RDMA
RDMA & NLMA's Joint Newsletter

Newsletter
JUNE 2015

See Where We Work & Live on page 8, 15 & 20.

Sussan Ley SpeechAt AMA Conference

President's Report Dr Kimberley Bondeson

Doctors in Queensland have a proud heritage, AMA House. Most of us who trained in Brisbane are very familiar with the building's unique copper dome structure, which is part of a circular tower protruding over the roof line, and its location near to the Medical School and the Royal Brisbane Hospital.

AMA House, the home of AMAQ, is a heritage listed villa at 188 L Estrange Terrace, Kelvin Grove in Brisbane, with a remarkable history. It was originally built from 1914 to 1916. It was also known as BMA House and is generally known as Hunstanton.

The stone for the house was quarried reputedly at The Gap. It is thought that the tiles on the verandah, hall, and other indoor floors and walls, were imported from either Italy or France, whilst the roof tiles bear the imprint of their manufacture in Marseilles, France (source: Wikipedia article based on the Queensland Heritage Register).

The property was sold to a Brisbane medical practitioner, Dr James Vincent Duhig. Dr Duhig was the first professor of Pathology at the University of Queensland, and founded the Red Cross Blood Bank in Queensland. The building was offered for sale to the Queensland Branch of the British Medical Association (BMA) in October, 1955.

A hall and additional office space was required by the early 1960's. A new building was connected to AMA House via a walkway, and was officially opened in 1965. Parts of the ground and first floors are leased to private firms.

As an AMAQ Councillor, it has been my privilege to attend meetings at AMAQ House, on the verandah of this magnificent building. I have seen policy made and discarded, political discussions, and the emergence of past and present AMAQ Presidents and Councillors. I have attended meetings for the membership, on the verandah, in particular most recently for the doomed Medicare Gap Policy.

The current board of AMAQ has deemed that this building be sold at auction, and that the AMAQ office move into the CBD. What exactly is the motivation & financial advice in regards to selling the major asset currently owned outright by the AMAQ?

It has been said that opposition to this sale would be purely emotionally based. Yet I ask respectfully: who sells a

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RDMA & NLMA's Joint Newsletter

WELCOME FROM

Dr BOB BROWN

President Northside Local Medical Association

The Redcliffe & District Local Medical Association sincerely thanks QML Pathology for the distribution of the monthly newsletter.

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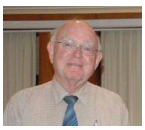

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RDMA 2015 MEETING DATES:

For all queries contact Margaret MacPherson
Meeting Convener: Phone: (07) 3049 4444

CPD Points & Attendance Certificate Available

Venue: Golden Ox Restaurant, Redcliffe

Time: 7.00 pm for 7.30 pm

	Tuesday	February 24th
	Wednesday	March 25th
	Tuesday	April 28th
	Thursday	May 28th
Next	Tuesday	June 30th
	Tuesday	July 28th
	Wednesday	August 26th AGM:
	Tuesday	September 15th
	Wednesday	October 28th
	NETWORKING:	
	Friday	December 4th

RDMA NEWSLETTER DEADLINE

Advertising & Contribution is 15th JULY 2015
Email RDMAnews@gmail.com
W: www.redcliffedoctorsmedicalassociation.org

NLMA 2015 Bi-MEETING DATES:

For all Northside LMA Meeting & Membership queries contact:
Meeting Convener:
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Website and Link:
Northside Local Medical Association Website
Link: http://northsidelocalmedical.wordpress.com/

Meeting Times: 6.45 pm for 7.15 pm

1	10th February 2015	2	14th April 2015
3	9th June 2015	4	11th August 2015
5	13th October 2015	6	8th December 2015

INSIDE THIS ISSUE:

CLASSIFIEDS remain FREE for current members. To place a classified please email: RDMAnews@gmail.com with the details. Classifieds will be published for a maximum of three placements. Classifieds are not to be used as advertisements.

AUSTRALIAN MEDICAL ASSOC PRESIDENT Dr CHRIS ZAPPALA

MEMBERS' UPDATE

Dear Members,

As I step into the role of the AMA Queensland Presidency, I am conscious of the formidable effort and achievement of my predecessor. Under Dr Shaun Rudd's leadership over the last year, we have benefited from a number of accomplishments for the association, including invaluable advocacy work on issues affecting members, a successful campaign targeting obesity in the regions, and the launch of the AMA Queensland Health Vision.

Over the next year, I look forward to building upon these successes, particularly in regards to the upcoming launch of Part 2 of the AMA Queensland Health Vision. Focusing on the medical workforce and training, the initiatives called for in this chapter will ensure Queensland has a knowledgeable workforce that can meet demands of a changing population. As in the public health focussed Part 1, our vision is far reaching and aimed to garner bipartisan support.

One factor ensuring patients have access to high quality care when they need it, is facilitating sufficient access to after hours care. AMA Queensland has welcomed the Federal Government's decision to reinstate incentives for medical practices that remain open after hours – returning this important function to general practitioners where it naturally belongs. The decision is mutually beneficial for both patients and medical practitioners. The incentives will allow general practitioners to provide services that previously might not have been viable and will ensure continuity of care for patients. Vigilance will be required to ensure the outcomes we and our patients expect will be achieved.

The AMA Queensland team is currently drafting a response to the Mental Health Bill 2015. We are in the consultation process and have been working with stakeholders to ensure our submission reflects the thoughts of members. Please keep an eye out for Online News as well as the AMA Queensland website for updates on this submission.

In addition to our work on the Mental Health Bill 2015, we recently released a submission for the Infrastructure, Planning and Natural Resources Committee's inquiry into fly in, fly out and other long distance commuting practices in Queensland.

Recognising the scope of the issue, the AMA Queensland submission considered a number of sources including member feedback, survey results from other states, and previous government reports. These highlighted concerns around the mental health, sexual health, fatigue and use of alcohol and drugs more common in FIFO workers and their families.

Whilst AMA Queensland is not opposed to FIFO practices, mandatory fly in, fly out practices are potentially detrimental to the physical and mental wellbeing of workers and their families. Voluntary FIFO, which also allows an employee to live near the community in which they work, seems to limit many of the detrimental effects. It also enables juxtaposed local communities to benefit from an association with mining ventures.

AMA Queensland's advocacy on behalf of members and the public is fundamental to ensuring the health of Queenslanders and the sustainability and quality of our health system. This work is only possible with the support, efforts and feedback of members. I welcome your thoughts and feedback at any time. Much of the last year's success can be attributed to the Association's consultative process and wide collaboration with members. I hope to continue this commendable work over the next year and encourage you to become an advocate around issues you are passionate about.

Sincerely,
Dr Chris Zappala
AMA Queensland President

Dr Kimberley Bondeson RDMA President Report

continued from front page.

major asset with no firm plans on reinvesting in some-thing of comparable value, let alone significance, without consultation with its membership who contributed in paying for it?

Many of the AMAQ membership, who have contributed by way of their membership fees towards paying for this building, would love to hold onto the solid stone symbol of our organization both financially and as a symbol. This may indeed be a purely sentimental response, but there are logical questions here that haven't been addressed.

https://heritage-register.ehp.qld.gov.au/AMA+House&site Tower Date 2009-03-11 Queensland+Government

Selling the AMAQ home is much more than a business deal (I like the comparison of a Husband selling the marital home without consulting the Wife, he might think it is a good financial decision, but not consulting his wife would be sheer folly.

Unlike the sale of any other asset it is very much a policy decision and he must discuss it with his wife first, as a matter of policy, not merely a dollars-and-sense decision. We think that such a decision should have gained the approval of the policy-making body, the Council, before becoming a done deal.

Among the reasons for the sale given by the board is that members are more likely to visit AMAQ head office in another location, and that parking at Hunstanton is a problem.

We have no evidence that the members are more likely to visit a CBD site than a Herston site. We are unconvinced that the limited (but free and nearby) parking would be any better in a CBD location (are visiting members prepared to spend up to $80 per 5 hours of Parking in a Public Parking Garage?)

We are all also aware that owning a heritage-listed property is potentially expensive and any variations to its structure and use are limited.

The Queensland state election demonstrated clearly what voters think of asset sales, when the governing body is broke. The AMAQ is not in financial difficulty.
Be assured that the AMAQ board DOES have the power to make fiduciary decisions, including asset sales, and can legally do so. The Board is proposing nothing improper or beyond its powers. I personally do not support this move. I feel that there are further options which have not been explored. I believe that, since this is a matter of image and policy and not mere finances, the membership of AMAQ, or at least the Council, should be asked what they would like to do with their historic building.

Further, the Board has not offered anything like a business case. They cannot tell us how much the building will be sold for. They do not have a clear alternative accommodation to move to. They cannot tell us how much any alternative accommodation would cost. They have not decided whether to replace our major physical asset with an alternative physical asset (although the message is that they intend renting, not purchasing).

It is just the case in this matter that a major asset sale should have been given wider airing before a final decision, and the Council and the membership should have been given enough information (excluding commercial in confidence) so that they could have decided for themselves whether the Board decision is a reasonable & sound one.

The refusal of the Board to consult with its paying members is ultimately the principal issue here. Is the Council not a representation of its Members?

The Board has arrogantly made a decision and completely overlooked any proprieties such as consulting the Council beforehand. The Board do not seem to hold themselves answerable to the membership!

[This opinion was written in close collaboration with the RDMA Vice-President, Dr Wayne Herdy, who is also a long-serving AMAQ Branch Councillor, and who agrees with the views expressed herein.]

Dr Kimberley Bondeson,
B.Sc(Hons). MBBS, FRACGP, DAME.
President Redcliffe District Local Medical Assoc.

AMAQ BRANCH COUNCILLOR REPORT
NORTH COAST AREA REPRESENTATIVE
Dr WAYNE HERDY

New AMAQ President, A New Home for AMAQ?, Pharmacy Windfall, GP Access Plan

WELCOME THE INCOMING PRESIDENT.
AMAQ has a new President. Chris Zappala is a thoracic physician with experience in public practice and now enjoys a city-based private practice in thoracic medicine. Chris also has years of experience in the battlefield of AMAQ politics so is well equipped to handle the coming year or two.

My phrase “year or two” is significant. Chris is the first President to take office under a modernised Constitution that allows a President to hold office for two consecutive years. He has indicated that he will probably serve a second term. A brave choice: apart from the financial losses that every President suffers during the tenure of office, we have a political world that takes personal tolls on bearers of higher office. AMAQ members should wish him well and he has the full support of all Councillors.

Chris presided over his first meeting of Branch Council by generating a discussion to guide the course of AMAQ for the coming year. The discussion ranged over three domains – advocacy, member engagement, and the role of Council and the Councillors. While I try not to breach Council confidentiality, members should be interested to know what their State Council is thinking and what we see as the pressing issues.

Under the heading of advocacy, Council raised a wide variety of live issues including

- health workforce - training pipeline and exit block
- task substitution
- Medicare fraud
- salaried doctor contracts
- community mental health resources
- safe hours, fatigue
- clinical/ social matters – soft drinks, ice epidemic DV, asylum seeker health.

I offer no prizes to my readers to recognize how many of these have been on our agenda forever and are still unresolved works in progress. I am disappointed at how few doctors can immediately recognize which issues are State issues and which are Federal issues. When an issue is primarily a Federal issue, I always wonder over the extent to which the State AMA can influence the Federal advocacy, and to what extent should we expend State resources to address a Federal problem?

Under membership, issues raised included

- Webinars and online services
- Utilising social media to share information
- IMG engagement – they are highly represented among our membership
- Members introducing non-members to meetings
- Relationships with Local Medical Associations
- Relationships with RMO associations.

Under the role of Council and Councillors, topics included

- Engagement with LMA’s, medical staff associations and IMG associations
- Ensuring that AMA members know who their local Council representative and/or craft group representative is
- Enhancing the two-way communications between AMA members and the Association through their representative members
- Developing local AMA meetings or videoconferences in regions.

With Chris’ consultative style, members can look forward to having more of a two-way dialogue with their Association.

A NEW HOME FOR AMAQ?
Members would have received a letter from AMAQ informing of the Board’s intent to sell the stately old stone home of Hunstanton and take up residence in newer and larger premises.

I have my own views on this proposal and welcome feedback from my readers.

PHARMACY WINDFALL.
I am so gobsmacked by this one that I can only plagiarise the Federal AMA release:

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Dr WAYNE HERDY AMAQ BRANCH COUNCILLOR REPORT cont from P6

"Pharmacists have won more than a billion dollars from the Federal Government for a major expansion of their role in patient care.

Despite her warning of a fiscal meltdown if spending is not controlled, Health Minister Sussan Ley (pictured) will sign the 6th Community Pharmacy Agreement on Wednesday, which will see pharmacies get $1.26 billion for "professional services".

Double the funding under the previous agreement, the new deal will see pharmacies receiving payments for providing dose-administration aids, advice to prevent medication adverse events and payments for home medication reviews.

Some $600 million will be spent on "new and expanded" services, but there is no detail on what services this will cover.

Related News Review: How was $15bn in pharmacy funding lost in space?

And the deal includes a further $50 million for a pharmacy trial program that will "seek to improve clinical outcomes for consumers and extend the role of pharmacists in the delivery of healthcare services".

Again there is no detail of what patient services will be trialled. However, the "intended focus" will be on supporting rural areas and Indigenous patients.

The agreement over the next five years also includes a shake-up of the rules around the incentives offered to pharmacies to encourage greater use of generic medicines.

A damning report by the Australian National Audit Office earlier this year said that the cash bonuses were being claimed by pharmacies even though doctors had already prescribed a generic medication to their patient.

The Pharmacy Guild of Australia, which negotiated the new deal with government, said professional programs would be assessed by bodies like the Medical Services Advisory Committee to ensure they were cost-effective.

The government said pharmacy location rules reducing competition would also be reviewed, however, the current rules will remain in place until 2020.

AMA vice-president Dr Stephen Parnis has already laid into the profession's expanding clinical role, saying: "Where's the training, where's the expertise, what happens when, not if, something goes wrong, and where is the evidence of cost-effectiveness?

"Last year the pharmacists put a proposal up that they'd take photos of skin lesions or moles … and send those off to doctors. Potentially things like checking of blood pressure, whatever that means.

"And one that really made my jaw drop was mental health assessments." "

We have to fight this one of course. Ignoring the interprofessional jealousies and doctors' belief that chemists make money out of unapproved generics and non-therapeutic retail sales, this proposal is taking money from doctors' budgets and putting patient care into hands that we believe are less safe.

GP ACCESS PLAN

I am happy to close this month's column with some good news. The GP Access plan has been abandoned.

To remind my readers, there was a "trial" involving select GP practices (up to 26 sites of IPN practices) and Medibank clients, offering special priority access to GP's, GP appointments within 24 hours, no out-of-pocket expenses and free after-hours GP access.

The AMA opposed the "trial" for setting a precedent that critics argued would erode clinical autonomy and undermine universal access to healthcare.

Let's consign this one to the scrapheap of history until a truly universal and non-selective patient triage pathway can be negotiated, based on need rather than on special favours.

As always, the opinions expressed herein remain those of your correspondent,
Wayne Herdy.

Wayne Herdy,
AMAQ representative, North Coast district.

Honorable Sussan Ley at AMA National Conference

Good morning and thank you for the invitation to address you today. It is always a pleasure to be able to talk directly to the medical profession and today is no exception. I would especially like to acknowledge:

Acknowledgements
AMA National President, Dr Brian Owler;
AMA Secretary General, Ms Anne Trimmer;
AMA Board members; and
All of you who have taken time away from your busy practices to be here today.

As I travel across the country I welcome the discussions and conversations I have right across the profession. These conversations and discussions are key to informing policy development. Yes we don't always see eye to eye but we certainly want the same things and that is improved patient outcomes.

I commend the AMA national conference for focussing on health policy and administration. I know you will support an interesting and rational debate. Medicine and health are very important in modern politics and government; and conversely, politics and government have a big impact on how you do your work. Successive governments have invested billions – many billions – to support your patients.

Next financial year, the Budget allocation for Medicare is more than $21 billion (plus a billion or so through veterans' affairs). Twelve years ago, it was just $8 billion – so that's more than a 150 per cent increase. Does that mean that health funding is in crisis?

No. Again, contrary to what you have read in the conference publicity, the Government is not claiming that we are in a health funding crisis. We are saying that we have to be realistic. If we don't make changes now, we will face a funding crisis. But I do agree with your conference theme. I think Medicare is at a midlife turning point.

It's blueprint, Medibank, was devised in the early 1970s – more than 40 years ago. And like most of us at that age, it has developed issues that require attention. Times and opinions have changed since the AMA called a doctors' strike to protest against Medicare in the 1980s! Now, I think we all agree that we want Medicare to live a long and happy life.

But we also agree that we can make better use of our health budget with strategic spending. That means better care for people with chronic disease. Two out of three Australian adults and one out of three children are now overweight or obese.

Around a million Australians are living with diabetes and the numbers are soaring.
That's not good enough. We need to stop this trend. We need sensible revision and renovation. The Government's 2015-16 budget and reforms to be announced in the near future, reflect these priorities. The Budget initiatives:
• will improve primary care and mental health outcomes, systems and structures;
• allow better management of chronic illness;
• provide affordable access to medicines;
• support regional, rural and indigenous health services;
• and deliver a more efficient health system.

Medicare
In terms of Medicare, we need to start by cleaning up the Medicare Benefits Schedule.
We will undertake the most comprehensive review of the MBS since it began. There are currently more than 5,500 services listed on the MBS. Since its inception, only around 10 per cent of these items have ever been reviewed. A new clinician-led MBS Review Taskforce will start work shortly. It will include practicing clinicians with a sound understanding of the MBS through regular use, health economists and academics, and will be chaired by Professor Bruce Robinson, Dean of the Sydney Medical School.

It will work with health professionals and patients to ensure that all therapies and technologies funded by Medicare are evidence-based and effective. By way of example, clinician-led reviews to date have resulted in better targeted items and removal of out of date items. We also need to look at alternatives to Medicare's fee for service funding model. We need to shift from a fragmented system based on individual transactions, to a more integrated system that considers the whole of a person's health care needs.

The Primary Health Care Advisory Group led by former AMA president, Dr Steve Hambleton will investigate options to provide better care for people with complex and chronic illness. This will include innovative care and funding models – some of which are already being trialled. It will also consider means to ensure that mental health is better recognised and treated in primary care; and greater connection between primary health care and hospital care. Innovative and blended funding models will be needed to provide appropriate care for patients with complex, ongoing conditions.

We will also develop clearer compliance rules and benchmarks for doctors – working with clinical

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AMAQ BRANCH COUNCILLOR REPORT GREATER BRISBANE AREA

Dr KIMBERLEY BONDESON

PBS Medications and the AMA National Conference Dinner Pictorial Brisbane 30/05/15

The Governments at it again.

Has anyone else noticed that patients are now paying higher prices for previously listed PBS medications?

Several years ago, all the oral medication for HRT was taken off the PBS.

Now they have made it extremely difficult to prescribe testosterone, requiring a specialist urologist review, even for Kleinfelders Syndrome, to validate the GP's diagnosis, and patients who previously fulfilled PBS criteria, must be reassessed before they can continue therapy.

It means a generation of woman will suffer hot flushes and sweats, and a generation of men will also experience the equivalent of menopause symptoms.

Other medications that have been slashed by the governments razor team include topical psoriasis medications, along with over the counter medications.

Of interest, I have noticed that some patients who now have to pay a premium for panadol, have simply stopped taking it. I suspect, that this is more because the drug does not work for them , rather than the cost of it.

Another issue which is ongoing, and causing grief, is the MBS rebate freeze. The Department of Health officials have confirmed that rebates will not be restored to their real-terms value when the freeze is lifted in 2018.

Kimberley Bondeson,
AMAQ Branch Councillor

Dr Steve Hambleton at AMA National Conference & entertainment on the night

Dr Di Minuskin SCLMA Pres at AMA National Conference

Dr Mukesh Haikerwal (President AMA 2005-2007), Dr Kimberley Bondeson, Dr Steve Hambleton at the AMA National Conference Gala Dinner on 30th May, 2015 in Brisbane.

REDCLIFFE & DISTRICT MEDICAL ASSOCIATION Inc.

MONTHLY MEETING

Date: **Tuesday 30th June**

Time: 7 for 7.30pm

Venue: Renoir Room - The Ox, 330 Oxley Ave, Margate

Cost: Financial members - FREE
Non-financial members $30 payable at the door. (Membership applications available)

Agenda:

7.00pm	Arrival and Registration
7.30pm	Be seated - Entrée served Welcome by Dr Kimberley Bondeson - President RDMA Inc.
7.35pm	Sponsor: ICON Cancer Care
7.40pm	Speaker: Dr Robert Hensen Topic: Exciting Developments in Haematology.
8.15pm	Main Meal, Question Time
8.40pm	General Business, Dessert, Tea & Coffee

RSVP: e: Margaret.macpherson@qml.com.au
t: 3049 4444 by Friday 26th June 2015

QML Pathology.

RDMA May Meeting 28.5.2015

Chair President Dr Kimberley Bondeson introduced the Guest Speaker Dr Roderick Chua (clockwise from right). Topic: Interesting Approaches to Cardiovascular Management. Sponsor for the night was Menarinapac Pharmaceuticals represented by Yvonne Smyth (left) and Sophie Watson (right). New Member was Jia (Frank) Cao, registrar and returning member Patrick Tomasiellao.

MEDICAL MOTORING
with Doctor Clive Fraser

Motoring Article #118
Safe motoring,
doctorclivefraser@hotmail.com.

"Car Insurance"

It's almost five years since it became mandatory for all doctors in Australia to have medical indemnity insurance.

I come from the low tax state, Queensland, where it was never essential to have indemnity insurance, though public Queensland doctors had always had discretionary cover for work performed at a public hospital.

The discretionary nature of that cover was tested at times, leading to a bitter dispute between Visiting Medical Officers and Queensland Health. At that time, I was unimpressed by the disingenuous nature of Queensland Health's insurance, and ventured onto talk-back radio to vent my spleen.

I was introduced as "Doctor Bruce from the Sunshine Coast", lest my true identity become known and my employer discipline or dismiss me for daring to speak publicly.

My point back then was that if I wasn't properly insured, then the patients weren't covered either. Next time I'll have to choose a more discrete moniker because, after getting off the air, I had three friends call me to ask whether that was yours truly on the radio.

I do recall as a medical student being told to never practice without insurance, and it was always my routine to ask colleagues who they were insured with before entering into an on-call arrangement.

As more international medical graduates arrived from countries with differing degrees of litigation, this became a more interesting conversation.

One +newly-arrived colleague told me that he was indemnified "by the Church" who owned the hospital that he worked at.

Could there be any better cover than that, I wondered!

It's hard to imagine how anyone would even dream of practising as an un-insured doctor, but national legislation eventually mopped up the recalcitrant.

In the same breath, it doesn't make sense to not insure your car, or does it?

Having owned a car that is 18 years old and worth about $3000 (if I'm lucky), I have dutifully forked out $750 every year for fully comprehensive cover. At first that seemed cheap when I considered that my car had cost me $68,000 in 1997.But that $750 has seemed to become increasingly steep as my car drifts further south in value.

Unlike lawyers who have a four-figure excess on their indemnity policies, doctors don't pay any excess at all, which will always be comforting when that inevitable writ arrives.I've just done the maths with an on-line tool that tells me I have a 42 per cent chance of having a complaint made against me to a regulator in the next two years, which reminds me that I must practice even more defensively.

In my practice, that might mean refusing to see anyone where there might be any risk of self-harm or any possibility of a side-effect arising from the prescribing of complex medication regimes. It's a bit like owning a car but never driving it, just in case you have an accident.

Excesses in motor vehicle insurance can be steep. My current policy carries an excess of $600 for myself, and another $1300 if an un-listed driver younger than 18 years crashes my car.That means I'm paying a premium of $750 a year for a car which, if written off, might return me a payout of $1100.

I've done my sums and decided to down-grade to a third party property policy for $150, and to keep the number of the wreckers in my glove box if I have a bingle. Well done I thought.

There is, after all, no point in paying for insurance you don't really need.

Now that brings me to reviewing my life insurance. Do I really need it?

Safe motoring,
Doctor Clive Fraser

NORTH LAKES
HAEMATOLOGY & ONCOLOGY CLINIC
- Montserrat Cancer Care -

New Bulk Billed Medical Oncology Service at North Lakes

As many Northern Area GPs and Surgeon's will now be aware, the North Lakes Haematology and Oncology Clinic has opened at the North Lakes Day Hospital.

Since commencing, we have been out visiting many local Doctors and the feedback from them has been that many of their patients struggle to afford a Private Medical Oncologist or would like a second opinion.

Dr Thaker and Dr Kharki (Medical Oncologists) have therefore agreed to see your patients in consultation, in a Bulk Billed capacity.

What does this mean for your patient?

1. They should be able to receive an appointment within 1 – 2 weeks;
2. If they require treatment, and have we can provide this on site;
3. The in hospital treatment will not incur any out of pocket expenses, other than those imposed by the health funds, and we accept all health funds (including BUPA and Medibank Private)

If you would like further information please visit www.nlhoc.com.au or feel free to give us a call on (07) 3859 0690 or referrals can be faxed to: (07) 3491 6803.

If you haven't yet met our Doctors, please call Nadine Carlson who can ensure that you receive a visit or invitation to one of our training evenings.

Our North Lakes facility was built with patient outcomes, comfort and atmosphere in mind. Our vision was to create a hospital environment that didn't have to look like a bland, plastic, sterile place of inconvenience. Our Day Spa environment makes people feel more welcome, calmer and nurtured. The manner in which we care for them eases the experience and improves the level of dignity and excellence all people deserve.

Interesting Tidbits

NATTY MOMENTS:

Funnies

I just took a leaflet out of my mailbox, informing me that I can have sex at 73. I' m so happy, because I live at number 71.

So it' s not too far to walk home afterwards. And it' s the same side of the street. I don' t even have to cross the road!

~~~~~

Answering machine message, I am not available right now, But thank you for caring enough to call.

I am making some changes in my life. Please leave a message after the beep. If I do not return your call, you are one of the changes."

~~~~~

My wife and I had words, but I didn' t get to use mine.

~~~~~

Frustration is trying to find your glasses without your glasses.

~~~~~

Blessed are those who can give without remembering and take without forgetting.

~~~~~

The irony of life is that, by the time you' re old enough to know your way around, you' re not going anywhere.

~~~~~

God made man before woman so as to give him time to think of an answer for her first question.

~~~~~

I was always taught to respect my elders, but it keeps getting harder to find one.

~~~~~

Every morning is the dawn of a new error.

~~~~~

The quote of the month is by Jay Leno: "With hurricanes, tornados, fires out of control, mud slides, flooding, severe thunderstorms tearing up the country from one end to another, and with the threat of bird flu and terrorist attacks, are we sure this is a good time to take God out of the Pledge of Allegiance?"

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Poole Group
ACCOUNTANTS & INVESTMENT ADVISERS

If you would like to discuss this topic please give Kirk Jarrot, a call on 07 54379900. Happy investing. Poole Group Partner

Is your Family Wealth Protected?

For most families preserving and enhancing family wealth and possibly passing it on to future generations may be important to you. The nature of a Trust can be a very powerful tool to protect and distribute family income and assets in a tax effective manner.

Broadly, a Trust is an agreement where a person or a company (the trustee) agrees to hold an asset or assets for the benefit of others (beneficiaries). The trustee is the legal owner of the Trust asset/s and the beneficiaries hold the beneficial interest in these assets.

Who is classified as family?

If family life is complicated Section 272-95 of the Income Tax Assessment Act (ITAA) 1936 sets out who is considered family.

Main Types of Trusts – Fixed, Discretionary and Hybrid

There are many different types of Trust however the most common are Fixed, Discretionary and Hybrid.

In Fixed Trusts the share that beneficiaries have in assets and income are pre-determined and fixed. An example of Fixed Trusts can be Unit Trusts (also known as managed investment funds) where each unit held in the Trust represents an entitlement to a certain proportion of income and capital.

A Discretionary Trust provides the trustee with discretion over the distribution of Trust income and capital in accordance with the terms of the Trust deed. Discretionary Trust structures are very common amongst family trusts due to the flexibility that they offer.

A Hybrid Trust has characteristics of both Fixed and Discretionary rusts. An example of a Hybrid Trust can be a Unit Trust with discretionary distribution options or a Discretionary Trust with certain fixed entitlements being fixed by the Trust deed.

Taxation of Family Trust income, Franked Distributions and Capital Gains

The trustee of the Family Trust must distribute the taxable income generated by the assets of the Trust to the beneficiaries. Franked distributions can be allocated to beneficiaries by making them specifically entitled to these distributions. The beneficiary will be taxed on the distribution and also receive the benefit of any franking credits. Capital gains generated by the disposal of a Trust asset, can be allocated to beneficiaries for tax purposes.

Benefits of Trusts

Income Splitting - It may be more tax effective to distribute most of the living Trust income (if not all) to adult beneficiaries, including senior family members who may be able to take advantage of the seniors and pensioners tax offset, also beneficiaries with lower taxable income. You need to be aware that you are only able to distribute a maximum of $416 to minors.
Asset Protection - The trustee does not personally own these assets. As such, the assets held by a person as trustee cannot be taken by creditors in the event of a trustee declaring bankruptcy or insolvency unless the debt relating to the creditors was a Trust debt.
Estate Planning - One of the main advantages of using the Trust structure is that it allows family assets to be passed on to future generations in a tax effective manner. This can be arranged while the person is still alive (living Trust) or after their death (Testamentary will Trust).

Conclusion

The Trust structure can be a powerful tool in protecting and distributing family assets in a tax effective manner. However the establishment and the structure of the trust must be carefully considered and as such professional legal, accounting and financial advice must be sought to ensure that the trust is established and operated in a manner that meets the family needs.

LETTER TO THE EDITOR

A recent article in the MJA June 1 2015 Vol 202 no10, p519-521 “The Scourge of Managerialism and the Royal Australasian College of Physician. This is essential reading and we must ask the question, has the AMA fallen into the same situation.

The recent proposed sale on Hunstantville, without this knowledge being known to the rank and file, suggest that this is the case. What other characteristics would suggest this change?

1. Does the annual report disclose the remuneration of the CEO or President?

2. Does the voting representation for AMA office holders reflect the will of the members or is the voting outcome about the 6%? Is there such apathy that the President Elect position was not contested?

3. Are all positions on the AMAQ council or are some areas not represented, and in unrepresented areas have all members been alerted to this?

I am afraid that the answers to the above reflect that the AMAQ suffers from the same problem. I have canvassed quite a few of members in my district about the role and relevance of AMAQ over the last 24 months. No one can remember an AMAQ member’s only function.
No one has availed themselves of the benefits except attending the overseas conference or buying a car.

Most cannot name the president, and at our last function, the AMAQ representative could not name our local representative on the board. Most believed that the involvement in the QHealth doctors fight was either an inappropriate usage of our resources, did not know how much of our resources were used, or had not felt the explanation given to justify this resource usage was adequate.

In summary, the decisions of AMAQ seemed irrelevant to most people’s medical practice and most only remained members due to historical sentiment, or to support the federal body.

The Scourge of Managerialism seems to have affected AMAQ.

Multiple more examples exit, why do you not ask your local members if they feel the same way?

Being ignorant of the ground swell or apathy is not the same as being supported.

Thank you
Dr John W.Cox

Honorable Sussan Ley at AMA National Conference

leaders, medical organisations and patient representatives. Together, these reforms will make a major contribution to getting Medicare back on track. They will refocus it on today’s needs and today’s patients, and improve the health value from taxpayer’s investment.

Primary Health Networks (PHNs)
The same goals will also be pursued by the 31 Primary Health Networks which will come into operation on 1 July. PHNs will work directly with GPs, other primary health care providers, secondary care providers and hospitals, to improve the coordination of care and ensure patients do not miss out.

This applies to physical and mental health care. As you know, mental health services and programmes have been reviewed. I will be working very closely with all stakeholders to develop a comprehensive response to the recommendations contained in the Mental Health Commission Review with a realistic way forward that improves mental health services for Australians. Improving local mental health services will be a priority for targeted work by PHNs, together with Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care. PHNs will have funding to commission health and medical services to fill gaps. The changes to Medicare, and to primary care via PHNs, will enable you as doctors to work much more effectively to prevent and manage lifestyle related disease. In the medium to long term, this will allow many patients to avoid the pain, disruption and costs of acute hospital care.

Public hospitals
This in turn will reduce demand pressure on hospitals. We can also reduce funding pressure by making hospitals more efficient. The Australian Government is discussing historic changes to our federated system of government. These discussions will be further framed by the upcoming White Paper on Federation. The paper will consider reform of federal-state relations and also the federal-state split of responsibilities in health. The White Paper is about getting clean lines and efficient administration. It does not mean the Commonwealth is pulling the rug out from under public hospitals. The Federal Government cannot fund unrestricted growth. This is a conversation I’m having with the states and territories to ensure patients receive the best clinical

continued P20

DUBAI, UAE - THE LAND OF EXTRAVAGANCE

By Cheryl Ryan

Dubai, also called as Dubayy in Arabic is one of the seven Emirates of the United Arab Emirates and the second largest town after Abu Dhabi. If you want to experience luxury and extravagance with a variety of things to do and see, head to Dubai!

The Enchanting Dubai

Popular for its man-made island, Palm Jumeriah, huge skyscrapers with the world's tallest building, Burj Khalifa, the city to have the seven star hotel, Burj-al-Arab, the luxurious yachts on the magnificent gulf coastline, and the very popular Dubai shopping festival, make it a destination for splendid holidays. Not just this, the city offers an easy way in to the Desert vegetation all around for you to watch the breathtaking sun sets across the sand dunes. When you are done with clicking sunsets and camels, move to some of the world's best restaurants in Dubai to stir up your taste buds! Well, what is travel without good food?

What have we got for you in Dubai?

1) Take the glimpse of Dubai skyline from the tallest building in the world. Burj khalifa, a man-made wonder, and beautifully constructed by 13,000 workers who worked day and night and completed each level in about only three days. There are two observation decks, the 128th floor and the 148th floor. For those who want to skip the line and see the skyline from the highest observation point, are taken to the 148th floor with the "sky-ticket". Includes Arabian refreshments, a guided tour and an interactive screen.

2) 4x4 Desert Safari is a must-do thing on your Dubai trip and we ensure you do not miss the golden sun kissed dunes, the magnificent views of the desert and incredible sunset. While you are taken to the desert, you get to hear the interesting tales of the region from the driver as you enjoy the hoard of camels passing by you. The desert in itself is fascinating; however, it gets even better when you are served with a barbecue dinner. A lot is packed in there for you like henna tattoo, camel rides, belly dance performance around the campfire and the heady shisha (Hookah) to end the evening with bliss and contentment.

3) A visit to gold souk, whether you want to buy gold or not is a must visit place just to see how much gold a city of Dubai can showcase! Gold worth millions of dollars in the form of jewellery is displayed in shops for people to buy at comparatively low rates.

4) Who does not love beaches? Guess, everyone! A visit to Jumeriah Beach Park, the longest beach in Dubai with silver sands gives a day to relax and rejuvenate amid Sun, sand and sea.

5) Meet the lovely dolphins at the Dolphin Bay in Atlantis. Interact and play with these gorgeous water creatures or just watch them with amusement as they show their skills in the water. Be friends with dolphins as you touch, hug and kiss them, an activity memorable for people of all ages!

How are things planned for you?

We have developed an interesting and comprehensive itinerary for you that include all the fascinating attractions and interesting things to do:

• Trip to Burj Khalifa to experience the Dubai Skyline

• A visit to Dubai Mall that has high end fashion stores and plenty of American and other food chains catering to people from all kinds of backgrounds and tastes. It also has one of the largest aquariums of the world with 33000 aquatic animals. Surely a delight to see those colourful creatures!

• Trip to Atlantis, a gorgeous hotel with plenty of things to do and see. You can interact with dolphins, enjoy with your kids at the water park or perhaps just enjoy the glorious architecture.

• Shopping trips to Gold Souk and Madinat Souk

• For a relaxed day out, we take you to Jumeriah Park Beach in the day and on an exciting boat cruise trip at the Dubai creek with dinner and drinks in the evening

• Not to forget, a desert safari is a part of this exciting itinerary that takes you to the gorgeous sun baked desert and gives you a true Arabian experience in Middle East.

Indulge yourself lavishly in this beautiful city of extravagance.

Cheryl Ryan 123Travelconferences
5/56 Burnett Street Buderim

AMA Family Doctor Week 2015
YOU AND YOUR FAMILY DOCTOR: THE BEST PARTNERSHIP IN HEALTH

AMA

MEDIA ALERT

AMA FAMILY DOCTOR WEEK, 19- 25 July 2015

You and Your Family Doctor: the best partnership in health

Family Doctor Week is the AMA's annual celebration of the hard work and dedication of Australia's GPs – your family doctors.

Each year, the AMA reminds the community of the vital role played by local family doctors in keeping Australians healthy.

Having a trusted family doctor is good for your health. People who have an ongoing relationship with a family doctor are shown to have better health outcomes.

This year, the theme for Family Doctor Week is *You and Your Family Doctor: the best partnership in health.*

During Family Doctor Week, the AMA will issue media releases highlighting the vital role played by family doctors in preventative health, aged care, and end of life care, and raise contemporary health policy issues such as the Medicare rebate freeze and general practice training and funding.

The AMA encourages local media to make contact with family doctors in your town, suburb, or local community to hear their stories about the joys and the challenges of providing quality health care in your area.

State and Territory AMAs can help you find local family doctors. Please contact:

NSW	Lachlan Jones, 02 9902 8113
Victoria	Felicity Ryan, 03 9280 8753
Queensland	Rachael Finley, 07 3872 2209
Western Australia	Robert Reid, 08 9273 3018
South Australia	Eva O'Driscoll, 08 8361 0106
Tasmania	Lucinda Bray, 03 6223 3333
ACT	Christine Brill, 02 6273 0455
NT	Fiona Thomson, 08 8941 0937

AMA Family Doctor Week is proudly sponsored by the Australian Government Department of Social Services, National Health and Medical Research Council, Cutcher & Neale, and AMEX.

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23 June 2015

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AMA NATIONAL CONFERENCE DELEGATES CONDEMN NEW MEDICAL SCHOOL, AND CALL FOR ACTION ON ASYLUM SEEKER HEALTH
AMA National Conference 2015 – Urgency Motions

Delegates to the AMA National Conference 2015 in Brisbane late yesterday unanimously passed two Urgency Motions and a Motion with Notice.

The first Urgency Motion relates to the decision to fund a new medical school at Curtin University in WA.

The second Urgency Motion relates to the health of asylum seekers.

The Motion with Notice relates to protection from prosecution for doctors who disclose, in the public interest, failures in health care delivery in immigration detention centres.

Urgency Motion 1:
That National Conference recognises that many graduating medical students and junior doctors around Australia are currently unable to find quality training positions due to a lack of available places. National Conference condemns the Government's decision to fund a new medical school when there is already evidence that some medical graduates will be unable to progress to full specialist qualification and that this decision will only make this problem much worse.

National Conference calls on Federal Council to:
· continue to strongly advocate for the commitment to a new medical school to be reconsidered;
· call for State and Federal Governments to collaborate to ensure robust health workforce planning through the National Medical Training Advisory Network so that medical workforce numbers are matched to community need; and
· requests that the Health Minister seeks the advice of the National Medical Training Advisory Network, as well as the AMA, AMSA, State health departments and the Department of Health as part of any process to consider any further increase in medical student numbers.

Urgency Motion 2:
Pursuant to existing AMA policy, "The Health of Asylum Seekers 2011", National Conference requests Federal Council to review its policy as a matter of urgency. The review should particularly note new evidence of ongoing and permanent damage being inflicted on detainees as a consequence of the 19 July 2013 Law.

Motion with notice:
That the delegates of AMA National Conference request the AMA Federal Council to call upon the Australian Parliament to amend the Australian Border Protection Act 2015 to provide an exemption (from prosecution) for medical practitioners who disclose, in the public interest, failures in health care delivery in immigration detention centres.

These motions have been referred to the AMA Federal Council.

The AMA will today release a resource to assist doctors to provide support for victims of family violence.

31 May 2015

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REDCLIFFE AND DISTRICT MEDICAL ASSOCIATION Inc.

ABN 88 637 858 491

NOTICE TO ALL NEW AND PAST MEMBERS

Membership Subscription Benefits

Don't waste time! Join now!

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Rounded off with the End of Year Networking Meeting

Get your membership benefits! Socialise! Broaden your knowledge!

Dear Doctors

The Redcliffe and District Medical Association Inc. have had another successful year of interesting and educative meetings on a wide variety of medical topics. Show your support for your Local Medical Association to continue the only local convocation for general practitioners and specialists to socialise and to discuss local and national medico-political issues.

Annual subscription is $120.00. Doctors-in-training and retired doctors are invited to join at no cost. This subscription entitles you to ten (10) dinner meetings, a monthly magazine, an informal end of the year Networking Meeting to reconnect with colleagues. Suggestions on topics and/ or speakers are most welcome.

RDMA SUBSCRIPTION FORM – INTERNET PAYMENT PREFERRED

Treasurer Dr Peter Stephenson Email: GJS2@Narangba-Medical.com.au.

ABN 88 637 858 491

1. **One Member (July to June: $120; Oct.-June: $90; Jan-June: $60.00; April-June: $30.00)**
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1. Dr. _____
(First Name) *(Surname)*

2. Dr. _____
(First Name) *(Surname)*

1. ***EMAIL ADDRESS***: _____@_____

2. ***EMAIL ADDRESS***: _____@_____

Practice Address: _____ Post Code: _____

Phone: _____ Fax: _____

CBA BANK DETAILS: **Redcliffe & District Local Medical Assoc Inc:BSB**: **064 122 Account**: **0090 2422**

METHODS OF PAYMENT:

1. **PREFERRED INTERNET BANKING**
2. **PAYMENT BY DEPOSIT SLIP**: Remember: INCLUDE your name i.e: Dr. F. Bloggs, RDMA A/c & date:
3. **ENCLOSED PAYMENT:** (Member Subscription Form on website, type directly into it and email)
   i) **Complete form & return:**
   - **c/-QML or Redcliffe & District Medical Assoc Inc. P O Box 223 Redcliffe 4020**

   ii) Or by email to GJS2@Narangba-Medical.com.au

outcomes and health experience.

Ehealth

In the longer term, we can make all levels of health care much more efficient – and better for patients – by effective use of information technology. The recent Budget delivers $485 million to reform the eHealth records system and make it work for doctors and patients. A fully functioning national electronic medical records system will be a huge step forward for patient safety, reducing mistakes, time and duplication. It could generate estimated savings to Medicare of $2.5 billion per year within a decade, and another $1.6 billion per year by states and territories to public hospitals. Obviously, we will be working very closely with you on this important reform and encouraging your feedback to ensure the system works and benefits professionals and patients alike.

Health workforce

The health and medical profession's input to the future of healthcare in Australia is central to improving our complex system. The government is working to increase the number of Aboriginal and Torres Strait Islander doctors, in partnership with state governments, GP practices, Aboriginal Medical Services, specialist colleges and groups like the Australian Indigenous Doctors' Association. We are also working to improve the cross cultural skills of the entire medical workforce – to encourage Aboriginal and Torres Strait Islander people to engage more with our health system and get better treatment when they do.

Other disadvantaged communities also need better access to medical care – including people living in rural and remote communities, and people experiencing socio-economic disadvantage. Despite attempts over many years, rural residents still do not have the same access to doctors as those in the cities.

For the future, we need to get back to where we were mid 20th century – with a highly skilled and well distributed health workforce, able to meet the needs of all patients. A workforce that provides "the right care at the right time in the right place". What I can announce today is that the competitive Approach to Market (ATM) for general practice training is now open. It will close on 10 July 2015. Through this Approach To Market, organisations will be funded to administer the Australian General Practice Training programme, by coordinating and overseeing training placements for GP registrars.

Current Regional Training Providers (RTPs), as well as other organisations, will be able to apply as part of this process. Successful applicants will be offered funding agreements with the Department from 1 October 2015 until 31 December 2018. Following completion of the process, current Regional Training Providers, where necessary, will work closely with new training organisations for a three month handover/transition period. This three month period will ensure a smooth transition for GP registrars, GP supervisors and the training practices and facilities. But we need to do more. We need to be innovative and think outside the medical service model developed nearly a century ago.

We need them to be willing to work in areas of shortage and, where appropriate, to practice as generalists, not super-specialists. We need doctors who are aware of the cultural needs of Aboriginal and Torres Strait Islanders and people from other cultural backgrounds. And – we need doctors to participate enthusiastically in service delivery reform and multidisciplinary care. I am also considering workforce reform in primary care and I will be looking at the results of several innovative trials which are either underway or soon will be.

After Hours Care

As a direct result of feedback from the AMA and other stakeholders, a new Practice Incentives Programme after hours incentive will be introduced on 1 July 2015. The Government has committed more than $410 million over four years for this incentive. It will support frontline services to give patients the right care, at the right place, at the right time. Ultimately, availability or after hours care and other services comes down to doctor choice. In Australia, the Government provides encouragement and incentives, but many choices about their practice remain with doctors. I think we all agree that we are in a time where we need to look at our system maturely and I work out our path forward. That needs to be done together.

Your continuing mission is to fulfil the health needs of the Australian people. But achieving this now and into the future will require greater flexibility from the profession. This is not me as the Minister dictating what will and won't happen, its about taking the advice of experts right across our health system to bring about the best outcome for patients. That will inevitably mean changes and the need for flexibility. Embrace change and work with me on this journey to bring about positive and improved results.

Conclusion

Reform is never easy and we are well placed to work together now to set the Australian health system up for the future to ensure we continue to provide high-quality care and Australians continue to provide world-class health outcomes.

Ends