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Cover: AMA President Associate Professor Brian Owler opens the AMA National Alcohol Summit in Canberra

AMA LEADERSHIP TEAM

President
Associate Professor
Brian Owler

Vice President
Dr Stephen Parnis

VICE PRESIDENT'S MESSAGE

BY AMA VICE PRESIDENT DR STEPHEN PARNIS

Calling time on a toxic booze culture

At this time every year, the nation becomes obsessed – however fleetingly – with horses and horse racing.

In homes and workplaces across the nation, people embrace the chance to come together and revel in the theatre surrounding the Melbourne Cup and the Spring Racing Carnival.

But, alongside glamorous pictures of sleek racehorses are the images of people swilling alcohol to the point of inebriation and passed out on the ground, staggering down the street or, all too often, ending up in a fight.

It says something not very flattering about our culture that having a good time seems almost inevitably to involve drinking and, for many, drinking to excess.

This has been a habit formed and reinforced across generations, and alcohol companies have been extraordinarily adept at making sure it is a link that is not broken.

Have a look at any major sporting event and it is bound to be infused with alcohol – from the drinks of fans in the stands to the logos emblazoned on jerseys and billboards to the ads that fill up broadcast time and the champagne showered by the winners atop the podium.

The none-too-subtle message is clear – drinking is part of sport, and to drink is to be a winner.

I am not against drinking per se.

Like most, I enjoy a drink.

But many people are drinking to the point that it is hurting their health and harming those around them.

A Foundation for Alcohol Research & Education poll released early this year found that almost a quarter of drinkers drank at least three times a week, one in six drinkers consumed more than six standard drinks in a typical session, around 25 per cent felt unable to stop drinking once they started, and more than a third said they drank to get drunk.

There is some evidence that per capita consumption is slowing, but Australians remain heavy drinkers by global standards – the World Health Organisation reported that we each drank, on average, 12.2 litres of pure alcohol in 2012, virtually double the international average.

Unsurprisingly, given the scale of the drinking problem, almost three quarters of us report being adversely affected by someone else's drinking, and more than a third say they have suffered from alcohol-related violence.

That is why the AMA organised the National Alcohol Summit late last month, bringing together politicians, doctors, public health experts, police, industry and members of the community to delineate the problem and, more importantly, to work out what can and should be done about it.

In this regard, it was inspiring to hear from Ralph and Kathy Kelly, whose son Thomas was killed in a random alcohol-fuelled attack in King's Cross in mid-2012.

Determined to do what they could to make sure something like this never happens again, they formed the Thomas Kelly Youth Foundation to campaign for changes to make the streets safer, including shorter opening hours, tighter licensing laws, and tougher penalties for those who attack others while drunk.

The Summit heard just how much the nation's drinking problem is costing us, in terms of lives cut short, families broken, people left maimed, serious and chronic illnesses, lost productivity, traffic accidents, mental illness, and social and emotional problems.

The toll is staggering – estimates of up to $15 billion a year from the burden of disease alone, and up to $36 billion taking into account all harms.

It is clear that a substantial majority of Australians is well aware of the problem, and want something to be done.

That is why the AMA, drawing on the proceedings of the Summit, has proposed the Federal Government adopt an eight-point National Alcohol Strategy that:

- sets out the Commonwealth's leading role in ensuring a nationally-consistent approach to rules governing the supply and availability of alcohol;

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Calling time on a toxic booze culture

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- includes the development of an effective and sustained public education campaign about the harm caused by alcohol;
- increased investment in alcohol prevention and treatment services;
- the development of measures specifically addressing the needs of the Indigenous community;
- the statutory regulation of alcohol marketing and promotion, backed by meaningful sanctions;
- improved research and data collection regarding alcohol use;
- a review of alcohol pricing and taxation; and
- transparent policy development independent of industry influence.

These are all things on which work can, and should, begin immediately.

The AMA was gratified to see that senior members of all the major political parties, including Assistant Health Minister Fiona Nash, Opposition leader Bill Shorten, Shadow Health Minister Catherine King, and Australian Greens health spokesman Richard Di Natale, attended the Summit and acknowledged the seriousness of the nation's drinking problem.

But the time for talk is done.

We now want to see them back up their words with action, and the AMA will not let up on the pressure for them to act.

As AMA President Associate Professor Brian Owler said when closing the Summit, we will use every road fatality, every bashing, every case involving a child with foetal alcohol spectrum disorder, and every other alcohol-related tragedy to hammer home to the Government its responsibility to act, and I urge you all to do the same.

INFORMATION FOR MEMBERS

AMA Careers Advisory Service

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

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

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

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

But the Service is not only there for those in the early stages of their medical careers. It has also helped qualified medical professionals looking to apply their skills and expertise in jobs beyond medical practice. Among these have been those looking for non-clinical roles in Commonwealth and State public services that take advantage of their skills and experience.

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

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

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

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

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

Email: careers@ama.com.au

AMA ramps up campaign against crippling co-payment

The AMA is ramping up its campaign against the Federal Government's co-payment plan amid evidence it could force many medical practices to shut down under the weight of greater red tape, Medicare rebate cuts and increased bad debts.

Adding to the evidence that the $7 co-payment was likely to undermine access to primary health care, a report commissioned by the AMA has found bad debts and increased administration costs caused by the measure were likely to add between $1.76 and $4.21 to the cost for each service, meaning that in many instances the $2 "windfall" to be passed on to practices under the Government's model would be completely outstripped by additional costs.

AMA President Associate Professor Brian Owler said the extra expenses, coming in addition to the planned $5 cut in the Medicare rebate, could push many practices over the financial edge and make them unviable.

"The Government's plan would rip $3.5 billion form frontline GP, pathology and imaging services [and] create a costly red tape nightmare for medical practices," A/Professor Owler said. "It would make many general practices unviable."

Under the Government's model, the Medicare rebate would be cut by $5 and all GP, pathology and diagnostic imaging patients would be charged a $7 co-payment. Doctors would retain $2. Concession card holders and children younger than 16 years would be eligible for bulk billing after their first 10 visits in a year, while practices that bulk billed any other patients, or which failed to collect the $7 co-payment, would face severe financial penalties.

The Kilham Consulting report said that in its first year of operation (2015-16), the co-payment was likely to apply to around 233 million services, including 195 million services that were previously bulk billed and that will therefore attract a higher cost to administer.

It said that, depending on staff costs and the level of automation, administering the co-payment was likely to cost between $1.41 and $1.61 per service, meaning that the total extra cost of administering the co-payment was likely to reach between $274 million and $313 million in 2015-16, and up to $331 million by 2017-18.

"This is a dead-weight cost to the economy," the report said. "There is no efficiency gain claimed for the measure. On the contrary, there is an efficiency loss as a result of additional transaction costs."

A/Professor Owler said this was completely inconsistent with the Government's promise to cut down on unnecessary rules and regulations.

"The Government has committed to an agenda of deregulation and red tape reduction, but its Medicare co-payment proposal achieves the opposite," he said.

The Kilham report shows practices will pay an even higher price if they defy the Government's intentions and continue to bulk bill their patients.

It said the proposed arrangements would very heavily discourage bulk billing. The current bulk billing incentive ($6.15 per service in metro areas, and $9.25 in others) would be converted into a low gap incentive that would only be payable for eligible patients who were charged exactly the $7 co-payment.

For example, an urban practice that continued to bulk bill patients would lose $11.15 per service, and those in rural areas would suffer a cut of $14.25 per service.

The report warned there was likely to be blow out in bad debts, particularly for practices in low income areas.

It said it was likely practices would invoice the co-payment "even when it is clear that the patient will refuse to pay, or will not have the means to pay. This also means necessarily that there will be bad debts".

Medical practices in low income areas with high rates of bulk billing told the report's authors that, "they believe that patients will expect to be treated whether they pay the co-payment or not".

It warned that for such practices bad debt costs could reach up to $2.80 per service, in addition to extra administrative costs of at least $1.41 per service.

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NEWS

AMA ramps up campaign against crippling co-payment

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"Bad debts are the 'sleeper' in the equation," the report said. "If they turn out to be high, the unit cost of bad debts will dwarf the unit costs of administering the co-payment."

It said the break-even point for the bad debt rate was 8.5 per cent, and "anything above that means the general practices will have to review their rates of patient billing and increase their prices in order to recover the costs of the scheme".

A/Professor Owler said the AMA was not opposed to co-payments per se, but the report's findings showed that the Government's co-payment was not only unfair for disadvantaged patients, but also hurt practices, and should be scrapped.

"We are not opposed to those patients who can afford to pay a co-payment sharing in the costs of their health care," he said. "[But] we do not support the Government's co-payment because it is unfair, inequitable and would hurt the poor…It would also make many general practices unviable."

He said the AMA had sought constructive discussions with the Government about modifications to its co-payment plan, including meeting its request for an alternative model.

But A/Professor Owler said an "absence of meaningful engagement" had left the AMA with no alternative but to intensify its efforts to have the Government's co-payment proposal scrapped.

"My focus in coming weeks will be to continue highlighting the risk to our high quality health system that the Government's model represents," he said. "It cannot be salvaged by small changes here and there, or a last-minute deal in the Senate. It needs to be dumped."

Adrian Rollins

Co-payment negotiations reach 'promising' stage: Dutton

AMA President Associate Professor Brian Owler (R) meets with Palmer United Party Senator Glenn Lazarus to talk about the $7 Co-paymnet and Univresity fee deregulation.

Federal Government negotiations to secure Senate support for the introduction of the controversial $7 GP co-payment have reached a "sensitive, promising stage", according to Health Minister Peter Dutton.

In a sign that the Government believes it is making progress on one of its most heavily criticised Budget measures, Mr Dutton said there was "a lot of good will" among independent Senators to support measures that would improve the sustainability of Medicare.

"Discussions [with the Senators] are at a sensitive, promising stage," the Minister said. "Our effort at the moment is to get agreement from the Senators to introduce the co-payment, [and] I think there is a lot of good will from the Senators to get a good deal done to make Medicare sustainable."

The AMA has been at the forefront of community criticism of the measure amid warning the co-payment will deter many patients, particularly the most vulnerable, from seeking timely care, exacerbating health problems and ultimately adding to the nation's health bill.

The Government has also encountered steadfast opposition to the proposal in the Senate, where Labor, the Australian Greens and the Palmer United Party have vowed to block the measure, and PUP Senator Glenn Lazarus met with AMA President Associate Professor Brian Owler last week to discuss the co-payment, among other issues.

But the PUP's backflip late last month on its long-standing opposition to the Government's Direct Action plan to curb greenhouse gas emissions has stoked speculation the Government may be able to muster sufficient Senate support to usher in the co-payment plan, under which patients would pay $7 for GP, pathology and diagnostic imaging services, and there would be a $5 cut to the Medicare rebate.

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NEWS

Co-payment negotiations reach 'promising' stage: Dutton

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AMA President Associate Professor Brian Owler with Research Australia Chair Professor Christine Bennett at the Research Australia Awards Dinner 2014

The Government has attempted to soften opposition to the co-payment by linking its introduction to the establishment of a $20 billion Medical Research Future Fund.

In its Budget, the Government announced funds raised by the co-payment and associated Medicare rebate cut would be directed toward the Fund, and has sought to mobilise support for the arrangement from the research and business communities.

But A/Professor Owler said the Government should abandon such tricky ploys, and instead make a real commitment to medical research.

"If the Government was truly sincere in its commitment to medical research, it would provide a fairer, untainted way to finance the Fund," the AMA President said. "It is appalling that a Fund designed to cure diseases and save lives in the future must rely on the chronically ill, the elderly, the poor, and Indigenous Australians paying more for their vital health services today."

A/Professor Owler called on health and medical researchers to reject the Government's attempts to turn them into lobbyists for the MRFF while the Fund remains linked to the Budget cuts to important health services.

"The medical research community should instead lobby the Government to de-link the Fund from the co-payments and Medicare rebate cuts," he said. "The Government must find another way to fund the MRFF, and we encourage Australia's medical researchers to reject a funding mechanism that hurts the most vulnerable Australians."

But the Government is pushing ahead with the MRFF as part of its much vaunted innovation agenda.

Late last month, Mr Dutton appointed former Australian Competition and Consumer Commission Chair Graeme Samuel to head a four-member review of the nation's independent medical research institutes to examine ways to improve their viability and competitiveness, and enhance collaboration among research organisations and business.

The review panel, which is due to report by the end of January 2015, includes merchant banker Alastair Lucas, who has convened the Medical Research Future Fund Action Group to champion the MRFF.

The Government has also called for comment on a discussion paper looking at ways to improve the commercialisation of Australian research.

Industry Minister Ian Macfarlane said Australia produced world-class research but collaboration with business was weak.

"We must lift our game when it comes to collaboration between business and research," the Minister said.

The research paper, which can be viewed at www.education.gov.au/current-reviews-and-consultations, is open for comment until 28 November.

Adrian Rollins

INFORMATION FOR MEMBERS

Medical tourism summit

Virtually unheard of a decade ago, medical tourism is becoming an increasingly common aspect of modern medical practise.

Cheap air travel and the spread of medical knowledge and technology has meant more people than ever before are willing to seek treatment overseas, lured by lower costs or cutting edge expertise and techniques.

The Medical Tourism 2014 Summit is being held next month to explore rapid growth in medical tourism and its impact on the Australian health system.

It will look at factors driving Australians to seek treatment offshore, as well as the flow of patients coming to Australia.

Speakers will include NIB Health Fund CEO Mark Fitzgibbon, Melbourne IVF medical director Lyndon Hale, Epworth Group medical director Professor John Catford and Global Health Travel, Thailand managing director Cassandra Italia.

The Summit is to be held on 20 and 21 November at Rendezvous Grand Hotel, Melbourne.

For details, visit: http://www.informa.com.au/conferences/health-care-conference/medical-tourism-summit

NEWS

Govt under pressure to do more on Ebola

AMA President Associate Professor Brian Owler has urged the Federal Government to consider deploying AUSMAT teams to assist the international fight against Ebola in west Africa following the announcement that a private company has been engaged to staff a treatment centre in Sierra Leone.

A/Professor Owler said the Government's decision to engage Australian-based global health provider Aspen Medical to staff and operate a United Kingdom-built 100-bed Ebola treatment centre in Sierra Leone was a welcome development given the enormous scale of the outbreak gripping west Africa.

Prime Minister Tony Abbott announced last week the Government would provide up to $20 million in the next eight months to support the operation of the facility, which will have 240 staff.

The announcement followed weeks of pressure for the Government to step-up its response to the epidemic which has so far claimed more than 4800 lives and infected more than 13,000 people.

The AMA first publicly urged the deployment of Australian health workers more than six weeks ago, and both the US and British governments have contacted senior Government ministers to ask that Australia upgrade its efforts.

Government hopes that the Aspen announcement would satisfy these demands appear forlorn.

In addition to A/Professor Owler's call, United States National Security Adviser Susan Rice has demanded, in unusually forthright language, that Australia do more.

Dr Rice told *The Australian Financial Review* that "we look to Australia and other partners…to fulfil the commitments they've made and do more, quite frankly. Because at this stage there are many needs that remain unmet in the west African region. We continue to look to capable partners like Australia to do their part."

A senior World Health Organisation has said there are glimmers of hope that the world's worst-ever Ebola outbreak may be slowing.

In its latest update, the WHO said the rate of new cases in Liberia appeared to be declining, while the outbreak in Guinea appeared to be stabilising. But it is still growing in Sierra Leone.

WHO Assistant Director-General Bruce Aylward said evidence of a slow-down in Liberia was welcome, but was at pains to caution that it was far too early to say that the worst of the outbreak was over.

"In Liberia, we've seen the disease slowing down. Now we have to be very careful when we say that though — it means it's going from an exponential rate of growth of what we call a linear, a sort of slower rate of growth," he said. "In key areas in Guinea and Sierra Leone, we're also seeing the disease dropping very quickly, and this is mainly because populations are starting to understand the risks associated with Ebola and how to protect themselves and their families from the disease. So that's very encouraging, it's going to slow the disease down, but it's not going to stop it."

Mr Abbott said most of the health workers engaged at the Aspen-operated clinic would be local, though some staff would be hired internationally, including possibly some Australians.

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NEWS

Govt faces pressure to do more on Ebola

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Aspen Medical chief executive Glenn Keys said on ABC radio that he expected Australians to comprise between 10 and 20 per cent of total staff, and the company has reported more than 350 health workers have volunteered so far.

The arrangement, thrashed out in discussions with UK and European governments, removes the key roadblock cited by the Government in resisting international pressure to send Australian health workers to west Africa.

"The Government has said consistently that it would not deploy Australians to Ebola-affected countries without a credible plan for their treatment or medical evacuation," Mr Abbott said. "Australia has now received credible assurances for in-country treatment and medical evacuation for Australian volunteers who provide health care in west Africa."

A/Professor Owler said the issue had never been about bringing infected health workers directly back to Australia, and the aim had always been to ensure any volunteers who became infected could be treated in west Africa, where possible, or be evacuated to countries like Britain or Germany where necessary.

"We are pleased that arrangements are now in place and we now need to move forward," he said.

This is the latest major government health contract awarded to Aspen Medical, which had also been subcontracted by Medibank Private offshoot Medibank Health Solutions to provide on-base health services for Australian Defence Force personnel.

Mr Abbott said the Government had decided to engage a private provider rather than provide the medical services itself because "it is a health emergency, not a military emergency".

"We are not sending people over," the PM added.

But A/Professor Owler said that, while the Ebola epidemic was indeed a health emergency, it was also a humanitarian, security and economic emergency, and said that – in addition to engaging Aspen – the Government should also be looking at deploying Darwin-based AUSMAT teams to west Africa.

"AUSMAT teams are prepared and ready for deployment, and would volunteer to go and do this work," he said.

The Government's decision to bypass non-government organisations already on the ground in west Africa and engage Aspen has raised eyebrows amid concerns the organisations may not have the competence to run an Ebola treatment centre.

But Mr Key said the company was already operating a clinic in Liberia and signalled its intention to work closely with other organisations already on the ground in Ebola-hit regions.

"We will be working really, really closely with MSF [Medecins Sans Frontieres], the WHO [World Health Organisation], Save the Children, as well as the various governments of Britain, Sierra Leone and Australia," he told the ABC.

"I don't think we're going in there operating on our own. We are going to be using all of the experience, including that of the MSF and the WHO," he said.

Health Minister Peter Dutton said there was nothing unusual in the Government's decision to appoint Aspen.

Mr Dutton said several European countries had engaged private companies to assist the Ebola effort: "We're seeing lots of private contractors because they've got the capacity and the logistical capacity to deliver very quickly what governments want on the ground".

The AMA President said the key to bringing the outbreak under control was to get as many people as possible into treatment facilities.

Mr Abbott said that, while the Government was engaging Aspen to boost international efforts on the ground in west Africa, it would also beef up preparations for any possible outbreak in the region.

"Consistent with the Government's long-standing priority to keep our country and our region safe from Ebola, we will provide an initial package of up to $2 million to train health officials in Papua New Guinea, Timor-Leste and the Pacific Islands to prepare for a potential Ebola outbreak," the Prime Minister said.

But A/Professor Owler said the best way to ensure the safety of the country and the region was to tackle the outbreak at its source in west Africa.

Adrian Rollins

NEWS

Govt reforms to deliver boost to country practice

The AMA has hailed the Federal Government's overhaul of outdated rural workforce classification systems as a major breakthrough for country health.

Assistant Health Minster Fiona Nash has announced that the Government will switch from current flawed criteria to a more accurate classification system to ensure doctors have the support and incentives to go where they are most needed.

Senator Nash said she had been working closely with the AMA, other medical organisations and rural and regional communities on scrapping the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) and the District of Workforce Shortage (DWS) systems and replacing them with arrangements that worked better and eliminated serious anomalies.

"We need to make it easier to get doctors to where they are needed most, with the right doctor, with the right skills, in the right place," the Minister said.

The AMA and other organisations have been highly critical of the ASGC-RA virtually since its introduction because the way it was structured led to many perverse outcomes, including creating incentives for doctors to move from small rural towns to large coastal cities.

There have been numerous perverse outcomes under the ASGC-RA system, such as doctors working in Cairns, a coastal city of 150,000 people, receiving the same incentives as those working in central west NSW towns such as Hay and Deniliquin.

"The AMA has been advocating for these changes for years," A/Prof Owler said. "We congratulate Senator Nash for engaging with the medical profession, hearing and understanding the concerns of country doctors and their patients, and delivering a positive outcome."

Senator Nash said that, instead of the ASGC-RA, the Government would now use the Modified Monash Model (MMM) to decide on the allocation of resources.

The MMM is based on the current Australian Bureau of Statistics remoteness classification structure, and classifies regional areas according to local town size.

The Minister said that, as a result, under the MMM system Charters Towers would be in a different category to Townsville, Port Fairy will have a different classification to Ballarat, Gundagai will be different to Hobart and Sale will differ from Mildura.

AMA President Associate Professor Brian Owler said changes to the DWS system were equally welcome.

Under the system, doctors recruited to serve communities classified as being a DWS are able to bill Medicare for their services - including those who are otherwise subject to Medicare billing restrictions, such as overseas trained doctors, foreign graduates of Australian medical schools and Australian-trained bonded doctors.

Senator Nash said under the old arrangement, DWS classifications were based on outdated population figures and lagged behind the needs of towns that experienced recent growth.

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Govt reforms to deliver boost to country practice

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She said the new DWS system would use the latest population and medical services data to more accurately determine areas of doctor shortage.

"The new system will create more stability for towns that fluctuate in their DWS status," the Minister said, adding that DWS determinations for GP services would be updated annually rather than quarterly, so that access to Medicare billing would be more assured.

A/Professor Owler said this was an important improvement that would "deliver more certainty for communities with poor access to medical services".

Complementing this change, Senator Nash announced that the Bonded Medical Places (BMP) program would be changed to allow any bonded student to complete their return of service obligation in rural towns of less than 15,000 people, regardless of whether or not they had a DWS designation.

A/Professor Owler said it was a common sense change.

"Some BMP graduates who want to stay in rural towns are currently prevented from doing so if the town is not classified as DWS," he said. "The Government changes provide more flexibility for BMP graduates who want to live and work in rural Australia."

Senaotr Nash said she would appoint an expert panel to advise on the transition to the new arrangements, a commitment A/Professor Owler said was "really important".

"Senator Nash has recognised the AMA's call for consultation on the implementation of these measures through the formation of the Expert Panel, and the reconvening of the technical working group," he said. "It is really important that we get these reforms right, and iron out any problems before the changes come into operation."

Groups including United Gneral Practice Australia, the Rural Doctors Association of Australia and Rural Health Australia also commended Senator Nash on the changes.

Adrian Rollins

INFORMATION FOR MEMBERS

AMA LIST OF MEDICAL SERVICES AND FEES

The 1 November 2014 edition of the AMA List of Medical Services and Fees will soon be available, both in hard copy or electronic format.

A hard copy of the fees book will be sent to AMA members listed as being in private practice or with rights of private practice, as well as salaried members who have requested a copy. Dispath will commence from 15 October.

The AMA Fees List Online **(http://feeslist.ama.com.au)** will be updated on 1 November. To access this part of the website, simply enter your username and password in the box provided on the screen. Members can view, print or download individual items or groups of items to suit their needs.

Electronic versions (PDF or CSV) of the AMA List will also be available for free download from the Members Only area of the AMA Website (www.ama.com.au/feeslist) [https://ama.com.au/node/4597] from 22 October 2014.

A Fees Indexation Calculator is also available for members to calculate their own fee increase based on their individual cost profile.

To access this part of the website simply enter your username and password in the box on the top right hand side of the screen and follow these steps:

1) once you have entered your login details, from the home page hover over **Resources** at the top of the page;
2) a drop down box will appear. Under this, select **AMA Fees List**;
3) select the first option, **AMA List of Medical Services and Fees - 1 November 2014**;
4) download either or both the **CSV** (for importing into practice software) and PDF (for viewing) versions of the AMA List;
5) for the Fees Indexation Calculator, select option **15. AMA Fees Indexation Calculator**.

Members who do not currently have a username and password should email their name, address and AMA member services number to memberservices@ama.com.au requesting a username and password.

If you do not receive your hard copy of the 1 November 2014 AMA List of Medical Services and Fees or would like one, please contact the AMA on 02 6270 5400 or email feeslist@ama.com.au

NEWS

Health a wise investment

H20 INTERNATIONAL HEALTH SUMMIT

13 & 14 November 2014 • Melbourne

The great social and economic benefits that derive from investing in health will be the focus of international discussion when health experts from around the world converge on Melbourne for the H20 Health Summit later this week.

The Summit, organised by World Medical Association, the federal AMA and AMA Victoria, is aimed at ensuring health is one of the top issues discussed by global leaders when they meet.

WMA Chair Dr Mukesh Haikerwal, who has been the driving force behind the H20 meeting, said that health was often neglected at top international meetings like the G20 despite the pivotal role it played in national prosperity and well-being.

Australia is hosting a meeting of G20 leaders in Brisbane this weekend, and Dr Haikerwal said that although it was too late to get health onto the agenda for this summit, the goal was to convince governments that health deserved to be at the centre of discussions when the G20 meets next in early 2015.

The H20 meeting, being held on 13 and 14 November, will include sessions on health as a wise investment, international health promotion efforts, an account of health policy in China, the global upsurge in non-communicable diseases and mental health issues, and the influence of social, economic and environmental factors on health, including climate change.

Speakers will include AMA President Associate Professor Brian Owler, WMA President Dr Xavier Deau, Australian Institute of Health and Welfare CEO David Kalisch, Professor Angang Hu, Dean of the Institute for Contemporary China Studies at Tsinghua University, China, Victorian Health Department Secretary Dr Pradeep Philip, World Psychiatric Association President Professor Dinesh Bhugra and Dr Alessandro Demaio of Harvard Medical School.

For more details on the H20 Health Summit, visit: http://amavic.com.au/page/Doctors_in_Training/Calendar/H20_International_Health_Summit/

The full program can be viewed at: http://amavic.com.au/icms_docs/204544_H20_International_Health_Summit_Program.pdf

Adrian Rollins

INFORMATION FOR MEMBERS

Advance care planning service launched

The hopes of elderly Australians to determine how they are treated and how they will spend their final days have been given a boost with the launch of an advisory service for GPs and aged care workers.

The service, Decision Assist, has been developed with Federal Government funding and aims to assist those caring for older Australians, including doctors, nurses, and allied health professionals, by providing them with additional knowledge and skills about advanced care planning and palliative care.

Decision Assist Chair Associate Professor Bill Silvester said that Decision Assist service aimeds to help meet the wishes of older people to avoid hospital where possible, and help them stay in their community.

The service includes:

- a national hotline to assist GPs and aged care workers with information about palliative care and advice on advance care planning advice (**the hotline, 1300 668 908, will operate between 8am to 8pm seven days a week**);
- specialised training and workshops for GPs and aged care staff to enhance their knowledge and skills about advance care planning and palliative care;
- online resources and mobile applications to enable quick and convenient access to up-to-date end of life care information, as well as links to promote the co-ordination of care among service providers; and
- a dedicated website (www.decisionassist.org.au) containing detailed information on advance care planning and palliative care.

Kirsty Waterford

AMA IN THE NEWS

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

Print/Online

Dial-up doctors in cyber surgery, *Courier Mail*, 23 October 2014

Patients would be able to visit a doctor online and get a prescription under a Medibank Private plan to bring medical care into the digital age. The proposal has drawn fierce opposition from the AMA, which will lobby the Government not to back the scheme.

Sobering statistics ahead of summit, *MX* Sydney, 22 October 2014

Alcohol misuse is the cause in the deaths of almost one in six young Australians, and no "one magic" remedy will solve the problem, the AMA National Alcohol Summit in Canberra will be told.

Ebola: plague of confusion, *Courier Mail*, 23 October 2014

The top doctor in charge of Australia's Ebola response did not know about a team of 20 medicos ready to deploy in case of an outbreak. AMA President A/Professor Brian Owler said the Chief Medical Officer's comments to a Senate committee showed that Australia was asleep at the wheel as far as Ebola was concerned.

Aussies set to up stakes on Ebola, *Adelaide Advertiser*, 24 October 2014

Australia is poised to upgrade its response to the Ebola crisis. AMA President A/Professor Brian Owler said it would be irresponsible for Australia not to send health workers to help contain the virus.

AMA slams Ebola response as first case hits New York, *Sydney Morning Herald*, 25 October 2014

The AMA has accused the Abbott Government of acting too slowly to tackle the Ebola crisis because of concerns about the political consequences of an Australian health worker being infected. AMA President A/Professor Brian Owler said there was a willingness to be involved in the Iraq-Syria conflict but not in the humanitarian crisis occurring in west Africa.

Risk rates turn health cover to stealth cover, *Adelaide Advertiser*, 25 October 2014

Patients who want comprehensive health cover now have to pay thousands of dollars more than they did in the past. AMA President A/Professor Brian Owler warned that community rating was one of the most important aspects of the health insurance system.

AMA head attacks Australia's response to Ebola as shambolic, *The Australian*, 26 October 2014

AMA President A/Professor Brian Owler called on the Government to develop and announce a plan for helping to tackle the Ebola crisis. A/Professor Owler said Australia's response to Ebola so far had been a shambles.

AMA wants assurance TPP deal won't push up medicine prices, *ABC News*, 26 October 2014

The AMA wants assurance that the mooted Trans Pacific Partnership trade deal will not push up medicine prices. AMA president A/Professor Brian Owler said the agreement could be beneficial, as long as it does not inflate medicine costs.

Australia must commit to the Ebola fight, *Sydney Morning Herald*, 27 October 2014

Time is running out for the Abbott Government to form, disclose, and implement a cohesive strategy to help limit the spread of Ebola in west Africa. The AMA has rightly seized on the perception that the government's response has been a shambles.

Irrational fear of Ebola hampering international response: scientist, *Sydney Morning Herald,* 30 October 2014

Rich countries such as Australia cannot protect themselves from the Ebola virus by retreating behind their borders. AMA President A/Professor Brian Owler described the decision by countries to close their borders as short-sighted.

Alcohol the mother of unemployment, *Herald Sun*, 30 October 2014

Mums who drink while pregnant could be consigning their child to a lifetime of unemployment and dependency, an AMA National Alcohol Summit has heard.

Doctors demands stronger stance and new laws to curb alcohol abuse, *Courier Mail*, 29 October 2014

Doctors are demanding new laws to crack down on alcohol. AMA President A/Professor Brian Owler called for a national strategy to deal with alcohol abuse and new laws to curb alcohol marketing at sporting venues.

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AMA IN THE NEWS

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Call to harden up liquor laws, *Courier Mail*, 29 October 2014

Doctors are demanding new laws cracking down on alcohol. In an emotional speech to the AMA National Alcohol Summit, AMA President A/Professor Brian Owler said doctors were often left to stich up victims and to inform parents their children were disabled as a result of excessive drinking.

Australia instigates Ebola-prompted ban on travel from West Africa, *CNN*, 28 October 2014

Immigration Minister Scott Morrison announced strong controls on arrivals from west African countries affected by cases of the deadly disease. AMA President A/Professor Brian Owler said that the chance of the disease entering the country through a migrant from the region was very low.

GP fee could bypass Senate, *Adelaide Advertiser*, 31 October 2014

The controversial GP fee could be brought into effect without Parliamentary approval in the same way the Government this week side stepped Parliament to introduce petrol indexation. AMA President A/Professor Brian Owler said he wouldn't be surprised if the Government went down that path.

We'll fight Ebola from afar, *Courier Mail*, 31 October 2014

A Morgan poll found 70 per cent of Australians supported sending doctors and nurses to west Africa. AMA President A/Professor Brian Owler said the poll showed that the majority of Australians had the same moral and ethical principles as the doctors and nurses who had already volunteered to go to west Africa.

Radio

A/Professor Brian Owler, ABC NewsRadio, 24 October 2014

AMA President A/Professor Brian Owler talked about the Federal Government being under pressure to do more in the fight against Ebola. A/Professor Owler believes Australia should be sending volunteers to west Africa.

A/Professor Brian Owler, 2CC Canberra, 27 October 2014

AMA President A/Professor Brian Owler talked about the Ebola crisis. A/Professor Owler said a key AMA concern was the safety of health care workers.

A/Professor Brian Owler, Radio National, 27 October 2014

AMA President A/Professor Brian Owler discussed the Ebola outbreak in west Africa and said there is no doubt that the world is dealing with a humanitarian crisis of an unprecedented proportions that would only be addressed with an international response.

A/Professor Brian Owler, 666 ABC, 28 October 2014

AMA President A/Professor Brian Owler talked about the importance of the AMA's National Alcohol Summit in Canberra.

Dr Brian Morton, 702 ABC Sydney, 29 October 2014

AMA Chair of General Practice Dr Brian Morton talked about Ebola preparations, how to treat the virus, and the incubation process.

Dr Brian Morton, 2SER FM Sydney, 4 November 2014

AMA Chair of General Practice Dr Brian Morton discussed the Ebola outbreak. Dr Morton said the public needs to urge the Government to fulfil its obligations to the rest of the world.

A/Professor Brian Owler, 774 ABC Melbourne, 5 November 2014

AMA President A/Professor Brian Owler discussed sending Australian health care workers to help fight the Ebola outbreak. A/Professor Owler said it is important to control the problem at its source.

A/Professor Brian Owler, ABC NewsRadio, 5 November 2014

AMA President A/Professor Brian Owler talked about the Federal Government preparing to announce plans to assist Australian volunteers who want to travel to west Africa to help fight the Ebola outbreak.

MORE P16

AMA IN THE NEWS

... FROM P15

Television

A/Professor Brian Owler, ABC Sydney, 23 October 2014

Questions have been raised about whether Australia is prepared to deal with an outbreak of the Ebola virus in this region. AMA President A/Professor Brian Owler has urged the Federal Government to do more.

A/Professor Brian Owler, ABC News 24, 25 October 2014

The AMA has criticised the Federal Government's response to the Ebola threat, labelling it as shambles. AMA President A/Professor Brian Owler said there had been a lack of transparency and information from the Government about its approach to the crisis.

Dr Stephen Parnis, ABC News 24, 27 October 2014

The Australian Government has increased measures to prevent Ebola from entering the country. AMA Vice President Dr Stephen Parnis said Ebola must be tackled in west Africa and the Government is asleep at the wheel.

A/Professor Brian Owler, Channel 9 Melbourne, 28 October 2014

AMA President A/Professor Brian Owler talked about the AMA National Alcohol Summit and the urgent need for the Federal and State Governments to get involved.

A/Professor Brian Owler, WIN Canberra, 29 October 2014

AMA President A/Professor Brian Owler discussed the AMA National Alcohol Summit. A/Professor Owler said there needed to be a change in the way alcohol was marketed to young people through sport.

A/Professor Brian Owler, SBS Sydney, 1 November 2014

The US has repeated its request for the Federal Government to increase its efforts to fight the Ebola crisis. AMA President A/Professor Brian Owler said there were no more excuses.

A/Professor Brian Owler, ABC News Breakfast, 5 November 2014

AMA President A/Professor Brian Owler talked about reports the Federal Government was preparing to announce plans to assist Australian volunteers who want to travel to West Africa to help fight the Ebola outbreak.

A/Professor Brian Owler, SKY News Australia, 5 November 2014

AMA President A/Professor Brian Owler discussed the Government's announcement to fund the staffing of a medical centre to help combat the Ebola outbreak in west Africa. A/Professor Owler said there are other medical teams ready to volunteer, such as the Darwin-based AusMAT teams.

INFORMATION FOR MEMBERS

AMA Indigenous Peoples Medical Scholarship 2015

Applications are invited for the AMA Indigenous Peoples Medical Scholarship 2015.

The Scholarship is open to Aboriginal and Torres Strait Islander people who are currently studying medicine, with the4 successful applicant receiving $10,000 year for the duration of their course.

AMA President Associate Professor Brian Owler said training more Indigenous doctors and health professionals was an important part of closing the health and life expectancy gap between Aboriginal and Torres Strait Islander people and the rest of the community.

"The AMA Scholarship aims to help increase the number of Aboriginal and Torres Strait Islander people in the medical workforce," A/Professor Owler said. "Previous AMA Scholarship recipients have graduated to work in Indigenous and mainstream health services, and some have spent time providing care in their own communities."

Since 1994, the Scholarship has assisted more than 20 Indigenous men and women to become doctors – many of whom would not otherwise not have had the money needed to study medicine.

"Increasing the number of Indigenous doctors and health workers improves access to culturally appropriate health care and services, and ensures medical services respond properly to the unique needs of Aboriginal peoples and Torres Strait Islanders," A/Professor Owler said.

Applications for the Scholarship must be received by 30 January, 2015.

To be eligible, applicants must be currently enrolled at an Australian medical school, be in at least their first year of medicine, and be of Australian Aboriginal and/or Torres Strait Islander background.

For more information, including how to apply, visit: https://ama.com.au/ama-indigenous-peoples-medical-scholarship-2015

NOVEMBER HEALTH EVENTS

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

Sun	Mon	Tue	Wed	Thur	Fri	Sat
26	27	28	29	30	31	**1** National Movember Month National Lung Awareness Month National Prematurity Awareness Month National Alpha-1 Awareness Month
2	**3**	**4**	**5**	**6**	**7** National Sunnies Day Walk to Work Day	**8** International Day of Radiology
9 National Phycology Week National Food Safety Week Spinal Cord Injury Awareness Week Walk to d'Feet MND - Sydney	**10**	**11** National Thank U NICU Day	**12** World Pneumonia Day	**13**	**14** World Diabetes Day	**15**
16	**17** World Prematurity Day National Cervical Cancer Awareness Week National Skin Cancer Action Week National DES Awareness Week World Antibiotic Awareness Week	**18**	**19** World Chronic Obstructive Pulmonary Disease Day World Toilet Day	**20**	**21**	**22**
23	**24** National Australian Mesothelioma and Asbestos Awareness Week	**25** National Disability Awards National White Ribbon Day	**26**	**27**	**28**	**29**
30	28	28	28	28	28	28

Your AMA Federal Council at work

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

Name	Position on council	Activity/Meeting	Date
Dr Robyn Langham (proxy required)	AMA Federal Councillor	AHPRA Prescribing Working Group	13/11/2014
Dr Richard Kidd	AMA Board Member	DSS showcase of the Aged Care Gateway portal functionality	12/11/2014
Dr Brian Morton	AMA Chair of General Practice	Better Targeting CDM Item Workshop	30/10/2014
Dr Michael Levick	AMA Member	Better Targeting CDM Item Workshop	30/10/2014
Dr Tony Bartone	AMA Victoria President	Nursing in General Practice Expert Reference Group	29/11/2014
A/Prof John Gullotta	AMA Federal Councillor	PBS Authority medicines review reference group	15/10/2014
Dr Ian Pryor	AMA Member	MSAC (Medical Services Advisory Committee) Review Working Group for Ambulatory Electrocardiogram for Arrhythmias	13/10/2014

INFORMATION FOR MEMBERS

Doctor Portal: the doctor's complete online resource

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

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

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

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

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

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

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

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

End the cheap grog and the saturation marketing, alcohol summit tells Govt

AMA President Associate Professor Brian Owler talks to the media outside the AMA National Alcohol Summit

The Federal Government has been urged to add alcohol pricing to its tax reform agenda as part of efforts to curb the enormous harm being caused by widespread and heavy drinking.

The two-day AMA National Alcohol Summit concluded with a call for a Commonwealth-led National Alcohol Strategy to deal with alcohol-related harms, including an overhaul of the excise regime to end the era of cheap booze, the statutory regulation of alcohol marketing and promotion, public education campaigns and more prevention and treatment services.

AMA President Associate Professor Brian Owler said the evidence and experiences presented at the Summit by a wide range of speakers underscored the need for immediate action to address the great damage inflicted on society by alcohol.

"Alcohol misuse is one of Australia's major health issues," A/Professor Owler said. "Alcohol-related harm pervades society. It is a problem that deserves a nationally consistent response and strategy."

The Summit heard estimates that the damage caused by alcohol – ranging from street violence, traffic accidents and domestic assaults through to poor health, absenteeism and premature death – cost the community up to $36 billion a year.

The AMA President said that although individuals and communities had a role to play, governments – particularly the Commonwealth – needed to be far more active in tackling the issue.

"Too many times we hear that it's all about personal responsibility. It's rubbish," A/Professor Owler said.

"Personal responsibility is important, but we can't rely on the personal choices of others for our own safety and health. Governments can influence behaviour through deterrents but, most importantly and more effectively, through shaping individual and societal attitudes to alcohol."

He said governments needed to take the lead in shaping attitudes to alcohol, and to act on its promotion, availability and price.

A/Professor Owler said that although the nation's alcohol problem would not be addressed overnight, it was nevertheless the time to take action, and a communiqué issued at the end of the Summit detailed an eight-point plan, including:

- a specific role for the Federal Government in co-ordinating a coherent national strategy;
- effective and sustained advertising and social marketing campaigns;
- increased treatment and prevention services;
- measures that respond to the needs and preferences of Aboriginal and Torres Strait Islander communities;
- independent statutory regulation of alcohol marketing and promotion, including the association between alcohol and sport;
- improved data collection and research;
- review and reform of taxation and pricing arrangements to discourage harmful drinking; and
- ensuring the transparency of alcohol policy development.

MORE P20

End the cheap grog and the saturation marketing, alcohol summit tells Govt

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The Federal Government has so far rebuffed calls to become more heavily involved with alcohol regulation, though Assistant Health Minster Fiona Nash said the Commonwealth was examining action on several fronts.

Speaking outside the Summit, Senator Nash said "it is like a jigsaw puzzle; there is no one solution".

She admitted, "there is a role for regulation", but emphasised the importance of education campaigns, particularly in social media – something the Summit's communiqué said was necessary.

But the Summit's call for independent, statutory regulation of alcohol advertising and promotion does not appear to have the same support.

Senator Nash reiterated the Abbott Government's reluctance to assume responsibility for regulating alcohol advertising, which currently operates on a voluntary basis.

The Minster said a recent meeting of the nation's food ministers had backed a two-year extension of the industry's voluntary code following signs of improved compliance by sections of the industry.

But Labor MP Graham Perrett said the warning labels about the dangers of drinking while pregnant that the alcohol industry put on their products were "pissweak", and the Summit heard evidence that the industry's system of self-regulation was inadequate.

Opposition leader Bill Shorten told the Summit that alcohol misuse was an issue of national significance that deserved Federal Government attention.

"I believe that the Australian people are ahead of Parliament on this issue," Mr Shorten told the Summit. "People know what is really happening, [and they] know that if we do not act quickly, the problem will get worse."

The Labor leader said the Federal Government had a role to play in increasing public awareness and education about the problem, but demurred on committing his party to reform of alcohol taxation or subject alcohol advertising to independent regulation.

But AMA Vice President Dr Stephen Parnis, who is an emergency physician, said it was time for an end to "piecemeal, ad hoc and inconsistent" policy action on alcohol.

Dr Parnis said he and other health workers were alarmed at what appeared to be an upsurge in alcohol-related harm, and the community wanted action.

AMA Federal Councillor Dr Richard Kidd said the solutions needed to be as comprehensive and far-reaching as the problem.

"Leadership and commitment at the Federal level is vital if this is be achieved," he said. "We do not believe that solutions are likely to be reached if governments continue to defer to the influence and interests of the alcohol industry."

A/Professor Owler said experience in New South Wales, where sustained pressure from groups including the AMA, public health organisations, community groups and others eventually led the State Government to introduce tough lock-out laws, reduced opening hours and alcohol-free areas in trouble-prone areas of Sydney, showed that governments could be forced to respond.

"The AMA pledges to continue to pressure the Federal Government to act. We will continue to fight," he said.

Adrian Rollins

Cut the harm, but at what price?

The AMA, public health experts and some industry groups back an increase in the cost of alcohol amid mounting evidence that making it more expensive will help curb consumption.

The AMA National Alcohol Summit was told that 112 academic studies have found that changes in the price of alcohol effect its consumption, lending support to the AMA's call for a review of current taxation arrangements.

Addiction medicine specialist Professor Paul Haber from the Royal Australasian College of Physicians, said the country was effectively subsidising the alcohol industry because the $9 billion raised in alcohol tax revenue each year was little more than half the annual cost of the burden of disease it created.

The Wine Equalisation Tax (WET), which encourages the production of large quantities of cheap wine, is the prime target of those seeking reform of alcohol taxation.

The WET is a tax applied based on the value of wine, and is applied at the rate of 29 per cent of the wholesale price charged. The tax is complemented by a scheme under which wine producers are entitled to an annual WET rebate worth up to $500,000.

Public health experts such as the Foundation for Alcohol Research and Education argue that, because the WET is levied according to value rather than alcohol content, it favours the production of cheaper, higher alcohol content wine.

The place to begin reform is the WET, according to FARE Chief Executive Michael Thorn: "Tax and price reform is the number one priority. Ten Government reviews have recommended changes to the way alcohol is taxed."

Among the critics of the WET is the Winemakers' Federation of Australia. Federation Chief Executive Paul Evans told the Summit that the WET encouraged the production of bulk and unbranded wines, creating an oversupply in the market that helped drive deep discounting and retail consolidation.

"Wine is too cheap," Mr Evans said. "The industry agrees with you on that one."

The Brewers Association of Australia and New Zealand also wants the WET scrapped.

"The current WET system provides wine with a significant advantage over other alcohol categories, and creates industry distortions," the Association said. "The current WET regime provides an incentive for wineries to produce low value, high strength products [and] the Brewers Association recommends that Government implement changes to the taxation treatment of wine by incorporating wine into the category-based approach."

A study published in the *Medical Journal of Australia* last year (https://www.mja.com.au/journal/2013/199/9/estimated-impacts-alternative-australian-alcohol-taxation-structures-consumption) found that axing the WET and replacing it with a volumetric tax on wine would raise an extra $1.3 billion a year in revenue, cut alcohol consumption by 1.3 per cent and deliver an annual $820 million saving on health expenditure.

Some have suggested any reform of alcohol taxation arrangements should go further.

Both the National Preventative Health Taskforce and the Henry Tax Review condemned the current system – which taxes wines, beers and spirits at different rates - as incoherent and flawed, both from an economic and public health perspective.

The Henry Review proposed that it be replaced with a volumetric tax on all alcoholic beverages, applied at the same rate of tax per litre of alcohol across all beverages.

Peoples Alcohol Action Coalition representative Dr John Boffa told the Summit that, rather than a volumetric tax, it would be more politically feasible and effective to introduce a minimum price regime because it would increase the cost of beer.

Mr Thorn said minimum unit pricing was "a critical part of the debate".

Adrian Rollins

SPECIAL REPORT

The tricks of the trade: how drinks companies lure us in

Ads featuring blokes standing around drinking beer have been a staple on Australian television screens for decades.

But alcohol promotion has evolved far beyond this as drinks companies develop ever-more sophisticated ways to convincing people, including the young, to use their products.

Presenters at the AMA National Alcohol Summit gave an insight into some of the tricks and techniques being used by manufacturers to lure in new consumers and keep the rest of us drinking.

Australian Catholic University's Professor Sandra Jones told of how price was used to convince consumers, particularly young drinkers, to buy more.

Professor Jones said alcopops were often sold in packs of four bottles that were cheaper than buying three individual containers. Another tactic is to award prizes or gifts to purchasers, but only if they buy in bulk.

Social media expert Dr Nicholas Carah of the University of Queensland said alcohol companies were at the forefront in using the internet, mobile communications and social media to promote their products.

Dr Carah said they often set up Facebook pages for their products and encouraged drinkers to share photos and posts depicting their use of the product with other users. He said that in some cases these had become major global platforms: the John Walker whisky Facebook page, for example, has more than 10.3 million fans.

Another tactic is to host parties and other social events where product branding is strategically placed. Party-goers are encouraged to take pictures and share them on their social media networks, inadvertently promoting the product on the company's behalf.

Adrian Rollins

The drinking and the damage done

AMA President Associate Professor Brian Owler (L) with Cathy and Ralph Kelly, whose 18 year old son Thomas died folllowing an unpovoked alcohol-fuelled assault in King's Cross

For Ralph and Kathy Kelly, the enormous daily toll alcohol takes on the nation's health and well-being has a deeply personal and devastating resonance.

Little more than two years ago their 18-year-old son, Thomas, was killed in a completely unprovoked alcohol-fuelled attack during what was meant to be a harmless night out with friends in Sydney's entertainment district.

Moments after Thomas got out of a taxi in King's Cross, a complete stranger charged out of the darkness and punched him so hard in the head that he dropped instantly to the ground and never regained consciousness. Within two days he was dead.

In a powerful address to the AMA National Alcohol Summit, Mr Kelly said of that moment that it changed his world, and that of his family, forever.

In a video played at the Summit, Mrs Kelly said how, "each and every day we pray he is safe and happy, he'll never leave our hearts and the sadness is that he'll never have a 21st birthday, he'll never be married. We won't be grandparents to his children, and that's what we have now lost".

The Kelly's experience is, tragically, far from unique.

Alcohol-fuelled assaults

Foundation for Alcohol Research and Education (FARE) Chief Executive Michael Thorn told the Summit that more than 70,000 people a year are the victims of alcohol-related assaults, and more than 24,000 suffer alcohol-fuelled domestic violence.

In all, around 5 per cent of those aged 14 years or older report having been physically attacked by someone under the influence of alcohol, and 25 per cent say they have been the victim of alcohol-related verbal abuse.

AMA President Associate Professor Brian Owler told the Summit the children were also victims of the nation's drinking culture, with at least 20,000 a year suffering alcohol-related abuse.

A/Professor Owler, who is a paediatric neurosurgeon, said in his practise he frequently saw "the results of willing abuse of a child's brain. It makes up a surprisingly large proportion of our work".

Mr Thorn told the Summit that 5500 people die every year from alcohol-related causes, and a further 150,000 end up in hospital – the equivalent of 15 deaths and 430 hospitalisations every day.

A survey of more than 2000 emergency department doctors and nurses by the Australasian College for Emergency Medicine found that almost all had been attacked or threatened by drunk patients in the previous year, and up to a third of patients in some areas required treatment for alcohol-related harm.

Northern Territory Children's Commissioner Dr Howard Bath detailed the enormous damage being caused in Aboriginal communities by alcohol.

Dr Bath said Indigenous people in the NT died from alcohol-related causes at 10 times the rate of other Territorians, and were twice as likely to be hospitalised because of assaults as Aboriginals in the rest of the country.

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The drinking and the damage done

... FROM P23

"The toll alcohol is taking on the population is devastating," he said. "It is truly a beverage of mass destruction. Binge drinking does not capture what is happening. People are drinking themselves into a stupor. It is a tragedy on a broad scale.

Alcohol and domestic violence

While alcohol-fuelled street violence tends to grab most public attention, speakers at the Summit emphasised that many people – mostly women and children – are attack at home in assaults that are triggered or exacerbated by alcohol.

Co-director of Deakin University's Violence Prevention Program Associate Professor Peter Miller told the Summit that domestic violence was "much more prevalent" than street violence.

Director of the Judith Lumley Centre at La Trobe University, Professor Angela Taft, said alcohol was implicated in a third to a half of all domestic violence incidents, and 44 per cent of cases of partner violence were alcohol-related.

A/Professor Miller said that although moderate drinkers made up the bulk of both perpetrators and victims of domestic violence, the likelihood of an assault increased dramatically the more that was consumed.

He said research showed that the ready availability of alcohol, rather than its price, was strongly related to rates of assault: "If you put a Dan Murphy's in a deprived suburb, you get a 26 per cent increase in domestic violence assaults".

He said taking alcohol out of the equation was the "low hanging fruit" in action to reduce the incidence of domestic violence.

Australia's drinking culture

A/Professor Owler said the health problems and injuries caused by alcohol amounted to an enormous burden on the health system, and contributed to the huge cost imposed on society by the drug – estimated to be up to $36 billion a year.

The AMA President said it was too easy for governments and others to sidestep the issue and paint the misuse of alcohol as a matter of personal responsibility.

He said, instead, that harmful drinking had multiple and complex causes, including community attitudes (which are in turn shaped and influenced by many factors including marketing and advertising), price and availability.

A/Professor Owler told the Summit that alcohol marketing had had a profound influence on the way Australians behave and the way they viewed themselves.

"To drink beer is to be Australian. In fact, not to drink heavily is almost un-Australian," he said. "We have learnt to pride ourselves on our ability to consume alcohol. [But] I think we have been sold a dud. Australia is a much more sophisticated society than that."

The Summit was told of the enormously sophisticated and effective strategies used by alcohol manufacturers to promote their products that include, but go far beyond, mass media advertising.

Professor Sandra Jones of the Australian Catholic University Health Institute said society needed to be concerned about alcohol marketing because of the strong association between it and the tendency of young people to drink earlier in life and more heavily.

Professor Jones said companies used sophisticated pricing and promotional tactics to lure in young drinkers, including working assiduously on building and maintaining a close association with professional sport.

Monash University's Associate Professor Kerry O'Brien said that up to 80 per cent of alcohol company marketing budgets were spent on sport.

"Sport plays a huge part in normalising alcohol in our lives," A/Professor O'Brien said. "Sport has really strong emotional ties for people, and products associated with that also tap into that emotion."

He said that alcohol products were advertised during sports broadcasts on television at 4.3 times the rate they were promoted during non-sports programs, and between 35 and 45 per cent of sports people received some form of alcohol sponsorship.

Adrian Rollins

Rivers of cheap grog blight Indigenous communities

For Ralph and Kathy Kelly, the enormous daily toll alcohol The cost of alcohol needs to be pushed up and its supply curbed if there is to be progress in reducing the enormous damage caused by alcohol in Indigenous communities, the AMA National Alcohol Summit has been told.

Public health experts attending the Summit said that cheap and readily-available grog was contributing to a dire situation in which Indigenous people were twice as likely to be drinking at levels harmful to their health as the broader population, and were at commensurately greater risk of harm such as illness, violence and premature death.

Though there are significant gaps in information about the damage caused by alcohol in Aboriginal and Torres Strait Island communities, data compiled by the Australian Indigenous Alcohol and Other Drugs Knowledge Centre indicate that, in 2004, 52 per cent of Aboriginal people drank at levels that put them at high risk of short-term harm (compared with 35.5 per cent of the broader community) and almost 23 per cent drank amounts that put them at high risk of long-term harm (compared with less than 10 per cent among non-Indigenous Australians).

Lowitja Institute Chair Dr Pat Anderson told the Summit that, in addition to health problems, the "rivers of grog" that flowed through Aboriginal communities contributed to high rates of violence.

Dr Anderson said Aboriginal and Torres Strait Islander women in the Northern Territory were 80 per cent more likely to be hospitalised as a result of an alcohol-fuelled assault than the rest of the community.

"Drinking [is] damaging health, but it is also driving destruction and chaos," she said.

Associate Professor Ted Wilkes, of Curtin University's National Drug Research Institute, said alcohol had "a big part to play in what Aboriginal people are enduring today".

He said the harmful use of drugs was directly related to disadvantage and poverty, and these had to be tackled as part of any attempt to curb the damage caused by alcohol.

The severity of the problem in the Northern Territory has prompted some radical policy experiments including community bans, mandatory treatment and restrictions on supply.

Dr John Boffa, of the Peoples Alcohol Action Coalition, told the Summit of several measures implemented in Alice Springs that had achieved marked success.

Dr Boffa said the availability of very cheap cask wine – often selling at the equivalent of 33 cents per standard drink – contributed to heavy drinking, and experience had

Aboriginal and Torres Strait Islander Human Rights Commissioner Mick Gooda: 'the right to drink involves the duty to exercise right in a way that does not impinge on the rights of others'

shown that simply doubling the price led to a 20 per cent fall in consumption.

Another approach that had proved effective was a system of photo identification introduced by the previous Labor Northern Territory Government.

Under the system, those wanting to buy take away liquor were required to first provide photo i.d., which would identify if they lived in communities where alcohol was prohibited or were on the Banned Drinkers Register.

The system was scrapped when there was a change of government, and Alice Springs police have instead introduced the Temporary Beat Location scheme.

Under the initiative, police are stationed outside each of the 13 liquor outlets in Alice Springs. They screen people who buy take-away alcohol and confiscate it from those who live in dry communities or who are on the Banned Drinkers Register.

MORE P26

Rivers of cheap grog blight Indigenous communities

... FROM P25

Dr Boffa said that in the first five weeks of the scheme's operation, the average number of presentations at the Alice Springs Hospital Emergency Department had halved, total assaults fell by 54 per cent, and instances of domestic violence dropped by 50 per cent.

What is more, he said, since the program has been operating, mandatory treatment beds for intoxicated people have been empty.

However, Dr Boffa added, a glaring problem with the scheme was that it was racially discriminatory.

Police Federation Australia President Vince Kelly told the Summit the Temporary Beat Location program was "very, very effective" in limiting the supply of alcohol and helping curb the damage it caused in Aboriginal communities.

Mr Kelly, who was also President of the Northern Territory Police Association for almost 14 years, said alcohol misuse was a major problem in Aboriginal communities and broader NT society.

He said 90 per cent of the problems dealt with by NT Police were related to the misuse of alcohol, and "our hospitals are full of people there because of the misuse of alcohol".

But Mr Kelly warned that Alice Spring police were unlikely to be able to maintain the level of effort needed to make the Temporary Beat Location program work.

"They [TBLs] are very, very effective, but they are also very resource-intensive, and I am not sure how long the police can sustain them for," he said.

Dr Boffa said, effective as the TBL program was, the demands it placed on police meant it would be impossible to implement in larger regional communities and cities where there were hundreds of liquor outlets.

Instead, he said, photo identification at point-of-sale had shown itself to be an effective, non-discriminatory and relatively low-cost measure that could be rolled out nationwide.

Dr Boffa said this should be complemented by moves to get rid of cheap plonk by setting a minimum floor price for alcohol.

He said just implementing these two measures alone would make a significant difference in curbing the harm caused by alcohol among Indigenous Australians.

Adrian Rollins

INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

The Toolkit is divided into five categories, presented as easy to use tabs, including:

- online practice tools that can be accessed and/or completed online;
- checklists and questionnaires in PDF format, available for printing;
- commonly used forms in printable PDF format;
- clinical and administrative guidelines; and
- information and other resources.

In addition, there is a State/Territory tab, with information and forms specific to each jurisdiction, such as WorkCover and S8 prescribing.

The information and links in the Toolkit will be regularly updated, and its scope will be expanded as new information and resources become available.

Members are invited to suggest additional information, tools and resources to be added to the Toolkit. Please send suggestions, including any links, to generalpractice@ama.com.au

Drinking – a lifetime of damage

Thousands of babies are being born each year with serious and incurable but entirely preventable disabilities because of the consumption of alcohol during pregnancy, the AMA National Alcohol Summit has been told.

While often dismissed as a problem largely confined to remote Aboriginal communities, experts addressing the Summit said that although Foetal Alcohol Spectrum Disorder – an umbrella term used to describe a range of abnormalities caused in unborn children by in utero exposure to alcohol – is most marked among Indigenous Australians, it is present across society.

According to the National Organisation for Fetal Alcohol Spectrum Disorder (NOFASD), the true incidence and prevalence of FASD in Australia is not known because children are not routinely screened in infancy or early childhood, and there is a lack of data that accurately reflects estimates of the incidence and prevalence of the disorder.

It has been estimated that for every 1000 live births, between 0.06 and 0.68 will involve children with Foetal Alcohol Syndrome (a subset of FASD), though some, such as the Tasmanian Department of Health and Human Services (DHHS) and the Australian Women's Health Network, think this is an underestimate, and that least 2 per cent of all Australian babies are born with FASD.

The incidence is thought to be significantly higher among Indigenous Australians – the Foundation for Alcohol Research and Education (FARE) estimates the incidence of FAS in these communities is between 2.76 and 4.7 for every 1000 births.

While there is uncertainty about the prevalence of FASD, the speakers addressing the Summit, including paediatrician Professor Elizabeth Elliot of the Sydney Medical School, NOFASD Chair Sue Miers and AMA Federal Councillor Dr Richard Kidd, said there was no doubt its devastating consequences for those affected, including both the child and those who cared for them.

Ms Miers said children with FASD required round-the-clock parenting, and their emotional and psycho-social development lagged far behind that of their peers, even into adulthood.

Dr Kidd told the Summit that the consequences of drinking during pregnancy could be devastating – linked not only to FASD, but also preterm birth, low birth weight and increased risk for sudden infant death syndrome.

But, he said, FASD stood out as the most common preventable cause of birth defects in Australia, and one which had profound lifelong consequences, not only for individuals and families, but also the health, social service, criminal justice, education and employment systems.

Investigations into FASD by intergovernmental committees and parliamentary inquiries have highlighted a general lack of awareness of the problem in the community, including the risks attached to drinking while pregnant, and the paucity of the nation's response.

One of the problems is that around 50 per cent of all pregnancies are unplanned, and Dr Kidd said evidence showed nearly half of all women consumed alcohol while pregnant before they knew they were pregnant.

But, he added, even when they knew they were pregnant, 19.5 per cent of expectant mothers continued to drink.

One of the issues has been a lack of awareness.

The National Health and Medical Research Council has issued guidelines specifying that maternal alcohol consumption can harm the developing foetus or breastfeeding baby, and that the safest option for women who are pregnant or planning pregnancy is to abstain.

But Dr Kidd said knowledge of this was imperfect, even among the medical profession. He cited a 2013 FARE survey of health professionals which found that, while most were aware of the NHMRC Guidelines, more than two in five (45%) were not familiar with the content.

MORE P28

Drinking – a lifetime of damage

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He said health professionals had a key role in making women aware of the effects of alcohol during pregnancy.

"Because most women seek prenatal care during their first trimester, this is an opportune time for GPs like me, obstetricians, midwives, Aboriginal health workers and others to help them make the changes necessary for a healthy pregnancy," Dr Kidd said. "It is important for health professionals to know that conversations about alcohol with women who are pregnant and planning a pregnancy are wanted, welcome and worth their time."

He told the Summit of the Women Want to Know Project, created by FARE in collaboration with the AMA and other health groups, to encourage health professionals to routinely discuss alcohol and pregnancy with women, and to provide advice that is consistent with the NHMRC's Alcohol Guidelines.

In addition to getting health professionals to talk about drinking with patients who are expecting or planning to get pregnant, public health experts are also pushing for much clearer and more prominent labels on alcohol products about the dangers of drinking while pregnant.

Senior federal Labor MP Graham Perrett, who addressed the Summit, dismissed the warning labels currently used by the industry under its self-regulation code as "pissweak".

But even more informative and prominent labelling may not, on its own, be enough.

According to a 2009 report by the Intergovernmental Committee on Drug Working Group on Fetal Alcohol Spectrum Disorders, many women continue to drink during pregnancy even after being told of the risks of FASD.

"Knowledge of adverse effects is not as strong a determinant of intention to drink as are tolerant attitudes towards alcohol use in pregnancy," the Working Group said. "Simply educating women about potential adverse effects of prenatal alcohol exposure will be insufficient to induce behavioural change. Societal attitudes about alcohol use, particularly during pregnancy, must also be addressed."

Dr Kidd said FASD was part of the wider and complex issue of alcohol use in the community, telling the Summit that, "the AMA believes that any attempt to tackle FASD must occur within a comprehensive and whole-of-government approach to reduce harmful drinking across the population".

Adrian Rollins

INFORMATION FOR MEMBERS

Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

- List courses completed, including the organisation that accredited the CPD activity;
- Store all certificates of completion;
- Keep a log of practice-based reflective activities, including clinical audits, peer reviews and perfomance appraisals; and
- Log hours spent on online learning, reading journals, teaching and other activities.

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

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

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

To register for the product, please sign up here.

The AMA National Alcohol Summit drew politicians, doctors, public health experts, police, community leaders, and industry representatives from across the country.

The brain-child of AMA President Associate Professor Brian Owler, Vice President Dr Stephen Parnis, immediate-past President Dr Steve Hambleton and former Vice President Professor Geoffrey Dobb, it was held to bring national attention to the enormous harm caused by excessive alcohol consumption and prompt the Federal Government into action.

The distinguished list of speakers included Assistant Health Minister Fiona Nash, Opposition leader Bill Shorten, Shadow Health Minister Catherine King, Australian Greens health spokesman Richard Di Natale, NSW Premier Mike Baird, Labor MPs Graham Perrett and Doug Cameron, Aboriginal and Torres Strait Islander Social Justice Commissioner Mick Gooda, NT Children's Commissioner Dr Howard Bath, Public Health Advocacy Institute Director Professor Mike Daube, Sydney University paediatrician Professor Elizabeth Elliot, Police Federation of Australia President Vince Kelly, and Lowitja Institute Chair Dr Pat Anderson.

The two-day Summit was held on 28 and 29 October at the National Convention Centre, Canberra.

Videos of Summit sessions and other information can be viewed at: https://ama.com.au/node/15484?no_cache=1415162069

The Summit communique can be viewed at: https://ama.com.au/media/ama-national-alcohol-summit-communique

Adrian Rollins

COMMENT

Opposition leader Bill Shorten: harm caused by alcohol is 'a matter of national importance'

NEWS

TB superbug makes landfall in Australia

Fears Papua New Guinea's tuberculosis health emergency could spill over the border into Australia have been realised following confirmation of the first Australian transmission of a highly drug-resistant form of the infection.

A Torres Strait Island woman who died in Cairns Base Hospital last month from multi-drug resistant tuberculosis (MDR-TB) is suspected to have caught the virulent bug during a visit to Saibai Island, which lies just eight kilometres south of the PNG mainland.

The case has punctured hopes that MDR-TB might not spread to Australia despite the very porous nature of the Australia-PNG border in the Torres Strait. Hundreds of people cross the border daily, trading goods and visiting relatives and friends.

Health experts warn that Australia needs to substantially increase its support for efforts to control the spread of MDR-TB in PNG, particularly the Western Province abutting Torres Strait, if it wants to prevent it getting a foothold on the Australian mainland.

The scale of the threat is significant.

It is estimated 680,000 people worldwide were infected with MDR-TB in 2012, and almost 60 per cent of tuberculosis cases occur in the Asia-Pacific.

Worryingly for Australia, the PNG Government has declared the country's high incidence of TB and MDR-TB as a national health emergency, indicating that it will struggle to bring it under control without much greater international assistance.

In 2012 a strategic plan to control TB in Australia, developed by the National Tuberculosis Committee, called for increased engagement by Australia with countries in the region, particularly in the case of PNG's Western Province.

Last year health journalist Tony Kirby, writing in the *Medical Journal of Australia,* warned that "well co-ordinated TB management programs and general health care provision for the people of Western Province must be urgently expanded to avoid increases in incidence of MDR-TB and [extensively drug-resistant] XDR-TB, and reduce the risk of more patients arriving in Australia".

"Patients who receive inadequate treatment in poor nations such as PNG, and patients who are unknowingly infected, will inevitably reach the Torres Strait or Australia's mainland," Mr Kirby wrote.

Earlier this year a group of TB experts briefed federal parliamentarians on the urgent need for an increased and co-ordinated response to what they described as a tuberculosis crisis in the Asia-Pacific.

Burnet Institute Director Professor Brendan Crabb said Australia had a "crucial" role to play in the regional response to the disease.

"It is a major issue on our doorstep, with 58 per cent of global cases in the Asia-Pacific region – this is a threat to both our neighbours and ourselves," Professor Crabb said.

The urgency of the problem has been highlighted by the humanitarian group Medicins Sans Frontieres [MSF], which has declared drug-resistant TB to be a "worldwide public health crisis".

MSF said an assessment of efforts to control the epidemic in eight countries where TB was highly prevalent was far from reassuring.

It found that in the countries – Brazil, India, Kenya, Myanmar, Russian Federation, South Africa, Uzbekistan and Zimbabwe – the disease was flourishing because control measures were "dangerously out of step" with what had been proven to work, with MDR-TB diagnosed in up to 35 per cent of new tuberculosis patients.

According to the World Health Organisation, less than a third of patients with MDR-TB worldwide are diagnosed, and only one in five receive appropriate treatment.

It identified five "deadly gaps" in the response to TB: inadequate testing, lack of treatment, outdated models of care, little access to new drugs and "dire funding shortfalls".

Combined, MSF Medical Epidemiologist Dr Petros Isaakidis said, these shortcomings had led to a "man-made disaster born out of years of neglect, and driven by a slow and piecemeal response".

Adrian Rollins

Putting patients first earns public trust

The importance of doctors in the national debate over far-reaching changes to the health system has been underlined by international research showing that Australians have a high degree of trust in the medical profession.

In a cautionary finding for the Federal Government as it tries to implement a $7 GP co-payment over the strong objections of the AMA, a study by the International Social Survey Programme has found Australian doctors are well regarded by their patients for the quality of care they provide, and are viewed with trust.

According to the survey, conducted in 29 countries between March 2011 and April 2013, 73 per cent of Australians believed that doctors could be trusted (ranked 10th) and 55 percent were completely or very satisfied with the treatment they received (ranked 4th).

Swiss doctors topped the rankings, earning the trust of 83 per cent of the public and the satisfaction of 64 per cent of their patients. By comparison, 56 per cent of patients in the United States were satisfied with their care (ranked 3rd), but less than 60 per cent thought they could be trusted (ranked 24th). Doctors in Poland were held in the lowest regard (just 43 per cent thought they could be trusted), while their colleagues in Russia were seen as the least satisfactory (only 11 per cent of patients reported they were satisfied with the treatment they received).

Doctors in the US have suffered a sharp decline in public confidence in the past 50 years, according to an analysis in *The New England Journal of Medicine*.

The discussion cited previous data showing that in 1966, 73 per cent of Americans expressed great confidence in the medical profession, compared with just 34 per cent in 2012. The decline echoed a broader increase in dissatisfaction with the US health system, such that by this year only 23 per cent surveyed by polling company Gallup expressed great or considerable confidence in the system.

The authors of the *New England* analysis suggested doctors in the US suffered from being seen as contributing to problems with the health system, particularly the cost of care, which 65 per cent of the public regarded as a very serious problem for the country.

The authors of the analysis suggested that, in order to regain the public's trust, the US medical profession and its leaders "deliberately take visible stands favouring policies that would improve the nation's health and health care, even if doing so might be disadvantageous to some physicians".

A similar point was made by *Professional Planner* editor Simon Hoyle in a piece about the AMA's advocacy regarding the $7 co-payment (which can be viewed here: https://ama.com.au/ausmed/why-promoting-public-interest-will-win-public%E2%80%99s-trust).

Mr Hoyle said that, in criticising the co-payment, AMA President Associate Professor Brian Owler focused on the impact on patients, rather than doctors.

"The impact of a policy may or may not be in the interests of the association's members, but that is not the association's first priority," Mr Hoyle wrote. "The AMA's first concern is that the healthcare needs of all Australians continue to be met, without favour and without discrimination based on an individual's ability to pay.

"Of course, in doing that, the interests of the AMA's members are advanced. But they're advanced in the context of what's good for the public interest, not what's good for the self-interest of doctors.

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

Adrian Rollins

COMMENT

NEWS

Advice to dump prostate test could 'cost lives'

Australian specialists have launched a rare broadside at their Canadian colleagues over suggestions that a widely used test for prostate cancer should be dropped.

As public consultations on new national draft prostate cancer testing guidelines is about to commence, the Urological Society of Australia and New Zealand has warned that revised Canadian guidelines issued late last month could "ultimately cost lives".

The Canadian Task Force on Preventive Health Care, in a report published in the *Canadian Medical Association Journal*, concluded that the "available evidence does not conclusively show that PSA [Prostate Specific Antigen] screening will reduce prostate cancer mortality, but it clearly shows an elevated risk of harm".

The recommendation has come amid claims that PSA screening has led to over-diagnosis of prostate cancer, causing many men to undergo biopsies and other procedures that can have serious side effects, including incontinence.

But Urological Society President-elect Professor Mark Frydenberg said the Society rejected the Canadian Task Force's interpretation of the data.

"While we acknowledge there have been issues with over-diagnosis of prostate cancer in the past, we believe these recommendations go too far and may lead to delayed diagnosis and increased mortality," Professor Frydenberg said.

He said that although the PSA blood test was "imperfect, it still remains the best chance of catching prostate cancer in time, and long-term international studies confirm that this simple blood test can reduce the risk of prostate cancer deaths by 21 per cent".

Professor Frydenberg said the Canadian interpretation did not take into account recent improvements in surgical techniques, nor the fact that 45-year-old men with a PSA level in the top 5 to 10 per cent comprised 50 per cent of subsequent prostate cancer fatalities – making them the ideal group to test.

"We don't want to return to the old days when men suffered and died unnecessarily, but we need to be smarter about how we use the test so that men are not harmed by unnecessary interventions," he said, adding that urologists sought to tailor treatment to eliminate unnecessary procedures.

Associate Professor Shomik Sengupta, of the Society's Genitourinary Oncology Special Advisory Group, said new diagnostic tools, such as multiparametric MRI scans, were being used to help rule out cancer in men with elevated PSA, helping reduce the number of biopsies, while improved techniques reduced the chances of complications like infection when biopsies were required.

> "We don't want to return to the old days when men suffered and died unnecessarily, but we need to be smarter about how we use the test so that men are not harmed by unnecessary interventions"

In addition, Professor Sengupta said, where a cancer is found to be of low risk, it is often managed through active surveillance rather than surgery.

He said currently 36 per cent of Australian men with low risk prostate cancer were subject to active surveillance, with little to no impact on their quality of life.

"[The Society] is concerned the Canadian publication appears to place greater emphasis on the potential risk and harms of PSA testing, based on low-level evidence, than on the potential benefits based on stronger evidence," Professor Sengupta said.

New draft guidelines on prostate cancer testing are due to be released by the National Health and Medical Research Council for public consultation on 4 December.

Adrian Rollins

NEWS

Phase in drug company disclosure regime, AMA tells ACCC

The AMA has given conditional support to a proposal by the consumer watchdog that drug companies would be banned from giving benefits or gifts to any doctor who does not agree to full public disclosure.

In a draft determination on the Medicines Australia proposed code of conduct issued last month, the Australian Consumer and Competition Commission said that a provision in the code allowing companies to withhold information where there is no doctor consent to its release seriously compromised the reporting regime.

"The ACCC is concerned that the benefit from the reporting of individual disclosures of transfers of value will be threatened if there is incomplete information, and anything less than universal disclosure may significantly reduce the potential benefits of the regime," the draft determination said. "Without knowing what has and has not been reported, it will be difficult to use or rely upon the information that has been reported. This fundamentally undermines the transparency objectives of the regime."

In a submission to the ACCC, the AMA said it did not object to the new provision, but suggested it be deferred for 12 months to allow both practitioners and drug companies to understand, plan for, and fully comply with, the new requirements.

The Association said that, in the interim, companies could continue to make transfers of value to doctors who have not consented to individual public disclosure, but that data on these relationships would only be reported on in aggregate.

"This will be the first time in Australia that the private income of individuals in a professional class will be subject to public scrutiny," the AMA said. "A 12 month delay in implementing the ACCC's condition would allow health practitioners to think about and plan for their ongoing relationships with pharmaceutical companies."

The ACCC's draft ruling is a setback to attempts to update Code of Conduct, which has been the subject of regular consultations between Medicines Australia, the AMA and other medical and consumer groups.

In its latest version (edition 18), the Code will require member companies to report on "transfers of value" (gifts, fees and benefits) made to individual practitioners, including the names of each recipient, as long as they consent to the disclosure.

The ACCC said that although the Code was "likely to result in public benefits", the provision that disclosure only occur with the consent of the health professional amounted to a "serious flaw" in the transparency regime.

The AMA and Medicines Australia have told the ACCC that there is a risk the proposed change would discourage some doctors from participating in conferences and other educational events, diminishing health outcomes for patients and creating an uneven playing field within the drugs market.

But the regulator said it was "not persuaded" that it proposed change would prevent doctors from receiving critical information about medicines.

"In particular, member companies can offer events that do not require reporting, and health care professionals can self-fund to attend third party conferences," it said.

Despite its concerns, the ACCC has granted the Code a conditional five-year authorisation and has indicated that it may allow the Code to go through without its proposed changes.

The regulator said that although it is able to impose conditions on the authorisation, "it is not for the ACCC to construct and impose its ideal or preferred system of self-regulation".

Adrian Rollins

COMMENT

GSK takes one in the eye

An eye ointment to treat herpes infections has been recalled amid safety concerns arising from the presence of metal fragments in the cream.

Drugs giant GlaxoSmithKline (GSK) has issued an urgent recall of two batches of its Zovirax Opthalmic Ointment (aciclovir 3%) after discovering that they were manufactured using active pharmaceutical ingredients that failed specifications regarding the presence of particulate matter.

The ointment is used for the treatment of herpes simplex virus infections of the eye. It works by stopping the production of the herpes simplex virus, though it does not get rid of the virus from the body.

"The main safety concern is for potential particles to physically damage the eye," GSK's Associate Medical Director Dr Navib Singh said, adding that the fragments had been identified as "metal filaments".

"As we are not able to assess the quantity and the size of potential metal particles in the finished products, we are taking the precautionary measure…to undertake a recall of all affected batches," Dr Singh said. "Patients should be urged to consult their specialist before ceasing treatment with this product."

He said the company was undertaking a thorough investigation of its manufacturing processes to ensure there was no repeat of the incident and warned that, as a result, "supply [of the ointment] is constrained".

Dr Singh said this was likely to mean it would be in short supply, if not completely unavailable, until at least the June quarter 2015.

Adrian Rollins

GENERAL PRACTICE

Non-medical prescribers threaten quality patient care

BY DR BRIAN MORTON

At a time when the AMA has been working with What is happening to our health care system?

In the pursuit of perceived cost savings, successive governments have and are increasingly threatening the quality of treatment by encouraging and facilitating the fragmentation of patient care.

Heavy GPs workloads, the difficulty some patients have getting to see their family doctor, and developments overseas are often used as reasons for expanding the scope of non-medical health professionals.

These arguments are often given greater credence than they deserve because of promised efficiencies and savings to the health system. The Menzies-Nous Australian Health Survey 2012, for example, found that the majority of Australians were able to get an appointment with their GP on the same day or following day.

Most of the overseas health systems we compare ourselves with spend more per on health per capita and more of their GDP on health than us, yet we have one of the best performing health systems in the world.

Who would have thought that seeing a qualified medical practitioner could be labelled as an inefficiency in the health system?

The Australian health system is predicated on the fact that GPs, the only medical professionals trained to care for the whole person, help ensure the efficient use of scarce resources, as they are leaders in preventive health care, early diagnosis and treatment, coordinated care and chronic disease management.

The GP is the medical practitioner trained to take a comprehensive history, examine the whole person when making a diagnosis, and initiate investigation, management and treatment.

Yet the Abbott Government, despite its talk of supporting and strengthening general practice, seems hell bent on replacing the holistic approach of GPs with fragmented care provided by non-medical health professionals. In this respect it is not much different from its predecessors.

Last November, the nation's Health Ministers sanctioned the development of a nationally consistent pathway for non-medical prescribing.

The Australian Physiotherapy Association applauded the decision, claiming a non-medical health prescribing framework would allow patients to receive improved care from physiotherapists, reduce the burden on doctors and decrease existing efficiencies in the health system.

But we know it won't. In fact, it is more likely to increase the costs to the health system. The possibility for adverse drug events will be higher, resulting in avoidable hospitalisations. Then there is the greater likelihood of missed or delayed diagnosis because of the single-system focus of many non-medical practitioners, which could have a significant impact on the course of a patient's treatment and health outcomes.

> “The GP is the medical practitioner trained to take a comprehensive history, examine the whole person when making a diagnosis, and initiate investigation, management and treatment”

The AMA supports prescribing by non-medical professionals, but only when carried out within strict collaborative care arrangements in partnership with doctors. Most prescribing by non-medical health practitioners currently occurs in public hospitals under strict protocols. That's to ensure prescribing is appropriate, and patient safety is protected.

The AMA maintains that only medical practitioners should have independent prescribing rights, and will continue to vigorously oppose any move away from this.

COMMENT

AMSA

Pharmaceutical exposure: what is the lethal dose?

BY AMSA PRESIDENT
JESSICA DEAN

I stood in the waiting room, looking around the sea of faces for the next patient on the list.

It was a Wednesday. Like every Wednesday, the room was filled with the usual warm smiles I had come to expect in this country general practice. One face, however, stood out. Each time I called another patient in, the same tall, handsome man in a well-fitted suit sat patiently in the corner, reading the newspaper.

After I had called in my last patient for the day, I approached the principle GP of the practice, concerned that the man must have been sitting there neglected for many hours. The GP identified him as a regular pharmaceutical representative. The man had been sitting there neglected, but deliberately. The GP had made a personal decision not to engage with him.

He offered me the opportunity to talk to the rep and 'make up my own mind', and so I invited the man into my clinical room and we discussed the mechanism of action of a new medication. He provided no food or presents, and I found the information delivered to be both informative and useful. Throughout the interaction, however, I couldn't help but feel that I was doing something wrong.

Evidence of a relationship between exposure to pharmaceutical products and prescribing behaviour is well established. There are legitimate and substantiated concerns that exposure correlates to altered prescribing behaviour, with no evidence of higher quality prescribing .

A systematic review in 2011 showed that, even for medical students, exposure to pharmaceutical company marketing may influence attitudes towards certain pharmaceuticals. Perhaps more concerning is that many students believed themselves to be immune to bias.

In the last few decades, the medical profession has experienced a monumental cultural shift away from expensive pharma-funded conferences and towards taking individual responsibility in safe-guarding one's exposure to pharmaceutical marketing. This has meant gradually decreased spending and smaller promotional products.

But how much exposure is too much?

There exists evidence that even smaller promotional items still exert influence on medical students' attitudes.

The Australian Medical Students' Association has had pharmaceutical guidelines in place for almost a decade that define 'pharmaceutical

> "A systematic review in 2011 showed that, even for medical students, exposure to pharmaceutical company marketing may influence attitudes towards certain pharmaceuticals"

company' very broadly, prohibit any direct sponsorship, and put in place rigorous evidence-based guidelines for any interactions with relevant marketing.

It's become increasingly clear that there is no safe level of exposure to pharmaceutical marketing

For more information please see AMSA's Pharmaceutical Sponsorship Policy here:

https://www.amsa.org.au/wp-content/uploads/2014/10/201410_Pharmaceutical_Sponsorship_Policy.pdf

Jessica Dean is the President of the Australian Medical Students' Association. Jessica is a 6th year Medicine/Law student at Monash University. She is currently completing an Honours Project in Bioethics at The Alfred. Follow on Twitter @AMSAPresident or @yourAMSA

COMMENT

RURAL HEALTH

Flood of new doctors a rare chance to improve rural health

BY DR NIGEL STEWART, REGIONAL PAEDIATRICIAN, NORTHERN REGIONAL PAEDIATRICS UNIT, PORT AUGUSTA HOSPITAL

For my sins, I am President of the Australian Paediatric Society, representing around 300 rural and regional paediatricians, and am a member of the AMA's Rural Medical Committee.

Currently, there is a huge increase in the number of young doctors graduating. This is a once in a generation, if not once in a century, opportunity to rectify the maldistribution of doctors in Australia.

In the past 15 years, large numbers of overseas-trained doctors, both GPs and specialists, have been recruited to work in rural areas where few Australian doctors are prepared to go.

While acknowledging the great contribution those doctors have made, as well as their right to improve their lives and that of their families and to move around the world, this does have the effect of denuding countries that are already incredibly short of doctors.

The right measures at this time would minimize this, and see Australian doctors moving into a rural and regional practice in Australia. What are particularly needed GPs, rural generalists and those from the specialties of paediatrics, obstetrics, gynaecology, general surgery and medicine.

In my state of South Australia, we talk about a tsunami of medical students and young doctors. Just like any tsunami, we expect it to wash inland for a mile or so and then to wash back out, with no long term benefit unless investments are made in rural health.

There are figures suggesting more doctors are working in outer metropolitan and inner regional areas. But they actually work fewer hours than the doctors who used to work in these areas, so community access has not really changed.

People often expect market forces and the "trickle down" effect to achieve a redistribution of doctors, but experience says this a vain hope.

If we want our least healthy and most vulnerable citizens to have access to access to these new graduating doctors, government intervention will be required.

Doctoring in rural communities is different. There is an aspect of professional isolation. These are often in towns that are seen as less desirable than living in a sophisticated urban environment for doctors and their families. There is a need to put in place social support services for doctors, their partners and their families. There can be issues around education, as well as financial concerns.

Importantly, people embarking on rural practice need to have the skills and support that gives them confidence to handle what will come their way.

All of these factors need to be taken into account and addressed to attract and retain modern day rural doctors.

Given the upsurge in junior doctors, we need to put in place incentives and programs to enable some of these to come to rural areas and meet the current shortages. As I said earlier, this is a once in a lifetime opportunity.

If we don't so this, some of these doctors will find themselves competing in cities over ever-smaller pools of patients and funds, while others will drop of practice early, or not even start.

To boost the number of rural doctors is one of the top priorities in health, and the solution is clear.

People say it can't be done. Rubbish.

Remember, people once said this nation could not successfully build rural clinical schools, but it has happened and they are flourishing.

To get young doctors into rural practice will need a mixture of incentives that are ring-fenced and not simply reallocated at the next election to outer urban areas.

We will need to provide the social support and capital necessary to maintain doctors within a rural setting, as well as excellent professional support, training and mentoring.

We also need to be realistic and accept that most doctors will work in a rural practice for five to 10 years before moving to a city.

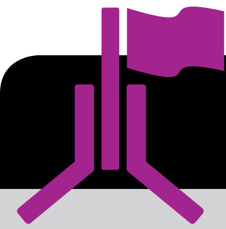
We need to make rural practice less heroic and more ordinary and, therefore, more accessible to a wider pool of doctors.

To achieve this solution will require great advocacy from the AMA, the input of training colleges, and co-operation between the State and Federal governments.

Unfortunately, there is as yet no great sense of urgency or clarity about this problem.

But we need to act now if we are to seize this rare opportunity.

COMMENT



Health on the hill

Political news from the nation's capital

Fears cloud trade pact despite Govt assurances

The AMA has urged the Federal Government to avoid any trade-offs in the terms of the controversial Trans Pacific Partnership trade deal that could push up the cost of medicines.

As negotiations on the heavily criticised agreement intensify, AMA President Associate Professor Brian Owler has called on the Government to ensure the interests of patients are not compromised, including by undermining the Pharmaceutical Benefits Scheme and forcing up drug prices.

"While there's been some discussion that won't be the case, obviously we don't want to see any trade-offs that might adversely affect the prices and availability of medications for Australian patients," Professor Owler told ABC radio. "I think it's very important that the interests of the Australian Government, but also of patients and individual consumers in Australia, are protected through trade agreements."

Pressure is mounting to finalise the negotiation of the TPP - which looms as the world's largest trade pact, encompassing more than 40 per cent of global economic output – as China pushes ahead with plans for a rival Free Trade Agreement for the Asia-Pacific.

Trade Minister Andrew Robb has expressed optimism that the deal can be completed next year, and has given assurances that the Government would not agree to terms that made drugs more costly or compromised the country's ability to protect public health.

"There is no way the Government would take a decision that would in any way adversely affect the PBS or the Australian health system more generally," Mr Robb told *The Australian*.

A spokesman for the Minister told the *Sun Herald* that the Government had "made it perfectly clear that we will not enter into any agreement that has a negative impact on our health system, our Pharmaceutical Benefits Scheme or, indeed, the price of medicines, and to say otherwise amounts to scaremongering".

But intense secrecy surrounding the negotiations has helped fuel fears about the TPP, which includes the United States, Japan, Australia, Mexico, Canada, Malaysia, Chile, Singapore, Vietnam and Peru.

Much concern has focused on protections for intellectual property that might be included in the deal, particularly the possibility that they might enhance the market power of multinational pharmaceutical companies by extending patents, discouraging competitors and potentially forcing prices higher.

Critics are also worried investor-state dispute settlement (ISDS) provisions could allow private corporations to mount legal challenges against public health measures, such as has happened with Australia's plain packaging laws.

The Government has insisted that ISDS clauses in the agreement contain carve-outs that would allow governments to continue to regulate in the public interest in areas such as health.

But University of New South Wales research Associate Professor Lynn Kemp told the *Sun Herald* that even if such clauses do exist, the possibility that they may be subject to legal action could discourage many governments from embarking on pioneering public health legislation.

"This is a real concern for Australia, because we've been one of the most innovative countries in public health measures, in particular in terms of smoking," A/Professor Kemp said.

Draft TPP documents obtained by the whistleblower website Wikileaks back Government claims that the negotiating texts are "live documents [that are] forever changing".

Wikileaks said the documents showed that between August 2013 and May 2014 there were changes in the treaty's patent provisions that had the potential to make some drug more costly, though they also showed significant resistance to a push by US and Japanese negotiators to allow drug companies to "evergreen" patents by making enabling them to claim new patents on drugs that are altered only slightly.

But, Wikileaks said, provisions that would allow for the patenting of surgical methods had been dropped - seen as vitally important in allowing doctors to use medical procedures without fear of legal action.

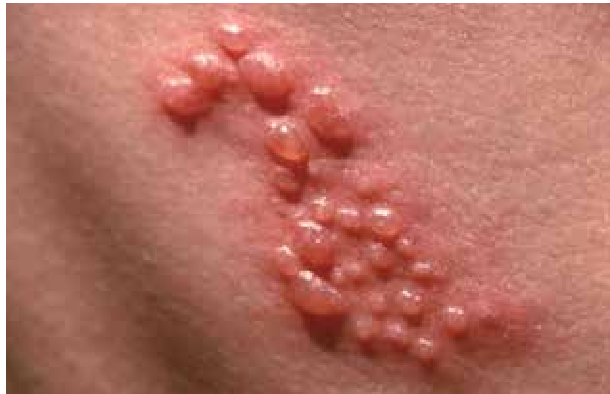
Prospects for the conclusion of the TPP have been complicated by developments in American politics.

Even before the Republican whitewash in the US Congress mid-term elections, the Congress had declined to renew President Barack Obama's negotiating authority, and although Republicans are generally seen as strong backers of the TPP, they may be reluctant to give President Obama the opportunity to conclude the deal during the final two years of his term.

Adrian Rollins

Research

Shingles patients at increased stroke risk



Doctors have warned that people who have contracted shingles need to vigilant for signs of stroke in the first six months after catching the virus.

A UK study has found the virus is an independent risk factor for stroke and other blood clot events in the first six months after contracting the disease.

Herpes zoster, more commonly known as shingles, is classified as the nerve rash in adults caused by reactivation of the chicken pox virus, and there are almost 100,000 GP consultations for shingles in Australian each year.

The UK study examined more than 6500 case of shingles in adults and found stroke was 63 per cent more likely to occur in the month following the initial shingles diagnosis.

Researchers from the London School of Hygiene and Tropical Medicine said although stroke was an unlikely event following a case of shingles, GPs should be aware of the association.

The researchers said the study had important implications for shingles vaccination programs which, in addition to reducing the incidence of shingles, may have the potential to reduce strokes following the virus.

In Australia, the herpes zoster vaccine is not currently on the National Immunisation Program and people who wish to get the vaccine have to do so at their own expense. The vaccine is also in short supply and can be difficult to access.

The UK study is not the only study to link shingles and stroke. Research published in the journal Neurology earlier this year also found that shingles was a risk factor for stroke, independent of other risk factors known to cause vascular events including obesity, smoking and high cholesterol.

The researchers found that the increase in risk was up to 70 per cent for some, and that people younger than 40 years of age who had shingles were 74 per cent more likely to have a stroke than those who had not suffered the rash.

The researchers analysed data from more than 450 general practices in the UK between 2002 and 2010. Almost 107,000 cases of shingles were found among the 3.6 million active patients.

Lead author Dr Judith Breur from the University College London said that people younger than 40 years were significantly less likely to be asked about vascular risk factors than older patients.

"Anyone with shingles, and especially younger people, should be screened for stroke risk factors," Dr Breur said. "The shingles vaccine has been shown to reduce the number of cases of shingles by about 50 per cent. Studies are needed to determine whether the vaccination can also reduce the incidence of stroke and heart attack."

The first study was published online in the *Clinical Infectious Disease* journal.

Kirsty Waterford

Efforts to unlock secrets of dementia set for major boost

Worthy but disparate efforts to understand and prevent the development of dementia, which blights the lives of hundreds of thousands of Australians and their families and carers every year, are set to become more targeted and co-ordinated.

The National Health and Medical Research Council (NHMRC) has invited expressions of interest for the

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establishment of a National Institute for Dementia Research, which is a key plank in the Federal Government's $200 million strategy to tackle the debilitating condition.

Currently, more than 332,000 Australians are living with dementia, and this number is expected to increase by a third to more than 400,000 within 10 years. Unless there is a medical breakthrough, the number of Australians with dementia is expected to soar to almost 900,000 by 2050.

Health Minister Peter Dutton said the NHMRC Institute for Dementia Research would help inject new momentum into efforts to unlock the secrets of the devastating condition.

"We are establishing an innovative research institute to help target, coordinate and translate the national research effort to ensure existing and new research translates into better understanding of these diseases, better treatment and care for dementia patients and hopefully one day a cure," Mr Dutton said.

"One of the key objectives of the Institute is to identify essential dementia research priorities for Australia across the full spectrum, from basic research to implementation."

For more information about the Institute, visit https://www.nhmrc.gov.au/research/boosting-dementia-research-initiative

Kirsty Waterford

Melanoma: from little things, deadly things can grow

When it comes to one of the nation's biggest killers, small can be every bit as deadly as big, researchers have warned.

A joint study by the QIMR Berghofer Medical Research Institute and the Cancer Council Queensland has found that that people are more likely to die from melanomas less than one millimetre in diameter than melanomas greater than four millimetres.

According to the Australian Institute of Health and Welfare, melanoma is the fourth most common cancer diagnosed in Australia, with 11,405 cases of melanoma diagnosed in 2010, accounting for nearly one in ten cancer diagnoses.

The QIMR Berghofer study reviewed Queensland Cancer registry data involving more than 4000 melanoma deaths between 1990 and 2009.

Thin melanomas (less than one millimetre in depth) accounted for 23 per cent of melanoma fatalities between 2005 and 2009, while during the same period thick melanomas (greater than four millimetres) accounted for only 14 per cent of deaths.

Lead researcher, Professor David Whiteman, from QIMR Berghofer said that although thick melanomas have a poor prognosis and lower survival rates, they make up

only a minority of melanomas diagnosed in Queensland.

"We found the huge increases in the numbers of thin melanomas being detected means that overall, they account for more melanoma deaths than thick tumours," Professor Whiteman said.

"Only a small proportion of patients with thin tumours die from their disease, but as the number of cases rise there has been a corresponding increase in the number of deaths.

"The statistics should serve to remind us that vigilance is essential to ensure that all melanomas are diagnosed as early as possible, or even better, prevented altogether."

Cancer Council Queensland spokesperson Katie Clift urged people to take steps to protect themselves from the sun whenever the UV index reached three or more, in order to reduce the risk of developing skin cancer.

"Early detection through self-examination or having a doctor check your skin is vital to reduce the burden of melanoma," Ms Clift said.

The study was published in the *Journal of Investigative Dermatology.*

Kirsty Waterford

MOTORING

Car servicing and the Hippocratic Oath

BY **DR CLIVE FRASER**

Car manufacturers spend millions every year on developing systems and software that keep new cars on the road.

Therefore, it is not surprising that they might be motivated to take steps to protect their intellectual property.

Hollywood and record companies have taken a financial battering because of the unlawful downloading of movies and music, so why wouldn't car companies try to maintain ownership of their data.

But, by refusing to share all of this information, owners have to take their vehicles back to the dealer for even the most basic of repairs.

I've experienced how annoying this is first-hand when my car simply got a flat battery.

My vehicle lowers the windows slightly when the doors open, so when my car senses low voltage from the battery my windows just keep coming down.

Not so good if it's raining, or you want to secure the vehicle because you can't get it started

Fortunately, my roadside assist got me going again, but they couldn't reset the airbag warning light, which is the default warning for any fault with my vehicle.

So off to the dealer I went for half a day, and paid $100 for the service light to be re-set.

But there are lots of places in Australia that don't have a dealer for every type of vehicle on the road.

And, in a key difference from movie and music piracy, independent repairers have always offered to pay for the use of the information.

But that still hasn't produced consensus between the manufacturers/importers represented by FCAI (Federal Chamber of Automotive Industries), the dealers represented by AADA (Australian Automotive Dealer Association) and the independent repairers represented by AAAA (Australian Automotive After-market Association).

FCAI and AADA last month pointed out that a 2012 review by CCAAC (Commonwealth Consumer Affairs Advisory Council) found that "there does not appear to be any evidence of systemic consumer detriment regarding the sharing of service and repair information in the automotive industry".

From that you might infer that it was all sorted. But CCAAC also recommended that, "the automotive industry develop, within a reasonable period of time, an outcome that ensures there is a process for independent repairers to access repair information".

Two years later that still hasn't occurred, and the FCAI and AADA still claim that they are "the only organisations that appear to be making progress on this matter" with a voluntary code.

AAAA have fired back with accusations that FCAI has "walked away from the negotiation table", and that the voluntary code is "biased and inadequate".

FCAI have accused AAAA of "abandoning the process" - a little unfair, I feel, when they released the voluntary code without consulting the other parties.

AAAA say that restricting access to the information is anti-competitive and restricts the owner's choice of repairer.

As a peace offering, the VACC (Victorian Automobile Chamber of Commerce) has offered to make their extensive repair information library available to all independent repairers in Australia.

Apparently, the VACC call centre currently answers 98 per cent of received technical inquiries.

AADA say that, "it's therefore difficult to understand what repair information AAAA wants, which is not readily available at a small cost, or provided as part of being a VACC member".

That all looks like smoke and mirrors to me, because AAAA have clearly said that they, "are seeking access to the information, tools and training required to diagnose faults, repair and maintain today's technically complex vehicles under 'fair and reasonable' commercial terms".

And just getting back to that 98 per cent figure regarding answers to technical inquiries, I'd bet that the remaining 2 per cent relates to information about the flux capacitor, which we all know is a very important component in modern cars.

While I'm not a betting man, I'm putting my money on the little guys at AAAA, who have said that, "as these are the same multinational car companies operating in the Australian market, we must ask the FCAI: 'Why do you believe Australian consumers do not deserve the same rights as car owners in Europe and North America?'"

As doctors, we are spared these silly arguments about who owns the fleas on the dog.

After all, the Hippocratic Oath states that, "I will teach them my art without reward or agreement; and I will impart all my acquirements, instructions, and whatever I know, to my master's children, as to my own; and likewise to all my pupils, who shall bind and tie themselves by a professional oath, but to none else".

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

COMMENT