30 APRIL 2018

How low can the AMA go?

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Recently *The Australian* newspaper made the surprising claim that only 30% of medical practitioners are AMA members.

In 1962, more than 95% of doctors belonged to the AMA. By 1987 it was 50%. AHPRA reports that in 2016 there were 107,179 registered medical practitioners. The 2016 AMA annual report notes a membership of 29,425. That is 27% of doctors.

The AMA remains the "go to" medical organisation for politicians and the media. However, the credibility of the AMA depends on maintaining the support of doctors. More prosaically, the AMA depends on members' annual subscriptions to fund its activities.

Many once-venerable organisations, including churches, unions and Rotary clubs, now struggle to attract and retain members.

Why are doctors not joining the AMA?

BACKGROUND

The interaction between the medical profession and the broader society is fascination and complex. The AMA's influence over that interface has altered in the last half century.

In 1973, new Queensland medical graduates were invited to a reception at AMA House. It was perhaps too cosy. Medical Board representatives at one desk collected our applications for registration as medical practitioners. At the next desk we joined the AMA.

Health consumer activism and episodes such as the Chelmsford and Bundaberg scandals prompted reviews of medical self-regulation.

State medical boards are no longer dominated by AMA influences and include non-medical "community" members. Since 2011 the boards sit within a national framework with policies determined by AHPRA and the Medical Board of Australia (MBA). Disciplinary functions are also undertaken by separate health complaints bodies.

The nebulous, but real, guild-like, "anti-competitive" influence, once exercised by the AMA over doctors finally disappeared with the 1990s extension of national competition law to the professions.

Up to the 1970s, it was not rare to see articles advising doctors not to apply for a particular position or to contact the state AMA branch before applying. As recently as 1989, the AMA code of ethics decreed doctors' telephone directory entries "should appear in small type only" and a doctor should not start "a competitive practice unless he satisfies himself, by reference to the state AMA branch council that the action he contemplates is free from ethical objection".

The AMA's reputation as a fearsome political machine was built on successful political advocacy. Australian doctors practise under enviable arrangements, beneficiaries of political battles won decades ago by the AMA or, before 1962, the Australian branches of the British Medical Association (BMA).

Before Medicare (1984), the big issue was how Australians could be guaranteed access to medical services.

A 1946 constitutional amendment confirmed the Commonwealth's power to pay medical benefits with the BMA securing a constitutional guarantee against "civil conscription" of doctors.

The regulatory and economic foundations of Australian medical practice, comprising private fee-for-service practice, federal government subsidisation of medical fees and financial support for private health insurance were laid in negotiations between the Menzies government and the BMA.

The AMA led the profession's response to the Whitlam and Hawke governments' Medibank (1975) and Medicare. Bill Hayden, the minister who introduced Medibank, has written of the "relentlessness" of the "tough militant AMA". These schemes expanded subsidisation of fees to the whole population, but did not challenge the 1950s "settlement" between the profession and government. Under Medicare, a doctor can practise anywhere with all services attracting a rebate. Medicare was based on the Ontario Health Insurance Plan, but Australia did not replicate the 1984 Canada Heath Act, federal legislation which coerced the provincial (State) governments into enforcing price control on doctors, limiting their fees to Medicare fees.

Until the late 1980s, the core business of the federal AMA was coordinating the profession's negotiations with government over medical insurance rebates. The AMA line was unambiguous and drummed into doctors every month through AMA publications: it was anathema to confuse a doctor's private fee, a matter between the doctor and patient, with the insurance "rebate".

An AMA/government committee met regularly to agree on all changes to the MBS. Annual inquiries into "medical fees for medical benefit purposes", established by formal agreement between the AMA and minister and chaired by an arbitration court judge, assessed trends in practice costs, community incomes et cetera.

Such "corporatism" has, in an era of deregulation and reliance on market forces, been largely abandoned across the whole economy.

THE PRESENT

The AMA's political achievement from the 1950s was to protect and bolster the small private practices in which the majority of doctors worked.

Cultural, scientific and economic changes are reshaping the professional and working lives of doctors. Potential members may not understand the AMA's many roles. When Director PSR, I met doctors who had never heard of the AMA.

The AMA's historical position on fees and rebates has fallen behind reality. AMA fees have seldom been adjusted to reflect technological and other efficiencies. Many medical organisations now engage in MBS negotiations.

Many GPs work as "contractors" in corporate bulk-billing facilities. Pathology and diagnostic imaging are provided by large publicly listed corporations. For most general practice and pathology services, the Medicare rebate is the fee.

Areas of specialist clinical practice, such as radiotherapy and oncology, are consolidating. For example, GenesisCare, valued in 2016 at $1.6 billion, provides the majority of private radiotherapy services in Australia and also operates many cardiology and sleep medicine clinics. Majority control now lies with Macquarie Bank and Chinese investors.

Until the late 1980s, the commonwealth had little direct influence over general practice outside the MBS. A bewildering array of commonwealth policies and programs has since sought to influence GP remuneration, education, practice organisation and distribution.

Many billions of dollars have been spent.

GPs no doubt appreciate the influence of the AMA and other medical organisations on these government initiatives, but are unlikely to perceive that their professional bodies are driving a clear strategic agenda.

There are indications the tectonic plates of health policy may shift and further disrupt the ways medical practice has operated in Australia.

The government is trialling Health Care Homes, shifting GP payments to capitation. Under COAG's 2011 National Health Reform Agreement, public-hospital funding is moving towards national "activity-based funding". Private insurers are redoubling their efforts to influence clinical practice.

Well-researched and defensible analysis is an essential part of high-level lobbying, as is the need to pursue long-term strategies over some years. The medical profession has been unfortunate over recent decades in not having a properly resourced credible economic and health policy research unit. The AMA is the obvious home for such a unit. For example, a policy unit could have analysed and explained the consequences of the recent dramatic growth in undergraduate medical school places on subsequent access to postgraduate education. The profession may not then have found itself playing second fiddle to ambitious universities.

Doctors are instinctively wary of intrusive bureaucratic interference. Is the AMA making clear to potential members that it is one organisation free of dependence on government financial or regulatory favours? Maybe potential members are confused about the AMA's priorities and wonder whether the AMA over-indulges in the Canberra media game, like a participant in an old-fashioned progressive barn dance having a quick turn around the floor with every health and social issue that comes along. The 2016 federal AMA report notes that during that year 250 media releases were launched.

Potential members might ask what the AMA provides that is not available elsewhere. The AMA no longer dominates the presentation and interpretation of medico-political news. Commercial newspapers supported by sophisticated online editions incorporate clinical articles as well as health sector political news and are sent free to all GPs and many specialists.

The "digital information age" allows specialist and other medical organisations to communicate with members directly. Dr Paul Mara, from Gundagai in NSW, has written on how his success in the late 1980s establishing the now influential Rural Doctors Association depended on liaison with rural colleagues through modern communication channels.

AMA STRUCTURE

It would be naive to suggest that cost is not a consideration for a doctor contemplating joining the AMA. Annual fees, around $1500, vary among states. There is not one AMA. The AMA is a "confederation" of eight legal entities. There is the "Federal AMA" in Canberra and an AMA in

each State and the ACT. This loose structure reflects the 19th century origin of State AMAs as colonial branches of the BMA. The 27% AMA membership figure probably masks significant State variation.

Doctors join a state AMA and the federal AMA. AMA subscriptions are paid to a state. A component is passed to the federal AMA.

Each state AMA has its own traditions, processes and assets. States elect a local AMA president. The position carries prestige in the state's halls of power and among local media.

When health policy is coordinated by COAG there remains much detail sorted out differently in different states. Some state AMAs formally represent salaried specialists, doctors in training or VMOs in industrial processes.

States differ in the range of services offered. Queensland once ran a "medical agency".

I used the agency in the 1970s when looking for a general practice to buy, to purchase practice supplies and to engage locums. Some states still establish services for private practices but commercial firms provide competing services. The RACGP now maintains an extensive on-line database of GP practice and employment opportunities.

The AMA "brand" is used freely, if not haphazardly, by states to endorse a maze of member deals with various banks, finance companies, airlines, car manufacturers et cetera. But doctors have other options. The RACGP website (which notes membership of 38,000) list member discounts "at hundreds of restaurants", "at major cinemas Australia-wide", and on a wide range of insurances. Deals with car companies are promoted.

AMA members' fees fund the *Medical Journal of Australia* . The *MJA* is uniquely positioned to promote serious commentary on the policy, regulatory and economic changes reshaping Australian medical practice, but now seems to prioritise the interests of academic doctors.

The commonwealth funds and regulates the MBS and PBS arrangements, establishes the regulatory framework for private health insurance and is responsible for veterans' health services. Many doctors including urban general practitioners have limited interaction with matters directly controlled by states and might ask why they must finance a diverse AMA conglomerate.

THE COTTON EPISODE

The AMA state entities have vigorously defended their influence within the AMA.

At any time, the federal and state AMAs might have some common board directors. However, each AMA is autonomous with its own board and CEO. Fiduciary responsibilities create potential for conflict among the various AMAs.

In 1991, Peter Sekuless, one of Canberra's first full-time professional lobbyists, published Lobbying Canberra. Sekuless had undertaken assignments for the AMA. He wrote "outsiders do not understand that national organisations with large memberships devote much of their time to internal matters" including "fractious branches, membership recruitment and endless meetings on finances".

In my years working at the AMA, 1987-98, a guaranteed way to precipitate a debate (or worse) was to suggest that internal improvements might be made to AMA processes. In the mid-1990s, the federal AMA met once with state AMA CEOs to discuss the scope for more coordination on internal matters. The Australian economy had evolved with many industries dominated by national entities. Did IT advances offer scope for efficiencies across the AMA? Did the AMA need to print and distribute nine hard copy monthly publications? Was it helpful or confusing to have eight AMA websites? The CEO of one state AMA famously turned up at the Canberra meeting only for the last hour to announce he came "to make sure nothing happens".

In 1987, a taskforce headed by Sir Robert Cotton, a minister in the Fraser governments, reported on the "structure, function and constitution of the Australian Medical Association". The decline in AMA membership from 95% in 1962 to 50% of doctors was the prime motive for the review.

Cotton's major recommendation was that "the AMA become a national association and that the autonomy of the branches be removed". Cotton proposed state "divisions" given the "federal-state system of health care" and for "other administrative and policy reasons".

I began work at the federal AMA in early 1987. A month later the Cotton report was delivered. An early meeting with state presidents to discuss the report was held at the federal AMA building. The federal president was ejected from the meeting.

Sir Robert recognised his proposals might seem "too far-reaching, too fundamental and too disruptive". A 1989 *MJA* article summarises the "often-turbulent debate" within the AMA following the report and pointed out that the federal AMA's constitution had made it "the creature of the state branches and, thus, left it with uncertain powers to act on its own account."

In 1987, no significant internal AMA constituency supported fundamental realignment. Some changes were made including the addition of specialty representatives to the federal council. It is impossible to know if a Cotton-type restructure in 1987 would have resulted in an AMA more likely to attract paying members in 2018.

Doctors are instinctively wary of any intrusive bureaucratic interference

WHERE TO NOW?

Has the AMA reached a time when uncertainty among potential members over the AMA's diverse national and state roles and its internal frictions can no longer be just brushed off as inevitable features of a loose federal structure?

In his column in *The Australian*, legendary ALP political fixer Graeme Richardson regularly reminds obfuscating politicians that "the mob is not stupid". Doctors are not stupid. It seems unlikely today's doctors will flock to the AMA until they more clearly comprehend what the AMA offers and seeks to achieve.

An option, in a sense the opposite of the Cotton proposal, would be to reconfigure the current AMA into a strong, independent, national AMA and independent state medical associations.

Each state association would then be unfettered, promoting its own unique suite of services to potential members. A state would be freed from requiring prospective members to pay for subscriptions to a distant national body. State associations would remain part of the governance structure of the national AMA.

For an aspiring medico-politician, experience in a state association could lead to service at the national AMA. The national AMA would remain a direct membership organisation (not a peak body) drawing members of its governance structures from its members and from a wider range of bodies than just state associations. It could have a dual mission, a strong national lobby for issues affecting the whole profession and a provider of high quality research, analysis and support for other medical groups, including state associations, pursuing more focused goals.

SUMMARY

The decline in AMA membership penetration from 95% to 50% to 27% of doctors is a significant historical trend. A US management guru once suggested, organisations are at risk if they respond to a changing environment by redoubling their efforts to do things the way they have always done them.

Let's hope the AMA does not become the Kodak of Australian medical history.

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