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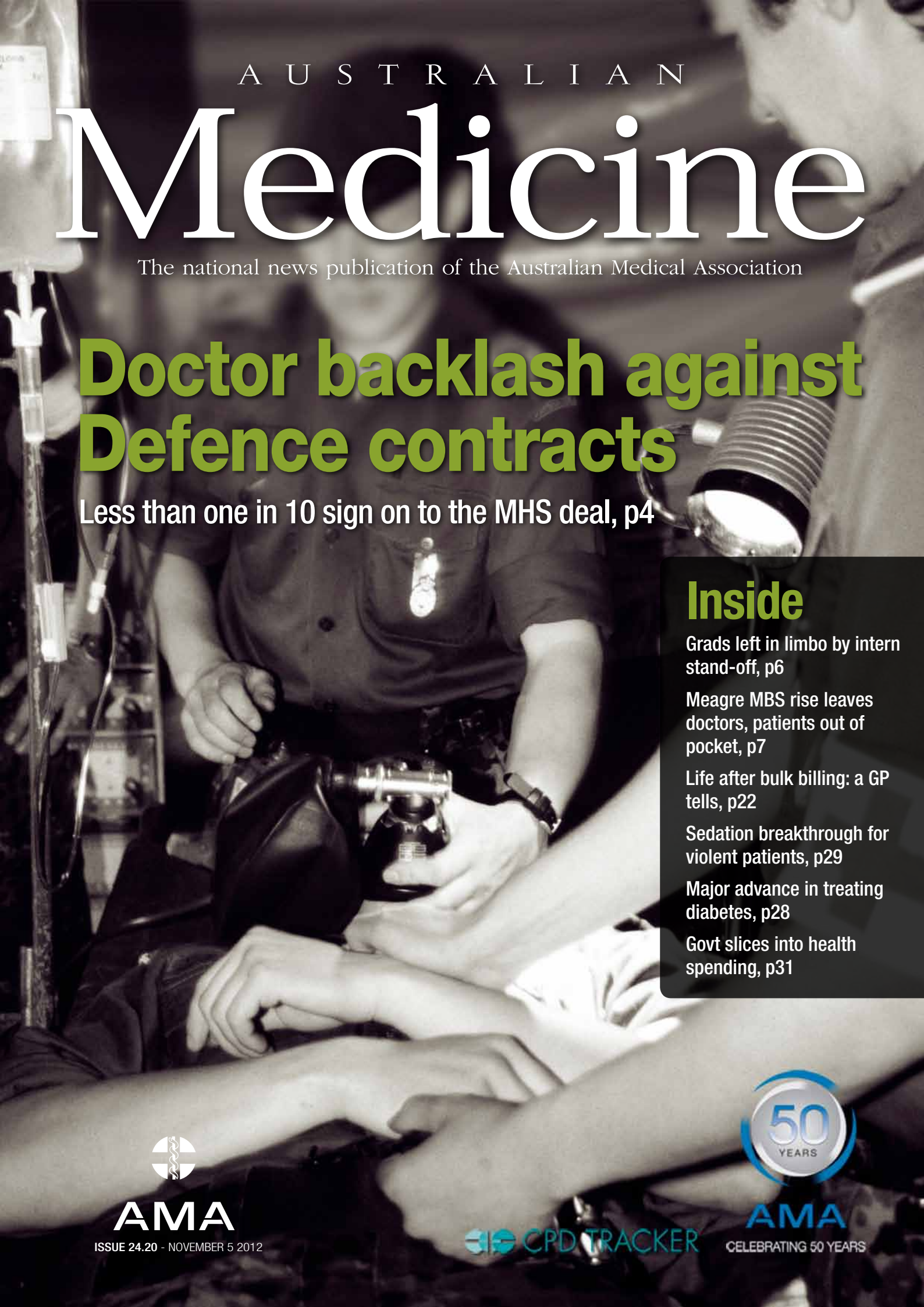

Doctor backlash against Defence contracts

Less than one in 10 sign on to the MHS deal, p4

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AMA

ISSUE 24.20 - NOVEMBER 5 2012

CPD TRACKER

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AUSTRALIAN
Medicine

Managing Editor: John Flannery
Contributing Editor: Dominic Nagle
Editor: Adrian Rollins
Production Coordinator: Kirsty Waterford

Graphic Design:
Streamline Creative, Canberra

Advertising enquiries
Streamline Creative
Tel: (02) 6260 5100 Fax: (02) 6260 5200

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

42 Macquarie St, Barton ACT 2600

Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499

Web: www.ama.com.au
Email: ausmed@ama.com.au

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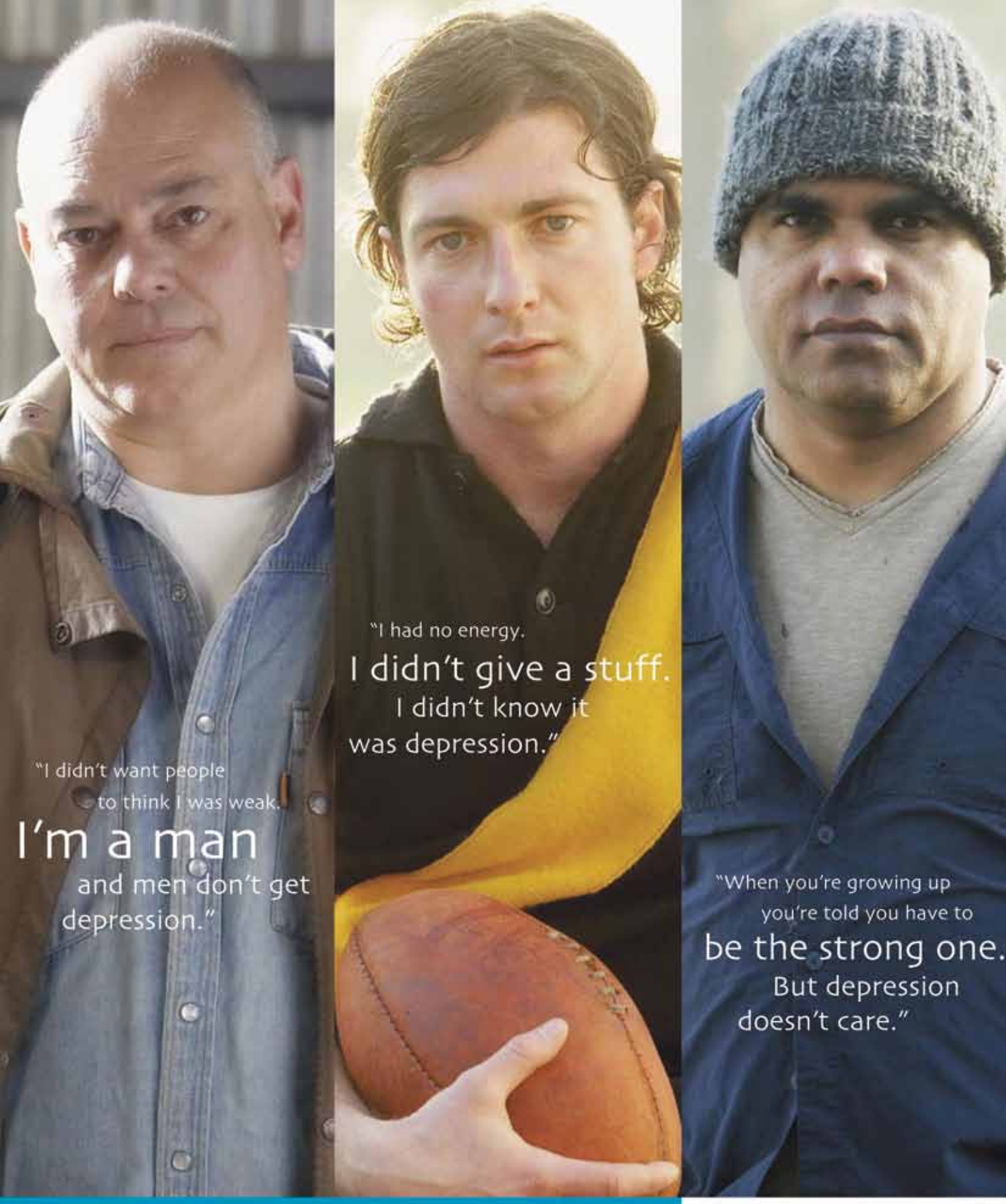

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Doctor backlash over Defence Force contracts

A backlash from specialists has thrown the takeover of Australian Defence Force health services by a Medibank Private subsidiary into crisis, with less than 10 per cent of practitioners signing up to controversial provider agreements.

The early results of a poll of members currently being conducted by the AMA indicates less than one in 10 specialists treating Defence personnel have accepted the terms of preferred provider arrangements set by Medibank Health Solutions (MHS), which earlier this year won a $1.3 billion contract to provide health care services to Defence Force personnel over the next four years.

AMA President Dr Steve Hambleton has warned the Federal Government that the health care of Defence personnel is being put in jeopardy by the new arrangements and should be abandoned.

"The ADF has given a clear commitment to Defence personnel that they will receive high quality health services in a timely fashion," Dr Hambleton said in a letter to the Minister for Defence Science and Personnel, Warren Snowdon. "On the evidence available, the new arrangements being implemented will not sustain this commitment, and access to health services for our valued serving personnel will be compromised.

"I would urge you to abandon these changes before it is too late and direct the ADF and MHS to work with the profession to develop more sustainable arrangements."

The AMA has been deluged with complaints from doctors about the terms of the MHS offer.

One doctor, who has provided orthopaedic services to Defence personnel for 14 years, told the AMA that he would "never consider entering into such a flawed and dictatorial contract", while an anaesthetist said he and four specialist colleagues would not accept the MHS under its current terms.

Another member accused MHS of attempting to introduce managed care "by stealth", while a former Regular Army Medical Officer lamented that a mass withdrawal by specialists from treating Defence personnel may be the only way to convince MHS and Defence to change their approach: "The less doctors that sign up, the better to demonstrate this is not the way to do things".

The AMA President said that in order to be accepted as a preferred provider, MHS required specialists to accept a significant cut in fees and acquiesce to conditions that had the potential to limit patient choice, constrain clinical independence and compromise patient confidentiality.

Under the new arrangements, which will apply to 100 barracks and bases serving 80,000 personnel, military doctors will no longer be able to refer patients to a local specialist of their choosing.

Instead, Medibank will encourage referral to a practitioner on a centralised database of preferred specialist providers.

Specialists who sign up to the new scheme face onerous demands, including a stipulation that all medical reports be completed and lodged within three days, while accepting a cut in fees of up to 50 per cent.

...CONTINUED ON PAGE 5

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Dr Hambleton has urged doctors to consider their position carefully before accepting the MHS offer.

"Seek independent legal advice, particularly in relation to the clauses about disclosure of medical records; consult your medical indemnity insurer; and carefully consider the impact of the new fees in light of your practice costs," the AMA President said.

Many specialists, including anaesthetists and orthopaedic surgeons, have so far refused to sign up to the agreements offered by MHS, raising concerns about the ability of Defence Force personnel to get the care they need.

"The AMA is very concerned that the new MHS arrangements will reduce access to medical services for Defence personnel," Dr Hambleton said. "In this regard, a number of members have already written to the AMA advising that they will not take up the MHS offer."

Dr Hambleton said the schedule of fees offered by MHS was "generally much lower" than previous arrangements, and members had advised that the new contracts could potentially interfere with clinical independence and patient choice.

Dr Hambleton said MHS had showed "a lack of understanding" of the complexity of health care.

"What happens when a surgeon is ready to operate, but no anaesthetist [who has signed a provider agreement] can be found?," he asked.

Dr Hambleton said the lack of consultation by MHS or the Defence Department in introducing the new arrangements was unacceptable but, unfortunately, unsurprising.

"The ADF has a very poor record of consultation on the provision of health services, with consultation normally taking place after the fact," he said, a situation he said the AMA had hoped had changed following an overhaul of contracting arrangements in 2007. "Unfortunately, the complete lack of consultation by the ADF or MHS is a return to the take it or leave it approach seen in the past."

Dr Hambleton said that the episode added to concerns about the involvement of health funds in providing health care services.

"It does raise some concerns about the role of health funds operating as service providers," the AMA President said. "There was a whole lot of assumptions made (by MHS) that were not appropriate."

Medibank Health Solutions executive, Dr Andrew Wilson, admitted that under its new arrangements, "some providers may be offered a rate which will be lower than what they are used to", but insisted that this would not compromise the health of enlisted personnel in any way.

MHS claims that 2500 specialists have signed up to its offer, along with 3000 allied health professionals and 112 hospitals.

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What AMA members were saying about the Medibank Health Solutions offer:

"Medibank Private made this sound like a wonderful offer, and that we were fortunate to be asked to join! Little did they realise that I have been providing orthopaedic services to Defence personnel for 14 years, and would NEVER consider entering into such a flawed and dictatorial contract."

– Anonymous, 30 October

"This is inching us ever so slowly towards private health insurance companies determining medical fees across the board. The people who stand to lose the most in all of this are the Defence Force personnel, who should be deserved of specialist medical advice and treatment of their own choosing."

– Anonymous, 30 October

"Managed care by stealth - a trial. I will not accept such a one sided contract, especially as there has been no consultation at all."

– John, 31 October

"Why would anyone sign such a contract. Why do the same work for less money and have to run everything past a commanding officer with dubious confidentiality of records?

Sounds like a very poor idea."

– John Keogh (not verified), 30 October

"No signing such a flawed contract. I chose to ignore it hoping many/all would do the same. Defence personnel will have no right of complaint under this managed care because of their unique situation, so it is up to us as civilians to protect standards."

– Anonymous, 31 October

"As a former Regular Army Medical Officer, I can say that a mass withdrawal of Medical Specialists from treating Defence Force personnel will seriously undermine the operational efficiency of medical care in the Army, but the effects will take a few months to filter through. The less doctors that sign up, the better to demonstrate this is not the way to do things."

– Anonymous, 30 October

Uncertain future for medical grads as governments squabble

AMA President Dr Steve Hambleton has urged the Commonwealth, State and Territory governments to put politics aside and resolve the medical internship crisis that has left the future of 180 graduates in limbo.

Dr Hambleton said the frustrating stand-off between Federal and State levels of government was dragging on too long, causing great distress for medical graduates caught in the middle of the political stoush and giving little confidence that agreement on a sustainable, long-term solution can be reached.

The Commonwealth has offered one-off funding of $10 million for an extra 100 intern places next year, provided the states and territories agree to pay $8 million for the remaining 80 places.

But so far, the states and territories have refused to accept the deal, leaving the future of 180 medical graduates of the class of 2012 dangling.

Dr Hambleton said governments collectively had to both tackle the short-term shortfall of intern places and ensure that in future graduates were guaranteed the opportunities they needed to complete their training and use their skills to provide much-needed medical services.

"There is an immediate and pressing need to give some confidence to the 2012 graduate class about their future," the AMA President said. "There is a relatively simple and cheap solution, and we don't understand why, when the Commonwealth has offered to fund half the outstanding internship places, the State governments are not coming to the party.

"This is not a material amount of money, and it is appalling that these young people have been caught up in the political fight."

The AMA Council of Doctors in Training (AMACDT), which met late last month, has called on all the nation's health ministers to "work together in a spirit of compromise to finalise a robust solution as a matter of the utmost urgency".

AMACDT Chair, Dr Will Milford, said it was "frustrating and disappointing" that the stalemate between the Commonwealth and the states was yet to be resolved, and raised concerns about the ability of governments to manage medical training long-term.

"The collective failure of governments to address the shortfall in intern training positions for next year is failing the community.

"It is a very worrying sign as Australia faces bottlenecks throughout the medical training pipeline that will see Australian-trained doctors left unemployed or forced to move overseas to work."

Late last month international medical graduates from the University of Sydney staged a protest to highlight their frustration that many of them could be forced to leave Australia with incomplete medical degrees despite investments in some cases of $300,000 in their education.

"The collective failure of governments to address the shortfall in intern training positions for next year is failing the community"

Dean of Medicine at the University, Bruce Robinson, told the *Sydney Morning Herald* the intern crisis could have a "devastating" impact on the international education industry, which generated about $84 million in fees from foreign medical students each year.

The issue has also drawn the ire of federal MPs, including Nationals Senator Fiona Nash, who has lamented the potential loss of 180 aspiring doctors when rural areas had a shortage of practitioners.

Dr Hambleton and Dr Milford said there was a broader crisis in medical training that went beyond the shortage of internships, with 260 fully-trained and registered doctors in Victoria failing to secure Hospital Medical Officer positions, while in Queensland up to 500 resident medical officers have not been offered a position by Queensland Health next year.

Dr Hambleton said it was particularly hard to make sense of such decisions when 1200 457 visas had been issued for international medical graduates to fill registered medical officer positions.

In reports released earlier this year Health Workforce Australia warned the nation faced a shortage of 450 first year specialist training places by 2016, and Dr Hambleton urged governments to act urgently and cooperatively to develop long-term solutions to the medical training crisis.

"They need to put together a group of people to look soberly at the figures and make preparations for the next generation of doctors and unscramble to egg of lines of responsibility," he said.

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Medicare rebate rise short-changes doctors and patients

A meagre 70 cent increase in the Medicare patient rebate for a standard GP consultation has been condemned by the AMA as woefully inadequate.

The increase, which came into effect on 1 November, takes the Medicare rebate for a standard GP consultation to just $36.30, an increase of less than 2 per cent.

AMA Vice President Professor Geoff Dobb said the increase, along with other rises outlined in the updated Medicare Benefits Schedule (MBS) that applied from last Thursday, failed dismally to reflect the true cost and value of quality medical care.

"It is not keeping pace with the increased costs of providing medical care and it is shifting higher costs to patients," Professor Dobb said.

Recent Government figures show that last financial year the average out-of-pocket expenses for patients for GP consultations was $26.97 – an increase of $1.72 – and data compiled by the Australian Institute of Health and Welfare (AIHW) show that last decade the proportion of the household budget needed to cover out-of-pocket health expenses swelled from 2.7 to 3.2 per cent to reach $1075 in 2010 – the fifth highest amount among developed countries.

Only patients in Switzerland, Greece, the United States and Belgium contributed more to the cost of their health care, the report showed.

Professor Dobb said the current rate of MBS indexation was totally inadequate.

"Successive governments have failed to index the MBS fees in line with other key indices such as the Labour Price Index and the Consumer Price Index (CPI), let alone the increase in the cost of delivering quality medical care," he said. "There is now a significant and growing disconnect between MBS fees and the realistic cost of providing services."

From covering 85 per cent of a standard doctor's fee when it was introduced, the rebate has now slipped to around 50 per cent.

In advice to members, the AMA has updated its fees list, recommending an average 3 per cent increase in charges.

The increase compares with a 3.65 per cent increase in the Labour Price Index in the past 12 months, and a 1.75 per cent rise in the CPI.

The increase means that the new AMA recommended fee for a standard GP consultation is $71, up from $69 last year.

AMA indexation places significant weight on increases in the Labour Price Index in order to reflect increasing practice costs such as wages, and operating expenses such as rent, electricity, computers and professional insurance.

Professor Dobb said the updated AMA List of Medical Services and Fees, which provides guidance to members in setting their fees, "better reflects the value of quality medical care and what is occurring at the coal face of health service delivery".

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GPs gain MRI scan authority for kids

General practitioners have been given authority to directly refer children for MRI scans as part of a major expansion in access to advanced diagnostic imaging services for all patients.

Under new arrangements that came into effect on 1 November, GPs will be able to request Medicare-funded MRI scans for all patients under 16 years of age for a range of clinically appropriate indications.

The move follows intensive lobbying by the AMA, and is part of a $104.4 million package of measures that will provide partial to Medicare-eligibility for 161 MRI units in metropolitan locations and full Medicare-eligibility for 30 MRI units in regional areas, according to Health Minister, Tanya Plibersek.

AMA President, Dr Steve Hambleton, said the new arrangements would improve access to care, cut costs and reduce the unnecessary exposure of children to radiation.

"Under previous arrangements, Medicare-funded MRI scans could only be requested by specialists, which could delay appropriate diagnosis and treatment," Dr Hambleton said. "GPs were not allowed access to the best available technology when caring for patients.

"This new arrangement will improve access to care, reduce costs to the health system, and provide further support for GPs to provide better care for patients.

"Importantly, it also avoids unnecessary patient exposure to ionising radiation in CT scanning."

Following the change, GPs can order Medicare-funded MRI scans for patients under 16 years of age for:

- scans of the head following unexplained seizures or headaches where significant pathology is suspected, and paranasal sinus pathology that has not responded to conservative therapy;
- scans of the spine following radiographic examination in cases where there has been significant trauma, or there is unexplained neck or back pain with associated neurological signs, and unexplained back pain where significant pathology is suspected;
- scans of the knee following radiographic examination for internal joint derangement;
- scans of hips following radiographic examination for suspected septic arthritis, slipped capital femoral epiphysis or Perthes disease (disorder of the hip joint);
- scans of elbows following radiographic examination where a significant fracture or avulsion injury is suspected that would change the way in which the patient is managed; and
- scans of wrists following radiographic examination where scaphoid fracture is suspected.

Ms Plibersek said the changes would "help cut down both the time and the money that parents spend on treating their children".

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Tap for cheap wine could be turned off

The cost of cask wine could soar under a plan by a key Federal Government health adviser to overhaul the taxation of alcohol to curb dangerous drinking.

The National Preventative Health Taskforce has issued a draft report calling for the introduction of a volumetric tax on wine that could see the cost of a four-litre cask virtually double to almost $27.

The report said there was widespread support for reform of alcohol taxation, particularly changes to the wine equalisation tax and the introduction of volumetric taxation.

But the Taskforce rejected calls for a minimum (floor) price for alcohol, warning the move could increase takings and profits for some retailers and manufacturers.

In a submission to the Taskforce earlier this year, the AMA argued that raising prices, such as through setting a minimum price, was a cheap and effective way to curb binge drinking and other harmful alcohol consumption, particularly among young people.

"A fundamental shortcoming of the current alcohol pricing and taxation system in Australia is that it is not based on public health principles," the AMA submission said. "By targeting low-cost alcohol, minimum pricing has important implications for young and heavy drinkers, and offers a potent means of tackling damaging patterns of consumption."

The World Medical Association (WMA) backed the AMA's call at its General Assembly in Bangkok last month.

The WMA's 102 member associations adopted an emergency resolution arguing that setting a minimum unit price for alcohol would reduce alcohol consumption among both heavy drinkers and young people, and was an important public health measure.

British Medical Association delegate Dr Vivienne Nathanson told the Assembly that increasing taxes alone was not effective in curbing consumption.

Dr Nathanson said that the United Kingdom had a major alcohol problem despite having among the highest alcohol tax regimes in the world, and setting a floor price would be more effective.

A Canadian study published in the *American Journal of Public Health* found that a 10 per cent increased in the minimum price of alcohol was linked to nearly an 8.5 per cent drop in alcohol consumption.

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INFORMATION FOR MEMBERS

Essential GP tools at the click of a button

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

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

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

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

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

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

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

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

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Future Fund takes a breather on tobacco

The giant Future Fund has agreed to review its $225 million investment in tobacco companies in response to pressure from the AMA, the Australian Greens and other health campaigners.

Late last month AMA Vice President Professor Geoffrey Dobb wrote to Future Fund Chairman David Gonski arguing the case for the $80.5 billion investment giant to divest itself of its tobacco holdings on health, moral and economic grounds.

In a briefing on 25 October, the Fund's Board revealed that it had directed its Governance Committee to review its tobacco investments.

Professor Dobb said there was overwhelming evidence that tobacco use killed people, destroyed their health and shortened lives, and had a devastating effect on the families of those who fell ill from smoking.

The AMA Vice President said smoking was linked to 15,000 premature and preventable deaths in Australia each year.

"Despite this evidence, the global tobacco industry knowingly continues to promote tobacco products, including in ways that are attractive to young people, and continues to try to find ways to get around legislation that limits tobacco marketing," he said.

Professor Dobb said it was "irrational" to have the Federal Government successfully introducing world-first plain packaging legislation for tobacco products while the Future Fund simultaneously helped prop up the industry through its investments.

In a rare appearance before a Senate committee last month, Mr Gonski said the Future Fund took a "very active" approach to environmental and social concerns, and had not set out to specifically invest in tobacco companies.

He said the shares had been purchased through investments made with fund managers, who frequently were required to have a holding of top-performing stocks.

"The Future Fund does not invest in particular companies," Mr Gonski said. "Our investment in tobacco comes from the fact that we have invested in a number of managers."

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Mental health of doctors to go under microscope

Thousands of doctors and medical students are set to be quizzed on their mental health in one of the most extensive efforts ever undertaken to gauge the extent of depression, stress and general mental wellbeing of the nation's medical workforce.

The depression-prevention organisation *beyondblue* has engaged pollster Roy Morgan Research to conduct a survey examining the mental health of the nation's medical students and doctors.

A pilot study involving questionnaires sent to a random sample of 2000 doctors and medical students will be conducted this month to fine-tune the survey.

The full study, which is intended to sample the views of around half of all medical students and doctors, is due for launch in February next year.

Results are expected to be finalised in May 2013.

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Nominations for admission to the Roll of Fellows

By-Law 16 enables Federal Council to admit members nominated by a Committee of Fellows to the AMA Roll of Fellows.

Any ordinary member of the AMA may nominate members of the Association who have given outstanding service to the AMA, have had 10 years uninterrupted membership (or shorter period if considered exceptional by Federal Council) and merit special recognition.

Members are reminded that nominations for admission to the Roll of Fellows of the AMA must be accompanied by a written citation setting out the particulars of the services given to the Association by the member, and for which it is considered the member merits admission to the Roll. Nominations should be sent via email to jthomas@ama.com.au, followed by a hard copy to the Secretary General, AMA, PO Box 6090, Kingston ACT 2604, no later than 31 December 2012.

It should be stressed that nominations of Fellows must be treated with extreme confidentiality. Only under exceptional circumstances may the nominated Member be informed and then, only by the President of the appropriate nominating body or, if relevant, the Federal Councillor representing a nominating Craft Group or Special Interest Group.

A Fellowship Committee of Federal Council, appointed by the President, will consider the nominations.

Francis Sullivan
Secretary General
24 October 2012

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

Health bid for asylum seekers, *The Age*, 29 October 2012

http://www.theage.com.au/opinion/political-news/health-bid-for-asylum-seekers-20121028-28djp.html

The AMA has urged that an independent body be established to monitor the health of asylum seekers in detention.

Fears of drugs on planes, *The Sunday Telegraph*, 28 October 2012

http://www.dailytelegraph.com.au/news/qantas-pilot-captain-steve-anderson-fears-of-drugs-on-planes/story-e6freuy9-1226504404807

Australian Medical Association President, Dr Steve Hambleton, said the purchasing of such drugs as antibiotics without prescription overseas is an enormous problem, amid concerns that travellers are buying prescription medicines over the counter overseas and bringing them into the country.

Women turned on to Viagra in world-first, *The Sunday Herald*, 28 October 2012

http://www.theaustralian.com.au/news/the-drug-trial-that-could-change-every-womans-life/story-e6frg6n6-1226504732280

Dr Steve Hambleton, Australian Medical Association President, warned that although it might be beneficial for some, such drugs carried with them the danger of "creating unattainable and unnecessary expectations in women".

'Chronic stress ruined my health', *The Adelaide Advertiser*, 27 October 2012

http://www.adelaidenow.com.au/news/chronic-stress-ruined-my-health/story-fnelof9k-1226504588769

AMA President, Dr Steve Hambleton, said doctors have long been aware of the broad connection between stress and illness, with some evidence that stress alters the reaction of immune systems and changed the outcome of illnesses. But he said more research was needed to closely investigate the connection.

Health experts call for restrictions on energy drinks, *The Herald Sun*, 25 October 2012

http://www.heraldsun.com.au/news/national/health-experts-call-for-restrictions-on-energy-drinks/story-fndo3ewo-1226502703061

The Australian Medical Association has called for supermarkets and convenience stores to be banned from selling the caffeine-charged drinks to minors.

Medics' drug pilfering rare but perilous, *The Herald Sun*, 23 October 2012

http://www.heraldsun.com.au/news/breaking-news/medics-drug-pilfering-rare-but-perilous/story-e6frf7kf-1226501687039

Australian Medical Association President, Dr Steve Hambleton, said the medical industry's priority is to protect patients and support practitioners who stumble into trouble.

Anais's tragedy: calls for restrictions on energy drinks after teenager's death, *The Sydney Morning Herald*, 23 October 2012

http://www.smh.com.au/world/anaiss-tragedy-calls-for-restrictions-on-energy-drinks-after-teenagers-death-20121023-282zi.html#ixzz2AGDMvt1J

Australian Medical Association President, Dr Steve Hambleton, said regulations governing the sale of energy drinks should be tighter.

Visit to doctor will cost more, *The West Australian*, 17 October 2012

http://au.news.yahoo.com/thewest/a/-/wa/15137806/visit-to-doctor-will-cost-more/

AMA Federal Vice President, Professor Geoff Dobb, said Medicare rebates were being eroded because the Government's indexation of the Medicare Benefits Schedule was totally inadequate.

Medicare rebates not keeping up with quality care, says AMA, *The Herald Sun*, 16 October 2012

http://www.heraldsun.com.au/news/national/medicare-rebates-not-keeping-up-with-quality-care-says-ama/story-fndo48ca-1226497157493

AMA Vice President, Professor Geoffrey Dobb, said the latest Medicare rebate rise failed "dismally to reflect the true value of quality medical care in Australia".

Future Fund invested millions in tobacco shares, *ABC News*, 16 October 2012

http://www.abc.net.au/news/2012-10-16/future-fund-invested-millions-in-tobacco-shares/4314294

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The $80 billion Future Fund has come under increasing pressure from the AMA and other health organisations over its investment in tobacco companies. "Tobacco kills approximately 15,000 Australians every year," Australian Medical Association Vice President, Geoff Dobb said.

Pharmacy group breached advertising rules, *The Sydney Morning Herald*, 16 October 2012

http://www.smh.com.au/business/pharmacy-group-breached-advertising-rules-20121016-27ogo.html

Australia's largest pharmacy retailer, Chemist Warehouse, has been found to have breached advertising standards in promoting a prescription-only cholesterol drug as free of charge — but has not been penalised. AMA Vice President, Professor Geoffrey Dobb, said it was "a concern when they allegedly weren't complying [with advertising standards], and it's a concern that they were found to have not complied, but I'm pleased to hear that they will".

Wine tax wowsers ruin life's pleasures for us all, *The Australian*, 16 October 2012,

http://www.theaustralian.com.au/news/wine-tax-wowsers-ruin-lifes-pleasures-for-us-all/story-e6frg6n6-1226496571139

AMA Vice President, Professor Geoffrey Dobb, said the fact you can buy a four-litre cask of wine for as little as $10 encourages people to drink more because it is so cheap.

Radio

Dr Hambleton, ABC Radio National, 29 October 2012

http://ama.com.au/node/8272

AMA President, Dr Steve Hambleton, discussed a report that found two-thirds of Australians did little or no exercise, and that 63 per cent of Australians were considered to be overweight or obese.

Dr Hambleton, 2UE Sydney, 25 October 2012

http://ama.com.au/node/8264

AMA President, Dr Steve Hambleton, commented on allegations that two qualified surgeons continued to work in hospitals despite admitting to cocaine use.

Dr Hambleton, ABC News Radio, 19 October 2012

http://ama.com.au/node/8261

AMA President, Dr Steve Hambleton, discussed the abuse and misuse of the highly addictive painkiller Fentanyl.

Professor Dobb, 2UE Sydney, 15 October 2012

http://ama.com.au/node/8253

AMA Vice President, Professor Geoffrey Dobb, commented on the Australian National Preventative Health Agency's plan to advise the Federal Government to introduce a floor price for alcohol.

TV

Dr Hambleton, Today, Channel 9, 27 October 2012

http://www.youtube.com/watch?feature=player_embedded&v=srNnlxv4akw

AMA President, Dr Steve Hambleton, called for age restrictions on energy drinks after a girl in the United States died after she consumed two cans. He said some people are very sensitive to caffeine and there are serious side affects. The Poisons Information Centre has reported an increased amount of calls from people who have had problems with energy drinks.

Professor Dobb, Channel 10 Sydney, 15 October 2012

http://www.youtube.com/watch?v=Nfa9EktadCU&list=UUx5NFeUd5hs3wnViy_LjWrw&index=2&feature=plcp

AMA Vice President, Professor Geoffrey Dobb, said the Australian National Preventative Health Authority has proposed putting a floor on the price of cask wines and 'clean skins'. He said it is only one way of reducing effects of harmful drinking and discussed the Australian cultural reaction to drunkenness.

TO COMMENT CLICK HERE

AMA in action

AMA President Dr Steve Hambleton has been busy these past few weeks. He met with Liberal MP Dr Sharman Stone, who is Co-Chair of the House of Representatives Committee inquiring into Foetal Alcohol Spectrum Disorder, to discuss the impacts of alcohol on women. Dr Hambleton also met with Jim McGinty, Chair of Health Workforce Australia and Mr Cormack, Dr Kearon and Mr Scheepers. Dr Hambleton met with AMA NSW President Dr Brian Owler and doctors from the Mount Druitt Aboriginal Medical Service to discuss Indigenous health issues and, while in Sydney, appeared on the *Today* show with weekend co-host Cameron Williams to discuss age restrictions on energy drinks following the death of a girl in the US after she consumed two cans. Dr Hambleton also attended the Royal Australian College of General Practioners' Fellowship and Awards ceremony, where he met with newly-elected President Dr Liz Marles. Earlier in the month Dr Hambleton met with Dr Dianne Watson, Chief Executive Officer of the National Hospital Pricing Authority.

TO COMMENT CLICK HERE

AMA President Dr Steve Hambleton with Liberal MP Dr Sharman Stone

Dr Hambleton meeting with Jim McGinty, Chair of Health Workforce Australia and Mr Cormack, Dr Kearon and Mr Scheepers

Dr Hambleton with Cameron Williams from the Today show on Channel 9

Dr Hambleton with AMA NSW President Dr Brian Owler (left) meeting with doctors from the Mount Druitt Aboriginal Medical Service

Dr Hambleton with Dr Dianne Watson CEO for the National Hospital Pricing Authority

Dr Hambleton with newly elected RACGP President Dr Liz Marles

World looks to Australia on key health issues

Dr Hambleton addresses the World Medical Association General Assembly, Bangkok

Australia was being looked to as a world leader in tackling lifestyle diseases and promoting preventative health initiatives, according to AMA President Dr Steve Hambleton.

Dr Hambleton said Australia's breakthrough action in introducing plain packaging for tobacco products, along with the unfolding debate on a minimum floor price for alcohol and health campaigns around diet and exercise, attracted keen interest from fellow delegates attending the World Medical Association's annual General Assembly in Bangkok last month.

At the meeting, the World Medical Association (WMA) passed a resolution applauding the Gillard Government for introducing the world's first plain packaging laws and adopted a statement supporting minimum pricing for alcohol.

Dr Hambleton said it was clear from discussions he had with delegates from around the world, but particularly near neighbours in the Asian region, that many were looking to learn lessons from Australia about how to curb tobacco and alcohol consumption and promote healthier lifestyles.

"It was heartening to realise how welcome Australia's point of view was in Asia, and how similar our problems were to those of our nearest neighbours," Dr Hambleton said. "It was clear that the experience we bring to solving these issues would be valued by the WMA, and particularly by less developed countries."

The General Assembly also debated, and passed, a statement on the right of doctors to strike.

Dr Hambleton said the statement, originally presented by the Israeli delegation, provoked much debate among delegates, particularly around the levels of health service that should be maintained during collective action by doctors.

Dr Hambleton eventually moved an amendment that effectively removed the need to speak about services in this context, and the suggestion was overwhelmingly supported by delegates and the amended statement was adopted by the Assembly.

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See page 15 for more photos.

TO COMMENT CLICK HERE

World looks to Australia on key health issues

WMA officials (from L to R): Past President Jose Luiz Gomes Amaral, President elect Dr Margaret Mungherera, President Dr Cecil B Wilson, Chairman of Council, Dr Mukesh Haikerwal, Secretary General Otmar Kloiber, and legal advisor Annabel Seebohm

Dr Hambleton and AMA Manager Belinda Highmore at the General Assembly

Dr Hambleton and Dr Mark Peterson, New Zealand Medical Association

Dr Hambleton and Mukesh Haikerwal with past President, Jose Luiz Gomes Amaral

Dr Hambleton votes votes during the WMA General Assembly

AMA Manager, Medical Practice, Belinda Highmore addresses the WMA General Assembly

Dr Hambleton and with WMA President elect, Dr Margaret Mungherera

World-leading plain packaging laws squeeze Big Tobacco*

BY AMA PRESIDENT DR STEVE HAMBLETON

Australian smokers will soon be plucking their cigarettes, cigars and other tobacco products from drab olive packets emblazoned with graphic health images and warnings, as the world's first tobacco plain packaging laws come into effect.

In a measure that has drawn widespread international interest, the Australian Government has successfully enacted laws virtually eliminating the ability of tobacco companies to market their products through their packaging.

From 1 December all tobacco products sold in Australia must be in plain packaging carrying large and explicit health images and warnings covering at least 75 per cent of the packet. Any product branding will be limited to words in small areas at the bottom and sides of packs.

The tough measures, strongly backed by public health organisations, came into effect after the High Court of Australia rejected a legal challenge mounted by the world's major tobacco companies. The Australian Medical Association has been a strong advocate for plain packaging, which it sees as an effective tool for combating the glamorisation of smoking, particularly to young people.

In their challenge, British American Tobacco Australia, Japan Tobacco International, Philip Morris and Imperial Tobacco Australia, argued the new measures amounted to the acquisition of their brands and logos by the Government without just compensation, and should be ruled unconstitutional.

But the High Court found in favour of the counter argument from the Government that although the laws required the removal of trademarks from all cigarette packets, they did not weaken the companies' exclusive ownership of their trademarks.

"Although the Act regulated the plaintiffs' intellectual property rights and imposed controls on the packaging and presentation of tobacco products, it did not confer a proprietary benefit or interest on the Commonwealth," the High Court said in a summary of its judgement.

The Government has insisted that the laws were aimed solely at reducing the incidence of smoking.

"Research shows that industry branding and packaging design on tobacco products can mislead consumers about the harms of smoking, make smoking more appealing – particularly among young people – and reduce the effectiveness of health warnings on tobacco products," the Department of Health and Ageing said.

Attorney-General Nicola Roxon, who introduced the plain packaging legislation as Health Minister, and her successor Tanya Plibersek, said the High Court decision was "a victory for all those families who have lost someone to a tobacco-related illness [and] a relief for every parent who worries about their child picking up this deadly and addictive habit".

"Plain packaging is a vital preventative public health measure, which removes the last way for big tobacco to promote its deadly products," the Ministers said in a joint statement. "Over the past two decades, more than 24 different studies have backed plain packaging, and now it will finally become a reality."

But the tobacco industry has not given up the fight completely.

In addition to the High Court challenge, it has also backed action being taken by several countries against the legislation under trade laws.

The Dominican Republic has joined has joined Ukraine and Honduras in complaining that the laws unfairly restrict trade and should be scrapped.

While the Caribbean nation is a tiny trade partner, exporting just $20 million worth of goods to Australia in 2011, it is a major producer of cigars, and has lodged a formal complaint about the plain packaging laws with the global trade umpire, the World Trade Organisation.

The Dominican Republic Government formally notified of a trade dispute by requesting consultations with Australia "on certain measures concerning trademarks, geographical indications and other plain packaging requirements applicable to tobacco products and packaging" through the auspices of the WTO.

Both Honduras and Ukraine, both tobacco-exporting nations, are already well advanced in the preliminary steps that need to be taken before the matter proceeds to WTO adjudication, having requested consultations with Australia over the measure.

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World-leading plain packaging laws squeeze Big Tobacco*

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Under WTO rules, if the matter cannot be resolved by negotiation within 60 days, the complainant can ask the WTO to set up a panel to adjudicate the case.

The issue has drawn significant international interest, with a large number of countries acting as third-party observers in the case.

The plain packaging laws are among a range of measures being taken by Australian governments at all levels to curb smoking, which is estimated to cost the nation $31.5 billion a year in health expenses.

In its May Budget, the Federal Government slashed the duty-free allowance for travellers bringing tobacco products into the country from 250 cigarettes or 250 grams of tobacco to 50 cigarettes or 50 grams of tobacco, and two years ago it raised the tobacco excise by 25 per cent.

The range and appearance of health warnings on tobacco products has been increased, restrictions have been imposed on advertising tobacco products on the internet in Australia, and access to nicotine replacement therapies and other aids to quitting smoking is subsidised.

These more recent measures follow a long-standing nationwide ban on tobacco advertising and sponsorships, particularly of sporting events, and the progressive introduction of laws prohibiting smoking at workplaces, sporting and entertainment venues and enclosed public places.

Official figures show the incidence of smoking among adults, particularly men, has been steadily decreasing in recent decades.

According to the Australian Bureau of Statistics, the proportion of men who smoke dropped from more than 27 per cent in 2001 to 23 per cent in 2008, while among women there was a more modest reduction from 21.2 to 19 per cent over the same period.

The AMA has been a long-standing advocate for plain packaging laws.

In mid-2009 it lobbied federal politicians to support the Plain Tobacco Packaging Bill introduced by independent Senator Steve Fielding, and eight months later threw its public support behind a decision by the Rudd Government to introduce plain packaging laws.

A year later, in July 2011, the Association made a submission to a Parliamentary inquiry in which it strongly backed the Government's Tobacco Plain Packaging Bill, and AMA officials were prominent advocates for the measure in the media.

Despite the breakthrough plain packaging laws, the Australian Government is under pressure to do more to combat smoking.

The AMA is among health groups critical of recent investments made by a public fund in tobacco companies.

The Government's $73 billion Future Fund, set up to offset future public servant superannuation liabilities, invested almost $38 million in tobacco company shares between December 2010 and February 2012.

The AMA believes it is simply irrational to have the good work that the Federal Government has done in tobacco plain packaging and tax measures undermined by Future Fund investments that help the tobacco industry to profit from selling a lethal substance.

The Future Fund has a responsibility to invest taxpayer money in a way that was consistent with the interests of the country and its people.

But the Government has so far firmly resisted pressure to dictate to the Future Fund how it should invest the money it manages.

* This story is also appearing in the World Medical Association's *World Medical Journal*

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INFORMATION FOR MEMBERS

Upcoming conferences

Silent Witnesses: The place of the coronial system in a civilised society

The deaths of asylum seekers in custody will be a focus of the Asia Pacific Coroners' Society's annual conference at the Amora Jamison Hotel, Sydney. Former High Court judge Mary Gaudron will speak on the role of the coroner and the rule of law in a keynote address to the conference on 21 November, while coroners from New South Wales and Western Australia will lead a discussion on asylum seeker deaths on 22 November. The conference will also hear speakers on forensic psychiatry, eyewitness memory, the future of autopsy and preventing deaths in custody.

For more information, visit: www.dcconferences.com.au/apcsc

Expert witness training

Doctors and other health professionals are invited to attend a two-day training session on providing expert testimony in court.

The course, to be run by the Australasian College of Legal Medicine, provides instruction on how to be an expert witness, and what will be expected when attending court.

As part of the training, attendees will be required to submit a report (from which identifying details have been deleted) a month prior to the course. During the training they will be led and cross-examined on the contents of the report.

When: 24-25 November, 2012

Where: Royal College of Surgeons, 250-290 Spring Street, East Melbourne

Registration: Forms available at www.legalmedicine.com.au

More information: Australasian College of Medicine, 02 4573 0775

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World medical body calls for universal plain packaging, warns on e-cigarettes

The peak international medical association has urged governments around the world to follow the Australian Government's lead by introducing plain packaging laws for cigarettes and other tobacco products.

At its annual General Assembly in Bangkok, Thailand, the World Medical Association (WMA) passed a resolution applauding the Gillard Government for introducing the world-first public health measure, and lambasted the major tobacco companies for taking legal action to oppose it.

In August, the Australian Government successfully saw off a High Court challenge to the laws from four of the world's largest tobacco manufacturers, meaning that from 1 December all cigarettes and other tobacco products sold in Australia must be in olive packets emblazoned with explicit health images and warnings.

"Big tobacco has aggressively fought this significant public health initiative to curb the dangers of smoking," WMA Chair and former AMA President, Dr Mukesh Haikerwal, said. "The WMA congratulates the Australian Government for showing leadership and resilience in refusing to bow to this pressure and successfully defending the legislation in the High Court of Australia."

The WMA Assembly also urged doctors to warn patients about the risks of using electronic cigarettes.

In a policy statement, the Association said there was little, if any, quality control used in manufacturing so-called e-cigarettes, and little research had so far been done into how much nicotine they exposed users and those around them to.

"Manufacturers and distributors mislead people into believing these devices are acceptable alternatives to scientifically proven cessation techniques," Dr Haikerwal said. "They are not. Unknown amounts of nicotine are delivered to the user, and the level of absorption is unclear, leading to potentially toxic levels of nicotine in the system.

Dr Hairkerwal said there were better and safer ways to stop smoking.

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Majority unhappy with the health system - report

Dissatisfaction with the health care system remains high despite a mounting belief that conditions are improving.

A Menzies-Nous Australian Health Survey report found that although attitudes have improved, with 37 per cent of people believing that on the whole the health system works pretty well, compared with 21 per cent in 2008, 63 per cent are still not happy with it.

AMA President Dr Steve Hambleton said the results showed that, although there had been improvements made in recent years, there was still much further to go.

Dr Hambleton said the health care system was built for financially stressed people and if they are not happy, it is a good indication that there is a problem.

"Sixty-three per cent of people aren't happy. That's a lot of people," Dr Hambleton said.

The biennial survey provides a snapshot of the perceptions of Australians about their health, and their attitudes toward the health care system.

Overall, 86 per cent of those surveyed considered their health to be good, and expressed confidence that they would receive quality and safe medical care, effective medication and the best technology if they fell seriously ill.

However, those under the greatest financial stress were much less satisfied with health care, with 15 per cent saying the system needed to be rebuilt compared with 8 per cent of those Australians not financially stressed.

Half of the 1200 people surveyed said more doctors, nurses and allied health professionals were needed, though 70 per cent indicated they were able to make same-day or next-day appointments to see a doctor.

Additionally, satisfaction with the service provided by GPs and other practitioners was high, with 78 per cent reporting they were satisfied after visiting their GP and 79 per cent were satisfied after visiting a specialist.

In an important result for the Federal Government as it tries to engineer an overhaul of the aged care system, the survey identified widespread dissatisfaction with the service provided by residential aged care facilities (just 54 per cent were happy with the standard of service) and 64 per cent said they would be willing to pay more tax if it meant the elderly could stay at home for longer and receive the care they needed.

Importantly, there was overwhelming support (92 per cent) for the proposition that people should contribute, alongside government, to the cost of aged care, based on their financial means.

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Nation packs on the pounds

The biggest check-up of the nation's health ever undertaken has found almost one in every 10 children is obese and more than 60 per cent of adults are carrying too much weight.

A study by the Australian Bureau of Statistics has found that more than one in every four children aged between five and 17 years of age is obese or overweight, as determined by their Body Mass Index, including almost 9 per cent of five to seven-year-olds considered to be obese.

The alarming findings underline concerns that many children have poor or inadequate diets and are at increased risk of developing dangerous and debilitating conditions including heart disease and diabetes later in life.

The *Australian Health Survey 2011-12*, based on a sample of 15,600 households and more than 30,000 individuals, found that while younger children were more likely than not to eat the recommended daily intake of fruit and vegetables, the diet of teenagers, in particular, was poor.

Only one in five 12 to 17-year-olds ate enough fruit or vegetables, the study found.

For the first time the Survey, which has been conducted about every five years since 1989, included figures on the weight of children as young as two years, and found that 21 per cent of two to four-year-olds were overweight or obese, while 74 per cent were considered to be of normal weight and less than 5 per cent were underweight.

On other measures, though, the health of children appears to be improving.

Australian Institute of Health and Welfare figures show infant death rates halved between 1986 and 2010, asthma cases are falling, and cancer survival rates are rising, from 68 per cent in the period 1983 to 1989, to 81 per cent between 2004 and 2010.

While a significant proportion of children are carrying too much weight, the study suggests waistlines really balloon when people reach adulthood.

According to the ABS, just 35 per cent of adults are of normal weight, while an equal proportion is overweight and more than 28 per cent are obese.

Disturbingly, the survey shows that the heft among adults has been rising remorselessly over time.

The prevalence among adults of overweight and obesity was at 56 per cent in 1995, increasing to 61 per cent in 2007-08 and reaching above 63 per cent last financial year.

But although waistlines are expanding, other measures of health are improving.

People are smoking and drinking less, the survey found.

The proportion of adults who smoke has plunged 3 percentage points in the past four years to just 16 per cent, and almost 90 per cent of teenagers have never smoked.

Over the same period, there was a 1.4 percentage point fall in the proportion of adults consuming on average more than two standard drinks a day.

Overall, more than 55 per cent of those aged 15 years or older believed they were in good or excellent health, while just 4 per cent – mostly among those aged 65 years or older – considered their health was poor.

Reflecting this, the survey found that rates of cancer and diabetes are stabilising, having remained virtually unchanged at around 1.5 per cent and 4 per cent respectively during the past four years, while the incidence of heart disease declined by 0.5 of a percentage point to 4.7 per cent over the same period.

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Health policy focus sharpens ahead of poll

Attention on health policy is set to sharpen ahead of the next year's federal election following the appointment of leading thinkers to influential research and advocacy positions.

Seven of the nation's leading universities have joined with the Australian Healthcare and Hospitals Association (AHHA) to established the Deeble Institute, which aims to bring together practitioners, policy makers and researchers to investigate health policy issues and help develop solutions.

The Institute, named after its patron, Dr John Deeble, draws on expertise from across the country, including the Queensland University of Technology, The Australian National University, the University of Western Australia, Griffith University and La Trobe University.

La Trobe University Professor Vivian Lin has been appointed inaugural Chair of the Institute's Board, and Dr Anne-Marie Boxall is its founding Director.

Included on the Board are Professor Andrew Wilson, Professor Christobel Saunders, Professor Allan Cripps, Professor Frances Shannon, Professor Hal Swerissen and Mr Robert Wells.

AHHA Chief Executive Officer Prue Power said that, in addition to undertaking its own research on important national health policy issues, the Institute would publish briefs on evidence-based health policy, organise conferences and seminars and help foster relationships between researchers and health practitioners.

The announcement came as the Grattan Institute appointed Professor Stephen Duckett to head its newly created health policy program.

Professor Duckett, a former Secretary of the Commonwealth Department of Human Services and Health, during the 1990s oversaw the introduction of casemix (activity-based) funding in Victoria, the first time this had been attempted in a capped, publicly funded system.

Grattan Institute Chief Executive Officer John Daley said that, despite its size and importance, health policy was a relatively neglected area of research.

Mr Daley said Professor Duckett, with his reputation for creativity and excellence, was well-placed to make a significant contribution to the national health policy debate.

Earlier this year Professor Duckett attacked what he described as "perverse incentives" in the new activity-based funding system for hospitals which could see providers getting paid for treating patients they had harmed.

He said the system should include "adjustments" in payments for hospital-acquired conditions in order to provide incentives to reduce the incidence of sub-optimal care.

Professor Duckett said that he would examine the cost of poor health investments and other waste of public funds, and consider ways to improve the quality, sustainability and accessibility of health care.

"Health policy is my passion, but it must have a strong analytical and evidence base," he said.

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Baseball strikes out alcohol sponsorship

The campaign to curb dangerous drinking, particularly among the young, has scored a home run after the Australian Baseball Federation and the Australian Baseball League agreed to sign up to the *Be the Influence: Tackling Binge Drinking* campaign.

Under the campaign, launched earlier this year, sporting codes that give up alcohol sponsorship can instead receive funding form the Government.

The AMA strongly backs the initiative as part of efforts to curb damaging alcohol consumption, particularly among young people.

In September, the AMA released a report highlighting the extent to which children and teenagers were being exposed to alcohol marketing through the social media, and called for policy and legislative reforms to curtail this.

AMA President, Dr Steve Hambleton, said young people, in particular, were easy targets of alcohol promotion at sporting and cultural events that portrayed drinking as part of a healthy and fun lifestyle.

"The involvement of key national sporting organisations in this campaign is vital. They are high profile role models," Dr Hambleton said. "They will provide sporting environments that are free of alcohol promotion and educate their communities about the dangers of excess alcohol consumption."

"The AMA would like to congratulate the Australian Baseball Federation and the Australian Baseball league for stepping up to the plate and signing up to the campaign."

Twelve of Australia's top sporting organisations – including Football Federation Australia, Netball Australia and Swimming Australia – are already funded out of the sponsorship program, meaning they can no longer accept alcohol sponsorship.

Australian Baseball League Chief Executive Officer Peter Wermuth said the sport was thrilled to join the initiative.

"The Australian Baseball League is very excited about our new partnership as it perfectly aligns with the Australian Baseball League's goal of providing a fun, family-friendly environment at games," Mr Wermuth said.

For more information about alcohol and marketing to young people visit: http://ama.com.au/alcohol-marketing-and-young-people

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Changing lanes – making the leap from bulk billing

BY **DR STEVE WILSON**

"The first thing to do is to value yourself, first and foremost – your thinking has to change"

In 1999 my practice partner and I came to the difficult realisation that continuing to bulk bill everyone was no longer financially sustainable.

Three years earlier we had taken over a practice in Bassendean from two very senior clinicians who had bulk billed everyone. Unsurprisingly, this had created an expectation among many patients that this was the way it should always be.

But this was unsustainable for a host of reasons that likely resonate with most practitioners:

- **practice costs** were rising (as they continue to do) by between 4 and 6 per cent a year.

  At the time, we had purchased new premises and had undertaken a massive fit-out, complete with a new IT system, updated plant and equipment and more staff - including a full-time practice nurse (this was before the Practice Incentives Program began). For the practice, it was full steam ahead;

- **workload issues:** the complexity of conditions our patients were presenting with meant that realistically we could only see four patients an hour. It is simply impossible to deal with multiple co-morbidities or presentations in 10 minutes;

- **government rebates:** The growing inadequacy of the Medicare rebate meant that we as GPs were increasingly subsidising the health care of our patients. There were many patients who had a capacity to pay, even if a little. Consumers have to pay everywhere else in life including at the chemist and supermarkets. Nowhere else in life do people get regular, massive discounting at point of delivery for a regular, repeated service – not at Coles, petrol stations or other utility services. It is the government's role to subsidise health care not general practitioners;

- **morale:** The increasingly inadequate bulk bill rate added to the feeling that the service we were offering was undervalued, which was demoralising and would build resentment; and

- **self-respect:** It had begun to gall me no end as patients wielding concession cards arrived in their Mercedes to get their medicines and vaccinations for an extended Asian trip. I admit I lost a few layers of enamel gnashing my teeth over that, one Saturday morning.

I could go on. But more importantly, what did we, and what can you, do about it? What must change? And what plans and steps can you, and should you, take?

The first thing to do is to value yourself, first and foremost – your thinking has to change.

Acknowledge that unless bulk billing rates decline, the Government has no evidence that the current rebate is inadequate in covering the cost of service.

You will discover that as you increase private billing, you will maintain - or likely increase - your income, without having to work as hard as you currently do.

Remember, when demand is so strong, it is a seller's market.

People will allow you to bulk bill them as long as you let them be bulk billed.

What we found is that people will stay if they value you. They will adapt.

So, how do you make the change?

Here are suggested steps for how to get there including, importantly, the "who" and the "when".

Your staff are pivotal, and so is practice communication. Have planning meetings.

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Changing lanes – making the leap from bulk billing

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- Set a **date**, for example 1 November, when the MBS is adjusted annually. And stick to it;
- you must **publicise** your change in fee structure widely in the practice. Be clear. Staff members are essential for sticking to the agreed fee by "the practice" as a whole. Your staff must advise patients verbally, distribute information sheets and put information in Practice Information Sheets as part of Informed Consent;
- hold regular practice discussions and meetings to make sure there is **universal agreement**. No one breaks ranks – except in exceptional circumstances;
- have **clear billing tiers**. For instance, specify private fee WITH a predictable gap over the Medicare Rebate for each item of Level A, B, C, and D.
- effectively, you need to move to **means testing at point of service**. In this case:
  - > full "private" patients may, for instance, pay the new agreed practice fee for any level of consultation or service;
  - > categorise those patients who you wish to NOT bulk bill as "discounted" patients. Advise them of the discount to "make them feel valued". For instance, your staff could say: "The doctor's charge is usually $xx, but he has discounted the fee by $yy";
  - > you may well elect to continue to bulk bill pensioners and HCC holders if you wish (especially if you get the larger 10991 Bulk Bill incentive payment), or charge a known predictable gap over the Item No with the 10990/10991 added on; eg $50 for a Item 23 (the patient will be only about $10 or so out of pocket).

Ultimately, the secret is the effective use of your staff. And for those practices that are computerised (which most are), the use of IT is essential. For instance, use Medicare On-Line or Tyro to ensure patients have their rebate "almost all back within 36 hours". They will barely miss it and be grateful for the quality service, the after-care and attention to detail.

Dr Steve Wilson is the Chair of the AMA (WA) Council of General Practice.

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INFORMATION FOR MEMBERS

AMA LIST OF MEDICAL SERVICES AND FEES

The 1 November 2012 edition of the AMA List of Medical Services and Fees is now available both in hard copy or electronic format.

Members listed as being in private practice or with rights of private practice should have received their hard copy by 31 October 2012. Salaried members who have ordered a hard copy should have received their copy by 31 October 2012.

The AMA Fees List Online (**http://feeslist.ama.com.au/**) has also been updated as at 1 November 2012. To access this part of the website, simply enter your username and password in the box provided on the screen. Members can view, print or download individual items or groups of items to suit their needs.

Electronic versions (PDF and CSV) of the AMA List are also available for free download from the Members Only area of the AMA Website (**www.ama.com.au/feeslist**).

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

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

1) Once you have entered your login details, from the home page go to **Members Benefits** at the top of the page.
2) Under AMA Member Benefits, select **AMA List of Medical Services and Fees** link.
3) Select first option, **AMA List of Medical Services and Fees - 1 November 2012**.
4) Download either or both the **CSV** (for importing into practice software) and **PDF** (for viewing) versions of the AMA List.
5) For the Fees Indexation Calculator, select option 13. **AMA Fees Indexation Calculator**.

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

If you do not receive your hard copy of the 1 November 2012 AMA List of Medical Services and Fees or would like one, please contact the AMA on **02 6270 5400.**

TO COMMENT CLICK HERE

GP expertise recognised as governments plan for the worst

BY **DR BRIAN MORTON**

"The AMA's policy work in promoting the role of GPs in emergency planning has already borne fruit"

A couple of editions ago, I wrote about the AMA's work in advocating for a more considered and active role for GPs in emergency planning and response measures.

With summer just around the corner, and the fire and storm season upon us, emergency planners across all levels of government will be busy preparing strategies to minimise the impact of any natural disasters.

At the same time, they will be planning for appropriate responses when disaster does strike.

To help with this planning, the AMA recently released two Position Statements:

- Involvement of GPs in Disaster and Emergency Planning 2012 (http://ama.com.au/node/8162)
- Supporting GPs in the Immediate Aftermath of a Natural Disaster 2012 (http://ama.com.au/node/8167)

At the time of my last article on GPs and emergency planning, copies of the AMA Position Statements were being forwarded to the Commonwealth, State and Territory governments with a letter asking health and emergency planners in all jurisdictions to use the Position Statements as a basis for thinking about how GPs can be more actively engaged in the planning process and incorporated in emergency response measures.

Sometimes the AMA's advocacy work on behalf of doctors goes under the radar as we constantly chip away at issues and don't take enough stock of the advocacy wins we achieve.

Sometimes, unless there is a big announcement in the press about a decision called for by the AMA, the fruit of our advocacy can be unnoticed.

I am pleased to say, however, that all the committee meetings we attend, all the submissions we submit to government and all the correspondence we write does indeed have an impact, and justifies the hours of policy work we do on behalf of Australia's medical profession.

The AMA's policy work in promoting the role of GPs in emergency planning has already borne fruit.

In a response to our Position Papers on this topic, the Commonwealth's Chief Medical Officer has written to the AMA advising that the two Position Statements will be discussed at the National Health Emergency Management Standing Committee (NHEMS), whose membership encompasses Australian, State and Territory health emergency managers and experts involved in developing the health aspects of disaster plans in their jurisdictions.

The Chief Medical Officer has asked NHEMS to discuss how to better involve GPs in State and Territory, as well as national level, emergency planning and responses.

I am sure you will agree – this a good outcome for our advocacy in this area.

TO COMMENT CLICK HERE

Intern crisis needs long-term plan, not government spats

BY **JAMES CHURCHILL**

"Our capacity to avoid such future crises depends on governments agreeing to develop mechanisms to better align the inputs and outputs of the medical training pipeline..."

At the time of writing, hundreds of Australian-trained medical graduates are waiting anxiously on Australia's governments to resolve the internship crisis afflicting our medical training system.

In recent months, the Australian public has seen our politicians dig into a classic State-Federal political stalemate on this issue. At the core of the problem is a disagreement over the appropriate division of responsibility between the public and private systems for medical training and, therefore, which level of Government should be notionally responsible for funding.

Key State Health Ministers have called for the required number of additional internships to be created outside of the public system, which they claim makes the Federal Government responsible. In various tones, they have asserted that the Commonwealth has not so far pulled its weight on the funding of postgraduate medical training, which includes having committed substantial funding for pre-vocational training places in community and general practice settings and specialist training places in private settings.

In response, the Federal Government refers to the States' responsibility for funding of training in public settings, which has and continues to be the cornerstone of Australia's medical training system.

While the number of internships has increased dramatically in recent years in response to increasing graduate numbers, it is claimed that additional capacity exists in many states' public systems and that State governments could, and should, be doing more to accommodate Australian-trained medical graduates.

The result: governments vigorously blaming each other for the crisis on our hands rather than working towards the kind of long-term, collaborative solutions needed.

All the while, final year medical students anxiously wait for governments to see sense and allow Australian-trained graduates to work in our hospitals and meet Australia's health needs.

The justifications for solving this crisis are clear: it's an excellent return on investment to employ work-ready medical graduates in a system with a demonstrated future need.

However, a chronic lack of nationally-coordinated workforce planning has brought us to this point, which is beginning to look alarmingly like the tip of an iceberg for a much larger training crisis in the coming years.

Our capacity to avoid such future crises depends on governments agreeing to develop mechanisms to better align the inputs and outputs of the medical training pipeline, including medical school places, internships, pre-vocational and vocational training places.

Coordination of medical training in Australia is currently a spaghetti-bowl of State, Federal and university responsibility, each with separate but clearly interdependent roles for funding and defining numbers.

Health Workforce Australia has recently proposed formation of a National Medical Training Network to tackle this issue.

Armed with the robust national data, such a network is intended to bring together bodies responsible for medical training to enhance workforce planning.

Today's medical students are hoping that this will bring with it a willingness to commit to building health systems with sufficient and sustainable capacity for medical training, rather than perpetuating the blame games that are too often a feature of our political system.

TO COMMENT CLICK HERE

PBS Authority System – a perfect waste

BY **PROFESSOR GEOFFREY DOBB**

"The AMA continues to lobby for the complete removal of the authority policy or, at a minimum, the transfer of all remaining authority-required medicines to streamlined arrangements"

Question: what is worse than medical practitioners waiting for 10 minutes on the phone just to provide a PBS prescription for their patient?

Answer: knowing that the Government requirement to obtain a Medicare authority number for that prescription is a waste of time!

In recent weeks the Federal AMA and its State branches have been inundated with complaints from members enduring lengthy waits on Medicare's 1800 phone line while trying to get an authority number.

The AMA wrote to the Secretary of the Department of Human Services last month seeking urgent action to address this situation.

It is not just the medical practitioner whose time is wasted. It is also inconvenient for the patient who needs the prescription, and there is a domino effect on all other patients as they are kept waiting for their now-delayed appointments.

An economist would be able to calculate the direct and indirect opportunity costs of all this wasted and unproductive time.

I'm not an economist, but I do know these facts.

There are still around 100 medicines requiring full Medicare authorisation before medical practitioners can prescribe them under the PBS.

The Department of Health and Ageing argues that the authorities policy is necessary to limit the use of PBS medicines to applications where cost effectiveness has been demonstrated.

However, the Drugs Utilisation Subcommittee of the Pharmaceutical Benefits Advisory Committee has found no evidence that prescribing practices have changed as a result of moving medicines from 'authority required' status to streamlined arrangements over the last few years.

The Department additionally argues that the authorities policy allows for close monitoring of high cost and/or high-risk medicines.

This is despite the introduction of a new prescription coding system last year that allows for full tracking of such medicines.

The Secretary of the Department of Health and Ageing told a Senate Committee that the authority system "makes the provider stop and think".

But many of the medicines that require authority to prescribe are used for cancer treatment. It is difficult to comprehend any medical practitioner prescribing these types of medicines casually or unnecessarily.

The Productivity Commission has twice recommended the removal of the PBS authorities policy, in 2006 and 2009, identifying it as unnecessary red tape.

The facts are that there is no evidence that the authorities policy reduces PBS outlays or provides unique information - but we have it anyway.

And, as taxpayers, we fund the Department of Human Services to operate an 1800 number to provide medical practitioners with authority numbers. But who pays for the time the medical practitioner spends waiting to obtain the authority?

The AMA continues to lobby for the complete removal of the authority policy or, at a minimum, the transfer of all remaining authority-required medicines to streamlined arrangements.

Last month I wrote again to the Minister for Health asking for this pointless policy to be removed.

A cynic might say this is also a waste of time, but I think this is one issue we can't afford to leave alone.

TO COMMENT CLICK HERE

Managed care need not be a health hazard

BY **PROFESSOR STEPHEN LEEDER**

Several large private health insurers in Australia have in the past 20 years moved beyond simply reimbursing members and health care providers for clinical services to become directly involved in the provision and management of care.

The big users of private cover are, as expected, people with multiple long-term problems, and it is in the interest of all health care providers – public or private – to ensure that such people receive efficient care and avoid, where possible, unmanaged deteriorations in their health that usually lead to hospital admissions.

Extensive studies in western Sydney and the ACT have shown what a crisis a hospital admission is for those with chronic illness.

Take, for example, a patient with chronic lung disease who panics in the middle of the night with breathlessness after a week of bronchitis for which he has not sought care. Unless there is a health care professional who knows him and to whom he can speak, he will call the ambulance. So would I.

The ambos do a great job, but the chances are that when he arrives in the emergency department - where his record will not be easy to retrieve and there is little chance of the staff knowing him well.

He will be given oxygen - no bad thing in itself, but which may depress his breathing and necessitate ventilation for carbon dioxide retention.

A couple of weeks and a few hundred thousand dollars later he may be out of hospital. The dislocation (will his cat still be okay?), the demands of hospitalisation on an individual with no physical or financial reserves, the impact on family and carers, is huge.

So pursuing alternative ways of handling such incipient disasters is to be highly prized.

If private health insurers can innovate better forms of coordinated care for such people, that is a good start.

Australia already has an integrated system of care for patients with such problems that deserves far greater scrutiny than it receives.

It works remarkably well. Patients appreciate it. It has a comprehensive computer-based data system for patients. It knows what happens to them when they use different hospitals and doctors. It has programs for managing patients with different ailments. It does not cost the earth. Doctors generally find it acceptable. It is called the Coordinated Veterans' Care Program.

It is a managed care system.

The allergic responses of elements of the medical profession to managed care take their origin from earlier models in the United States that limited clinical freedom and, while successful in reducing health care costs, were hugely unpopular.

But progress has overtaken these old models and contemporary managed care in the US deserves a closer look.

Two years ago I visited Kaiser Permanente (KP), a prepaid health insurance and care provider agency that cares for about nine million people in California and beyond.

It has its own hospital medical centres, primary care, preventive services, community-based practices and contracted medical staff.

You pay your premium and you receive all necessary care, managed through KP.

The outcomes (and KP does measure them, whereas in Australia generally we don't) are superior to expensive, unmanaged systems. A formal evaluation several years ago showed that the costs were less in KP than in the British NHS and that performance was high.

The essence of managed care is that the payer - in this case the KP insurance company - has a vested interest in making sure you get the best outcome and that you, as the patient, stay as well as possible, thereby costing the insurer less.

It manages all aspects of your health care with you. Not just internal medicine and surgery either. I saw effective GP-based preventive care in KP that made me cringe over our paltry efforts in Australia.

In Australia we preserve a system that rewards cost shifting – or guilt-shifting – from the Commonwealth to the states and back.

If you have a chance, visit KP or any one of the dozen other first-class managed care organisations in the US.

They all have sophisticated IT systems that link all providers and patients in a kind of social network.

Talk to the doctors working in the system. They are intelligently aware of reducing clinical error, assuring quality and operating efficiently.

Private health insurers in this country have a very long journey ahead of them to achieve the successes of the American industry.

But fledgling efforts deserve more than knee-jerk criticism based on perceptions formed decades ago about what managed care can offer.

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RESEARCH

Major advance in combating diabetes

Australian scientists have developed a drug that not only prevents the development of type 2 diabetes, but can reverse its progress, in a breakthrough that could revolutionise treatment of the debilitating condition.

The drug, known as 2H10, blocks signals emitted by the Vascular Endothelial Growth Factor B (VEGF – B) protein, which affects the transport and storage of fat in body tissue. In particular, it stops the accumulation of fat in areas such as the heart and muscles, allowing cells in these tissues to once again respond to insulin, thereby restoring blood glucose levels.

Professor Ulf Eriksson, one of the project's senior researchers, discovered that the VEGF-B protein affects the transport and storage of fat in body tissue in 2010 after researching insulin resistance – often a precursor for type 2 diabetes.

Insulin resistance, which often stems from obesity, causes the cells to no longer respond sufficiently to insulin, leading to elevated blood sugar levels.

Dr Andrew Nash, a lead researcher of the project and Vice President at CSL Limited in Australia, said insulin resistance is related to the storage of fat in the wrong places such as the muscles and in the heart, although exactly how this relationship works is not fully understood.

The drug was tested in four different studies on mice, with the findings published in *Nature*.

In one study, mice were bred to develop diabetes and were treated with 2H10. The mice neither developed insulin resistance, nor diabetes. The mice were also bred with mice unable to produce VEGF-B, and it was found that their offspring were protected from developing diabetes.

In another two studies, mice were fed a fat-rich diet to develop obesity and, as a result, type 2 diabetes. The drug was again able to prevent the development and progression of the disease.

Dr Nash said the results seen in these laboratory studies were very promising for the millions of people around the world who are affected by type 2 diabetes.

"This disease is reaching epidemic proportions and is a significant public health burden," Dr Nash said. "We are very hopeful that the anti-body based drug that we have developed and tested will ultimately lead to a new treatment option for people with diabetes."

Professor Joe Proietto, a diabetes specialist at Austin Hospital in Melbourne and co-author of the paper, said the results generated through this international collaboration represent a major breakthrough and provide a new way of thinking about the treatment of type 2 diabetes.

"There is a need for new treatment strategies for type 2 diabetes as existing treatments can cause adverse reactions and their effects can wear off," Professor Proietto said.

The most common treatment for type 2 diabetes involves placing patients on a special diet that is supplemented by medication to stimulate insulin secretion and make the cells more sensitive to insulin. However, after a few years, about one third of patients require insulin injections.

Dr Nash said he hoped that human trials would begin in the next two years.

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Antipsychotics accelerate patient sedation

The task facing emergency physicians in managing agitated and aggressive patients could be made easier by the discovery that combining antipsychotics with sedatives can shorten the time to sedation by five minutes.

Researchers from Monash University have found the sedation of severely agitated emergency patients is achieved much more quickly, and is likely to last longer, if the sedative, midazolam, is used in combination with the antipsychotic drugs, droperidol and olanzaphine.

The findings are based on a study involving 336 patients with acute agitation requiring intravenous sedation in three emergency departments. Patients were randomised to receive either a saline solution, doperidol or olazapine, immediately followed by incremental intravenous midazolam boluses until sedation was achieved.

The researchers found that, compared with the saline solution, patients were sedated four minutes earlier when sedative drugs were combined with doperidol, and five minutes earlier if combined with olazapine.

Lead researcher Dr David Kong, from the Centre for Medicine Use and Safety, said although a wide range of drugs and drug combinations were used in clinical settings to sedate very agitated patients, the clinical evidence to support the combinations was lacking.

"Agitation and aggression are frequently observed in patients admitted to the emergency department as a result of mental illness, drug and alcohol intoxication, or both," Dr Kong said.

"Our findings provide important evidence about how patients with acute agitation in EDs could be optimally managed by clinicians utilising a combination of medications.

"More effective management of acute agitation could significantly reduce stress and maximise the safety of both the patients and health professionals in clinical settings."

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RESEARCH

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Professor David Taylor, from the Emergency Department at Austin Health, said four to five minutes was a long time to wait for effective sedation of emergency patients with mental illness and/or intoxication.

"This drug combination is safe, fast and inexpensive and we found no negative effects," Professor Taylor said.

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Rethink on resuscitation after starch fluids linked to kidney failure

Resuscitation practices are being revised following the discovery that a widely used starch fluid has been linked to kidney failure and found to be of no clinical benefit.

Starch is widely used overseas as a first-time treatment to maintain blood pressure and deliver oxygen and other nutrients to vital organs in acutely ill patients, and has been increasingly used in Australia since its registration in 2006.

But researchers from the University of New South Wales have found that patients resuscitated using starch fluids have a 21 per cent greater chance of developing kidney failure than those administered saline solution.

The study, which involved 7000 patients – half of whom received either starch or saline for fluid resuscitation during their admission to intensive care - found that there was no significant difference between the solutions in terms of the mortality risk over a three-month period.

But it showed that patients who received the starch solution were not only more likely to suffer kidney failure, they were also exposed to greater side effects, particularly itching and skin rashes.

Lead researcher Professor Simon Finfer, from the University of New South Wales, said starch has been marketed as being more effective than saline or other fluids on the basis of small studies of its short-term effect on blood pressure and heart rate.

"With patients who are critically ill, there will be a proportion who will develop kidney failure as part of that illness, but what this tells us in that if we use starch as opposed to saline to resuscitate these patients, more of them will develop kidney failure and will need dialysis," Professor Finfer said.

"Approximately 100,000 patients are treated in intensive care units in Australia each year. If everybody got starch, it might result in an extra thousand people having kidney failure."

Professor Finfer said he expected doctors worldwide would change their practice in light of the study.

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HIV rates on the increase

Experts have called for greater investment in HIV testing facilities and community sexual health campaigns following evidence that HIV infection rates have surged more than 8 per cent higher in the past year.

A report released by the Kirby Institute at the recent Australasian HIV/AIDS Conference found that the number of new HIV diagnoses in Australia in 2011 was 1137, an increase of 8.2 per cent compared with 1051 diagnoses in 2010, and 719 cases reported in 1999.

HIV infections rates differed across the states and territories, with Victoria, New South Wales and South Australia all seeing increases. Of the cases of HIV infection newly diagnosed in 2007-2011 that were attributed to heterosexual contact, 60 per cent involved people or their partners from countries with a high prevalence of the disease.

University of New South Wales Associate Professor David Wilson, lead author of the report, said that some of the rise in reported HIV diagnoses could be attributed to changes in testing trends among men who have sex with men.

"We believe that between 20 and 30 per cent of HIV cases in Australia remain undiagnosed, and that earlier diagnosis among these people and initiation of antiretroviral therapy would have large health benefits for the individual and reduce new infections in the community," Associate Professor Wilson said.

Professor John de Wit, lead editor of the *Annual Report of Trend in Behaviour 2012*, said that HIV prevention efforts needed to be re-invigorated if Australia was to maintain its role as a global leader in the response to HIV/AIDS.

"It remains critical to invest in effective programs and campaigns to reinforce condom use and inform men of the appropriate use of other sexual risk reduction practices, such as limiting condom-less sex to partners of the same HIV status," Professor de Wit said.

"Strengthening HIV testing facilities in community locations, and the use of testing technologies that provide rapid results, will be critical to further promote regular HIV testing, as is addressing the stigma that continues to be related to HIV, including in the gay community."

The Gay Community Periodic Survey found almost 90 per cent of gay men had been tested for HIV at least once in their lifetime, and 60 per cent of HIV-negative gay men had been tested in the past year.

Australia is a signatory to the 2011 United Nations Political Declaration on HIV/AIDS, which sets bold targets for the reduction in HIV/AIDS transmission by 2015.

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HEALTH ON THE HILL

Doctors lack basics to join PCEHR

More than one million health professionals and thousands of medical practices lack the basic information needed to link in with the Federal Government's trouble-plagued electronic health records system.

Figures released by the Department of Health and Ageing show that 1.4 million health providers are yet to use a Health Identifier (HI), which is a unique reference number used to ensure that all information for a particular patient, doctor or practice is complete and correct at the point of care.

In its 2011-12 Annual Report, the Department acknowledged that while HIs had been assigned to 24,555,487 people, only 3 million of an anticipated 4.4 million had been utilised by providers, and just 1224 Healthcare Provider Organisation Identifiers had been assigned an HI – well short of the target of 4500.

The Government blamed the shortfall on delays in developing software.

"The deliverable was affected by the pause in the development of the specification for the Primary Care desktop software developed by NEHTA [National E-Health Transition Authority] for the eHealth lead sites," the annual report said.

The HIs are integral to the establishment and operation of the Personally Controlled Electronic Health Records system, which has been plagued by delays.

"HIs ensure that individuals and providers can have confidence that health information accessed through eHealth technologies is linked with the correct individual at the point of care," the Department said. "The PCEHR system is supported by the national HIs for individuals, health care providers and health care organisations, as well as authentication services and standard clinical terminologies."

To help test and refine the system, the Government has developed a number of lead sites where e-health infrastructure and standards have been implemented in "real world settings".

"These sites provided a foundation for secure electronic communications such as referrals and sharing of summary health information to support continuity of care between health care providers," the Department said.

But the annual report showed the software delays had caused a significant setback to plans to introduce the PCEHR system.

The Government had intended that 500,000 people would have registered for a PCEHR before it was launched on 1 July this year, but little more than 100,000 people had consented to participate, and these were drawn from the lead sites.

Adding to the scheme's problems, the Department admitted there had been a substantial change of tack regarding the integration of pathology services into e-health system.

"Instead of a requirement for the inclusion of patient healthcare identifiers into pathology records by July 2012, it was determined that the integration of pathology services into the broader e-Health agenda was more appropriately met by development of a framework for ensuring pathology data could be accommodated within specifications of the PCEHR," the annual report said. "This activity continues to be progressed [sic] with key stakeholders."

Confirmation of continuing problems with the introduction of the PCEHR came despite Government efforts to encourage adoption of the system by patients and doctors.

In August Health Minister Tanya Plibersek acceded to pressure from the AMA and allowed doctors to bill for time spent preparing and maintaining shared electronic health records, and delayed until May 2013 the introduction of requirements that practices have PCEHR capability in order to remain eligible for Practice Incentive Program e-health payments.

But the AMA remains vigilant that practices should not be penalised because of delays in providing them with the software they need to link in with PCEHR system.

The concerns have come amid warnings that practices could face fines of up to $55,000 if they fail to report PCEHR data breaches.

The Office of the Australian Information Commissioner has proposed that there be mandatory reporting of all data breaches, even those deemed not serious, including unauthorised access to and use of patient information and "events" that compromise the security or integrity of the system.

The penalties range from $11,000 for an individual to $55,000 for a body corporate.

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Veterans win in war on red tape

The Government has moved to make it much faster and easier to arrange for rehabilitation equipment to be supplied to veterans and war widows.

The Department of Veterans' Affairs has simplified and streamlined rules governing the provision of almost 65 pieces of equipment including beds, walking frames, continence products and humidifiers in changes it expects will make life easier for both patients and doctors.

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HEALTH ON THE HILL

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Under the changes, health providers – who in the past had to seek prior approval from the Department – can now lodge requests for 19 different aids and appliances directly from approved suppliers, including beds, personal alarm systems, hoists, stationary bicycles, ventilators and blood glucose monitors.

In a further improvement, doctors do not need to get prior approval to exceed quantity limits for a further 45 items, including back supports, catheters, bed wedges, talking book devices, scooter batteries and toilet frames.

Department Assistant Secretary Dr Christine McPaul said the changes would "help veterans receive the aids and appliances that meet their clinical needs more quickly".

But although procedures had been streamlined, Dr McPaul warned that the provision of devices still had to be based on assessed clinical need, and requests for items would be monitored to detect any possible "administrative errors or misunderstandings".

"There are no changes to the eligibility criteria for veterans and war widows," she said. "The prescription of items will continue to be based on an assessed clinical need, and health providers will still need to complete direct order forms and to document the clinical justifications for prescribing items."

For more information, call: 1300 550 457 (metropolitan) or 1800 550 457 (rural and regional); or visit: http://www.dva.gov..au/service_providers/rap/Pages/index.aspx

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Medibank delivers $300 million windfall to beleaguered Budget

The Federal Government has confirmed it has no plans to privatise Medibank Private, amid accusation it is milking it heavily to help prop up Budget revenues.

Finance Minister Penny Wong has confirmed that Labor's policy is to retain the nation's largest health insurer in Government ownership after a Senate committee was told the organisation would draw on capital reserves to contribute a $300 million special dividend to Commonwealth coffers this financial year.

Medibank Private Managing Director George Savvides told a Senate estimates hearing that despite the payment, the second such special contribution in three years, the insurer remained in a sound financial position and was able to implement to lowest premium increases in the industry.

The Opposition claims the Government has pressured the insurer into contributing more than $1 billion to the Budget in the last three years as part of efforts to plug holes in the Budget and return a surplus this financial year.

But Mr Savvides said the payment was part of moves to "restructure the capital base of the organisation to reflect a more efficient capital structure".

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Health fund rebate dwindles as Govt hunts for savings

Private health insurance premiums are set to accelerate and access to telehealth rebates will be tightened after the Federal Government targeted health spending to deliver many of the savings needed to protect the Budget surplus.

Private health fund members will pay up to $30 a year more under a Government move to index the 30 per cent private health insurance rebate to increases in inflation rather than rises in health fund premiums, a measure expected to save $700 million over four years.

The Government expects to save a further $386 million by withdrawing the rebate for the lifetime health cover component of health premiums, paid by people who delay taking out private health cover when they turn 30 years of age.

The measures were announced as part of the Mid-Year Economic and Fiscal Outlook, in which the Government recommitted to delivering a Budget surplus in 2012-13 despite a collapse in tax revenue.

Treasurer Wayne Swan revealed that the projected Budget surplus had been cut by $400 million to $1.1 billion, largely because of a massive $22 billion write-down in tax revenue over the next four years, including a $4.3 billion downgrade to revenue estimates from the Minerals Resource Rent Tax.

To help offset the revenue shortfall, the Government has cut tax breaks, increased a range of imposts and levies, and implemented spending cuts.

As a result, according to *The Australian Financial Review's* Laura Tingle, revenue as a proportion of gross domestic product will surge to 24.4 per cent this financial year, up from 23 per cent in 2011-12 – an increase of more than $35 billion.

At the same time, Government spending as a proportion of GDP will fall from 25.7 per cent to 24.5 per cent.

In addition to cuts to the private health insurance rebate, the Government has also flagged a $765 million reduction in health grants to the states and territories this financial year.

A further $134 million will be saved by providing Medicare rebates only for telehealth consultations that occur outside major metropolitan areas.

The Government also expects to save $500 million over four years by cutting the baby bonus from $5000 to $3000 from 1 July, 2013.

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HEALTH ON THE HILL

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All up, the Government expects to save $2.1 billion from its health spending cuts.

Dr Lesley Russell, Senior Research Fellow at the Australian Primary Health Care Research Institute described the health cuts detailed in the MYEFO as a "hidden disaster" for preventive and public health.

In an analysis published on the *Croakey* website, Dr Russell said the Government has cut $400 million from public health spending over the next four years, while the outlay for preventive health initiatives has been slashed by $100 million.

Dr Russell said that because funding in these areas was relatively meagre, "every dollar counts here".

"If Australia is to tackle the growing and costly burden of non-communicable diseases and ensure that our population is as healthy as possible throughout life, then increased efforts and investments in public health and prevention are essential," she said. "To date there is little evidence that the Government is committed to these."

The Government estimates its changes to the health insurance rebate, to come into effect from April 2014, will add $28 to the premium paid for typical family cover next financial year, and $14 extra for singles.

But health fund members have been warned they are likely to see an acceleration in their premiums as the changes to the indexation arrangements for the health insurance rebate come into effect.

To this point the rebate has been indexed to rises in private health insurance premiums, which have typically risen by between 5 and 7 per cent a year.

But under the change, the rebate will instead be indexed to the consumer price index (CPI), which on average increases by between 2 and 3 per cent a year.

An analysis of the change by Citigroup, reported in the *Sydney Morning Herald*, suggests that over time the gap between the rise in health insurance premiums and the CPI will erode the effectiveness of the 30 per cent rebate by 1 per cent a year.

Economist Ian McAuley told the *SMH* medical and hospital service costs – which rose 9.5 per cent in the year to 30 September – would grow faster than the CPI, forcing premiums higher and eroding the value of the rebate.

Health Minister Tanya Plibersek said the Government remained committed to the rebate – which is subject to means testing following the introduction of legislation earlier this year – but had to act to curb its growing drain on the Budget.

"[It] will soon, by around 2022, cost around $8 billion a year," Ms Plibersek told *The Australian*. "In fact, it's already costing us about as much as it costs for everyone to go to the doctor through Medicare. So it was important to reduce it as an area of health expenditure because it's not a fonrtline service, it's not paying the wages of doctors and nurses. It's a contribution to the cost of health insurance."

The Minister said a balance needed to be struck between the Government's contribution to public and private health care.

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Few doctors and patients tuning in to telehealth

The Federal Government is struggling to encourage doctors and patients to use telehealth services, official figures show.

The Department of Health and Ageing has reported that just $3.6 million was paid out in MBS rebates to doctors for video consultations last financial year, virtually 10 per cent of the $30.6 million it had budgeted for.

The rebate was introduced in 2010 as part of a $352 million package of measures intended to boost the use of technology to improve the provision of health services, particularly for patients in rural and remote locations.

The rebate overturned a Medicare rule that consultations had to be conducted face-to-face to be eligible for a rebate.

The result reflects the outcome of an online survey of 200 health professionals conducted by conference organiser Healthcare IQ which found widespread uncertainty about the potential benefits of telehealth services.

More than 49 per cent of those surveyed were undecided about the usefulness of telehealth services, eclipsing the 47.5 per cent who believed it would improve efficiency.

One of the concerns was the cost in time and money of setting up such services. While 44 per cent thought the initial investment would eventually be worthwhile, the majority were sceptical.

But the Department said it was confident the use of telehealth items would accelerate this financial year, with more than 5000 doctors providing such services.

Specialists, in particular, appear to be making use of telehealth technology to reach patients in rural, remote and outer metropolitan areas.

Department figures show that almost 14,000 patients accessed MBS-funded telehealth services in 2011-12, with rebates for online specialist consultations reaching $17.6 million – well above the target expenditure of $12.3 million.

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US doctors learn the value of social media

A study of more than 480 doctors in the United States has found that nearly a quarter of them make daily, professional use of social media to share and exchange medical information with colleagues.

The study – conducted by email and reported in the *Journal of Medical Internet Research* – involved responses from 186 oncologists and 299 primary care practitioners.

Exploring the ways practitioners use social media, the study found 14 per cent of those surveyed used it on a daily basis to contribute new information, while 46 per cent made such contributions on a weekly basis and 61 per cent used social media each week to scan for new information.

The aim of the project was to identify how physicians were using social media to share and exchange medical information with other physicians, and to identify the factors that influenced physicians' use of these media as a component of their continuing learning and professional development.

"Within the medical community there is persistent debate as to whether the information available through social media is trustworthy and valid, and whether physicians are ready to adopt these technologies and, ultimately, embrace them as a format for professional development and lifelong learning," the report says.

According to the study, 57.5 per cent of respondents perceived social media to be beneficial, engaging and a good way to get current, high-quality information, while almost 58 per cent thought it helped them to care for patients more effectively and 60 per cent said it improved the quality of patient care they delivered.

Interestingly, neither age nor gender had a significant affect on the adoption or use of social media.

The report concluded that the use of social media applications might be seen as an efficient, effective method for physicians to keep up-to-date and to share newly acquired medical knowledge with other physicians, as well as to improve the quality of patient care.

"The amount of information that a practising clinician must learn, understand and apply in practice is growing at unprecedented levels, and has long surpassed our cognitive capacities," it said.

"Social media, and social learning models in general, provide an important opportunity to manage this information overload, but only if the media are being used effectively."

Future studies were needed to examine the impact of the meaningful use of social media on physicians' knowledge, attitudes and skills, the report said.

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NZ doctors to help fight child abuse

The New Zealand Medical Association has commended the NZ Government's White Paper that recommends that professional groups such as doctors and teachers share information to identify and care for vulnerable children.

The *White Paper for Vulnerable Children* – just released by the NZ Minister for Social Development – puts forward a three-year Children's Action Plan that includes a proposal to train "frontline people who work with children (eg, doctors, teachers)" to recognise the signs of child abuse. The training program is planned for Year 3 of the plan - that is, by the end of 2015, at the same time as the government runs a public awareness campaign.

NZMA Chair Dr Paul Ockelford said that the association had previously expressed concern that the current child protection system was reactionary rather than preventive and that there was little inter-agency cooperation.

The changes proposed in the White Paper should ensure that fewer children were lost to the system.

A code of conduct would be developed to provide robust safeguards for information-sharing, he said.

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Fears compounding over deadly US meningitis outbreak

US health authorities have widened an investigation into a deadly meningitis outbreak linked to a drug compounding operation.

In a case that has raised concerns about the safety of the largely unregulated drug compounding industry, 15 people have died and more than 200 have fallen ill across 15 states after taking medicines prepared by the New England Compounding Center (NECC).

The Food and Drug Administration and the Centers for Disease Control and Prevention estimate that about 14,000 people in 23 states may have been exposed to fungal meningitis after being administered the steroid methylprednisolone prepared by the Massachusetts-based company.

Authorities are also investigating whether two other medications prepared by the NECC, the steroid triamcinolone and an unidentified heart medication, are the source of three more fungal meningitis cases.

The FDA has warned doctors not to use any of the NECC's products, and the company has recalled the steroid linked to the original outbreak and suspended its operations.

The incident has prompted US legislators to consider changes to strengthen federal drug safety regulations.

There is confusion about what authority the FDA has to regulate drug compounding, in which pharmacies alter or recombine approved medications to meet the specific needs of doctors and their patients.

Pharmacists have a legal exemption to prepare customised doses of medicine for individual patients, but some politicians are concerned the NECC operated far beyond this limited mandate and instead functioned like a manufacturer, preparing more than 17,000 vials of compound steroids for patients in 76 facilities across 23 states.

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Indonesia joins campaign to produce cheap generics

The Indonesian Government has over-ridden patents on seven Big Pharma-produced medicines to allow local production of cheap generic drugs to treat HIV/AIDS, sparking outrage among major drug manufacturers.

In a decree quietly issued earlier this year, Indonesian President Bambang Yudhoyono overrode patents held by companies including Merck & Co, GlaxoSmithKline and Bristol-Myers Squibb, drawing condemnation from the International Federation of Pharmaceutical Manufacturers and Associations, which has drawn attention to the move as part of a campaign to protect their access to markets in the developing world.

The Federaiton's Director of Innovation, Intellectual Property and Trade, Andrew Jenner, said that although developing countries had the right to take such action - "this should be a last resort".

"Systematic issuance of compulsory licences by Indonesia can reduce the incentive to invest in the research and development of new medicines, including HIV/AIDS and hepatitis therapies," Mr Jenner said.

"We believe that negotiated approaches, such as tiered pricing or voluntary licensing, are generally more effective and sustainable, both medically and economically."

Indonesia's action accords with World Trade Organisation rules, which allow countries to over-ride patents when they deem it necessary to protect public health. The UN estimates that about 310,000 Indonesians are living with HIV.

Indonesia is not the only battlefront in Asia pitting governments against foreign drug manufacturers.

In India, the Government is strenuously defending its position as a leading producer of cheap generic drugs for such conditions as HIV/AIDS and leukaemia in a number of court cases, while China has amended its patent law to allow companies to produce generic versions of patented drugs in state emergencies or in the public interest.

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Doctors' role in capital punishment, organ transplants: WMA rules

The World Medical Association resolved at its Annual General Assembly in Bangkok that doctors should "not facilitate the importation or prescription of drugs for execution".

It also reaffirmed its position that "it is unethical for physicians to participate in capital punishment in any way . . . including its planning and the instruction and/or training of persons to perform execution".

The WMA position, contained in the Declaration of Geneva, is that doctors should "maintain the utmost respect for human life" and should "not use their [medical] knowledge to violate human rights and civil liberties, even under threat".

The association also revised its opposition to a commercial market in organs for transplantation to make it clear that the only costs involved should be "contributions towards funeral costs given to the family of those who donated after their death".

Organs or tissue suspected to have been obtained through unlawful means must not be accepted for transplantation, its revised policy says. Transplant surgeons should refrain from transplanting organs and tissues that they "know, or should suspect, have not been procured in a legal and ethical manner".

The new WMA President, Dr Cecil Wilson of the United States, took office at the three-day assembly. Dr Margaret Mungherera of Uganda was elected unopposed as President-elect. The Medical Associations of Myanmar and Sri Lanka were admitted as members, bringing the number of national associations in the WMA to 102.

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Cigarette vending machine ban stands

A Scottish ban on the use of cigarette vending machines has been upheld after an appeals court rejected an attempt by Britain's biggest cigarette vending machine operator to block it.

The ruling ends a 17-month bid by Imperial Tobacco subsidiary Sinclair Collis to have legislation passed by Scottish Parliament in 2010 to ban cigarette vending machines from October last year ruled invalid.

Sinclair Collis operates more than 1700 of Scotland's 6500 cigarette vending machines at more than 1400 sites. According to evidence given during the course of the legal action, more than 36 million cigarettes are sold through the machines each year.

In its case, Sinclair Collis argued that the legislation breached European law guaranteeing free trade.

The laws had been as part of a drive to encourage young people to quit smoking, and advocates pointed out that the ban was necessary because age checks could not be made by vending machines, unlike sales sites for alcohol or fireworks.

The legislation also banned cigarette displays in shops. Imperial Tobacco is challenging this too, in the Supreme Court in London next month.

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Leaner times for British GPs

The British Medical Association, confronted by historic declines in the incomes of family doctors in the UK, has called on the Government to step up funding for general practice.

The latest statistics (*GP Earnings and Expenses 2010/11*, issued by the Information Centre for Health and Social Care) show that British GPs' expenses had risen 3.5 per cent over the previous 12 months while average income had fallen 1.5 per cent. The incomes of salaried GPs have also fallen, though only by about 0.9 per cent.

Dr Richard Vaufrey, chair of the BMA GPs Committee, said that GPs would not be surprised by the statistics.

"GPs are working harder than ever before and trying their best to maintain high quality services," he said. "But they are operating in an increasingly tough financial climate, in which funding is being squeezed at the same time as costs are rising.

"The Government needs to recognise the economic straitjacket that many practices are finding themselves in."

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Mt Rosa, Central Otago – Land of the long whites (and reds)

BY **DR MICHAEL RYAN**

The Kiwis are consistent. Not necessarily predictable, but it is well recognised in the wine world that if you buy a Marlborough Sauvignon Blanc, then you will get a wine that is consistent in its expression.

Pinot Noirs from Central Otago enjoy a similar reputation, though some shine brighter than the others.

Mt Rosa in the Gibbston Valley sub-region of Central Otago is one such winery. It not only punches above its weight for Pinot Noir, but dances on a different stage with world-class whites.

Initially, Mt Rosa was like a lot of Otago properties in that sheep were the priority, and it was not until an epiphany by owner Jeremy Railton (who, along with wife Jo and business partners Anne and Guy Boanas run the place) in 1997 that there was a change of tack with a foray into grape growing.

Mt Rosa was originally one of 16 runs for the massive Kawarua station, which sprawled over 83,000 hectares and carried 40,000 sheep.

Mt Rosa itself covers 2205 hectares, and while sheep farming is no longer its mainstay, a few merinos still graze the hills, along with a multitude of rabbits (according to Jeremy a ratio of about 1000 bunnies per head of sheep), plus a sprinkling of wild deer and goats.

As Jeremy puts it, the decision to go into winemaking was not particularly difficult.

"Wool prices were crap and by 2000 we decided that a vineyard was the way forward and so we began here," he said.

The first planting of vines, covering 6 hectares, began in 2000, followed by an additional 12 hectares in 2001, 9 hectares in 2002 and 8 hectares in 2003. The composition of its vineyard plantings is 23 hectares of Pinot Noir, 8.5 hectares of Pinot Gris, 1.8 hectares of Riesling, 0.5 of a hectare each of Sauvignon Blanc, Gamay and Pinot Blanc 0.5, and 1.5 hectares of Chardonnay.

Sustainability is the key to survival, and while the Mt Rosa team don't claim to be "moon gazers", they appreciate the need to look after the place where they live. It has a predominately rocky soil with limited nutrition. But the grapes seem to love this Spartan existence.

There is minimal use of liquid sprays, they ensure there is appropriate ground cover to encourage favourable insect life, and water use is carefully monitored.

While the choice to grow grapes over sheep was a financial one, the unpredictable nature of the global financial crisis certainly blurred this vision.

The Kiwis have been doing it tough since 2008. Some good and bad vintages haven't helped but they are a chipper bunch.

Jeremy says philosophically, "What can you do but plod on and get as much wine into people's glasses as you can. Then maybe they will buy a bottle not a glass at a time, thereby solving demand issues."

I certainly think that if the punters were exposed to their delicious whites, not forgetting the Pinot Noir, that that would certainly boost demand.

For a special AMA price please email Jeremy: office@mtrosa.co.nz

Wines Reviewed

Mt Rosa 2009 Central Otago Pinot Gris

White peach and rose petals abound in the bouquet. Hints of citrus and grassy notes complement this fine wine. The palate starts delicately then ramps up in the mid palate to finish with that Kiwi magic of nicely balanced acidity. I would have this with XO scallops.

Mt Rosa 2011 Central Otago Pinot Blanc

Not a common grape, but a little under-recognised in the Southern Hemisphere. It is more at home in Austria. It is light yellow in colour. The aromas of white peach and hints of ginger spice are the mainstays; but hints of smoke and sandalwood make this an alluring bouquet. I believe there is some old oak and lees exposure. The palate is full, luscious, but not sweet, and has nicely rounded acidity. Asian steamed whole fish in ginger and shallots would be perfect.

Mt Rosa 2011 Central Otago Rose

A bright, transparent garnet in colour. The nose is an intriguing mix of dark cherries and strawberries, with hints of smokey nuances. Complex peppery and brambly notes lift in the background as the wine uncoils. The palate is a delightful mix of elegant fruit sweetness, hints of pepper and a satisfying dry finish. An excellent wine with smoked salmon pasta or even a Thai beef salad, indicating its versatility.

Mt Rosa 2009 Central Otago Reserve Pinot Noir

This is where the love heats up. The nose exudes the dark fruits and complex oaky notes that carry hints of spice and star anise. The palate is generous, balanced by acidity and complex tannins making this an elegant wine of great length. An absolute terrier of a wine that will cellar for seven years. Have with braised duck.

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