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Health and the ACT Budget

The Chief Minister and Minister for Health, Ms Katy Gallagher, MLA and the Opposition Health spokesperson, Mr Jeremy Hanson MLA write exclusively for "Canberra Doctor" on the 2012 ACT Budget

In some of the coverage of this year's budget, health was described as the "big winner". This might not be the expression I would have used, but it is certainly the case that health care is a major priority for the ACT Government. We have consistently funded more beds, more staff and better facilities and this budget continues that focus.

This was a budget where a balance was struck between helping our economy continue to grow by maintaining government spending, while also being responsible about our bottom line.

In this context, we announced $109.5 million over four years in recurrent funding from the 2012-13 Budget to meet growing demand for health services in the Canberra community.

We will continue to deliver excellent frontline services to the Canberra community while work on new investments is rolled out.

Increased services in health will support the ACT economy by creating jobs for almost 150 additional nurses, doctors and allied health professionals during 2012-13.

The budget will also see the health workforce given world class facilities to help them continue to do an excellent job.

For example, the new CT scanner at the Canberra Hospital will improve the quality of vascular, neurosurgical, neurology, cardiology and oncology. It will produce better quality images faster, so urgent cases can be diagnosed quickly and accurately. It will reduce scanning radiation doses by up to 80 percent dose of radiation which is significant for paediatrics, young patients and the chronically ill who receive multiple CT.

To help meet the four-hour rule for the emergency department there are new resources for the ED, including 30 new staff into the ED and see new facilities added including 6 new treatment cubicles to expand capacity, 4 new nurse-led treatment spaces in the ED and 4 new cardiac assessment beds to target treatment to these patients and reduce pressure on ED beds.

This year's Budget demonstrates our commitment to enhance health services in the region and help us move into our future.

The Budget will provide the following recurrent funding over the next four years:

- $31.6 million to meet growth in demand for acute services;
- $10.5 million for four additional intensive care unit beds to meet increasing demand for critical care services for adults and children;
- $12.6 million to meet the four hour emergency department rule;
- $12.6 million to meet growth in demand for surgical and interventional services, including $1.3 million for an extra 140 elective surgery operations;

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There are many incidences of high quality and considered healthcare provided in the Territory. I often hear of dedicated and compassionate healthcare professionals providing high quality care whilst under-resourced and under-supported. It is clear that under ACT Labor, that not only have the statistics fallen but also the support for staff.

However, instead of seeing staff applauded for their hard work in trying circumstances, this Health Minister has attacked them. We have lost dedicated professionals, especially in areas like obstetrics where bullying claims were rife. It is an extraordinary set of circumstances that would see a group of doctors call for the resignation of the Health Minister. Nothing in this year's budget, or the commentary provided, indicates that anything is going to change the toxic culture Katy Gallagher has created.

Under eleven years of ACT Labor, six of which Katy Gallagher has been Health Minister, we have gone from one of the best performing health systems in the country to one of the worst. The latest Institute of Australian Health and Welfare Hospital Statistics report shows that since 2001, the median number of days spent on elective surgery waiting lists has doubled, the percentage of people seen on time at the emergency department have fallen to amongst the worst in the country, and we have some of the lowest number of GPs in the country.

In this year's budget we saw bogus money thrown at a Secure Mental Health Facility – a promise made in 2008, delayed in 2009 and 2010, and cancelled in 2011. The money provided in the budget does not actually build the facility, but merely buys ACT Labor further time in 'design work.' At the last election, Labor also promised three nurse walk in clinics, and only opened one. In October last year they made this promise again to open three clinics – but only provided the budget funding for two. It is clear that Labor cannot be trusted to deliver on their promises.

In the 2012 Budget, the Government has promised extension of the Emergency Department at Canberra Hospital. Given this Government's record on health infrastructure – always over budget, always late – this extension is unlikely to help the thousands of Canberrans stuck

waiting in ED over the coming years, let alone this winter.

The budget failed to properly address preventative health issues. Renovation and development of community health centres have further been delayed – meaning that important services are still not being provided out in the suburbs. In this budget alone over $75 million of health capital was rolled over. This means that over $75 million of important health infrastructure has fallen behind time.

This year's budget also contained an extraordinary statement. Instead of providing information on waiting times at emergency department, the budget states. "The results of emergency department performance in the Territory are under a formal investigation."

…Continued page 3.

Tterritory topicals – from President, Dr Andrew Miller

Dr Andrew Miller

Budget time again

Budget time is here again. I was happy to see that health spending continues to be a priority. The increased capacity in A&E departments is welcome. The planned expansion of the walk-in clinics is however problematic. These have been shown to be expensive indulgences that arguably divert resources away from more efficient care providers.

Mention was also made of recruitment of more doctors, nurses and other allied health staff. It is essential that medical recruitment for our public hospitals consider the full impact on health care for the territory. We need to ensure that each new specialist attracted to Canberra is available to the entire community to help reduce both public and private waiting lists. This means that attention needs to be paid to keeping a healthy mix of staff and VMO positions.

The Women's and Children's Hospital at TCH is soon to open. Of concern however is the news that while bed numbers and delivery suites will be increased, it may not be sufficient to meet the community needs of the future. In the short term, there will be some changes to bed numbers, for ante-natal and post-natal care, as the 3-stage relocation into the new facility occurs and some increase in bed numbers overall by completion of the final stage. Ultimately there will be 4 additional beds for the community midwifery program and an outpatients ante-natal assessment clinic.

The AMA GP Forum is also concerned about the proposal to move shared care away from GPs and to focus more on midwife care. The supposed advantage is continuity of ante-renatal and post-natal care; however we all know that pregnancies do not occur in isolation, but are part of a family context. The exclusion of GPs from involvement in shared care flies in the face of the concept of holistic family care. The AMA will continue to agitate to maintain the position of GPs at the centre of family care, including sharing in prenatal care.

Pearls from the National Conference

The AMA National Conference was held in Melbourne this year. The funny hats and rah-rah of a GOP convention were sadly not evident. Instead discussions revolved around the tasks of reforming health and the Australian version of national health reform; climate change and e-health.

Of timely interest to Canberrans was a discussion of the remaking of urban Melbourne around sustainable and healthy city principles. Professor Rob Adams, director of city design, City of Melbourne showed how cityscapes could be transformed to encourage a healthier lifestyle and also improve environmental sustainability. I was struck by the similarity of Melbourne's plans for the future and Burley Griffin's original design for our own city. The urban sprawl we are indulging in is far removed from his conception of the way our community should grow; and certainly not compatible with healthy city design ideals. I find it ironic that our town planners are requiring more and more stringent individual building standards whilst the whole urban plan is deviating more and more from sustainability principles. The matter of healthy city development was flagged by our treasurer in his budget speech. As doctors we should be engaging in these debates and ensuring that urban planning considers our community's long term health and welfare.

We heard form Lord Darzi of Denham PC KBE, the former minister for health in the UK about the task he faced in trying to make the NHS monolith work. His speech was most revealing; it showed that simple attention to caring for the human capital in a health system, consulting and being flexible rather than ideologically bound can turn a behemoth bent on self-destruction around. It was also interesting to see that whilst Australia didn't rate too badly in OECD report cards on healthcare systems, we didn't excel.

Our own brand of health reform was also discussed, including the impact that the efficient price will have on our public hospital funding. Since the conference the Independent Hospital Pricing Authority has released its efficient price. There is an information piece in this issue, but our conversations with other state AMA groups and with the ACT Health Directorate indicate that we are very much feeling our way; and that a lot more work will need to be done.

PCEHR

The much vaunted PCEHR is scheduled to go on line on 1 July. Whilst the concept of a centralised up to date patient health record is attractive, the devil is in the detail and it is the detail that is sadly lacking to date. Unresolved issues include the remuneration for doctors maintaining the health records; confidentiality for competent minors; safe and practical institutional access; and liability for inaccurate out of date information.

Minister Plibersek has said that doctors may use consultation items to obtain remuneration whilst entering data on their patients' PCEHR. This presumes that such activities will need to take place in association with a patient attendance; the item claimed will as always "be at the doctor's discretion".

What also of the competent 16 year-old who wants contraceptive advice? Do you enter the consultation and her prescription onto her PCEHR where, as a minor, her responsible parent has viewing and editing rights? What if her parents are separated, who will have access; or will they both if there is shared custody?

The public hospitals in the ACT and larger institutional and corporate practices will all have their own difficulties ensuring that access to the record is appropriately controlled without rendering it a practical nightmare that intrudes precious minutes into every patient encounter. As yet neither of our public hospitals has complying software.

And the final gem: consider the vast amounts of information that some patients generate in their journey through the system. If you do sign up and accept responsibility for your patients' PCEHR, what if the data is out of date or incorrect? Where does liability lie in these circumstances? The government's attitude is reflected in the statement that the PCEHR does not replace patient notes. This implies that their responsibility begins and ends with providing the platform; we are responsible for all of the content.

The AMA is trying to bring the government to the table to address these issues. I wish I could report resolutions but at this time it appears that the government is more focussed on the publicised launch date than the data. The best advice we can give is to make yourself aware of all the implications of the new system and to only become involved if you are confident that you understand all of the implications; are fully aware of the capacities and limitations of your own computer systems; and are prepared to put in the time necessary to ensure that the records for which you may be the nominated treating medical practitioner are complete, up to date and accurate.

Rewards Program Partner Profile – Pepe's Paperie

Pepe's Paperie is a treasure trove of fine stationery and gifts including stylish pens, notebooks, journals, photo albums, leather goods, cards, gift wrap and more. With a wide selection of products locally from Canberra, from further across Australia and from around the world, those who have a passion for fine stationery, like Pepe, will find an abundance of products to interest and delight. With a reputation for seeking out and stocking quality goods, Pepe's Paperie has become a destination rather than a store with customers coming from far and wide to experience the passion for fine paper goods.

Pepe's Paperie stocks a wide range of stylish and practical pens for all your letter, or script, writing needs from the colourful *ACME* range and natural elegance of *E+M* through to the traditional style of *Lamy* and go anywhere ability of the *Space Pen*. There is also a whole range of new products now available in store and online including *MyWalit* compendiums and bags, *An April Idea* letter writing sets and note pads and *Labrador* organisers to name just a few.

Customers can expect a friendly welcome and helpful advice from the staff when visiting either of the two stores. Whether you're in the City and meet Michelle, Keren and the team or you head south side to Phillip and see Stewart, or maybe even catch Pepe himself, you're sure to find something beautiful.

Pepe's Paperie

Health and the ACT Budget...continued

…Jeremy Hanson
Continued from page 1.

The emergency department data scandal at the Canberra Hospital raises two very serious questions. First, what kind of culture has developed that causes someone to deliberately manipulate waiting times to make them look better? And second, how can we trust any information provided by the Minister when she has stated that this manipulation continued for at least the last 18 months without causing concern?

In an election year, the Minister has maintained that elective surgery waiting times are being cut. Whilst there is improvement, it is improvement from the problem Labor created. Under ACT Labor we had the longest waiting times in the country. Under ACT Labor we had, as the Auditor-General found, "the reclassification of patients without documented clinical reasons." Elective surgery in the ACT has been a debacle. Not only the longest waiting times, and deceitful waiting list practices, but valuable money spent on equipment like the MRI machine that was then unusable.

The ACT Labor 2012-13 Budget is too little, too late. After being elected on a platform of promoting the health system, ACT Labor has failed our health system across virtually all key indicators. In this election year budget, they have thrown money at problems they have created, failed to fulfil promises and continued to hide the truth from Canberrans.

ACT Labor is the highest taxing government in the country. But they have failed to invest wisely in our health system. We can only expect to recruit and retain the best health professionals if we give them adequate support and resources. It raises the question – how did ACT Labor get it so wrong? The 2012 Budget fails to provide us with any indication that ACT Labor can provide any answers or solutions.

Jeremy Hanson

…Katy Gallagher
Continued from page 1.

- $0.5 million to fund an expansion of endoscopy services at Canberra Hospital, and a new neuro-interventional coiling service at Canberra Hospital, which will provide non-surgical intervention for stroke patients, increasing the options available to our community; and
- $12.1 million for the new Women's and Children's Hospital to provide the funding to meet growing demand for services in our new, specialist facility.

In 2012-13, we will boost our public hospital capacity even further by adding another 40 new beds across both public hospitals and the equivalent of another 15 beds through the expansion of the hospital-in-the-home service.

This total will include 23 general inpatient beds, five critical care beds for adults, children and babies, a four-bed cardiac assessment unit and eight beds in the new medi-hotel, which will provide patients from outside of Canberra with short-term accommodation on the hospital campus prior to final discharge home.

We have also allocated significant funding towards delivering on the Health Infrastructure Program since 2008-09. In this year's Budget, funding for new projects and ongoing projects, $237.8 million in 2012-13 and $143 million in 2013-14, is provided to complete planned capital works programs linked to the HIP.

This year's budget also includes a new allocation to manage 'staging and decanting'. This program will allow for services to be relocated while upgrades are carried out or moved into areas that become available when services move to new facilities. Through careful planning and staged relocations, there will be a smooth progression between old and new buildings, minimising disruption to health professionals and ensuring continuity of care to patients.

In 2012-13, we will open our new Hospital for Women and Children on the Canberra Hospital campus. This new facility will provide our community with a state-of-the-art facility to meet our needs well into the future.

Work will continue on planning for the new northside sub acute hospital with funding allocated to finalise the early scope works.

Since coming to power in 2001, Labor has added more than 250 new beds to our public hospital system, making up for the 114 beds removed by the previous government. The Australian Institute for Health and Welfare reported that our public hospitals had access to 926 beds in 2010-11. On preliminary figures, this has increased to 934 beds in the 2011-12 financial year.

In 2012-13, we will match the additional commitment to elective surgery we made in 2011-12, providing capacity for at least another 11,000 elective surgery operations for people on public hospital waiting lists.

This additional investment has resulted in considerable improvements for people waiting for elective surgery in the ACT. Over the two years to April 2012 there has been a 61 per cent reduction in the numbers waiting too long for care, and the total number of people on the waiting list at 30 April 2012 is 3,827, which is the lowest figure in a decade.

Canberra's doctors and other health professional do a great job caring for our community. I am confident this budget will help you to continue your outstanding work.

Katy Gallagher

Free CME lectures 'for everybody'

John Biggs hasn't always been involved in continuing medical education. He first became an academic obstetrician and gynaecologist, and was Chair of the Education Committee of the RACOG when it established a mandatory program of CME for Fellows.

Later he was Dean of the University of Queensland Medical School, before he became Dean of Postgraduate Medicine at the University of Cambridge. Since retiring and returning to Australia in 2004 he has been Chair of the Coast City Country General Practice Training, a regional training provider of General Practice Education and Training. In 2009 he was appointed Chair of the ACT Health Research Ethics Committee.

Since 2007 he has organised, in association with the ACT Medical Board, series of free lectures for retired doctors providing updates on prescribing. The lectures have been well received and continue in 2012.

Prof Biggs on 6161 6643 and Dr Gordon Adler on 6257 8483 will welcome enquiries relating to the lectures.

Lecture program

16 July Dr Simon O'Connor
Recent developments in cardiac medication

23 July Dr James D'Rozario
Diagnosis and treatment of common anaemias

30 July Dr Libby Hillman
Treatment of gastro-duodenal ulceration

The lectures are free and are held on Mondays as shown in the First Floor lecture theatre of the ANU Medical School at The Canberra Hospital

Dr John Biggs.

Coag report confirms no improvement in public hospitals and shortage of hospital beds

AMA President, Dr Steve Hambleton, said that the COAG Reform Council's latest report on the National Healthcare Agreement confirms the findings of the AMA's annual Public Hospital Report Cards – there are not enough hospital beds and there are too many patients languishing on waiting lists.

Dr Hambleton said that, on the basic measures, there has been no real change in the capacity of our hospitals to meet demand.

"Despite an almost 10 per cent increase in recurrent expenditure on public hospitals, there has been no real change in the key performance measures," Dr Hambleton said.

"Doctors on the ground, working in public hospitals every hour of every day, know that there has been little change to relieve the stress on hospitals and the health professionals who work in them.

"There were 872 more public hospital beds than in the previous year, but the number of beds per 1,000 population did not change. This means the new beds merely kept pace with the population and did nothing to increase the capacity of the hospitals.

"This has a direct impact on elective surgery performance, which is not improving. This is not acceptable to the patients waiting long periods for treatment."

Dr Hambleton said the situation is even worse when you consider the hidden waiting lists.

"There are people who have been referred by their GP and waiting to see a public hospital specialist to be assessed for surgery who are not counted in the waiting list data. They only get counted after they see the specialist and get booked in for surgery.

"This is the sort of information that patients want and need to know. It is a real measure of the health system," Dr Hambleton said.

"The AMA recommends that, as well as measuring the hidden waiting lists, the COAG Reform Council should adopt the AMA's "*Bedwatch*" proposal to conduct a national stocktake of the actual numbers of beds needed in each hospital to provide safe care.

"*Bedwatch*" would track existing beds, new beds and bed occupancy rates to ensure that bed occupancy rates in public hospitals meet the AMA's preferred level of 85 per cent bed occupancy,"Dr Hambleton said.

The Reform Council Report highlights affordability as a reason for people delaying or not going to a GP.

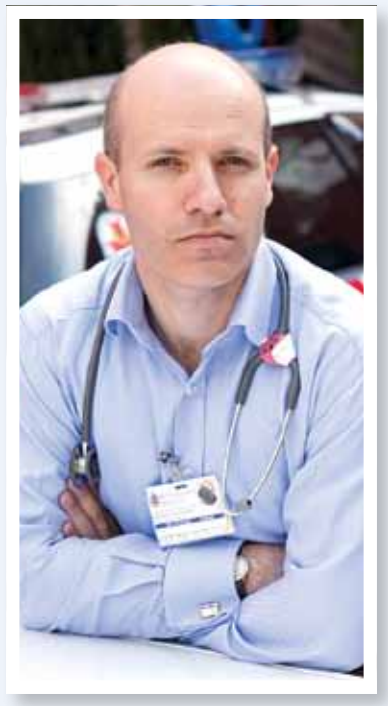
Dr Hambleton said this is not consistent with Medicare data that show 80 per cent of GP services are provided with no out-of-pocket costs for patients.

"Our hardworking GPs are bearing the financial burden of providing safe, high quality, affordable primary care to the Australian community," Dr Hambleton said.

Pressing need for more graduate training places

By Dr Stephen Parnis

It is a myth widely held by governments and members of the community that once a medical student has graduated from university they are a fully-qualified medical practitioner.



Little or no account is taken of the years junior doctors must commit to postgraduate training in order to become the independent practitioners that they need to be, and the community expects them to be. Adequate training can take many years; in some cases upwards of 10 years.

All junior doctors require specialist training, though the number of senior specialists available to train them is inadequate at best. Senior doctors are under a great deal of pressure to provide training and mentoring to trainees. They do this willingly, in the knowledge that they are helping to create the next generation of competent doctors who will continue to provide leadership in the health care system, but they need support and adequate resources in order to prevent them from becoming inundated.

How do we achieve a balance between trainee and supervisor numbers to ensure standards are maintained, without leaving despondent junior doctors stuck in limbo for years, waiting for appropriate training places to come up?

Currently there are simply not enough positions for the increasing number of junior doctors emerging from medical schools. In recent years, the number of junior staff has more than doubled, without an associated increase in the number of training places or senior staff to supervise them. The number of junior doctors is set to increase further in the next few years. Greater numbers of graduates and inadequate training places means a frustrating bottleneck at a critical stage in the career of junior doctors, and there is no solution in sight.

This is completely at odds with Health Workforce Australia's Health Workforce 2025 report, which calls for long-term reforms to various areas of the training and workforce systems to better provide for Australia's future health workforce.

Public teaching hospitals are still the mainstay of clinical placements for junior doctors, but other settings may also provide potential for quality training, including aged care and community settings, private hospitals and general practices. All of these have potential, but also come with challenges, and will require significant commitment and resourcing to develop. For example, the format and quality of assessment in settings other than public hospitals is an issue that is far from settled, and needs to remain on the public health agenda.

The responsibility for resourcing training places is shared among the Commonwealth, the States, Territories, Colleges and General Practice Education and Training Limited.

The system is complex and inadequately funded. The recent Commonwealth Budget has not made health care a priority, and there is no direct provision for training places for medical graduates. State budgets offer little in the way of funding in this area either. For example, the Victorian State Budget 2012-13, released on Tuesday 1 May, had no allocation for education and training of junior doctors.

The need for training places for medical graduates is not going to go away, nor is it an issue that can be solved overnight. Australian governments and healthcare providers need to look to the future and plan for long-term, sustainable delivery of quality training places for medical graduates and on-going support for the senior doctors who supervise them. This needs to be clearly reflected in budget allocations.

Stephen Parnis represents salaried doctors on the AMAs Federal Council and is an emergency physician in Melbourne.

Medical indemnity claims surge

The number of medical indemnity claims has jumped almost 30 per cent in three years, though almost half are dropped before settlement and the majority of payouts are less than $10,000.

Figures compiled by the Australian Institute of Health and Welfare show that there were almost 2900 claims lodged between July 2009 and June 2010, a 28.6 per cent increase from 2007-08, with general practitioners the most common target of complaint, accounting for 18 per cent of all new claims.

According to the Institute report, 58 per cent of all claims closed in 2009-10 were settled for less than $10,000 – including 17 per cent where no payment was made – while the payout exceeded $500,000 in just 6 per cent of cases.

The figures show that only a fraction of claims are decided by court.

A majority (51 per cent) were resolved in 2009-10 through negotiated settlements, the action was dropped in a further 46 per cent of cases, and just 3 per cent ended up being ruled upon by a court.

The AIHW report showed that, reflecting their preponderance in the medical profession, GPs accounted for the largest share of medical indemnity cases, being the subject of 522 new claims in 2009-10, followed by obstetricians and gynaecologists (268 cases, equivalent to 9.3 per cent of all new claims), general surgery (220 cases, 7.6 per cent), orthopaedic surgery (178 cases, 6.2 per cent) and emergency medicine (144 cases, 5 per cent).

The most common source of complaints arose from procedures, including the failure of treatments or post-operative complications, and were particularly associated with obstetrics and gynaecology and general and orthopaedic surgery.

GPs, by contrast, were the most likely to be hit with claims regarding diagnosis or medication, accounting for a third of all such actions served on the medical profession as a whole, though around 10 per cent of diagnosis-related complaints involved physicians in emergency medicine or diagnostic radiology.

Not only do GPs account for the largest proportion of diagnosis-related claims but, the Institute reported, their share of such actions is growing.

In 2007-08, 22 per cent of new diagnosis-related claims involved GPs, but by 2009-10 that had risen to 28 per cent. Over the same period, the share of such actions involving emergency medicine practitioners had virtually halved from 25 to 13 per cent.

The findings come against the backdrop of a cut in Federal Government subsidies for medical indemnity insurance payments by doctors through the Premium Support Scheme.

Under the scheme, if a doctor's gross medical indemnity costs exceed 7.5% of his or her gross private medical income the Commonwealth will pay 80 per cent of the premium above that threshold.

But cuts announced in the 8 May Budget will wind back the Commonwealth's contribution to 70 cents in the dollar from 1 July 2012 and 60 cents in the dollar from 1 July 2013.

Time for a 50th Anniversary check-up

Time to move forward with a new governance and policy development structure

Prior to 1962, the British Medical Association existed in all the States as the British Medical Association in Australia. The Australian Medical Association came into being and is now proudly celebrating its 50th anniversary of leadership and advocacy as the premier association for all members of the medical profession.

Throughout its 50-year history, the AMA has changed and evolved and adapted to be able to lead effectively and to respond to issues, both external and internal.

There is a widespread view within the Federal Council the AMA can better utilise the expertise of its directors/councillors by allowing the function of Federal Council to be exclusively about policy development and analysis.

The Federal Council has discussed the AMA's governance structure over the course of the last two years, its impact on the efficient development of public policy, and its responsiveness to the membership.

The Federal Council is representative of all the State and Territory AMAs, craft groups and geographic interests. Its 32 members are directors of Australian Medical Association Limited and have the dual role and responsibilities of being both governors and policy formulators. The expertise the Federal Councillors and individual members bring to the AMA is considerable and its wealth is valued and valuable.

The AMA operates in a highly dynamic political and industrial environment – and there is recognition by the Federal Council of the need to be inclusive, represent the entire profession, and for it to use its time more effectively in what is becoming an increasingly complex and challenging health care environment.

The Federal Council has resolved to embark on a consultation with the membership - who, after all, will have the final determination in the matter – to become engaged in the options to achieve the particular model of a smaller board of governance.

This is consistent with current best practice, whereby every organisation should regularly review its own internal governance performance and structure to analyse whether it best aligns with the role, function and activities of the organisation. The AMA ACT restructured in 2009 to provide for a small board of directors, with its focus being on all aspects of "running the company" and a larger, more representative and inclusive advisory council to respond to external health policy and providing policy advice to the Board.

"The Federal Council has not taken this step lightly", said Dr Hambleton, President of the Australian Medical Association. "It acknowledges the AMA's history and the significant participation of the various stakeholders and other AMAs to the work of the Council".

The last major inclusive consultation with the membership was conducted by Sir Robert Cotton, on behalf of the then Federal Council, in the late 1980s. His model has served the Association and its members well. It provided for, among other things, representation of the two Territories at Federal Council and their sending delegates to the annual National Conference as contributors – not observers. However, now is the time to consider the issues anew recognising the changing face of medicine and the differing expectations members have of their professional association and the level of contribution its members are willing to make – either as governors or as policy makers and advocates for patients.

To separate governance from policy, the Council resolved to adopt a smaller board of governance for the Federal AMA.

Federal Council recognises that the AMA's core purpose of representing the medical profession requires a more streamlined governance framework to diligently lead the operations of the AMA group of companies, while its representative framework enables it to comprehensively assimilate the voice of the profession into public policy advocacy.

Federal Council will be presented with and consider the results of that consultation at its November 2012 meeting.

The next phase of governance reform will then be determined and a report to all members will be provided immediately after that Council meeting.

Dr Steve Hambleton, encourages all members to be a part of this process to help guide the AMA through the next 50 years of advocacy and achievement for members and for the Australian health system.

Further information will be provided to members in due course.

AMA (ACT) LIMITED

Investec + AMA ACT = best finance arrangements for you and your practice – Leveraging your SMSF

Any medical professional who doesn't own his or her own rooms in their own self-managed super fund (SMSF) could be missing out on a range of tax and business benefits, according to the experts at Investec.

"At Investec we've always viewed the commercial property purchase of practice rooms by doctors a bit like a savings plan," says Investec's Stafford Hamilton. "What they're really doing is locking in their rent at the purchase price. As long as the interest rate doesn't change significantly, the repayments should stay about the same, and because they own the asset at the end of the day it resembles a forced savings plan – hopefully with a capital growth upside."

But it isn't just disciplined savings – property is a popular and savvy investment. That isn't news in and of itself: the appeal of property investment for medical professionals is pretty clear, says Investec's Barry Lanesman. "Property is easier to look after," says Lanesman. "It's something where you require less expertise than that needed for equities investments and it is less volatile than equities markets."

However, access to capital for investment has remained a traditional roadblock for many. Up until a few years ago, even though many had a pool of savings in their own self-managed super fund, unless they had the full value of the property they wanted to purchase, that did them no good.

"Historically you haven't been able to borrow in super," explains Hamilton. "Several years ago the ability to borrow became allowable. Before gearing was allowed your SMSF could only purchase property if you had sufficient capital, but now an SMSF can take on debt. It opened up the avenue for investing in your own commercial property through your self-managed super fund. Under current legislation, there might be no capital gains tax payable on some assets that increase in value inside super."

This opportunity is particularly appealing for practitioners who already own their own rooms. Under the present legislation, you might be able to sell your rooms to your own SMSF and hopefully watch the value increase over the period of time you remain there. "We've seen that medical professionals will often stay in the same rooms for a very long time, so if you sell it into your super fund you could end up with a very tax effective investment from that point onwards," Hamilton explains.

The appeal of this is not just related to capital gains tax, he adds. "Income in the SMSF is taxed at concessional rates. So if your property is positively geared, effectively you are getting investment returns in super at a very reasonable tax rate."

There are many banks which will lend to your SMSF, but as Hamilton points out, they will generally only lend up to around 63 per cent of the value of the property. If you don't have enough tucked away in super to make up the difference, the investment isn't an option.

"The difference with Investec is that our lending is designed for doctors and dentists, and the level of gearing we allow them to borrow is higher – up to 90 per cent for an owner-occupied commercial property," says Lanesman, "which allows those with smaller SMSF balances to consider getting into the property market."

Of course, nothing comes for nothing. "There are costs to getting a property into the fund regardless of which lender is used," Investec's Stafford Hamilton cautions. "The costs may involve setting up a SMSF in the first place, and you have to have a separate instalment trust to own the property in trust on behalf of the SMSF. Often, there are also costs for the valuations, loan documentation, and potentially stamp duty. However, due to the different tax treatment of assets and investments held in a super fund environment, our clients have often commented that they feel it's probably worth the costs incurred if they are able to access different tax treatment within the super fund."

The reason Investec can do this? "Given the medical and dental clients we're dealing with, we're more comfortable with that level of gearing," says Lanesman.

"But we know the medical and dental professions are a lower risk area. As a result of this, and being specialists in that area we are able to do things which the general financiers are unable to do. We've been doing it for 20-odd years, so we know this market in a deeper way than anyone else."

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Editorial:
Christine Brill
Ph 6270 5410 Fax 6273 0455
editorial@ama-act.com.au

Typesetting:
Design Graphix Ph 0410 080 619

Editorial Committee:
Dr Ian Pryor – Chair/Editor
Dr Jo-Anne Benson
Mrs Christine Brill – Production Mngr
Dr Ray Cook
Dr John Donovan
A/Prof Jeffrey Looi
Dr Peter Wilkins
Mr Jonathan Sen

Advertising:
Ph 6270 5410, Fax 6273 0455
execofficer@ama-act.com.au
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Initiatives in tobacco control acknowledged

2012 Tobacco Scoreboard winner is South Australia

The 2012 AMA/ACOSH/ASH Tobacco Scoreboard Award for outstanding tobacco control was awarded to the South Australian Government at the recent AMA National Conference. The Victorian Government scored The Dirty Ashtray Award for the poorest tobacco control record, which included cutting back proven tobacco control initiatives.

On World No Tobacco Day, AMA President, Dr Steve Hambleton, called on the State and Territory Governments to follow the strong leadership of the Federal Government on tobacco control by doing more to stop people smoking.

Dr Hambleton said much more could be done by all governments to save lives and improve public health with initiatives and legislation stop people smoking and to stop people, especially young people, from taking up the killer habit.

"Some State and Territory Governments have improved their performance, others have dropped the ball," Dr Hambleton said.

"Strangely, some who were leaders have now become followers.

"We need nationally consistent momentum to achieve meaningful action to combat smoking.

"More action is needed from various States on smoking in outdoor areas, point of sale displays, sales to minors, smoking in prisons and correctional facilities, smoking in nursing homes, smoking at public hospitals and health facilities, and refusing political donations from the tobacco industry.

"Some States are strong in some areas and weak in others."

The theme for this year's World No Tobacco Day was: **Tobacco industry interference**.

In its efforts to derail or weaken strong tobacco control policies, tobacco industry interference takes many forms, including:

- Manoeuvring to hijack the political and legislative process;
- Exaggerating the economic importance of the industry;
- Manipulating public opinion to gain the appearance of respectability;
- Fabricating support through front groups;
- Discrediting proven science; and
- Intimidating governments with litigation or the threat of litigation

The AMA/Australian Council on Smoking and Health (ACOSH)/Action on Smoking and Health (ASH) National Tobacco Scoreboard this year rated the States and Territories in the following order (from best to worst) in tobacco control – South Australia (1), Western Australia (=2), Tasmania (=2), ACT (4), New South Wales (5), Northern Territory (6), Queensland (7), Victoria (8).

Tanya Plibersek and Steve Hambleton.

Australian Government honoured for global leadership in tobacco control

The Australian Government was presented with a Global Leadership Award by three of Australia's leading public health organisations for outstanding national and international action and leadership in tobacco control.

AMA President, Dr Steve Hambleton, said the Australian Government won the Global Leadership Award for leading international action on tobacco over the past year.

"Australia is setting an example for the rest of the world to follow in the ongoing battle to stop people smoking and destroying their health, and is not afraid to take on Big Tobacco in the process," Dr Hambleton said.

"This included passage of world-leading plain packaging legislation as part of a comprehensive program of initiatives.

"With welcome support from all parties, the Government pursued plain packaging despite massive and desperate opposition from the global tobacco industry.

"The Government also continued its record of investment in combating smoking, including funding through the Council of Australian Governments to address key aspects of tobacco control, not least Indigenous smoking.

"The Government banned electronic and internet advertising for tobacco, and established the Australian National Preventive Health Agency with specific funding commitments for tobacco control.

"The Commonwealth committed $100 million over four years to the Tackling Indigenous Smoking initiative.

"Further to recent tobacco tax increases, the Government recently decided to significantly reduce duty-free sales of tobacco.

"And the Government is to be commended for not accepting political donations from the tobacco industry.

"With this record, the Australian Government is rightly seen as a global leader in tobacco control and resisting tobacco industry pressures.

"The Government's determination and commitment in its battle against Big Tobacco has prompted other governments to follow its lead, and its efforts have been widely recognised as an inspiration to the global health community.

"The AMA, ACOSH and ASH congratulate the Government on its outstanding contribution to public health," Dr Hambleton said.

We note that the Government's tobacco control work is continuing, with regulation of cigarette contents and additives to be addressed in an options paper due out later this year.

Australia provides support to international tobacco control, including through:

- substantial funding for the World Health Organisation to help implement its non-communicable disease (NCD) action plan;
- funding to assist with the control of NCDs in the South Pacific; and
- support for global tobacco control through the Framework Convention on Tobacco Control.

It is hoped the Government will expand its efforts to improve transparency when dealing with the tobacco industry by fully implementing the World Health Organisation's Framework Convention on Tobacco Control Article 5.3 Guidelines to protect health policies from tobacco industry interference.

Big Tobacco wins the Global Coffin Nail Award

The 2012 Global Coffin Nail Award was presented to the Big Tobacco industry for its desperate, devious and dishonest tactics in opposing the introduction of plain packaging for tobacco products.

The Award – presented by the AMA - was announced at the May 2012 AMA National Conference in Melbourne. No representative from Big Tobacco was in attendance to accept the Award.

Dr Steve Hambleton, said that tobacco is the only industry that markets and sells a product known to kill half of its regular users.

"Around the world, smoking kills nearly six million people each year," Dr Hambleton said.

"Over a million Australians have died because they smoked since clear evidence about the dangers of smoking was published in 1950.

"During that time, Big Tobacco has done everything in its power to promote its products and delay or prevent action to reduce smoking.

"The tobacco companies have opposed plain packaging with a ferocity that confirms the importance of the Australian Government's plain packaging legislation – both for Australia and as a model for other countries," Dr Hambleton said.

Tobacco industry strategies to oppose the introduction of plain packaging include:

- mass media campaigns using the loophole of 'political advertising' to get around tobacco advertising bans;
- threats to flood the country with cheap cigarettes;
- lobbying at all levels;
- setting up and using 'front' organisations to oppose and undermine health policies and to produce flawed reports to lobby politicians with unfounded claims;
- online campaigns with false and misleading claims;
- legal actions against the Australian Government;
- funding legal action by countries such as Honduras and Ukraine to challenge plain packaging through action at the World Trade Organisation; and
- flooding the Department of Health and Ageing with Freedom of Information applications to tie up resources and intimidate policy makers.

"Smoking is gradually decreasing in developed countries, but the tobacco industry is promoting its products ruthlessly in developing countries," Dr Hambleton said.

"The World Health Organisation estimates that the global tobacco death toll will rise to eight million by 2030.

"Big Tobacco is the world's most lethal industry, and is a worthy recipient of the Global Coffin Nail Award."

Evidence of greater government commitment to indigenous health but still much more to do

AMA Aboriginal and Torres Strait Islander Health Audit Report: Progress to Date and Challenges that Remain

The AMA released the *AMA Aboriginal and Torres Strait Islander Health Audit Report: Progress to Date and Challenges that Remain*, which summarises the recommendations of the AMA Indigenous Health Report Cards over the past 10 years and analyses the major Government measures related to the recommendations that have been implemented.

AMA President, Dr Steve Hambleton, said that the Audit Report shows evidence of a greater Government commitment to Aboriginal and Torres Strait Islander health in recent years, with new programs and increased funding, but there is still much more to do to close the gap in health inequalities.

"The track record has been varied over the decade, but there has been building momentum in recent years," Dr Hambleton said.

"In 2008, COAG made a commitment to close the gap in life expectancy between Aboriginal peoples and Torres Strait Islanders and other Australians.

"Broad goals to close the gap were set out, mainly in primary health care, along with general program objectives. To support these commitments, Australian governments undertook to provide $1.6 billion over four years.

"This funding better reflects the genuine needs in Aboriginal and Torres Strait Islander health and must continue beyond 2013, when the *National Partnership Agreement on Indigenous Health Outcomes* expires.

"There is recognition of the important role of the Aboriginal community-controlled health sector and a modest boost to the workforce for Aboriginal and Torres Strait Islander health. This will improve with the implementation of the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011-2015*.

"The Prime Minister delivers an annual Closing the Gap speech, which provides greater transparency on Government action to improve Aboriginal and Torres Strait Islander health, and there is also now a designated Minister for Indigenous Health. The AMA welcomes both these initiatives.

"We also welcome the formation of the National Aboriginal and Torres Strait Islander Health Equality Council and the current process for drafting the *National Aboriginal and Torres Strait Islander Health Equality Plan*.

"Overall, there has been significant recent progress, but many challenges remain," Dr Hambleton said.

Key findings of the Audit Report include:

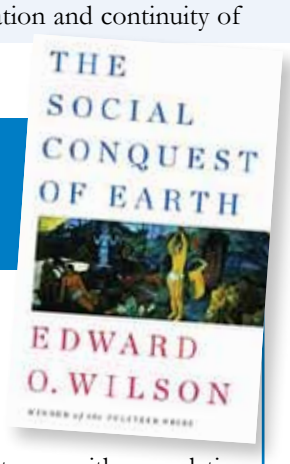
- The injection of funding into primary care for Aboriginal and Torres Strait Islander health through the COAG National Partnership Agreements is welcome and significant. But this level of funding must be sustained after the expiry of these agreements in 2013 if the gap is to be properly closed.
- Significant funding of primary care services will not be used to best effect if there is not the appropriate workforce to provide these services. Much more needs to be done to develop a high quality workforce for Aboriginal and Torres Strait Islander health.
- Australian governments are now recognising the importance and potential of intersectoral collaboration, integration and continuity of care in improving health outcomes for Aboriginal peoples and Torres Strait Islanders. Greater emphasis must be given to building the capacity of Aboriginal community-controlled health services so they can maximize their high potential for best practice primary care.

- The rate at which Aboriginal people and Torres Strait Islanders are incarcerated is thoroughly disproportionate and unacceptable. A great deal more needs to be done to stop the cycle of offending, incarceration and ill-health, particularly in relation to young people.
- Punitive approaches to health improvement, and measures that demean and stigmatise (such as the signs proscribing alcohol and pornography) do not contribute to healing, and inevitably fail. Australian governments should immediately abandon these approaches.
- Greater support should be provided to Aboriginal and Torres Strait Islander communities to build their capacity to develop meaningful and effective solutions to local health problems.
- There has been a poor track record on the part of governments in engaging Aboriginal peoples and Torres Strait Islanders in genuine partnership in the planning and implementation of national solutions to their health problems. The AMA is encouraged to see that this is now beginning to change, particularly through the formation of the National Congress of Australia's First Peoples and the advisory roles given to the National Aboriginal and Torres Strait Islander Health Equality Council.

The Audit Report is at http://ama.com.au/aboriginal-reportcards/auditreport-2012

The AMA's Report Cards on Aboriginal and Torres Strait Islander Health can be viewed athttp://ama.com.au/aboriginal-reportcards

BOOK REVIEW: Social Conquest of the Earth



Edward O. Wilson, Liveright Publishing Corporation, New York, ISBN 978-0-87140-413-8, $USD 27.95

This is a remarkable capstone of a lifetime of work by Professor Emeritus E.O. Wilson of Harvard University. From the prescient and controversial "Sociobiology" (1975) through "Consilience" (1998), to this magnum opus, Wilson has combined pioneering entomological observation of ants with the rich fields of neuroscience, anthropology, social psychology with his own field of sociobiology. Wilson seeks the keys to the existence of advanced social life, focusing on the most successfulconquerors of the Earth, social insects and humans. He describes these truly social animals as "eusocial, in that they form colonies consisting of multiple generations that work efficiently to a division of labor that may be construed as altruistic. Ants may be considered the extended phenotype of the queen due to the fact that all castes of ants, save males, are the genetic derivatives of the queen. In contrast, humans form social groups that are not based solely on kin relationships.

Wilson observes that humans' unique social organization is due the competing effects of two levels of evolution. Within groups of humans, we compete individually with each other for survival. This, observes Wilson is the basis of our individual social competitiveness, and he argues, is the basis of some of our more selfish traits. However, groups of humans compete with each other, and this, he argues is the basis of some of our most redeeming traits of altruism, morality, spiritual belief, musicality and loyalty towards our own group. Yet there is the wrinkle that groups will also compete, and this is the basis of tribalism, which can manifest from ostracism of the non-conformist to inter-group conflict, which on the grand scale manifests as war. It is within the dual nature of individual and group evolution of humans that our relatively unique abilities arise. In so doing, Wilson challenges the shibboleth of inclusive fitness with population genetics applied at multiple levels; and observes that group selection explains much that would otherwise be perplexing about human nature.

In this masterwork, Wilson has realized his overarching framework of consilience, weaving together a multiplicity of science and art, in a wondrous tapestry depicting the history and future challenges for the eusocial conquerors of the Earth. As Wilson observes, there are sobering challenges ahead: the loss of biodiversity, transformation of the climate and environment, and consumption of irreplaceable resources. In this context, which species will be most successful, eusocial insects or humans?

Reviewed by: Associate Professor Jeffrey Looi, Academic Unit of Psychological Medicine, ANU Medical School.

Greens legislation passes: major reform of complaints scheme for vulnerable people

ACT Greens Health, Disability, Housing and Corrections spokesperson, Amanda Bresnan MLA, says the successful passage of the *Official Visitors Bill 2012* in the Legislative Assembly is a win for people in care in the ACT.

The legislation provides for an improved complaints system for people who are being held in a government institution or are staying in a community facility, and are dependent on the provider looking after them. The legislation also proposes to make the complaints system more independent of ACT Government Directorates.

"There are a number of people in Canberra who, because of illness, disability, or life circumstances are dependent on the Territory and community organisations to care for them", Ms Bresnan said.

Speaking after the successful passing of the legislation, Ms Bresnan said: "The legislation passed today ensures these people have someone independent to check that service providers are treating the person fairly and providing adequate care.

"The reforms passed today have been more than 10 years in the making, and despite promises by past governments they would occur, it took Greens legislation with Liberals support for changes to pass.

"The Minister for Community Services proposed, after the Greens Bill was tabled, to establish a Community Visitor for people with disabilities funded directly by the Community Services Directorate. That model did not provide the independence needed. The legislation passed today supersedes the Government scheme and an independent official visitor for people with disabilities will be created.

"All official visitors will now operate in a collegiate model, funded and supported by the Public Advocate. This will provide benefits to all official visitors and the people they help.

"The official visitors for mental health will now be able to inspect community mental health facilities where people stay, as well as the Crisis Support Unit at AMC. The official visitors for mental health will also be able to receive complaints from people who are subject to mental health orders and living in the community.

"The role of the Aboriginal and Torres Strait Islander official visitor for corrections will now be enshrined in legislation, and an Aboriginal and Torres Strait Islander official visitor for children and young people staying at Bimberi or in care and protection will be created.

"An official visitor for people who are homeless and are staying in emergency accommodation will be created. People who are homeless have nowhere else to go and are dependent on those housing them.

"In the area of disability the Government will also have to maintain a register of 'approved disability accommodation' to ensure that when government funds are used to pay for a person with disabilities to stay in a disability accommodation place such as respite, that accommodation place is an approved place," Ms Bresnan said

The professional relationship between doctors and patients – updated AMA guidance

The AMA has released two updated statements that deal with the professional relationship between doctors and patients.

Doctors have an ethical and legal duty to maintain appropriate professional boundaries with their patients.

The *AMA Position Statement on Sexual Boundaries Between Doctors and Their Patients 2012* provides guidance to doctors on maintaining appropriate sexual boundaries with patients, former patients, and patients' carers and close family members. This Position Statement replaces the *Position Statement on Sexual Conduct Between Doctors and Their Patients 1994*.

The major amendments to the Position Statement include:

- It now refers to maintaining appropriate boundaries with former patients as well as patients' carers and family members;
- There is a greater emphasis on consent, including where consent is uncertain or has been withdrawn;
- It now refers to chaperones; and
- It refers to guidelines from the Medical Board of Australia on sexual boundaries as well as mandatory reporting.

The *Patient Examination Guidelines 2012* statement provides advice to doctors on conducting physical examinations. The Guidelines address consent and communication, privacy, examination of patients who lack decision-making capacity, and the use of chaperones. It replaces the *Patient Examination Guidelines 1996*.

The major amendments to the Position Statement include:

- There is a greater emphasis on consent, including where consent is uncertain or has been withdrawn;
- There is a greater emphasis on how to appropriately conduct an examination; and
- It now refers to chaperones.

The *AMA Position Statement on Sexual Boundaries Between Doctors and Their Patients 2012* is at http://ama.com.au/node/521

The *AMA Patient Examination Guidelines 2012* statement is at http://ama.com.au/node/514

Call for anaphylaxis action

School teachers and childcare workers will have to know how to treat children suffering an anaphylactic reaction under rules being considered by Parliament.

The House of Representatives is debating a motion calling for nationwide laws to ensure all schools and childcare centres educate staff and students about the dangers posed by food allergies and are well-prepared to handle medical emergencies, particularly potentially life-threatening anaphylactic reactions.

The motion, which is still being debated, calls for Federal Government legislation requiring all preschools and primary and secondary schools to educate students on the case, effects and treatments of anaphylaxis, have action plans in place in case of an anaphylactic reaction, ensure staff are trained in life-saving techniques when such reactions occur, and have an anaphylaxis management program in place for each student.

Deputy Speaker Anna Burke, who led debate on the motion late last month, said that rapid growth in food allergies in recent years meant nationally-uniform measures to raise awareness of anaphylaxis and how to treat it were becoming critically important.

"The need for government action in relation to anaphylaxis has become even more apparent, given that the number of children suffering from severe food allergies has doubled in a generation," Ms Burke told Parliament on 21 May. "The number of hospital admissions for anaphylaxis has doubled in the last 15 years [and] a study has estimated that a quarter of the population will have an adverse reaction to food, especially during infancy and early childhood."

Three other MPs, Laura Smyth from the ALP, and Karen Andrews and Greg Hunt from the Liberal Party, spoke in support of the motion.

Independent hospital pricing authority releases national efficient price 2012-13

The inaugural National Efficient Price (NEP) Determination 2012-13, and the Pricing Framework, have been released by Independent Hospital Pricing Authority (IHPA). The following information has been taken from IPHA media releases and associated documents.

The national efficient price for 2012-13 is $4,808 per National Weighted Activity Unit.

The national efficient price for public hospital services will underpin the introduction of activity based funding (ABF) for Commonwealth funded services nationally from 1 July, 2012.

Shane Solomon, Chair of the Pricing Authority said this Determination is one of the key national health reforms agreed to by the Council of Australian Governments in August, 2011.

"The implementation of ABF will improve transparency, and strengthen incentives for efficiency in the delivery of public hospital services," Mr Solomon said.

"The benefits to public hospital patients of ABF include better value for public money spent on hospital services and a more transparent system.

"Public hospital governing bodies and managers will be in a much better position to measure their efficiency against a range of other hospitals in Australia."

The system of activity based funding that will be used by IHPA involves the calculation of National Weighted Activity Units for a range of hospital services. These units reflect the cost of each of these services.

For example, a same day inpatient admission for a cataract procedure has a weight of 0.5726 NWAU (12), a Triage 1 non-admitted Emergency Department Presentation has a weight of 0.2203 NWAU (12), and a General Medicine Outpatient service has a weight of 0.0588.

ABF is actually payment for the hospital services that are provided – which means States and Territories have an incentive to provide more services.

"IHPA only determines the Commonwealth funding for public hospital services. The States and Territories can contribute above or below the price set by IHPA," Mr Solomon said.

"Furthermore, in 2012/13 and 2013/14 the States and Territories have guaranteed level of funding from the Commonwealth.

"From 1 July 2014, Commonwealth funding will be uncapped so public hospitals will be paid more if they provide more services."

IHPA has consulted widely with the Commonwealth, State and Territory governments and undertook an extensive public consultation process on the draft Pricing Framework in January and February this year which has informed the NEP Determination 2012-13 and the final Pricing Framework.

The Independent Hospital Pricing Authority (Pricing Authority) is established under the National Health Reform Act 2011, and is invested with the following functions relevant to this National Efficient Price Determination 2012-2013 (Determination):

(a) to determine the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis;
(b) to determine the national efficient price for health care services provided by public hospitals where the services are block funded;
(c) to develop and specify classification systems for health care and other services provided by public hospitals;
(d) to determine adjustments to the national efficient price to reflect legitimate and unavoidable variations in the costs of delivering health care services;
(e) except where otherwise agreed between the Commonwealth and a State – to determine the public hospital functions that are to be funded in the State by the Commonwealth; and
(f) to publish a report setting out the national efficient price (NEP) for the coming year and any other information that would support the efficient funding of public hospitals.

This inaugural Determination is the initial output of the performance of those functions by the Pricing Authority.

In making this Determination, the Pricing Authority has relied on a number of different data sources. Costing information used to determine the NEP has been drawn from the National Hospital Cost Data Collection (NHCDC) Round 14, as provided by States. Whilst there have been considerable improvements in the consistency of cost allocation methods applied across States in recent years, the Pricing Authority recognises that there needs to be further improvements made in this respect in coming years.

The classification systems in use for Emergency Departments and non-admitted services are being used for the first time and the activity and costing data for these are less mature than for acute admitted hospital services. For this reason, these classification systems will both be substantially reviewed and redeveloped in coming years. Notwithstanding these limitations, the Pricing Authority is satisfied that this Determination is fit for use for funding in 2012-2013.

In performing the functions outlined above and preparing this Determination, the Pricing Authority has had regard, as required to:

(a) relevant expertise and best practice within Australia and internationally;
(b) submissions made at any time by the Commonwealth or a State;
(c) the need to ensure:
  (i) reasonable access to health care services;
  (ii) safety and quality in the provision of health care services;
  (iii) continuity and predictability in the cost of health care services; and
  (iv) the effectiveness, efficiency and financial sustainability of the public hospital system;
(d) the range of public hospitals and the variables affecting the actual cost of providing health care services in each of those hospitals; and
(e) relevant intergovernmental agreements (including the National Health Reform Agreement 2011 (Agreement)).

AMAs early response to the Determination:

Bearing in mind that this is newly released information and detailed analysis has not yet been undertaken, the AMA acknowledges that this is a significant body of work, representing an equally significant change in the funding arrangements for public hospital services.

The national 'efficient' price will determine the Commonwealth's share of public hospital funding.

If there is any shortfall between the efficient price and what local services actually cost, State and Territory governments will have to pick up the difference in their share.

The public reporting of funding flows into and out of the National Funding Pool will, for the first time, provide transparency of Commonwealth funding for public hospital services.

The AMA has called for an 'effective' national price rather than an 'efficient' national price.

An effective price is one that provides sustainable and equitable access to high quality hospital services. The national price should deliver quality, not just efficiency.

If hospitals are struggling on quality performance, it could be because they are under funded.

What impact the efficient price will have on the capacity of public hospitals to meet the demands is yet to be seen. Will more beds to be opened so that more elective surgery can be performed?

There is still much work to be done to secure proper funding for teaching, training and research - particularly as we need additional funding for this activity to ensure quality training places for the increased number of medical students graduating over the next couple of years.

The *summary* document sheds more light on 'growth funding". It describes it as "From 12 July 2014, Commonwealth funding will be uncapped so public hospitals will be paid more if they provide more services."

The IHPA Press release states that Activity Based Funding (ABF) provides an incentive to State and Territories to provide more services.

The national efficient price only relates to operating costs. States and Territories are responsible for planning, funding and delivery of capital costs.

ABF can deliver a one off increase in efficiency. This can provide 'space' for more services to be provided within existing capacity, but only up to a point.

More services requires more beds. There is no guarantee that States and Territories will provide the capital funding to increase the capacity of public hospitals to meets the demands of the local communities.

The Determination was released just prior to Canberra Doctor going to print, so further comment on this will follow when it becomes clearer what this will mean for Canberra and Calvary public hospitals.

Canberra Doctor acknowledges with thanks the comments provided by the Federal AMA

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MBBS, FRANZCR
p: (02) 6203 2023

Erindale & Queanbeyan

Dr Jenny Bramley
MBBS(Hons), FRANZCR, BSc(Med)
p: (02) 6203 2030

Garran

Dr John Faulder
MBBS, FRANZCR, BSc(Med)
p: (02) 6203 2025

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