual Report) "as a demonstration of unity and limbering up for the struggle ahead". The AMA was further alarmed by a meeting later in January at which Secretary General Dr Edward Stuckey and his deputy Dr George Repin learned from members of the Health Insurance Planning Committee that there would be three non-negotiable pillars of the new system: a single health insurance commission financed out of taxation, free standard ward accommodation without means test and a negotiated or arbitrated schedule of fees, and that any submission to the Committee should relate to matters outside these three issues. When this was reported to Federal Council, it set up a working party (President Dr Keith Jones, three Federal Councillors and Dr Repin) to hold more talks with the Planning Committee. It also decided to put a submission to the Planning Committee and invited views from the Branches and affiliated organisations. According to the 1973 Annual Report, "there were many responses".

The AMA working party met a working party of the Planning Committee where it raised the AMA's views on such matters as bulk-billing, fee schedules and VMOs. It pointed out that the Planning Committee knew of the AMA's policies and that these policies were in conflict with what the Planning Committee was proposing. Federal Council decided after this to reserve more comment until the Planning Committee had produced the final version of the Green Paper. A media statement made it clear that the AMA was not negotiating with the Planning Committee. As the *MJA* reported at the time, the AMA would wait and see "what Mr Hayden's department will come up with in detail".

The Green Paper, when it was tabled two months later than scheduled, on 2 May, kept to the limits that the Government had imposed on it, save for a couple of financial matters, including whether or not the $5 gap was realistic. It emphasised that the proposed system would need to be negotiated with the funds and state governments and that it would need legislation to set up the statutory Health Insurance Commission as well as amendments to existing legislation. It would also need consultation with the medical profession about methods of payment and fee schedules. It recommended that charges for medical services be overseen in a system similar to that operating at the time in the Pensioner Medical Service, which would include sanctions such as the publication of names found to be over-charging. It also proposed the creation of a Transitional Arrangements Committee, composed of fund representatives and Department of Social Security officials, to organise an orderly process of change in the proposed arrangements for the health insurance industry.

The Green Paper attracted a furious reaction from the medical profession, the funds and the private hospital sector. "From this point on, battle was joined," the 1973 Annual Report says. "The AMA made its opposition clear in a press statement that night [2 May]". The following four weeks were spent in studying the details and the wide implications of the Green Paper, consultations with the Opposition, GP organisations and other groups, preparing a detailed submission to the Government and planning a political and public campaign against the Green Paper's proposals. A Federal Council meeting on 31 May-2 June resolved that the AMA should declare total opposition to the proposals, interpreting them as "a blueprint for the total nationalisation of medical and hospital services . . . coupled with regimentation of the community". It decided to commission experts to assess the proposals' economic implications.

With the information it had gathered from all this, the AMA handed a detailed 19-page submission on the Green Paper to Mr Hayden on 13 June, and later sent it to all AMA members and "to a wide range of people influential in the community, including politicians". The submission listed three broad objections to the Green Paper's proposals:

"There was no genuine public demand for change, and remaining problems of the existing scheme could be readily solved.

"An interim Hospitals and Health Services Commission had been set up to assess Australia's healthcare problems. Imposition of the purely financial proposals of the Planning Committee would place the Commission in a straitjacket.

"The Planning Committee's proposals would regiment the public, lessen free choice, reduce healthcare standards, and were a blueprint for nationalisation of healthcare."

The AMA argued that the Government should suspend consideration of the Green Paper for at least six months.

Meanwhile, the AMA's political and public campaign went ahead, its objective (according to the 1973 Annual Report) being "defeat, amendment or delay of legislation by the Senate, where

There was no genuine public demand for change, and remaining problems of the existing scheme could be readily solved.

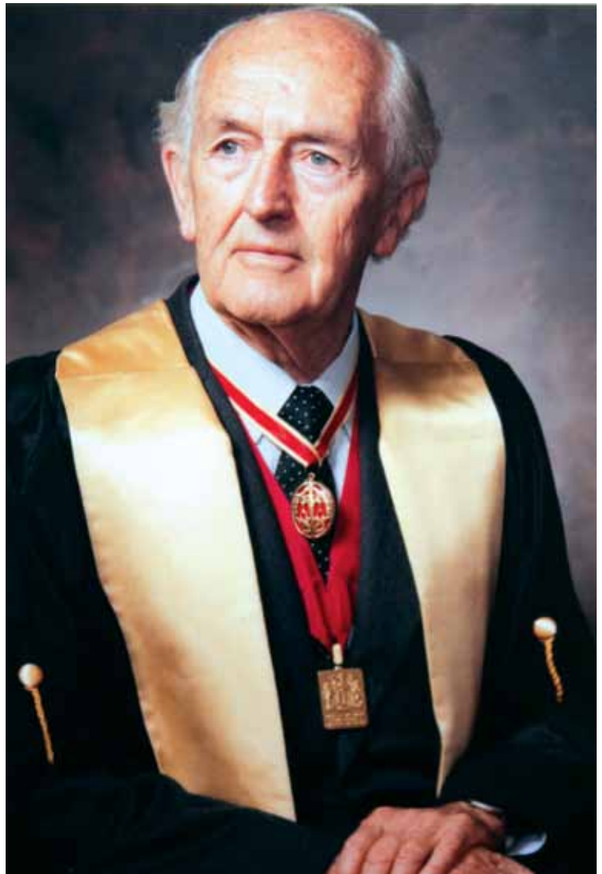
the Government had no majority". *The* "Say NO to nationalised medicine" campaign employed a public relations and advertising agency, 16,000 publicity kits for doctors' surgeries, more than one million leaflets, addresses to the National and Perth Press Clubs and community organisations such as Rotary, employment of a former Miss Australia to speak to women's groups, petitions to Parliament – all designed, the 1973 Annual Report said, to "keep up a high 'noise level' . . . to sustain interest in the health controversy so that the public would be receptive to the arguments put forward". Federal Treasurer Dr Lionel Wilson, (later Federal President) took leave for 12 weeks from his practice to lead the political campaign. Meetings were held with members of the Coalition and the DLP, including two "rather unproductive meetings with the Labor Party Parliamentary Health Committee".

In September, Mr Hayden wrote to Federal Council that the Government was close to completing its consideration of the Green Paper and asked for a meeting before publication of a White Paper which would detail the Government's decisions. After the meeting, which took place on 29 September, Federal Council agreed that, "though some changes were apparently being made to the Planning Committee's proposals, nothing was said at the meeting to change the AMA's opposition to the plan". In October, Mr Hayden suggested further talks between the AMA and officials but "it was later mutually agreed that there was little point . . . because they would not influence what would be included in the White Paper".

The point – and Federal Council's view of the 29 September meeting with Mr Hayden – was correct. The White Paper was tabled in November, and the Government also circulated it around the medical profession. It was less dogmatic in tone than the Green Paper. It also contained some reasonable changes. The proposition to ban private medical insurance was withdrawn. The funds would be allowed to be agents of Medibank for the first few years of operation of the scheme. Controls proposed for private hospital fees would not be proceeded with. The per day/bed subsidy would be increased from $10 to $16. The gap between schedule fee and benefit would not be greater than $15. Proposed incentives for bulk-billing would not proceed. Over-charging would attract peer review rather than sanctions. Medical services in hospitals would still be better served through salaried staffs and sessional payments. But those who saw the White Paper as a significant climb-down by the Government were a tad optimistic.

Former Health Minister Forbes described it in a later debate in the Parliament as "a triumph for balance, reason and compromise". But the AMA was not overly impressed. Dr Repin told the media that "only the rough edges [of the Green Paper] were knocked off". The *AMA Gazette* said that it included all its former fundamental defects "dressed with glib phrases and public relations language". The AMA reaction was supported in unlikely places. Those who knew both papers from the inside disagreed with the view that the White Paper represented a huge reversal of policy. Dr Scotton said later that "the program remained substantially unaltered from the time of its adoption" and Dr Deeble thought that "the main principles remained . . . the amendments made little difference to the basic structure of the scheme".

Dr (Sir) Keith Jones, Federal President, 1973-76



ENGAGING WITH GOVERNMENT

While my Presidency lasted from 1998-2000, my active involvement with the AMA began in 1990. It was 10 turbulent years.

For general practice, it saw the introduction of the Vocational Registrar (an important step in the formal recognition of general practice as a specialty), the Practice Incentive Program (the first non-fee-for-service government remuneration for general practices), financial incentives for performing and recording vaccinations (a highly successful public health program) and the formation of divisions of general practice (later GP Networks and now Medicare Locals).

There were incentives to try and improve the rural GP workforce, GP-based research, and ongoing debates about just how many GPs we needed in Australia.

Many of these changes started with the General Practice Reform Strategy in 1992 and were revised in detail with the involvement of the AMA and other GP groups in the General Practice Strategy Review launched by the then health minister, Dr Michael Wooldridge, in 1998.

Private health insurance and concerns about US-style managed care were major issues for privately practising specialists. The Private Health Insurance Rebate was introduced during the term of my Presidency. The rebate was hard fought for, and with no certainty to succeed in a Senate where the Liberal Government did not have the balance of power. No-gap private health insurance products were also introduced under which the majority of private hospital services are now provided.

And ticking away in the background was the Relative Value Study, a probably always ill-fated process that involved countless hours from doctors and consultants, the political management of which was like trying to keep chunks of fissile material apart before they came together in a supercritical mass to blow the profession apart.

These were interesting times indeed.

The AMA supported many – but not all – of these changes. Some of the ones we opposed were introduced anyway with the support of other medical groups.

As the government moved ahead, I believed the AMA was faced with a clear choice. Either get on the playing field and engage the government and try to slow or redirect some of these changes, or remain a noisy spectator shouting insults at the referee but not changing the course of the game.

Not all AMA members agreed with that course of action. Despite widespread consultations, sections of the profession continued to oppose engagement and change.

In addressing that discontent, it is important to understand there was a clear mandate.

I did not become President by accident or subterfuge. My view on how we should proceed was put forward at Federal Councils and National Conferences and was my consistent platform. Every time I stood for an elected position in the AMA it was contested, giving those who voted a clear choice between my approach and that of the opposition. That culminated in 1998 when I became Federal President, defeating the incumbent president. That win stemmed at least in part from a desire by National Conference to engage the government.

That engagement was always underpinned by the AMA's basic principles – the professional freedom to always provide care in the best interests of our patients, and the right to charge a fair and reasonable fee independent of any government or private health insurer's interference.

Despite the consultation and re-election of the Executive at National Conference, the opposition continued. After being challenged to put up or shut up, those opposed to our approach sought to remove the entire executive at an Extraordinary General Meeting (EGM) of AMA members. Two EGMs later, the Executive, already elected by National Conference, was endorsed by the full membership.

These were turbulent times and I could not have survived without the support of my Executive, Federal Council and, perhaps importantly for my sanity, the unwavering support of my family.

Perhaps time has dulled my memory but, despite the upheavals and the near total destruction of my solo general practice caused by constant absences, it was a great time to lead a great organisation.

In 1993, the then prime minister, Paul Keating, described the AMA as, "The greedy doctors who are represented by the most rapacious union boss in the country". In 2006, in the last survey of federal politicians' lobbying preferences, the politicians voted the AMA the top Canberra-based lobby group.

If I were part of leading the AMA from where it was in 1993 to the respect it enjoyed in 2006, and I believe it enjoys still, then all the elections and all the EGMs were worth it.

Dr David Brand: AMA President 1998-2000

MEDIBANK GOES TO PARLIAMENT

The enabling legislation was introduced into the House of Representatives at the end of November. It was in the form of two Bills: the *Health Insurance Bill* and the *Health Insurance Commission Bill*. The House passed them by a small majority. They were passed on to the Senate, for the Government enemy territory, where the DLP was enjoying the balance of power. The Coalition had announced that it would oppose any legislation as early as October, well before they had seen it. The DLP remained cagey until the last possible moment, on 12 December, when the Senate voted. The Coalition and the DLP together rejected the Bills, 30 to 23. The 1973 Annual Report said that the AMA officials who witnessed the Senate vote were aware that this was the end of only the first round.

The second round took place in April the following year when the Government reintroduced them into the House, where they were again narrowly passed after a debate on legislation that the Government now designated as urgent and therefore terminated after one hour. Reintroduced into the Senate, they were rejected again and joined a list of other Bills that had been rejected twice. A few days later, on 10 April, the Government dissolved the Parliament and called a double dissolution election. Having gained slight ground in the Senate and losing only slight ground in the House, the Government was able to gather a combined majority in a sitting of both chambers that, under the Constitution, was able to break legislative deadlock. The Government's proposals were now law.

The Government now prepared to implement its scheme, but the AMA and its supporters continued their campaign. Most of the funds rebuffed an offer from the Government to accept agencies for the Health Insurance Commission. Four non-Labor States refused to implement the hospital aspects of the Government's scheme, though it was accepted by South Australia and Tasmania. More than 300 doctors in South Australia refused to cooperate with it. Their action was copied by doctors in the ACT, where the Commonwealth attempted to provide free treatment and ward accommodation without means test in two public hospitals.

In November, a National Joint Health Advisory Committee was formed, with representatives of the AMA, the Voluntary Health Insurance Association and the National Standing Committee of Private Hospitals, that reiterated opposition to Medibank. In December, the Senate rejected ancillary legislation that was needed by the Government scheme and the Opposition announced that a Coalition Government would disband the Medibank scheme "within a reasonable time".

Encouraged by this pledge and being concerned that the Government might be able to introduce its scheme in the middle of the year as it planned, the AMA continued its campaign into 1975, though the National Joint Health Advisory Committee decided to ease down its advertising component. Federal President Dr Keith Jones announced the results of an actuarial study commissioned by the AMA that showed that Medibank would increase net Commonwealth spending in 1975-76 by about $1,500 million (in today's values), which would have been equal to an increase in personal income tax at the time of between 7 per cent and 8 per cent.

In March, the political terrain was changing. Soon it would be changed completely. The question for the AMA was whether the change would permit implementation of Medibank, as the AMA suspected, delay it or stop it altogether. The Government continued in office, but it was leaking public support furiously as it ran into all kinds of problems, including the Loans Affair and the dismissal of Ministers. Mr Malcolm Fraser then challenged and won the leadership of the Opposition from Mr Bill Snedden, which led to much public expectation of a more belligerent Opposition. Mr Fraser said, after his elevation, that the Opposition would not block Supply or force an early election unless there were more government scandals. His statement was sufficiently delphic that much public confusion ensued about what exactly he meant. For the AMA, no early election would mean that the Government would be able to implement Medibank on 1 July; no blockage of supply would mean that the Government could continue to pay for it. The President sought and won an early meeting with Mr Fraser. Mr Fraser reaffirmed his statement. The Labor Government could be confident that it could start up Medibank, and pay for it, from 1 July.

So, having received "an appreciation of the situation" from the President, Federal Council drew up advice for members. It resolved "to institute a continuous and vigorous educational program to explain to the medical profession the disadvantages of direct billing; in cooperation with the NSW Branch, to work out a system of immediate billing and offer it to the profession; and promote to the public the advantages of private healthcare and private health insurance and work to create and maintain a social and political climate in which private healthcare would continue to flourish". The President issued a notice asking members "in the light of the new situation, and in the interests of your patients and the community . . . that you do not seek to add to the confusion that will inevitably occur with the introduction of Medibank. Disruption of medical service will not help our cause." Though Medibank was a federal scheme, the notice said, "States will continue to run their own hospitals. Thus, when it comes to the details of hospital arrangements, these must be dealt with by AMA Branches at a state level."

In response to the Minister's request before July that the AMA clarify as early as possible its intentions with regard to billing pensioners, Federal Assembly had reaffirmed its opposition to bulk-billing and resolved that patients under the former Pensioner Medical Service be billed individually at a fee to be determined by their own doctor. It had advised Federal Council that, "in the great majority of cases, members of the Association will continue to subsidise the medical care of pensioners who, at June 30 1975, hold Pensioner Medical Service entitlement cards so that such pensioners will not have to meet any of the cost of medical care from their own resources".

The medical services of the scheme were introduced in July, as Federal Council had anticipated. But, encouraged by the AMA advice, most doctors adopted immediate billing, the level of bulk-billing remained below 30 per cent for the first three months, and membership of voluntary health funds continued to be high. Hospital Medibank could not be put into operation in July because all but two of the States still opposed it and doctors were still refusing to cooperate with it. The Labor States of South Australia and Tasmania had agreed terms with the Commonwealth by July. It was not until August that the Victorian and Western Australian Governments joined the scheme. Queensland reached agreement with the Commonwealth in September. Agreement with the NSW Government had not been reached when 1975 ended (and a Coalition Government had won office in Canberra).

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Dr Lionel Wilson, Federal President, 1979-82

Medibank may have attracted all the headlines in 1974 and 1975 but it was far from being the only cause of disagreement between the AMA and the Government. Another serious point of contention stemmed from a decision that the Whitlam Government had inherited from its predecessor. Concerned at the rising cost of nursing home benefits, the McMahon Government had introduced changes in 1972 intended to make sure (among other things) that patients would not be admitted to nursing homes without prior approval of the Department of Health. The changes were supported by the AMA, which had agreed on procedures that made sure that the question whether patients needed nursing home care was a clinical one, therefore capable of being made only by a doctor. But doctors objected that the certificate that approved admission that the department had drawn up (Form NH5) demanded in effect that their signature affirming their clinical judgment needed counter-signature by a departmental official. This implied an infringement of the independence of doctors that the AMA could not accept. So Federal Council decided at a meeting in the very last days of the McMahon Government to inform the Director-General of Health that, though it reaffirmed the AMA's support in principle for the new arrangements, it was "not prepared to agree that either admission to a nursing home or payment of benefits in respect of such an admission shall be subject to the approval of the Commonwealth Department of Health prior to admission". It would be prepared to agree that "such admissions or payments of benefits shall be subject to certification by a doctor that admission was deemed necessary by him and that such a certificate must be issued prior to admission".

LABOR SACKED, MEDIBANK KEPT

The Fraser Government was swept into power in an election on 13 December, with one of the largest majorities in Australian history in the House of Representatives and a healthy majority in the Senate. The Coalition, with a new Minister for Health, Mr Ralph Hunt, was now able to bring about the changes to the system that it had been seeking since 1973. But, instead of immediately dismantling Medibank as was widely anticipated, the new Government set up a committee to review it. The Medibank Review Committee was chaired by Dr Sidney Sax, chair of the Hospitals and Health Commission set up by the Whitlam Government and a huge influence on Labor's policy towards greater Commonwealth involvement in health services. The AMA had sent an introductory submission to the new Minister within a week of his appointment. At a meeting in January, Federal Council decided on the submission that the AMA would make to the committee early in its deliberations. The basic points of the submission were that bulk-billing should be abolished, that the Commonwealth-State Hospital Medibank Agreements should be reviewed to allow the States to operate their own hospitals and negotiate terms with doctors on the provision of services to standard ward patients and that Sec. 18 of the *Health Insurance Act* be repealed.

Dr (Sir) Roderick McDonald, Federal President 1970-72

The committee's report was not published but the Government's complicated response to it was announced in May. It proposed a number of major changes to be introduced in six stages between October 1976 and September 1981, which included many of the AMA's suggestions – the review of hospital agreements, for example – but which "presented the health funds, private hospitals and the AMA with a whole new range of problems", according to the Annual Report for 1976.

Intense speculation ensued about the Government's intentions regarding health insurance, causing Federal Council to set up a committee led by Vice President Dr Lionel Wilson to consult representatives of the funds and the private hospital in forming a position on health costs generally. It came to a number of points that were considered critical. Bulk billing should be abolished. A so-called "crisis" in health costs did not exist: though costs were rising, the rate of increase was slowing, and the AMA had a good record in cost containment. There was not enough information about the changes to health insurance in the second of the six-stage Medibank changes known as Medibank Mark II to justify a major overhaul of the system; changes without adequate information could be disastrous, the AMA said. Its cooperation with these changes would become more difficult "if the present type of health insurance scheme, which had received the support of the AMA since 1953, should suddenly be virtually dismantled".

In March 1978, the speculation continuing, President Dr Rupert Magarey sought a meeting about it with Mr Fraser himself. The meeting, described by Secretary General Dr Repin as "polite but not reassuring", took place later that month. In May, the Government announced its first series of changes to health insurance arrangements. Essentially, they were that bulk billing would be abolished, except for pensioners and

patients whom doctors would have to determine to be socially disadvantaged. (Many doctors had misgivings about this, according to the 1978 Annual Report, but Federal Council decided not to oppose the idea. Its view was that doctors in the past had always accepted the need to consider their patients' ability to pay and had modified their charges accordingly.) The level of benefits would be cut from 85 per cent to 75 per cent of scheduled fees, the maximum gap to be $10, with optional insurance to cover it. The funds were to be given more freedom to operate but the new Medibank Private would survive, administered by the HIC, to compete against them. Sec. 18 of the *Health Insurance Act* would be repealed but Sec. 17 would remain in the legislation, a kind of booby trap that would explode later.

The 1978 Budget in May introduced another series of changes which Federal Council condemned, describing them as another incomprehensible about-face in healthcare policy. They included abolition of compulsory health insurance and the health insurance levy. A universal Commonwealth medical benefit would be introduced, financed from consolidated revenue and covering 40 per cent of scheduled fees, with a maximum gap of $20. Free standard ward accommodation would be retained without means test. The AMA sought urgent talks with the Government to explain its concerns about these changes, and another public campaign had to be cranked up to inform patients about the danger involved in failing to take out insurance to cover their effects.

Throughout this period, the AMA was maintaining a consistent dialogue with the Government on other emerging issues. A Fees and Benefits Committee and a Medical Benefits Schedule Committee were helping the Government to make the changes as smooth as possible, for example, and the AMA had a representative on a committee that was examining the costs and ramifications of new high-technology diagnostic services.

But, while this cooperation was happening at ground level, not just health insurance arrangements but also the entire system was going through an upheaval. The new Government was setting about broad economic policy change; health could not be protected. The system was consuming a large and growing share of the public purse. The Government wanted ways to relieve this financial pressure. The very basis of much of the administration of public policy areas – including health – was being challenged by Treasurer Phillip Lynch's Administrative Review Committee. The Government disbanded the Hospitals and Health Commission, which had been heavily involved in policies for supplying and distributing health services – though not before the Commission had added to the atmosphere of change by publishing a discussion paper (Paying for Healthcare) which expanded debate on the system. Meanwhile, the health system was groaning under more investigations and inquiries.

Dr Sax, by now probably the most influential health official country – and soon to be a special health policy adviser to the Prime Minister – was appointed chair of a Committee of Officials on Medical Manpower Supply (the other officials coming from Treasury and the Prime Minister's and Health Departments). The committee was to analyse and report on a range of ideas being mobilised by the departments represented on it (there being a range reflecting that there was a fair measure of disagreement among them). In May 1979, the Jamison Commission of Enquiry into the Efficiency and Administration of Hospital Services, was given the almost impossible task of giving the Government, within one year, a basis for negotiating new cost-sharing hospital funding agreements with the States. On top of all this, a government backbench committee decided to do its own efficiency audit of hospital services.

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MEDIBANK MARK II DIES, SLOWLY

It was no surprise therefore that, by September 1979 (the date at which the latest health insurance changes were to come into operation), all the adjustments and modifications in policy were creating uncertainty and confusion, not only among professional groups and individuals working in the sector but also among the public at large.

Dr Wilson, by now President, warned in a public statement in 1979 that the system was in "an unholy mess". Politicians "had been looking round for scapegoats and had picked on doctors as an easy target". In fact, it was a remarkable tribute to the patience and perseverance of the doctors, nurses and everybody working in the system that patients were still receiving first-class service. "After suffering frequent changes in healthcare policy over the past seven years, most of them for the worse, Australia now has no coherent health policy at all," Dr Wilson said, and "dissatisfaction is such that it seems highly probable that health will become a major issue at the next federal election." Public opinion polling suggested that people generally were becoming so disenchanted by having to cope with all the change that they were saying that they wanted the original Medibank system back.

In April 1980 – that is, eight months after the latest change in health insurance arrangements had been made – Dr Wilson was still showing his concern. The system was "slowly bleeding to death", he said, and it needed urgent treatment. Government figures had shown that people had dropped out of basic medical insurance in the second half of 1979 at a rate of nearly 700 a day and more than 1,600 had dropped out of basic hospital insurance each day. Because of time lags in updating these statistics, Dr Wilson said that they "almost certainly fail to reflect the full impact of the changes . . . introduced last September". Four people in 10 were now outside the standard health insurance system. "I forecast that by the time the general election is held at the end of the year half the population will stand outside the system unless corrective measures are taken," Dr Wilson said.

Despite its differences with the Government on the workings of the health system, the AMA continued to work with it on improvements. For instance, it was represented on the Health Insurance Commission and on a government working party formed to keep bulk-billing arrangements under review. An AMA committee produced a number of suggestions to deal with problems with potential over-servicing, and the association worked with the Department of Health on health insurance benefits for ambulatory surgery and problems with the system of referral forms. This was in addtion to the previous year's work on the impact and cost-effectiveness of medical technologies and the question whether or not they should be eligible for medical benefit.

The election campaign that took place for much of the second half of 1980 met Dr Wilson's expectation that the health system would be a significant election issue, along with a poorly-performing economy. The Fraser Government was re-elected, but with a greatly reduced majority and loss of its majority in the Senate, where the Australian Democrats held the balance of power, with differing views from those of the Government on health and other social policy. The election result, plus corrosive leadership tensions in the Coalition and continuing worries about economic management, led to widely-held views that the Fraser era was coming to an end.

Early in 1981, the Jamison Commission managed to provide the Government with a three-volume report which contained proposals similar to those promoted by the AMA. As a result, the Government agreed in May to replace the hospital cost-sharing agreements with the States with a system of identified health grants. Among other things, the new health arrangements ended free hospitalisation for all patients, except those who were identified by Commonwealth criteria as being in special need. The AMA was happy that its proposals to help users and consumers of medical services had been recognised, including tax incentives, the 'user pays' principle for hospital services and the extension of subsidised healthcare to socially disadvantaged patients. Dr Wilson said that the new arrangements represented a substantial political success for the AMA. They restored the community rating principle to the forefront of health policy. They would be effective in meeting the needs of pensioners and socially disadvantaged people, he said, and ensure that those who could afford it would contribute to their health costs either through insurance or by direct payment. The AMA especially welcomed the Government's "reaffirmation of the role of private medical care, in particular the role of the GP in providing the most cost-effective primary healthcare". Opting out of insurance was decreasing; taking out insurance was substantially increasing. The Government accepted the AMA's ideas on the referral form system. The AMA continued to press on the Government its advice on the concept of hospital insurance benefits for ambulatory surgery. Dr Repin was named as the association's representative on a National Health Technology Assessment Advisory Panel established to advise the Government on the impact, cost-effectiveness and potential eligibility for medical benefits of new medical technologies.

But health still continued to be a delicate and often contentious issue in national affairs in the meantime, and the results of the earlier uncertainty were still working their way through the system. Federal Council still needed to keep an eye on the economies proposed by the Lynch Administrative

At one point in 1981, the very existence of the Department of Health was questioned in reports circulating around Canberra, making it necessary for the AMA to warn that ill, aged and handicapped people would lose their champion if the department was abolished.

Review Committee. At one point in 1981, the very existence of the Department of Health was questioned in reports circulating around Canberra, making it necessary for the AMA to warn that ill, aged and handicapped people would lose their champion if the department was abolished. "Unless there is a department in Canberra run by professionals who care about people's health and who understand healthcare needs," an AMA public statement said, "health services will suffer." In the event, the department was not abolished, though (over the AMA's objections) the Government enacted legislation that ended the longstanding legal requirement that the Director General of Health should be a medical practitioner.

By the end of the year, the ALP (preparing well ahead for the next election expected in late 1983) was busy developing alternative health and hospital policies through wide public consultations, including with AMA representatives, via seminars and workshops. As Dr Wilson had said, though he had no great faith in the ability of the ALP, it would not have been difficult for it to come up with some better answers.

The new year was an especially difficult one for the AMA, (first) because of members' misgivings at events emanating from a 1981 Health Department audit of servicing, the Government's reaction and the AMA's response; and (second) as the implications for the profession became clearer of the new health system proposed by the ALP – in other words, the party that public opinion polling suggested was likely to form the next government.

The over-servicing issue occupied the AMA for much of the year. In the middle of the previous year, AMA representatives had discussed allegations of over-servicing and even fraud at a meeting with officials from the Health and Attorney-General's Departments, where it was agreed that the Health Department would brief the AMA on its system of monitoring medical services. It became clear after this, and was reported to Federal Council, that the amount of money involved in over-servicing was considerable, probably as much as $100 million.

Early in 1982, Dr Wilson, in a media statement that quoted this figure, condemned offenders, warned that the good name of the profession was at stake and offered the AMA's full support for a government overhaul for a monitoring system that had proved itself inadequate. The Annual Report for 1982 said that doctors clearly found the statement distressing and the AMA received protests about it. Dr Wilson, in his President's Message in the 1981 Annual Report (written in early 1982 while the episode was still being discussed) welcomed this reaction because the problem discovered by monitoring would not be brought under control unless a high level of concern was maintained. The $100 million figure could prove to be too high on further investigation, Dr Wilson said. But abuse by a relatively small group adversely affected the good name of every doctor. It placed a forceful argument in the hands of those who wished to abolish the private practice of medicine and "weakens the political viability of private practice by making alternatives look more attractive". Shortly after this, Federal Council emphasised that, though over-servicing and fraud could not be condoned, the frequency of a medical service was a clinical evaluation dependent on medical judgment and that there should be early involvement by the profession in any procedure that examined cases of over-servicing.

Federal Council also analysed legislation proposed by the Government that sought (among other things) to impose new penalties on doctors found guilty of defrauding the system. It welcomed the legislation in general

but suggested amendments – which the Government accepted – that protected patients' privacy and the interests of innocent doctors in group practices where offences had been committed. In May, AMA representatives helped Health Department officials in identifying the kinds of problems with the monitoring system that needed overhaul. In August, an AMA ad hoc committee drew up ideas for Federal Council for ways in which professional involvement could be inserted earlier in the process of evaluating over-servicing and fraud. These ideas were circulated among state branches and craft groups and discussed with government representatives on a working party set up in the previous year to investigate the issue. In November, Health Minister Jim Carlton announced new administrative measures to tackle over-servicing and fraud, including large increases in the budget and departmental investigation and surveillance staff.

Meanwhile, following Dr Wilson's injunction about the importance of communicating with "those in power and those who might exercise power in the future", senior AMA representatives throughout 1981 and into 1982 had been observing and providing guidance to the ALP's program of seminars and workshops organised by the ALP to discuss its election health policy. They included, at various times, Dr Wilson himself, the then Treasurer and later President Dr Trevor Pickering, Dr Repin and Federal Councillors. At first blush, elements of what the ALP had in mind at this time could be applauded, as Dr Lindsay Thompson said in his first President's Message in the 1982 Annual Report, though there were others that the AMA would oppose and still more that needed clarification. The AMA's approach in dealing with the ALP's proposals would be "essentially practical and pragmatic in the interests of our patients and the profession as a whole", he said.

When what was called the Hayden Health Plan was finally launched in February, the AMA found much in it that caused concern, including its animosity towards voluntary health insurance and its views on billing practices. But most worrying of all was its lack of detail about the implementation of the proposed Medicare, a problem that remained to be solved well into 1983 – an election year. That election came in March, nine months early, and it resulted in a Labor Government, headed by Bob Hawke, who had succeeded Mr Hayden as Leader of the ALP.

NEW GOVERNMENT, ANOTHER REFORM

The new era started well. Dr Thompson said in a speech in Victoria that the AMA did not propose to start its relationship with the new Government on the basis of confrontation, as had occurred with the last Labor Government in 1972. The Government, in turn, invited the AMA to take part in the National Economic Summit Conference which would produce the government-union accord and other economic policy changes made by the new government. The AMA produced a range of ideas for the economics of healthcare in general and medical practice in particular, and Dr Thompson noted that the AMA's invitation to the summit was an indication of its national significance and influence. Apart from the summit, the major focus for the AMA in 1983 was the new government's health policy and the impending introduction of Medicare. As Dr Thompson had said, the AMA wished to discuss these issues with Dr Neal Blewett, the new Health Minister, and his advisers, provided that the discussions would be meaningful and that they would produce a flexible approach to implementing the new policy. "Frank discussions took place on a number of occasions in the following nine months," the 1983 Annual Report says, "but, as the Government's plans unfolded, more and more difficulties arose".

In May, two months after the new Government had come into office, Federal Council was still concerned about the absence of information about the new policy timetable, and it identified a number of other major issues about which it had difficulties. Among other things, it resolved that individuals should be able to opt out of paying the proposed health insurance levy by taking out private insurance, that gap insurance to the level of the MBS fee should be available, that doctors should remain free to charge fees that they considered fair and reasonable. It reiterated that the AMA still opposed bulk-billing, except for pensioners and economically disadvantaged people.

At the same time, the AMA, in liaison with voluntary health fund and private hospital organisations, launched a campaign involving public statements and representations to all the political parties (including the Australian Democrats, who held the balance of power in the Senate) to protect and support private health insurance. Polling was conducted among private practitioners to gauge their support for the AMA's policies. The response rate was 60 per cent. It showed general support for the position that bulk-billing should occur for pensioners and economically disadvantaged patients only. But 11 per cent reported that they would not bulk-bill at all. Only 5 per cent of the respondents said that they would bulk-bill all their patients. As a result, the AMA directed a campaign among GPs to reinforce its anti-bulk-billing policy, which included information about the adverse effects that the practice had on their incomes. In tandem with this, and in cooperation with state branches, Federal Council ran a public campaign supporting the AMA's view that people would not be able to choose their own doctor in public hospitals under Medicare and that they would still need to take out extra hospital insurance to cover private hospital charges and the costs of being a private patient in public hospitals.

INFORMING THE PUBLIC

I became AMA President at the turn of the century – 2000 was a fortuitous time in Australian medical politics. The medico-political landscape was tough, divided, and complex.

The big issue was the medical indemnity crisis. We were at risk of losing entire specialties like obstetrics and neurosurgery. Procedural specialties would have become uninsurable and unaffordable. Major indemnity providers were at risk of imminent bankruptcy.

Yet we were faced with a health minister who did not want to know about it. Blocked by the minister, Michael Wooldridge, we had to find a way to get the Government's attention. The public picture was one of a bitter feud, but I just needed to focus the government on this issue.

We engaged every member of both Houses of Parliament until then prime minister, John Howard, eventually became convinced that this was an issue of national importance.

Working directly with his office, and through a taskforce involving every state and territory government, we forged a long-term solution through scaffolding of the existing system and tort law reform to reduce the level of litigation that was plaguing the effective delivery of medical services.

One of the things I sought to do as AMA President was to inform the Australian people about their health system – how it worked, where it was successful, and where it fell short of reasonable expectations.

The Australian public became, through the media and directly through their doctors, a far more informed participant in the Medicare debate than they had ever been.

What resulted was a more sophisticated understanding of how health funding and bulk billing work, who ultimately pays, and why doctors were so concerned about the level of funding failing to keep up with a growing and ageing population. No longer could governments of any persuasion get away with the old 'greedy doctor' argument.

When I became AMA President, we were being told there was an oversupply of doctors, yet this was at odds with information from our members and from the public. We commissioned our own modelling and were able to demonstrate that the workforce figures were wrong. In fact, there was an undersupply in critical specialties like general practice. We were able to convince the Government to change the way they assessed the medical workforce to plan more appropriately for future needs.

The Government could no longer use a mythical oversupply as an excuse for draconian or inappropriate workforce policies.

We took the message beyond the major centres to rural and remote parts of Australia.

We were also perennially frustrated with the cost-shifting games being played by successive state and federal governments, so I coined the term "blame-shifting" to focus attention on the way that different levels of government attempted to foist responsibility for health funding shortfalls onto the other levels. That is still unresolved.

Along with the battles about health funding, workforce supply and tort law reform, I was determined to pursue a parallel public health agenda.

The Australian medical profession has a long and proud history of advocacy for public health, and the AMA was ideally positioned to contribute. During my Presidency, the AMA team:

- developed a Position Statement on Climate Change and Human Health;
- developed a Position Statement on Complementary Medicine;
- addressed the issue of preparedness for bioterrorism;
- created the AMA Indigenous Health Report Card;
- developed a Position Statement on Sexual Diversity and Gender Identity; and
- worked to improve the occupational health and safety of young doctors with the Safe Hours Project.

While we worked closely with the Government on a raft of major issues, we also kept up the pressure with a unified message and a sophisticated media campaign of constructive commentary, positioning the AMA as the powerful independent voice of the medical profession that it always must be.

Professor Kerryn Phelps: AMA President 2000-03

MEDICARE

The package of Medicare legislation – the *Health Legislation Amendment Bill No 54*, the *Health Insurance Amendment Bill No 15*, various regulations under these Bills and legislation enabling Commonwealth-State Medicare Agreements – was introduced into the Parliament in September and approved essentially as the Government designed them, despite the efforts of the AMA and others to have them amended. Basically, Medicare was Medibank, and it would have a huge impact on private hospitals and private health funds. A major difference was that Medicare was to be the nation's compulsory monopoly health insurance fund, compared to Medibank, which allowed people to opt out and take out insurance from a private fund. It limited private health insurance to covering treatment for private patients in either private or public hospitals, though funds could cover dental, physiotherapy and some other services. It proposed that the Commonwealth would offer to pay for a range of hospital services provided that patients agreed to receive the services in public but not private hospitals. Public hospital accommodation would be free at the point of service, with a maximum gap payment for medical services of $10 per service or $150 per year.

Most importantly, because of the upheaval it would create, a provision of Medicare was that, in the Commonwealth-State Medicare Agreements, the Commonwealth would offer untied grants to the States on condition that they entered into contracts with hospital doctors whose terms would help control costs and private practice in public hospitals. So the new Medicare legislation retained a provision (Sec. 18, but Sec. 17 in its predecessor) that sought to amend the original Medibank legislation to the effect that Medicare benefits would now not be paid to patients in public hospitals unless the doctor providing the services had a contract with the hospital in terms approved by the Minister. In the AMA's view, this allowed the Minister to be free to change or cancel new or existing contracts between state hospital authorities and salaried and visiting medical officers, with no right of appeal. This provision was not an unintended consequence. It would operate through Commonwealth-State Medicare Agreements, requiring state governments not to confer the right to private practice in public hospitals on doctors who had not accepted a contract under the old Sec. 17 arrangement. By getting the States to be the actual agents in these Sec. 17-type decisions, the Commonwealth would be able to get around the 'civil conscription' prohibition imposed on it by the Constitution. The AMA sought vigorously but unsuccessfully to have a right of appeal included in the legislation, along with the requirement that regulations by which the Minister exercised this power be subject to Parliamentary scrutiny and/or disallowance. The Government's refusal to recognise the AMA's view on this would shortly lead to chaos in the hospital system.

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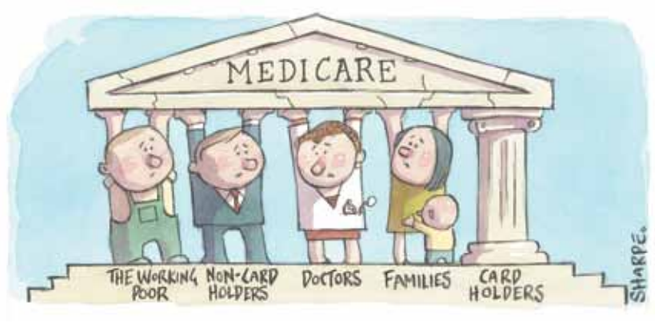

The Parliament did amend the legislation in line with AMA advice on such matters as the need for Parliamentary scrutiny of Ministerial directions to the Health Insurance Commission and Ministerial decisions concerning the private funds and reducing the minimum length of stay in hospital by day patients for eligibility of benefit. The AMA also persuaded the Government to remove a provision in the legislation that would have annulled a previous provision that the AMA must be consulted about membership of the Medicare Benefits Advisory Committee (though the new provision did allow the Minister to consult other organisations also). And the Government accepted the AMA's objection that the payment of multiple 'gaps' might disadvantage patients, amending the legislation to provide that, after patients had paid a total of $150 in 'gaps' in any one year, the

Medicare benefit would rise to 100 per cent of the schedule fee for any more claims in that year. But the rest of the legislation remained pretty much as the Government intended. In the House, it had the numbers; in the Senate, where it did not, the widely-signalled and -anticipated opposition to the legislation by the Australian Democrats disintegrated. The legislation, having been approved by both Houses of the Parliament, was given assent in October 1983.

Immediately, Dr Thompson arranged a meeting with AMA branch presidents and executives in Sydney to ensure an integrated approach to the introduction of Medicare. He also explained the new legislation to a number of meetings of doctors in each State. The branches embarked on a major communications exercise to keep members informed of developments. Multiple copies of a working paper containing as much information as the AMA could glean about the Medicare scheme was distributed among the branches and affiliated organisations. A handbook was prepared containing advice on the practical effects of Medicare on doctors. The AMA maintained close liaison on developments including a meeting in December with representatives of the Australian Association of Surgeons, the Australian Society of Anaesthetists, the National Association of Medical Specialists and the National Association of General Practitioners of Australia. This was the second of such meetings, the first in August convened to discuss what information was then available about such issues as bulk-billing, choice of doctor in hospitals, gap insurance and the monopoly role of the Government regarding medical benefits. The December meeting dealt with the Sec. 17 threat to doctors' existing hospital contracts emanating from the new powers given by the legislation to the Minister for Health.

CONTRACTS

If 1983 was a busy year for the AMA, 1984 was frantic, the reason being the reaction by the association and the profession generally not just to the onset of Medicare but particularly to the Sec. 17-type provision concerning the contract terms for doctors working in public hospitals. The agenda on this particular point was filling up well before the year began. Medicare was scheduled to begin operations on 1 February.

In November 1983, the Australian Association of Surgeons had already recommended that no surgeon sign any contract with a public hospital, state government or federal government based on the Sec. 17 provision or on any subsequent regulation based on it as might be gazetted by the Federal Minister for Health. In December 1983, Federal Council, expressing its "continued strong opposition" to the Sec. 17-type proposal, had advised AMA members to consult their state branches before signing any Sec. 17-type contracts. At the urging of AMA members in the ACT, it also empowered the Federal President to seek legal advice as to whether the new section contravened the "civil conscription" prohibition in Sec. 51 of the Constitution. Very late in 1983, Health Minister Blewett issued his response to the AMA's objection to the new section. It was that he would prescribe all pathology, radiology, nuclear medicine and other services, that guidelines applying to the contracts of doctors providing these services would require that all charges be at or below the schedule fee and that all revenue received be credited to funds approved by him. For full-time staff with rights of private practice, revenue would be applied in this order: facilitating charges according to a scale laid down by the Commonwealth, plus any administrative charges raised by the hospital; drawings by doctors up to 25 per cent of salary, and then payment for equipment and educational and other activities. Similar conditions would apply to VMOs, except that drawings by them would be discounted; in other words, the more work they did, the less they earned. Dr Blewett's response is described in detail because it led to Australia's first doctors' strike, exhausting meetings between AMA representatives and Ministers that sometimes stretched far into the night and at times even involving the Prime Minister himself, and a period of great discord within the AMA.

On 11 January 1984 – less than three weeks before the onset of Medicare – AMA representatives discussed Dr Blewett's response at a meeting with him in Adelaide. He refused any substantial changes to it. Three days later, Dr Thompson issued a statement that most doctors in most States would not sign the proposed new contract. They were willing to work under their existing arrangements, he said. But, unless the dispute was resolved, patients would not receive benefits for diagnostic services after 1 February. Either the power that the Minister had given himself should be removed from the legislation or the right of appeal to the Minister's decisions should be put into it. In the meantime, the Australian College of Orthopaedic Surgeons and the Australian College of Radiologists had warned of industrial action if the contracts problem was not resolved. A few days before Medicare came into operation, Dr Blewett announced that the application of his guidelines would be deferred for a month, that the proposed limitation on VMOs' earnings would be withdrawn and that a

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three-person committee (including one AMA representative) would inquire into private practice arrangements in public hospitals. The chair of the Committee of Enquiry into Rights of Private Practice in Public Hospitals would be Professor David Penington of The University of Melbourne. The AMA nominated radiologist Dr John Cashman as its representative. The problem seemed to be heading towards compromise, if not solution. But the Government proceeded with formal gazettal of the prescribed services, and the profession was not happy with Dr Blewett's public references in the meantime to "the cancer of medical fraud and over-servicing" costing the public purse nearly $10 million a year. Trouble still lay ahead, for the Government, for the hospital system, for the profession generally and for the AMA.

The AMA remained deeply unhappy with Dr Blewett's position. It thought that he appeared to be trying to drive a wedge between salaried doctors and VMOs by offering concessions to one group but not the other. It suspected that the Government's intention that the Penington Committee should look at the private practice arrangements of all specialists meant that its offer to introduce new contracts only for doctors who provided diagnostic services was not being genuine. Nevertheless, it was prepared to continue to negotiate.

In two more meetings in February with Dr Blewett, the AMA won substantial change in the Penington Committee's terms of reference. It would now be able to recommend ways in which Ministerial decisions under the Act could be reviewed or appealed. There would be no limitation on the earnings of either salaried or visiting doctors pending the report of the committee. The level of facility charges would be decided by the States rather than imposed by the Commonwealth. The rest of the Minister's guidelines would apply, but doctors already working in the new conditions would not have to sign new contracts. Meanwhile, most of the state governments had decided to await the report of the Penington Committee before introducing the Medicare legislation for which they were responsible, thus suspending any action on the Sec. 17-type contracts front.

Dr Thompson reported the results of the discussions with the Minister to a meeting on 22 February of representatives of state branches and organisations of specialists and salaried doctors. The meeting supported the President's agreeing to the enquiry occurring with its amended terms of reference. But it did not support the modified guidelines, calling on Dr Blewett not to introduce them, and it decided that doctors should be advised through media advertisements not to sign any document relating to private practice in public hospitals. The AMA continued to maintain that doctors were still willing to work under the existing contracts but it warned (in the words of the 1984 Annual Report) that, if they were prevented from doing so, "the resulting chaos would not be the profession's fault".

By the end of the month, however, the disagreement was moved up another notch – and the hospital system another step closer to the chaos that the AMA had predicted. The Government gazetted the modified guidelines that the 22 February meeting had rejected and Dr Blewett announced that benefits would be paid for diagnostic services where either the doctors had contracts that met these guidelines or the state government had introduced price control, forcing doctors to charge schedule fees for diagnostic services. The AMA responded by warning that by imposing price control the Government would escalate the dispute and declared that the AMA would fight the Government's action vigorously. "Price control rewards mediocrity, ignores excellence and ends up disadvantaging those it is meant to

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benefit, if it can be made to work at all," Dr Thompson said. On 1 March, Prime Minister Hawke decided to intervene. He invited the President to meet him the next day. At that meeting, the Government offered that, if the AMA asked doctors to sign new contracts where this was required, the Government would agree in advance to any recommendation relating to appeal and review procedures by the Penington Committee. Three days later, on 4 March, Federal Council decided at a special meeting that it appreciated the Prime Minister's conciliatory approach, but that his Government's offer did not meet the concerns of doctors, and it urged branches to continue negotiating mutually satisfactory arrangements with state governments. By then, dissatisfaction had turned into action.

INDUSTRIAL ACTION

Procedural specialists and radiologists in New South Wales, supported by the NSW branch, had already threatened to withdraw all non-urgent services from 1 March and a 24-hour work stoppage also took place on that day. One week later, at its scheduled meeting, Federal Council declared its support for the industrial action in New South Wales and recommended that other branches consider it. The Government again deferred implementation of the guidelines (to 14 March) but on 6 March the NSW branch had already called on medical staff at public hospitals in the State to withdraw all but emergency services for 24 hours on 19 March, on 27 March, again on 4 April and thereafter on a weekly basis. Later in March, it decided to extend its industrial action by calling a one-week strike from 9 April. Radiologists in New South Wales had withdrawn services from 14 March. Visiting doctors in the ACT began an indefinite strike on the same day. The next day, a meeting of members in South Australia authorised the State President to call a 24-hour stoppage at his discretion. On the day after that, 1,200 members in Victoria authorised the state branch to initiate industrial action on 27 March and to plan selective withdrawal of services from 29 March. It was decided later that all but emergency services would be withdrawn in Victoria from 5 April. Dr Blewett invited Dr Thompson to discuss the situation with him on 18 March, but Dr Thompson had to decline (though he said that he was willing to talk to the Minister) because he had already arranged a meeting of all the groups involved at about that time. That meeting authorised the AMA to organise a nationwide extension of industrial action aimed at the repeal of the Ministerial powers provisions of the Act and to plan a nationwide one-day stoppage on 9 April. The chaos of which the AMA had warned had well and truly started.

Late in March – on the initiative of the Australian Democrats – the Government amended the Act to provide that the guidelines be tabled in Parliament where they would be subject to disallowance. The AMA decided that this was still not enough to solve the problem, but it did offer in response a proposal that, if a system of consultation, review and appeal was formally included in the legislation, the industrial action planned in Victoria for 5 April would be called off as a demonstration of goodwill. As a result, discussions were arranged between the AMA, Dr Blewett and Industrial Relations Minister Ralph Willis (including one meeting that went from 9pm to well into the early hours of the next day) that resulted in a truce – uneasy, but a truce. The Government had already offered, at the 1 March meeting attended by the Prime Minister, to accept whatever Penington recommended on consultation and appeal. It now agreed to set up a working party with the AMA to recommend to Penington a method of formal government-AMA consultation on the guidelines and appropriate appeal and arbitration processes in the event of disagreement over the quantifiable elements of the guidelines. (After several meetings, the working party did disagree, including both sides of the argument in a submission to Penington in August.) The Government also agreed to delete the 46 miscellaneous services from the prescribed services list, thus limiting the area of contention. Tension had eased somewhat also when most of the state governments agreed to halt any complementary Medicare legislation – and therefore any Sec. 17-type activity – until the final report of the Penington committee. Dr Thompson told AMA members that the truce meant that the Minister's powers to dictate the terms by which doctors "will provide hospital services with no avenue of appeal can now be effectively curbed by further negotiation of details along an agreed path. The onerous terms the Minister sought to impose have also been neutralised for the present".

The AMA put a preliminary submission to Penington on 18 April, and a final submission on 15 May, the main thrust being that the existing system, which allowed patients the right to treatment by their private doctors in public hospitals, met the community's wishes and the Government's objective of making available to all healthcare that was efficient and of high quality. The submission argued that moves to make private practice in public hospitals more restricted and less attractive would cause the best doctors to leave the system. This could result in separate streams of private and public care instead of the present integrated system, with the government sector (deprived of the best talent) running second best. If the AMA and the Commonwealth could not agree on arbitration and appeal processes for determining doctors' hospital contracts, he said, the offending provisions in the Act should be repealed.

The final Penington report, proposing that an interim AMA-Government consultative committee consider its many detailed recommendations, was published in October 1984. Its

recommendations included that private doctors' fees for diagnostic services in public hospitals such as radiology and pathology should be at or below the schedule fee, and that schedule fees be reviewed annually by a committee of medical peers. It also judged that the Medicare procedures were being implemented in New South Wales by people "whose aim was to control" and whose approach was marked by failure to understand the "social culture of Australian hospitals". And there was more proposed in the report – creation of a mechanism for appeal and recourse from Ministerial decisions, for example – for the AMA to label it constructive. Dr Thompson commented that it had shown that the Government had acted in haste on wrong information when it provoked Australia's first doctors' strike. The AMA reserved its right to agree or disagree with the Committee's recommendations, but it decided that it would join the proposed committee. In New South Wales, however, where doctors and the Government had been in dispute for most of the year over several issues, including differences over sessional fees and the fee-for-service principle, surgeons' organisations especially were not happy either with the report or the AMA's response to it. Though much of the reason for the dispute remained, both sides had negotiated enough areas of agreement that there were grounds by October for hoping that peace might yet break out. The newly-formed Council of Procedural Surgeons (COPS) was concerned that the Penington recommendations did little or nothing to resolve the issues still in dispute. "Suddenly, we were back to mid-winter status in our dispute," Dr Bruce Shepherd, founding President of COPS, recalls in his *Shepherd: Memories of an interfering man*. A combination of this reaction and the issues fought over but still to be resolved in the NSW doctors' dispute was to have unforeseen but severe consequences for the AMA.

NEW SOUTH WALES DISPUTE

In December 1984 – despite the well-understood formal limits to the power of the Federal AMA to influence what was clearly an internal state matter – the NSW branch of the AMA and senior royal clinical colleges asked Dr Thompson to intervene in the NSW dispute, which had been festering for most of the year. The request was made because it had become clear by then that, though resolution of some differences had been or was being achieved, the dispute could not be settled completely because, as the 1984 Annual Report points out, "the underlying issue was the viability of private medical practice under Medicare". In other words, it was a NSW dispute, but with national implications. The surgeon groups involved in the dispute were reported as disagreeing with this federal intervention, probably not knowing or misunderstanding that the intervention had been requested.

The dispute had arisen early in 1984 when the State Government had enacted complementary Medicare legislation that gave it powers over how doctors would be appointed to, and work in, public hospitals. These powers in effect gave the NSW Government the kind of control that had been proposed and resisted in the Sec. 18 dispute – control permitted when exerted by a State but not by the Commonwealth because of the anti-civil conscription clause in the Constitution. Thus, while the Sec. 17 disagreement was easing everywhere else, it was being born again in New South Wales. Moreover, the NSW Government was the only jurisdiction that had not agreed with all the others in February to delay implementing the Medicare legislation. Doctors and government in New South Wales joined battle early in 1984 over the new government controls of private practice. By the end of the year, by the time that Dr Thompson was asked to intervene in it, the dispute had become very ugly.

The NSW *Private Health Establishment Act* of 1982, which blocked the expansion of private hospitals, had the effect that 80 per cent of all hospital beds in the State were in public hospitals by 1983. In an interim report in June 1984, the Penington Committee had found a significant decrease in health insurance cover since the introduction of Medicare. Before Medicare, 60 per cent of patients in public hospitals had had private health insurance; the figure was now 40 per cent. This, among other things, had had a huge impact on the incomes of doctors working in public hospitals everywhere. In New South Wales, the situation was worse. The *Public Hospitals Act* of 1983 had given the State Government power not only to regulate doctors' working conditions, but also to do so in ways that threatened their income. A regulation under the Act (Sec. 54a) had the effect that doctors who wanted to practise in public hospitals had to agree not to charge private patients any more for their services than the schedule fee. Taking its lead from the Commonwealth, the NSW Government was insisting on limited sessional fees for doctors treating Medicare patients. Workers compensation and third party accident patients had to be admitted as 'public' or 'hospital' patients, which meant that no fees were charged. Patients who did not nominate particular doctors to look after them had been assigned 'hospital patient' status.

As a result, doctors in New South Wales were resigning from the public hospital system. By the end of May in 1984, more than 100 orthopaedic

Dr Bruce Shepherd, Federal President 1990-93

surgeons had resigned from surgical posts in public hospitals. They were followed by plastic and urological surgeons and anaesthetists. The Government enacted emergency legislation that nullified the resignations and banned those who had submitted them for up to seven years. Doctors were so outraged by this that more resignations followed, including by 600 surgeons and physicians who had discussed the legislation at a meeting in Sydney, followed a few days later by 140 anaesthetists. The AMA rejected as inadequate a government offer that, if surgeons withdrew their resignations, it would defer proclaiming the banning provision in the legislation. It refused any negotiations until the provision was actually repealed, and recommended that members not provide any but emergency services in NSW public hospitals. The Public Medical Officers Association, which represented staff specialists, said that its members would go on strike if they were ordered to perform the duties of the specialists who had resigned for which they were not qualified. Towards the end of the month, the interim report by the Penington Committee supported the right of doctors to charge more than the schedule fee for clinical services in certain conditions. On the day that the report was released, the NSW Government made another offer: it would repeal the provision, but it insisted on keeping the provision that nullified the resignations. This was also rejected. By the end of June, the NSW hospital system was in crisis: the Health Department admitted that more than 1,000 specialists had resigned; surgery in most public hospitals was down 50 per cent; waiting lists for some procedures were up to 18 months.

Late in June, a Doctors' Negotiating Committee put a three-stage settlement plan to Premier Neville Wran. The committee comprised Dr Tony Buhagiar, President of the NSW branch of the AMA, Dr Bruce Shepherd, President of the Australian Society of Orthopaedic Specialists (ASOS) and Dr Michael Aroney, President of the Australian Association of Surgeons (AAS). The plan called for (1) repeal of the emergency legislation, upon which doctors would return to work in public hospitals; (2) negotiations with a mutually-agreed deadline between doctors and government, during which VMOs would provide essential services, leading to resolution of all outstanding issues, including repeal of the law relating to VMO contracts at public hospitals; and (3) restoration of VMO contracts. Very shortly after that, the Premier announced that the emergency legislation would be repealed, but that the rest of it (including that nullifying the doctors' resignations) would be proclaimed. The doctors decided to continue resigning.

Early in July, Mr Wran and some of his Ministers met the Doctors' Negotiating Committee in a discussion that led to both sides giving some ground. In addition to rescinding the seven-year ban, the Government would repeal the legislation nullifying resignations. The doctors dropped their demand that repeal would have to be completed before any negotiations and they accepted the basic principles (if not all the details) of Medicare as a national health plan. Later, the Government agreed to create and give legislative basis to a Medical Services Committee that would be consulted on all changes to medical practice in public hospitals. It would comprise four AMA representatives, two from AAS, one from the Association of Anaesthetists and one

from ASOS. The Government also agreed to repeal legislative control of doctors' fees and practice outside public hospital work, to re-examine fee-for-service and sessional payments in hospitals and increased funding in the 1984-86 Budget. With the Commonwealth's agreement, Sec. 54a was rescinded.

But members of all the major medical organisations remained wary. The Minister's power over the appointment and management of VMOs remained. Much of what had been agreed was far from concrete; much of what was in dispute remained. The Government changed the law to provide that regulations could not be made that affected VMOs' conditions until advice had been submitted to the Minister by the Medical Services Committee, but the change did not stipulate that the advice be heeded. The fees issue was not settled; it was only to be re-examined. Negotiations dragged on, but with little result. Sessional payments for surgical services to Medicare patients remained inadequate. Attempts to raise these issues in the negotiations were met by Government claims that such 'militancy' showed that doctors were interested only in money. Meanwhile, the prevailing atmosphere hardly encouraged give and take. The media were reporting that the State Government was about to recruit replacements overseas for orthopaedic surgeons who had resigned their positions in public hospitals, and that the Commonwealth Government was planning a campaign against over-servicing and fraud by doctors. The goodwill was running out. The leaders of AAS and ASOS (Drs Shepherd and Aroney), arguing that the NSW Government was refusing to consider the demands of the specialists and that the AMA was not representing them energetically enough, formed the COPS to negotiate on the specialists' behalf.

FEDERAL INTERVENTION

Dr Thompson's first move on being asked to intervene was, accompanied by NSW Branch representatives, to hold talks with the Commonwealth and NSW Ministers for Health. He came away with a proposal from the two governments for a committee that would review all medical services in all the NSW public hospitals. The 1985 Annual Report records that the proposal was rejected by representatives of the NSW doctors' groups. The dispute continued; so did the deteriorating state of the NSW hospital system. Prime Minister Bob Hawke then called a meeting midway through January to discuss further options for ending the dispute that comprised, for the Government, Mr Hawke, Premier Wran, the Commonwealth and NSW Ministers for Health and their senior officials and, for the doctors, Dr Thompson, Dr Repin, Dr Buhagiar and AMA officials, representatives of the NSW surgeon's groups and a representative of the medical schools. This meeting dropped the idea of a review committee and agreed to meet again to draw up a process for negotiating an end to the dispute. The second meeting took place a week later, this time without the surgeons representatives. At this meeting, the two governments offered an "unequivocal public undertaking" that they did not intend to abolish private practice in public hospitals and an offer to negotiate changes that would ensure "maintenance of private practice at a viable level". In return for this, the doctors would return to their hospital positions.

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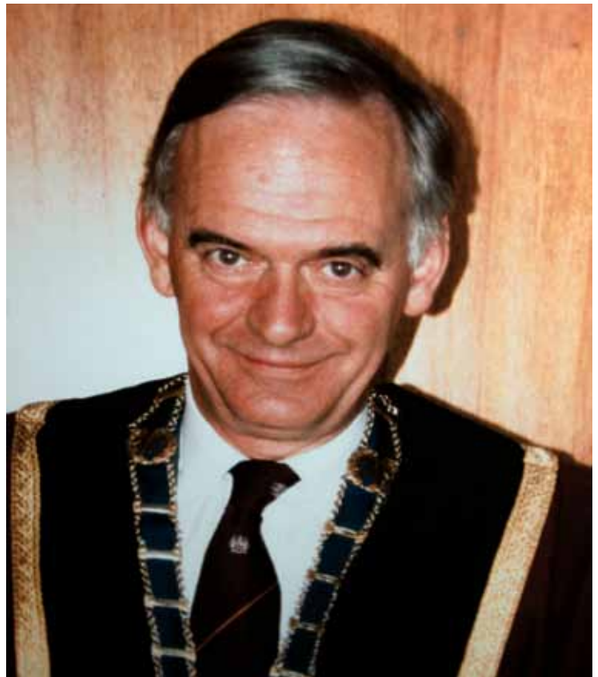
This proposal also was rejected by the NSW Branch, as well as spokespersons for the surgeons and others involved in the dispute. Dr Thompson issued a statement that emphasised that the precondition that the resignations had to be withdrawn before negotiations could begin was unacceptable to the doctors who had resigned. "The proposals, while long on promises, do not contain any assurance that specific changes of substance will take place promptly," he said, and he informed the Prime Minister that he could not negotiate any settlement on the basis that had been proposed. At this point, hundreds more procedural specialists who had largely kept out the dispute and supported the system set up to provide emergency care while the dispute was continuing, decided to resign from their positions more or less immediately. In addition, the dispute generated a kind of civil war among the ranks of the doctors.

The COPS claimed that the AMA was prepared to accept peace at any price, that it should withdraw from the dispute and that it (COPS) was the only organisation entitled to negotiate on behalf of procedural specialists. Dr Thompson responded that the dispute was fundamentally about Medicare. Settlement would affect every doctor in Australia. He could not stand aside and allow a small group of doctors in one state to make deals with government that might disadvantage all their colleagues everywhere else. Federal Council viewed the situation "with the gravest concern". If the deadlock were not resolved, it said, the standard of healthcare in New South Wales would "fall to levels unacceptable to the medical profession", and it authorised Dr Thompson, in the interests of the whole profession, to take whatever steps were necessary to resolve the dispute. Dr Thompson wrote to all doctors in New South Wales and all AMA members in other States to keep them informed of developments. In the light of threats by the NSW Government to recruit replacement doctors overseas, medical organisations overseas were warned of the circumstances that had caused the dispute. The colleges called for a four-week moratorium on resignations by specialists in the NSW teaching hospitals. The Executive Committee met the presidents of the state branches in a meeting on 20 February that reaffirmed

Dr Bryce Phillips, Federal President 1988-90



that the AMA must continue as the central negotiating body of the profession, but that representatives of the procedural specialists should be included in negotiations.

AGREEMENT, BUT NOT PEACE

On that same day, Prime Minister Hawke held talks with COPS representatives that proved unproductive, Mr Hawke stating afterwards that "it became apparent during the discussions that the specialists had no real intention of reaching an agreement. They came to Canberra simply to tear up Medicare." Mr Hawke also contacted Dr Thompson after his talks with the COPS to suggest a meeting with the AMA on the following day. That meeting reached agreement on negotiations on the basis of a call by the AMA to doctors to return to work, though not to withdraw their resignations, which could be reactivated if necessary, and an undertaking by the Government not to advertise specific specialist vacancies pending an assessment of the extent to which normal duties were resumed. The return-to-work call was made in newspaper advertisements in which Dr Thompson cited the deep concern felt by most doctors about the effects of the dispute on patients. "I share the frustration and anger of the profession regarding the damage done to private practice in NSW hospitals by actions of the NSW Government and by Medicare," he said. "Nevertheless, I believe with the strongest conviction that the path down which the profession has been proceeding will lead to disaster."

The COPS reacted with hostility to the advertisements, urging doctors to maintain their resignations. In a move led by doctors in the ACT, a group of AMA members requisitioned an Extraordinary General Meeting to consider a vote of no confidence in the Federal President. The EGM was arranged for 11 May. In the meantime, the negotiations agreed with the Prime Minister on 21 February proceeded until, on 2 April, agreement was reached, which was widely interpreted in the media as a victory for the AMA and a backdown by the Government. The COPS, as anticipated, rejected it.

The basic elements of the agreement were that, within four weeks if possible:

- the Sec. 17 powers would be rescinded;
- the Commonwealth would withdraw from the regulation of private hospitals (control by the state governments to continue);

VMOs in NSW metropolitan and large regional hospitals would be able to choose between fee-for-service or sessional payment arrangements and the Commonwealth would fund an increase in sessional payments (with the NSW Branch having the option of going to arbitration for more);

- an improved hospital insurance package estimated to be able to achieve a 10 per cent increase in the number of private patients in public hospitals; and
- privately-insured hospital admissions would be automatically classified as 'private' unless they chose otherwise.

The AMA strongly recommended a return to work, but it also decided on a plebiscite through which members nationally could express their views on the agreement, particularly since the association at the national level had come under such challenge. The result of the plebiscite was that, of the 40 per cent of members who returned their completed plebiscite forms, 75.6 per cent supported resuming normal hospital services. The only sub-group that did not support the agreement were NSW surgeons, 57 per cent of them being opposed.

Early in May, the Government accepted that the return-to-work condition in the agreement had been met. On 15 May, it introduced enabling legislation into the Parliament, which quickly passed through both Houses. On 25 May, Federal Council advised the NSW Branch that the association had no further role to play in resolving the dispute. There now being no need for it, the consultative committee recommended by the Penington Committee was disbanded. Some procedural surgeons objected, but the dispute had ended. The EGM would be their last hurrah.

It took place in Canberra on 11 May – that is, only a few weeks before Dr Thompson's term of office would expire. With the notice of the meeting, all members received a letter from Vice President Dr Trevor Pickering in support of Dr Thompson's record of service to the AMA and two proxy voting forms for those who could not attend: one authorising Dr Pickering to vote against the motion and the other nominating any other officer of the association to vote how he or she wished. According to members who were there, the meeting of 116 members was not pleasant. Dr Pickering led the argument against the motion because Dr Thompson was refused the right to speak. The motion was carried on the floor but thumped on the proxy votes: 7,232 votes to 1,196. The entire episode – involving organising the meeting, preparing and sending out the paperwork, arranging an extraordinary meeting of Federal Council – cost the AMA nearly $50,000. After the meeting, Dr Thompson called the result not just vindication of him personally but that it also preserved "the honour, stability and credibility of the association . . . I deeply regret the divisions that have occurred," he said. "The task now is to heal the rifts and restore unity." Part of this task would need to be to tackle the structural problems shown up so harshly in the doctors' dispute, when separate professional groups had gone their separate ways and when the federal AMA had to be asked to find a solution but not given the authority to do so. As outgoing President, Dr Thompson issued a plea for change at the Federal Assembly a short time after the dispute had been settled. As incoming President, Dr Pickering decided to take up the challenge.

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REORGANISATION

COTTON REVIEW

Dr Pickering and Dr Repin visited the State branches and Territory groups to pursue the idea of structural change. Their discussions convinced them that an internal review of the structure would not succeed; an external review was the only way to obtain the kind of solution that would be accepted by the profession as unbiased. In September, Federal Council decided that an approach be made to "an eminent well respected, non-medically qualified person" to conduct a dispassionate review of the structure, function and constitution of the AMA. Dr Pickering and Dr Repin met Sir Robert Cotton – experienced in business before becoming a Federal Cabinet Minister and, later, Ambassador to the United States – to ask him to take on the task. He accepted. In November, Federal Council formally invited Sir Robert to undertake the review. The Cotton Task Force operated out of federal headquarters (then in Sydney), with staff from the Federal Secretariat. Federal Council later decided to enlarge the Task Force, adding three eminent members of the profession and one lay person. They were Dr Rod McEwin (physician, formerly head of the NSW Health Department), Dr Brian Shea (psychiatrist, past Chairman of the South Australian Health Commission), Dr John Clareborough (past president of the Royal Australasian College of Surgeons) and, at Sir Robert's request, Mr Leonard Hinde (actuary and former adviser to the Board of the Reserve Bank).

The Task Force report was delivered – a more accurate word would be 'exploded' – three months early, in March 1987. Among the core recommendations of *A Review of the Alternatives for the Reorganisation of the Australian Medical Association* was Recommendation 2: that "the AMA becomes a national association and that the autonomy of the Branches be removed". As Dr Pickering says, "it was a brave, bald statement and I believe was made as such to gain maximum emphasis. Such a recommendation could never have originated from within the AMA. It screamed out 'This is what is wrong with the AMA' and was to be the major debating point of the whole Report."

Before that could happen, Federal Council had to decide how the report should be released. Since it had commissioned the report, Federal Council thought it should have the chance to discuss it first. It realised that its decision would create some angst within the branches, who would prefer that they and their secretariats should see it before the general membership and the public. Federal Council had some sympathy with this, Dr Pickering says. But it decided that a general release would allow rank-and-file members - ie, those who would have the final say - to see it at the same time as branch councils and so become immediately involved in the review process. Dr Pickering released the report at a media conference on the day that the full report was published as a supplement in the *MJA*.

The Cotton proposals were essentially that authority in the organisation should be shared – that the constitution should reflect that, while the branches continued to have authority over state matters, the federal AMA should have sole authority over those relating to the Commonwealth. In other words, a true federation, in which the federal AMA would have powers to act that the NSW doctors' dispute and other incidents showed that it did not then have. Apart from any other consideration, this would replace the existing time-consuming, laborious and basically inefficient process in which the federal AMA needed to gather the advice of branch councils before it could act or react to events for which there was often no AMA policy to guide it. Apart from Rec. 2, which was radical enough, another courageous recommendation was that Federal Council should be replaced by a General Council, with members directly elected and including delegates of craft groups, thus representing more accurately the current state of the profession. And it proposed that, if there was one organisation, its assets should be available to the whole membership. These were highly contentious ideas and Dr Pickering appreciated that some would be vigorously opposed. Nevertheless, he set out on a national round of discussions about them with the branches, individual members of the AMA and the colleges.

He saw his role in these discussions as conveyor of information, not opinions, he says. "My aim was to stimulate sufficient interest in the report to get people thinking and to receive feedback on what was perceived to be its good and bad features. I felt it most inappropriate for me to take a fixed position. If I could be seen to be neutral, I was more likely to gain the confidence of the membership and more likely to receive constructive feedback. I sought full and informed discussion that would lead to the development of a new constitution that the majority of the membership would comfortably accept and even welcome."

OPPOSITION

He found that, as it stood, the report would not be accepted. There were at least three major sticking points: the proposed loss of state branch autonomy, the proposed distribution of assets and the composition of the proposed General Council. There was strong opposition among the branches, especially from Victoria and New South Wales. (Dr Pickering reports that there was even some misrepresentation of the Cotton proposals by branch officials in both these States.) One of the proposals in the report was that the General Council should in effect replace the Federal Assembly as the supreme body in the AMA: Victoria remained implacably opposed to this to the end of the reform process. He found opposition also in Queensland, though to a lesser extent. The other States were "somewhat ambivalent", but some were prepared to accept a loss of autonomy for the sake of a unitary organisation. Dr Pickering found from his discussion that individual members were not so hostile. His impression overall was that they were prepared to contemplate loss of autonomy for state branches if that was the price to pay for a strong national organisation that represented the profession effectively. The colleges and craft groups, as would be expected, were definitely in favour of the Cotton proposals.

The two views would clash first at a meeting on 17 July between the Federal and State Presidents. Federal Council had decided in May that the Federal President should develop detailed proposals for the reorganisation "as a basis for definitive discussion by appropriate groups within the profession". It authorised him to convene a meeting with State Presidents to consider proposals for the reorganisation. Dr Pickering has described what happened as "one of the most unpleasant and difficult meetings I ever attended" – and a graphic illustration of why the AMA needed to change its constitution. The meeting broke up after some willing but unproductive exchanges over who should chair it: the Federal President who had convened it or those who sought to run it. As soon as Dr Pickering had opened the meeting, Dr David McNicol of the ACT moved that he vacate the chair in favour of a branch President and that the agenda be set aside. Dr Pickering refused to accept the motion, deeming it unacceptable: Federal Council had called for the meeting, and as the agent of the Council he had convened it. The NSW delegates threatened to walk out. In the circumstances, the meeting was now pointless, he said, and left the room. Dr McNicol, acting as spokesman for the branch Presidents, approached Dr Pickering about an hour later to ask that he reconvene the meeting. The Presidents wanted a constructive outcome from the meeting, he said, and wanted Dr Pickering to return. But, when it also became clear that the Presidents' terms included insistence on their own chairman and their own agenda, Dr Pickering refused. The Presidents then continued with a meeting of their own. Later, in discussion between him and the Presidents in the Secretary General's office – neutral ground – Dr Pickering says he expressed his disappointment and displeasure at how the branch Presidents had behaved at a time when "a difficult and unsettling time of approaching change" needed a strong sense of unity. The only point of agreement reached on the day came in this discussion, when it was recognised that the meeting had failed and that a less uncooperative attitude was needed in the future. The Queensland members' newsletter later called the aborted meeting "a fiasco of pre-meeting deals between power brokers, clever procedural tactics to thwart the purpose of the meeting, threats to go home and pushing personal barrows. Our future is too important for this sort of behaviour. We can only hope that more mature counsel will prevail." It would be a while before their hopes were met.

Federal Council met one week later, from 23 to 25 July. Among other things, the agenda included the Federal Secretariat's analysis of the Cotton Report and decisions by the unofficial version of the Presidents' meeting. The two NSW delegates had advised it on the previous day that they deemed it inappropriate for them to attend. This might have been true, but Dr Pickering pointed out to the NSW President that it meant that NSW members would not be represented at a discussion about the Cotton Report and other significant matters such as members' subscriptions, fees under the MBS and a Senate report into the ownership and administration of private hospitals. The Council expressed grave concern about this formally, noting that the NSW delegates' decision not to attend effectively disenfranchised approximately 30 per cent of AMA members. It agreed unanimously two other resolutions of great significance for the period ahead: that Federal Council remained responsible for managing AMA affairs during "the current period of discussion and debate" over the Cotton proposals, and that it believed that the NSW delegates' decision, "subsequently supported by the [NSW] Branch Council, to be divisive at a time when the profession needs unity and strength of purpose". Events over the next six months would shake the very foundations of the AMA, and at a time when the entire national health system was undergoing radical change.

Not only that, while the turbulence was continuing, there was change at the top of the Federal Secretariat. Dr Repin, who as Secretary General had led the AMA from 1973 – through Medibank and Medicare as well as the Cotton review – had stepped down, to be succeeded by Dr Allan Passmore.

On the Cotton Report, Federal Council decided to set up an ad hoc committee to provide recommendations for the reorganisation of the AMA to its next meeting in September. The committee comprised the President as chair and each State President – ie, much the same people as those who were at the "unpleasant and difficult" 17 July meeting. It was decided that the committee would beforehand put its proposals to the Executive Committee and that the President would ascertain the craft groups' comments on the Cotton proposals. The results of the whole exercise were to be put to the September meeting of Federal Council, "with a view to the formulation of proposals to be submitted to an Extraordinary General Meeting after consideration by the Association's legal advisers".

Federal Council duly met in September, though not before another outbreak of hostilities during August between it and elements in the NSW branch. An extraordinary general meeting of NSW members was called early in August to consider a proposal by the Branch Council that the AMA Constitution be amended in two ways that the Federal leadership considered would in effect result in de facto secession of the branch. One change proposed was that the obligation on the branch to collect the Federal moiety on members' subscriptions should be removed. The other was that NSW doctors be permitted to join the NSW branch only, rather than becoming simultaneously members of both the NSW Branch and the Federal AMA. The Federal leadership called for legal advice about both changes and their implications. The advice was that the actions proposed were not constitutionally possible. Dr Pickering wrote to all NSW members to advise them about this and to urge them not to vote for the changes. His view was supported by a list of past NSW presidents. The vote at the EGM, including by proxies, rejected the proposals overwhelmingly. Despite this result, the criticism of the Federal AMA out of New South Wales continued. The Federal AMA fought back, publicly and in a letter to all AMA members and all doctors in New South Wales, arguing against the criticism and accusing "the fringe group" making it as acting against the interests of the profession and the public at large. The prospects for a harmonious reorganisation were not good.

The September meeting of Federal Council – with the advice ordered by the July meeting, plus commentary from various interested parties, and this time with the attendance of the NSW delegates – took three "long and tiring" days, in Dr Pickering's words. Apart from what could be called the normal agenda items to be discussed (eg, finances, MBS and other fees, restrictions on PBS items and health insurance) the meeting dealt with more than 70 motions and many more amendments relating to the Cotton proposals. It agreed in principle with the thrust of these proposals, though in its model members of Federal Council (other than special group representatives) would continue to be nominated or appointed rather than directly elected. Its model was to be referred to the branches for comment. Both Federal Council's model and the branches' comments were to be discussed at the November meeting of Federal Council (the proposed title General Council having been rejected). The restructure thus approved included that:

- the AMA be restructured as a federal organisation;
- Federal Council have autonomy to act on matters in the area of federal jurisdiction, and that the State and Territory councils have the same autonomy on state and territory matters;
- members of Federal Council be nominated or appointed annually, with no limit on their term on Council;
- the composition of Federal Council would be four Executive Officers elected from within Council (President, Vice President, Treasurer and chair of Federal Council), one representative nominated by each state and territory, one representative of each of six special interest groups: physicians (including psychiatrists); GPs; pathologists and radiologists; surgeons (including ophthalmologists, obstetricians and gynaecologists and anaesthetists); full-time salaried and academic doctors; and doctors in training. Representatives of these groups would be elected by AMA members who identified with each group;
- an Executive Council be established, comprising the President, Vice President, Treasurer and Chair of Federal Council, with two Federal Council members to be coopted if necessary;
- subscription to the AMA be dependent on membership of both the appropriate branch and the Federal body;
- with craft representation now on Federal Council, the existing system of affiliation of national bodies be reviewed;
- any member objecting to a Federal Council decision could, with the support of 500 signatories, requisition a referendum of all members on it; and
- the amended constitution be reviewed at least every three years.

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FINAL DECISIONS

The major agenda item for the November meeting of Federal Council was to make final decisions on the draft constitution prepared by the meeting in September. After a process that the record suggests was as tiring as that in September, the Council had retained much of what had been proposed then. But it had added elements that had the effect of neutralising the main point that Cotton had proposed, and that the federal leadership supported. In addition, it had couched the proposal for reorganisation that would need to be put to members in such a way that, whatever they decided, the status quo ante would be protected.

First, it was decided (on a split vote – eight to four, with three abstentions) that Federal Council define a preferred restructured federation option and, second, that a plebiscite be organised urgently by which members could choose between this preferred option and retention of the existing structure. The preferred option contained major changes from what had been decided in September, including that:

- there would be two representatives on Federal Council nominated by each state and territory;
- there would be 10 special group representatives on Council elected by AMA members identified as members of the groups (physicians; psychiatrists; GPs; pathologists; radiologists; surgeons, including ophthalmologists; obstetricians and gynaecologists; anaesthetists; full-time salaried doctors, including academic and research doctors; and doctors in training);
- Executive Officers and Federal Council members would be elected or nominated annually, with no limit to their term on Council, as the September meeting of Council had resolved, but that the President would be elected annually but only for a maximum of two consecutive years; and
- there would be an annual forum (convocation) at which members could discuss topical issues, the forum to be chaired by the chair of Federal Council and to have an advisory role to Council.

Thus, representation of the branches on Federal Council would be doubled to 16; that of the special groups would be increased from six to 10. Branch representatives would continue to be nominated; special group representatives would be elected. In reality, whatever option members chose, the plebiscite would result in the AMA structure remaining basically as it was. The Council authorised the President and the Secretary General to have preliminary discussions with the AMA's legal advisers about a new constitution "based on the preferred option". It is no surprise, therefore, to find that Dr Pickering was "terribly uncomfortable, even dismayed" by the outcome of the meeting. On his assessment, the membership was in favour of the Cotton model and so were the special groups; but the branch councils were opposed. If the branches' domination was to be broken, he said later, "there must be at least equal representation from the branches and the craft groups, or at least a preferred balance".

Dr Pickering was not alone in his view. The 1987 Annual Report records strong objections "from many quarters, particularly the craft groups" to what the Federal Council had wrought. Dr Michael Jones, a Federal Councillor from Western Australia, gave notice that he would move for rescission of the Council's decision. He was supported by a fellow Councillor, Dr Peter Joseph from South Australia. Having discussed these developments

with Executive Officers of the Council, rather than organising the plebiscite, Dr Pickering instead called an Extraordinary General Meeting of Federal Council for 23 December; "not a good time to arrange a meeting," he said later, "but the situation was critical."

In the meantime, he decided to act on his view that, if real reorganisation was to be achieved, it would need the clinical colleges – many of whose members were members of the AMA – to join the effort. Dr Jack O'Loughlin was at the time chair of the Committee of Presidents of Medical Colleges (CPMC), President of the Royal Australasian College of Obstetricians and Gynaecologists, and an advocate for meaningful craft group representation on Federal Council. He agreed that Dr Pickering come and explain to a CPMC meeting soon to be held in Melbourne what was happening to the Cotton report. He told the meeting of his concern at the direction in which the proposed new AMA constitution was going, especially the risk that was being posed to adequate representation on Federal Council of the craft groups, and asked CPMC members to encourage their Fellows to support an AMA constitution that would allow proper representation at the federal level of the entire profession. The meeting resolved that the CPMC supported Dr Pickering's view.

The next stage in Dr Pickering's strategy depended on there being considerable cross-membership among the branches, craft groups and the membership at large, and the fact that the Federal Council decision had denied direct representation on it of the members generally. In the latest draft of the new constitution, the branches had two nominees each on Federal Council. Dr O'Loughlin agreed with a suggestion by Dr Pickering that, if one of the branch representatives was elected by the branch membership rather than nominated by the branch council, the branches and craft groups would have equal opportunities to fill the position. Dr Pickering invited him to explain the views of the colleges and propose this new concept of Council representation at the EGM. Dr O'Loughlin agreed and asked that Dr Durham Smith, then President of the Royal Australasian College of Surgeons, come to the EGM with him. The EGM heard from Dr Pickering, Dr O'Loughlin and Dr Smith, agreed with their proposition and amended the Federal Council draft accordingly. It now proposed that Federal Council comprise one nominee of each of the eight branches and one representative from each of 10 special interest groups, elected by AMA members who identified themselves as members of the group concerned, and one representative elected by and from the general membership in each of these six areas: New South Wales (including the ACT), Queensland, Victoria, South Australia (including the Northern Territory), Western Australia and Tasmania. Thus, Federal Council now had 28 members, the majority directly elected. Dr Pickering recognised that 28 was "unwieldy, and not ideal for decision-making". But this problem would be overcome by the Executive Committee having full power between Council meetings to deal decisively with emergent problems demanding prompt answers. The reorganisation process had taken the best part of three years. All that was needed now was the approval of AMA members. It would require a two thirds majority at an Extraordinary General Meeting of members. The EGM was arranged for 25 May. But there was yet one more problem to be solved before this could be organised.

The reorganisation process had taken the best part of three years. All that was needed now was the approval of AMA members. It would require a two thirds majority at an Extraordinary General Meeting of members.

GETTING THE MESSAGE ACROSS

Can you imagine a time when up to 20 per cent of the medical profession was being sued, most of whom had never been sued before, and most of whom were not guilty of medical neglect?

Can you imagine a time when nearly every obstetrician, gynaecologist, and neurosurgeon was considering leaving their profession because of either the fear of being sued or actually being sued?

Can you imagine a time when irresponsible plaintiff lawyers were running amok across the health system sucking the goodness out of the hearts and souls of the medical profession?

Can you imagine a time when the medical indemnity industry was brought to its financial knees and put into voluntary liquidation?

Can you imagine a time when more than 5000 doctors would turn up to the Randwick Racecourse in Sydney saying "enough is enough"?

That time was my Presidency of the Federal AMA from 2003 to 2005.

Never before was the profession so united behind one single cause. The state AMAs, the craft groups, the colleges, the societies and, more importantly, the public in general stood firm to make the government realise that circumstances had woken the sleeping giant – the medical profession.

The medical profession often reminds me of a big brown bear hibernating – it takes a lot to wake it up, but if you prod it, poke it, and pull its hair, it will eventually stand up and take out those who stand in its way.

Although the medical indemnity crisis represented dark days for the profession and for our patients, it united us in a way that we probably have never seen before and may never see again.

The outcome of the rally and mass meeting at Randwick Racecourse, where the AMA NSW chief executive officer, Laurie Pincott, was a driving force, was the replacement of health minister, Kay Patterson, with Tony Abbott.

Over the subsequent days and weeks, the AMA and the profession worked very closely with the Howard Government to find a solution to this crisis. I have to acknowledge a number of people, both within the AMA and within government, who delivered what I believe was, and is, a sustainable but fair outcome for both patients and the profession.

The new health minister, Tony Abbott, drove the medical indemnity solution from the top. He worked personally, first hand, to solve the crisis.

The Minister was ably supported by his chief of staff, Maxine Sells, and other key players.

I would like to particularly acknowledge John Perrin (now deceased) from the Prime Minister's Office and Health Department Secretary Jane Halton, who was backed up by David Kalish, Louise Morauta and Rosemary Huxtable, who all worked with the Minister's office in designing a way forward.

Our AMA team, led by Dr Andrew Pesce, worked tirelessly with all parties concerned to deliver the ultimate outcome.

The shadow health minister at the time was Julia Gillard, and she remained supportive through the whole process.

I would also like to acknowledge the state presidents, the CEOs and Dr David Molloy from Queensland, who led the tort law reform agenda at the state level. AMA Queensland CEO, Kerry Gallagher, AMA Western Australia CEO, Paul Boyatzis and AMA Victoria CEO, Dr Robyn Mason need to be singled out for the outstanding roles they played in both the federal and state reform agendas.

My Executive – vice president Dr Mukesh Haikerwal, Dr Dana Wainwright, Dr Rosanna Capolingua, Dr Andrew Pesce and Dr Choong-Siew Young – helped manage and carry the medical indemnity and other issues across the country.

Dr Mukesh Haikerwal was my right-hand man and handled all issues relating to primary care. He was and continues to be a wonderful friend and supporter of the profession of medicine. Pam Burton, Roger Kilham and John O'Dea at the AMA Secretariat provided the legal, economic and policy backbone for our Executive and Council to be fully briefed across all issues of interest.

At the same time, many of this same group worked with me and the AMA to deliver the Safety Net which, despite some more recent watering down, still continues to provide great support to a significant number of patients and makes the Medicare system more like the system that was originally intended.

One of my major highlights during my term as the AMA President was to meet and work with John Flannery, the head of the Federal AMA's Media and Public Affairs Department. He taught me so much about how to get a message across to politicians, the media and the public. His message was always simple, clear, and always picked up by the press gallery, the national media, and the medical press. I am indebted to him for his support during my term.

Dr Bill Glasson: AMA President 2003-05

The Victorian branch – which, with New South Wales, had the largest bloc of AMA members and therefore huge influence on whether or not the draft constitution would be approved – still firmly opposed that part of it that defined the division of autonomy between the federal AMA and the branches, and with some reason. For most of its existence, the branch had legal standing in the State's industrial relations system as the recognised advocate for doctors in industrial matters in the State. It had legal advice that the proposed new autonomy provisions would vitiate its legal standing on these matters. Legal advice to Federal Council was that the draft constitution would not have this effect. Nevertheless, both sides agreed that the relevant passage be amended to make it clear that the powers of Federal Council would be over national medico-political and international issues, powers that did not derogate from the powers, function and responsibility of the branches. The relevant passage was thus almost exactly that which was in the existing constitution. Federal Council ratified the agreement with Victoria at a meeting three days before the EGM. The Victorian problem was overcome. But this then led to another: the draft constitution thus amended was not the one that the other branches had approved to be put (and had been circulated) to members. The branches had given their approval to the amended draft before the EGM, but it would have been new to members. The EGM had to go ahead on 25 May because due notice of it had been given to members. But notice had not been given to the amendments negotiated between Federal Council and the Victorian branch. So Federal Council decided that the EGM should either be adjourned or a new EGM convened not later than 17 August.

RESOLUTION

The EGM took place on 25 May in The University of Sydney, as arranged. Dr Pickering explained the circumstances and the agreement with the Victorian branch. The meeting resolved that, instead of the amended draft constitution being dealt with that day, it would need to be put to another EGM, which would be held within three months. In the event, it was convened on 22 July. There was minimal debate on the motion for the new constitution. Eight proxy votes were received against approval; 4,433 votes were in favour. In the words of the 1988 Annual Report, "following three years of study, debate and negotiation, radical changes to the AMA Articles of Association were adopted".

The AMA could now concentrate for a while on another core issue that had been building up during 1988 – and another battle over it with the Federal Government . It concerned the AMA List of Medical Services and Fees, in particular to what the AMA considered to be the need for a new approach to the existing time-based system of charging fees in general practice. There had been growing dissatisfaction among GPs that this system did not reflect changes in general practice. A working party composed of representatives of the AMA, the Royal Australian College of General Practitioners and the National Association of General Practitioners of Australia had been set up in 1987 to examine the issue. It had recommended in April 1988 that all GP services in fees lists be based on descriptions of content, not on time alone. Federal Council resolved in May that the three bodies should discuss new descriptors and benefits for GP consultations with the then portfolio Department of Community Services and Health. In August, it decided to develop an action plan to "elevate the level of GPs' items of service to reflect the worth of services rendered in general practice", and to exert political pressure for adequate rebates for these services. In September, the AMA announced that, with effect from 1 November, its List of Medical Services and Fees would include content-based GP fees. The new descriptors would be: minor service, special service, extended service and comprehensive service. The reaction of the Minister, Dr Blewett, was not at all friendly. He said that he was not unsympathetic to the concept-based system, but he condemned the AMA for not consulting the Government before deciding on the change. The AMA responded that it had tried frequently but unsuccessfully to raise the need to restructure GP items between 1983 and 1987. Moreover, the Government had made fundamental changes to the MBS affecting GPs (removing after-hours MBS fees, for example) without consulting the AMA. In any case, the Government would never have agreed to consider the concept-based change if the AMA had not forced the issue by setting it in place from 1 November.

On that day (ie, the day that the new fees came into effect), the AMA, with representatives of the RACGP and NAGPA, met Dr Blewett to brief him on the new concept, and both the AMA and the Minister offered the idea of a joint medical profession-Government working party to explore the concept-based system. But this brief accord ended when Dr Blewett insisted that the Government would participate only if the AMA deferred the new fees for three months - a condition that was unacceptable to the AMA and NAGPA. The RACGP, on the other hand, reached agreement with the Government on the creation of a Vocational Register of GPs, which included the introduction into the MBS of content-based GP item descriptions, but with a time element. GPs choosing not to register would attract lower rebates for the time-tiered items of service. Opposition to the agreement was widespread, not only in the ranks of the AMA but also generally among GPs and RMOs. When legislation was introduced into the Senate to establish the Register, the resistance managed to persuade the Australian Democrat Senators to join the Opposition in sending it to a select committee. The Committee recommended more or less what the AMA had proposed to the Government in the first place: a standing review group that would oversee the introduction of the register and other matters relevant to general practice.

The list, with the changes, duly came into effect on 1 November. The President, Dr Bryce Phillips, said that he expected the changes would be evolutionary, rather than revolutionary. But, within a few weeks, the Federal Secretariat was reporting response from metropolitan, provincial and rural areas that the changes were gaining steady acceptance among GPs. In the meantime, the AMA continued to press the change, whether the Government supported it or not. Federal Council set up an AMA Practice and Fees Committee that would propose alterations or additions to the AMA List of Medical Services and Fees and, more generally, provide advice on the economics of private medical practice. It agreed in a meeting in October to advise GP members not to seek vocational registration because its full implications and requirements were still not available. It decided on a public campaign to explain the AMA's decision – especially among pensioner and consumer groups that the 1988 Annual Report noted had issued "simultaneous and coordinated" media announcements criticising it - and to warn people generally of the loss of confidentiality of their patient records if they attended a vocationally-registered practice after 1 December. And it agreed on a promotional and political strategy whose objective was to secure improved conditions for GPs, including "positive promotion of the implementation of content-based descriptor reform".

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The era of great change carried over into 1989, most of it resulting from the previous year's upheavals. In his message in the 1989 Annual Report, Dr Phillips recorded that events in that year had seen the AMA emerge "from its period of political introspection with organisational restructuring and the accompanying inertia, to a far more active engagement of the professional interests of our members". Federal Council reformed its committee system. It broadened the scope of activities and interests in which the AMA should be involved. A corporate plan was drawn up that set out the political and professional priorities for the period ahead. A start was made to transferring the Federal Secretariat from Sydney to Canberra, where it would begin its strategy of greater and closer involvement in national health policy.

Federal Council adopted the new corporate plan that would enable the association and the profession in general to deal with approaching medico-political issues. One such issue was the MBS. In 1989, the AMA persuaded the Government to agree to set up a Medicare Benefits Consultative Committee on which the craft groups would work with the AMA in negotiating effectively the contents and structure of the MBS. Other emerging issues identified in the corporate plan included the growth of high technology, declining private health insurance, the need to develop the AMA as a union at the national level and the continuing failure of governments to include doctors on committees and other bodies with influence on health policy and practice. A particularly important objective in adopting the plan was to restore "amicable relations" with the RACGP. These had been going through a bumpy patch, as could be seen in the controversy over the Vocational Register of GPs and the changes to time-based system of charging fees in general practice.

An important change in 1989 associated with the restructure was the abolition of specific committees of Federal Council – 18 in all (though the President's Advisory Group on Women in Medicine was retained, with its remit to advise on women's health and professional medico-political issues that affected female doctors). The 18 were replaced by seven committees with broader agendas that reflected the new strategic challenges: public health issues such as AIDS and substance abuse, for example, and even – as the reach of public health expanded – immigration and climate change. The new challenges also included aged care; Indigenous health; medical ethics; medical science and education; and increasing calls on the AMA to protect the interests of doctors working in public practice, especially as the old Repatriation hospitals were being integrated into state hospital systems.

A start was finally made to fulfilling the longstanding ambition for a national

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headquarters in Canberra. The Federal Secretariat had been working out of a building in Sydney owned since 1924 by the Australasian Medical Publishing Company (AMPCo, publisher of the *MJA*) but which was sold in 1989 to The University of Sydney. The *MJA* was still published in Sydney; the new Federal Secretariat was to be in place in Canberra by the end of 1991. In the interim, Federal Secretariat staff occupied an office in Queanbeyan, on the NSW-ACT border a few miles from Parliament House, near where the new office was to be built. In synchrony with this environment of change and increasing national activity, and as part of the physical transfer from Sydney to Canberra, the AMA adopted a new national logo and launched a new national journal, *Australian Medicine*, which – like all these changes associated with the restructure of the AMA – exists today. The transition process was completed in March 1991, when AMA House was officially opened in Canberra by the illustrious biologist (and AMA member) Sir Gustav Nossal. In its new home, and to deal with its new responsibilities, the Federal Secretariat quickly created sections with expertise in general practice, medical fees and medical insurance, public relations and communications, public health and hospital and health funding.

This expertise was needed – and later sorely tested – by the AMA's involvement with the Government in a process to determine MBS fees for services (other than pathology and diagnostic imaging) on which Medicare rebates would be paid. The genesis of what became known as the Relative Value Study was actually in the National Conference of 1991, which carried a motion that "the Federal AMA undertake a work value and relative value study to reassess the appropriateness of the AMA List of Medical Services and Fees".

In the early 1990s, there were other issues to be settled – and even battles fought – over government activities and policies that the AMA judged to be inappropriate and even inimical to doctors' interests; a mix of government attempts to exert greater control over doctors' remuneration and government encouragement of community expectations of virtually free access to healthcare. By then, Dr Shepherd had become Federal President, and he brought to these issues all the ferocity and energy that he had shown in the NSW doctors' dispute. Before his term of office ended, the AMA had extended it from the traditional two years to three, so that he was able to continue to lead the AMA through the problems ahead. (Ten years later, Dr Kerryn Phelps, confronting the medical indemnity crisis, was also given an extra third year in office - she and Dr Shepherd being the only Presidents in the AMA's half century to serve more than two years.) With Dr Shepherd at the helm, and under the rubric 'Political Control of the Medical Profession', Federal Council discussed this troublesome political terrain at its first meeting in 1991. When discussion ended, the Council resolved (among other things) that the AMA should preserve its commitment "to the present standard of excellence required to practise medicine in Australia", and that it plan and mount "a public political campaign to have its values made known", in coordination with state branches and the colleges. Four government activities in particular were agitating the Council's members at the time:

the National Office of Overseas Skills Recognition [NOOSR] which, as the agenda papers said, "many people believe will tend to diminish the standards required for recognition of medical qualifications in Australia"; an investigation by the then Trade Practices Commission "of the professions generally, and the medical profession specifically, clearly prompted by political considerations"; consideration by the Tasmanian Government of proposals to establish "minimal professional standards"; and proposals by the Australian Health Ministers' Advisory Council to establish a national system of medical registration.

(NOOSR was established in 1989, part of the Hawke Government's Migrant Skills Reform Strategy, to expedite the use of skills of immigrants. One of its proposed activities at the time was a review of examination procedures by the Australian Medical Council. The Trade Practices Commission had announced in 1989 that it would conduct a research study of the impact of professional regulation on competition. In December 1990, it produced a discussion paper that observed (among other things) that it was important to assess whether or not government or self-regulation of the professions provided net benefits for consumers. Subsequently, its *Study of the Professions* concerned accountants, architects and lawyers, but not doctors. The national registration proposals were ignored by the Howard Government later, at the urging of the AMA, but resurrected by the Rudd Government in 2008.)

"LAWRENCE" CONTRACTS

A fifth problem was a serious struggle over two and a half years that arose from another discussion paper, this time published in 1993 by the then Minister for Health, Graham Richardson, describing two broad proposals for arresting a serious decline in private health insurance coverage, which the paper said was caused by rising out-of-pocket expenses and premium rates. One suggested reform of the private health insurance sector in a number of ways, including an amalgamation and/or rationalisation process that would bring about funds that were bigger, fewer and more efficiently administered, and therefore able to offer lower premiums. The other suggested changes in payment arrangements for treatment in private

hospitals that would put a brake on the fees by doctors for that treatment. These changes would include private hospitals contracting services from doctors at agreed rates and legislation that would limit the cost of services negotiated between doctors, private hospitals and the funds. The paper said that the result would be a more efficient system "to achieve the competitive pressure which would restrain the rising costs of healthcare and the fees charged by doctors", or, as Senator Richardson himself put rather less fastidiously, a system that would leave doctors "free from any incentive to perform unnecessary procedures in order to maximise payment".

The AMA set out to oppose these ideas vigorously; publicly, in a document entitled *Right Problem, Wrong Answer*, and internally, in expanding its expertise in the Federal Secretariat by setting up a new Hospital Policy Department. It argued that, apart from the control over doctors' fees that the Richardson proposals envisaged, they were more likely to reduce insurance coverage than to reduce it and that coverage was more likely to be increased by encouraging it among lower and middle income earners through tax incentives. The response of Senator Richardson's office was that the AMA's suggestion would involve huge expenditure on subsidies fo doctors, hospitals and the funds. But the proposals were creating such aggravatior – not just within the AMA and the profession at large but also within its own ranks – that the Government referred them to a Caucus-ACTU Working Group. Even the Working Group found them too contentious. In its report in June 1994, it opposed the idea of a higher Medicare levy on higher-income people who refused to take out health insurance coverage, but it also rejected the payment arrangements option as unworkable and described the assumption in the paper that a floor was needed under the health insurance participation rate as neither warranted nor necessary. The Richardson proposals ended there. But the state of affairs that gave rise to it lived on: rising out-of-pocket expenses and insurance premiums. A couple of months after the Caucus-Working Group had reported, the Government launched for discussion yet another set of proposals to save costs through reform of the health insurance system – this time by the new Minister for Health, Dr Carmen Lawrence.

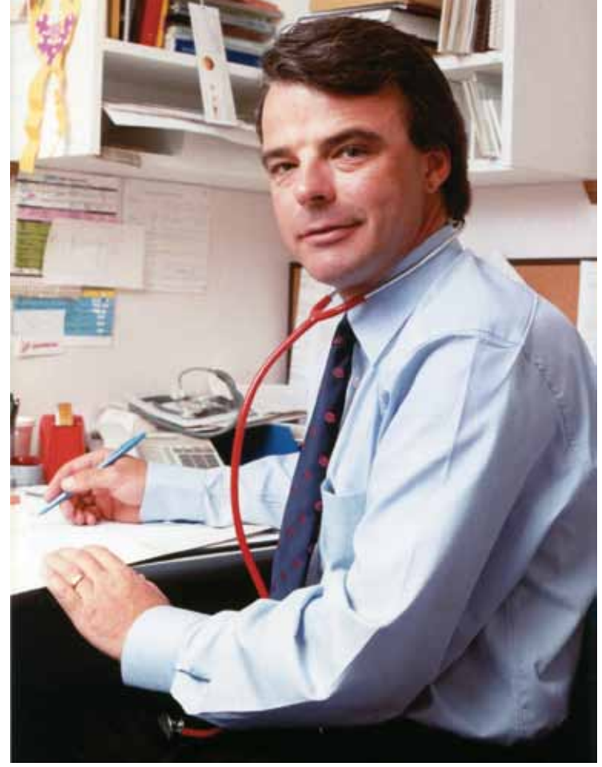
In a meeting towards the end of July, the Executive Council had anticipated possible directions in Dr Lawrence's proposals, including preferred-provider arrangements with private hospitals and mandatory informed financial consent, but little information had been given about their detail. In August, when the proposals were finally released, they differed in several respects from those put forward by Senator Richardson but, though they were still weak on detail, there was enough in them to alarm the AMA, which began to prepare for the next stage in the process: legislation. The point of the Lawrence proposals for discussion was said to be to remove "regulations that restrict efficiency and competition", allowing the funds to negotiate with doctors and hospitals arrangements that gave "a better deal on behalf of their members". They envisaged (among other things) the funds covering members for the full cost of medical services if they could reach agreement with doctors, a system of single billing for hospital treatment, a formal financial consent process requiring doctors to explain to patients what they could expect to pay for particular services, a 'Private Patients Hospital Charter', and an independent process to sort out complaints about insurance. The Lawrence proposals were seen to have changed in some ways in the enabling legislation introduced by the Government in December. The charter and the informed financial consent ideas had been dropped. The preferred provider arrangements had been set out in detail. The AMA had anticipated much of what had been left.

The *Health Legislation (Private Health insurance Reform) Amendment Bill* was the vehicle for managed care, a concept that, the AMA argued, not only severely compromised the quality of patient care but had also torn the profession

apart when it was introduced into the United States. It provided (among other things) that insurers would be allowed to reach preferred provider arrangements with doctors through medical purchaser provider agreements (MPPAs) and hospitals through hospital purchaser provider agreements (HPPAs). MPPAs would allow insurers to strike agreements with doctors in which – with a number of ifs and buts, some of them concerning fee levels – the insurers would pay directly for medical services eligible for Medicare benefit provided by doctors to patients in hospitals. HPPAs would allow insurers to negotiate agreements with preferred hospitals for 100 per cent coverage for members for charges by these hospitals, but not with others. Insurers would have to provide benefits for members for treatment in non-preferred hospitals only in emergencies.

The Executive Council had a long discussion in December about the Bill and its ramifications for medical practice, especially its potential for enabling the progressive introduction of case payments. It asked the Federal Secretariat to coordinate legal advice for members about the legislation and agreed that Dr Nelson (now President, succeeding Dr Shepherd) would consult Senators with a view to their referring the Bill to a Senate committee where it would be properly analysed. Dr Nelson succeeded. In May 1995, the Senate passed and sent a Bill to the House of Representatives which was heavily amended and subject to review after 12 months. But, with the support of Liberal-National Coalition Senators, it also referred the Bill to the Community Affairs Legislation Committee for inquiry and report on or before 1 July 1996. An election was due before then.

The managed care issue was not the only reason for the AMA's markedly more belligerent attitude in the early 1990s. Its relationship with government had been tested by other issues of the kind summed up by Dr Nelson in his



Dr Brendan Nelson, Federal President 1993-95

Presidential Messages in the annual reports for 1993 and 1994. By the end of 1993, the relationship had improved. But the AMA still needed to oppose government intervention that it judged to be inappropriate; for example, changes to private health insurance that necessitated "a protracted political campaign" by the AMA. These changes had not just been unworkable, he said, but they had also been philosophically unacceptable because they violated "the principles of the private doctor-patient relationship". In 1994, the sins of government included a hospital system unable to cope and widely believed to be in crisis, continuing decline in a private health insurance scheme that should have been releasing some of the strain on the health system, government threats to private medical practice and standards, including "the unilateral transfer of money from Medicare benefits to direct practice income subsidy schemes" – and, at the base of it all, a Commonwealth policy vacuum. For all these reasons, the AMA was operating "at a turning point for medicine".

There were other reasons. The AMA was turning its attention to questions that were broader than medicine, though with implications of significance for medicine and health generally. Dr Nelson reported in 1993 that he had taken the AMA "into a range of important health and social issues". They included Indigenous health, mental illness, unemployment and the effects of drug and other substance abuse on young people. In that same year, the AMA appointed its first Aboriginal Health Policy Coordinator and established links with the Aboriginal and Torres Strait Islander Commission and several Indigenous health services. The structure of Federal Council committees (and that of the Federal Secretariat) reflected the new range of interests as it developed through the 1990s. At the

beginning of the decade, the interests of Federal Council's 12 committees reflected the AMA's political, professional and industrial agenda, only two of them covering road safety and aged care. In 1997, a youth health committee was created and a Youth Health Advocate appointed. Dr Mukesh Haikerwal, who would be Federal President from 2005 to 2007, was anticipating the impact of new technology on medical practice, including the use and privacy of patient information. At the end of the decade, when Dr Kerryn Phelps had become the first female Federal President of the AMA, road safety had gone but aged care had been joined at various stages by Indigenous health, public health, and complementary medicine. Early in the new century, under the Federal Presidency of Dr Haikerwal, the AMA continued to focus its advocacy energies on more such broad emerging issues: the health effects of climate change, access to IVF, better health care for asylum seekers and refugees. The health environment had broadened to extent rarely imagined back in the 1980s; the structure and focus of the AMA had changed with it. In his Presidential Messages, Dr Nelson had reported on two other developments that were to give the AMA much grief later, after he had moved on to federal politics. One was his report of a growing tendency among patients, "fuelled by government-funded community organisations", to litigate to win compensation for mistakes or misadventures in medical treatment, a development that was seriously pushing up the costs of medical insurance. The other was his observation that the AMA-Government relationship had improved since the early turbulent 1990s. The first was to create enormous problems for members, especially specialists, and preoccupy the AMA for some years. The second would lead to such a serious convulsion within the organisation that one of the branches was reported to be seriously considering secession.

The AMA was entitled to anticipate a complete change of scene in March 1996 when the Labor Government had been replaced by a Coalition Government. Before the election campaign, the Coalition had among its health policies supporting health insurance and the private system and abolishing Medicare. But, during the campaign, there being little evident public support for the idea, abolition of Medicare was very publicly dropped. But the Coalition maintained its policy of support for the private system and, when it came into office with a strong majority, AMA member Dr Michael Wooldridge became Health Minister. But the AMA-government relationship was not, as expected, about to become all that less uncongenial – not immediately, at any rate. And the Lawrence legislation was not yet quite dead.

NEW GOVERNMENT, NEW RELATIONSHIP, NEW PRIORITIES, NEW STRUCTURES

The Senate Committee's eventual report on the Lawrence legislation recommended more or less the status quo. This was a surprise and a disappointment for those, like the AMA, who had hoped for

a more positive endorsement of their analysis of its effects. The new Government, moreover, seemed in no great hurry to withdraw it. The AMA therefore continued to pursue its concerns, pointing out to the Government that the legislation had clearly failed to meet its aims anyway because increases in insurance premiums had already outstripped any benefit from a rebate, which had not yet been introduced.

The new Government agreed finally to refer the private health insurance question to the Productivity Commission for inquiry and report. It was a recognition of sorts of what had become a large problem but not quite the full one that the AMA thought that the problem demanded. The terms of reference that the Government gave to the inquiry were so narrow that it was hard to see how the Commission could come to any effective result. It was prevented, for example, from examining Medicare, including bulkbilling, and its terms precluded abandonment of community rating. The AMA was dismayed by this limitation, given that almost 75 per cent of expenditure on hospitals and 80 per cent on medical services came from government. Nevertheless, it put a submission to the inquiry arguing that private health insurance could not be stabilised without an examination of the overall financing arrangements, that the managed care agenda be abandoned and that the proposed rebate be targeted to support private healthcare more effectively. The AMA also offered the profession's cooperation on informed financial consent, simplified billing and better use of resources. The Commission did not report until February 1997, when it handed down a report that traversed the general problems of the private health insurance sector but, presumably because of the limitations on its terms of references, that reached no conclusion and recommended no action on the question, other than proposing unfunded lifetime community rating.

The Lawrence contracts issue aside, the immediate post-election environment in general continued to encourage the AMA to look forward to a more agreeable relationship with the new Government. Dr Wooldridge met Dr Weedon and Dr Coote informally within a few weeks of his becoming the new Minister and the AMA welcomed him in its 1996 Annual Report as "accessible and consultative", as befitted a member of the association. Dr Wooldridge was on the record as saying that he wanted "to get government off the back of GPs", that he wanted to work with the profession to improve healthcare, and that change would be impossible without cooperation. He established a group of private health insurance organisations known as the Round Table to help identify areas of agreement on change. Within six months, the Round Table issued a report that pointed to two such areas: simplified billing and informed financial consent. On several fronts, cooperation between the AMA and the Government and its agencies was close and relatively smooth. The joint AMA-Government Relative Value Study was proceeding well; the Medical Benefits Consultative Committee (with AMA, craft groups and government representatives) was concentrating on making sure that the schedule reflected developments in medical practice. The General Practice Accreditation Steering Committee was helping build a system of accreditation that was acceptable to members, including a suitable set

The Lawrence contracts issue aside, the immediate post-election environment in general continued to encourage the AMA to look forward to a more agreeable relationship with the new Government.

of practice standards. But, not too long into the term of the new Government, the expectations of the AMA and the profession of a generally smoother relationship with it were beginning to be shaky.

The new Government's first Budget ordered unexpectedly large cuts in expenditure on health – along with those in other sectors, it is true – but alarming to the AMA because of their effects on the health system and on doctors. The medical Medicare budget was cut by more than $1.5 billion between 1996 and 2000, the reductions including restrictions on access by new graduates to Medicare benefits, non-indexation of MBS fees for rebate purposes and cuts to rebates for psychiatry and assistance at operations. The PBS was cut by more than $0.75 billion and Commonwealth grants to the states for hospitals were reduced by nearly $0.35 billion. The Government did eventually heed an AMA campaign against these cuts to the extent that it reversed its decisions affecting psychiatry and assistance at operations, but not those implementing the rest of the health budget. This posed real problems for the profession and the sector at large, and it provoked concerns in the AMA about the strength of the Government's commitment to cooperation and consultation.

An even more difficult bump in the road was caused by the Government's decision in 1996 to restrict Medicare provider numbers to doctors who had completed postgraduate training. This was an idea aired (though never adequately explained) and never implemented by the previous Government. The AMA had for some time argued there was a problem of over-supply of GPs in major cities that was not being managed, and it had supported the idea of postgraduate training before independent practice. But the new Government decided to use Medicare provider numbers in a way that the AMA interpreted as meant to exert control over the medical workforce more generally. Whatever its intent, the decision was grossly unfair to interns and medical students who had begun and finished studies in good faith, in the AMA's view. It warned that the Government's action would be bitterly resisted by junior doctors. The warning was prescient. Unprecedented action by Resident Medical Officers in New South Wales (described by Dr Wooldridge as "industrial thugs in white coats") and lobbying by the AMA and its Council of Doctors-in-Training led to a re-think by the Government. After protracted negotiations with the AMA, it agreed to reverse its decision. It was also agreed that the AMA would be represented on a Medical Training Review Panel set up by the Government to improve and regulate medical training.

The managed care issue was grumbling along in the meantime, surviving so long as the Lawrence legislation survived. Early in 1996, most private hospitals had signed up for Lawrence contracts, no doubt because they were initially secure under them, as the Federal President, Dr Keith Woollard, had noted at the time. But they were also steadily pressuring doctors to fall into line via MPPAs – steadily, but not all that successfully, because the great majority of the doctors concerned refused to be tempted.

Late in 1997, the Government introduced the *Health Legislation Amendment Bill (No. 4)*, which included a provision that actually extended Lawrence contracts into consultations and other medical services provided by community organisations by approving private health insurance for charges above 85 per cent of the MBS, but only if the doctors providing the service signed a Lawrence contract. The AMA strenuously opposed the idea, mailing the membership and lobbying the Government about it. Eventually (and, on the face of it, reluctantly) the Government withdrew the offending provisions in the legislation: the first time that the AMA had succeeded in winning withdrawal of legislation that had been tabled in the Parliament.

Even later in 1997 (on the last sitting day of the year, in fact), the Government got its 30 per cent rebate through the Parliament. This was expected to interrupt the apparently irresistible shrinkage in health insurance coverage, though the relief would be temporary, in the AMA's view. Lawrence contracts had not succeeded in encouraging coverage. A new way was needed. The AMA continued to press alternative ideas on the Government and offer its support for ways to reverse the movement of people out of health insurance, such as lifetime community rating, informed financial consent, simplified billing and increased Medicare rebates in areas where they were seriously deficient. It proposed legislation that would allow gap medical insurance without Lawrence contracts and, to deal with any concerns about fee inflation, a gap cover scheme in which the funds would put proposals about premium levels to the Minister for approval. By the end of 1997, the pattern of decline in coverage had resumed. In December, coverage was down to 31.6 per cent; ie, 4.8 per cent lower than that reported in January.

It was not only private health insurance that was giving the AMA cause for concern about the way things were going. The Annual Report for 1997 recorded complaints by members about low morale and deteriorating working conditions. Dr Woollard spoke of the Government's "appalling treatment of GPs". As early as May in 1997, Federal Council decided to mount a Campaign in Support of GPs, to continue until 1998 (when a federal election was already anticipated), to stimulate debate in the community, the profession and the Government about the issues facing GPs and the need for change. *The General Practice at Breaking Point* campaign was launched five months later, after the Minister was told about it and the AMA's expectation of formal negotiations that would produce measures to reposition general practice and confirm its leading role in the health system.

The campaign had two major, linked objectives. One was awareness-raising: to inform the community as a whole – including governments and policymakers – and the profession about the issues confronting the contemporary GP. The second was to achieve better conditions for GPs and to encourage less reliance among them on bulkbilling – but also to increase the AMA's profile as the foremost GP political organisation in the country and increase its GP membership. These objectives were pursued in five ways: negotiating to achieve remuneration and professional goals; using a network of doctors to lobby members and candidates in every federal electorate; distributing profile-raising material such as stickers; organising professional events such as the campaign launch and professional conferences; and pursuing the campaign through media and public relations.

Among the achievements that the AMA claimed for the campaign was the full indexation of GP rebates in November 1998 (with another increase four months later) and federal funding for information technology in general practice. More importantly for the AMA's political agenda – and with the axiom 'all politics is local' at the core of it – it designed, produced and distributed basic tools with which GPs could campaign for better conditions among their MPs and Senators: information about bulkbilling and co-payments, general practice financing, the impact on GPs of taxation, including the FBT and the GST that were then being promoted, and the various impacts on (and consequences for) general practice of information and other new technologies.

It was about this time – 1997 and 1998 – that the AMA's role was evolving (in the words of Dr Bill Coote, the then Secretary General) from representing one monolithic professional view on issues related to fees and insurance to one in which it would be also a facilitator and a resource for other groups in the field. Apart from any other reason, it reflected and was a consequence of what Dr Coote called "the growing sophistication and detail with which the Government was managing Medicare, using the vast amount of data generated by the Medicare system". This needed informed response that could only come about with the help of relevant experts. So the AMA began looking closely at ways to coordinate the expertise of craft and speciality groups. But the issue of fees for medical services and medical benefits still remained a major priority at this time, when the AMA was involved with the Government in a relative value study (RVS) of the MBS, up to then seen as a theoretical exercise, as Dr Coote stated in the Annual Report for 1997, but which "will eventually impact on every doctor whose services attract Medicare benefits". The RVS idea had been born and put to work in the Keating days; the incoming Government had endorsed it in its platform for the 1996 election. Its future looked secure. But it would provide the ground for yet another clash between the AMA and the Government.

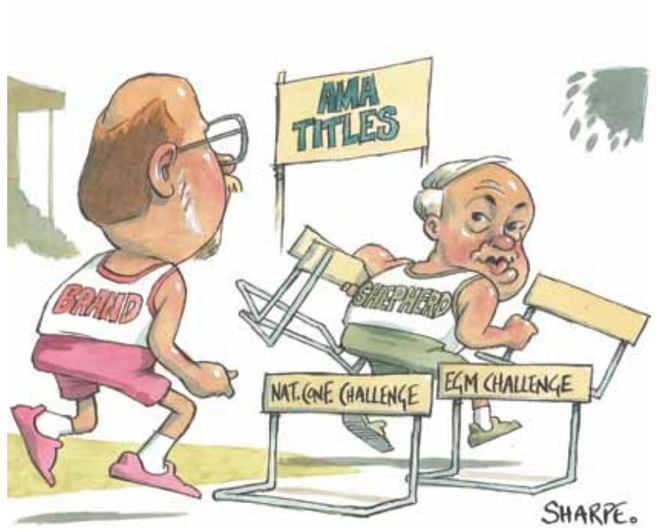
The RVS would take the best part of seven years to complete. A joint Commonwealth-AMA Medicare Schedule Review Board (MSRB) was created to determine MBS fees for all services excluding pathology and diagnostic imaging on which Medicare rebates would be paid. The genesis of the whole operation was actually in the AMA National Conference in May 1991, which carried a motion that "the Federal AMA undertake a work value and relative value study to reassess the appropriateness of the AMA List of Medical Services and Fees". The AMA agreed to comply with the motion only after much internal discussion. Indeed, Federal Council, in its first meeting after National Conference in September, resolved that an RVS "would not achieve the appropriate objectives, particularly in the light of overseas experience". Instead, it decided that the Federal Secretariat should "consider the value of

Secretary General Dr Bill Coote and Federal President Dr Keith Woollard meet Prime Minister John Howard

consultative items in the AMA List of Medical Services and Fees in the light of remuneration of other professions, having regard to perceptions in some sections of the profession that consultative items are under-remunerated".

The AMA's objective for the RVS was that it would help reflect more accurately the medical and non-medical resources needed to support the provision of private medical services, including the rising cost of indemnity insurance. Its own modelling suggested that MBS fees might need to be increased by at least $1.5 billion a year in then dollar values, if Medicare rebates were to match the anticipated results of the RVS. This "apparently high price tag", the 2000 Annual Report said, "is no surprise to those familiar with the way MBS fees and rebates have been screwed down over the years". It was also no surprise, therefore, that the Government took its time agreeing to cooperate with the RVS. Indeed, in her 2001 President's Report to members, after the results of the RVS had been handed finally to the Minister, Dr Kerryn Phelps took aim at the Government not just for being reluctant to cooperate with the RVS, but also for actually trying to sabotage it. "The Health Minister and his department took every opportunity to try to undermine and pour scorn on the RVS and suggest that the AMA's involvement was purely a massive pay demand by already well-paid doctors," she said.

The RVS and medical indemnity were still unfinished business for the AMA as late as 2000, when Dr Phelps succeeded Dr Brand as Federal President. Before then, however, the association had had to endure seriously damaging internal division.



CLASH OF STRATEGIES

Dr Nelson had reported an improvement in the AMA-Government relationship back in 1993. But there were influential members who were not happy when, in the 1998 Annual Report, Dr David Brand talked in his first Presidential Message of his ambition for a fresh approach to its role by the AMA, turning it "into a more professional lobby group – one that . . . avoids the conflict and marginalisation of the past". Support for this new approach had been very gratifying, Dr Brand said. "It is the approach that will lead the AMA into the next century." Early in 2000, when Dr Brand composed his last Presidential Message for the 1999 Annual Report, he defended his policy "of constructive engagement with government without compromising our principles". Members had had the chance to reject this approach in 1999, he said. "In the end, you made a clear decision and supported dealing with government in a professional and constructive manner rather than returning to the unnecessary confrontation and marginalisation of the past". Those few words did not quite adequately describe probably the most turbulent period for the AMA in its 50 years.

Dr Shepherd's period as President had ended five years before but his interest in the directions that the AMA was taking had never waned and his influence was as active as ever among influential senior members. During 1996 and 1997, he says in his book *Shepherd: Memories of an interfering man,* he had been dismayed by what he considered to be "a steady drumbeat of doctor bashing" by Dr Wooldridge. Late in 1997, in a letter to all Coalition MPs, he warned that the Government's health policies, particularly its retention of Medicare, would cause it to survive only one term. Dr Wooldridge responded in a letter, also circulated to all Coalition MPs, stating that Medicare would be retained "because it ensures universal access, does not discriminate or ration services based on a patient's capacity to pay and actually helps contain expenditure on health". Dr

A LONG ILLUSTRIOUS LINE

It is with great pleasure as the 19th President of the Federal AMA that I write to contribute to the celebration of the 50th anniversary of our great Association.

My thoughts are about the giants on whose shoulders I have stood.

The spectacular changes in health, healthcare, health delivery, safety and quality, and public health that the AMA has brought in its time have been a collective effort over many years with many significant contributions. It is the work of the many that brings the accomplishments of the AMA and its presidents into the light.

In my case, the line of presidents I was guided and influenced by is long and distinguished. Each brought their own style and made their own marks on the medico-political landscape.

I worked tirelessly to build on the work and the contributions and the changes and improvements of my predecessors, adapted and applied them in the contemporary environment of my Presidency, and shaped a new AMA manifesto to pass on to the formidable presidents to follow me.

I was a voice for grassroots members and was always available to them, the Association, and the profession to be a strong advocate to the government. I learnt a lot.

My passions in office were to meet the people in each part of our great land. Our very talented members – my colleagues. They are all fierce defenders of their patients and masters of their own destinies, staunch advocates for health and their part in it. Fearless but fair proponents for a better deal for justice in health for all, they were always fun to be with.

There were big issues to deal with. I played a part in consolidating the benefits to doctors, patients and communities from taming the 'mammoth' of the medical indemnity crisis, which spanned many years. I championed public health through promoting awareness of issues such as pandemic influenza (bird flu in my day), childhood obesity, immunisation (including HPV), the great increase in anaphylaxis and improving the safety of those with it.

Aboriginal and Torres Strait Islander Health was a special interest of mine. The AMA expressed strong public concern about the ability of the Northern Territory Government to look after the health of its people. This led to urgent meetings with the NT government, including with the Chief Minister.

It was soon after this that the Federal Government's Intervention rolled into the territory, vindicating AMA concerns. The merits or otherwise of the Intervention are still being debated.

We also questioned the Work Choices legislation and the veracity of the heart tick, when a high calorie food manufacturer was granted a tick to a few products leading to a halo effect on its other products

Politically, supporting the private health sector and promoting informed financial consent successfully kept new legislation at bay. The Medicare system's many changes – including changes to care planning and nurse rebates – and the addressing of the burgeoning medical school training posts and the surge in unfunded bonded medical student places were tackled. So too was the poor access to medical services in rural, regional and remote Australia. The AMA also confronted the dastardly spectre of medical racism, which involved taunting of international medical graduates after well-publicised cases of poor medical practice around the country.

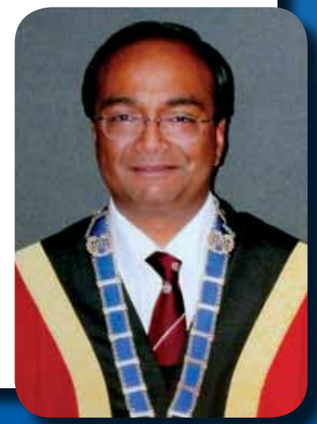
The AMA's serious incursion into e-Health began with its National e-Health Conference in Old Parliament House, progressing e-Health in general practice with the Practice Incentives Program incentives (among other enhancements), and an analysis of the readiness of specialists for e-Health. The use of new technology for using the services of Medicare was progressed, but the ill-fated Access Card was laid to rest as the parameters around it became unacceptable.

My trajectory since the Presidency has been, in my opinion, directly due to my roles with the AMA at state and federal levels. The prestige and high regard given to the AMA as the peak membership driven organisation representing the breadth of the medical profession – albeit sometimes begrudging and fearful – was absolutely instrumental in my various appointments post-Presidency.

The accompanying kinship, friendship, support and respect afforded me is not something I would ever take lightly.

I feel I have been very fortunate to have the opportunity and the confidence of my peers to represent them and to promote their agendas and the best interests of the profession and the Australian people.

It was an honour to lead the AMA.



Dr Mukesh Haikerwal: AMA President 2005-07

Shepherd responded in a letter (to the Prime Minister but also circulated to all Coalition MPs) that "if you are content with the accelerated removal of a profession's independence under your regime, a profession whose abilities and ethics you and your family will need at some time in your lives, so be it". It was shortly after this that Dr Brand was elected President with a policy that the AMA could do better with less confrontation. It was not long before the forces for and against this policy hurtled into battle. Dr Shepherd's forces believed that engagement with government led to surrender to government; Dr Brand's believed that engagement got results. The argument dogged almost the entire Brand Presidency.

An early battle was joined between those (the Brand school of thought) who supported the AMA's agreement with the Government over no-gap health insurance and those (the Shepherd school) who believed that no-gap insurance would result in high premiums and reduced health insurance cover. The two points of view came to an especially virulent clash over a draft Memorandum of Understanding in 1999 between the AMA and the Government in which the Government would allow fees for medical services to rise a certain amount over a certain period in return for the AMA's agreement that outlays on Medicare rebates would be held to certain levels. The idea had aroused strong opposition among members all over the country. The Brand forces argued that the AMA had not actually accepted the MOU but decided only that it was serious enough to be put to members. The Shepherd forces asserted that the AMA had indeed accepted the MOU and had decided to put it to members only after being shaken up by members' protests about it. In Western Australia, there was even talk of secession if Dr Brand continued as Federal President, and the Branch Council there resolved that, if the Federal AMA signed off on the MOU, it would, in the words of the then WA Branch President Dr Rosanna Capolingua in a radio interview, "have to reconsider our relationship with the Federal AMA".

The controversy had grown to the point that the Shepherd forces produced enough members' votes to force an Extraordinary General Meeting in June to debate a motion of no confidence in Dr Brand. The motion was carried, by about 54 per cent of a little more than 9,000 votes. But Dr Brand, who had recently been easily re-elected by National Conference, refused to resign. Executive Council called another EGM in August, this time to debate its own motion for a spill of all Executive Council positions. Dr Shepherd organised his own ticket for all Executive Council positions but Dr Brand and his Council colleagues were returned. The Shepherd forces had been gazumped. Some senior figures in the AMA (not necessarily Shepherd supporters) said later that Dr Brand should have resigned after the first EGM. Dr Brand told the ABC after the second EGM that he had thought "very long and very hard" about resigning alone after the first EGM. But, "even if I resigned, [Vice President Dr Sandra Hacker] would become President and Dr Shepherd said that wouldn't stop him. He wanted to get rid of all of us, so that was why the Executive in the end said 'well, look, it's one in or all in . . . it's either all of us to chart a course for the AMA that will take us into the future or it's back to the past with Dr Shepherd'."

It is not clear what this episode proved. Dr Shepherd's argument prevailed heavily in one EGM and lost heavily in another. Dr Kerryn Phelps from the Shepherd side of the argument was elected President in 2000 to succeed Dr Brand. Under Dr Brand, AMA membership levels were increased. Before it was over, AMA members had resoundingly rejected the draft MOU proposal and the AMA had announced that it would not sign it. The AMA could now get down to preparing to deal with some really serious threats heading its way.

The controversy had grown to the point that the Shepherd forces produced enough members' votes to force an Extraordinary General Meeting in June to debate a motion of no confidence in Dr Brand.

INTO THE 21ST CENTURY

NATIONAL INFLUENCE

In the first 10 years of the new century, Australia had four federal elections. It can safely be said that federal elections will generate policy as well as political upheavals, a kind of rapids to be negotiated by organisations such as the AMA concerned to see consistent standards in areas in which they are interested at least maintained, if not improved. This was certainly the case for health policy, especially in the case of the third of the four elections, that in 2007, when a new government came into office with a strong ambition to reform the entire system. So the new era was going to be a testing time for the AMA as it approached its 50th anniversary. It was fortunate, therefore, that it had undergone a reform process of its own since the reorganisation of the late 1980s.

By the time Dr Kerryn Phelps had succeeded Dr Brand as Federal President, health policy and practice had become central national issues, and the AMA had evolved into a truly national organisation, ready for involvement not just in the great medico-political questions of the day, as it had for a long time, but also now ready for involvement in new, pressing and complex health issues that could not have been anticipated even as late as 1962. The AMA's ability to carry out this wider role came about very largely from reorganisation and the consequent reform of the Federal Council committee and Federal Secretariat structures to reflect both the changes in health policy and recognition of its wider ramifications. By 2000, the AMA was more than just one of many lobby groups agitating in Canberra for a limited range of interests or a group of professionals who coped with, or managed, or cleaned up after broader health issues devised by others. It was now an accepted part of planning and helping develop the policies and programs that would deal with these issues and defend and advance the society's health.

On Indigenous health, for instance, the AMA had followed up its internal changes with informing public debate with two position statements - on strategies to prevent chronic disease and on the links between health and education – and began its annual Indigenous Health Report Card series. Following its creation of an IT Expert Group within the AMA to consider advances and advantages in e-Health, it was represented on the National Health Information Management Advisory Council and was involved in developing good e-Health practice through the Better Medication Management System. On immigration, it had joined the medical colleges in putting a submission to a Human Rights and Equal Opportunity Commission inquiry into the conditions of children in detention. Quite early in Dr Phelps' time, the AMA released a position statement on sexual diversity and convened influential national summits on environmental health and drug abuse, especially use of party drugs by young people. With Access Economics, it developed the GP Workforce Survey that demonstrated a severe shortage of doctors, especially in rural and outer metropolitan areas, against the Government's continued contention that there was no shortage but only a maldistribution of doctors. This was a

position that the AMA interpreted as a threat to the quality of the system (and one that was contradicted later by the Productivity Commission, the Australian Bureau of Statistics and the Australian Institute of Health and Welfare). Significantly, it broadened its spread of contacts with government: not just the health ministers and departments but also with other ministers and other portfolios, with government and non-government members of Parliamentary committees and other backbenchers with an interest in health policy.

The AMA also pulled off some significant coups early on in the new century in influencing government policy and legislation on health. An instance was the *Health Legislation (Gap Cover Schemes) Act,* which was passed with the support and advice of the AMA and which more or less saw off any threat of a resurgence of managed care via the Lawrence contracts. Another was the AMA's role in encouraging and promoting the Government's Lifetime Health Cover scheme. All the problems of the old era had not yet been seen off, however.

Dr Phelps came into office with much unfinished business to sort out: restoring peace after the three previous tumultuous years, establishing her view of relations with a government that, in the view of influential members and supporters, sought to control doctors, implementing the RVS and, most urgently of all, dealing with the medical indemnity problem, which had become serious.

Aside from all this, one of her earliest objectives was to update the committee structure to what Federal Council considered to be the AMA's priorities. This was when the Indigenous Health Task Force and Complementary Medicine Committee were formed, and the committees dealing with public health, aged care, medical economics and medical workforce were strengthened. To improve communications between the federal and state levels of the association, she instituted regular teleconferences with branch presidents and CEOs to coincide with meetings of the executive. "In advocating AMA objectives," she said in her first presidential Message in 2000, "our strategy has been to give the Government credit where credit is due on health policy, but to speak out when we believe that doctors, patients and the overall healthcare system have been let down." It was not long before the AMA felt that it needed to speak out.

RELATIVE VALUE STUDY

The Relative Value Study, conducted by AMA and government members of the MSRB, had been completed and the MSRB had handed its report to the Government and the AMA in December 2000. The AMA saw the result as providing a realistic picture of the cost structure on which fees should be adjusted. It recognised that several details had to be sorted out before implementation, but it expressed its strong expectation to Minister Wooldridge that implementation would be settled in the 2001-02 Budget and the results of the survey in operation by November 2001 – round about the expected date of the next federal election. The 2000 Annual Report commented that successful implementation "will be a necessary commitment for any political party wishing to claim a commitment to Medicare

in the coming election". The election took place early in November and the Howard Government was returned. Senator Kay Patterson was appointed Minister for Health in place of Dr Wooldridge, who had retired and whose relationship with the AMA President had been notoriously fraught until what Dr Phelps called "a delicate détente" had been reached towards the end of Dr Wooldridge's tenure. But the return of the Government and the appointment as Minister of somebody other than Dr Wooldridge were no help, as far as they concerned the RVS. Instead of moving on its implementation, the Budget ignored it, choosing instead "to put money into a number of disease-specific items in general practice," in Dr Phelps' words, "which may well involve more red tape than benefit and have the potential to fragment patient care." At this point, after nearly seven years of work by the AMA, the RVS – which had never really been high on the Government's list of priorities – seems to have disappeared off the Government's radar, and the AMA Economic and Workforce Committee started looking at alternative ways to update the MBS, "as well as making appropriate adjustments to the AMA's own List of Medical Services and Fees".

MEDICAL INDEMNITY

Medical indemnity was an even bigger problem, arguably the most difficult that the AMA had ever had to deal with. Its solution had to be extruded from the Government very slowly and often painfully. Over more than 10 years, though it almost certainly had the odd Ministerial file on it and probably its own inter-departmental committee, the problem had been meandering along with no apparent timetable or sense of priority. Back in 1991, the then Labor Government had flicked the problem to a Professional Indemnity Review (or PIR, as it became known throughout a long life) "to examine the current arrangements relating to professional indemnity and current experience with compensation for medical misadventure". PIR took four years to come back with a final report that offered very little in the way of practical solutions but an enormous number of ideas for identifying more areas to be investigated. There PIR rested – a huge disappointment to the AMA.

For years, members had been expressing alarm and despondency at the mischief that the problem was wreaking on medical practice and the AMA had been warning the Government about it. By 1995, "in response to growing concerns … at the direction legal decisions affecting the profession were taking", as the Annual Report said, an AMA Ad Hoc Medico-Legal Committee had been set up to advise Federal Council on ways to press resolution of the matter. The AMA formed the view that resolution should come in two ways: reform of state tort law to provide short- to medium-term relief and, for the longer term, amendments to federal tax law that would allow structured settlements instead of the usual lump sum payments. The effect of the amendments would be that injured patients could receive compensation in stages, thus providing patients with regular incomes over the periods in which their injuries could be cured.

Finally, in 2000 and into 2001, the Government had to pay attention when the problem went critical. United Medical Protection (UMP) and its subsidiary Australian Medical Insurance Ltd (AMIL) issued a call-up of members in November 2000 equal to a full year's premium plus a general increase in its premiums of 8 per cent. At the time, UMP was Australia's largest medical defence organisation (MDO), covering about 60 per cent of doctors nationally and about 90 per cent of doctors in New South Wales and Queensland.

In February 2001, a chink of light appeared when the NSW Government agreed to amendments to tort law and caps on compensation payouts in some areas of practice. It also included a proposal that professional indemnity insurance should be compulsory for medical practitioners. The NSW Government produced its reform legislation in June. The AMA welcomed this first sign that its concerns were registering at government level. But it was unhappy about the compulsory nature of the scheme, which Dr Phelps said would effectively give insurers greater power to disqualify doctors than the NSW Medical Board had, and which could make practice non-viable for doctors working part-time or nearing retirement. No other state government showed any sign of similar interest and, on the national level, a solution was a long way off.

Federal President Dr Kerryn Phelps and Vice President Dr Trevor Mudge meet Prime Minister John Howard

In March 2001, the broad Australian insurance industry, including medical indemnity insurance, was badly shaken up when HIH Insurance, one of Australia's largest insurers, sought voluntary liquidation. Later in the year, it was reported that UMP had not recorded about $455 million of incurred but not reported (IBNR) claims which it expected to pay over the next years. (IBNRs result from the long period that can occur between when an injury happens and when an MDO receives a claim for it, the effect being that MDOs cannot assess what funds they will need to hold in reserve to meet these claims.).

Meanwhile, a consultancy report was being prepared for the Australian Health Ministers Advisory Council (AHMAC) that showed that "the difficulties faced by UMP were of a kind which may well have been identified and acted on earlier if there were a regulatory regime in place". IBNRs were a particular problem. The report would be released early in 2000. A significant part of the problem was of the Government's own making. It could not look the other way now. On 19 December 2000, the Prime Minister announced that a summit would be held early in the new year to seek solutions to the crisis.

Dr Phelps put a plan to that summit, which took place in April, that included a commitment by doctors to safety and quality programs to minimise claims in return for which the Commonwealth would support MDOs, ensure that Medicare rebates reflected actual costs and set up a national "community-funded" scheme to care for and rehabilitate injured patients. The plan called on the other jurisdictions to carry out legal reforms and deal with "the activities of contingency fee lawyers". Senator Coonan confirmed that the Commonwealth would amend tax legislation when the Parliament met in the winter to make structured settlements "more attractive and available", but she said that tort law reform was a matter for state and territory governments.

Unhappily, on the same day as the summit, the media reported that the Government had rejected a request from UMP for more assistance for AMIL so that it could continue providing insurance cover. Six days after the summit, UMP applied for provisional liquidation. Dr Phelps met Senator Coonan and advisers to the Prime Minister on the following day, 30 April. It was agreed (among other things) that the Commonwealth would give priority to developing the care and rehabilitation scheme that the AMA had proposed, that in consultation with the AMA it would draw up and (before the end of June) introduce legislation to guarantee the security of claims incurred between 29 April and 30 June, and that the outstanding issue of IBNRs would be dealt with "at the earliest opportunity".

On 31 May, the Prime Minister offered to extend the UMP/AMIL guarantee to the end of 2003. He called on state and territory governments to continue tort and legal system reform and to maintain indemnities for doctors in public hospitals and in rural areas. He said that MDOs would be brought into a new regulatory framework administered by Australian Prudential Regulation Authority. The Australian Competition and Consumer Commission would monitor premiums to determine whether or not they were actuarially and commercially justified. The Government would fund IBNR liabilities.

The AMA's immediate reaction was that there were still plenty of unanswered questions about the detail in the package, which was incomplete in any case without law reforms by the states. Bringing MDOs into the regulatory framework for general insurers meant that doctors would be able to buy only 'capped' cover, which would expose them to amounts granted by courts over the cap – the so-called 'blue sky' amounts. The AMA was particularly wary about the levy. In October, the Government added extras to its May rescue package. Among other things, it offered to set up a scheme to fund IBNRs that were currently unfunded. This would be financed by the levy on doctors in MDOs with unfunded IBNRs. The AMA welcomed all this, but it still insisted that it would not even discuss the levy until this reform had been implemented.

It was now mid-December. The Federal Parliament had passed the legislation to enable the structured settlements proposal but half of the doctors in Australia had to renew their indemnity insurance by 1 January, and no progress had been made on important elements of the rescue package. And the AMA still had another particular concern: that retired or disabled doctors might have to pay premiums for years after they had left practice to cover incidents that might not attract claims for years into the future. It was impossible for doctors to estimate or buy insurance for such claims, Dr Phelps said. The Government was unmoved, but the AMA continued its public campaign into 2003. In March, the Prime Minister came back with adjustments to the Government's October rescue package, following "further consultations with relevant stakeholders".

The changes included a pledge to extend its guarantee to prop up UMP/AMIL until the end of 2003. It would pick up 50 per cent of the costs over $2 million for long-term care. It would raise prudential and disclosure standards for MDOs to those governing general insurers with effect from 1 July. *The Medical Indemnity (Prudential Supervision and Product Standards) Bill* would provide that minimum levels of retirement cover were available and the Government would commission a study of options to examine the retirement issue further, in consultation with the AMA and MDOs. The AMA was pleased, but hardly overjoyed. The package still left doctors in a precarious position, especially because of the rare but inevitable threat of 'blue sky' claims. It organised a rally in Sydney early in April at which doctors would protest about "the uncertainty surrounding the medical indemnity and their careers". This was the first such reaction to what Dr Bill Glasson, who had succeeded Dr Phelps as Federal President, called "the roller-coaster ride that is medical indemnity". It would not be the last.

Towards the end of May, the Government had another crack at completing its rescue package, in particular dealing with the 'blue sky' problem. It involved a scheme to assume liability for 100 per cent of any damages payable against a doctor that exceeded a specific level of cover by the doctor's indemnity provider. The Prime Minister said that rapid progress by the states and territories on tort law reform and in developing "effective damages regimes" would reduce the likelihood that the scheme would be needed. The Government would review the scheme after three years and it would also closely monitor progress on tort law reform by the states and territories. Dr Phelps welcomed the extra commitment, which had come after "a very long, tortuous, complicated but ultimately . . . very rewarding process". Two issues remained: the national medical accident scheme and the levy.

The reformed rescue package came into effect in July 2003, but it was still a mess. Premiums were still rising beyond the ability of many doctors to afford them. The levy remained a special problem. It had been legislated for but would not come into effect until November, but it was already creating great uncertainty: a tax that would be imposed on some doctors but not on others; that discriminated against doctors in new practice and doctors leaving practice. The legal reforms that would reduce its uncertainty were still not in place. So, early in July, the AMA Medical Professional Indemnity Task Force formally withdrew any AMA support for it. The Government made some changes to it soon afterwards to reduce its effect on retiring doctors but the AMA still opposed what it started to call Patterson's Curse (after the Health Minister), both because of its surviving discrimination and the effects it was going to have on healthcare costs. At

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The long-term viability of the medical indemnity scheme was still a cause of concern, but the immediate crisis was solved.

a meeting early in September with the AMA, the Prime Minister agreed (in the words of Dr Glasson, the new Federal President) "to look at specific strategies that were raised to see whether we can move forward . . . as quickly as possible". Further meetings held soon afterwards with Ministers Patterson and Coonan were followed almost immediately by the Health Insurance Commission issuing levy demands on doctors. The reaction of the AMA and members was furious: huge rallies in Sydney and Brisbane, write-in campaigns to MPs and (with the 2004 election in sight) in marginal electorates. Two weeks later, Senator Patterson had been moved on, to be replaced by Mr Tony Abbott.

Medical indemnity: Federal President Bill Glasson presses the AMA view on new Health Minister Tony Abbott

Three days after that, on 10 October, Mr Abbott and the AMA had produced a plan to bring an end to the crisis. The levy demands would be withdrawn. Any levy payments would be refunded. Doctors leaving or planning to leave their practices would continue working. Mr Abbott would chair a policy review group, which would include Senator Coonan, two doctors and two insurance experts. The group would report to the Prime Minister in December. Among other elements in the plan, exemptions from any levy were given to doctors aged 65 and over (regardless of practice income), doctors who needed to retire early because of disability and doctors working in public hospitals. The long-term viability of the medical indemnity scheme was still a cause of concern, but the immediate crisis was solved. Early in November, legislation was introduced to give effect to the plan. The Government, having received the policy review report, agreed to a package of measures in December that included caps on premiums and the levy. It did not quite meet all that the AMA had requested (or, according to reports, what Mr Abbott had proposed) but the AMA judged that it would provide certainty, security and affordability to allow doctors to continue working. The Government gave the package 18 months to prove itself. Dr Glasson said that the AMA would go along with that, so that any shortcomings could be dealt with. With that, the 15-year saga came to an end.

PROTECTING THE PBS

Meanwhile, problems never coming in singles, there was the PBS to be protected from moves to create a US-Australia trade agreement. This difficulty had arisen early in Dr Phelp's tenure when Prime Minister Howard and President Bush agreed to negotiations on a bilateral free trade agreement. Apart from other arising from this idea, a long-standing hostility to the PBS by US pharmaceutical companies meant that it would inevitably be a central factor in the negotiations. Negotiations would take the best part of four years, but the AMA realised straight away that an agreement would have its impact on health, and particularly medicines. It became alarmed (though not surprised) when the PBS was indeed being targeted early on in the negotiations, partly because the US position aggressively supported the argument by US pharmaceuticals: eg, that the scheme unfairly depressed the returns from their investment in research and development, and that it represented some kind of threat to their intellectual property rights. Negotiations continued until final agreement was reached late in 2003. The AMA's alarm was justified. The agreement included extensive clauses regulating the operation of the PBS, a right of appeal against Pharmaceutical Benefits Advisory Committee (PBAC) decisions, and more protection for the drug companies' patents.

This was not acceptable to the AMA. It had been campaigning strongly against any limitation on the PBS, warning that it would mean that Australian patients could end up paying at least twice as much for medicines. Making the PBS subject to the agreement, it said, would undermine its ability to negotiate lower prices for Australian patients than those operating in the US. The agreement – understandably, because it so suited US interests - was ratified by the US Congress with huge majorities. In Australia, on the other hand, it had aroused great controversy, thanks in part to the AMA campaign. So, in the treaty ratified in the Australian Parliament late in 2003, appeal against PBAC decisions had been watered down to review only. The Australian legislation also prevented abuse of patent law through a device known as "ever-greening" that allowed the drug companies to make trivial and meaningless modifications to drugs under patent so as to extend the effective life of the patents. The US Government was not happy and, for a while, refused to certify the Australian legislation, which was necessary for the agreement to begin to operate. The agreement finally came into force in January 2005, its form to a significant extent shaped by the AMA campaign to protect the PBS.

A FAIRER MEDICARE?

Not long after Dr Bill Glasson had succeeded Dr Phelps in 2003, bulk-billing had declined to about 66 per cent from its 1997 peak of about 80 per cent. The Government therefore introduced a $900 million Fairer Medicare package, which (among other things) provided incentives to GPs to bulk-bill, and a range of so-called safety net measures that covered patients' out-of-pocket costs over a certain amount. The response was not good, including that by the AMA, and the package was sent off to a Senate committee. The committee was not impressed either, describing the package as "a decisive step away from the principle of universality that has underpinned Medicare since its inception". So, with a 2004 election in sight, the Government had to find a Plan B: Medicare Plus. This package (at a cost of $2.85 billion) retained bulk-billing incentives but expanded the safety net concessions, added a dental plan for people with chronic or complex health conditions, and provided new medical school places in rural and remote areas. Though the AMA thought that Medicare Plus meant "a more complex Medicare and more red tape for doctors" and said that it was still concerned about the

Government's "focus on bulk-billing as a cure for the ills of the health system", the new package – "a positive second-best option" – was slightly more acceptable, it said, and called on the Parliament to pass the enabling legislation. Meanwhile, the medical indemnity issue continued to bubble along, dominating the AMA's agenda in 2002 and into 2003.

THE RUDD REFORMS

When regimes change, health systems tend to change – or, at least, attempts are made at system change. For the AMA, this has been one of its most frustrating occupational hazards. Over its 50 years, the AMA and its members have had to face this problem six times. So, late in 2007, when the Howard Government gave way to that of Kevin Rudd, the AMA prepared to knuckle down once more.

A major concern at the time of this regime change was the consequences for the hospital system of the failures and inconsistencies over the years of the funding arrangements between the Commonwealth and the states. The Rudd health policies for the election campaign dwelt to a large extent on this problem. They included a formula that would swing the bulk of the responsibility for funding public hospitals on to the Commonwealth (subject, among other things, to the states accepting some serious ifs and buts involving taxation arrangements) that, if it worked, could begin to tackle a serious and growing shortage of hospital beds. But the Rudd proposals also included other ideas that, if they too worked, contained the potential to cause difficulties for the operations and prospects of

AMA members, especially GPs. This was at a time when, though there was strong growth in the number of specialists and trainee specialists, the supply of full-time practising GPs was in decline, according to *Medical labour force*, a contemporary report by the Australian Institute of Health and Welfare.

One such proposal was for 36 GP Super Clinics around the country, which the new Government considered would improve access to, and coverage of, community healthcare by providing under the one roof a multidisciplinary team comprising GPs, nurses and other allied health professionals. The AMA was pessimistic, advocating in a submission to the Government that GPs should not be displaced by the clinics, that the clinics should be located where they were genuinely needed, that they should operate strictly according to clinical need and that the multidisciplinary teams should be led and coordinated by GPs. Meeting these conditions seems not to have been easy, which may well have contributed to the fact that, between the onset of the scheme and when the AMA celebrated its 50th anniversary four years later, barely three quarters of the clinics planned were operating or being established.

Nevertheless, at the onset of Rudd rule, some signs, as the AMA saw them, were fairly positive. The AMA was encouraged early in 2008 when the new Government set up (among a large number of other policy reviews) a National Health and Hospitals Reform Commission to "develop a long-term health reform plan for a modern Australia". It was especially pleased that former Federal President Dr Mukesh Haikerwal was a Commission member, which (the then Federal President Rosanna Capolingua said) was an acknowledgment of the AMA's "unique ability to provide advice across all aspects of health". The Commission was asked to bring down an interim report by the end of 2008 and a final plan in mid-2009, which would provide a blueprint for tackling challenges to the system, "including the rapidly increasing burden of chronic disease, the ageing of the population, rising health costs and inefficiencies exacerbated by cost-shifting and the blame game". This looked more promising, and the AMA welcomed it, pledging to support the Commission "in its efforts to build a modern, responsive, affordable and equitable health system to meet the needs of all Australians, no matter their means and no matter where they live". The AMA's sixth health system change was on its way. Before the Commission could produce its long-term reform plan, though, the Government had to get on with dealing with its immediate problems in healthcare delivery, and the first sign of what it had in mind would come in the first Rudd Budget.

The AMA's immediate reaction to this Budget was relief that it had not imposed major expenditure cuts on health and that many of the issues on which it had campaigned had been supported: Indigenous health, preventive measures for diseases such as cancer and investment in the public hospital system. A few days later, after closer analysis, the AMA's response was not so benign. The detail of the Budget showed that it had taken the razor to a number of programs that supported GPs so that it could find about $170 million to pay for the GP Super Clinic scheme, Dr Capolingua said. The AMA said that the Budget had provided barely more than half the number of GP training places that the Australian Medical Workforce Advisory Committee had recommended. It had failed to increase the indexation of the Medicare patient rebate so that it could keep pace with the cost of care. Its proposal to increase the Medicare levy surcharge would precipitate an exodus of young healthy people from the funds, which would then result in 5 per cent increases in premiums. This decision would start "a vicious cycle of unaffordable private health insurance".

About a month later, in June 2008, the Government released *Towards a National Primary Healthcare Strategy*, a discussion paper on "a wide range of issues associated with . . . current planning, delivery, governance and financing" of primary care. It set up an External

Federal President Dr Mukesh Haikerwal, Federal President 2005-07

STANDING UP FOR THE PROFESSION

Becoming Federal President of the AMA was never a specific goal in my life, but rather an evolution of passion and commitment.

As leader of the AMA, you are able to serve your profession and patients across the spectrum. As President, you are the servant and your master is high quality, equitable, clinical care for Australians, ensuring that the medical profession can practice its craft with responsibility and clinical independence.

It is a role that should always be observed with humility. It is a role that represents the entire profession and must not be affected by vested interests. It is a role that should be underpinned by patient care as a priority, utilising tax dollars efficiently and effectively for healthcare delivery.

My Presidency commenced in 2007 with the secretary general's position vacant and a federal election five months away. It was like being chair of the board of a major company facing a critical time in business, with no chief executive officer. The AMA relies on the intellect, ability and hard work of good staff, and the overwhelming voluntary contribution of colleagues. On these shoulders we were able to continue to do business, but it was an additional challenge.

During the election lead up, the AMA made health a pivotal issue and it was a hot contest between a government facing loss and an opposition striving for power. That election and the change of government was an exciting time to be a federal president. Many current issues are a legacy of policy proposals debated then, and the AMA's ability to influence is essential for better outcomes.

A good example is a headline story in *The Australian* on 5 March 2012 when the new health minister allowed up to 10 'health professionals' prescribing rights under the Australian Health Practitioners Regulation Agency (AHPRA) workforce improvements. This ongoing 'deregulation' of quality healthcare for Australians was borne out of the concept of national registration.

Initiated by the Howard government, this legacy is based on lowest common denominator ideologies rather than recognition of the requirement for training, standards, and complexity of skills to deliver optimal care based on expertise. We continue to suffer the afflictions of AHPRA on medical practice and care.

During my term as President, we finally enlightened then health minister, Tony Abbott, and subsequently the prime minister, that this national registration model was convoluted, bureaucratic and expensive. The AMA was instrumental in stopping John Howard from signing the intergovernmental agreement.

There was an interval pause for some sense to be applied but, with a change in government, Kevin Rudd hurriedly went ahead. Many have experienced the inefficiencies and costs of this system of registration, and the ongoing repercussions to the medical profession. More importantly, our patients are being shortchanged with attempts to con them into accepting that 'medicine', while 'diagnosis', 'prescribing', 'clinical management' and 'investigation' can be delivered by a range of health professionals to the same intellectual ability and safety as a doctor.

At election time, the AMA had to hold the parties accountable with regards to bed shortages, emergency department overload, hospital occupancy, cost shifting, health funding, general practice infrastructure, rural health services, Medicare, training, public–private split and, of course, party ideology.

Misdirected drivers to pork barrel electorates with Super Clinics; babies put at risk with a push for home births that made mothers feel inadequate if they chose a hospital; the 'buck stops with me' and Nicola Roxon's 2008 Ben Chifley Memorial Light on the Hill speech, as health minister – these were all at play during my 2007–09 Presidency.

In the 2012 Labor leadership battle, Roxon's references to Kevin Rudd, which – according to *The Australian* – "revealed the depth of this shambolic policy-making" in health, were an insight into those times.

We have an AMA for a reason. We must never assume that government policy should not be questioned, challenged and informed by service providers at the coalface who understand what is needed and what can be responsibly and sensibly provided.

So, in my Presidency, to be constantly analysing and questioning, to be putting forward alternative, more effective and efficient solutions, and to be pushing hard against the juggernaut of a confident new government bureaucracy, was energising. Bringing together our colleagues across colleges and craft groups was important. We achieved this across the medical profession, and even across the allied health providers on the issue of the AHPRA model.

Federal Presidency is a learning curve across all issues. The big picture is as important as attention to detail. You need to be able to stand in the face of attack, and stand on principle for the profession, not for yourself. The reward is the experience and the privilege.

Dr Rosanna Capolingua: AMA President 2007-09

Reference Group of health experts who would develop the strategy and present it to the Government by the middle of 2009. The paper echoed the proposal made in a Productivity Commission report on the health workforce two years earlier that doctors should move over and let some of their role be carried out by other health professionals. The discussion paper emphasised that allied health professionals such as nurse practitioners and pharmacists were increasingly important in multi-disciplinary primary care teams, and that some health professionals might already be providing some aspects of care that "could be delivered equally effectively by another health professional". The AMA could see where this was heading and reacted badly. This was a backward step, it said. Nurses and other health providers were skilled and respected in their role of assisting patient care "but, in terms of comprehensive primary care, they are most effective for patients while under medical supervision". And the AMA questioned how the Government intended to maintain high-quality patient care "while diverting patients from seeing doctors". The attack continued a week later, when the AMA organised a statement signed by the Presidents of the AMA, the Royal College of General Practitioners, the Rural Doctors Association of Australia and the Australian College of Rural and Remote Medicine that was critical of the view expressed by the discussion paper: "Medical competency, diagnosis and management and effective team-based care were the foundation of best practice and safe primary care," the statement said, and this care was best delivered "under medical supervision with assistance from other trained health service providers".

At about the same time, the AMA issued more formal statements that dissented from the Government's "restrictive policy framework". One renewed the AMA's attitude towards GP Super Clinics, calling for the Government to dump the idea and work with the AMA instead on other "broad measures" that would improve access by patients to GPs. Another urged the Government "to address the policy inertia that continues to restrict medical services for the sick and frail residents of aged care homes". By now it was clear that the early neutrality between the AMA and the new Government had disappeared. There might be elements in the Government's health reform policy about which the AMA was not too unhappy and it might be prepared to coexist with the policy, if not embrace it, but it had come to the view that the reform package as a whole at best did not benefit eeither patients or its members.

Over the next few years, as more of the package unfolded, this view hardened. Many AMA members would see the Rudd proposals as arguably the most difficult – and most foolhardy – of the six reform challenges that the AMA has faced. Indeed, by the time that she reported to members in the 2008 Annual Report, Dr Capolingua had dropped the niceties, referring to a reform agenda that contained "a grab bag of proven failures as the principal policy options", including models from the National Health Service "that have failed generations of patients in the UK and other options that have seen the provision of healthcare in the United States increasingly become the domain of big business instead of care givers. "The bureaucratisation of health in Australia is building a faceless future," she said, "where patients are numbers and the family GP – the person generations of families have turned to in good times and bad – becomes a thing of the past." The AMA was no longer making nice with the Rudd Government. It is hard to imagine a worse moment than this for a long-dormant proposal for a national registration scheme for all health professionals to re-emerge.

Dr Rosanna Capolingua, Federal President 2007-09

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NATIONAL REGISTRATION AND ACCREDITATION

The AMA did not oppose the principle of a national, as distinct from state-based, system of registering medical professionals. In fact, it supported it. What it complained about was that so much of the influence on standards would be exerted by bureaucrats – people who in the AMA's view would not know the difference between a speculum and a sphygmomanometer.

A national registration system had been considered in 2001 by federal and state health ministers and then deferred at the request of the AMA. It had argued that, though it supported the principle, the version that the Ministers were considering had massive deficiencies, not the least of them being that it proposed loading bureaucratic requirements on to doctors without improving patient safety. The matter seemed to have ended there. But, in 2006, the Productivity Commission (which had been asked to report generally on health workforce issues) resurrected the idea and proposed ways to do it that were accepted later in the year by Council of Australian Governments (COAG).

The Commission had proposed a single national registration and accreditation system (NRAS) in which a national accreditation board (whose membership would "reflect the public interest generally rather than represent the interests of particular stakeholders") would police standards and a single national registration board would handle registration to practise. COAG preferred a slightly different version: a single cross-profession national registration board, primarily to manage policing and disciplinary matters, which would be set up in 2008 in parallel with a national accreditation system. It would apply to the nine occupational groups that were already subject to statutory registration: the medical, dental and nursing/midwifery professions, optometry, osteopathy, pharmacy, physiotherapy and psychology. COAG did accept the Commission's proposal, though, that membership of the accreditation board should be "structured to reflect the public interest generally rather than represent the interests of particular stakeholders", and it directed "senior officials" to oversee implementation "in consultation with relevant stakeholders" and report back to COAG by the end of 2006. Template enabling legislation would be developed by the Queensland Government.

The AMA was severely critical of NRAS. It supported national accreditation and registration systems for doctors, Federal President Dr Mukesh Haikerwal said, "but we are opposed to systems that bundle doctors in with everybody else under the heading of 'health professionals', but that's what COAG has done. It would be a world first in health to have a brand new huge bureaucracy that has a positive impact in delivering quality healthcare. This is dumbing down and de-medicalising the health system and it erodes quality." The Government was heading for an extremely difficult election; an angry and threatened health workforce was the last thing it needed. The AMA persuaded Prime Minister Howard that NRAS should be deferred.

Early in 2008, COAG presented some significant goodies to the health system, for which the AMA had been agitating: an immediate $1 billion allocation to public hospitals, for example, and agreement that the Australian Health Agreement funding formula – which had been the cause of sustained game-blaming, leading to the States having to assume a greater share of funding – should move "to a proper long-term share of Commonwealth funding for public hospitals". But it also gave life back to NRAS, with all its bureaucratic superstructure and oversight that the AMA had fought two years before. The AMA was outraged: NRAS would "empower Ministers to decide on the accreditation of training for health professionals", Dr Capolingua said, and on "what is required to become a doctor, a dentist or a nurse". As the details of the scheme became clearer, through the progress of the enabling legislation and a series of discussion papers and other publications by COAG, the AMA put forward seven formal submissions on the scheme. It organised a consciousness-raising campaign among allied professions about the deficiencies of the scheme. The Government persisted, however, and the *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* enabled NRAS to start operating in 2008. By then, other fields of battle were opening up and relations were turning decidedly sour between the Rudd Government and the AMA over other elements of health policy.

When the Government drew up its infrastructure stimulus package to deal with the global financial crisis of 2007-09, the AMA attacked its "inexplicable exclusion" of health. This "singular failure of government", as Dr Capolingua described it, ignored the potential of the sector for providing "the same immediate benefits to the economy as other infrastructure projects, stimulating employment and supporting business but with the added bonus of expanding the nation's capacity to deal with tough new economic circumstances".

Battle was joined again when the AMA fought "another piece of bureaucratically-driven" legislation *(the Health Insurance Amendment (Compliance) Bill)*, which enabled the Increased MBS Compliance Audits Initiative announced in the 2008-09 Budget, which (among other things) increased penalties on doctors for incorrect Medicare billing and permitted Medicare to expand its audit program by giving it access to medical records so as to verify billing by doctors. A formal submission to a Senate committee on the Bill explained the AMA's fundamental concerns about how the proposal would compromise "the central ethic in medical practice which preserves the privacy of the doctor-patient relationship" and the unnecessary additional

Federal President Dr Andrew Pesce meets Prime Minister Kevin Rudd

red tape it would impose on doctors. In her statement to the committee when introducing the AMA submission, Dr Capolingua said that the Bill sought "to strip patients of their privacy on a whim" through what was no more than a fishing expedition, "a huge expensive net being dragged through the profession but, more importantly, through the intimate details of our patients, in the hope that it will dredge up some mistakes and, fingers crossed, perhaps a few real areas of concern". At the annual AMA Parliamentary Dinner, she told the politicians and bureaucrats who were there that she stood with doctors who said that they would go to jail rather than divulge personal patient information, which was what Medicare was demanding.

WINNING SOME, LOSING SOME

When Dr Andrew Pesce succeeded Dr Capolingua as President in mid-2009, it was clear that he wanted to exchange hostilities for consultation, telling the AMA journal *Australian Medicine* that he thought that the profession was not comfortable with the notion that the AMA was always at war with the Government. In his first Presidential Message in the 2009 Annual Report, he pointed out that the organisation that Dr Capolingua, had handed over had become "the most powerful and respected lobby group in the country" and he acknowledged her work that had "significantly improved" NRAS. But he had campaigned for the leadership of the AMA on a platform of engagement, he said, "engagement with our members, engagement with the broader medical profession and the other health professions, engagement with patients and the community and engagement with the government of the day". This did not mean being captive to the Government, he said. "It means having a strong relationship of trust and respect in which you can argue your case openly and forthrightly in public and behind closed doors. It means that you will win some and you will lose some, but you are always part of the conversation."

The AMA had won some and lost some over the years immediately preceding Dr Pesce's Presidency. It had been a tough time. It and its members had grappled with arguably the most disruptive of the four attempts at system reform in its history and it is fair to say that they became truculent as their exasperation grew over what they had been asked to do.

To understand the reason for this hardening of attitudes, to understand the AMA's judgment on the Rudd reforms, it is necessary to move beyond reliance on the familiar complaint that the AMA is congenitally anti-ALP or reactionary. It is necessary to see the world as the world appears to many of its members. The Rudd-Gillard reform was but another in a long list over the AMA's 50 years of politicians coming up with beaut ideas for their view of a better health system, a great many of these ideas having as their basis an ambition for greater central control over the system and its workforce. Apart from anything else, whatever the reasons for these reforms, whether they work or not, they inevitably mean disruption in the workplaces of its members. The AMA and its members would not have this problem of reform on their own, of course. But they would see elements in the sixth and latest reforms as worse than merely inconvenient or disruptive.

General practice has been made more complicated in previous reforms, its operation altered, the incomes it generates often monitored and sometimes limited. But the actual role and position in the system of the GP have never really been threatened. As the AMA has often pointed out, the GP is always the gate-keeper, the central figure in primary care provision. The Rudd proposals for the public hospital system – the area that often attracts the most attention – do not seriously change the role of the doctors practising in it. On the other hand, in primary healthcare, where 28,000 to 29,000 general practitioners work, they propose a quite serious challenge to the role of the doctor.

One immediate difficulty with the GP Super Clinics and Medicare Locals proposed in the latest reforms, as the AMA would see it, is that the detail of where they fit in the primary healthcare system is not clear, or at least inadequately explained. A longer-term, more important issue is the competition and change that they threaten to GPs' interests. But there is a potential problem with these schemes with even more significance, at least to the AMA's GP members.

The Primary Healthcare Strategy was a central element in the Rudd reforms, and a central element of that strategy

REFORMING HEALTH CARE

It is indeed a great honour for all AMA presidents to represent our profession and, in a sense, be seen as the public face of the medical profession.

Without doubt, the defining issue for the AMA and my Presidency was the health reform agenda of the Rudd labor government. Rudd had correctly identified the widespread dissatisfaction from patients and health professionals with the increasing failure of the health system to cope with the community's healthcare needs.

Identifying that a problem exists is one thing, fixing it is another.

The AMA did its best to help steer the reform process in a direction that would allow doctors to deliver the best care that they could for their patients, while not themselves having to pay the price of health reform. It was important that the AMA was seen to be part of health reform, rather than an obstacle to it.

History will judge the success or failure of the health reform initiatives. At present, it appears that the only significant outcomes of the process were to introduce activity-based funding in those states where it had not previously been used, and the move to increase local decision-making via the appointment of local governing councils to oversee local management of health district hospitals. Medicare Locals provide an opportunity for sensible structured assistance to our long-suffering general practitioners, but also for difficulties if they are not properly run.

It was inspiring to me to see the passion and dedication of doctors at all levels and our AMA secretariat work to improve the health system.

I was proud of how they rose to the challenge of working with sometimes unsympathetic political and bureaucratic systems to provide constructive solutions to problems not of their own making. For example, the AMA's consensus document on training of the future medical workforce remains the single concise template for an effective training system from medical school intake to vocational specialist training, which will provide the doctors that our communities need.

The opportunity to promote and advance the cause of a National Disability Insurance Scheme was a personal highlight. A journey that for me had begun a decade earlier as a struggle to address the unaffordability of the medical indemnity insurance system now took on more widespread significance as the AMA championed support for disability based on need rather than blame.

The Productivity Commission delivered visionary and aspirational recommendations recognising that the political realities of a federated system should not forever condemn Australians with disabilities to fragmented and inadequate support. An opening now exists for a once-in-a-generation opportunity to progress a problem that has remained in the too-hard basket for too long.

Should a National Disability Insurance Scheme proceed, I believe all AMA members can be proud that the AMA played its part in assisting our most vulnerable patients.

Dr Andrew Pesce: AMA President 2009-11

was the notion of the multi-disciplinary team of health workers, with the doctor as one member. The AMA has insisted, successfully, that the primacy of the GP in the multi-disciplinary primary care team is acknowledged. It has even been formally included in enabling legislation. But GPs have a special place in the AMA story. The AMA has gone to battle many times to protect their interests. GPs have watched with growing trepidation as governments have toyed with ideas about increasing the role in the health system of health workers other than doctors, such as pharmacists, nurses and opticians. There will be members of the AMA, and doctors generally, who will react in the same way to what they will see as role substitution, activities in the primary healthcare team that used to be reserved for doctors. The multi-disciplinary primary healthcare team may yet be the most contentious of all the elements in the sixth system reform that the AMA has had to deal with.

For most of its 50 years, and especially as its influence on the national health system has increased, the AMA has had notoriously difficult relationships with various governments, especially when they have sought to reform of the system. There have been periods when it has opposed governments, especially when in its view they have tried to control the operations and incomes of its members. There have even been periods when it is fair to say that it has fought government not just because they have seen it as hostile to private practice (where most of its members earn their living) but simply because it is government per se.

When it was born in 1962, the AMA faced a difficult dual challenge: getting out from under the aegis and, to some extent, the control (however benign) of the BMA, while also evolving from a grouping of distinct branches into one truly national organisation. Fifty years later, its status as an influential national body is assured. It is demonstrated by the range and scope of the information and advice that over the years it has put into the mix that goes into policy-making: aged care, new diagnostic technology, climate change, e-Health, dietary standards, hospital funding, Indigenous health, medical standards and best practice, patient privacy and doctor-patient confidentiality, collaborative care, medical education, taxation, the health and safety of the medical workforce, smoking, substance abuse, immigration, advertising, cyber-bullying, genetic testing. The range of the AMA's interests and influence can also be seen in the scores of position statements it has drawn up over recent years: boxing and health, for example; child abuse; physical activity; reproductive technology; complementary medicine; equal opportunity in the workplace; domestic violence; healthcare of people in detention, rural and remote health. Whether its views on these issues are

A HISTORY OF
THE AMA

acceptable or not, or comfortable or not, that they are held and advocated by the AMA and its members makes it impossible for governments to ignore them, impossible for health policies proceeding without heed taken of them.

Michael Wooldridge, Minister for Health in the first Howard Government, may have himself been a doctor, but he was one of many health ministers on both sides of politics who have found the mettlesome AMA a trial and a tribulation. His mark on the health system was relatively insignificant but he may well be remembered for having sought to dismiss the AMA as "just a doctors' union". But the story of the AMA, especially since its reorganisation 23 years ago, demonstrates how mistaken this attitude can be, how government can underestimate to its disadvantage the strength of the AMA's involvement and influence in health – and wider, but related social issues.

AMA President Dr Steve Hambleton with Prime Minster Julia Gillard, the then Health Minister Nicola Roxon and Dr Christine Bennett

THE PCEHR:
A CATALYST FOR E-HEALTH

By Dr Mukesh Haikerwal AO, Head of Clinical Leadership, Safety and Engagement, NEHTA

We are poised on the brink of an evolution in health: the widespread use of technology in the health sector via e-Health. This will enhance and support the healthcare we provide our patients – the consumers of healthcare.

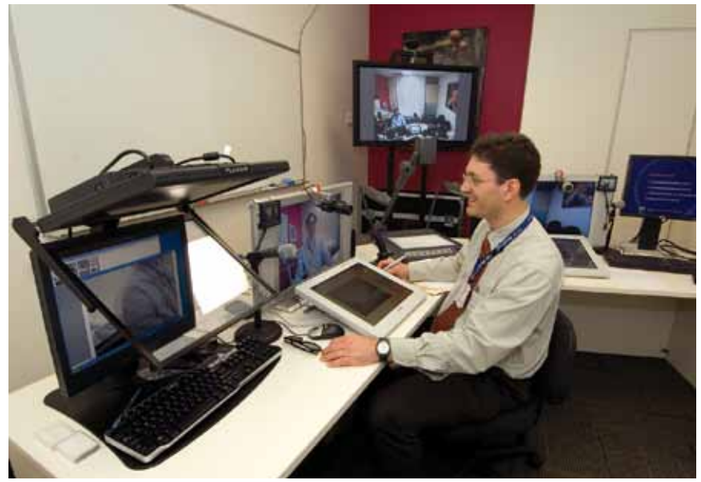
With widespread uptake of e-Health technologies, and the prerequisite change management, we will have at our disposal good, clear, accurate, timely clinical information that will improve our 'healthcare journey'.

My interest in health IT started back in the 1990s through my committee work with the AMA in Victoria. It became a passion for me over the years and was a feature of my advocacy as AMA Victoria President and Federal AMA President. I also championed the e-Health cause in my time as a Commissioner with the National Health and Hospitals Reform Commission.

I started at the National E-Health Transition Authority (NEHTA) in 2007 to provide clinical input to the emerging national e-Health system.

The formation of the National Partnership on e-Health by the Council of Australian Governments has seen a national agenda to bring a standard rail gauge for the way in which we as a nation pursue the widespread deployment of modern electronic technologies in the healthcare system.

The need for such a gauge allows leveraging of developments across the nation and avoids perpetuating the current situation of multiple technologies used across the system which can't talk to each other (interoperate), rather like the good old days when one telephone handset or carrier was unable to receive from another, or when automatic tellers from one bank could not transact with a card from another.



CSIRO's RIDES technology allows surgeon to consult with patients in remote locations in a realistic way.

Image courtesy of The Royal Children's Hospital, Melbourne.

Using technology is what Australians are very good at doing across sectors of the economy and current directions will see this happen in health with multiple benefits.

A recent investment by the current government of $466.7 million over two years for the introduction of the Personally Controlled Electronic Health Record (PCEHR) for all Australians to register for from 1 July 2012 is on track. It will be the catalyst for widespread use of e-Health in Australia with multiple dividends for the nation.

My views on e-Health are fuelled by my daily experiences in my general practice and that of a brilliant team of over 60 clinical leads who work to optimise its use and the likelihood of uptake outside of the NEHTA. They do this to ensure that the many pieces of the e-Health

E-HEALTH

Image courtesy of Centre for Online Health, The University of Queensland, Australia.

jigsaw are clinically relevant, robust and safe, and will improve the patient journey when properly implemented.

Adopting and using e-Health should not be an additional burden on clinicians. It should support and enhance their work, while not intruding into it. It must incorporate good clinical governance, be a clinically safe and robust technology, and follow the code of "First do no harm".

The basis of good clinical information transfer is secure messaging delivery (SMD). SMD takes us away from a 'superhighway to nowhere', where I cannot send a well-designed, computer generated referral, with all the relevant reports attached, to anyone without first printing it and using the 'oh-so-secure' fax or snail mail as tools.

There are multiple suppliers of SMD and hardly any talk to each other.

Most GP desktop software systems have around 10 agents delivering information – for example, pathology reports, radiology reports, some specialist records and other agencies' information (locum agency, allied health). There is no reason why these agents – buckets of information – can't talk to each other if they all adopted the national standard that has been set.

This has not been easy as each software system works differently. Each specialist in each practice has a different workflow. Each needs a PKI (public key infrastructure) key from Medicare. It is free but tedious to get.

The key danger points for e-Health systems arise if not enough people enrol, or if the information on their PCEHR is of poor quality or is insufficient – or, indeed, if key expected information, like pathology and radiology reports, is not available. Complexity or increased risk to clinicians, or increased workload, will see it fail.

Worldwide, if the systems have no clinical utility, have no clinical governance, or if clinicians are not fully part of the decision making process, they simply won't work.

The Australian system has seen a way to succeed where others have not, learning from them as we are proceeding. National standards and working at an early stage with consumers and clinicians – as well as the IT sector – continue to be critical. Better understanding between what I have coined the 'four cornered roundtable' (discussion across a round table with each of the four members of the healthcare community to bring a common understanding from all sections about all elements) is essential to reach a solution that can work for all.

Overall, the benefits and change and the actual technology itself need to be clinically determined and led.

Australia can succeed in e-Health where others have failed. It is a big task, but one we must not shirk. To succeed, we must work together with a unity of purpose.

LEFT: Physiotherapist support by videolink.

TOWARDS A BRIGHTER FUTURE?

By Professor Ian Ring, Professorial Fellow at the Australian Primary Health Care Research Institute, University of Wollongong

There has been a remarkable transformation in Australian government policy towards Aboriginal people. In a few short years, Australia has gone from being seen as hypocritical when speaking out about international human rights because of the manifest poor state of Australian Aboriginal health, to a country whose policies on a broad range of Indigenous initiatives – the Northern Territory intervention aside – are internationally competitive.

This remarkable transformation has been a long time coming, after the Aboriginal and Torres Strait Islander Commission (ATSIC) era which basically let mainstream government agencies off the hook, followed by a prolonged period of limited, or unfunded, policy. Not much changed apart from infant mortality, because far too little was done. The net result, as far as we can tell from the inadequate data available, was that Indigenous health in Australia was substantially worse than it was in New Zealand, Canada and the USA, and had not experienced even those limited improvements that had been seen in other countries.

Report after report documented the poor state and lack of progress in Indigenous health, but the reports were generally noted rather than acted upon. Few voices were raised about this appalling state of affairs other than those of Aboriginal people themselves, who, in despair over mainstream health services, set up their own system of Aboriginal Community Controlled Health Services (ACCHS).

From the time of Brendan Nelson on, however, the AMA has consistently advocated for this appalling state of affairs to receive the recognition and action it deserves, and virtually every AMA President since Dr Nelson has taken Aboriginal health on as a personal and institutional crusade. That has continued through to the present day, up to and including the AMA's current President who chairs AMA's Indigenous Taskforce with broad membership of AMA members and Indigenous organisations. This Taskforce produces regular report cards on key aspects of Indigenous health.

In 2005, Tom Calma, the then Aboriginal and Torres Strait Islander Social Justice Commissioner, introduced the notion of Indigenous health equality within a generation in his annual report to Parliament. Tom is a truly remarkable Aboriginal leader and an Australian of extraordinary ability and record of service to Australia. He established the Close the Gap campaign, a coalition of every non-government Indigenous and mainstream organisation with expertise and involvement in Aboriginal health, including the National Aboriginal Community Controlled Health Organisation (NACCHO), the representative bodies for Indigenous doctors,

> In a few short years, Australia has gone from being seen as hypocritical when speaking out about international human rights because of the manifest poor state of Australian Aboriginal health, to a country whose policies on a broad range of Indigenous initiatives the Northern Territory intervention aside are internationally competitive.

nurses and other health professionals, the AMA, the Royal Australasian College of Physicians, the Heart Foundation and other bodies. Most importantly, NGOs with lobbying skills like Oxfam, the Fred Hollows Foundation and ANTaR were included, and this coalition, an internationally unique group, set about building a climate of public support for action on Aboriginal health.

In late 2007, the Council of Australian Governments (COAG) committed themselves to halving the child mortality gap in a decade and closing the life expectancy gap within a generation. This was followed by a series of highly important symbolic actions: a welcome to country in the National Parliament; a deeply moving apology for the Stolen Generation by the then Prime Minister Kevin Rudd, who many believe played a crucial role in the turnaround in government policy towards Aboriginal people; a National Summit which endorsed the set of targets prepared by the Close the Gap coalition; and the signing of the Statement of Intent by the Prime Minister, Opposition leader and national leaders of Indigenous and mainstream health organisations – a statement which has now been signed by governments and opposition parties in almost all states and territories.

But it hasn't just been fine words. This time the words have been accompanied by significant funding and action. COAG agreed in 2008 to new initiatives for Indigenous Australians of $4.6 billion across early childhood development, health, housing, economic development and remote service delivery, including $1.6 billion for health. In a move which was presumably designed to keep the pressure on, the Prime Minister committed to tabling a statement on progress in Closing the Gap at the opening of Parliament each year.

But policy and funding are one thing, and implementation another. Not unexpectedly, given the complexity and ambitious nature of these initiatives, there have been a number of challenges and controversies about implementation of the initial four years of these programs.

First and foremost has been the question of partnership – genuine partnership, that is. In practice, while politicians appear to have seen the need for a new partnership approach with Aboriginal people, the incentives in the public service do not make this easy.

What eventuated was that the programs to be developed with the new funding were largely drawn up by public servants with little genuine involvement of Indigenous organisations, who were at best essentially asked to ratify what had been formulated by others. The concept of non-Aboriginal people developing programs for Aboriginal people has been tried and tested for a couple of hundred years and there is little reason to believe this is an effective approach. For partnership to work, Aboriginal organisations are going to need some additional resources so they can develop their own thoughts on how best to implement national policy and then work with government to find a common agreed path.

This is in marked contrast to the current situation where governments have the resources to develop programs and Aboriginal organisations become passive recipients of government, largely non-Aboriginal thinking.

The second issue was the absence of the comprehensive long term action plan promised in the Statement of Intent. Instead there were a series of initiatives centred around the 'patient journey'. While most of the initiatives made some sense in their own right, collectively they were piecemeal, bitty and fragmented, didn't add up to a comprehensive plan,

and were drawn up with inadequate involvement of the Indigenous people and organisations with the best experience and expertise in health service delivery for Aboriginal people, notably NACCHO.

A major issue was that there was little or no formal consideration of fundamental issues such as what services are required to achieve the COAG goals for child mortality and life expectancy, what services are currently available, what services are missing and therefore what services need to be in a capacity building plan so the COAG goals can be achieved.

There was also the issue of how to allocate additional funds between mainstream and ACCHS services. Public servants felt that the new funds should be distributed in broadly the same proportion as the current use of these services by Aboriginal people. Others felt that there was little argument in favour of perpetuating the current pattern of service since the whole reason for the new programs and funding was that the current system was not doing the job adequately. Rather, the additional funds should be directed largely towards the services that were most likely to achieve the COAG goals, and there were substantial reasons for concluding that the ACCHS offered distinct advantages in term of better access and more effective and appropriate services for Aboriginal people.

In addition, there have been major issues in measuring the size of the gap – and knowing whether or not it is narrowing. Further, annual progress reports to date have not fully understood the time needed to fund new programs, roll them out, for the programs to become effective, to achieve outcomes, and for data to become available for those outcomes. So the data in the annual progress reports has the appearance of having been pushed to the limit to try and provide good news stories, but in fact they have largely reported on what was happening prior to the new money hitting the ground – a point which has not been generally understood.

The good news is that the Health Minister and the Minister for Indigenous Health have committed to the establishment of a National Aboriginal and Torres Strait Islander Health Plan by the Australian Government working with State and Territory governments and in genuine partnership with Aboriginal and Torres Strait Islander people and organisations.

The hope is that the lessons of the first four years will be learnt and incorporated in the next stages. Implementation is hard and Aboriginal health is extremely complex in terms of the health service, social, economic and political issues on which progress must be made.

While there have been many good features of the first four years, it is unlikely that a continuation of the current approaches will achieve the COAG goals for child mortality and life expectancy. The funds that have been provided, while in the ball park of what is required, are less than the estimates of requirements and definitely inadequate if not spent optimally, which will almost certainly be the case. Tight budgets for the foreseeable future mean that, more than ever, there is no money to waste on amateurish, seat-of-the-pants approaches.

There is a need to pay more attention to social and emotional wellbeing, to introduce more health planning skills into the complex tasks which lie ahead, and to incorporate Aboriginal health much more directly into the national health reform agenda.

The will to act has never been greater and the recent commitments to planning and partnership are necessary and welcome. But it all lies ahead.

Image courtesy of the Royal Flying Doctor Service of Australia. www.flyingdoctor.org.au

FAR LEFT: *Aboriginal leader Tom Calma.*
LEFT: *Child receiving oxygen in South Australia as part of the service provided by the Royal Flying Doctor Service.*

INDIGENOUS

IN PURSUIT OF PREVENTION

By Professor Stephen Leeder, Director of The Menzies Centre for Health Policy

Fifty years is a long time in modern medicine. It is in public health as well. Notable progress has occurred in public health in Australia for which many people, lay and professional, deserve applause, including the AMA.

In 1962, the coronary disease epidemic was still growing in Australia. It did not peak as a cause of death until the late 1960s. Since then, it has fallen steadily, by over 80 per cent, due to effective public health prevention and improved medical and surgical care. The contribution of public health measures is especially impressive.

As Richard Taylor and colleagues from Sydney showed following detailed analysis of trends in risk factors in 2006, "Over the period 1968–2000, 74 per cent of the male decline and 81 per cent of the female decline in coronary heart disease mortality rate was accounted for by the combined effect of reductions in three risk factors.

"In males 36 per cent of the decline was contributed by reductions in diastolic blood pressure, 22 per cent by cholesterol and 16 per cent by smoking. For females 56 per cent was from diastolic blood pressure reduction, 20 per cent from cholesterol and 5 per cent from smoking. Effects of reductions in serum cholesterol on coronary heart disease mortality occurred mainly in the 1970s.

"Declines in diastolic blood pressure had effects on coronary heart disease mortality over the three decades, and declines in tobacco smoking had a significant effect in males in the 1980s."

Image courtesy of American Heart Association.

The role of the AMA in the struggle against tobacco was powerful, as it was in the treatment of hypertension and cholesterol lowering. The AMA has had active groups working in public health, auspiced by a special committee, for decades. Alongside others working in public health, advocacy has been strong.

The support of general practitioners for efforts to reduce tobacco smoking among their patients, as well as offering wise counsel to those who come seeking ways of living healthier lives with better nutrition and more physical activity, have been many and noteworthy.

Detecting and treating hypertension and elevated lipids, especially when efficacious treatments became more palatable with fewer side effects, has been an important contribution in the campaign to reduce death and disability form cardiovascular disease (CVD). The improved outlook and the control of the epidemic of CVD (well, it's still a huge problem but much less so than 50 years ago) shows what can happen when high quality clinical care combines with public health in the pursuit of prevention. Primary prevention in the population (tobacco control, changing the availability and use of animal fats, encouraging more physical activity) combined with secondary prevention in the clinic (treating blood pressure etc.) have all contributed.

LEFT and ABOVE: General practitioners support more physical activity and better nutrition.

Immunisation is another public health field where the AMA has spoken with a clear and consistent voice. It has been a good half century for immunisation, with the World Health Organisation (WHO) certifying the eradication of smallpox in 1980 after a killing spree that lasted 12,000 years. A global effort to eliminate polio started in 1988, led by the WHO, UNICEF and the Rotary Foundation. While huge progress has been achieved, cutting the hundreds of thousands of cases a year to a thousand or so, and eradication may have occurred in India, the final lap is yet to be run. A lack of basic health infrastructure limiting vaccine distribution and delivery and the disrupting effects of war prohibit the implementation of effective immunisation programs.

Another challenge has been maintaining the potency of live (attenuated) vaccines in extremely hot or remote areas. (I once saw a photo of an 'immunisation camel' fitted with solar panels to power a small fridge containing vaccines!) I am told that oral polio vaccine must be kept at 2-8° Celsius to assure potency.

It is natural for people unaware of the risks of whooping cough, for example, to be indifferent to immunisation especially when the public discourse around immunisation takes unhappy twists as parent interest groups claim a connection between immunisation and childhood developmental disorders. Despite this, through a series of national seminars in company with the Public Health Association of Australia and consistent promotion of immunisation by AMA members, aided in the previous Liberal coalition government by the leadership of Federal Health Minister Michael Wooldridge, alarming trends in non-immunisation rates in children have been reversed in Australia.

Rafts of new vaccines and formulations offer a bright future for immunisation as a major instrument of public health and prevention. The future, as veteran immunisation guru Margaret Burgess suggested 20 years ago, beckons with the possibility of immunisation effecting dramatic changes in the natural history of many chronic disorders.

The persistent difficulty in developing effective vaccines against HIV reminds us that, over the past 50 years, we have had to come to terms with this new and devastating disorder. When HIV/AIDS appeared in Australia in 1982, we wondered what we had struck. Yet Wikipedia records that "the history of HIV/AIDS in Australia is distinctive. Australia was a country which recognised and responded to the AIDS pandemic relatively swiftly, with one of the most successful disease prevention and public health education programs in the world. As a result, despite the disease gaining an early hold in at-risk groups, the country achieved and has maintained a low rate of HIV infection."

Image courtesy of American Heart Association.

The HIV prevention program owed much to the inspired, tenacious and canny political leadership of Neal Blewett, then Federal Minister for Health, in recruiting an astonishingly broad group of activists and concerned citizens. Blewett fashioned a campaign from these interest groups. Its activities included the Grim Reaper advertisements in the mainstream media and in-depth public education, especially among high risk groups. High profile people including David Penington, Ron Penny and Ita Buttrose were recruited to the cause. The medical profession featured strongly in a response that attracted international attention as a fine example of what can be done when patients, community, non-government organisations, professionals (basic science, clinical and public health) and government work together. Would that this occurred more often!

It would be an unreal half century if we had succeeded in everything we set out to do, and of course we have had our share of failures. We do not yet have the answers to overcome the appalling health disadvantages of our Indigenous people. Alcohol remains untouched and untouchable as a massive clinical, psychiatric and public health problem in our nation. We have no cure, save bariatric surgery, for established obesity, despite (as is the case with Indigenous health) multiple itty-bitty programs and neatly captioned initiatives that claim to achieve results but then disappear without trace.

Where might we look for answers to these problems? It is probably true, but not helpful, to say that unless we prevent obesity there is nothing we can do. New medications may well become available within the next 50 years that render obesity treatable. Nor does it help to say this about Indigenous health. I wish there was a pharmaceutical fix in sight for Indigenous health. Admit it: we need a new way of thinking about these problems, in both clinical and public health terms. The AMA might provide leadership here, assembling twenty 'outside the box' thinkers from engineering, information technology, management, education and architecture for a weekend of serious imagining.

We have yet to reorganise ourselves to provide the continuity of care needed by the growing numbers of frail older people and those with chronic illness. But in the case of these two challenges, we probably have at hand the means and ideas to come up with solutions.

In summary, clinical medicine and public health have had a good half century in Australia. I'd give them a seven or eight out of ten. The inclusiveness of the AMA, and (when it is working at its best) its overriding interest in promoting the health of the nation has contributed strongly to what we have achieved together.

A FLUCTUATING FRAMEWORK

By Dr Kerry Breen

In the relatively short history of the existence of the AMA, the medical profession's awareness of ethical issues and the nature of ethical debates and their participants have varied considerably. There have been several driving forces, often linked to either medical advances that disturbed the equilibrium of the community and the medical profession, or to egregious behaviour of members of the medical profession, both abroad and at home. This is readily demonstrated by mention of just a few examples that also put a timeline to these developments.

The World Medical Association (WMA) held its first assembly in Geneva in 1948, some 14 years ahead of the establishment of the AMA. A highlight was the publication of the Declaration of Geneva, a modern version of the Hippocratic Oath. In 1964, two years after the AMA was formed, the WMA issued the Declaration of Helsinki, entitled Recommendations Guiding Medical Doctors in Biomedical Research Involving Human Subjects. Both documents undoubtedly owed their origins to the uncovering of gross departure from generally accepted ethical standards of medical practice and medical research by some members of the medical profession in Nazi Germany during the Second World War. The AMA first issued its own Code of Ethics in 1964. It is revised from time to time and continues to serve as the national code of ethics for Australia's doctors.

Advances in medicine and especially in biotechnology have often preceded the development of ethical (and legal) standards of practice or research in the new field. The announcement of the first baby born through the use of in vitro fertilisation techniques in 1978 eventually led to the development of ethical codes and regulation for the practice of this form of medicine. Advances in biotechnology in the 1970s and 80s also spawned the new specialty of bioethics and thus for a couple of decades medical ethics was frequently equated with bioethics.

This era also saw governments take a more active role in ensuring broad debate of ethical issues, with many developed countries establishing national bioethics commissions. In Australia, a National Bioethics Consultative Committee (NBCC) was formed in 1988 but when the legislation governing the National Health and Medical Research Council (NHMRC) was changed in 1992, the government chose to replace the NBCC with the Australian Health Ethics Committee (AHEC) and make it a "principal" committee of the NHMRC. One of the contrasts between the AHEC and other national ethics committees is that the statutory membership of the AHEC must contain people drawn from a wide range of backgrounds in the community rather than concentrating on those with academic expertise in bioethics or medical ethics.

More recently, we have seen national debate and community concern over the possibility of using biotechnology to clone a human being that resulted in federal legislation to ban human cloning and regulate the use of human embryos.

Good communication skills are essential to recognising and resolving most ethical issues doctors face in everyday practice.

Image courtesy of 2012 Health Workforce Australia, an Australian Government initiative.

More recently, we have seen national debate and community concern over the possibility of using biotechnology to clone a human being that resulted in federal legislation to ban human cloning and regulate the use of human embryos. The starting point for that debate was a request made by the Federal Health Minister to the AHEC in 1998 for urgent advice on the matter. We have also seen national inquiries into issues such as the use of genetic information, the safety of animal to human transplantation and the diagnosis and management of post-coma unresponsiveness. Each of these inquiries included a strong focus on ethical considerations.

One conclusion to be drawn from this short history is that new ethical and legal issues will continue to arise in relation to medical advances. The AMA and the community need to have in place processes for debating and where possible resolving ethical issues in the best interests of our increasingly diverse community.

Awareness of ethical issues in what I like to term 'everyday medical practice' seems to have fluctuated during the 50 years of the existence of the AMA. As a medical student and young graduate in the 1960s, I was exposed to little or no formal teaching in medical ethics and was instead expected to absorb the unstated professional and ethical values of the profession from observing good role models.

The 1970s and '80s saw the rapid growth of the new field of bioethics, and the community (and to a lesser extent the medical profession) turned to bioethicists for advice and guidance whenever an issue was deemed to involve 'ethics'. In my view, this otherwise healthy development had the perverse effect of marginalising or excluding practising doctors from engaging in the debates around ethical issues. This exclusion may have been partly related to doctors feeling uncomfortable with the language of bioethics. It was not helped by some enthusiastic bioethicists who believed their role was to tell doctors what they should think rather than assisting them in thinking through issues and reaching their own conclusions.

Fortunately we now seem to be well past that era. Medical ethics (as well as the closely related themes of professionalism and medical law) is integrated into, and is visible within, the medical student curriculum. Knowledge is examinable for domestic students and for overseas graduates who sit the examinations of the Australian Medical Council. Increasingly medical ethics and professionalism are also being integrated into vocational (specialist) medical training. Teaching and discussion is often led by practising clinicians.

For our current purpose, ethics can be defined as "a form of rational inquiry that concerns how we should live and what we should do". One of the remaining obstacles to doctors engaging in ethical debate is the language of medical ethics and the various ways of thinking about medical ethics. It can be intimidating to feel that one might be asked to explain whether one's case is being couched in a consequentialist (the end justifies the means) or a deontological (some things ought never be done, whatever the consequences) framework. These frameworks can help a doctor appreciate from where stated viewpoints might originate but they are not a necessary accompaniment to any debate on a clinical ethical issue.

It might sound impressive to toss around ethical terms such as beneficence, nonmaleficence, justice, veracity and fidelity but again these are not vital to debating ethical issues as ethics is defined above.

As has been observed by many commentators, ethical principles are not fixed for all time, which, given the definition of ethics, is not surprising. Neither is the relative importance of ethical principles permanently fixed. It is abundantly clear that over the last 50 years, the medical profession has moved almost completely away from medical paternalism ("doctor knows best", a form of beneficence) to respect for patient autonomy (the patient-doctor partnership). The adverb "almost" reflects the reality that faces most doctors of having to both genuinely respect a patient's autonomy and yet act appropriately in a medical emergency or where a patient appears to want the doctor to make a decision for them. As in other aspects of clinical practice, this dilemma calls for well developed communication skills. Indeed good communication skills are essential to recognising and resolving most of the ethical issues doctors encounter in everyday practice.

MANAGING THE AGEING DEMOGRAPHIC

By Dr Mark Yates

The population of Australia is middle aged with the girth to match. Its challenge now is how to age well. The AMA has a proud record in aged care policy and is hence well placed to help our country achieve this goal. The strength of the AMA's position is that it represents all crafts in the profession, and good health outcomes for older people more often than for the young require coordinated and considered action from multiple crafts over a prolonged period of time.

DEMOGRAPHIC CHANGE

Most junior doctors today would say they manage a lot of older people. In reality, they can expect to be managing twice as many in their practice life. The proportion of the population over 65 will double in the next 30 years and those over 80 will increase by 400 per cent. With this ageing will come the expected rise in chronic diseases; notably, the prevalence of dementia in Australia is expected to increase from 257,000 in 2010 to more than 1.1 million by 2050, while diabetes numbers are also expected to double in next 20 years.

No member of the profession will be immune from the impact of ageing, whether that means managing an older mother in obstetrics or the frail elderly in surgery. Older patients are also being distributed across both public and private systems, with the private hospital sector seeing the greatest growth in separations, particularly same day separations, across all cohorts over 65 years of age.

According to the Australian Government Productivity Commission's *Economic Implications on an Ageing Australia*' report, ageing is projected to account for about half of the increase in health expenditure as a proportion of gross domestic product (GDP). A significant part of the remaining expenditure growth has occurred because of non-demographic factors.

"Non-demographic growth is the real increase in per person costs that is not attributable to changes in the age structure of the population or population growth," said the report. Such factors include:

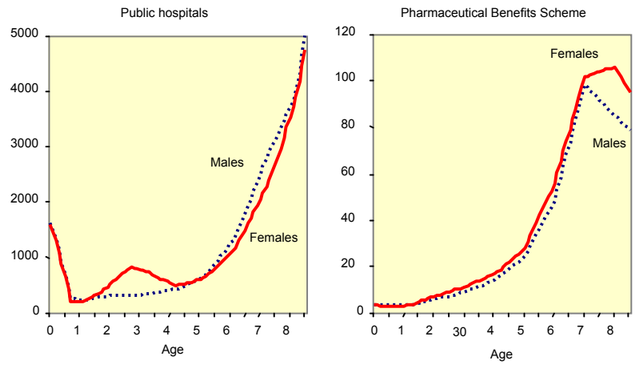
- increases arising from the introduction of new technology;
- increased demand from consumers arising from greater wealth or changing community expectations;
- changing patterns of demand arising from increased prevalence of conditions; and
- any excess health inflation (where health prices rise at a greater rate than general prices).

Non-demographic expenditure growth, unlike ageing, is potentially modifiable and should be the focus of health policy to help Australia's population age well.

While increasing funding will be critical to sustainable healthcare delivery, by 2030, the number of working population members for every adult over 65 will drop from four to only 2.4. In other words, not only will demand be greater, but that demand will need to be met from a more limited tax base. As a profession, we must engage with and advise our community on how health and aged care can be provided efficiently and with a sufficient evidence base to justify the cost. Three areas worthy of investigation are: prevention, both primary and secondary, the hospital-General Practice interface, and managing medical futility.

COSTS OF HOSPITALS AND DRUGS BY AGE

Dollars per person



Data source: Hospital profile is based on NSW unit record data provided by NATSEM, Thurecht et al (2003); PBS: Health Insurance Commission, unpublished 2002 03 data. Via Productivity Commission's 'Economic Implications on an Ageing Australia' report.

ABOVE: Cognitive activity could minimise the risk of dementia.

PREVENTION

Avoiding chronic illness in older age often requires attention to important medical treatments and healthy living strategies throughout middle age. Some have already delivered significant improvements, with projected stroke incidence expected to reduce by 50 per cent by 2030 and coronary heart disease estimated to decline by a similar amount. In other areas we are going backwards. Diabetes prevalence is set to double in the same time frame, reflecting a doubling in obesity prevalence, with one in five Australians now considered obese. This growth in diabetes and obesity will have a significant impact on wellness in later age, with higher risk of peripheral vascular disease, amputation and dementia. It also has the potential to undermine the projected reductions in stroke incidence.

Maintaining physical fitness has well documented benefits in older adults and should be supported by affirmative policy. Epidemiological data also suggests that adding cognitive activity and community engagement to physical activity could minimise the risk of dementia.

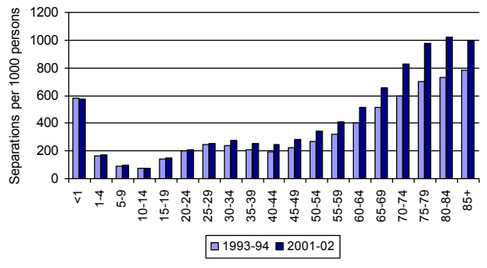
If the Australian population is to age well, we need a healthcare system that can effectively influence individual behaviour. At a minimum, this will require primary practice models that provide for long term doctor patient relationships, the input of allied health and nursing, and a close working relationship with other specialists and the hospital sector.

THE PRIMARY HEALTHCARE HOSPITAL INTERFACE

While much has been written about the interdisciplinary models of primary care, the hospital-primary care interface has had less policy attention despite the widespread recognition that unnecessary hospital admissions are a risk for the elderly. Productivity Commission data demonstrates that those over 75 are admitted to hospital almost annually, suggesting room for alternative pathways.

HOSPITAL SEPARATIONS PER 1000 PERSONS, BY AGE, 1993-94 TO 2001-02

Separations from public and private hospitals

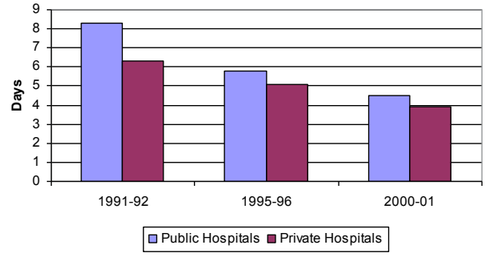


Data source: AIHW (national morbidity data base). Via Productivity Commission's 'Economic Implications on an Ageing Australia' report.

While there were marked reductions in length of hospital stay for older people in the 2000s this has not continued to the same extent more recently.

AVERAGE LENGTH OF STAY FOR PEOPLE OVER 65 IN HOSPITAL

Length of stay per episode



Data source: DoHA (2003 p.73). Via Productivity Commission's 'Economic Implications on an Ageing Australia' report.

Greater efficiency in bed usage and reduction in associated health costs is still possible with a closer relationship between the hospital and primary care sectors, as demonstrated by the use of hospital lead shared care models for congestive cardiac failure and chronic obstructive pulmonary disease. These models could be built with private or public specialist involvement and potentially supported within the new Medicare Local structure.

Similarly, movement of the frail elderly from residential aged care facilities to hospital and back can be a source of distress for older individuals, their families and aged care staff. Policy that promotes a greater ability to share clinical information, more regular access to the usual primary care team, even after hours, and direct clinical support from the acute

sector that provides full clinical handover on return to a residential aged care facility will help to ensure that older people are neither denied access nor exposed to the risks of inappropriate acute healthcare. The risk most often feared by staff and families is the use of futile medical care.

MANAGING MEDICAL FUTILITY

In 2006, the AMA released its policy on 'The Role of the Medical Practitioner in Advance Care Planning' and called for all states and territories to "enact legislation that establishes advance directives as legally enforceable". This policy was initiated in response to frustrations voiced by both general practitioners and hospital-based specialists, who claimed that the very frail were often caught in a vortex of hospital intervention with no evidence-based benefit, often with the associated complication of acute intervention.

Unfortunately there has been little progress and the elderly remain at risk because intervention is the course of greatest safety for both individual families and the wider hospital system. Without legislative support, conservative management decisions by cover medical practitioners are difficult to make.

> If the Australian population is to age well, we need a healthcare system that can effectively influence individual behaviour.

Image courtesy of John Gollings.

As a profession, we need to engage in the debate around medical futility that is active today. In a recent article entitled 'Defining Medical Futility and Improving Medical Care', published in the *Journal of Bioethical Enquiry* in 2011, Lawrence J. Schneiderman suggested that medical futility be defined as treatment that has an "unacceptable likelihood of achieving an effect that the patient has the capacity to appreciate as a benefit." This debate needs to engage the wider community and acknowledge that, in judging futility, we as a profession have an obligation not to provide just a stream of probabilities of outcome to families and patients, but to direct advice with transparent acknowledgment of our own preconception and ethics.

LOOKING FORWARD

Australia's population is no doubt middle aged; it is increasingly obese and faces a worrying future dogged by diabetes, dementia and a variety of other chronic diseases. To be true to its children, our country needs to act now to reduce its weight and, supported by the medical profession, partake in known preventative steps that will assist the ageing process.

While not everything is preventable and the management of accumulated chronic disease is expensive, results can be more efficiently achieved with close cooperation and coordination between multiple medical craft groups and professions. Finally, at end of life, the risk of medical futility by default must be acknowledged and avoided. As the only body that can bring all the disparate but thoughtful minds of the profession together, the AMA has a key role in Australia's successful ageing process.

ABOVE: *Frail elderly within hospitals is a source of ongoing debate.* ***BELOW:*** *Cooperation and care between many medical craft groups and professions can help the Australian population age well.*

Image courtesy of Microsoft

AT A TIPPING POINT

By Professor Justin Beilby, Executive Dean of the Faculty of Health Sciences, University of Adelaide, and President of the Medical Deans of Australia and New Zealand.

Our medical and health workforce are the foundation of the world class healthcare system we enjoy. We have every right to be proud of the current educational and training continuum that equips the broad range of our graduates with the skills to provide quality care across all of Australia. This well-established and well-respected training framework that has served us so well for such a long time is now facing a number of challenges.

At a time when we are experiencing unprecedented health reform, the health system is being placed under enormous pressure due to the ageing of our population and the tsunami of chronic illness, unacceptable workforce maldistribution, the explosion of health costs and shortages in some specialist groups. Added to this is the perceived decreased interest in younger graduates and health service managers in educating our future workforce.

New organisations such as the Independent Health Pricing Authority and the National Health Performance Authority (NHPA) have been established as part of the health reform agenda and are creating new paradigms of public accountability and resource allocation. The challenge now is to make sure that the focus on teaching and training and ongoing support for our workforce is not lost in this drive for efficiency, national consistency and accountability. Unless a national coordinated approach is taken and successfully established, involving educators, universities, colleges, clinicians and state and Commonwealth governments, we will limp along with a piecemeal and reactive approach to workforce education, support and planning.

THE MEDICAL WORKFORCE TODAY

In writing this article, I have concentrated principally on medical practitioners. According to Health Workforce Australia's 2012 report entitled *Australia's Health Workforce Series: Doctors in Focus*, in 2009, there were 82,895 doctors, 72,739 (or 88 per cent) of whom were working in clinical practice.

Over the last 10 years, the number of doctors has increased by 44 per cent (from 57,533 registrations in 1999). When the mix of clinical groups are examined, there were 25,707 primary care practitioners (mainly general practitioners (GPs)) (38.0 per cent), 24,290 specialists (35.9 per cent), 9154 specialists in training (13.5 per cent) and 7677 (11.4 per cent) hospital non-specialists. Of these four groups, the greatest growth over 10 years has been in specialists in training (9 per cent to 13 per cent) and the largest fall has been in GPs (41 per cent in 1999 to 35 per cent in 2009).

More recently, there have been concerted efforts to increase the number of GP prevocational and vocational training places. The number of prevocational training places will increase from "approximately 400 to 975 in 2014 and the number of vocational training places will increase from 600 to 1,200 by 2014". It is unclear if this will translate into a greater percentage of clinicians becoming GPs. This is one of our challenges – incentivising the role of general practice – as there is substantial evidence worldwide that strengthening primary care will create a more equitable and efficient healthcare system.

If we look at speciality groups in more detail, 62 per cent were concentrated in the top 10 in 2009. These were, in order, anaesthesia, psychiatry, obstetrics and gynaecology, diagnostic radiology, paediatric medicine, general surgery, orthopaedic surgery, emergency medicine, ophthalmology and cardiology. Interestingly, when this list is compared to a similar breakdown in 1999, the only change in this top ten is the addition of emergency medicine and the "falling out" of general medicine. This decrease in the interest in general medicine needs reversing. The frail aged and very complicated people with multiple chronic illnesses need this type of broad clinical input.

A number of other important trends are also influencing how our workforce is being shaped. Female clinicians are increasing at a faster rate than males. From 1999 to 2009 the percentage of female doctors increased by 75 per cent to 11,471 and males by 31 per cent to 11,045. This trend is likely to continue, as almost 50 per cent of all medical students are female.

> The challenge now is to make sure that the focus on teaching and training and ongoing support for our workforce is not lost in this drive for efficiency, national consistency and accountability.

A modern hospital, Robina Hospital, filled with light, colour, artworks and landscaping.

Images courtesy of John Gollings.

The feminisation of the workforce is influencing the spread across different age groups. Over one third of working males were over 55 with 44 per cent under 45 years of age. Correspondingly for females, 13 per cent were over 55 and 62 per cent were under 45. Finally, doctors are working fewer hours per week – 42.2 hours in 2009 versus 45.6 hours in 1999.

Three final issues are impacting on how we manage the medical workforce, both now and into the future. Across the states and territories, the highest number of working doctors per 100,000 population is 474 in the Australian Capital Territory (ACT) and the lowest is 309 in New South Wales (NSW), while the Australian average is 331. This distributional difference is even more stark when we look at specific regions. Major cities have a rate of 372 per 100,000, which contrasts with the rate of 188 in outer regions and 216 in remote or very remote areas.

Secondly, medical schools have been expanding dramatically since 2000, with a doubling of students from 1660 to 3469 in 2010. These graduates need postgraduate career pathways.

Finally, Australia's reliance on overseas trained doctors is substantial, with 18,458 of our clinical workforce in 2009 having obtained their qualification overseas. Over the last 10 years, there has been a particular increase in internationally trained GPs in Australia, resulting in more than one third (35 per cent or 9191) falling within this group in 2009-10. A higher portion of these GPs are currently working in outer regional (51 per cent) and remote (47 per cent) areas compared to 39 per cent in major cities. This reliance on overseas graduates to spend long periods in rural and remote settings is not sustainable as countries worldwide look to strengthen their own health systems and workforce training.

Medical workforce planning is difficult and complex, and in the past we have often been proved wrong about the number of students and clinicians we have trained. Adapting to the shorter working hours and the feminisation of our workforce, finding the correct ratio of general practitioners to specialists and the right mix of specialist skills, and improving the rural and remote workforce are together creating a new and dynamic planning and educational environment.

In 2008, the Council of Australian Governments (COAG) agreed within the National Partnership Agreement on Hospital and Health Reform to the need for a national coordinated approach to health workforce reform, with a specific emphasis on co-coordinating the health and education sectors. Health Workforce Australia (HWA) has been established to lead this approach, with a focus on workforce self-sufficiency by 2025. The HWA plan currently being completed and appropriately named 'Health Workforce 2025' is an important initiative. The remainder of this article will briefly explore some of the issues that have to be considered as the new 'coordinated' national perspective evolves.

Top: Feminisation of the workforce is a growing trend. ABOVE: Working within the interior intensive care unit bedroom at the New Royal Adelaide Hospital.

Image courtesy of SA Health, Government of South Australia.

ISSUES FOR RESOLUTION

International Students and Doctors

Australia has unresolved issues regarding the training of international students and their role in the solutions for our workforce priorities. These students make up approximately 16 per cent of medical graduates, and almost two thirds want to stay in Australia long term. The appropriate balance of graduates and international medical students who would like to stay long term has not been clarified and needs further urgent debate. This is a particular concern, with the possibility that many Australian international medical graduates may not obtain intern placements in 2013.

Indigenous Australians

The unacceptable disparities around the health of our Indigenous populations demand that we work to establish and promote medical careers for Indigenous people. Partnership models, such as the longstanding one between the Australian Indigenous Doctors' Association (AIDA) and the Medical Deans of Australia and New Zealand, are the ideal workforce foundations to create and foster these goals.

Regional and Remote Areas

There have been some policy responses to rectifying Australia's doctor maldistribution problem, including the Bonded Medical Places Scheme, the Five Year Overseas Trained Doctors Recruitment Scheme and the General Practice Rural Incentives Program. Small gains have been made, with an increase in the number of employed doctors in remote/very remote areas from 127 per 100,000 population in 2001 to 216 per 100,000 in 2009, according to *Australia's Health Workforce Series: Doctors in Focus* from Health Workforce Australia. This is only part of the solution as the different service models needed in rural and remote settings will require training with a broad range of clinical skills. One of the most interesting and innovative developments is the concept of a 'Rural Generalist'. New specialist training pathways are also needed that allow interested graduates to complete the bulk of their training in non-urban settings.

Educational Training Resources

Delivering a quality educational program requires appropriate funding. The recent establishment of the Independent Hospital Pricing Authority (IHPA) and their stated move to Activity Based Funding (ABF) has caused concern among educators. There is now some confusion about how training can be funded within an ABF model in both urban and rural environments. There is a need to establish a reference group across all medical education 'silos' and, working in partnership with the IHPA, to define the true cost of delivering education.

Health Reform

As the health reform agenda gathers momentum, it is crucial that workforce reform is concurrently fostered. It is not good policy to suggest new models of service delivery that we have no workforce to deliver. Integrated health teams, physician assistants, nurse practitioners and the implementation of telehealth, for example, must be factored into any workforce planning and education. We have a number of new organisations that will deliver health reform across the health system.

With the creation of new Hospital Networks and Medicare Locals we are entering a new era. These new organisations need to successfully integrate clinicians into their management and planning framework or they will fail to deliver on the strategic objectives. Teaching and training indicators that will make these new structures and their managers accountable for educational delivery are required. The recently established NHPA must be challenged to develop and implement indicators that will drive this change. The 48 interim indicators that are presently established disappointingly do not deliver this.

We are at a tipping point. The complexity of the workforce planning and education debate requires engagement of all parties to craft and develop flexible and sustainable solutions. It is no longer acceptable to drift along without a shared and agreed and appropriately funded vision for the development and support of our workforce.

We are at a tipping point. The complexity of the workforce planning and education debate requires engagement of all parties to craft and develop flexible and sustainable solutions.

‘VIRTUOUS’ TRANSFORMATIONS

By Sir Gustav Nossal, Department of Pathology, University of Melbourne

It is a pleasure to join the AMA in celebrating 50 years of grand achievements for Australian medicine. Of course, the track record is actually much longer than that; when I was a medical student and young doctor, it was still the British Medical Association (BMA). Just as well we have grown up! The opportunity to reflect on 50 years of medical research is welcome, because within this half century, medical practice has been transformed through research.

My junior residency at Royal Prince Alfred Hospital in Sydney began in 1956 and we really thought we were pretty good. But let us look at what we did not have to offer our patients.

For diagnosis, we had no ultrasound, no CT scanning or MRI imaging. We tried to judge the size of tuberculous cavities by plain tomography with limited success. In my senior residency year, my first rotation was neurosurgery. We were proud when we found a berry aneurysm via manual carotid angiography; I became quite good at hitting the carotid artery with my needle and syringe, but sadly not (Lord help us) the vertebral artery.

To image a possible brain tumour, we used pneumoencephalography. For blood chemistry, there were no autoanalysers so we had to be very careful what we ordered. Determining electrolyte levels by flame photometry was a big deal! For haematology, again no cell sorters.

For prevention, the polio vaccine came as a new miracle, but we had no vaccines against measles, mumps, rubella, hepatitis A, hepatitis B, Haemophilus, meningococci, pneumococci, rotavirus or human papillomavirus.

For treatment, all we could do for advanced chronic renal failure was to put the poor patient on a rice diet, low in protein and salt. Neither haemodialysis nor renal transplantation were yet available. Cardiac surgery was just beginning; I remember a fair number of corpses. In the cardiovascular field, all the diuretics were injectables. The first anti-hypertensive drugs, ansolysin and vegolysin, had just come in, also injectables, and did we see a lot of fainting!

In psychiatry, there were no antidepressants and no lithium, though chlorpromazine was a pretty good tranquilliser. In cancer, there was as yet no chemotherapy. When a child came in with leukaemia, all we had to offer was brief respite through the adrenocorticotropic hormone (ACTH). One could go on.

How medical research has transformed the scene in a brief half century! Of course, it has been a global effort. Australia represents less than 0.3 per cent of the world’s population and a recent report by Deloitte Access Economics estimates that we do 3 per cent of the world’s medical research. That is in itself an astonishing statistic, but better still, the quality of that research is high, with citation rates well above world average and the objectively measured impact factor also being high. Clearly the six Australian Nobel Prizes in Medicine since 1960 are only the tip of the iceberg.

Perth-based Fiona Stanley is one of Australia’s leading researchers.

Image courtesy of Telethon Institute for Child Health Research.

Australia has always had a major position in basic or fundamental medical research. This has a great deal to do with tradition and the influence of the early giants. Sir Frank Macfarlane Burnet was interested in the mysteries of viral replication and in the way the immune system worked. Sir John Eccles studied the transmission of nerve impulses in simple reflexes like the knee jerk. Professor Derek Denton learnt more than anyone in the world about the significance and metabolism of salt, whereas Professor Paul Korner dissected all the components regulating blood pressure. These pioneers set the pattern, respectively, for The Walter and Eliza Hall Institute, The John Curtin School of Medical Research, and the Florey and Baker Institutes.

At the same time, research of a more practical nature was not neglected. John Cade made the brilliant discovery that lithium was a specific and highly effective treatment for mania. Graeme Clark began the long odyssey that led eventually to the ‘bionic ear’, the cochlear implant for profound deafness. Fiona Stanley and her group in Perth showed that a diet rich in folic acid could markedly reduce the incidence of spina bifida if taken before and early in pregnancy. Robin Warren and Barry Marshall discovered that peptic ulcer, long ascribed to high stress levels, was actually caused by a bacterium – *Helicobacter pylori* – and could be readily cured by antibiotics. A sceptical world waited quite a few years before accepting the findings, but eventually their Nobel Prize came as no surprise. Ian Frazer surveyed the evidence that certain strains of the human papilloma virus caused pre-malignant and malignant lesions of the cervix uteri, leading to the development of the vaccine Gardasil, now given routinely to pre-pubertal girls in Australia.

Some practical discoveries arise rather unexpectedly from basic research. Donald Metcalf was interested in the regulation of blood cell growth and development and how this was distorted in leukaemia. Key molecular regulators included four colony-stimulating factors, or CSFs, namely GM-CSF, G-CSF, M-CSF and multi-CSF (also known as IL-3). It turns out that G-CSF is brilliant at helping to restore granulocyte numbers after cancer chemotherapy and radiotherapy, or after bone marrow transplantation. G-CSF has by now helped over 10 million cancer sufferers.

Against this background, a major review of the National Health and Medical Research Council (NHMRC), the Wills Report, identified a “virtuous cycle” between government, research bodies and industry where value was generated for health expenditures by insistence on research and evidence-based policy and practice and by the development of an internationally linked biotechnology industry.

A second review, the Grant Review, recommended further increases in NHMRC funding with special emphasis on the translation of research into practice. Following these reviews, the NHMRC budget rose at a compound rate of 14.7 per cent per annum from 2000 to 2011, and now stands at $754 million, funding a total of 4205 grants. As a result, the medical research system is quite vibrant in Australia across a broad spectrum of endeavours. There is a much greater consciousness of the need for commercialisation, a widespread use of powerful platform technologies, a real emphasis on multidisciplinarity and teamwork and a fully international outlook.

The Australian Society for Medical Research (ASMR) has commissioned Deloitte Access Economics to study the financial and health returns from NHMRC-funded medical research. Assuming that 50 per cent of health gains were attributable to research, that Australian R&D contributes 3 per cent to the world total, and that 25 per cent of Australia’s health research is NHMRC-funded, the benefit-cost ratio for cardiovascular research was 6:1 and for cancer research 2.7:1. Based on these encouraging calculations, the ASMR is advocating a gradual rise in medical research expenditures from the present 0.8 per cent of all health expenditures to 3 per cent over a period of 10 years or so. In this regard, a new review of health research chaired by Simon McKeon is particularly welcome.

We have every right to be proud of Australia’s achievements in health and medical research and it is time that this effort was seen as an investment and not just as a cost.

ABOVE: *To become a doctor in Australia, extensive education and training is required.*
INSET: *Baker IDI Heart and Diabetes Institute: Professor Paul Korner was its director 1975 - 1990 before the move to these new premises in 2002.*

Image courtesy of 2012 Health Workforce Australia, an Australian Government Initiative INSET: Heart and Diabetes Institute.

ACQUIRING THE COMPETENCY: A HOLISTIC APPROACH

By Professor Russell Stitz, Senior Surgeon at the Royal Brisbane and Women's Hospital and at the Wesley Hospital, and Adjunct Professor at the University of Queensland .

Image courtesy of 2012 Health Workforce Australia, an Australian Government Initiative.

Medical education and training must be based on the concept of lifelong learning and the maintenance and expansion of skills throughout one's career.

The modern healthcare system is complex, multidisciplinary, resource intensive and theoretically driven by safety, quality and evidence-based medicine. Because of the immensity of the knowledge base underpinning medical practice, education methodology has been increasingly focused on self-directed and problem based learning, plus techniques designed to facilitate access to educational materials, research and clinical guidelines.

In addition, the practice of medicine has become more and more specialised as doctors endeavour to achieve higher standards of care by concentrating knowledge and skills. This in turn has had an adverse effect on the number of 'generalists', thus impacting on the provision of acute medical services. The situation is compounded by pressure to shorten training times in an environment of shorter working hours and greater emphasis on work/life balance.

The non-technical professional competencies resulting in the acquisition of emotional intelligence are now an integral part of our education and training programs.

Australia is heavily reliant on international medical graduates (IMGs), particularly in regional areas, and will continue to be until the increased number of medical graduates addresses the national shortage of doctors. The increased numbers, while commendable, have placed additional pressure on the provision of intern and vocational training places.

University medical schools are often reliant on overseas students, who can provide up to half the school revenue. These students are not guaranteed intern positions, although to date, the graduates who wish to continue in the Australian system have been accommodated. Surveys suggest that a majority would remain in Australia as they pursue their vocational training and future careers. It does seem logical to cultivate this pathway rather than being dependent on IMGs.

The shortage of medical practitioners has also spawned the debate about transfer or delegation of what has been previously considered 'medical care' to non-medical health professionals. I support the view that these initiatives should not only maintain safety and quality but, where appropriate, take place in a 'team environment'. In the context of this paper, these initiatives also have educational and training implications.

Medical education and training is about lifelong learning and maintaining and expanding skills.

Image courtesy of 2012 Health Workforce Australia, an Australian Government Initiative.

Colonoscopy is a good example. As we struggle to deliver colonoscopic services, there is a legitimate argument to consider training health professionals other than gastroenterologists and surgeons.

It would seem logical to concentrate initially on training rural GPs rather than nurses as the need is greater in rural and regional Australia. Currently, it is a challenge enough to train general surgeons to an accredited standard without adding to the training burden. There is, however, adequate data to indicate that nurses can be trained to perform colonoscopy in a structured endoscopic unit led by more well-trained specialists. Regardless, given the pressure on training places, the need must be carefully assessed and based on health priorities, rather than simply developing additional career pathways.

One argument is that greater use of simulators will facilitate colonoscopic training. However, the current simulators are useful in only the early stages of the development of colonoscopic skills and are not yet technologically advanced enough to be a significant substitute for real life training on the human colon. Thus healthcare needs, together with safety and quality, must drive this debate, and doctors must avoid vested interest, basing their advice on what is best for the community.

COMPETENCE AND COMPETENCY

The discussion about colonoscopic training raises the whole issue of competencies and the question of when a health professional becomes 'competent'. In delegated care, it is argued that a health professional can be trained to a specific competency. While this is true, it does not address the holistic approach required to be passed as 'competent' in a field of medicine.

In 2009, the Australian Medical Council (AMC) appointed a working party to address this issue and to inform the AMC's role in accrediting medical education and training programs both at the university medical school level and subsequently in vocational training. The working party concluded that knowledge could be codified and explicit (i.e. learnt from teachers, text books, web programs etc.) or tacit. The latter refers to knowledge that is "not able to be made fully explicit … and is dependent on multiple experiences and reflections".

For a doctor to be competent, he or she must combine both codified and tacit knowledge to generate the judgement integral to optimal patient management. That is, competence is not just the sum of a number of competencies, which is why adequate training in the clinical environment is critical if we are to continue to graduate doctors and specialists of a high standard. Further, these skills must be maintained throughout one's professional career.

THE GOAL OF MEDICAL EDUCATION

Ultimately, the goal of medical education should be to produce a specialist in one of the medical disciplines. In an ideal model, the medical student would progress seamlessly through medical school, intern clinical years and vocational training in their chosen speciality to graduate as an independent practitioner. In this model, each component would provide the educational building blocks to proceed to the next level. This implies that there should be considerable collaboration by the responsible educational sectors, as was recommended at the MedEd 09 conference.

It would seem obvious that the goal of a university medical course is not only to graduate

University medical schools are often reliant on overseas students who can provide up to half the school revenue.

The shortage of medical practitioners has also spawned the debate about transfer or delegation of what has been previously considered 'medical care' to non-medical health professionals.

Melbourne Medical School: the building, built in the 1960s, is opposite the Royal Melbourne Hospital within the biomedical precinct in Parkville.

Image courtesy of the University of Melbourne.

a competent intern but to prepare that doctor for their subsequent career progression. To deliver health services, we require a broad range of medical specialties based on the core specialty of General Practice.

The Confederation of Postgraduate Medical Education Councils has developed a curriculum framework for educational requirements in postgraduate years one and two.

The medical colleges select, educate and train specialists but there is currently limited dialogue between universities and colleges regarding the content of the medical course curricula. Universities are controlled centrally and recommendations by individual disciplines are often modified by internal hierarchies. There is a quaint argument that an eclectic university education, which includes intellectual pursuits and subjects not germane to medical practice, somehow produces a better doctor. There is no evidence to support this either way in terms of the quality of graduating doctors. When I was a first year medical student, we were required to take a subject entitled 'The History of Western Civilisation'. Although interesting, neither I nor my colleagues felt that this influenced our ultimate function as doctors.

MEDICAL COURSE CURRICULA

In the mid-1980s, graduate medical courses (GMCs) were introduced into Australia, based on the North American model. I do not intend to comment on the relative merits of postgraduate and undergraduate medical courses. The reality is that there are commercial and international student factors that favour graduate courses, so my intention here is to try to influence the content rather than the structure.

To a clinician, GMCs cannot provide adequate clinical exposure because of the time constraints and the amount of educational and professional material that needs to be covered. There is also the matter of introducing students to research, although the recently introduced University of Melbourne GMC, which culminates in an MD qualification, has been extended to include a research component.

If we accept the argument that the ultimate aim is to produce a qualified specialist in a medical discipline and that the educational spectrum should encompass the acquisition of knowledge, clinical skills, professionalism and academic pursuits, then the current curricula need to evolve.

Modern medicine is based on science, as is research and development, so our education systems must provide adequate basic science building blocks. Although surgical specialties emphasise the importance of anatomy, it is equally relevant to have a sound background in physiology, biochemistry, embryology, molecular biology, genetics, pharmacology and pathology. All these areas should, however, be orientated to applied science and their relevance to the practice of medicine.

To accommodate all these demands in a rational way, it would seem to be self evident that, in the GMC model, the best option would be for aspiring GMC medical students to undertake an undergraduate degree specifically orientated towards medicine. In the interests of shortening the training time in medicine (of vital interest to the community and government), this undergraduate program could have a two year expanded semester structure; this approach has already been trialled successfully. The GMC could then focus on the clinical, professional and academic aspects of medical education and training. Such a move is also likely to re-engage many medical specialists, who are often critical and indifferent in regard to university curricula.

One practical consideration is the previously mentioned dependence of many universities on overseas students. Universities are therefore reluctant to insist that these students have the proposed prerequisite knowledge. Our primary responsibility is to provide the best educational opportunities for medical students in our efforts to produce skilled graduates who are well equipped to continue their vocational training. If necessary, bridging courses could be provided to ensure a common entry standard.

VOCATIONAL TRAINING

Specialty education and training is largely in the hands of the colleges and their associated specialty organisations. These bodies pride themselves on their quest for high standards. The increased number of graduates is placing pressure on training places and teachers. Teaching time is often limited, particularly in the case of visiting medical officers (VMOs), who are obliged to concentrate on delivering the service.

Shorter working hours are impacting on clinical training time, particularly in procedural specialties, and educational initiatives such as simulation and small group learning cannot compensate for this.

In surgery, post Royal Australasian College of Surgeons Fellows (FRACS) refine their skills by sub-specialising, for example in breast/endocrine, colorectal surgery or spine surgery. Recently, there have been proposals to create additional Fellow positions at Senior Registrar level to foster generalism, provide extra experience and help service regional centres.

With the increased emphasis on sub-specialisation, doctors are withdrawing from emergency rosters, arguing that they are no longer competent outside their specialty area. Put another way, they have not maintained their general skills – which may be convenient, but is contrary to the College's policy. In addition to facilitating educational programs to maintain the necessary skills, governments should be encouraged to create incentives that foster and reward generalists, particularly in the acute medicine arena.

NON-TECHNICAL COMPETENCIES

Popularised in the CanMEDS program, non-technical competencies include professionalism and ethics, health advocacy, communication, teamwork, leadership/ management and scholarship/teaching. Although now integral to college programs, the educational and assessment components vary. As they are common to all bodies involved in medical education, there is considerable opportunity for collaborative processes to achieve defined objectives.

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

As it is currently a requirement of the Medical Board of Australia and the AMC that medical practitioners have CPD certification, all the medical colleges have programs that are designed to foster maintenance of knowledge and skills. Some colleges incorporate elements of assessment and performance appraisal. There is an emphasis on adult and self-directed learning techniques and generally a points system to authenticate educational activities and achieve certification.

PERFORMANCE

'Competency' refers to what a doctor is qualified to do, whereas 'performance' is how the practitioner delivers the care. There is considerable debate about whether colleges and their allied specialty groups should be taking greater responsibility for ensuring that health professionals are performing to a satisfactory standard.

The Medical Board of Australia (MBA) is the regulatory and disciplinary body and, theoretically, mandatory reporting has been introduced to identify underperforming practitioners. There is a widespread view that this approach is flawed and may be having an

The ultimate aim of all our educational programs is to produce well-trained, competent practitioners.

adverse effect on the management of doctors' health problems. Nevertheless, we have the privilege of being a largely self-regulated profession and it is my opinion that we have a responsibility to the community to promote processes that monitor performance. RACS Fellows, for example, are required to undergo a peer reviewed audit of a component of their practice each year. Annually, 3.5 per cent of the Fellowship is randomly selected to verify the activity. While commendable, the process is limited by self selection. The College has also driven the Australian Audit of Surgical Mortality, but this audit is designed to improve system delivery rather than identify underperforming individuals.

Although the number of underperforming practitioners is small, as a profession, we should introduce processes that identify problems at a much earlier stage so that remedial measures can, if possible, be introduced. There needs to be an underlying principle that doctors must not be scapegoats for system failures, and investigative processes should remain confidential until the risk adjusted outcomes are finalised using a peer reviewed process. Obviously this approach is negated if there is a risk of personal harm.

THE CHALLENGE AHEAD

Medical education and training institutions face increasing challenges as outlined in this paper. Although we can be smarter and educationally more effective in the way we deliver the programs, the reality is that there is no substitute for experiential clinical exposure in the acquisition of clinical skills, technical expertise and, above all, judgment. The development, maintenance and expansion of skills requires lifelong learning programs. In addition, we have a professional responsibility to ensure that we are not only competent but performing to a high standard. The ultimate aim of all our educational programs is to produce well-trained, competent practitioners. To do this, there must be a more collaborative and pragmatic approach to curriculum development by the bodies responsible for constructing the educational and training pathways

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