

A U S T R A L I A N

# Medicine

The national news publication of the Australian Medical Association

## Tax cap reprieve

But AMA will fight on until cap is scrapped, p5



**AMA**

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### Inside

Federal election and health – all the news from week 1, pp16-21

Make food star ratings mandatory: AMA, p8

Health needs to share in cigs excise revenue, p9

Hospitals on superbug front line, p23

Worse than the 80s: organ donation rates lag, p25

Millions ignorant of chronic disease risk, p38



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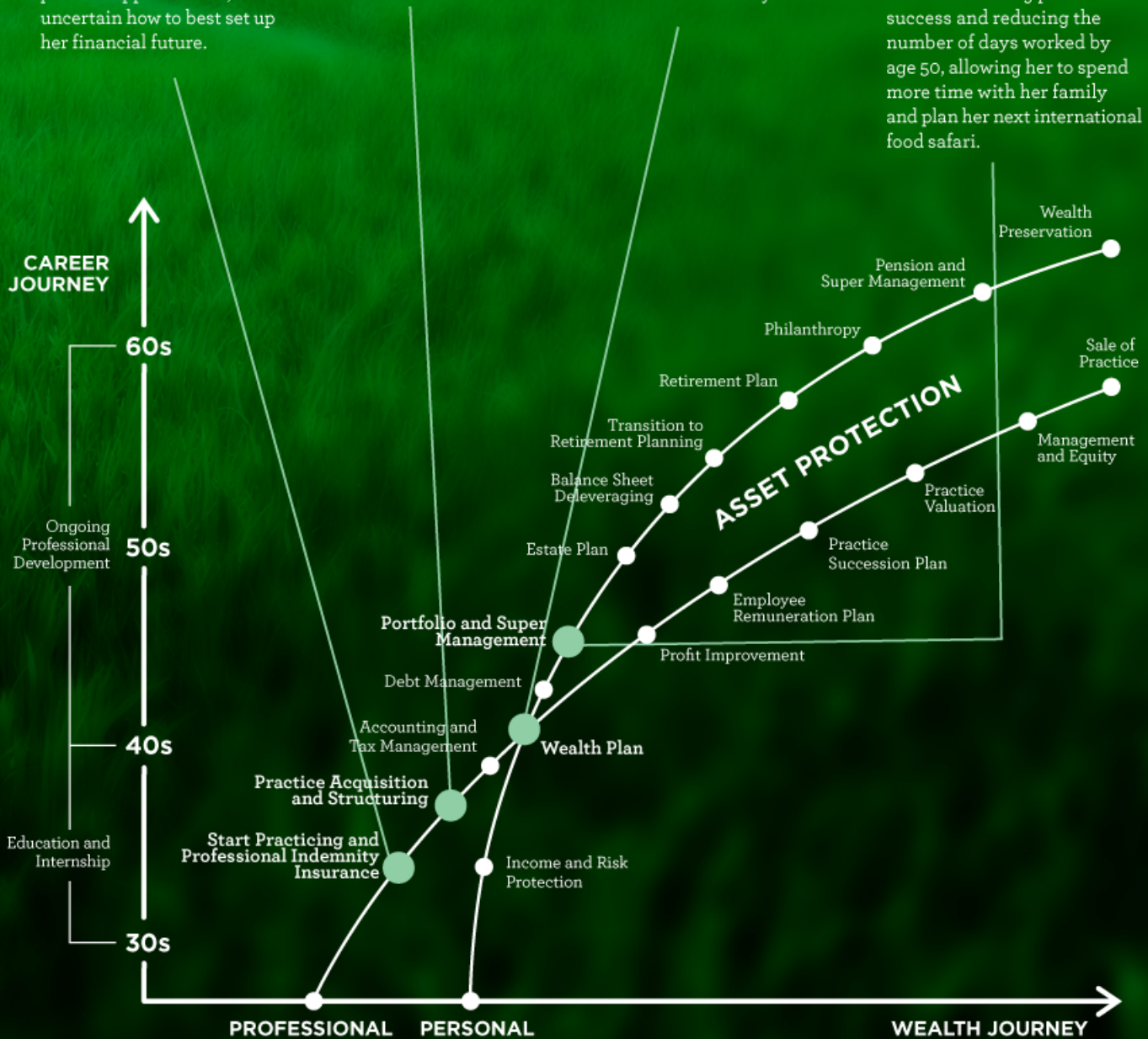
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## IN THIS ISSUE

### NEWS

5-15, 23-29, 40-41

### SPECIAL FEATURE

16 FEDERAL ELECTION

### REGULAR FEATURES

21 OPINION

30 HEALTH ON THE HILL

31 GENERAL PRACTICE

32 AMSA

33 RURAL HEALTH

34 THERAPEUTICS

35 PUBLIC HEALTH & CHILD  
AND YOUTH HEALTH

36 MEMBERS' FORUM

38 RESEARCH

42 BOOK REVIEW

43 WINE

44 MEMBER SERVICES

# Tax cap fight not over despite deferral



AMA President Dr Steve Hambleton has vowed to continue the fight to get the \$2000 cap on tax deductions for work-related self-education expenses scrapped despite the Federal Government's decision to defer the tax change until mid-2015.

Dr Hambleton said the Government was "wise" to delay the introduction of the cap by a year, adding that the opportunity for more comprehensive consultation would show the change was "dumb policy" that needed to be dumped.

The Government announced the deferral just two days before calling the Federal election as part of efforts to clear the political decks ahead of what is shaping as a fiercely contested ballot.

Opinion polls indicate that the Coalition is likely to win the 7 September election, but the gap in voter support between the major parties has narrowed sharply since Kevin Rudd was re-elected as Labor leader last month.

The Coalition is expected to snare the two seats being vacated by retiring independents Tony Windsor and Rob Oakeshott, and is tipped to poll strongly in New South Wales, where Labor's image

has been badly damaged by the recent ICAC investigation that recommended corruption charges be laid against former senior Labor figures Eddie Obeid and Ian Macdonald, as well as a separate Victoria Police investigation that resulted in fraud and theft charges being laid against former Labor MP Craig Thomson, who holds the central NSW coast seat of Dobell.

The Government's decision to defer the introduction of the tax cap came as opposition to the deeply unpopular measure continued to mount.

The AMA is a founding member of the Scrap the Cap Alliance, which has swelled to encompass more than 70 professional, educational and business organisations representing in excess of 1.6 million professionals.

Advisers from Treasurer Chris Bowen's office attended a meeting of the Alliance held at the AMA's offices in Canberra late last month (see *Treasurer gets the message: tax cap all con, no pro*, p7), where they were informed of the depth of anger felt by doctors and other professionals at what was seen as a poorly-conceived, unfair and counter-productive policy.

Just three days after the meeting, Mr

Bowen announced the tax cap would be deferred until 1 July 2015, slicing \$250 million from the revenue the Government expected to gain from the measure.

Dr Hambleton said the Treasurer's decision was "a big win for common sense ahead of the election".

"The education expenses cap was a bad policy in April this year and it will still be a bad policy in July 2015 – but we now have more time to convince the next Government to scrap the cap," he said.

The AMA President said the cap was a tax on learning and would be a major disincentive for doctors to undertake the additional education and training required to stay at the forefront of developments in medicine.

"Quality medical education is expensive, and the \$2000 cap defied the reality faced by doctors wanting to improve and broaden their skills," he said.

Dr Hambleton told the Treasurer's advisers that the AMA accepted and supported tax changes to crack down on self-education expense claims that were not in line with community expectations.

But he warned the policy as currently framed would have far-reaching consequences for the nation's health and economy that vastly outweighed any benefit from clawing back unjustified expense claims.

In a statement that picked up on Dr Hambleton's comments, Mr Bowen said the deferral would "allow for further consultation on how best to target excessive claims, while ensuring the impact on university enrolments and genuine continuing professional development is minimised".

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)

# Treasurer gets the message: tax cap all con, no pro

Representatives from more than 30 organisations that are part of the 75-member Scrap the Cap Alliance have met with officials from Treasurer Chris Bowen's office to underline the depth of opposition to the \$2000 cap on tax deductions for work-related self-education expenses across a broad swathe of the community.

The meeting, held at the AMA's national headquarters in Canberra, brought together representatives from the medical professions, engineers, accountants, small business, the tertiary education sector and the hospitality industry, who provided detailed accounts of how the cap would hurt their members, undermine the quality of vital services and damage the economy.

## Destructive and far-reaching effects

AMA President Dr Steve Hambleton told the Treasurer's advisers that the Government was yet to grasp the enormous follow-on effects the tax change would inflict on the country, and which were the focus of enormous anger among doctors.

He warned that doctors spent, on average, more than \$12,000 a year on self-education, meeting mandatory continuous professional development requirements, acquiring new skills and learning of new treatments.

Dr Hambleton said the \$2000 cap was a huge disincentive for doctors and other health professionals to undertake such activities, which underpinned the quality of the health system.

He told the Treasurer's representatives that no other issue in the history of the AMA had drawn such a response from members – including the medical indemnity crisis early last decade.

"This is the issue with the single greatest impact on members that the AMA has ever had experience of," Dr Hambleton told the meeting. "We have had more contacts [from members] over this issue than even the indemnity crisis."

He said there had been more than 50,000 views on the website related to the tax cap, and more than 10,000 members had taken part in AMA polls and surveys.

Economic modelling prepared by Universities Australia suggests the cap will have a devastating effect on post-graduate education, with a third of students indicating that they would be forced to ditch further learning in the face of an effective increase of between 30 and 54 per cent in the cost of post-graduate study.

The peak university body predicted this would cost the economy \$2.8 billion a year in reduced skills and productivity.

## Rural communities to be hit hardest

Groups including the Country Women's Association have joined the Scrap the Cap campaign amid warnings the measure could be particularly damaging for rural communities.

Doctors, dentists, nurses, engineers, veterinarians and accountants working in rural and remote areas face among the highest self-education costs because of their need to travel to receive necessary training, and groups warned of the danger that the cap would make it harder to attract and retain professionals providing vital services, and undermine the scope of services they would be able to provide.

"The tax change is also expected to undermine the nation's ability to bid for and host major international conventions, conferences and other events"

Australian College of Rural and Remote Medicine President Professor Richard Murray said the tax cap "cuts right across" policies and programs intended to support and boost the rural health workforce, and warned rural communities would pay for the measure with their health.

"A lack of skills in rural communities kills," Professor Murray said.

## Cap hurts not just professions

The tax change is also expected to undermine the nation's ability to bid for and host major international conventions, conferences and other events.

Association of Australian Convention Bureaux Chief Executive Officer Robyn Hendry told the meeting that Australia's position as one of the top 20 destinations in the world for conventions and conferences would be put in jeopardy by the cap because it would make it very hard to guarantee the strong domestic attendances vital to getting the organisers of international events to choose Australia.

Ms Hendry said it also threatened to rob many towns of the economic boost they got from hosting conferences and conventions.

...CONTINUED ON PAGE 7

# Treasurer gets the message: tax cap all con, no pro

...CONTINUED FROM PAGE 6

## Threat to productivity, prosperity

Dr Hambleton said the Government's own Asian Century White Paper highlighted the importance of education and training to future national prosperity.

In Chapter 5.2, the White Paper said "education and training are crucial to Australia's future productivity. The greater the skill level of each worker, the higher the potential productivity of the workforce – a highly educated and skilled workforce supports innovation, the spread of technological advances and the accumulation of physical capital".

Engineers Australia Director of Policy Brent Jackson said the tax cap undermined the white paper's policy goal of making Australia a high-skilled, high wage economy.

Mr Jackson said the tax change would discourage people from becoming or remaining engineers, increasing the nation's already heavy reliance on engineers from overseas to fill gaps in the workforce.

Representatives from the Australian Chamber of Commerce and Industry, the Tax Institute and the Institute of Chartered Accountants pointed out that the policy discriminated against professional education, leaving claims for work-related expenses such as tools and equipment untouched.

The groups said there was already ample provision in existing tax laws for measures to crack down on extravagant expenses claims, and condemned the cap as a very blunt instrument.

Dr Hambleton said the Government needed to re-think its policy.

"The Government must heed its own messages about the importance of education and training and dump this policy before the election – or pay the political consequences," Dr Hambleton said. "There are votes to be won and lost on this issue."

**Adrian Rollins**

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# Food star ratings should be mandatory: AMA



The AMA has called for food star ratings to be made compulsory after industry backflipped on agreements for their voluntary introduction.

In a stunning about-face, the Australian Food and Grocery Council has reneged on its support for the system, which has been hailed as an important weapon in tackling the nation's ballooning waistline.

The Council has complained that flaws in the rating system mean it is not an accurate guide to the healthiness of food, and would be expensive to implement.

But the AMA has accused the Council, which has been involved in the system's development for much of the past two years, of trying to sabotage efforts to bring rates of obesity down.

"It is irresponsible for the food industry to walk away from the new system at this late stage," Dr Hambleton said.

"The AFGC has been heavily involved in discussions with governments and public health advocates for more than

18 months, and has had plenty of opportunities to voice any concerns they may have had."

Australian and New Zealand food ministers unveiled the star rating system in June following widespread consultations with governments, business and health groups.

Under the system, packaged food will be assigned a rating of between half a star and five stars, which will be displayed on the front of the packet.

The star rating is based on a nutrient profiling system developed by Food Standards Australia New Zealand, and will be accompanied by a panel displaying details of the food's energy content, as well as how much saturated fat, sugar, sodium and one other positive nutrient (such as calcium or fibre) it contains.

The ministers initially gave industry two years to voluntarily comply with the new labelling code, but Dr Hambleton said the

Council's rejection meant governments had no choice but to make the system mandatory.

"The recalcitrant food industry is clearly putting profits ahead of public health by undermining a voluntary system it helped to put in place," the AMA President said. "Governments must now bring the industry into line by making the system mandatory."

AFGC Chief Executive Gary Dawson told *The Australian Financial Review* the threat to make the system mandatory was very disappointing.

Mr Dawson said initial tests of Food Standards Australia New Zealand's nutrient profiling system had thrown up significant anomalies, such as crinkle cut potato chips getting two stars, while far healthier dry roasted unsalted cashews get just two-and-a-half stars.

In addition, he said, repackaging products to include the stars would cost the industry as much as \$200 million.

But public health expert Michael Moore, who helped design the profiling system, told the AFR such anomalies had affected just 5 per cent of the 3000 products so far tested, and could be easily rectified.

Dr Hambleton said the star rating system was an important way of helping consumers make informed choices about the food they were buying and eating.

"Consumers must be empowered to identify and choose healthy food, and research shows that the health star rating system is an easier and more effective way to improve consumer choices," he said.

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)



# Health needs to share in tobacco excise revenue



AMA President Dr Steve Hambleton has called on the Federal Government to ensure that “a significant proportion” of the funds raised by a hike in the tobacco excise are invested in health care.

Dr Hambleton said Australia’s reputation as a global leader in the fight against smoking had been enhanced by the excise increase, but the Government needed to use some of the extra revenue to help relieve funding pressure in the health system.

Treasurer Chris Bowen announced on 1 August that the tobacco excise would be increased 12.5 per cent over the next four years, adding an extra \$5.25 to the cost of a packet of 20 cigarettes by the end of 2016 and netting the Commonwealth an additional \$5.3 billion of revenue.

The rise follows a 25 per cent increase in 2010.

Mr Bowen said that lifting the excise was “the single most effective way” for the Government to reduce the premature death and disease caused by smoking.

“The increase in the excise serves several purposes – it will provide funds for cancer and stroke-related health services, it will deter young people from taking up smoking, and it will help return the Budget to surplus,” the Treasurer said.

The Government has jacked up the excise to help plug a huge hole in Commonwealth revenues, with Treasury estimates the shortfall could reach more than \$20 billion over the next four years.

The tobacco industry has attacked the increase, claiming it will simply increase demand for illicit tobacco as smokers seek cheaper supplies.

But Dr Hambleton said evidence showed that raising the cost of cigarettes and other tobacco products helped convince existing smokers to give up the habit and discourage others, particularly young people, from ever starting.

Tobacco consumption tumbled 11 per cent following the 2010 excise hike, according to the Heart Foundation, and Cancer Council Australia estimates the latest increase will prompt around 210,000 smokers to quit and deter 40,000 teenagers from taking up the habit.

Higher prices are seen as contributing to the steady and sustained fall in rates of smoking in recent decades, from 34 per cent of adults in 1980 to 17 per cent in 2010.

Other factors encouraging people to quit or not take up the habit include stringent controls on the promotion and sale of tobacco products, bans on smoking in workplaces and many public areas, and increased awareness of the harmful effects of smoking.

Adding to the pressure on the tobacco industry, Australia last year became the first country in the world to introduce plain packaging laws for tobacco products after successfully fighting off a High Court challenge mounted by the major cigarette companies.

Dr Hambleton said the excise increase would confirm Australia’s position at the forefront of global efforts to curb smoking.

“Plain tobacco plain packaging legislation made Australia the world leader in the war against smoking,” the AMA President said. “The move to make tobacco products more expensive – which is a proven disincentive – will enhance that reputation.”

Dr Hambleton urged the Government to direct a significant share of the funds raised by the excise to health, especially given the heavy burden of disease created by smoking.

Mr Bowen said 750,000 hospital bed days each year were attributed to tobacco-related diseases, and smoking was estimated to annually cost the country more than \$31 billion.

“Tobacco is the only legal drug that kills half its users when used as the manufacturer intended,” he said. “Thirty per cent of all cancers can be linked to tobacco. Smoking leads to respiratory diseases, cardiovascular diseases, stroke, emphysema, bronchitis, asthma, renal disease and eye disease.”

The World Health Organisation estimates tobacco causes the death of almost six million people a year.

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)

# Abortion law must respect dictates of conscience

The AMA has called on the Tasmanian Government to axe proposed laws that would compel doctors who conscientiously object to performing an abortion to refer their patient to a doctor willing to terminate the pregnancy.

While applauding provisions in the *Reproductive Health (Access to Terminations) Bill 2013* that remove the threat of criminal sanctions for women and medical practitioners regarding abortions, AMA President Dr Steve Hambleton has voiced concerns that the Bill would also coerce some doctors to act against the dictates of their conscience.

The Private Member's Bill, introduced by Tasmanian Health Minister Michelle O'Byrne, seeks to remove the provision of abortions from the criminal code and make it easier for women to obtain a termination of their pregnancy.

In a letter to the Chair of a Parliamentary inquiry into the Bill, Paul Harriss, Dr Hambleton said the AMA respected the right of medical practitioners to hold differing views regarding the termination of pregnancies.

He said that both the AMA's Code of Ethics and Medical Board of Australia guidelines affirmed the right of practitioners not to provide treatment that contradicted their moral judgement or

religious beliefs.

"Neither document requires the medical practitioner to assist the patient access the treatment elsewhere," Dr Hambleton said.

He said this principle was expressly contravened by subclause 7(2) of the Bill, which requires a doctor with a conscientious objection to terminations to still refer a woman to another medical practitioner who does not hold such objections. Under the proposed law, failure to do so would constitute a criminal offence.

"As such, subclause 7(2) removes the rights of medical practitioners to conscientiously object to particular treatments without having to facilitate the patient's access to the treatment," the AMA President said.

"Respect for a conscientious objection is a fundamental principle in our democratic country, and medical practitioners expect that their rights in this regard will be respected, as for any other citizen.

"Accordingly, subclause 7(2) should be removed from the Bill," he said.

**Adrian Rollins**

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

[TO COMMENT CLICK HERE](#)

# Track scripts to prevent drug deaths: AMA



The AMA has called for nationwide opioid prescription tracking system amid reports of a spate of deaths involving the painkiller Fentanyl.

AMA President Dr Steve Hambleton said a Tasmanian system that tracks patients who see multiple doctors to obtain prescriptions for opioid medication should be adopted nationally to prevent drug abuse and save lives.

Dr Hambleton made his call in a report by ABC's *Lateline* program detailing a string of deaths in western New South Wales attributed to abuse of the prescription painkiller Fentanyl.

According to the report, at least three people have died in the past three months after overdosing on the drug, which is a powerful synthetic opioid – usually prescribed as a patch – used to treat chronic pain.

Fentanyl is much stronger than morphine and oxycontin, and *Lateline* said those using it to obtain a high were boiling the patches and using household chemicals to extract opiates in a concentrated form that was then injected into a vein for an intense hit.

A former user interviewed by the ABC said addicts and their accomplices would visit multiple doctors, claiming back pain or other chronic pain ailments, in order to obtain Fentanyl prescriptions.

Dr Hambleton said a nationwide prescription tracking system like Tasmania's would make it much easier for doctors and pharmacists to identify people who were doctor shopping.

"This is the system we have been asking for, for some time, because we do need to help make our prescribers make the right decision," he told *Lateline*.

"If someone before them that they don't know is asking for this product, then we are suspicious that this is not legitimate.

"If we had a system where we could check that, it would make it a lot easier for the doctors and the pharmacists.

"Tasmania does have it. We need to see that rolled out right across the country."

Australia has adopted a system under which those who buy products containing pseudoephedrine-based substances from a pharmacy are supposed to provide identification, which is then entered into a national database, but this has not yet been extended to other medications.

And the widely disliked authority prescription system is not seen as an effective tool to prevent doctor shopping.

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)

# 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

### **Coalition to scrap the cap, hints Pyne, *Australian Financial Review*, 26 July 2013**

AMA President Dr Steve Hambleton welcomed a call by Shadow Education Minister Christopher Pyne for the cap on tax deductions for self-education expenses to be scrapped.

### **The State of health, *Hobart Mercury*, 26 July 2013**

Dr Hambleton was joined by AMA Tasmania President Dr John Davis, Health Minister Michelle O'Byrne, Opposition Leader Will Hodgman and Greens senator Richard Di Natale at the Tasmanian Health Conference.

### **Overexposure is making teens pawns to porn, *Sun Herald*, 28 July 2013**

The AMA said there is a strong relationship between exposure to sexually explicit material and sexual behaviour that predisposes a person to adverse sexual and mental health outcomes.

### **Sky-high specialists, *Sunday Territorian*, 28 July 2013**

Patients are being financially stricken by specialists who charge up to 475 per cent more than their peers. Dr Hambleton said patients should not get surprisingly big bills anymore.

### **Staffing crunch at new RAH, *Adelaide Advertiser*, 29 July 2013**

Doctors and nurses had their say on the new Royal Adelaide Hospital. State Parliament's Budget and Finance Committee invited the Australian Medical Association to give evidence at a hearing.

### **Greens promise \$85m to help farmers sell straight to locals, *Australian Financial Review*, 29 July 2013**

The Australian Greens have made \$600 million election pledge to reverse the Federal Government's decision to freeze indexation of Medicare rebates until mid-2014. The AMA called on the Government and the Opposition to match the promise.

### **Outrage on food ratings, *Adelaide Advertiser*, 30 July 2013**

The AMA condemned a move by the Food and Grocery Council reneging on its commitment to accept a five star food rating

system. Dr Hambleton said the industry was putting profits ahead of public health.

### **Jobe not in any danger, says dad, *The Age*, 30 July 2013**

Essendon great Tim Watson said he was satisfied his son Jobe would not suffer any harmful side effects from using AOD-9604. Dr Hambleton said he had no knowledge of the drug being used by doctors in any Australian hospital.

### **Get married, get a job and live longer, *Adelaide Advertiser*, 1 August 2013**

To protect their health, men need to get married and keep a job, demographic figures show. Dr Hambleton said partnering was beneficial for health because there were two people thinking about a person's health, not one.

### **Medicine price plunge, *Hobart Mercury*, 1 August 2013**

Dr Hambleton welcomed substantial price cuts in a range of prescription medicines but said the 18 month delay in feeding the changes through to consumers was too slow.

### **Tax breaks stay for year, *Australian Financial Review*, 3 August 2013**

The Federal Government deferred its plan to impose a \$2000 cap on work-related self-education expenses. Dr Hambleton welcomed the decision and promised doctors would continue to fight the change.

### **Man flu not fatal, *Adelaide Advertiser*, 3 August 2013**

AMA Council of General Practice Chair Dr Brian Morton said there was simply no scientific evidence to prove man flu exists.

### **Definition of cancer may be narrowed, *Australian Financial Review*, 3 August 2013**

Australian health experts have questioned whether the definition of cancer should be narrowed to prevent patients from suffering unnecessary emotional distress. Dr Hambleton said the power of the word cancer often made calm discussion of treatment options difficult.

...CONTINUED ON PAGE 13

# AMA IN THE NEWS

...CONTINUED FROM PAGE 12

## Digger cancer claim, *Weekend West*, 3 August 2013

A device used by Australian Soldiers in Afghanistan to jam the detonation of roadside bombs has been linked to a cluster of cancers among returning Diggers. Dr Hambleton revealed he was aware of four cases where the bomb-jamming device had been linked to cancer in returned soldiers.

## Greens back calls to establish health panel to monitor asylum seekers overseas, *The Age*, 6 August 2013

The Greens have backed calls from the AMA to establish an independent medical panel to monitor asylum seeker health in offshore detention centres.

## Forces deserve inquiry into cancer fears, *West Australian*, 6 August 2013

Serious concerns were raised about Diggers' use of a device to jam the detonation of roadside bombs. The AMA said the device worked on the microwave band, which should not be able to cause the kind of tissue heating that damaged DNA.

## A nation of sick people, *The Daily Telegraph*, 6 August 2013

Many Australians have heart disease and diabetes but do not know it. Dr Hambleton said every adult in Australia should know their cholesterol level and everyone should be assessed at the age of 45 and earlier if there is a family history of cholesterol-related health issues.

## Radio

### Dr Steve Hambleton, 936 ABC Hobart, 28 July 2013

The AMA joined the Greens to call for a return of \$660 million for Medicare. AMA President Dr Steve Hambleton said restoring the funds would save the Government money in the long run.

### Dr Steve Hambleton, 4BC Brisbane, 29 July 2013

Dr Hambleton discussed the growing trend of people shopping around for specialists. Dr Hambleton said people should be looking at whether health funds and Medicare rebates are matching what specialists need to charge for quality service.

### Dr Steve Hambleton, 3AW Melbourne, 31 July 2013

Dr Hambleton discussed the responsibilities of GPs when prescribing medication to people under the age of 18.

### Professor Geoffrey Dobb, SBS Ethnic Radio Melbourne, 30 July 2013

A growing number of Australians are choosing to go overseas for medical procedures in a trend known as medical tourism. AMA Vice President Professor Geoffrey Dobb said Australians should avoid undergoing medical procedures overseas.

### Dr Steve Hambleton, 2UE Sydney, 31 July 2013

Dr Hambleton discussed Australia's system for subsidising medication. Dr Hambleton said a lot of doctors and scientists look at trials and assess the benefits versus the risks of various treatments.

### Dr Steve Hambleton, ABC Newcastle, 6 August 2013

Dr Hambleton discussed the deferral of the \$2000 cap on tax deduction for self-education. He claimed the deferral was a big win for common sense.

### Dr Steve Hambleton, 891 ABC Adelaide, 6 August July 2013

Dr Hambleton discussed the rising cost of GP visits. He said the Government was pushing costs back onto patients, decreasing access to quality health services.

## TV

### Dr Steve Hambleton, Southern Cross Tasmania, 27 July 2013

The Greens want \$600 million pumped back into Medicare as cuts are pushing up costs. The AMA supports the Greens proposal.

### Dr Steve Hambleton, Win Hobart, 27 July 2013

AMA President Dr Steve Hambleton joined Tasmanian health professionals at the AMA Health Conference in Hobart.

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# AMA in action

AMA President Dr Steve Hambleton has had a busy fortnight. Dr Hambleton attended the Scrap the Cap Alliance meeting held at AMA House in Canberra on 30 July, which was also attended by advisers to Treasurer Chris Bowen. Dr Hambleton and representatives from more than 30 other organisations representing doctors, nurses, engineers, architects, universities, the hospitality industry and small business used the opportunity to drive home widespread anger and dismay about the proposed \$2000 cap on tax deductions for self-education expenses and the damaging effects it would have on professional education, service quality and national productivity and prosperity. Within three days of the meeting, the Federal Government

decided to defer the cap until 2015.

Dr Hambleton and Federal Councillor Dr Beverly Rowbotham met with Director Dr Heather Buchan and Project Manager Luke Slawomirski from the Australian Commission on Safety and Quality in Health Care, at which they discussed Australia's participation in the OECD Medical Practice Variation Study and Australian data on variations in knee replacement, knee arthroscopy, hip fracture, revascularisation procedures, cardiac catheterisation, caesarian sections and hysterectomy procedures.

Later, Dr Hambleton travelled to Queensland where he met Greens Senator Larissa Waters to talk about AMA's view on the burgeoning coal seam gas extraction industry.

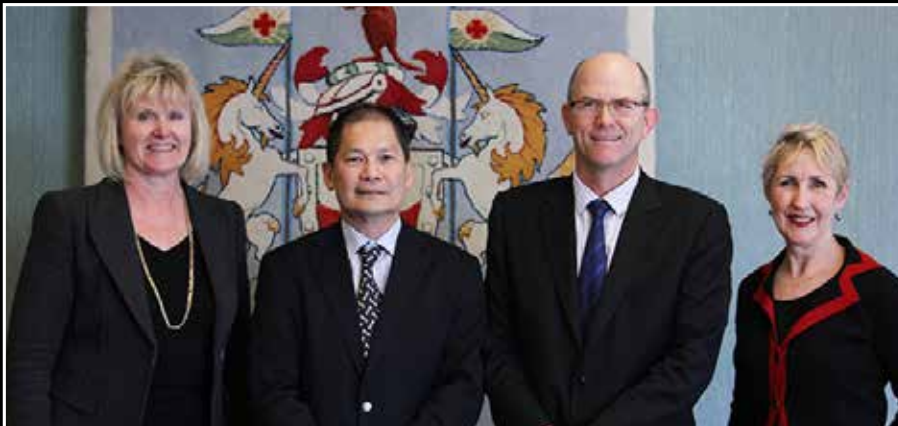
Dr Hambleton also visited Tasmania,

where he spoke at an AMA Tasmania's Health Conference. He went on to visit Adelaide, where he met with AMA South Australian President Dr Patricia Montanaro at East Adelaide Healthcare.

On 31 July Dr Hambleton held a meeting with Opposition Leader Tony Abbott and Shadow Minister for Health and Ageing Peter Dutton to talk about the tax cap on self-education expenses, as well as several other issues important to AMA members.

After the election was called, the AMA sent out the one cap it does not want scrapped. To spread the message that health should be a central issue in the Federal election, the AMA has given federal politicians and Parliamentary Press Gallery journalists AMA caps emblazoned with the slogan 'Vote 1 health'.

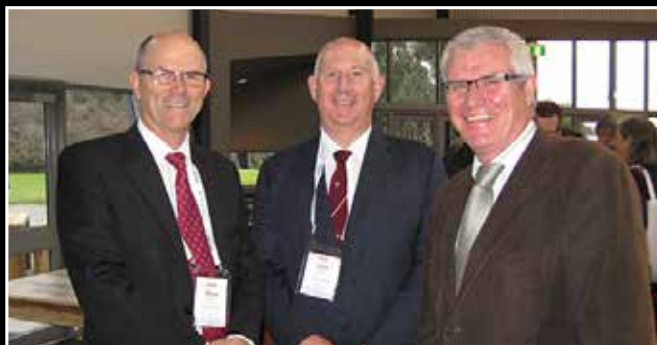
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Dr Hambleton with Dr Heather Buchan (r), and Luke Slawomirski from the Australian Commission on Safety and Quality in Health Care and Federal Councillor Dr Beverly Rowbotham



Dr Hambleton at the Scrap the Cap Alliance meeting in Canberra



Dr Hambleton with AMA Tasmania President Dr John Davis and Graham Lynch CEO of the Heart Foundation



Dr Hambleton (L) with and AMA South Australian President Dr Patricia Montanaro and guest



The Scrap the Cap Alliance



AMA President Dr Steve Hambleton with Opposition Leader Tony Abbott



Dr Hambleton with Shadow Minister for Health and Ageing Peter Dutton



Dr Hambleton with Greens Senator Larissa Waters



This is one cap that the AMA definitely does not want scrapped



## Australian Federal Election

# 2013

# Federal Election 2013 – The Final Countdown

The first week of the 2013 Federal Election campaign has been as fiery and lively – and as full of surprises – as anybody would have expected.

The campaign slogan battle is between 'A New Way' (ALP) versus 'Choose Real Change' (Coalition). Both three-word slogans, but neither as good as Clint Eastwood's 'Make My Day'. Music aficionados would much rather prefer 'Love My Way' (The Psychedelic Furs) or 'Something Better Change' ('The Stranglers').

The Coalition, however, has a couple of back-up slogans – 'A Stronger Australia' and 'A Better Future'. Personally, I would have gone with 'The Final Countdown' (Europe).

Back to the campaign, and there has been punch and counterpunch on the state of the economy, interest rates, the carbon tax (aka the ETS), costing of election promises, the NBN, support of the car industry, reductions in company tax, unemployment, asylum seekers, the GST, the NDIS, and the Better Schools program

More interesting has been the resurrection of Peter Beattie to contest Forde (Qld); the candid photo of Deputy Prime Minister Anthony Albanese having a beer with disgraced MP Craig

Thomson in a Sydney bar; gaffes by candidates (both experienced and inexperienced, with a One Nation candidate claiming Islam is a country); the PM and the Opposition Leader wearing caps and funny hats, launching new candidates, promising new promises, kissing babies and, in an interesting new trend, kissing hair (Tony Abbott's lips missed the baby and locked on the mother's locks in one celebrated incident).

One big gap in the policy battlefield so far is health policy, with The Greens the only players with a rebadged AMA policy for an independent health panel for asylum seekers in offshore detention. All credit to them for recognising and promoting good AMA policy.

There are still four-and-a-bit weeks to go, so we remain confident that Tanya Plibersek and Peter Dutton will share the spotlight soon with their leaders to say something serious to shake up the health policy battle in this election.

We want health policy, and we want it now.

Stay tuned.

**John Flannery**

[TO COMMENT CLICK HERE](#)

## Health budget hit in latest update

The Federal Government expects to save almost \$390 million from cheaper medicines, but has been hit by a surprise \$180 million slug for private health insurance subsidies, according to a pre-election reckoning of its Budget position.

The Commonwealth's Economic Statement, released just two days before the Federal election was called, showed there has been a massive \$33 billion write-down in anticipated revenues since the May Budget, pushing Government finances deeper into the red and forcing a desperate scramble for savings.

Treasurer Chris Bowen said the Rudd Government had been compelled to make "responsible" savings worth \$17.4 billion over the next four financial years in order to help ensure the Budget returns to a narrow surplus of \$4 billion in 2016-17, after an unexpected blow-out in the deficit to more than \$30 billion this financial year.

Health is among many areas of expenditure that have been hit hard as the Government has tightened the financial screws.

In addition to massive cutbacks outlined in the May Budget,

including freezing Medicare rebates until mid-2014 for a saving of \$664 million, a virtual doubling of the Medicare Extended General safety net threshold to \$2000 and a wind-down in the tax offset for medical expenses, the Government has revealed it expects to save an extra \$388 million this financial year, and \$2 billion over the next four years, by extracting better pricing deals from drug companies having their products listed on the Pharmaceutical Benefits Scheme.

But this saving will be largely offset by increased expenses in other areas, including an extra \$276 million this financial year, and \$1.5 billion over four years, for new and amended listings on the PBS and the Repatriation Pharmaceutical Benefits Scheme.

In a result that has given a lie to warnings there would be an exodus from private health insurance when means testing for the rebate was introduced, the Government has had to make provision for an additional \$184 million in private health insurance rebate payments in 2013-14 – an additional \$769 million over four years – because of unexpectedly high take-up rates.

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)





# Greens put Medicare, asylum seekers at centre of health pitch

The AMA has urged the major parties to match commitments by the Australian Greens to restore Medicare Benefits Schedule indexation, boost health funding and establish an independent panel to monitor the health of asylum seekers.

In a move to make out-of-pocket medical expenses an election issue, the Greens have promised to reverse the Federal Government's \$664 million decision to delay indexation of MBS rebates until mid-2014 – winning praise from the AMA.

AMA President Dr Steve Hambleton said that, through the commitment, the Greens had shown “health policy leadership”.

In the May Budget, the Government announced it would freeze Medicare rebates until mid-2014 for a saving of \$664 million, virtually double the Medicare Extended General safety net threshold to \$2000 to save \$105 million and phase out the tax offset for medical expenses for a saving of almost \$964 million.

The AMA condemned the measures at the time as a massive \$1.8 million hit to health that would shift an increasing share of the funding burden onto patients.

In its pitch to voters, the Greens said Australia should not go down the same health policy path as the United States, “where how much money you have decides how well you get looked after”.

“The Greens understand that out-of-pocket costs in health care are rising, and that people are finding it increasingly difficult to afford to see a doctors,” Greens health spokesman Senator Richard Di Natale said. “The Greens are committed to universal health care and believe your health shouldn't be determined by your bank balance.”

In addition to indexing Medicare rebates,

the Greens have promised to reverse funding cuts to public hospitals – though they have not specified how much money this would involve.

Dr Hambleton said the minor party's Medicare rebate commitment was an important step in preserving the affordability of health care, and should be matched by Labor and the Coalition.

“The MBS freeze and other Budget measures shifted the health cost burden to patients,” he said.

“As a result, families are paying higher out-of-pocket costs for their health care, which will ultimately make it more difficult to access medical services when they need them.

“The Greens' announcement demonstrates a clear understanding of the negative impacts of the Government's Budget health decisions, and displays great empathy with the health needs of Australian families,” Dr Hambleton said.

The AMA also praised a promise by the Greens to establish an independent medical panel to monitor the health of asylum seekers held in detention.

Picking up on a long-standing call by the AMA for independent medical oversight of the health of immigration centre detainees, the Greens have unveiled a policy for the establishment of an Independent Health Advisory Panel comprising medical and mental health experts.

Under the Greens proposal, which mirrors that of the AMA, the Panel would be invested with authority to inspect offshore immigration detention centres and personnel, and report to Parliament twice a year.

Echoing concerns raised by the AMA for the past two years, the Greens said indefinite

detention was “disastrous” for the mental health and well being of asylum seekers, many of whom were already traumatised.

“Long-term detention of vulnerable people will lead to an epidemic of mental health disease resulting in suicides, self-harm, long-term depression and anxiety-related disorders,” Senator Di Natale said.

The Greens announcement followed the release of the AMA's Federal election issues document in which it called for the appointment of a independent medical panel to oversee asylum seeker health care.

In his speech to the National Press Club on 17 July, the AMA President said that “once we take responsibility for people seeking asylum in Australia, they should have access to an appropriate level of health care, whatever the detention arrangements or location in which they are placed”.

Dr Hambleton said asylum seekers usually had multiple health problems that required complex treatments, and detention raised the risk of exacerbating already serious and chronic conditions.

He said the Greens' policy was “very welcome”, but urged that the remit of the proposed Independent Health Advisory Panel be extended to include onshore as well as offshore detention centres.

“The prospect of long-term detention – both onshore and offshore – poses a great risk to the mental health of detainees,” the AMA President said. “We would like to see the Greens extend their policy to include the monitoring of the health care of asylum seekers in onshore detention facilities.

“And we urge the major parties to support this initiative. It is the right thing to do.”

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)



2013



Australian **Federal Election**

# Damaging drinking Labor's first policy target



The Federal Government has promised to boost efforts to prevent, diagnose and manage foetal alcohol spectrum disorder (FASD) if re-elected on 7 September.

In its first health policy announcement of the Federal election campaign, the Labor Party has committed to providing \$20 million to combat the disorder, which was described in a recent parliamentary committee report as "the largest cause of non-genetic, at-birth brain damage in Australia".

Minister for Mental Health Jacinta Collins said the money would be used to help prevent alcohol abuse by pregnant women, and improve the understanding and detection of the disorder.

"FASD is an entirely preventable condition, and we need to take strong action on this

critical issue," Senator Collins said. "Our action plan will continue efforts to improve the diagnosis of FASD, which will help support those affected."

The disorder can result in learning difficulties, a reduced capacity to remember tasks from day to day, anger management and behavioural issues, impaired speech and muscle coordination, and physical abnormalities in the heart, lung and other organs, and the effects can range from mild impairment to serious disability.

A House of Representative Committee inquiry into the condition said that, although there was little known about the extent of the problem, it was likely to be becoming more common.

"The causes, effects and the prevalence

of FASD are largely unknown or hidden in Australia," the Committee said. "It is a totally preventable condition which has no place in a modern developed world, and yet in Australia over 60 per cent of women continue consume alcohol when pregnant. It is expected that FASD is becoming more prevalent."

The Foundation for Alcohol Education and Research warned the nation was at a "critical juncture" in tackling the condition, and has devised a plan for national action.

"For too long there has been a lack of coordinated action to prevent FASD and assist people affected," the Foundation said.

Labor has identified five priorities: prevention of FASD, targeting health campaigns at women with alcohol dependency, improved diagnosis and management of FASD, targeted preventive and management action in Indigenous communities and areas of social disadvantage, and national coordination of research and workforce support.

Labor's plan falls well short of the action urged by the Foundation, which has set out a detailed strategy encompassing comprehensive community education and awareness campaigns, support for those with FASD and improved data collection and research, with a total bill of more than \$36 million.

The Foundation's plan was commended by the Parliamentary committee.

**Adrian Rollins**

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**ON THE TRAIL ...**

# Lots of smoke when tobacco is involved

It took just two days into the election campaign for the issue of who takes money from Big Tobacco to come to the fore.

Ever since the Labor Party formally decided to knock back donations from tobacco companies, it has taken to goading the Coalition during every election campaign about its reluctance to follow suit.

This election the issue has carried an extra tinge of *frisson* because of the furore that has engulfed British Prime Minister David Cameron over his decision to dump tobacco plain packaging legislation.

The backflip has given the British Opposition all the opportunity it needs to cast doubt on the integrity of Mr Cameron and the Conservative Party, noting that key political adviser Lynton Crosby has one of the major tobacco companies as a client.

The story was given extra legs after former AMA President Dr Bill Glasson, who is a running as a Liberal candidate against Prime

Minister Kevin Rudd in his Queensland seat of Griffith, went much further on the issue than party leader Tony Abbott.

Dr Glasson said on ABC radio that – if elected – he would lobby the Liberal Party to reject tobacco company donations.

“If I was in the party room – and I hope to be successful – then I will be lobbying against it,” Dr Glasson said.

So far, Mr Abbott has rejected suggestions that the Liberal Party should follow Labor’s lead on the issue.

Labor didn’t have it all its own way on the issue.

Prime Minister Kevin Rudd was challenged at a media conference over revelations that, while a backbencher, he had some of his travel paid for by a German foundation that is funded by a global cigarette vending machine company.

**Adrian Rollins**

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## INFORMATION FOR MEMBERS

# Free tool to track registration requirements

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

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

The AMA CPD Tracker has been developed to enable doctors to progressively gather and organise the information needed to substantiate

declarations made to the Board about CPD, so that evidence can be quickly and easily produced on demand.

The AMA CPD Tracker can be used to:

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

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

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

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

To register for the product, please sign up here.



# Doctors win in slow early going

Doctors and other professionals have emerged as one of the early winners from the 2013 Federal election campaign after Labor decided to defer its highly unpopular cap on tax deductions for self-education expenses.

While the AMA and more than 60 other professional organisations, business groups and education providers remain committed to having the measure scrapped, the Federal Government hopes to have drawn much of the short-term electoral sting out of the issue by holding the introduction of the cap over

until mid-2015.

But, aside from this move – made on the eve of the campaign proper - the Australian Greens have made most of the early running.

Even before the election was called, they had flagged they would reinstate indexation of Medicare rebates.

Barely a week later, the Greens again grabbed the initiative by promising to establish – as per AMA policy - an independent panel of medical experts

to monitor and report on health care for asylum seekers being held in detention.

The announcement overshadowed a commitment by Labor to provide \$20 million to prevent, research and manage foetal alcohol spectrum disorder, which has blighted the lives of many children, particularly from disadvantaged communities.

Even less visible has been the Coalition, which has so far largely kept its own counsel on health policy.

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)

## Promises, promises....

### Who has promised what on health policy so far...

ANNOUNCEMENT	DATE	COST	COMMENT/REACTION
<b>LABOR</b>			
\$2000 cap on tax deductions for self-education expenses deferred 12 months to mid-2015	2 August	\$250 million over four years	AMA and Scrap the Cap Alliance vow to continue fighting measure; Coalition yet to comment
Medicare rebate indexation frozen to mid-2014	14 May	\$664 million	Greens promise to reinstate indexation
Foetal alcohol spectrum disorder strategy	6 August	\$20 million	
<b>COALITION</b>			
Medicare Locals to be reviewed	24 May	n.a.	
Medibank Private to be sold off		tbc	Greens don't rule out supporting sell off
Private health insurance means test to be scrapped	24 May	tbc	
Government policy to cap indexation of private health insurance rebate backed	27 May	\$700 million saving	
National Health and Medical Research Council funding guaranteed	24 June	\$3.7 billion	
<b>GREENS</b>			
Medicare rebate indexation reinstated	27 July	\$600 million	
Independent Health Advisory Panel to oversee asylum seeker health care		tbc	Greens don't rule out supporting sell off
Universal dental care	27 July	tbc	
Ban on junk food ads to children	8 August	n.a.	

n.a. – not applicable tbc – to be confirmed

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# The smoking paradox: why is Australia's biggest killer being neglected?

BY DR COLIN MENDELSON, TOBACCO TREATMENT SPECIALIST AT THE BRAIN & MIND RESEARCH INSTITUTE, CAMPERDOWN, SYDNEY AND VICE-PRESIDENT OF THE AUSTRALIAN ASSOCIATION OF SMOKING CESSATION PROFESSIONALS. [WWW.COLINMENDELSON.COM.AU](http://WWW.COLINMENDELSON.COM.AU)



Smoking is the single greatest preventable cause of death and illness in Australia, but a recent study confirmed that doctors are less likely to treat smoking than many other major health risk factors.

The study, published in the *American Journal of Public Health* earlier this year, found smoking patients received medication for smoking at fewer visits (4.4 per cent) than patients with hypertension (57.4 per cent), diabetes (46.2 per cent) and hyperlipidaemia (47.1 per cent). Smokers were also less likely to receive behavioural counselling.

This finding is paradoxical.

Smoking is the single greatest cause of death and illness. Effective treatments are readily available, and quitting leads to dramatic and rapid improvements in health.

Quitting smoking reduces mortality by 36 per cent for patients with cardiovascular disease, which compares favourably with the effectiveness of widely used treatments such as statins (29 per cent reduction in mortality), aspirin (15 per cent), Beta-blockers (23 per cent) and ACE inhibitors (23 per cent).

In spite of this, smoking is often neglected in medical practice

Smoking is a genuine medical condition requiring urgent management.

Smoking (nicotine dependence) is defined by the American Psychiatric Association in its Diagnostic and Statistical Manual of Mental Disorders as a substance abuse disorder, not simply a lifestyle choice or bad habit.

Without assistance, quitting is typically a journey of repeated unsuccessful attempts over many years. Each individual attempt has only a 3 to 5 per cent chance of success which comes at a high cost. For every year that abstinence is delayed beyond the age of 35 years, a smoker loses on average three months of life expectancy.

Many now argue that smoking should be reframed as a chronic condition like hypertension and diabetes, and treated in the same way. Chronic conditions require long-term management with patients re-engaged and supported over time with evidence-based therapies.

Why, then, is smoking being neglected in medical practice?

Doctors have reported a number of barriers to intervention, each of which can be overcome.

## Lack of time

It is a reality of current medical practice that doctors are time poor.

Many do not raise the subject of smoking because of time pressures, assuming that effective action to encourage quitting must be complex and time-consuming. But this is not the case.

Interventions that take as little as a minute can be effective, such as asking a patient if she or he is a smoker, advising him or her to quit, and providing a script for nicotine patches.

Another quick solution for busy doctors is to use the Ask-Advise-Refer protocol. This involves asking all patients if they smoke, advising smokers to quit and referring them to a specialist service for treatment. This fits the current model of medical practice where patients are referred to medical specialists for further care of specific disorders.

A national network of tobacco treatment specialists is now available through the Australian Association of Smoking Cessation Professionals (AASCP).

Members are health professionals, including GPs, nurses, psychologists, drug and alcohol workers and pharmacists, who are accredited annually and use best practice evidence-based treatments.

...CONTINUED ON PAGE 22

# The smoking paradox: why is Australia's biggest killer being neglected?

...CONTINUED FROM PAGE 21

Tobacco treatment specialists can be found in most areas by visiting the Association's website at [www.aascp.org.au](http://www.aascp.org.au).

Other referral options include the Quitline (call 137 848) and a range of hospital and health service smoking clinics.

## Fear of alienating smokers

Doctors often raise the concern that addressing smoking might alienate smokers, especially those who are not ready to quit. But research shows that, actually, the opposite is true. Patients report greater overall satisfaction with consultations where smoking is raised. In fact, satisfaction increases as more assistance is provided.

It is important to raise the subject of smoking in a non-confrontational and non-judgemental way to minimise the risk of a hostile response.

Australian smoking cessation guidelines suggest asking 'How do you feel about your smoking?' which can open a dialogue without the smoker feeling under pressure.

The subject of smoking should be raised at every opportunity at follow-up visits.

## Lack of skills

Smoking cessation is neglected in undergraduate training and there are few opportunities to acquire the necessary skills and knowledge. It is no wonder that many doctors lack the confidence to counsel smokers.

Doctors who wish to learn more could consider joining AASCP, which provides regular training and education for members.

The Association provides a monthly

webinar that can be accessed on any computer; a monthly newsletter with clinical papers, news and treatment tips; an annual conference; and a peer-reviewed journal, the *Journal of Smoking Cessation*. The Association also provides networking opportunities and an interactive online forum for sharing information and raising queries.

Another educational opportunity is the Australian Smoking Cessation Conference 2013 which is being held from 6 to 8 November in Sydney ([www.sydney.edu.au/bmri/ascc2013](http://www.sydney.edu.au/bmri/ascc2013)). The overriding aim of the conference is "Translating the research into practice", and it aims to update practitioners on the latest practical, evidence-based skills and information to help smokers quit.

The four conference themes are smoking and mental illness, adolescent smoking, smoking in pregnancy and in indigenous populations. The program includes four interactive workshops on the major themes, as well as presentations from leading international and Australian experts designed to enhance everyday clinical practice.

The conference is being organised under the auspices of Sydney University, in collaboration with the Australian Association of Smoking Cessation Professionals. The Australian Medical Association is an official supporter of the conference.

## Lack of efficacy

Doctors often express a sense of despondency regarding smoking, which is no surprise given that the majority of attempts to quit fail. Doctors see many more failed attempts at quitting than successes.

However, a large body of research shows

that interventions by medical practitioners are effective.

Even brief advice increases quit rates by 70 per cent compared with no advice or usual care. More intensive interventions are even more effective.

It is important to have realistic expectations. Even with a comprehensive best-practice program of medication and counselling, success rates for a given quit attempt are typically only 25 to 30 per cent.

For most smokers, successfully quitting requires repeated attempts over time. Relapse is a normal part of the journey and doctors should be prepared to repeatedly raise the subject and try to re-engage the smoker in further attempts.

Repeated failed attempts are discouraging and can lead to a fear of failure, which often underlies an unwillingness to try again. However, this belief is often based on past 'cold turkey' quit experiences rather than the use of evidence-based therapies and professional support. Patients should be encouraged to keep trying to quit using proven and effective treatments.

Unsuccessful attempts should be reframed as 'learning experiences'. The smoker learns something from each attempt, making the next attempt more likely to succeed. The only failure is to stop trying.

In contrast to the magnitude of its health effects, smoking is relatively neglected in medical practice.

However, brief interventions by doctors are effective and can enhance patient satisfaction.

*For details of sources referred to in the article, please visit: [www.colinmendelsohn.com.au/references](http://www.colinmendelsohn.com.au/references).*

TO COMMENT CLICK HERE

# Hospitals on superbug front line



Hospitals will become the frontline of efforts to detect and control deadly superbugs amid warnings rising antibiotic resistance threatens to make even simple infections potentially deadly.

A government-appointed infection control taskforce has recommended that all hospitals take part in a nationwide screening program to detect patients carrying carbapenem-resistant Enterobacteriaceae (CRE).

The call follows warnings from the Office of the Chief Scientist (OCS) that superbugs pose a major health threat.

In a paper released last month, the OCS said the rise of antibiotic resistant infections and dwindling investment in research had left the community badly exposed to the risk of deadly outbreaks.

The Multidrug Resistant Gram Negative Taskforce has drawn up a set of guidelines to help control the spread of CREs, which health authorities warn could make even mild and routine infections such as a sore throat deadly.

Taskforce member Associate Professor John Ferguson told an Australasian Society for Infectious Diseases conference that virtually all the major international strains of carbapenem resistance, including the virulent New Delhi metallo-beta-lactamase-1 (NDM-1), have been detected in Australia, though they remain relatively rare.

NDM-1 and the similar IMP-4 are genes that render bacteria such as *Escherichia* and *Klebsiella pneumoniae* resistant to carbapenem and other penicillin-type antibiotics.

Associate Professor Ferguson, who is Director of Infection Prevention and Control at Hunter New England Health, said patients infected with CRE were in danger of developing

septicaemia and other serious infections that had high mortality rates.

He said it was important to act quickly to control the spread of CRE while it remained relatively uncommon.

“The Taskforce believes that implementation of consistent CRE control measures at this early stage is critical,” he said. “If CRE is allowed to spread unchecked, then the number of patients with serious, including fatal, infections due to CRE will increase [and] subsequent control measures will become much more difficult.”

The Taskforce, in consultation with Dr Cate Quoye from the Australian Commission for Healthcare Safety and Quality, has developed guidelines to reduce the risk of CRE infection, improve detection and surveillance and suppress cross-transmission.

In particular, it has recommended hospitals begin active screening to detect several categories of at-risk patients, including those admitted to or transferred from an overseas hospital in the preceding 12 months, those who have had tested positive for CRE and are yet to test negative, and patients with a history of CRE infection.

“All hospitals will have to implement systematic questioning of patients at triage or during the admission process,” Associate Professor Ferguson said, urging that a nationally consistent approach be considered.

The Taskforce’s recommendations, which are due to be finalised later this year, came as the OCS said the widespread and indiscriminate use of antibiotics, including over-prescribing and for treating viral infections, had fuelled the growth of resistance.

This had been coupled with a dramatic slowdown in the discovery of new antibiotics.

“The rise in bacterial resistance has coincided with a collapse in the antibiotic discovery pipeline,” the OCS paper said. “Only one antibiotic that works in a novel way has been discovered and developed for use in humans in the last 50 years.”

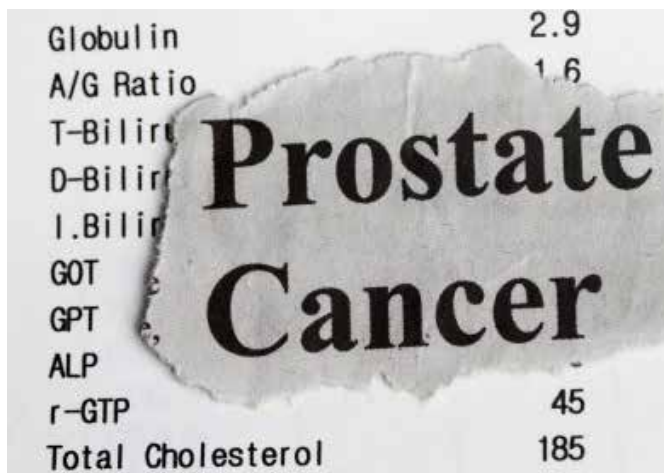
It said most companies had either abandoned the field or were cutting back on their investment.

“There is now a genuine threat of humanity returning to an era where mortality due to common infections is rife,” the OCS said. “Nothing short of a global revival in antibiotics R&D is required. It is critically important that we build up a new arsenal of effective treatments and diagnostic tools to combat resistance in the longer term.”

**Adrian Rollins**

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# Prostate cancer tests should begin in the forties



Doubts remain about how frequently men should be tested for prostate cancer despite international consensus that screening should begin when they are in their forties.

The Urological Society of Australia and New Zealand said it agreed with “most of the conclusions” on prostate cancer testing reached by a international panel of experts meeting in Melbourne last week, but warned several key questions remained unresolved.

In a seminal conclusion that is expected to bring to an end years of disagreement, a group of 14 experts attending the Prostate Cancer World Congress 2013 have agreed that all men should have a baseline prostate-specific antigen (PSA) test while in their forties.

The panel said the test would set a baseline, and allow for assessment of the risk of developing prostate cancer later in life.

Those assessed of being at low risk would not need to have follow-up test for at least five years, while those with a PSA above the median for their age would be placed under active surveillance, with test and physical examinations every 12 months.

The panel recommended that men aged between 50 and 69 years undergo a PSA test because of strong evidence it helped in the early detection and treatment of the disease.

Urological Society Vice President Professor Mark Frydenberg said the panel’s conclusions were largely in line with the Society’s recommendations, which were formulated in 2009.

But Professor Frydenberg said there were still unanswered questions regarding the frequency of PSA testing of men of all ages.

He said the Society was contributing to a review of testing

guidelines by the National Health and Medical Research Council and Cancer Australia.

“This means that consensus can be built, not only among urologist, but also the non-urological community, so GPs and patients have clear and concise guidelines, and can be reassured they are getting multi-disciplinary agreement about early detection strategies for prostate cancer,” Professor Frydenberg said.

While consensus has been reached about when testing for prostate cancer should begin, American cancer experts have called for a reassessment of the use of the term ‘cancer’ in diagnosis.

The United States National Cancer Institute has raised concerns that many patients suffer unnecessary alarm distress, and undergo unnecessarily aggressive treatment, because they are told they have cancer.

The Institute said many patients with pre-malignant conditions or lesions should not necessarily be told they have cancer, because the problem may not be as serious or urgent as the term suggests.

It cited as an example the strain of breast cancer known as ductal carcinoma in situ, which was slow growing and non-invasive but was often treated as if it were aggressive.

AMA President Dr Steve Hambleton admitted to *The Australian Financial Review* that using the word cancer when describing a diagnosis often made measured discussion of treatment options difficult.

“When you go to a lady and you say ‘we’ve done a mammogram, turns out you’ve got DCIS’, they say ‘Did you say cancer, doc?’” he said.

“[When] we say we think the best treatment for you is to watch and wait, the person says, ‘You what? You’ve just told me I’ve got cancer and you’re not going to treat me?’

“The challenge here particularly is, do you call it cancer when it’s not going to be progressive and aggressive? Or do you try to identify a characteristic that gives you some guidance on whether you should be treated or not?”

Cancer Council Chief Executive Professor Ian Olver told *The Australian Financial Review* the best approach may be to strengthen understanding that cancer is a term that encompasses many forms of the disease, rather than try to change the definition of the word cancer itself.

“The real issue is to educate people to understand that cancer is a very general term, and to not always associate it with invasive, highly aggressive disease,” Professor Olver said.

**Adrian Rollins**

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# Organ donation not like it was in the old days

Australians are more reluctant to donate organs than they were 20 years ago despite a recent improvement in donation rates.

Official figures show that although there has been a jump since 2007 in the number of people willing to donate their organs, rates still lag behind those achieved in the late 1980s and early 1990s.

The Australia and New Zealand Organ Registry (ANZOR) has reported a 33 per cent jump in the number of deceased organ donors in the first half of the year to 216 people – up from 162 in the same period in 2012 – putting it on track to easily exceed the record-high 354 donors recorded last year.

The result builds upon a 79 per cent jump in donor numbers since 2007, and has prompted Federal Government to claim that its efforts to boost organ donation rates are succeeding.

Parliamentary Secretary for Health and Ageing Shayne Neumann said work to remove barriers to donation and better identify potential donors was paying off, and Government reforms were “achieving sustained growth in donation and transplantation outcomes”.

Mr Neumann said the result showed the country was on track to achieve the goal of 17.8 donors per million people this year, which equates to 414 donors.

Such a result would give Australia around the sixth highest number of donors per million among countries included on the International Registry of Organ Donation and Transplantation.

Highest, according to figures compiled in 2010, was Portugal, with a rate of 30.4 donors per million, followed by the United States (25.6) and Austria (23.4). Australia was ranked 10th that year, with a rate of 13.8 per million.

Figures prepared by the ANZOR show that Australia’s organ donation rates have been rebuilding in recent years after bottoming out in the late 1990s and early 2000s.

The Registry’s records go back to 1989, when the number of donors per million was at 13.6. The figure subsequently dropped, reaching a low of 8.6 in 1999, and it remained in single digits during much of the early 2000s before jumping to 12 in 2008, reaching a fresh high of 13.9 in 2010, and continuing to rise up to 15.6 last year.

But the Registry said a more meaningful measure of donor rates was to express them a proportion of deaths.

“Historically, the comparison of organ donation rates between states and countries has been based upon donors per million population,” it said. “However, using the number of deaths and, therefore, the ability of a deceased person to be a donor, as a denominator may be a more reasonable way of comparing donation rates.”



According to this measure, donation rates still have some way to go to match those reached 20 years ago.

The number of donors per 1000 was at 3.5 in 1989 and around 3.2 in the early 1990s before sliding as low as 1.4 in 2007.

It has been recovering since then, and reached 2.3 in 2011.

Despite the improvement, Mr Neumann admitted that the country still had some way to go to boost rates of donation.

According to the registry, just 1 per cent of those who die in hospital – around 790 people last year – are potential organ donors.

It reported that of 710 cases where requests to donate were made in 2012, families gave their consent on 410 occasions, resulting in a total of 354 donors providing 1109 organs transplanted to 1052 recipients.

The most common organs transplanted in the first six months of this year were kidneys (56 per cent), livers (whole or partial) (21 per cent), lungs (14 per cent), hearts (6.4 per cent) and pancreas (2.7 per cent).

The number of deceased donors is overshadowed by donations from living donors.

Of 3843 tissue donors last year, 95 per cent were living, and the most common donation was of the head of the femur as a result of hip replacement surgery.

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)

# Medicine costs drop as pricing process speeds up

Patients are expected to save millions of dollars on the cost of prescription medicines after the Federal Government moved to speed up the price disclosure process.

The Government has declared it will cut the time taken to bring the cost of off-patent medicines in line with market prices from 18 to 12 months, saving taxpayers \$835 million over four years and giving patients quicker access to cheaper medicines.

The change has been met with outrage from pharmacists, with the Pharmacy Guild claiming the change will put 5000 jobs in the sector at risk.

But the Government shows no inclination to back down from the reform, which will save it hundreds of millions of dollars and speed up the flow of cheaper medicines to patients.

The move came just days after Health Minister Tanya Plibersek announced patients would save up to almost \$15 a time on the cost of hundreds of medicines under its price disclosure arrangements with pharmaceutical companies.

Ms Plibersek said the Commonwealth would save around \$20 million a year on subsidies for 492 brands of medicine listed on the Pharmaceutical Benefits Scheme after negotiating reduced prices for drugs that have come off patent.

She said the price cuts would also flow through to patients, who would face substantially lower out-of-pocket expenses at the chemist.

Among the price falls is a \$14.68 plunge in the cost of the antibiotic Ceftriaxone, a \$10.43 drop in the price of cholesterol-lowering medication Simvastatin and a \$3.64 dip in the cost of the anti-depression pill Sertraline.

Under the price disclosure regime, which came into effect in 2007, manufacturers of publicly subsidised medications that come off patent are required to disclose the reduced price they are offering the market.

The Government then brings the public subsidy for the drug in line with the average lower price.

But the system has been heavily criticised for still saddling taxpayers and patients with excessively high prescription medicine costs.

The Grattan Institute think tank earlier this year claimed that Australia is paying \$1.3 billion a year too much for drugs listed on the PBS because of poor pricing deals with manufacturers.

The focus of much concern is the cost of one of the most widely prescribed drugs, the cholesterol-lowering medication Atorvastatin, sold under the brand Lipitor.

University of Melbourne health economist Professor Philip Clarke told *The Age* 180,000 patients taking Lipitor were paying \$170 a year more than they should if price cuts recommended by an expert advisory panel were implemented.

Professor Clarke said there should be a cut in the price of Atorvastatin similar to the 44 per cent price drop for another cholesterol medication, Simvastatin.

But the Federal Government rejected the criticism, arguing it had already negotiated a 41 per cent price drop for Atorvastatin in April last year.

Mr Plibersek said the price disclosure regime was set to save taxpayers more than \$2 billion in the next 10 years.

The Minister added that 16 medicines, including treatments for melanoma, breast cancer, prostate cancer and stroke had been added to the PBS at a cost of almost \$918 million, and would benefit 350,000 patients each year.

**Adrian Rollins**

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## INFORMATION FOR MEMBERS

### Doctor health under examination

The wellbeing of health professionals themselves will be the focus of a conference to be held in October.

The Health Professionals' Health Conference 2013, under the title the *Caring for You, Caring for Others*, will bring together local and international experts to discuss all aspects of the health of doctors and other medical professionals, including physical and mental wellbeing, mandatory reporting, managing conflict, ageing and "compassion fatigue".

The Conference is being held at the Sofitel Brisbane from 3 to 5 October.

For more details and to register, visit: [www.hphc2013.com.au](http://www.hphc2013.com.au)

# Phone health advice comes under scrutiny

The status of health advice provided by telephone help lines has come under scrutiny at a Western Australian coronial inquest.

In a case that could have ramifications for how telephone health advice services operate, a coroner inquiring into the death of a six-month-old baby has raised questions about the ethical obligations and standards of nurses providing advice.

According to a report in the *West Australian*, the inquest into the May 2011 death of Allegra Scafidas was told her mother called the HealthDirect service for advice after the infant fell ill.

The inquest was told that a HealthDirect nurse advised the mother her child was likely to have a “tummy bug”.

Eleven hours later Allegra was rushed to Princess Margaret Hospital, where she was diagnosed with pneumococcal meningitis and placed in an induced coma, but died six days later.

Much of the focus of the inquest has been on the status of advice provided by the nurse to Allegra’s mother.

Coroner Dominic Mulligan questioned Dr Georgia Karabatsos from Medibank Health Solutions about the possibility that Allegra’s mother interpreted the nurse’s assessment as a diagnosis, discouraging her from seeking further advice unless her daughter’s conditions deteriorated.

According to the *West Australian*, Dr Karabatsos admitted to the inquest that she “could see” how Allegra’s mother may have thought the advice provided by the HealthDirect nurse was a diagnosis.

“I can see objectively how it sounds like a diagnosis,” she said.

Mr Mulligan indicated that the ethical standards and obligations set by Medibank Health Solutions regarding the conduct of HealthDirect nurses may be the subject of an adverse coronial finding.

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)

# Mentally ill still turn to GPs for help

The rate at which people suffering depression and other serious mental health problems see their local GP for help has slowed sharply, underlining fears that patients and the community will pay a heavy price for cuts to Medicare rebates for GP mental health services.

A national snapshot of Medicare-subsidised mental health care has shown annual growth in mental health-related GPs visits has slowed sharply since 2011, down to less than 2 per cent after climbing by more than 10 per cent a year through the late 2000s.

The slowdown followed the Federal Government’s decision two years ago to slash the rebate for GP mental health services by 50 per cent.

The AMA warned at the time the decision would be counter-productive and deter

people from seeking help with mental health problems.

The centrality of GPs to the provision of mental health care has been underlined by Australian Institute of Health and Welfare figures showing they provided almost 28 per cent of mental health-related services in 2011-12, compared with 26 per cent each for psychologists and psychiatrists.

In addition, 86 per cent of all prescriptions for mental health-related medications were written by GPs.

Despite the slowdown in the growth of patients seeking GP help for mental health concerns, they still made up a sizable proportion of the patients most practitioners see.

According to the Institute, 12 per cent of all visits to general practitioners in 2011-12 were for mental health issues,

most commonly depression, which accounted for a third of all mental health consultations.

Despite the slowdown in growth in GPs visits by patients with mental health problems, the Institute’s figures show that the incidence of such concerns is growing.

An extra 100,000 people used publicly subsidised mental health services in 2011-12, reaching 1.6 million people.

In a sign that people are heeding public health messages to seek help for mental health problems rather than suffer in silence, demand for mental health care jumped by more than 6.6 per cent in 2011-12, far outstripping population growth of less than 2 per cent during the same period.

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)

# Telstra makes health records play

Telecommunications giant Telstra has extended its foray into health care, acquiring a major stake in a company providing electronic health record systems for hospitals.

Pursuing its search for growth, Telstra has invested in IP Health, whose principal product is the Verdi system, which aggregates patient information from multiple sources across a hospital and presents it as a single view.

The telecommunications company sees IP Health and its Verdi product as an opportunity to extend its reach in the hospital sector.

Telstra Ventures Managing Director Matthew Koertge said IP Health would be an "important asset" for the company in increasing its presence in the burgeoning area of health information systems.

"There are more than 1300 hospitals in Australia, most using multiple systems," Mr Koertge said. "This new partnership will help IP Health accelerate its growth by combining our strong and trusted brand, our technology know-how and scale with an innovative software solution."

Telstra has made its foray into the provision of electronic health record systems for hospitals amid doubts about the clinical usefulness of the Federal Government's much vaunted Personally Controlled Electronic Health Records (PCEHR) system.

The AMA has raised concerns that, as currently designed, the PCEHR is of only limited clinical use because it allows patients to remove or restrict access to information.

The AMA has called for the appointment of a clinical advisory group to review the system's design and make it a much more useful and valuable resource for both doctors and patients.

The Federal Government has so far resisted such calls, and Health Minister Tanya Plibersek told a conference last month that the PCEHR was steadily establishing itself, with more than 520,000 patients and 5000 health organisations signing up.

**Adrian Rollins**

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## INFORMATION FOR MEMBERS

# AMA Careers Advisory Service

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

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

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

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

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

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

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

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

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

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

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

## INFORMATION FOR MEMBERS

# Can I prescribe ...?

Most doctors know what the rules are for prescribing medicines in Australia. Or do they?

AMA members frequently ask whether they are able to prescribe in certain circumstances. The most common questions are:

- Can I prescribe for myself?
- Can I prescribe for my family?
- Can I prescribe for someone who isn't directly my patient (a third party)?
- Can I backdate prescriptions?

It is understandable that doctors are uncertain, because there is no simple answer.

Prescribing in Australia is regulated by a range of laws.

For a medicine to be prescribed in Australia, the Therapeutic Goods Administration (TGA) must approve it for sale.

However, each State and Territory has its own laws regulating the prescription of medicines.

These laws determine who can prescribe, which medicines, in what circumstances, in what manner and for what purpose. In addition, specific conditions must be met to prescribe certain classes of medicines, such as some with Schedule 4 and Schedule 8 classifications.

These laws vary in each jurisdiction, so doctors must be careful they understand and comply with the laws in force where they practise.

A further layer of compliance is added for patients to receive a government subsidy under the Pharmaceutical Benefits Scheme (PBS) when they purchase prescribed medicines. Doctors must comply with requirements and restrictions under Commonwealth laws in order to prescribe under the PBS.

Finally, all doctors are bound by the Medical Board of Australia's code of practice – *Good Medical Practice* – as a condition of their registration to practise in Australia.

So can doctors self-prescribe, prescribe for family or for a third party?

Here's what the different laws say:

- Commonwealth, NSW, Queensland, Tasmanian and South Australian laws do not appear to prohibit self-prescribing, prescribing for family or for a third party.
- Doctors practising in Victoria cannot prescribe any S4 or S8 medicines for themselves or for a third party.
- In the Northern Territory, it is slightly more complicated. Doctors cannot self-prescribe S8 medicines or certain

restricted S4 medicines, and cannot prescribe for a third party unless the third party is the partner of a patient being treated for Chlamydia who is also likely to have Chlamydia.

- In the ACT, doctors are only prohibited from prescribing for themselves if they are still an intern, or the medicine is a restricted medicine.
- WA law simply prohibits prescribing for the purpose of self-administration.

*Good Medical Practice* cautions against prescribing for self, family, friends or "those you work with".

It recommends "seeking independent, objective advice when you need medical care, and being aware of the risks of self-diagnosis and self-treatment".

It also advises doctors to "avoid providing medical care to anyone with whom you have a close personal relationship ... because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient".

No State or Territory law appears to specifically prohibit backdating of prescriptions. Interestingly, neither does Commonwealth law. While the PBS website states that prescriptions must be not backdated, in fact neither the *National Health Act* nor the *National Health (Pharmaceutical Benefits) Regulations* provide any power to enforce this.

However, all prescribing-related laws require that the prescriber signs and dates prescriptions. It is likely that the intention, while not enforceable, is that the date is contemporary with the signature.

In summary, it is important that you understand the laws in force in the State or Territory in which you practise. Don't rely on hearsay (or this article), because laws change or can be misinterpreted without legal expertise.

If in doubt, check with the drugs and poisons unit in your State/Territory. The TGA maintains up-to-date contact details on its website at: [www.tga.gov.au/industry/scheduling-st-contacts.htm](http://www.tga.gov.au/industry/scheduling-st-contacts.htm).

Information about PBS prescribing rules is available at [www.pbs.gov.au](http://www.pbs.gov.au).

*Good Medical Practice* is available at: [www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx](http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx).

The AMA's website also maintains a summary of prescribing rules information and links to other sources at <https://ama.com.au/node/12303> or you can go to the 'resources' tab on our homepage and look under 'FAQs'.



# Health on the hill

Political news from the nation's capital

## Opt-out breast implant registry established

The Federal Government has agreed to establish an opt-out registry of breast implants in response to criticisms of the nation's response to the Poly Implant Prothese implant scandal.

The Government has accepted virtually all the recommendations made by a Senate Committee critical of the handling of the PIP breast implant episode by the nation's medicines and medical device watchdog, the Therapeutic Goods Administration.

The PIP scandal erupted in 2010 when a world-wide recall of the silicone breast implants was issued after French authorities discovered they had been manufactured using industrial-grade rather than medical-grade silicon, and warned they had an elevated rupture rate.

Concerns have been raised about the TGA failure to detect problems with the implants, with Independent Senator Nick Xenophon among those highly critical of what they say was a failure of the regulator to protect Australian patients.

According to a report by the medical director of United Kingdom's National Health Service, Sir Bruce Keogh, PIP implants were up to six times more likely to fail than the alternatives within the first five years of implantation.

About 13,000 PIP implants were supplied in Australia between 1998 and 2010, and regulators have confirmed 451 incidents of rupture, and 22 unconfirmed, with most commonly occurring between four and seven years following implantation.

In its response to a Senate Committee inquiry into the handling of the PIP scandal, the Government accepted that the TGA needed to improve its performance, including increased vigilance and rigour in overseeing the supply and use of implantable medical devices, better communications with the public, and the establishment of a breast implant registry.

The Government said "the TGA will adopt a strong focus on improving its communication and engagement with the community".

"The Government will ensure that the TGA focuses on the information needs of the community and other stakeholders to ensure that the right information is presented in a way that meets the varying needs of all stakeholders," it said.

The Government also embraced a recommendation by the Committee that an opt-out Breast Implant Registry be established as a priority.

It allocated \$5.1 million in the May Budget to establish and

maintain two clinical registries – one for breast implants, the other for cardiac devices.

It said the money would cover the first two years of operation, until funding arrangements based on cost recovery from industry were put in place in 2015.

"The Government agrees that an opt-out approach will be adopted by the new breast implant register, in line with the recommendation of the Australian Commission on Safety and Quality in Health Care," it said.

The Government also agreed to extend until 11 March 2015 the access of women with PIP implants to Medicare rebates for MRI scans to detect any leakages or abnormalities involving the implants.

Adrian Rollins

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# A medical home – what you’ve told us

BY DR BRIAN MORTON

“The goals are to keep everyone as healthy as possible through preventive services and early interventions, and to supply the needs of those older people with a high burden of chronic conditions”

Populations are ageing and the incidence of chronic and complex disease is rising. I see plenty evidence of this in my own practice.

Governments around the world, Australia included, are looking at new models of primary care to keep their populations healthy and contain rising health costs. The only thing missing here is a financial commitment in general practice to match this interest.

The goals are to keep everyone as healthy as possible through preventive services and early interventions, and to supply the needs of those older people with a high burden of chronic conditions.

It is not surprising that the focus is shifting to primary care and the central role played by GPs.

We know that the health of patients is improved if they have better access to GPs. Avoidable hospital admissions can be reduced and long-term savings to health systems are possible.

It is in this context that the Federal Government is exploring the potential of the “patient-centred medical home” model of primary care to strengthen the role of GPs in the health system and deliver better outcomes for patients by encouraging continuous and coordinated care. It is consulting with major health groups such as the AMA and the RACGP.

In broad terms, the medical home formalises the link between the patient and the GP or practice. It aims to facilitate partnerships between patients and their GP.

Based on a concept developed overseas, the medical home could involve voluntary patient registration with a GP or practice, and voluntary participation by the GP.

From my perspective, patients would only benefit from the medical home if fee-for-service is maintained and extra funding made available for the non face-to-face work undertaken by GPs.

Many of you may think that, registration aspects aside, the medical home is a simple extension of the family doctor, where the GP leads a team of health care professionals in the practice who collectively provide and coordinate patient care.

Indeed, our own research shows that 88 per cent of people have a family doctor and, therefore, a medical home.

In late May and early June we surveyed our GP membership to find out what you thought of the medical home concept.

More than half of you agreed that the term ‘medical home’ is an appropriate description of general practice.

Other key findings were:

- nearly three-quarters of you believe the AMA should support the medical home model, provided that linkages are voluntary and reversible, and that the ability of the doctor to charge on a fee-for-service basis is maintained;
- there is support for voluntary registration of patients at a practice, but strong opposition to compulsory

registration;

- more than half of you believe that you could manage the needs of your patients with chronic disease and co-morbidities more effectively with a defined patient population;
- there is uncertainty whether an annual registration fee would be an appropriate means of charging for the cost of non face-to-face work done for our patients; and
- more than three-quarters of you have some level of concern that the government will use the medical home concept to change the way general practice is funded.

So there you have it. The AMA is presently working up its position on the medical home, and we are being guided by the survey findings.

I understand that the RACGP sees great merit in the medical home. We are taking a more cautious approach, as there is the potential for more bureaucracy and capitated funding.

I’ll keep you posted on developments in future columns.

Thank you to those who participated in the survey.

If you would like to find out more about the medical home model and the full findings of the survey, go to: <https://ama.com.au/ama-member-survey-patient-centred-medical-home>

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# Re-election at what cost?

BY AMSA PRESIDENT BEN VENESS

The policy agenda at AMSA's most recent Council Meeting was huge. Our burgeoning global health arm, in particular, had put in an enormous effort to update existing policy and draft more besides. One of these was an extension of AMSA's support for the health and human rights of asylum seekers and refugees.

Just two weeks after our meeting, Prime Minister Kevin Rudd announced a new policy that read like a piece of satire straight out of *The Onion*.

Our government will now automatically reject any person who seeks asylum in Australia, by exporting them to Papua New Guinea and leaving them there even after they are confirmed as a refugee. Note that this is only for "boat people"; plane people are OK. It's no wonder so many Australians have trouble distinguishing their right from their left.

Article 14 of the 1948 *Universal Declaration of Human Rights* affords everyone the right to seek asylum. The legal hurdles to implementing this policy are significant but, if overcome, its immorality will remain.

Asylum seekers and refugees already tend to suffer significant physical and mental health disadvantages, which is completely unsurprising from a social determinants perspective.

As medical students and doctors, we have a very legitimate interest in ensuring these disadvantages are addressed, and certainly not exacerbated.

The AMA recognises this in its 2011 position statement, *Health Care of Asylum Seekers and Refugees*.

It calls for asylum seekers and refugees to be treated with compassion, respect and dignity.

At point 11, the statement calls on medical practitioners to "...at all times insist that the rights of their patients be respected and not allow lower standards of care to be provided."

The statement further asks at point 16 that governments "...strive to achieve world's best practice in all Australian detention centres, whether located within Australia or offshore."

AMSA has looked at both of these issues and is deeply troubled by the Papua New Guinea plan.

With regard to standards of care, the Australian Government's own [smartraveller.gov.au](http://smartraveller.gov.au) site says, "Health care facilities in Papua New Guinea, including in the capital Port Moresby, are poor by Australian standards."

AusAID cites Papua New Guinea's social indicators as "among the worst in the Asia Pacific", and describes the significant risks of HIV, tuberculosis and cholera infection, as well as the country's pronounced rates of maternal and child mortality.

Homosexuality is illegal in Papua New Guinea, engendering a tragic irony for those seeking asylum because of persecution based on their sexual orientation.

The United Nations High Commission for Refugees has inspected the detention centre on Manus Island twice this year, reporting "...poor physical conditions within open-ended, mandatory and arbitrary detention settings."

Even if resettled in Australia, refugees' battle is uphill. I recall those I met in the under-resourced Friday morning clinic at The Children's Hospital at Westmead: dental caries in almost every refugee

child's mouth, a reliance on charity, and behavioural issues steeped in years of enduring very challenging living environments.

Rather than reject the new asylum seeker agreement, Leader of the Opposition Tony Abbott has criticised the conditions associated with increased foreign aid that will be paid to Papua New Guinea, and suggested Labor breached the caretaker government conventions by signing a memorandum of understanding after the election had been called.

Australian Greens Leader Senator Christine Milne branded the agreement "refugee cruelty" and "ruthless electioneering", and would rather see an end to deterrence and a better regional approach, coupled by an emergency humanitarian intake from Indonesia and Malaysia of at least 3800 people.

Since Mr Rudd's announcement on 19 July, he has called the election. His pollsters' view is obviously that more votes can be won with a policy like this, than without.

For humanity's sake, let's all hope they are wrong. This is not good policy, this doesn't deserve to win votes on September 7. This deserves condemnation from those of us with a voice.

If you care about the health and wellbeing of some of the world's most vulnerable people, please join AMSA in opposing such callousness.

Out of sight is not out of mind for all of us.

*Benjamin Veness is President of the Australian Medical Students' Association. He is studying medicine and a Master of Public Health at The University of Sydney. Follow Ben on Twitter @venessb and @yourAMSA*

[TO COMMENT CLICK HERE](#)





# Roadblocks to health

BY DR DAVID RIVETT

“Responsibility and blame is being placed on nursing administrators, rather than the politicians who leave the system underfunded”

I have just had a great four weeks on leave in Europe, finishing with a reality check in London.

Believe me, the Aussie cricketers lacked a lot of skill and dedication at Lords and it was painful to be present, but more alarming were the London tabloid headlines.

Firstly, professional hackers obtaining personal National Health Service (NHS) data for insurers and legal firms on the Internet were the front-page allegations, and a parliamentary inquiry is to be held - certainly very sobering, and a wake up call for all of us regarding electronic record storage. Privacy is a cornerstone of the doctor-patient relationship.

The internet is a great tool, I love its speed and ease of access to all manner of things: medical information and research, my family, other professionals and its ability to simplify and enable banking from anywhere, anytime.

But hackers are able to penetrate its defences, and are very keen to do so if the rewards are great enough.

‘What safeguards has the National E-Health Transition Authority put in place to ensure security?’ and ‘what communication has it had with both the British NHS and our own banking sector on their experiences?’ are the obvious questions springing to mind which demand answers.

Secondly, fiscal belt tightening or “austerity measures” have seen the NHS budget frozen. Its

Chief Executive Officer Sir David Nicholson bravely claimed patient care will not be affected as new, yet to be devised “efficiencies” will cover the lack of funding.

Well hello, this is plainly not imaginable, as the same newspapers are baying loudly about a lack of adequate nursing numbers resulting in less than optimal care all too often. Responsibility and blame is being placed on nursing administrators, rather than the politicians who leave the system underfunded.

Politicians must be held accountable.

If the tax system allows only second class public hospital care, let us be open about it and ask if a higher tax base is the best solution, or if there need to be changes of practise - in particular, humanely reducing the huge costs of often futile end of life care or improved better primary care provision to reduce tertiary care expenses.

To date, the public debate on these issues has barely started, but it must if patient outcomes are to be maximised.

Finally, it is great to see the Opposition supporting the repeal of Labor’s draconian restrictions on the tax deductibility of education expenses.

The introduction of such a cap would be a huge set-back for rural practice, and I must thank National senators Bridget McKenzie and Fiona Nash for their support after I lobbied them recently.

[TO COMMENT CLICK HERE](#)



# Responsible medicine use a top AMA priority

BY PROFESSOR GEOFFREY DOBB

“I encourage you make use of the extensive material and resources it produces, including information you can provide to your patients, which is available free from its website”

Earlier this year, the United Kingdom’s Chief Medical Officer Professor Dame Sally Davies described microbial resistance to antibiotics as a “catastrophic threat” to modern medicine. Last month, Australia’s Office of the Chief Scientist issued a warning that “there is now a genuine threat of humanity returning to an era where mortality due to common infections is rife”.

Australia is in a strong position to meet this challenge because the availability of antibiotics is highly regulated and those legally able to prescribe antibiotics – medical practitioners and veterinarians – are highly trained professionals.

However, differences in overseas practices and standards mean that Australia is also at risk of antibiotic resistance coming into the country via travellers and imported food products.

The AMA is actively engaging in the national effort to control anti-microbial resistance.

Our President, Dr Steve Hambleton, promotes the quality use of antibiotics whenever opportunities arise in media interviews and other public forums. For example, he was sought out as an authoritative spokesperson on the issue when the Chief Scientist’s report was released.

AMA Federal Councillor Dr Liz Feeney met with the Chief Medical Officer Professor Chris Baggoley, the Chief Veterinary Officer Dr Mark Schipp, and the National President of the Australian Veterinary Association Dr Ben Gardiner last month to discuss ways to improve collaboration between the medical and veterinary professions. The AMA and AVA agreed to work on consistent public messages and member communications.

The AMA also supports the Australian Commission for Safety and Quality in Health Care in implementing antimicrobial stewardship programs in hospitals.

We participated in the first ‘Australian One-Health’ Antimicrobial Resistance Colloquium, focusing on surveillance measures, that was hosted by the Commission as part of the development of a new national strategy to prevent and contain antimicrobial resistance.

The AMA is also a full member of NPS Medicinewise, the national organisation providing independent, evidence-based advice to prescribers and patients about medicines.

I encourage you make use of the extensive material and resources it produces, including information you can provide to your patients, which is available free from its website.

For example, practice points for prescribers and advice on assisting patients to adhere to therapy duration is available at: <http://www.nps.org.au/publications/health-professional/nps-direct/2013/june-2013/duration-of-antibiotic-therapy>; and a respiratory tract infections symptomatic management pad and patient counselling tool is available at: <http://www.nps.org.au/health-professionals/resources-and-tools/decision-and-management-tools>

The AMA, as an organisation and through its members, has a key role to play in promoting the responsible use of all medicines to ensure Australia’s enviable health care standards are maintained into the future.

[TO COMMENT CLICK HERE](#)



# Get those patients moving

BY PROFESSOR GEOFFREY DOOB

Physical activity forms an important part of the energy balance equation and is therefore a significant focus in Australia's efforts to reduce rates of overweight and obesity.

Physical inactivity is also an independent risk factor for acquiring chronic diseases including diabetes, cardiovascular disease, osteoporosis and depression, which means it warrants attention in its own right.

“As leaders in the community, doctors play an important role in encouraging physical activity and regular planned exercise”

Recently released data from the Australian Health Survey showed that 43 per cent of adults were sufficiently active (meaning they met the recommended amount of at least 30 minutes of moderate physical activity on most days).

Participation was greatest among 18 to 24-year-olds, with rates generally decreasing with age. Levels of activity were also found to be associated with socioeconomic status, health, Body Mass Index and whether or not a person was a smoker.

Incorporating exercise into travel has been identified as a highly effective way of increasing levels of physical activity.

Earlier this week, the Commonwealth Department of Infrastructure and

Transport released the Ministerial Statement *Walking, Riding and Access to Public Transport – Supporting active travel in Australian communities*.

The Statement sets out how the Australian Government will work to increase the proportion of people walking and riding for short trips. No specific funding was associated with the Statement, but it does highlight that in addition to the obvious public health benefits (including reduced health care costs), active travel increases capacity in the overall transport network, reduces congestion, lessens environmental impacts and improves community well being and social cohesion.

The Statement also made reference to research commissioned by the Queensland Government in 2011 which found that for each person who cycles 20 minutes to and from work, the economy benefited by \$21.20, and for each person who walked 20 minutes to work and back, the benefit was \$8.48. These calculations took into account injury costs associated with walking and cycling, which were still significantly outweighed by the health benefits gained.

We know that bicycle riding can be encouraged with safe, well connected bicycle pathways and secure cycle storage facilities, and that participation in walking can be increased with convivial streetscapes, access to public transport as well as having local shops, cafes and other desirable locations. These effects of town planning and urban design on physical activity and health were highlighted during a presentation at the AMA's 2012 National Conference.

As leaders in the community, doctors play an important role in encouraging physical activity and regular planned exercise.

They do this by example through their own participation in various sporting and recreational pursuits, and through brief interventions with patients.

It is expected that updated national physical activity recommendations will be released shortly.

If the recently revised Australian Dietary Guidelines are any indication, it is likely they will recommend an increase from 30 minutes to 45 to 60 minutes of moderate physical activity on most days for those wishing to maintain a healthy weight, and 60 to 90 minutes of activity for those wishing to lose weight, or to prevent weight gain in those previously obese.

While these recommendations would acknowledge the current health impact of overweight and obesity, the risk is that people find the time commitment unrealistic in the context of their daily lives. Any recommendations in relation to the interaction between the duration and intensity of physical activity will also be of interest.

The AMA's Public Health and Child and Youth Health Committee recently considered the importance of physical activity and agreed that it was timely to update the AMA's Position Statement *Physical Activity – 2006*.

The revised policy will include a specific emphasis on the importance of physical activity for brain development during childhood, and a focus on the role of physical activity in the prevention and management of chronic disease.

I know that many AMA members are strong advocates for increasing levels of physical activity, and I welcome your feedback on this important issue.

[TO COMMENT CLICK HERE](#)



## Members' Forum

Here's a selection of what AMA Members have been saying about the latest issues affecting the profession:

**A \$54 million purpose-built brain research facility has opened in Sydney on the Prince of Wales Hospital Campus. One reader expresses the need for more information on spinal cord disease.**

Stem cell therapy in relation to spinal cord diseases is a topic that more information and research would be great to be shared

*by Chloe Joseph (not verified)*

**Doctors face a \$10,000 hit to their bank balance when the \$2000 cap on tax deductions for education expenses comes into force next year. One reader compares the Australian Government's decision with New Zealand policy and points out the difficulties doctors will face in Australia.**

In all countries that I am aware of, doctors can deduct the cost of their continuous medical education from their taxes. This is in most countries written in law as it is an expense that is incurred to be able to performance one's profession. We never like to look at New Zealand but there doctors can claim \$16,000 per year if they show the invoices and justify the training or continuous education sessions they went to. The system actually pays its doctors 100 per cent back to make sure they remain up-skilled. Here, we have dropped far below that standard with no longer allowing to make tax deductions. Consequences? Very predictable: doctors will no longer go to the important schooling and "maintenance of professional standards" events, but get their education for free over the internet, often provided by the drug industry. There will be no Australian doctors anymore at world stage conferences, and no scientific data will be presented anymore. For the rest of the medical world it will look like Australia has fallen off the map.

We will become a medical third world country. At least people from real poor third world countries can attend conferences as they are often subsidised by richer countries (ironically, for example, by Australia).

*by Carl Boden (not verified)*

**A senior Coalition frontbencher has called for the Federal Government's \$2000 cap on tax deductions for self-education expenses to be scrapped, undermining previous bipartisan support for the measure. Members voiced their opinion on the disadvantages of the cap and one reader is unconvinced about the Coalitions commitment.**

The proposed \$2000 education rebate cap is inconsistent with all other tax deductibles in all other businesses. Why would this be an advantage to anyone, let alone businesses that benefit from doctor spending? Non-tax deductible spending would far outweigh tax deductible spending in the setting of educational activities such as conferences and travel.

*by Georgina (not verified)*

I am unconvinced these comments amount to a Coalition position on the tax deductibility cap for self-education expenses. When I wrote to my coalition MP (a senior member of Shadow Cabinet), the reply I received was lukewarm and did not offer any commitment to scrap the cap if the Coalition wins office. Similarly, a national medical body I am involved with has received a lukewarm response from Joe Hockey in relation to scrapping the cap. Christopher Pyne can hold whatever personal view he likes (which is all that this amounts to) but the AMA should not be seduced into believing that this amounts to Coalition policy, and should not drop its pressure on both sides of government until the respective leaders have publicly declared a policy position to reverse the proposal. Even then, we should remember L-A-W and how promises can be rescinded at a moment's notice.

*by Bill Macdonald (not verified)*

**Doctors are being forced to waste hours every week that could be spent with patients, waiting for government bureaucrats to answer phone calls under the Federal Government's cumbersome prescription authorisation rules. Readers agree that waiting for phone authorities is a waste of time.**

The system of having to phone and get approval from someone who has no idea of the medication (and seems these days to be in another country) is totally ridiculous. The assumption that by making it harder to prescribe, we will give up and order something different has never been proven; what about some evidence based bureaucracy!

*by John Buchanan (not verified)*

Phone authorities are a complete waste of time. I could see some benefit in integrating the authority system into practice software, so that the software sends the script details to Medicare. Even if there was a short delay, at least that time could be spent talking to the patient instead of listening to some nauseating hold music.

*by Chris Wood (not verified)*

...CONTINUED ON PAGE 39



# Members' Forum

...CONTINUED FROM PAGE 38

**AMA President Dr Steve Hambleton has declared that far-sighted health reforms are urgently needed if the nation is to cope with the growing burden of chronic disease and a rapidly ageing population. AMA members congratulate Dr Steve Hambleton on his call to health reform.**

Excellent presentation. Australia is fortunate to have such a forward thinking AMA President.

*by Avni Sali (not verified)*

As a retired allied health professional and an occasional consumer of health services, I congratulate Dr Hambleton on this wide-ranging call to health reform. Especially the message that prevention is always better than cure.

*by Anne Atkinson (not verified)*

**The medicines watchdog has admitted that pharmaceuticals and medical devices proven to be unsafe may still be sold on the market. One reader shares his view.**

I have recently received a pamphlet showing how my use of CTs is much higher than other GPs. A lot of my work relates to WorkCover claims, as the other MOs will not treat them at our practice because they are time consuming. Before Medicare gets too heated up, break up these stats reflecting different practice styles based on Level B vs Level C and D billings to make the figures more meaningful.

*by Joe Cacek (not verified)*

[TO COMMENT CLICK HERE](#)

## INFORMATION FOR MEMBERS

### Guide for Practitioners: Notifications in the National Scheme

The Australian Health Practitioner Regulation Authority (AHPRA) has prepared a guide and a series of information sheets to explain to doctors what happens when it receives a notification about a practitioner from the Medical Board of Australia.

The publication, *A Guide for Practitioners: Notifications in the National Scheme*, and the information sheets can be viewed and downloaded at: <http://www.ahpra.gov.au/Notifications/Fact-sheets.aspx>

The guide for practitioners was written by AHPRA, in conjunction with the various national boards, to explain to health practitioners the complaints process.

AHPRA Chief Executive Officer Martin Fletcher said that the majority of health care practitioners were highly skilled and deeply committed to providing safe care, and acknowledged it could be very confronting for them to be the subject of a notification.

The guide describes what occurs when AHPRA receives a notification from the Medical Board.

This information will complement the direct correspondence that individual practitioners will receive if a notification is made about them.

The AMA first called for the development of the Guide in its submission to the Senate Finance and Public Administrative References Committee in April 2011.

The document sets out the notification process, including the time limits that apply.

It is intended to enable practitioners to better understand the process and what is required of them, as well as providing a means to verify that their matter is being handled in a manner consistent with AHPRA processes.



## Don't let her drink dirty water

**malaria, typhoid, dysentery, cholera, diarrhoea, intestinal worm infection, ... dirty water can kill.**

6,000 children are dying every day – and it's because they don't have clean water. So they're forced to drink water that could make them sick with diarrhoea, cholera and typhoid.

**The good news is, problems like dirty water can be solved.** You can help children access clean water through World Vision's Water Health Life program by providing practical and effective solutions.

From \$39 a month your support will help drill boreholes, protect water sources and provide health and hygiene training. You'll be helping communities to make long-term changes that ensure a clean water supply and basic sanitation.

**Stop dirty water killing children, support Water Health Life: visit [worldvision.com.au](http://worldvision.com.au) or call 13 32 40.**

**Water Health Life**  
Basic Needs. Permanent Solutions

World Vision Australia is a Christian organisation pursuing freedom, justice, peace and opportunity for everyone in the world. ABN 28 004 778 081 RefB 5199 C16215 A961 R37





# Research

## Millions ignorant of chronic disease risk

Millions of adults are unaware that they are living with dangerous health conditions that put them at risk of diabetes, heart disease and kidney and liver problems.

In a landmark study, the Australian Bureau of Statistics discovered that one in three Australians has unmanaged high cholesterol, and 1.3 million have both unmanaged high cholesterol and unmanaged high blood pressure.

The study, based on blood and urine samples from 11,000 adults tested for various chronic disease and nutrient biomarkers, found that three out of every four Australians aged 45 years or older had risk factors for heart disease, while almost half of those aged between 18 and 45 years had at least one risk factor for heart disease.

Furthermore, one in ten adults were found to have chronic kidney disease and almost 12 per cent had liver problems.

Disturbingly, the survey found that many were unaware that they had, or were at significant risk of developing, serious chronic illnesses.

Just 10 per cent of those who took part in the survey identified high cholesterol as a current health condition and hundreds of thousands were living in ignorance of the fact they had diabetes.

Almost one million Australians have been formally diagnosed with diabetes but, based on the study's findings, the ABS estimates a further 231,000 have the disease but do not know it, and an additional 700,000 are at risk of developing the condition.

Adding to the nation's potential health burden, the ABS study found that more than 4 per cent of adults had anaemia, a condition that causes the heart to work

harder to ensure muscles and organs get the oxygen they need.

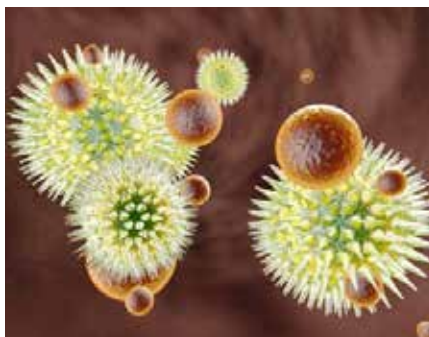
AMA President Dr Steve Hambleton said every adult should know their cholesterol level and everyone should have a cholesterol test when they reach 45 years of age, or earlier if there was family history of problems.

The Heart Foundation said the results showed that there needed to be more routine checks to identify people at risk of heart attacks, strokes and chronic disease.

**Kirsty Waterford**

[TO COMMENT CLICK HERE](#)

## New weapon to fight superbugs



Researchers have developed an antibiotic that could be a new weapon in the increasingly desperate global battle against the rise of superbugs.

The new treatment, developed by University of Adelaide scientists, targets a bacterial enzyme critical to metabolic processes, stopping infections in their tracks.

The compound is a protein inhibitor that binds to the enzyme – biotin protein ligase – stopping its action and interrupting the life cycle of the bacteria.

Researchers developed the new protein inhibitor using the 'in situ click chemistry' approach, where a selection of small

molecules or precursor fragments are presented to bacteria in a way that the target protein enzyme itself builds the inhibiting compound and also binds with it.

Lead researcher Professor Andrew Abell said that, in a sense, the bacteria unwittingly chooses and assembles a compound that will stop its growth, not unlike building a weapon and using it against itself.

"We've gone a step further to specifically engineer the enzyme, so that it builds the best and most potent weapon," Professor Abell said.

"Our results are promising. We've made the compounds; we know they bind and inhibit this enzyme, and we've shown they stop the growth of a range of bacteria in the laboratory," he said. "The next critical step will be investigating their efficacy in an animal model."

Professor Abell said the compound, although at an early stage of development, has the potential to become the first of a new class of antibiotics.

"Existing antibiotics target the bacterial cell membranes, but this potential new antibiotic operates in a completely different way," Professor Abell said.

"Bacteria quickly build resistance against the known classes of antibiotics and this is causing a significant global health problem," he said. "Preliminary results show that this new class of compound may be effective against a wide range of bacterial diseases, including tuberculosis, which has developed a restraint to all known antibiotics."

The research was published in the journal of *Chemical Science*.

See also *Hospitals on superbug front line*, p23.

**Kirsty Waterford**

[TO COMMENT CLICK HERE](#)



# Research

## Stubborn breast cancers come under fresh assault



The discovery of a new technique for treating breast cancer may provide hope for women whose disease has become resistant to treatment.

Australian scientists believe they can identify when to provide additional chemotherapy to patients whose cancer is becoming resistant.

They are developing a blood test that can determine when a gene that keeps cancer cells alive is silenced, leaving the cells more susceptible to chemotherapy.

The research on the BCL-2 gene is anticipated to help the 70 per cent of breast cancer patients who have oestrogen receptor positive cancer.

The researchers found that the BCL-2 gene is silenced in tumours that develop resistance to anti-oestrogen treatments such as tamoxifen. They believe this process is detectable in blood, and propose combining tamoxifen and a chemotherapy drug to kill the cancer when the gene is silenced.

Lead researcher Professor Susan Clarke from the Garvan Institute told the *Courier Mail* that the new technique could be quickly incorporated into existing clinical practice because the technology now exists to profile methylation of BCL-2 in all

patients – both those oestrogen-responsive and oestrogen-resistant.

“If such a test were to be implemented, we believe it could help patients much earlier, hopefully shutting down tumours at an early stage,” Professor Clarke said.

Breast cancer affects one in nine women and one in 100,000 men.

The research was published in *Molecular Cancer Therapies*.

**Kirsty Waterford**

[TO COMMENT CLICK HERE](#)

## Live fast, die young ideal takes heavy toll



Men who want to live and long and healthy life should get married and have a job, according to Australian Institute of Health and Welfare research.

A study examining the health risks posed arising from the behaviour and lifestyles of men found that, in their first 24 years of life, Australian males were nearly twice as likely to die as females in the same age group.

The research showed that car accidents and suicides were the major killers of males in childhood and the early years of

adulthood, and they were also more likely to be hospitalised for injury and more likely to die from injury than females in the same age group.

The Institute found that male babies born between 2009 and 2011 could expect to live, on average, to almost 80 years of age – but this was close to five years less than females born during the same period, and male babies were more likely to die of sudden infant death syndrome, congenital illness and drowning.

Although young men were less likely than females to smoke, they were more likely to drink weekly and 40 per cent of those between 14 and 19 years of age drank to levels that put them at risk of injury.

AMA President Dr Steve Hambleton told the Herald Sun that the glorification of alcohol and its marketing was partly to blame for male health problems.

The health problems of boys and men were not confined to fast cars and heavy drinking – the Institute found that half of all males between 17 and 24 years of age, and 44 per cent of those older than 25 years, were overweight, while 31 per cent in this older age group were obese, and 66 per cent had a waist circumference that put them at an increased risk of chronic disease.

In a finding that showed there was nothing inevitable about these health outcomes, the study found that married men with jobs enjoyed better health than those without either a job or a partner.

The Institute found that the mortality rate among married men was 8.1 deaths per 1000, compared with 12.8 per 1000 among those who had never married, and men who were employed were less likely to rate their health as fair or poor (11 per cent) than unemployed men (37 per cent) or those not in the labour force (41 per cent).

**Kirsty Waterford**

[TO COMMENT CLICK HERE](#)

# Brain injury just not sport



The sight of footballers and other athletes being knocked out on the playing field should no longer be accepted as the price of playing sport, according to one of the world's leading health institutions.

The United States' Centers for Disease Control and Prevention (CDC) has identified concussions and other brain injuries acquired in the course of playing sport and other activities as a serious public health problem, and urged much greater focus on preventing them occurring.

In a statement released last month, the CDC called for a substantial improvement in surveillance systems to identify instances of such injury and provide information on how best to prevent it in future.

"TBI (traumatic brain injury) is an important public health problem that requires more attention, societal engagement and research," the CDC said.

Its call follows alarming reports, both in the United States and Australia, of serious brain damage suffered by professional footballers.

Former Australian Rules Football player Greg Williams, who had an illustrious career playing with Carlton and Sydney, earlier this year went public with his belief that being concussed numerous times on the playing field had contributed to increasing memory loss.

In the United States, alarm bells were rung after a study found 40 former National Football League players suffered progressive brain disease.

The finding has helped spur a multi-billion-dollar lawsuit that has been filed against the NFL on behalf of more than 4000 former gridiron players and their families over claims they suffered life-long brain injuries as a result of the playing the sport.

The CDC has called for improvements in injury surveillance systems in the United States to better understand the epidemiology and long-term outcomes of such injury.

Acting head of the CDC's Health Systems and Trauma Systems Branch Arlene Greenspan told *amednews.com* that improving knowledge was vital to devising the best ways to prevent such injuries occurring.

"There are things we know that we can do about TBIs that aren't uniformly being carried out," she said.

In Australia, the professional football codes have introduced rules that penalise players that hit the heads of opponents, and that require any player who suffers some loss of cognitive function on the playing field to be tested for concussion, and to be prevented from returning to play if concussed.

But Monash University brain injury expert Professor Mark Stevenson has warned that such practices were not being emulated at lower levels of these sports, putting the health of players at risk.

Professor Stevenson, who has previously worked at the CDC, conducted a study involving 3000 Sydney school-grade and suburban rugby union players aged between 15 and 48 years for between one and three seasons.

The research found a high incidence of concussion among players – 7 per cent sustained a concussion within 10 hours of

play, and the incidence doubled to 14 per cent with 20 hours of play.

Players who sustained one concussion were twice as likely to sustain a second, and those with a lower body mass index were 10 per cent more likely to sustain a concussion, and those who trained for less than three hours a week were 20 per cent more likely to be concussed than those who spent more time training.

Alarming, Professor Stevenson said, many of those who suffered concussion risked exacerbating the injury by returning to play early,

In a column in the *Sydney Morning Herald* on 27 February, Professor Stevenson said the study found 48 per cent of players who sustained a concussion returned to play in the same game, and 34 per cent did not leave the field at all.

This was despite a recommendation from the International Rugby Union Board, supported by the Australian Rugby Union, that players who suffer a concussion take a three-week break from training and play.

He said only 22 per cent of players identified as receiving a concussion in the study reported receiving any return-to-play advice. And 75 per cent of those players did not comply with the three-week stand-down period.

"Not one player in the study who received the recommended post-concussion advice complied," Professor Stevenson said. "Eighty-seven per cent of concussed players returned to either training or competition within one week, and 95 per cent had returned within three weeks of injury.

"So it's not just a lack of awareness of the rules regarding concussion - the rule itself is seen by the players as largely meaningless."

**Adrian Rollins**

[TO COMMENT CLICK HERE](#)



# Gene test hopes chilled by legal action

Hopes that life-saving genetic tests will become cheaper and easier to access after a breakthrough United States Supreme Court ruling have been clouded by legal action launched by patent holder Myriad Genetics.

Two companies that offered cut-price screening tests for BRCA 1 and 2 genes in the wake of a Supreme Court judgement that human genes could not be patented have been sued by Myriad Genetics, alleging breach of its patents.

Myriad has filed complaints with the US District Court in the District of Utah against two companies, Ambry Genetics and Gen by Gene Limited, that began offering BRCA 1 and 2 diagnostic tests immediately following the Supreme Court's decision.

In the action, Myriad claims the companies have infringed 10 of its patents related to tests of the BRCA 1 and 2 genes, mutations of which have been implicated in the occurrence of several cancers including breast cancer.

BRCA testing came to international prominence earlier this year when it was revealed actor Angelina Jolie had had a double mastectomy after tests revealed she was at high risk of developing breast cancer.

The legal action is expected to deter other potential test providers from entering the market until it is resolved, dimming hopes that the Supreme Court decision would quickly pave the way for cheaper and more readily accessible BRCA gene tests.

Under Myriad's monopoly, the tests have cost between \$3300 and \$4500 in the United States, but following the Supreme Court ruling this had dropped as low as \$1100.

Ambry Genetics said it would vigorously defend itself against the Myriad lawsuit.

"We have had an overwhelming response from our clients seeking an alternative laboratory to perform BRCA testing, and Ambry is fully committed to supporting our clients and patients moving forward," Ambry Chief Executive Officer Charles Dunlop said in a statement.

But Myriad spokesman Ron Rogers told *amednews.com* its legal action was a "classic patent case" that had nothing to do with issue at the centre of the Supreme Court ruling.

"We consider this to be ordinary, classic patent cases," Mr Rogers said. "They're infringing our patents covering the use of primers, probes and arrays, as well as methods of testing."

While the Supreme Court ruled that human genes could not be patented, Mr Rogers said it nonetheless affirmed the eligibility of patents on complementary DNA, synthetic genetic sequences and new applications for genes that had been discovered.

"Those are the claims that are really at issue in what we consider

to be classic patent cases that we recently filed," he told *amednews.com*.

The US Supreme Ruling, and the subsequent District Court action, have no legal standing in Australia, but they are likely to be taken into account by the Full Bench of the Federal Court when it rules, possibly within days, on an appeal against a court ruling that upheld Myriad's patent claim on human genes.

Adrian Rollins

[TO COMMENT CLICK HERE](#)

## INFORMATION FOR MEMBERS

### PBAC nominations invited

AMA members are invited to nominate to a specialist position on the Pharmaceutical Benefits Advisory Committee (PBAC).

This is a challenging and stimulating position that provides the opportunity to contribute directly to pharmaceutical benefits policy in Australia.

PBAC is an independent expert committee that advises the Minister for Health on medicines in relation to the Pharmaceutical Benefits Scheme. PBAC is required to consider the clinical effectiveness, safety and cost effectiveness of a medication compared with existing therapies. Members must be able to interpret the comparative outcomes of therapy involving a drug and appraise evidence.

The AMA has been asked to nominate a range of potential candidates, particularly those with expertise in epidemiology. The AMA's Federal Executive Council will assess nominations prior to forwarding them to the Minister for potential appointment.

PBAC meets for three, three/four-day meetings a year and may hold up to three additional one-day meetings. PBAC members currently receive an annual salary of \$36,750 and all travel costs are reimbursed. Appointments are for four years.

Further information about PBAC can be found on the DoHA website at [www.health.gov.au](http://www.health.gov.au).

To nominate, please forward a curriculum vitae no longer than 2 pages (Click here [[https://ama.com.au/system/files/sample\\_cv.pdf](https://ama.com.au/system/files/sample_cv.pdf)] for an example) to [cmoylan@ama.com.au](mailto:cmoylan@ama.com.au) **by Tuesday, 20 August 2013**. If you have any questions, please contact Georgia Morris on 02 6270 5466.

## BOOK REVIEW



# Menopause: Change, Choice and HRT

By B. G. Wren and Margaret Stephenson Meere

Rockpool Publishing, RRP \$24.99, pp240, ISBN 978-1-921878-69-5

Reviewed by Sam Merriel

The benefits of hormone replacement therapy (HRT) have been suggested to include the relief of perimenopausal symptoms, as well as prevention of chronic diseases such as cardiovascular disease, osteoporosis and dementia in women.

The optimal timing and duration of HRT has been a subject of confusion and debate in the medical, academic and public arenas for the past decade.

As pointed out in this book by Wren and Meere, the unexpected findings and subsequent media coverage of the Women's Health Initiative (WHI) study in 2002, which linked HRT to increased risk of breast cancer, blood clots and strokes, caused a seismic shift in the use of the therapy by physicians.

Upon reflection, the authors share the beliefs of other academics and gynaecologists that these findings have been generalised too broadly.

As a consequence, some women's health may have suffered as a result of the recommendations of the study author's, the US Food & Drugs Administration (FDA) and others, and women and their doctors remain unclear about the safety, efficacy and appropriate use of HRT today.

*Menopause: Change, Choice and HRT* aims to inform women, and other interested parties, about the role of hormones in female growth, development and ageing.

The stages and impacts of the menopause on a woman are described and explained.

The book provides detailed information on HRT; its various forms, uses, benefits and some adverse effects.

Wren and Meere add their own critique of the conduct of the authors of the WHI study, the manner in which the data was interpreted and released to the public, and flaws in their methodology and analysis.

Information on the alternatives to HRT is also presented, and recommendations are given for women about vital considerations to take into account in deciding whether to commence HRT or not, and when.

This book contains lots of detail on hormonal physiology and pharmacology, and is well referenced to studies and sources of health information.

A key criticism that Wren and Meere level at the WHI study authors, as well as academics and journalists who wrote pieces on the study's findings following their release, is that these individuals and groups used select data, low-quality evidence and anecdotal stories to campaign against the use of HRT.

This book uses some of the same techniques to communicate the benefits of HRT, and presents a subjective point of view on the issue.

The concept of Cochrane reviews and systematic assessment of evidence is introduced, but a pertinent 2012 Cochrane review of HRT titled *Long term hormone therapy for perimenopausal and postmenopausal women* is not even mentioned, and has findings that do not agree with the authors' summation of the evidence for HRT.

In summary, this book contains a thorough and detailed discussion about the menopause, HRT, the recent controversies surrounding the use of HRT, and alternatives to HRT for the relief of perimenopausal symptoms and the prevention of some chronic diseases faced by postmenopausal women.

This book is not a completely objective representation of HRT, and women and health professionals reading it should also consult other sources of reliable information when making decisions about the use of HRT.

[TO COMMENT CLICK HERE](#)

# A taste of Italian heritage in the Adelaide hills

BY DR MICHAEL RYAN



As with many grape growers and wine makers in South Australia, the roots of Amadio Wines can be traced back to the “Old Boot” in the Mediterranean.

These Italian pioneers helped shape primary production in Australia, and it is Giovanni Amadio that I have to thank for making his journey to Australia and having the foresight to grow grapes.

Mr Amadio arrived in 1927, with his wife and son joining him two years later.

Like many Italians, homemade wine was an essential way of life for Giovanni. His neighbors enjoyed his lighter, Mediterranean-style concoction, and commercial production soon ensued, using fruit from leased vineyards. He registered the name “Dry Table Wine”, which stood out at the time amid a sea of heavy fortified sweet wines.

His son Gaetano Amadio, a builder by trade, felt the pull of the vine and set up large grape growing area in the Adelaide Hills. This formed the basis of what are now known as the Kersbrook vineyards in South Australia that supply many other winemakers. The Chain of Ponds label was formed and became highly awarded, before being sold in the early 2000s.

Giovanni’s grandson Danielle, whose fingernails were smitten with the fertile soil of the Adelaide Hills, also felt a strong yearning for the grape, and he set about defining his own label under the well-respected family name Amadio Wines.

The enthusiastic team is backed up by his wife, who handles the bookwork, leaving Danielle is free to create and guide his vinous journey.

My attention was drawn to Amadio wines by the many varieties grown. In addition to the well-known grapes such as Shiraz, Cabernet Sauvignon, Merlot, Grenache, Sauvignon Blanc and Chardonnay, there are heritage Italian varieties such as Sangiovese, Nebiolo, Pinot Grigio, Lagrain, Barbera and Arneis. The shooting stars of this group include Sagrantino and Aglianico.

Danielle’s vigour and drive is evident in the fact that 65 per cent of production is exported. He has been nominated for many business and entrepreneur awards.

The use of the Italian varieties is not necessarily a sentimental family journey, but reflects a keen sense of new directions in what drinkers want to consume.

## WINES TASTED

### 1. 2011 Adelaide Hills Pinot Grigio

Pale yellow, with tinges of green. The nose is a basket of honeyed stonefruits, lime and hints of straw and minerality. The palate is on the Gris side of this style, meaning a full mouth feel and slight sweetness, but balanced by some abundant natural acids. Have with a green mango and scallop Asian salad.

### 2. 2007 D3/V14 Adelaide Hills Merlot

The code in the name indicates the specific Merlot clone used by the family vineyard. The wine is getting touches of brown against a deep garnet background. The nose is a maturing raft of red plums, spices, and prunes. The secondary tobacco and twig essences are equally satisfying. The palate washes over the anterior and mid sections with integrated fruit tannin and acid structure. In a blind tasting it smacks of a Shiraz with some Cabernet elements. A truly great Australian Merlot that sits well with an old-fashioned rare roast beef. Drink now, as it is already six years old, but will cellar for another five years.

### 3. 2011 Adelaide Hills Aglianico

This southern Italian grape has found a new home. It has a bright garnet hue with a depth of color. The nose has cherry and spiced raspberries notes. The aromas change over time, and become more intense on the darker fruit range, and there are background hits of earthy, twiggy aromas. While juicy in its palate, the acidity is intense but balanced. I liked this with my duck ragout pasta and, while it can be enjoyed in its youth, it will be a fascinating wine in three to five years.

2011 Adelaide Hills Sagratino - another southern Italian cousin. Similar colors to the Aglianico, and looks lively. The nose is a little more on the stewed fruits end of things, with winter berries running into a deeper brooding plum range. The palate is mid-weighted, but has an anterior juicy burst of quality fruits, with some acid and structured tannins. I had with a rare steak and horseradish sauce. Cellar for three to five years. Very enjoyable wine on many levels.

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<sup>1</sup> The monthly amount payable for the Total Disability Benefit is the lesser of (1) the monthly benefit that you choose to insure (to a maximum of \$20,000) and (2) 75% of the first \$20,000 per month of your pre-claim earnings plus 50% of the next \$10,000 per month of your 'pre-claim earnings' less 'other payments'. Please refer to the Glossary in the PDS for further information on 'pre-claim earnings' and 'other payments'. It is in your interest to not insure more than the maximum you can be paid. The monthly amount payable excludes business expenses.

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