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A U S T R A L I A N  
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The national news publication of the Australian Medical Association

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AMA

# Co-payment bypass

## Govt may dodge Parliament to introduce \$7 GP charge, p6

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**Cover:** AMA President A/Professor Brian Owler, World Medical Association Chair Mukesh Haikerwal, WMA President Dr Xavier Deau, WMA Secretary General Dr Otmar Kloiber, AMA Victoria President Dr Tony Bartone and other participants at the H2O International Health Summit pose on the steps of Parliament House, Victoria.

## AMA LEADERSHIP TEAM



President  
Associate Professor  
Brian Owler



Vice President  
Dr Stephen Parnis



BY AMA PRESIDENT  
ASSOCIATE PROFESSOR  
BRIAN OWLER

# Co-payment policy at crossroads

It is being widely speculated this week that the Government may choose to put its controversial GP and other co-payment proposals 'on hold'.

Reports indicate that the Government has not been expending too much energy trying to win the support of crossbench Senators.

Time is running out for the Government to get the co-payments through the Senate this year. Most crossbenchers – including the newly independent Senator Lambie – are strongly opposed to the co-payments, and are not for turning.

There are just two sitting weeks to go, and all indications are that the Government will try to focus on its equally unpopular higher education reforms before Christmas, leaving the co-payments battle to another day.

The AMA has major concerns with aspects of the tertiary education changes, but our primary focus is on the co-payments and the under-reported Government plan to cut the Medicare patient rebate by \$5. Any moves to cut the rebate must be resisted, and the AMA has been leading the

resistance.

We have been engaging with politicians of all persuasions to argue against the Government's co-payment and the Medicare rebate cut.

We have also been explaining the merits of the AMA's alternative co-payment plan.

The Government clearly has a major political and public problem with its co-payments - but there is a clear way forward.

The compromise it should consider is to accept the AMA's alternative co-payments proposal.

Our plan invests in general practice and protects vulnerable patients, without cutting the Medicare rebate or the bulk billing incentive.

Our plan would reduce bulk billing rates to about 50 per cent, and it achieves the Government's aim of a price signal for patients who can afford to pay in general practice.

Our proposal would also allow the Government to achieve its \$20 billion goal for the Medical Research Future Fund (MRFF) over eight years,

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“ The AMA has major concerns with aspects of the tertiary education changes, but our primary focus is on the co-payments and the under-reported Government plan to cut the Medicare patient rebate by \$5. Any moves to cut the rebate must be resisted, and the AMA has been leading the resistance ”

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instead of six. Or it could settle for a \$15 billion MRFF, which is still substantial.

Better still, the Government could find less controversial ways to fund the MRFF.

The AMA is the only group with an alternative plan to invest heavily in general practice to meet the community's growing demand for quality accessible primary care services.

Investment in general practice for prevention and chronic disease management is the best strategy – not only for a sustainable health care system, but also for economic prosperity.





BY AMA SECRETARY  
GENERAL ANNE TRIMMER

“ The AMA has led a campaign against the unfair nature of the proposal and the impact which it will have on the quality delivery of these services ”

# Year of major change in health and AMA

In preparing for the upcoming meeting of the Board of Australian Medical Association Limited, I was reflecting on the changes that have taken place this year and the lift in tempo of activities within the secretariat.

There isn't one change that I can identify which has created the momentum but a combination.

At the start of 2014, I foreshadowed to the staff in the secretariat that this would be a year of substantial change, and that we would not really know the impact until the end of the year. The major developments have included:

- the adoption of a new Constitution by both Australian Medical Association Limited (the parent company of the AMA) and its wholly-owned subsidiary Australasian Medical Publishing Company Pty Limited (AMPCo – the publisher of the *Medical Journal of Australia* and the *Medical Directory of Australia*);
- the establishment of a new Board for both AMA and AMPCo;
- the adoption of governance documents including By Laws, a Board Charter, and a Board Protocol;
- the establishment of a new structure for Federal Council and its committees to enhance the work of Federal Council as the centre of medico-political debate;
- the development of a mission statement and

strategic objectives for the AMA (which will be published to members following the November meeting of Federal Council);

- the recruitment of a Human Resources Manager to assist in driving organisational improvement;
- the development of a shared IT resource across the AMA Group, adding depth and skill in IT projects, and providing improved services. A new website will be launched before the end of the year, with improved member information and search capability;
- increased capacity and capability in the membership and marketing team, with tools and resources under development to better support members, such as the new Careers Advisory Service;
- the recruitment of a Public Health Campaign Manager to support a shift to campaign-style public health advocacy. The recent National Alcohol Summit provided a good example of the change in emphasis for the AMA's approach to public health; and
- a major refurbishment project to upgrade the core services in AMA House, to make the building more functional and energy-efficient.

While these organisational changes have been taking place, the AMA has continued its place at the front and centre of medico-political advocacy.

A new President and Vice President elected in May are the first with fixed two-year terms. The President was elected to bring fresh energy and ideas to the AMA.

In politics, the year has been dominated by the Federal Government's announcements in the 2014 Budget, particularly the proposal to introduce a \$7 co-payment for general practice, pathology, and diagnostic imaging services.

The AMA has led a campaign against the unfair nature of the proposal and the impact which it will have on the quality delivery of these services.

The AMA developed an alternative model which reflected some of the 'signals' that the Government wanted to introduce, but which also protected those patients who are most vulnerable and least likely to access medical services if a fee is attached.

The co-payment battle continues.

Among the many major policy developments announced during the year have been the proposal to introduce changes in the funding of higher education, which will have an inordinate impact on those wishing to study medicine; the abolition of Medicare Locals and the proposal to introduce Primary Health Networks; and changes to the training of GP registrars.

On all of these issues the AMA has been active in its advocacy.

While the AMA will examine proposals on their merits, the AMA does not accept changes that undermine the quality of health care, no matter what form they take.

While it seems very early, my best wishes for a peaceful and enjoyable holiday season.



# Co-payment may be put on bypass

Concerns are mounting the Federal Government may try to bypass Parliament and introduce its unpopular \$7 patient co-payment by regulation in a desperate ploy to salvage a key plank of its Budget.

In a worrying sign that the Government intends to push ahead with the controversial measure even though it has little prospect of passing the Senate, the Department of Human Services has asked medical software providers to incorporate the charge in their products, according to a report in *Pulse+IT Magazine*.

The move follows the refusal by Health Minister Peter Dutton and Treasurer Joe Hockey to rule out circumventing Parliament and implementing the co-payment through changes to regulation.

And it comes amid speculation the Government will put the co-payment legislation on hold for the rest of the year.

Asked during an interview on ABC's Radio National whether the Government was planning to introduce the co-payment with legislation, Mr Hockey replied: "I am not speculating on what the outcome is".

AMA President Associate Professor Brian Owler said it was quite feasible for the Government to cut Medicare fees by \$5, which would in turn reduce the rebate by \$5, thereby implementing the key savings measure in the \$7 co-payment proposal.

But A/Professor Owler warned the Government risked incurring the wrath of the public if it behaved in such cynical manner.

"There was never a mandate to do this [introduce a co-payment], so actually trying to bypass the Senate would show complete contempt for the Senate and contempt for the Australian public," he said. "To introduce this proposal, which is not supported by the Senate, [and] is not supported by the public, and try and bypass Parliament, is a very poor approach, a very cynical approach, to what is very poor policy."

The Government is yet to introduce legislation for its co-payment plan into Parliament, where it faces almost no prospect at this point of being passed.

Labor and the Australian Greens have vowed to block the measure, and there is no sign that Mr Dutton and other senior ministers have been able to convince Palmer United Party senators to soften their stance opposing the co-payment.

A/Professor Owler, who met with PUP Senate leader Glenn Lazarus and Senator Jacquie Lambie earlier this month to discuss the co-payment, said he had been assured the minor party would not support the measure.

Aside from the legislative hurdle, the Government is also facing enormous practical challenges in implementing the co-payment, particularly if it wants it to begin on 1 July 2015.

One of the biggest headaches is working out how to track the number of co-payments made by patients who are concession card holders or children younger than 16 years.

Under the Government's plan, all patients would be liable for a \$7 co-payment on GP, pathology and diagnostic imaging

services. But, in a gesture to patients from disadvantaged backgrounds, concession card holders and children younger than 16 years will only have to pay the co-payment for the first 10 services each year – an effective cap of \$70.

But this will mean tracking patients as they move through the health system from general practice to pathology, diagnostic imaging and back again.

A/Professor Owler said this was a major issue.

"Clearly there are problems with implementing this policy," he said. "The software is nowhere near ready. There is no way to track when a patient on a concession goes from a GP to a pathologist, [then] to have their x-ray, [and] back to the GP."

The Department of Human Services has written to medical software companies advising them that "sites will need to check whether the patient has a concessional status, and may choose to charge a patient contribution at the point of service, as appropriate", according to an email obtained by *Pulse+IT Magazine*,

But Medical Software Industry Association Chief Executive Bridget Kirkham told news.com software companies had not yet been given enough information to act on the Government's plan.

"There are still details to be worked out before we could consider going forward," Ms Kirkham said.

A/Professor Owler warned the Government would be foolhardy to attempt to force the implementation of the co-payment in the next seven months.

"Implementation of this very poor policy is going to be very difficult," he said. "I think it will be a disaster if they try to push ahead with some kind of proposal by 1 July 2015."

**Adrian Rollins**



# Cost-effective GPs seeing more patients, treating more problems



The nation's GPs are treating more patients with increasingly complex health problems for a fraction of the cost of hospital based care, further undermining the Federal Government's case for introducing a \$7 co-payment.

The long-running Bettering the Evaluation and Care of Health (BEACH) study has found that 85 per cent of all Australians see their GP at least once a year, and in 2013-14 there were 35 million more GP services than a decade earlier, a 36 per cent increase.

The BEACH reports, *A decade of Australian general practice activity 2004-05 – 2013-14* and *Australian General Practice Activity 2013-14*, showed that not only are GPs seeing people more often, but they are spending more time with them – the average GP consultation now takes almost one minute longer than a decade ago because their patients are ageing and presenting with a

wider array of chronic and complex health problems. In all, GPs spend an extra 10 million clinical hours with their patients, a 43 per cent increase.

Underlining the cost effectiveness of general practice, the authors found that the same service provided by a GP for around \$50 would cost between \$396 and \$599 if performed in a hospital emergency department.

AMA President Associate Professor Brian Owler said the findings showed that, far from taking money out of general practice, the Federal Government should be increasing its support for GPs if it wanted to save money.

"General practice keeps people healthy and out of hospital. It makes sense for the Government to invest heavily in primary care, and the most cost-effective quality primary care is provided by GPs," A/Professor Owler said. "It is definitely not the time to be introducing disincentives – such as the Government's proposed model of co-payments for GP, pathology, and radiology services – that would deter sick people from visiting their GP."

The proportion of patients 65 years and older seen by GPs has surged in the past decade, from little more than a quarter to almost a third, bringing with them a multiplicity of concerns – the number of health reasons for each visit has multiplied, from less than 150 per 100 consultations in 2004-05 to 158 last financial year.

In all, there has been a 50 per cent increase in the problems managed by GPs since 2004-05, and a 36 per cent increase in consultations. Over the same period, the Medicare rebate for a standard level B consultation has risen from around \$25 to \$36.30, and the Government's co-payment model would see that cut to \$31.30.

Not only are GPs seeing more patients, the increase in the complexity of patient health problems has meant they are spending longer with each patient – the average consultation time has increased from barely 14 minutes in 2004-05 to 14.8 minutes last financial year. This has amounted to an extra 10 million hours of GP clinical time in the past decade.

Among the big drivers of the increase was a 40 per cent jump in the proportion of patients requiring blood tests (such as monitoring the effect of anticoagulants such as warfarin) and a 20 per cent rise in patients presenting with mental health problems. On the flip side, GPs saw proportionally fewer patients with eye, ear or neurological complaints.

According to the BEACH study, the health issues most frequently encountered by GPs were hypertension, health checks, vaccinations, colds and the flu, and in the past decade there had been significant increases in presentations for depression, diabetes, anxiety, nutritional deficiencies, bursitis and tendonitis.

Reflecting the older profile of patients, GPs are encountering more patients seeking help with managing chronic conditions.

The BEACH report found that, in 2004-05, 52 out of every 100 visits involved managing chronic conditions, and this proportion had risen to 56 per 100 by last financial year.

But, contrary to common perception, doctors are less likely than they have been to reach for the prescription pad.

GPs are managing more problems at each encounter, but they are doing so using fewer medications, the BEACH study found, though the authors said this was explained, in part, by a sharp 10 percentage point jump in the proportion of five-repeat prescriptions issued to almost 40 per cent of all prescription in 2013-14.

*See also 'GP workforce aging despite influx of women' p8*

**Adrian Rollins**

COMMENT

# GP workforce ageing despite influx of women

Almost half the nation's GPs are now women but the overall workforce is ageing rapidly, underlining calls for greater investment in general practice in order to improve access to primary health care.

A snapshot of the GP workforce by the Bettering the Evaluation and Care of Health (BEACH) project has found that 43 per cent of family doctors in 2013-14 were women, up from 32 per cent a decade earlier.

But, highlighting the need for a significant influx of new GPs in coming decade if access to primary care is to be maintained and improved, the study found a large proportion of the current workforce are rapidly approaching retirement age.

The study found that 48 per cent of GPs were aged 55 years or older last financial year, a big jump from 34 per cent a decade earlier.

As the workforce ages, GPs are cutting back on the hours they are working – the proportion working more than 40 hours a week has fallen from 42 to 31 per cent in the past decade.

Reflecting the rise of commercial practice groups and the aging of the GP workforce, particularly in rural and regional areas, small and solo practices are disappearing.

The proportion of GPs working solo had dropped from 12 to 9 per cent in the past decade, and the percentage of those working in practices of two to four doctors has shrunk from 36 to 23 per cent. Meanwhile, those working in large group practices of 10 more virtually doubled over the same period, and now a quarter of GPs work in large practices.

**Adrian Rollins**




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# Experimental drugs rushed to trial as Ebola effort ramps up

Health authorities and medical researchers have rushed experimental drugs and therapies to trial in west African countries ravaged by the Ebola virus as international efforts to contain the world's worst-ever outbreak intensify.

In an unprecedented transnational initiative, research institutes, public health agencies, health departments and humanitarian organisations have collaborated to fast-track clinical trials of three different Ebola therapies at west African treatment centres operated by medical charity Medecins Sans Frontieres.

The urgency of the effort has been underlined by confirmation the deadly disease has spread to Mali, where at least five people – including two health workers – have died, in a setback for hopes the outbreak was losing momentum.

In its most recent update on the epidemic, the World Health Organisation said the rate of new infections in Guinea and Liberia had levelled off, though transmission remained intense in key districts in both countries.

The outlook is much less promising in Sierra Leone, where the virus is yet to show signs of slowing, and the WHO reported that across the eight countries where the disease has occurred, 5420 people have died so far and there have been 15,145 confirmed, probable or suspected

cases.

The outbreak has taken a particularly heavy toll of health workers – a total of 584 were known to have been infected with the virus as at 16 November, 329 of whom have died.

The magnitude of the crisis was recognised by the leaders of the world's 20 largest economies who gathered in Brisbane earlier this month.

In a joint statement, the G20 leaders declared they were “deeply concerned” about the outbreak, urged governments to commit more money and resources – particularly trained medical teams and equipment – to combat it and called on researchers, regulators and drug companies to intensify their efforts to develop safe, effective and affordable diagnostic tools, treatments and vaccines.

After weeks of resisting calls from the AMA and others to support the deployment of health workers in west Africa, the Abbott Government earlier this month announced it had engaged private provider Aspen Medical to staff and operate a 100-bed British-built treatment centre in Sierra Leone.

But its tardy response has failed to impress some, including the US Government.



President Barack Obama has pressed governments around the world, including Australia, to do more,

US National Security Adviser Susan Rice said that, “we look to Australia and other partners... to fulfil the commitments they’ve made and do more, quite frankly”.

Ms Rice said the international efforts still fell well short of what was needed to help bring the outbreak under control, and added that US Government would “continue to look to capable partners like Australia to do their part”.

AMA President Associate Professor Brian Owler said that the Association had for some time stressed that the key to controlling the Ebola outbreak was to tackle it at its source in west Africa.

As Professor Owler said that, in addition to the Australian Government's \$20 million decision to contract Aspen to provide on-the-ground medical services in west Africa, “we must support initiatives to provide further support for these efforts in the affected nations”.

## Experimental drugs rushed to trial as Ebola effort ramps up ... FROM P9

He said the AMA supported the Doctors' Day for Ebola initiative, which aims to raise money to provide equipment and support for those combating the disease in west Africa, as "a practical way to tap the generosity and compassion of Australian doctors to save lives in Africa".

The G20 leaders said the epidemic highlighted shortcomings in the world's preparedness to cope with serious outbreaks, and they jointly committed to fully implement the WHO's International Health Regulations, support other countries in doing the same, and to fight anti-microbial resistance.

The International Health Regulations are legally binding rules aimed at helping countries work together to prevent the spread of disease and other health risks while minimising interference with international trade and travel.

In Australia, the AMA has been working with the Commonwealth's Chief Medical Officer Professor Chris Baggoley to ensure GPs have up-to-date advice on the Ebola outbreak, the disease's symptoms, and how to manage any patients suspected of being infected.

Chair of the AMA Council of General Practice Dr Brian Morton said advice from the Office of Health Protection was that it was "very unlikely" the GPs would encounter patients with Ebola.

Dr Morton said only about 10 people a week arrived in Australia from west Africa. Under upgraded processing arrangements, all such arrivals will have their temperature taken and their risk assessed before being allowed to

leave the airport.

Travellers who do develop Ebola-like symptoms are advised to call the dedicated national Ebola hotline – 1800 186 815 – rather than see their GP, he said.

Reflecting the urgency of the situation, organisations from across the world have joined efforts to rush experimental treatments to trial.

In Guinea, the French National Institute of Health and Medical Research will lead a trial of the antiviral drug favipiravir, and the Antwerp Institute of Tropical Medicine will oversee tests of an experimental convalescent whole blood and plasma therapy. An Oxford University team, acting on behalf of the International Severe Acute Respiratory and Emerging Infection Consortium, will administer a Wellcome Trust-funded trial of the antiviral medicine brincidofovir at a location yet to be confirmed.

"This is an unprecedented international partnership which represents hope for patients to finally get a real treatment against a disease that kills between 50 and 80 per cent of those infected," senior MSF official Dr Annick Antierens said.

The trial protocols are in the final stages of development, and have a simple target of 14-day survival.

It is intended that they commence in early December, with initial results available in February.

**Adrian Rollins**



## Climate change and health pioneer dies

Public health experts from around the world have paid tribute to Australian epidemiologist Professor Tony McMichael, whose pioneering work on the links between climate change and health helped inform the AMA's policy on the issue.

Professor McMichael, who was Professor Emeritus of Population Health at the Australian National University when he died from complications associated with pneumonia in late September, has been hailed for his world-leading work in epidemiology, including his efforts from the 1980s to draw international attention to the health effects of climate change.

His world leadership in this area of work was acknowledged when he appointed the chair the committee assessing health risks for the United Nations Intergovernmental Panel on Climate Change between 1993 and 1996, and he continued to contribute to the stock of knowledge about how climate change is and will affect health right up until his death.

Among those to benefit from his scholarship was the AMA.

Professor McMichael was one of the principle speakers at the AMA Environmental Health Summit in November 2002, and his research was drawn upon by the AMA in the development in 2004 of its *Climate Change and Human Health Position Paper* (revised in 2008).

Professor McMichael, who was 71 when he died, is survived by his wife Judith and two daughters.

**Adrian Rollins**



# Health a lower priority than gambling, pets

The Federal Government’s Budget cuts to Medicare rebates and hospital funding have been panned at a meeting of international health leaders amid warnings that governments worldwide need to invest in health in order to drive economic prosperity.

In the latest assault on the Abbott Government’s strategy to pare back Commonwealth spending and load more health care costs onto patients and doctors, experts addressing the H20 International Health Summit in Melbourne warned inadequate funding for health undermined a country’s growth potential.

The Summit, convened by the World Medical Association in collaboration with the federal AMA and AMA Victoria, was organised to help elevate health as an issue for major world leaders, including forcing it onto the agenda of the G20.

It was told that, since the global financial crisis, governments across the developed world have been cutting their health spending, increasingly forcing individuals and households to make up the difference.

## Govt spending on health falls worldwide

Andrew Goodsall, Head of Health Care Research at UBS Wealth Management Australia, said that among Organisation for Economic Co-operation and Development governments, spending on health had stagnated or shrunk between 2008 and 2011, while over the same period spending by the private sector had grown 2.5 per cent and among individuals it had increased 1.4 per cent.

It was a development that AMA President Associate Professor Brian Owler and several other speakers warned would come at the cost of prosperity as well as health.

Professor Owler told the Summit that, particularly when it came to improving the prospects of the disadvantaged, such as Indigenous communities, better health was fundamental.

“Without improving health, education and employment will not follow. That is why investment in health must continue,” he said.

Professor Angang Hu, Director of the



School of Public Policy and Management at Tsinghua University, said the strong link between health and economic growth had been explicitly acknowledged by the Chinese Government in its development plans for the world’s most populous country.

Professor Hu said targets regarding life expectancy, child vaccination rates, infant mortality and maternal health were integral parts of the five-year economic plans developed by the Chinese Government.

In its latest five-year plan, covering the period 2015 to 2020, the Government aimed to lift the immunisation rate to 95 per cent of the population, boost life

expectancy to 77.5 years, and halve infant mortality to six deaths for every 1000 live births.

The Chinese Government’s ambition, Professor Hu told the Summit, was to lift the country’s performance on the main health indices above those of all other developing countries by next year, the on a par with middle-level developed countries by 2020 and to achieve results equivalent to those of the top developed countries by 2030.

This is because, he said, health was seen as “the foundation for comprehensive development - health is both a means and end of development”.



## Health a lower priority than gambling, pets

... FROM P11

### Health integral to growth

The economic importance of health was underlined by Australian Institute of Health and Welfare Chief Executive Officer David Kalisch, he told the Summit that, "a healthy population is integral to a healthy economy".

"If the health of a people falters, there is a major impact on the productive potential of the economy," Mr Kalisch said.

But speakers including A/Professor Owler and health economist Roger Kilham said this was a lesson that the Abbott Government was not heeding.

Health Minister Peter Dutton has defended the Government's health cuts on the grounds that health spending has been growing unsustainably.

But A/Professor Owler said the claim was "rubbish", and that what was masqueraded as health policy was actually driven by a desire to balance the Budget.

Mr Kilham said the Budget settings reflected the priorities of the Government.

"All these things are choices," he told the Summit. "We spend a lot on public hospitals, but we spend more on legal and illegal gambling, [and] we spend more on pet care than we do on GPs."

He said that many Government decisions about health care were taken within the "very narrow framework of costs to the Budget", which he said was a totally wrong and inadequate way of examining the issue.

"You would never build a road if you were only looking at the costs and not the benefits," Mr Kilham said.

Speakers at the Summit said the focus needed to shift from how much was spent, to how effectively it was used.

Dr Neil Soderland, Head of Health Care Practice at the Boston Consulting Group, said, "we should not be looking at health spending, but value of that spending".

Dr Soderlund said the focus tended to be on how many procedures or other services were provided, rather than what the care was ultimately intended to achieve.

"The issue isn't growth in health spending, but outcomes - value for money," he said.

A/Professor Owler urged a change in the mindset of the Abbott Government away from viewing health purely as an expense to seeing it as an investment fundamental to fostering growth and prosperity.

He said to achieve the best value for its health dollar, the Government should work closely with medical practitioners.

"We can't have poor policies, purely fiscal policies, developed in isolation [from] health, thrust upon the community such as we have seen with the blunt \$7 co-payment proposal," AMA President said. "If we want to get wise investment in health, then we need to have a process of collaboration and consultation for general practice. Engagement with clinicians is key. It can't be token."

**Adrian Rollins**



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Professor McMichael, who was 71 when he died, is survived by his wife Judith and two daughters.

**Adrian Rollins**



# Clinical mobile images guide released



Whipping out the mobile and taking a quick photo of a suspicious rash, an open wound or just about any other medical ailment, and texting it to a colleague has become almost a routine aspect of medical practice.

The advent of smart phones, tablets and other mobile devices with the ability to take and share images has been a boon for clinicians, giving them a handy record of a patient's medical complaint or providing a means to quickly and easily seek the opinions of others.

But the convenience of capturing, storing and distributing the images of patients brings with it a host of significant legal, professional and ethical issues that have so far received little attention, but which it is vital that clinicians are aware of and take into account.

To fill this gap in knowledge, and to provide practitioners with a practical guide to how to avoid legal and ethical pitfalls, the AMA and the Medical Indemnity Insurance Association of Australia has, with specialised input from the AMA Council of Doctors in Training and the AMA Council of Salaried Doctors, developed a booklet, *Clinical Images and the Use of Personal Mobile Devices*.

AMA President Associate Professor Brian Owler said the booklet detailed the key ethical and legal issues doctors needed to be aware of before using a personal

mobile device to take or transmit clinical images for the purpose of providing clinical care in the Australian health care system.

"Medical professionals routinely take clinical images while caring for patients," A/Professor Owler said. "Sharing clinical images is extremely valuable for teaching, research, and advice – but there are also associated legal, professional, and ethical responsibilities."

He said that that, with an ever-increasing range of portable devices available to the medical profession, "it is important that doctors and medical students are aware of the benefits and risks associated with the use of this new technology in clinical settings".

The AMA President said that clinicians needed to be aware that such images formed part of a patient's medical record, and so were subject to the same privacy and confidentiality principles as any other part of the record.

The guide includes detailed information about what constitutes a clinical image, how it can be collected, used and stored, and how doctors can fulfil their ethical and legal obligations to their patients.

"Under Australian privacy laws, clinical images should only be taken where necessary, and with consent, where practicable," A/Professor Owler said. "The images must be stored securely, and

only disclosed where needed in line with the consent given, or if there is a legal obligation to do so."

The guide includes a handy flow chart that allows clinicians to quickly and easily navigate the legal and ethical considerations involved in taking, storing and sharing clinical images.

But A/Professor Owler said this was not just an issue for the medical profession, and urged governments to develop better systems to integrate clinical images into the medical records of patients.

He said the AMA had written to State and Territory Health Departments to encourage them to provide a secure platform to enable doctors to use this technology safely, efficiently, and effectively.

Some of the practical tips included in the guide include:

- before taking a clinical image, consider the purpose for which it is required, and obtain appropriate consent;
- make sure the patient understands the reasons for taking the image, how it will be used and to whom it will be shown; and
- document the consent process in the health record and check health service or hospital requirements regarding obtaining written consent.

**Adrian Rollins**



# Care needed in doctor-health fund collaboration

AMA President Associate Professor Brian Owler has warned the private health insurance industry off arrangements that compromise the doctor-patient relationship and crimp access to care.

In a period of upheaval for the sector marked by the privatisation of the country's largest health fund and an aggressive push by insurers into primary care, A/Professor Owler said in a major speech to the peak body for private insurers, Private Health Australia, that the time had come for discussion about the role GPs could play in private health insurance arrangements.

But he said this should only occur in ways consistent with the principles that made Australia's health system one of the most efficient and effective in the world, including universal and equitable access to care, the independence of the doctor-patient relationship, community rating and the right of practitioners to set their own fees.

"The AMA believes it is time for a discussion about how GPs could play a

more prominent and central role in private health insurance arrangements," the AMA President said. "[But] any move to expand the role of private health insurers should be carefully planned and negotiated with the profession to ensure that the outcome is in the best interests of patients, and does not compromise the clinical independence of the profession, or interfere with the doctor-patient relationship."

The AMA Council of General Practice has been examining the possibilities for some time, and has identified a number of possible areas of collaboration including wellness programs, the maintenance of shared electronic health records, hospital in the home initiatives, palliative care, minor procedures and GP-directed hospital avoidance programs.

The Federal Government has encouraged insurers to look at ways of expanding their operations, and Health Minister Peter Dutton has remarked approvingly on the controversial Medibank Private/IPN trial in Queensland in which the fund contributes to the administrative costs of

selected general practices in exchange for preferential access to care for its members.

But A/Professor Owler said the Medibank arrangement jarred with the principle of equity of access to care and was unacceptable.

He said any model of care agreed to by doctors and insurers must respect the foundation principles of the health system and avoid any hint of managed care.

"If we can agree on a model that ensures the integrity of the doctor-patient relationship, equity of access, and universality, then this is an area where the AMA and PHIs [private health insurers] can work together," the AMA President said.

"That discussion can only proceed if the independence of the doctor-patient relationship is preserved.

"We cannot have a situation develop where a doctor's ability to order a test, prescribe a treatment, or refer to another doctor is influenced by a third party or 'payer'. That is a managed care system."

A/Professor Owler said that, in addition, the AMA would like to see the health funds dump policies and practices that were having undesirable consequences.

He said one of the big gripes of patients and doctors were policies with multiple exclusions.

The President, who works as a paediatric

neurosurgeon, said he had personal experience of patients in need of surgery only to find that it was not covered by their insurance policy.

"Too often, my members see patients who think they have cover, but don't, because they purchased a cheaper product several years ago," he said. "Sometimes treatment is planned and surgery is booked, only to be cancelled shortly beforehand because the hospital's health fund check reveals that the patient is not covered. It is not an unusual scenario."

In addition, he called on health funds to stop exaggerating how often patients are charged gap fees.

"It would be preferable if some of you were a bit more open and honest with your members that the vast number of services are provided at the level of benefit set by the insurer, instead of portraying isolated cases as the norm, or even going to the extent of briefing the media with specific cases," A/Professor Owler said.

He said almost 90 per cent of services were provided at no gap, and only a "very small" proportion involved higher charges.

He said the AMA was keen to work with insurers and the Health Department to ensure that neither they nor Medicare was billed for purely cosmetic surgery, and said there were opportunities for the health funds to support quality assurance and outcome measurement activities.

**Adrian Rollins**



# Millions dying for want of a decent toilet

The AMA has joined health leaders from around the world in urging a dramatic increase in the number of people who have easy access to safe drinking water and proper sanitation.

AMA Vice President Dr Stephen Parnis said that 2.5 billion people, around a third of the world's population, did not have access to a safe and clean toilet, putting their health at risk.

"Access to basic sanitation is fundamental to human health, yet inadequate sanitation continues to leave billions around the world prone to illness, poverty and death," Dr Parnis said.

One of the biggest killers is diarrhoea, particularly among children. It is estimated that around 4000 children die every day from diarrhoea as a result of drinking unsafe water, and inadequate sanitation and hygiene.

"At any one time, more than half the hospital beds in the developing world are occupied by patients suffering from diarrhoea," Dr Parnis said. "Each year, around four million people die from diseases linked to a lack of safe drinking water, inadequate sanitation, or poor hygiene."

It is estimated that about a billion people defecate in the open – about 600 million of them in India alone. According to the World Health Organisation and UNICEF, in all there are 19 countries where more than half the rural population defecates in the open.

In a promising initiative, the Indian Government has embarked on a program to build millions of toilets, at the rate of about one every second.

Dr Parnis said having access to a toilet and adequate sanitation was not only important to help ward off disease, but also helped prevent sexual violence and assaults.

"Having no home toilet means that women and girls in some countries must relieve themselves in open fields and public areas, which exposes them to an increased risk of assault," Dr Parnis said.

"And the failure to provide safe female sanitation in schools contributes to lower educational attendance for girls."

Inadequate sanitation is not only a problem in south Asia, sub-Saharan Africa and south-east Asia.

Dr Parnis said Papua New Guinea had one of the lowest rates of access to safe and clean toilets of anywhere in the world - just one in five people had access to improved sanitation.

"Dramatic improvements must be made to water, sanitation, and hygiene access if we are to sustainably raise living standards and build prosperity in our region," he said, adding that it was also a problem in parts of Australia.

"There are also many Australians who suffer from poor sanitation," he said. "The Productivity Commission report,



*Overcoming Indigenous Disadvantage 2014*, shows that a considerable number of Indigenous communities lack proper access to clean water and functioning sewerage services."

The AMA has added its signature to a letter to UN Secretary-General Ban Ki-moon from leading health organisations including the World Medical Association urging that the Millennium Development Goals be renegotiated to ensure many more have access to adequate sanitation and safe drinking water.

The sanitation goal under the current MDG agreement, which aims to halve the proportion of the world's population without access to basic sanitation by the end of next year, appears unlikely to be met.

**Adrian Rollins**

COMMENT

# Medical degrees for richest, not smartest under Govt's uni plan

The Federal Government's plan to deregulate university fees will push the cost of medical degrees up to \$250,000, discouraging low income students from becoming doctors and skewing the medical workforce toward higher paid specialties and city practices.

AMA President Associate Professor Brian Owler has accused the Abbott Government of failing to appreciate the full consequences of its deregulation policy, warning the skyrocketing cost of a medical degree would undermine efforts to end the shortage of rural doctors, intensify the concentration of practitioners in the most lucrative specialties and discourage people from a career in medical research.

The Federal Government is trying to win Senate support for the deregulation of university fees, which it argues will unshackle universities and allow them to fully compete in the international education market.

So far its way has been blocked by the Palmer United Party, which has joined Labor and Greens in opposing the measure, and A/Professor Owler was assured of the PUP's continuing opposition when he met with the minor party's Senate leader Glenn Lazarus earlier this month.

The AMA President said the Government's policy was ill-considered and, by saddling medical graduates with crushing debt, would exacerbate existing problems regarding rural shortages of doctors and the difficulty of luring graduates into vital but less well remunerated areas of medicine such as general practice, paediatrics and rehabilitation.

Medical Deans Australia and New Zealand have estimated that students embarking on a graduate medical degree will already be carrying a HECS debt of about \$55,656 from their undergraduate studies.

A/Professor Owler said that on top of this, domestic students were likely to incur an annual debt of \$52,000 for their four-year degree, even taken into account a Commonwealth subsidy of \$18,000 a year, leaving them with a total debt of more than \$250,000.

He said that although medicine was a relatively well paid profession, making the degree so costly would have a number of undesirable consequences for patient access to quality care.

The AMA President said the threat of such heavy debts would be a significant deterrent for people from lower socio-economic backgrounds, including rural and Indigenous Australians, from considering a career in medicine.

A/Professor Owler said that, even without these big fee increases, the bulk of students studying medicine were from better off backgrounds.

A 2011 report commissioned by the Group of Eight universities found that 45 per cent of students applying to study medicine came from well off families, compared with 15 per cent from low socio-economic backgrounds.

The AMA President warned the deterrent effect for low-income students would be strong, regardless of any loan assistance offered, and was a serious problem for the profession.

"This is a real issue in medicine. We want the best and brightest, not the wealthiest," he said. "We want the medical profession to have the same diversity as the communities it serves. Australia has gained significant benefit by attracting medical students from diverse backgrounds... [and] that is something that we should continue to value."

In addition to deterring lower income people from entering medicine, high fees would also skew the career choices of graduates toward better remunerated areas of practice, he said.

A/Professor Owler said overseas evidence showed that students carrying big debts gravitated toward better paid specialties, and the deregulation of fees was likely to see more medical graduates seeking to become surgeons and procedural specialists rather than GPs, paediatricians and other less lucrative areas of medicine.

He warned there would also be a flow-on effect for rural areas.

"Areas of medicine that are better remunerated will become more attractive. Ultimately, these decisions will exacerbate doctor shortages in rural and regional areas," he said.

Not only that, it would also make it much harder to encourage graduates to embark upon research.

"High debt levels among medical graduates will deter our best and brightest, our future leaders, from undertaking PhD programs," A/Professor Owler warned. "As a medical graduate, already with significant debt, often at the stage of life of starting a family, it would not be surprising to see commitment to further research, to science, questioned. For all the talk of the Medical Research Future Fund, it is disappointing that implications such as these do not seem to have been considered."

**Adrian Rollins**

COMMENT

# AMA IN THE NEWS

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

## Print/Online

### [Aussies to help in Ebola hotspot, \*Courier Mail\*, 5 November 2014](#)

The Federal Government is set to back down on its refusal to send medical works to west Africa, after striking a deal with the UK to treat Australians who become infected with the virus. AMA President A/Professor Brian Owler welcomed the deal and said he knew of doctors who were ready to go.

### [Australians cleared to join Ebola fight, \*Sydney Morning Herald\*, 5 November 2014](#)

The Abbott government will help Australian volunteers to travel to one of the Ebola hotspots in Africa to help control the epidemic. The AMA has said that many doctors are willing to assist.

### [Hunt for helpers to fight Ebola, \*The Australian\*, 6 November 2014](#)

Tony Abbott announced the government would hire Canberra-based Aspen Medical Centre to provide 240 staff for a 100-bed medical facility being built by the British government in Sierra Leone. AMA President A/Professor Brian Owler welcomed the announcement but questioned why AUSMAT teams were not being used.

### [Who'll budge it?, \*The Saturday Paper\*, 8 November 2014](#)

Tony Abbott urged scientists to make their case for the \$20 billion Medical Research Future Fund, to be financed in part by the Medicare co-payment. AMA President A/Professor Brian Owler said the debate on the co-payment should be separated from the issue of funding research.

### [Results should go to the patient, \*The Sunday Age\*, 9 November 2014](#)

Patients will be able to access their test results via electronic health records after seven days, giving doctors time to manage the communication of results to their patients. The AMA signed off on the seven-day delay.

### [Neurosurgeon defended, \*The Canberra Times\*, 10 November 2014](#)

The Canberra Times published a letter questioning AMA President A/Professor Brian Owler's credentials in his commitment to the treatment of and research into brain cancer. AMA Secretary General Ms Anne Trimmer said A/Professor Owler does not deserve to have his professionalism and commitment questioned.

### [Medical degree fees may preclude some students, \*Australian Financial Review\*, 13 November 2014](#)

The cost of a medical degree will rise to about \$250,000 if university fees are deregulated, AMA President A/Professor

Brian Owler has warned. A/Professor Owler said the prospect of larger debts would deter students from rural, poor and Indigenous backgrounds from pursuing a medical career.

### [\\$7 GP fee 'by stealth', \*The Herald Sun\*, 13 November 2014](#)

Fears the \$7 GP fee flagged in this year's Budget could be implemented without parliamentary approval have been heightened. AMA President A/Professor Brian Owler questioned the legitimacy of any move by the Federal Government to work around Parliament to introduce its co-payment plan.

### [Push to sell Pill without a script, \*Courier Mail\*, 19 November 2014](#)

Women will be able to get the contraceptive pill over the counter in pharmacies without a prescription under a controversial proposal before the nation's medicine watchdog. AMA Chair of General Practice Dr Brian Morton said it was a significant issue because the pill does have risks for women.

## Radio

### [A/Professor Brian Owler, 2SM Sydney, 6 November 2014](#)

AMA President A/Professor Brian Owler talked about the Federal Government's announcement to fund an Ebola medical centre built by the UK. A/Professor Owler said the AMA welcomes the announcement.

### [A/Professor Brian Owler, 2UE Sydney, 9 November 2014](#)

AMA President A/Professor Brian Owler talked about educating young people on the harms of alcohol and drugs. A/Professor Owler said the best education was to try and



## AMA IN THE NEWS

... FROM P17

get people to avoid taking these substances all together.

**Dr Stephen Parnis, 2SER FM Sydney, 11 November 2014**

AMA Vice President Dr Stephen Parnis talked about fee deregulation for medical students. Dr Parnis said it would be a recipe for inflation.

**A/Professor Brian Owler, ABC NewsRadio, 19 November 2014**

AMA President A/Professor Brian Owler discussed a new report by the Australian Commission of Safety and Quality in Healthcare that found up to a third of antibiotics prescribed in Australian hospitals were given out inappropriately. A/Professor Owler believes community expectations must be adjusted in line with the report.

### Television

**Dr Stephen Parnis, Channel 10, 6 November 2014**

A new study showed Australian hospital medical staff are being

assaulted by drunk patients every day, and some hospitals found up to a third of emergency admissions are alcohol related. AMA Vice President Dr Stephen Parnis said doing something about alcohol would help improve emergency over-crowding.

**A/Professor Brian Owler, Channel 9 Melbourne, 10 November 2014**

AMA President A/Professor Brian Owler talked about a teenager who died of a suspected drug overdose at a Sydney dance festival. A/Professor Owler said the death was very tragic. He said it was incorrect to describe it as an overdose problem, because that implied there was a safe dose.

**A/Professor Brian Owler, Channel 10, 13 November 2014**

AMA President A/Professor Brian Owler discussed accusations the Federal Government was considering sneaky tactics to force Australians to pay an extra \$7 for GP visits. A/Professor Owler said trying to bypass the Senate to introduce the \$7 co-payment would show contempt for the Senate and the Australian public.



## 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 the 4 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>**

# Noose tightening on e-cigarettes



The crackdown on e-cigarettes is intensifying amid alarm that teenagers are being lured into using the controversial devices despite uncertainty about their safety and long-term effects on health.

The Australian Capital Territory is considering joining Queensland in subjecting e-cigarettes to the same laws and regulations as tobacco products, making it illegal to sell them to people younger than 18 years.

Health authorities worldwide have been caught flat-footed by the rapid spread of e-cigarettes – battery operated devices that are tobacco-free and instead heat solutions to produce a vapour that users inhale.

They are often promoted as an aid to giving up smoking, though such claims are yet to be substantiated and the

World Health Organisation has called for strict regulation around their use amid uncertainty about their health effects.

While the sale of e-cigarettes containing nicotine is banned in Australia, in most states there are no restrictions on the availability and use of non-nicotine versions, and their ready availability online has made it difficult for authorities to police.

The ACT Government is considering restrictions on the promotion of e-cigarettes and a ban on their use in smoke-free public places and around children.

This follows Queensland's move to become the first State to subject e-cigarettes to the same laws as tobacco products, a ruling by a Western Australian court earlier this year that effectively banned the sale of e-cigarettes in that State, and South Australia's decision to prohibit the sale of e-cigarettes that resemble tobacco products.

Despite these moves, there is anecdotal evidence that e-cigarette use is growing fast, and public health experts in Victoria have accused tobacco companies of targeting children by marketing lolly-flavoured e-cigarettes.

Quit Victoria tobacco control policy manager Kylie Lindorff told *The Age* that the sale of e-cigarettes, often colourful and lolly-flavoured, was completely unregulated as long as they did not contain caffeine, meaning children could buy them.

"We're incredibly concerned about that," Ms Lindorff told *The Age*. "We'd like to see the sale of these products banned outright."

Earlier this year, public health experts worldwide made a joint appeal to the World Health Organisation to ignore tobacco industry claims about e-cigarettes and instead focus on the evidence in assessing their health implications.

Leading Australian public health advocates Professor Stephen Leeder, Professor Alan Lopez, Professor Ian Olver, Professor Mike Daube, Professor Simon Chapman and Associate Professor Freddy Sitas were among 129 international public health physicians and campaigners who wrote to WHO Director General Dr Margaret Chan in support of the organisation's evidence-based approach to electronic nicotine delivery systems.

Promoters claim the technology provides a safe alternative to tobacco products and is an aid in kicking the smoking habit, and tobacco companies have quickly moved into the e-cigarette market.

But there is insufficient evidence so far to substantiate these claims.

A study published in the *Society for the Study of Addiction* journal questioned calls for e-cigarettes (EC) to be regulated as strictly as conventional cigarettes are finding that allowing e-cigarettes to compete with cigarettes in the marketplace might actually decrease smoking-related illness and deaths.

But doubt has been cast on this conclusion by a study of 1074 New York cancer patients who smoked which found that those using e-cigarettes were just as likely to be smoking after a year as those who did not use them, and that seven-day abstinence rates were virtually the same for both groups.

The National Health and Medical Research Council is funding a clinical trial to investigate whether or not e-cigarettes are an aid to quitting smoking.

**Adrian Rollins**

COMMENT

# Doctors too ready to turn to antibiotics



Thousands of hospital patients are being prescribed antibiotics that are too broad, do not treat the problem, are of the wrong dose or are not what they need, adding weight to calls for improvements in prescribing practices to combat the rise of antibiotic resistance.

In a result that calls into question how and why many antimicrobials are used, an Australian Commission on Safety and Quality in Health Care (ACSQHC) study has found almost a third of antibiotics used in Australian hospitals are being prescribed inappropriately, either because they were too broad, were being used for too long or too short a period, were of incorrect dose or were too narrow.

The findings came as a National Prescribing Service survey showed many GPs were prescribing antibiotics for health problems where they would be no use because of a desire to keep their patients happy.

The NPS survey found 57 per cent of doctors would prescribe an antibiotic for patients with a viral infection of the upper respiratory tract, blaming limited consultation time, a desire to preserve their relationship with their patients and concern they might be sued if they missed a diagnosis.

Already, Australia is one of the world's heaviest users of antibiotics, with concerns it is contributing to the worldwide rise of antibiotics resistant infections.

Each year, an average of almost one antibiotic prescription is issued for every man, woman and child in Australians, and there are 24 daily doses prescribed for every 1000 people – well above the developed country average of 18 per 1000.

Commonwealth Chief Medical Officer Professor Chris Baggoley said antimicrobial resistance was “one of the major threats to human health”.

There is a real concern that, without new antibiotics in the development pipeline, some infections will be difficult or impossible to treat,” Professor Baggoley said.

The threat has increased the focus on how antibiotics are being used in the nation's hospitals, where the evidence is mixed.

Based on data from 151 public and private hospitals, the ACSQHC report *National Antimicrobial Prescribing Practice: Results of the 2013 National Antimicrobial Prescribing Survey* found antibiotics were being used in a clinically appropriate manner in 70.8 per cent of cases, and compliance with best practice was higher among narrow-spectrum agents such as flucloxacillin, benzylpenicillin and vancomycin.

But the quality of prescribing fell away when it came to broader spectrum antibiotics, particularly cephalexin, ceftriaxone and cephazolin.

Based on data from 12,800 prescriptions, the study found that the prescription of cephalexin, often used to treat pneumonia and urinary tract infections, was inappropriate in almost 40 per cent of cases, most commonly because it was too broad or was of incorrect dose or duration.

Worryingly, the use of the most commonly prescribed antibiotics, ceftriaxone and cephazolin (each accounting for almost 10 per cent of all antibiotics prescribed) was considered inappropriate in one out of every three instances.

The study found that antibiotics were most commonly prescribed for surgical prophylaxis (11.5 per cent of indications) and, disturbingly, were being used inappropriately 42 per cent of the time. Even worse, it was prescribed for more than 24 hours in 41 per cent of cases – far in excess of the 5 per cent that is considered best practice.

The level of appropriateness was even worse when it came to prescribing antibiotics for patients with chronic obstructive pulmonary disease – antibiotic use was considered acceptable in just 52 per cent of instances.

**Adrian Rollins**



## 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](mailto:generalpractice@ama.com.au)

# Common pill riskier than we think

Patients taking a commonly prescribed antibiotic are at increased risk of developing diarrhoea and thrush, adding to concerns about the extent of its use.

A systematic review of controlled trials has found that the widely used antibiotic amoxicillin, usually prescribed for respiratory infections, can cause diarrhoea and candidiasis when taken in conjunction with clavulanic acid.

One of the study's authors, Dr Chris Del Mar of Bond University's Centre for Research in Evidence-based Practice, said the findings should give doctors pause for thought when considering whether or not to prescribe amoxicillin for their patients.

Dr Del Mar said there was a dearth of systematic research into the harms associated with the use of amoxicillin, and the incidence of adverse effects was likely under-reported.

The researchers identified 45 eligible controlled trials out of 730 studies assessed for the investigation. Of those 45, 25 included reports of adverse effects, though it was not done on a systematic basis.

Nevertheless, Dr Del Mar, there was found to be a statistically significant association between taking amoxicillin in conjunction with clavulanic acid and the incidence of diarrhoea and candidiasis.

He said for every 10 prescriptions of amoxicillin in conjunction with clavulanic acid, there was one extra case of diarrhoea that required treatment, while

there was an extra case of candidiasis for every 27 prescriptions.

Dr Del Mar said because so few controlled trials of amoxicillin included reports of harm, it was likely the incidence was under-reported and the extent of side effects was higher.

But, even at these levels, it should cause the cost-benefit equation of using amoxicillin to be reassessed, he said.

"The important consequence of under-reporting of harms is the tilting of the balance of benefits and harms towards amoxicillin," Dr Del Mar said.

"[The findings] will help clinicians in shared decision-making with patients to help balance the benefits together with the harms of using antibiotics, and hopefully there will be a reduced number of antibiotics prescribed."

His concerns were backed by University of East Anglia researcher Dr Yoon Loke, who said it was "shameful" that there had been so little research into the harms associated with such a widely used drug.

"For this drug, clinicians and patients must not construe 'absence of evidence of harm' to be the same as 'evidence of absence of harm'," he said.

The study has been published in the *Canadian Medical Association Journal* and can be viewed at: <http://www.cmaj.ca/lookup/doi/10.1503/cmaj.140848>

**Adrian Rollins**



# ANZAC spirit fails drug test

Hopes to make drugs in Australia and New Zealand cheaper and more quickly available have been dealt a blow after the Federal Government announced that plans to bring the regulation of drugs and medical devices across the Tasman under a single umbrella have been abandoned.

In an unheralded development that has also dented efforts to increase trans-Tasman co-operation and economic integration, Australian Health Minister Peter Dutton and his New Zealand counterpart Dr Jonathan Coleman have jointly announced agreement to “cease efforts” to establish a joint therapeutic products regulator.

The announcement brings to an abrupt end 11 years of work, after the two countries jointly committed in 2003 to the establishment of the Australia New Zealand Therapeutic Products Agency to oversee the regulation of medicines and medical devices across the two jurisdictions.

The decision comes despite the fact that both governments reaffirmed their commitment to the Agency as recently

as last year, when the-then Prime Minister Julia Gillard and NZ Prime Minister John Key issued a statement reiterating their commitment to the ANZTPA.

At the time, the prime ministers said the agency “should provide for efficient and cost-effective regulation of medicines and medical devices. . . [as well as] a trans-Tasman centre of regulatory excellence for positioning Australia and NZ therapeutic producers in the regional and global market place”.

In 2011, the countries agreed to a three stage approach over a period of up to five years that would see the scheme operational by mid-2016.

The decision to axe the project is a blow to efforts to increase economic co-operation and integration between Australia and New Zealand, given that the ANZTPA was to have been the first fully joint trans-Tasman regulator.

It raises doubt about the prospects for success of other attempts to achieve some form of trans-Tasman

harmonization.

In their joint statement, Mr Dutton and Dr Coleman said the decision to abandon the project was taken “following a comprehensive review of progress and assessment of the costs and benefits to each country of proceeding”.

“Each country will now proceed with its own domestic therapeutics regulatory reform program, but we remain open to future co-operation activities,” the ministers said.

The Abbott Government has already initiated a review of Australia’s therapeutic goods regulatory regime amid industry complaints the system is too bureaucratic, costly and slow.

A particular gripe is that sponsors are required to conduct tests and provide evidence for products that have already been approved for use by regulators in other countries, particularly in Europe and the US, and the review will consider automatic approval for therapeutic goods already accepted by credible regulators offshore.

Despite abandoning the ANZTPA project, the ministers said their two countries would “continue to co-operate on the regulation of therapeutic products where there are mutual benefits for consumers, businesses and regulators in each country”.

Adrian Rollins



## INFORMATION FOR MEMBERS

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\*Applicable taxes may apply. Prices are subject to change without notice.

# Over-the-counter pill, Viagra a bad idea: AMA

Proposals to allow women and men to buy reproductive medications such as the contraceptive pill and Viagra over the counter without prescription are fraught with danger, the AMA has warned.

Pressure is mounting to relax restrictions on access to commonly prescribed drugs as pharmacists come under increased financial strain and the Therapeutic Goods Administration undertakes a review of the scheduling of medicines.

A submission before the TGA has proposed that pharmacists be allowed to dispense the pill to patients who fill out a small questionnaire detailing any family history of heart problems, hypertension or stroke.

And the Australian Self Medication Industry wants Australia to copy New Zealand's move to allow over-the-counter sales of Viagra, as well as flu vaccines and treatments for urinary tract infections and migraines.

But Chair of the AMA Council of General Practice Dr Brian Morton told the *Adelaide Advertiser* it would be dangerous to give people access to such medications without the supervision of a doctor.

Dr Morton said the pill carried with it the risk of stroke, and doctors were required to assess this risk, as well as provide advice on other aspects of reproductive health such as the need for regular Pap smears – intimate conversations that would be very difficult to conduct discretely in a chemist shop.

He warned that, in the long term, there could be

“dramatic impacts” from such a change: “We’ll go back to the bad old days of cervical; cancer because women won’t be having Pap smears”.

Dr Morton said that, similarly, giving people access to Viagra without investigating why erectile dysfunction was occurring raised the possibility that a serious health issue would go undiagnosed.

“Erectile dysfunction in young [or] middle-aged men is usually related to lifestyle and health issues like obesity, diabetes, cardiovascular problems, depression and alcohol misuse, so you run the risk of the cause not being looked at,” he told *Six Minutes*.

The debate arose as supermarket giant Woolworths has stepped up its lobbying effort to convince the Federal Government to relax some of the rules governing retailing, including restrictions on the ownership of pharmacies.

Under current rules, pharmacies must be owned by a qualified pharmacist, and there are geographic restrictions on where they can be placed.

The regulations have prevented the major supermarket chains from achieving their long-held ambition to open on-site pharmacies.

So far, however, the Federal Government appears to have no interest in loosening the rules governing the ownership and placement of pharmacies.

**Adrian Rollins**

COMMENT

## Mentally ill increasingly turning to GPs for help

More anxious and depressed patients are turning up in GP waiting rooms as the family doctor increasingly becomes the first port of call for Australians with mental health problems.

More one out of every 10 patients seen by a GP are there because of mental health issues, according to the Australian Health and Welfare in a report that sheds light on the treatment of depression, anxiety and other psychological problems in the community.

The report, *Mental health services in Australia*, shows that almost 16 million visits to the GP in 2012-13 were because of mental health problems – 12.3 per cent of all GP encounters.

By far and away, the most common complaint encountered by GPs was depression, the AIHW reported, accounting for almost a third of all consultations for mental health issues, while anxiety (16 per cent) was the second-most frequently managed issue, followed by sleep disturbance (12 per cent).

The Institute said that Australians were increasingly likely to turn to their GP for help with mental health problems – the proportion of visits to the family doctor for such concerns has been growing at an average annual rate of 4.7 per cent since 2008-09.

By comparison, psychologists provided 3.7 million MBS-subsidised mental health services to almost 806,000 patients in 2012-13, while psychiatrists provided 2.1 million services to around 323,000 patients.

Underlining the importance of medication in treating mental health problems, the AIHW reported that drugs were the most common form of treatment prescribed by GPs, particularly antibiotics.

**Adrian Rollins**

COMMENT



# Partying teens go on massive alcohol benders

Young drinkers are downing massive quantities of alcohol in destructive 'preloading' binges before heading off for a night out, putting them at far greater risk of sexual assault or violent attack.

As the annual schoolies celebrations get underway, a Drug and Alcohol Services SA survey has found children as young as 15 years are drinking dangerous amounts of alcohol, including at home before going out.

The finding came as an 18-year-old West Australian girl died at her birthday party after drinking shots of Polmos Spirytus Rektyfikowany, a Polish spirit with a very high alcohol content that the AMA called to be banned two years ago.

The parents of Nicole Bicknell have added their voices to the call for the ban amid fears other young people celebrating schoolies will imbibe the potentially deadly drink.

The call came as the SA survey of 3000 young people found more than 500

admitted to being drunk in public in the preceding 12 months.

Of these, 60 per cent said they had preloaded before going out, with some claiming to have binged on up to 17 drinks before going to night clubs, bars or other public venues.

University of South Australia researcher Professor Jason White told the *Adelaide Advertiser* that both boys and girls indulged in preloading to roughly the same extent, and binge drinking was more common among young people than older party-goers.

He warned the drinking habits of many young people was putting their health at risk, saying those who indulged in preloading typically drank massive amounts in a short space of time, leading to a rapid jump in their blood alcohol levels.

"People do die as a result of alcohol intoxication, due to breathing slowing down to a level [that] they're effectively



not breathing at all," Professor White told the *Adelaide Advertiser*. "You also get more impairment of normal function, which means the risk of accidents is greater, and the risk of behavioural changes where they get involved in fights and other incidents can be greater."

The AMA National Alcohol Summit convened last month was told of the danger many young people were placing themselves in as a result of heavy drinking, including increased risk of being

involved in car accidents or physical or sexual assaults.

At the Summit, the AMA called for the Federal Government to lead a national approach to curbing the nation's destructive drinking problem, including tighter restrictions on the marketing and promotion of alcohol to young people, getting rid of cheap booze by reforming alcohol taxation and severing the link between alcohol and sport.

**Adrian Rollins**

COMMENT

# Whooping cough vaccine wearing off

The incidence of whooping cough has surged amid worrying signs that the effectiveness of a widely-used vaccine is wearing off.

Communicable diseases experts have reported that a pertussis epidemic that has recently swept the country has been caused, in part, by a decline in the protection provided to young children by vaccination.

Writing in the Department of Health's latest *Communicable Diseases Intelligence* report, National Centre for Immunisation and Research of Vaccine Preventable Diseases senior research fellow Dr Helen Quinn said that although part of the increased reported incidence of the disease was due to improved testing, there was also concerning evidence of weakened protection from the disease.

Dr Quinn said that in the recent outbreak there had been increased pertussis notifications among children from as young as six months to as old as nine years, "which had not been seen since the introduction of acellular pertussis vaccines".

The communicable diseases expert said vaccination coverage was not to blame – it had remained steady at 92 per cent among 12-month-olds, 95 per cent at 24 months and 90 per cent at five years.

"Instead, waning of vaccine-induced immunity appears to be a factor," Dr Quinn said. "The increase in cases aged six months to four years may have resulted from removal of the 18-month dose from the National Immunisation Program in 2003, thereby increasing the interval between the last dose of the primary series and the first

booster dose."

Studies in both Australia and the United States have shown that immunity wanes with age and time since the last dose.

Dr Quinn said that, even though the protection provided by vaccination may be waning, it still meant that vaccinated children who caught the high contagious disease had a milder form of the infection than would otherwise be the case.

The big concern was instead that vaccinated children with the disease would pass it on to vulnerable younger children, particularly infants, Dr Quinn said, citing a study from Perth which found that more than a third of cases reported in a four-year period were as a result of sibling infection, with the majority involving two to three-year-olds who had been fully vaccinated.

Dr Quinn said there was mixed evidence regarding some strategies to try and combat this. Vaccinating a child immediately upon birth may reduce the effectiveness of later vaccinations, while the "cocooning" strategy used in some states (vaccinating all close contacts of infants, such as parents) was effective, but only if the vaccination was comprehensive and timely.

Instead, she said, "it is clear that a third generation of pertussis vaccines, providing long-lasting protection, are required", though adding that the most likely prospects were still "some years away" from development.

**Adrian Rollins**

COMMENT

## INFORMATION FOR MEMBERS

### National residential medication chart released

A new national medication chart that can be used to prescribe and supply PBS medicines is now available free from the Australian Commission on Safety and Quality in Health Care at <http://www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/nrmc/>.

Doctors and pharmacists in the ACT, Tasmania, Victoria, Queensland, Western Australia and South Australia can now prescribe and supply most PBS medicines to residents of aged care facilities using this chart without needing to also write prescriptions. (Legislation is yet to be passed in NSW and the Northern Territory to allow the NRMCM to be used for medicine prescribing and supply purposes.)

The National Residential Medication Chart (NRMCM) has also been designed to provide a central point for information. 'Prescriptions' and the record of medicine administration are co-located, with the resident's details including their photograph and known adverse drug reactions visible from each page. Relevant pathology, doctors' instructions and special considerations are also included.

The NRMCM was developed, tested and evaluated in 2013-14 by

the Commission in over twenty residential aged care facilities in NSW (specially exempted from current NSW legislative restrictions). AMA members, Dr Brian Morton and Dr Richard Kidd, participated in the expert reference group providing advice.

The Commission found that the NRMCM improved medication safety for residents as well as considerably minimising the administrative burden of prescribers, aged care staff, and pharmacists when ordering, administering and supplying PBS medicines.

While NRMCM test sites provided very positive feedback and have chosen to continue using it, their experiences indicate that everyone involved initially needs training and support to move successfully to an NRMCM model.

The next step is for commercial companies to develop electronic versions of the NRMCM to streamline processes even further.

Use of the NRMCM is a decision of the residential aged care facilities and is purely voluntary but AMA members may wish to encourage the facilities they work in to investigate its adoption.



BY PROFESSOR  
STEPHEN LEEDER

“As with meetings of the UN and with similar cultural festivals, there were side-shows, fringe gatherings and protests in Brisbane”

# H2O: putting health on the global agenda

What an astonishing collection of nations was represented at the recent meeting of the Group of 20!

Argentina, Australia, Brazil, Canada, China, France, Germany, India, Indonesia, Italy, Japan, Republic of Korea, Mexico, Russia, Saudi Arabia, South Africa, Turkey, the United Kingdom, the United States and the European Union. Spain, New Zealand, Myanmar were guests this year. Was this World Cup of economics?

G20 members account for two-thirds of the world's population, 85 per cent of global gross domestic product and over 75 per cent of global trade.

The meeting was the culmination of months of off-stage manoeuvring and discussion among the stage hands and extras as they choreographed the presentations and prepared cosmetics for the principals.

Growth was the topic - how to increase global activity by 2 per cent a year. No-one wants another GFC, so discussions about how to maintain economic momentum are vital.

As with meetings of the UN and with similar cultural festivals, there were side-shows, fringe gatherings and protests in Brisbane.

As the G20 website says, the G20 also regularly engages with non-government sectors:

“Engagement groups from business (B20), civil society (C20 – led by Tim Costello), labour (L20), think tanks (T20) and youth (Y20) held major events during the year, the outcomes of which contributed to the deliberations of G20 leaders”.

H2O, held in Melbourne by the federal AMA, the Victorian AMA and the World Medical Association (WMA), was a belated attempt to put health issues on the G20 agenda.

H2O was attended by about 150 delegates from across Australia and from the member countries of the World Medical Association, together with public health and environmental groups and medical students.

While the concerns of attendees were disparate, there was unity around six themes:

- how do we make health care a sustainable enterprise?
- How can we do better at advocating for health and health care as vital for economic development?
- How do we show that investing in health is exactly that, and not a sunk cost?
- How do we confront the perpetual downward

pressure of unfair disadvantage and social inequality on health, and rescue the health and well-being of humanity from its position low down the priority list in many countries?

- How do we contribute to the push towards responsible conservative behaviour in the light of climate change and its long-term effects on health?
- How do we keep health workers safe in dangerous and insecure places?

These questions assail us in Australia and beyond, and speakers at the Summit from around the world highlighted the urgency of action from all of us on a number of fronts, including communicable and non-communicable disease control and management, clinical practice and public health, through advocacy and involvement in service provision and representation.

There is always a serious risk with events such as these that, in laying bare the massive global challenges we confront, those attending head home feeling depressed and disempowered.

This need not be so, because we as a medical profession have great strength, credibility and skill to address all of the six principal concerns listed above.

So how should we go about it? What should we do?

Here are some practical ideas about things we can do today that will go toward addressing these great global challenges:



## H2O: putting health on the global agenda

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- advocate for **international action and support** for organisations committed to action on these challenges, such as the International Red Cross, OXFAM, *Médecine sans frontières* and UNICEF;
- take an interest in **upstream causes** of ill health like poor diets, smoking, excessive drinking and poor urban design, and support the efforts of those such as the AMA working for reforms like tighter regulation of alcohol marketing and labelling practices;
- support efforts to achieve **integrated care** for those with chronic illnesses. Linking all modalities of care from hospital to the community is the ambition of many health services internationally, and Australia can pioneer the way to do this best;
- support efforts to establish **national, state and local prevention programs**. By working with agencies such as the National Heart Foundation, cancer councils and the prevention arms of health departments, we can help in finding the most effective ways to prevent the major illnesses afflicting much of the world today (obesity, diabetes, heart disease and stroke) and act as a guide for other countries that are facing the same problems; and
- keep an eye open for **preventive opportunities in the clinical setting**. Much prevention occurs in the clinical setting. We have done well in Australia in helping, through clinical care, to prevent complications of diabetes, stabilise the risk of heart disease, immunise and screen. These have paid off well. The world needs examples of clinical service that contribute to prevention.



### 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](mailto:careers@ama.com.au)**



BY DR BRIAN MORTON

# BEACH reports throw sand into Government cost claims

General practice delivers the best value for money in the Australian health system.

If there was ever any lingering doubt of this, it has been dispelled by the latest reports from the Bettering the Evaluation and Care of Health (BEACH) project, *General practice activity in Australia 2013–14* and *A decade of general practice activity 2004–05 to 2013–14*, which together show GPs are treating an increasing number of patients with complex and chronic conditions at a fraction of the cost of other areas of the health system.

GPs instinctively know that they are busier than ever before, and the BEACH reports back these anecdotal observations up with hard evidence, showing that between 2004–05 and 2013–14, general practices:

- managed 68 million extra problems (a 48 per cent increase), of which 24 million were chronic conditions such as diabetes and depression;
- had 35 million extra GP-patient encounters (a 36 per cent increase), 17 million of which were with patients aged 65 years or older (a 67 per cent increase);
- contributed 10 million extra hours of GP clinical time (a 43 per cent increase); and
- performed 10 million extra procedural treatments (a 66 per cent increase).

Importantly, the reports also showed that if such services were performed in other areas of the health

system, they would cost both the Government and patients much more than they do when provided by GPs.

For example, GP services in a public hospital Emergency Department would cost between \$396 and \$599 each, compared with the average cost of a GP visit of around \$50.

To justify its extreme health Budget measures, the Government has claimed that health spending is out of control.

This has been clearly demonstrated not to be the case as our President has consistently highlighted. Australian Institute of Health and Welfare figures show total national spending on health grew by a record low 1.5 per cent in real terms in 2012–13, underpinned by a big 2.4 per cent fall in Federal Government funding. Health's share of the Commonwealth Budget has fallen in the last seven years from more than 18 per cent to 16.1 per cent.

These numbers clearly demonstrate that there are simply no grounds for taking even more money out of health.

Indeed, if the Government wants to get more bang for its health dollar, the numbers clearly show it should be directing more funds to general practice.

By investing in primary care, the Government would support one of the most efficient parts of the health system and help ensure the gains keep coming.

Certainly, the last thing the Government should be doing right now is strangling general practice with a \$5 cut to the Medicare patient rebate and imposing an unfair co-payment model that will hurt the most disadvantaged in the community and discourage preventive health care and chronic disease management.

After all, these are the very things that will help curb the growth of health costs.

Discouraging GP visits will increase overall health costs by making people delay access to vital health care. General practice is worth greater investment, not less.

Instead, the Government's proposed co-payment model will make life even harder for the nation's GPs.

A report commissioned by the AMA, *The Red Tape Burden of the Proposed Medical Services Co-payment*, found that the extra costs of administering the co-payment (and the additional bad debts that would arise) would totally erode the \$2 "windfall" the Government said general practices would receive under its plan.

Add in the proposed \$5 cut to the Medicare rebate, and many practices may become financially unviable and have to close.

Such an outcome just doesn't make sense if the Government truly wants to control its health spending.

It is time the Government realises that, if it is serious about saving money and ensuring the sustainability of the health care system, then actually investing in general practice is the key, and must be given the highest priority.



BY DR JAMES CHURCHILL

“ Many doctors do not realise that an image, even if captured on a personal mobile device, forms part of a patient’s medical record, and is subject to the same privacy and confidentiality principles as any other element of the record ”

# Guide on using mobiles to capture and share clinical images

Any junior or senior doctor can tell you that clinical images are routinely captured and used by doctors, every day and in every ward, in the course of caring for their patients.

But, in doing so, are doctors and medical students meeting their significant legal, professional and ethical responsibilities?

In response to this uncertainty, the AMA has collaborated with the Medical Indemnity Insurance Association of Australia to develop guidelines covering the key issues that doctors must consider before capturing and transmitting images on personal mobile devices like smart phones.

There’s no doubt that images are valuable for capturing clinical signs, injuries and lesions, and monitoring of these over time.

Appropriate transmission of clinical images aids professional referrals for improved diagnosis, treatment and management, particularly in regional, rural and remote settings, where specialist services may be limited or not available.

Clinical images may also be used for non-

clinical purposes, such as teaching, training and research.

However, there is concern that clinicians have inadequate understanding of their significant legal, professional and ethical obligations regarding the use of clinical images. To date, there have been no clear national professional guidelines to guide clinicians in meeting their responsibilities.

Many doctors do not realise that an image, even if captured on a personal mobile device, forms part of a patient’s medical record, and is subject to the same privacy and confidentiality principles as any other element of the record.

Additional complexities that arise from the capture of images on personal mobile devices, such as ensuring adequate quality, managing automatic cloud backups and the recording of metadata such as image location, can prove difficult for clinicians to navigate.

Under the new *Australian Privacy Principles*, revised in early 2014, there are significant legal penalties for breaches in confidentiality of medical records, in addition to a clinician’s

professional and ethical obligations.

*Clinical Images and the Use of Personal Mobile Devices: A Guide for Doctors and Medical Students* outlines professionally appropriate processes of informed consent, documentation, capture, secure storage, disclosure, transmission and deletion of clinical images, including considerations of quality, de-identification and privacy legislation. Case reports and discussion of complex situations are included, as is a simple flow-chart, summary and checklist for busy clinicians.

Despite the existence of clinical imaging departments in many hospitals, pragmatic clinicians who capture images using personal mobile devices often find it difficult to integrate these images into the medical record.

Alongside release of this guide for clinicians, the AMA will be advocating for health services to improve systems for the secure uploading of images into patients’ records.

The guide, released on 21 November, has been developed through collaboration between the AMA Council of Doctors-in-Training and the Medical Indemnity Insurers’ Association of Australia, and is a must-read for doctors and medical students who capture clinical images in Australian hospitals.

**For further information, and to download a copy of *Clinical Images and the Use of Personal Mobile Devices: A Guide for Doctors and Medical Students*, visit the AMA website: [www.ama.com.au](http://www.ama.com.au)**





## OPINION

BY A/PROFESSOR  
HELENA BRETT,  
DIRECTOR OF THE  
FAMILY MEDICINE  
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SYDNEY; ET AL

# Medicare spending on general practice is value for money

*This article first appeared at The Conversation on 11 November, 2014 and can be viewed at: <http://theconversation.com/medicare-spending-on-general-practice-is-value-for-money-33948>*

Last year taxpayers spent \$6.3 billion on GP services through Medicare, about 6 per cent of the total government health expenditure. This was a 50 per cent increase (\$2.1 billion) in today's dollars over the past decade and equates to about \$60 more per person in real terms.

Health Minister Peter Dutton says this growth is "unsustainable". He plans to introduce a GP co-payment in hope of reducing the number of times Australians visit a GP and to ensure users foot some of the bill.

But targeting primary care for cost savings could backfire.

Research we've undertaken shows that while the number of GP visits has increased, the services are cost-effective. If the same services were performed in other areas of the health system, they would cost considerably more.

## Under pressure

Unsustainable or not, Australia's health-care system faces a number of challenges, most notably from the rising prevalence of chronic conditions,

such as type 2 diabetes, heart disease and cancer. This is due to three major factors:

1. Australia has an ageing population as our world-class health system keeps us alive longer;
2. in response to government encouragement through Medicare initiatives, GPs are diagnosing disease earlier and providing preventive interventions for health risk factors and diseases such as hypertension, high cholesterol and type 2 diabetes; and
3. an increasing proportion of Australians are overweight or obese, putting them at risk for chronic conditions.

Earlier diagnosis means people are living longer with diagnosed disease. The result is exponential growth in required care over their lifetime.

The search for more cost-effective health care for our population should be applauded. But reducing spending on GP services is not the answer.

## What do we get?

Our team has been studying general practice activity for over 16 years through the Bettering the Evaluation and Care of Health (BEACH) program.

This cross-sectional encounter-based study uses changing random samples of about 1000 GPs per year, each of whom contribute details of

100 encounters with consenting patients. This provides a representative sample of about 100,000 encounters per year from across the country.

“ Unsustainable or not, Australia's health-care system faces a number of challenges, most notably from the rising prevalence of chronic conditions, such as type 2 diabetes, heart disease and cancer ”

Results from one of the BEACH books shed some light on what we got for the \$2.1 billion of extra Medicare spending on general practice. In 2013-14 there were 35 million more GP services than 10 years earlier, a 36 per cent increase. This included 17 million more attendances by patients aged 65 years and over (a 67 per cent increase).

Length of GP consultations recorded through BEACH suggest that the average consultation now takes almost one minute more than a decade ago. The result is that GPs spend an extra ten million clinical hours with their patients, a 43 per cent increase.

The number of problems managed at these consultations has also significantly increased. GPs managed an additional 68 million health problems at these encounters (an increase of 48 per cent), including 24 million more chronic problems.

## Medicare spending on general practice is value for money ... FROM P30

Management of these problems involved an additional ten million procedures (a 66 per cent increase) and 12 million clinical treatments, such as counselling, advice and education, than a decade ago.

Clearly, increases in the amount and complexity of GP clinical work are reflected in additional Medicare expenditure. If other medical specialists and/or emergency departments had provided these extra services, they would have cost far more.

The average cost of a GP visit was \$47 from Medicare, plus a \$5 patient contribution. For a private specialist, the average visit costs Medicare \$82 plus a \$38 patient fee.

A visit to the emergency department, which is paid by state and territory governments, costs far more. In Western Australia, for example, an emergency department visit in 2011-12 cost \$599 on average.

### More, not less primary care

International research has repeatedly concluded that investment in primary care is the most cost-effective way to provide population health care.

As GP services are far cheaper than other types of medical services, discouraging GP visits by introducing a standard co-payment for most patients would increase costs to governments, now and later.

It may seem counter-intuitive, but one effective way to contain the cost of Australia's health care would be to expand the use of GP services.

One issue not acknowledged in the discussion about health costs is the increasing number of patients with multiple chronic conditions. These patients use more resources and are more likely to have fragmented care due to the number of health professionals involved. GPs play the central role in co-ordinating the management of patients with multiple chronic conditions, reducing costly hospitalisations.

As the age of government-supported retirement increases, many Australians will have to work until they are 70. This highlights the importance of promoting good health across the lifespan, through a strong focus on primary and secondary prevention and co-ordinated management of chronic conditions.

In any one year 85 per cent of us visit a GP, but only about 15 per cent of us are admitted to hospital, where a far greater proportion of health funds is spent. GPs supply the bulk of care to the population, so general practice is where our investment should be.

If we want to strengthen our health-care system and ensure its sustainability into the future, it makes sense to encourage people to use its cheapest and most efficient arm: general practice.

## Free tool to track registration requirements

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

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

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

The AMA CPD Tracker can be used to:

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

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

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

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

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

**To register for the product, please sign up here.**





# Health on the hill

Political news from the nation's capital

## Govt eyes off \$6 billion windfall from Medibank sale

The Federal Government will reap \$5.7 billion from the float of Medibank Private following strong interest among institutional investors.

As the insurer pushes ahead with its controversial foray into the provision of primary health care, it has been revealed that retail investors were allocated shares at \$2 each – the top of the indicative range in the offer document – and a 15 cent discount on the price paid by institutional investors.

The result is a welcome boost to the Commonwealth's coffers, which have been savaged by plunging iron ore and coal prices and a stalemate in Parliament over a range of unpopular Budget measures, including the \$7 Medicare co-payment.

Shares in the insurer began trading today, soon after it began a six-month trial of a program to manage the health of policyholders with chronic health problems.

The trial involves 300 Medibank members with five medical conditions at six Queensland GP clinics who will be given a personalised self-management support

plan, health coaching from a nurse, and interactive tools so that they can monitor their condition.

AMA President Associate Professor Brian Owler has been critical of other forays by Medibank into the provision of health care, particularly a scheme at several Queensland GP clinics where it covers administrative costs in return for guarantees that its members will receive an appointment within 24 hours, as well as after-hours services.

A/Professor Owler told a conference of health fund executives earlier this month that such an arrangement was unacceptable because it undermined the principle of universal and equitable access to care by privileging health fund members over other patients.

The AMA President said the medical profession was ready to work with health funds on ways to improve patient care, but only in ways consistent with universal and equitable access, and which respected the sanctity of the doctor-patient relationship.

Many institutional investors are enthusiastic about the Medibank float because health stocks generally are considered a defensive investment, and the potential for growth

given the ageing of the population and consequent increase in demand for health services.

But several key risks have also been raised, including the implementation of a major IT upgrade at the insurer, its ability to further reduce administrative overheads, and the fact that private health insurance premiums are heavily regulated.

**Adrian Rollins**

## Trade pact opens health door to China

Sales of Australian drugs and health services in China are expected to expand following the relaxation of tariffs and other barriers under the terms of the Australia-China Free Trade Agreement.

While the detailed text of the treaty is yet to be publicly released, it includes the elimination of tariffs of between 3 and 10 per cent on Australian pharmaceuticals, as well as provisions that drop joint-venture requirements, allowing for the establishment of wholly Australian-owned hospitals and other health services in the giant country.

China's rapid economic development in the past three decades has transformed the country into the world's second largest economy.

Economic growth has dragged millions out of poverty and driven the emergence of massive, and expanding, middle class.

Already, China has become Australia's largest offshore market for pharmaceuticals

– last year, sales reached \$559 million.

National Australia Bank Health General Manager Nehemiah Richardson said the trade agreement would also open up rich opportunities for exporters of health services.

"With the FTA permitting wholly Australian-owned hospitals and aged care institutions to be established in China, there are suddenly many new prospects on the horizon for Australian health and aged care businesses," Mr Richardson said.

"The FTA provides Australian hospitals, aged-care and pharmacy businesses the opportunity to leverage their Australian know-how and capability across Asia."

Ramsay Health Care Chief Executive Chris Rex told *The Australian Financial Review* said that although his company was currently pursuing a joint-venture with China's Jinxin Group to develop five hospitals operating 2300 beds in Chengdu, the trade pact was "a favourable development".

"China has favourable demographics for health care, with a population of 1.3 billion, a growing middle class and an ageing population," Mr Rex said.

In an attempt to allay concerns the trade deal could include provisions which hamper the ability of the Australian Government to implement public health measures that might impede commercial interests, Trade Minister Andrew Robb said the pact included "strong safeguards to protect the Australian Government's ability to regulate in the public interest... in areas such as health, safety and the environment".

**Adrian Rollins**



# Rock solid base for good winemaking

BY DR MICHAEL RYAN

Apparently, some Kiwis are proud of their rocks.

Greywacke rock is everywhere. This ubiquitous, highly compacted gray sandstone “rock” is the foundation of soils in many areas of New Zealand.

Marlborough, in particular, has Greywacke rock in abundance, which contributes to the terroir of the wine-making region.

Kevin and Kimberly Judd own the Greywacke label, named after this rock. They produce flavorsome complex wines that reflect the taut mineral quality supplied by the “rock”.

English-born and raised in Adelaide, Kevin went to Roseworthy College and made wine in Reynella in South Australia.

In the early 1980’s, the chance to work at the frontier of cool climate crisp and aromatic whites drove Kevin to travel to Marlborough.

Originally, he was to stay for three years but, three decades on, he has yet to leave.

He initially worked for Selaks wines, and then became the foundation winemaker at the iconic Cloudy Bay winery.

In many ways, Kevin is akin to a virtual winemaker because he does not own any vineyards. But through experience and well-formed relationships, he sources premium fruit from older vines on select vineyard sites, which is brought to the Dog Point vineyard facilities he uses for his winemaking (the vineyard also supplies some of the fruit).

The Greywacke label features primarily Sauvignon Blanc and Pinot Noir varieties, though Pinot Gris, Gurgiztraminer, Chardonnay, and Riesling are made in limited quantities.

Sauvignon Blanc (SB) is the work horse of the NZ wine industry, making up 87 per cent of all wine exports.

Marlborough SB is somewhat predictable, but is always value for money. Grown in the “sunniest” place in NZ, it can be sunshine in a glass.

It is always a pleasure when craftsmen like Kevin cajole a predictable grape into an alluring wine.

The Wild ferment SB gets special old-world attention, with wild yeast fermentation, some old French oak barrel exposure and some malolactic fermentation. Kevin developed the much sought-after Cloudy Bay Te koko SB. His wild ferment SB has some links to this, but is indeed its own wine.

1



MARLBOROUGH SAUVIGNON BLANC

2



WILD SAUVIGNON  
MARLBOROUGH NEW ZEALAND

3



MARLBOROUGH PINOT GRIS  
NEW ZEALAND WINE

4



MARLBOROUGH PINOT NOIR  
NEW ZEALAND WINE

## WINES TASTED

### 1. 2013 Greywacke Marlborough Sauvignon Blanc

Pale yellow in color. The nose is an attractive array of gooseberries, melon and slight herbal grassy tones. The palate has medium fruit levels but fine acidity that melds into a soft finish. Have with oysters. Not your average SB, with finesse.

### 2. 2012 Greywacke Marlborough Wild Ferment Sauvignon Blanc

The color is a light straw, with tinges of green. The bouquet exudes a complexity rarely seen with SB. No cats pee etc. in this beauty. Nectarines, lime notes and a funky, almost meaty, aroma excite the olfactory nerves. The palate is a generous, plush fruit-driven taste, but melded with appropriate acid levels. Almost creamy in nature. Have with Sashimi scallops and sea urchin. I believe this will cellar for seven to nine years and be extraordinary

### 3. 2013 Pinot Gris

Pale yellow. White peach and funky rose petals with hints of Asian spices beckon the vinophile. Some old oak exposure and wild yeast marry up nicely. Super generous palate with balanced acidity make this a velvety-style suave wine. Enjoy with brie and quince paste.

### 4. 2012 Greywacke Pinot Noir

Nice crimson/garnet color. Dark fruit spectrum with plums and spices. Some oak charring effect and mild funky nuances waft in and out. Elegant palate with moderate integrated tannins. Described as a feminine style, this will man up in four to five years. Made for Canard!