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Transcript: AMA President, Dr Michael Gannon, AMA Vice President Dr Tony Bartone and AMA Queensland President, Dr Bill Boyd, AMA Queensland, Brisbane
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Subject: AMA's 2018 Public Hospital Report Card Launch

MICHAEL GANNON: Thank you for joining us for the launch of the AMA's 2018 Public Hospital Report Card. My name is Dr Michael Gannon; I'm the National President of the AMA. I'm pleased today to be joined by the President of AMA Queensland, Dr Bill Boyd, and the National Vice President, Dr Tony Bartone.

This year's Public Hospital Report Card does not paint a pretty picture of Australia's public hospitals. Using the Government's own data, using data from the AIHW on elective surgery waiting time and on the time it gets to be seen in our emergency departments, it shows that our public hospitals are failing to keep pace with demand. Year on year, we see ageing of the population, an increased complexity of the caseload, as drivers of the increased need for our public hospitals. According to these measures, the system is at best plateauing, or at worst going backwards. We see population growth year on year, we see an additional complexity to the caseload being presented to hospitals, so we expect extra dollars are needed.

This report card has the numbers, the proof, to show that we need greater cooperation between the Commonwealth and the States, we need additional investment in our public hospitals. Let's not forget that for every Australian, public hospitals are their champions in providing care in sometimes their darkest hour. For Australians who live in the regions, it's the only hospital. For that half of the Australian population that doesn't have private health insurance, it's the only option. For certain types of high level care, it's the only option. And of course, the public hospital system is the substantive majority provider of emergency care and intensive care for all Australians.

I'd now like to introduce Dr Bartone, a GP in Melbourne, to talk about the importance of public hospitals to GPs and how public hospitals intersect with primary care every day.

TONY BARTONE: Thank you, Michael. The human face of the report card that we're releasing today is one of a patient management system that's complex. What we're seeing now is that my patients, who regularly are managed by myself, my colleagues in my practice, are having to wait longer and longer to see a specialist in outpatients. What does that mean? That means that I'm managing my patients for longer with conditions that need treatment. I'm managing the delayed outcomes of that. For example, if we're looking at orthopaedics, if we're looking at a knee joint that is painful, it's the pain that I'm managing. It's the additional medications that they don't need to take. It's the delayed outcome. So they've got other conditions that I'm trying to manage - their diabetes, their heart disease, they can't exercise. So this is all compounding in the end and leading to worse outcomes. It's not giving them the quality of care that they deserve in our society.

What I'm seeing more and more is that patients are required to wait months, sometimes 12 months or more, to see the specialist in outpatients to be put onto the elective surgery list. That means that for some of them, they're waiting up to two years or more for the management of their condition, to have a definitive outcome implemented that allows them to get on with the quality of life they deserve. This is not what we would expect from a first order health society. This is not what we expect in a modern-day Australia. It's selling our patients short, and we

really need to ensure that the funding that allows the access continues to be implemented and increased sufficiently to allow timely access.

Access to public hospitals for those who don't have private health insurance is an important part of their right, their equity, when it comes to access in this country. Let's not also forget that in some cases, the house full sign comes up at the local outpatient department. That is, they say no, sorry, we can't manage your patient, try your luck elsewhere or go privately. For some of my pensioner patients who are on really low incomes, that's just not an option. That's condemning them to further time, further wait, further delayed outcome management, and also unnecessarily clogs up time in my practice, in our family practice, in terms of managing other patients and managing other conditions.

So it's about access and timely access, and really it's about managing patients' frustrations and their desires for just access to that treatment that they so richly deserve.

MICHAEL GANNON: So what we see in this report card is the fact that we need additional funds to deal with the increasing amount of care and complexity of care that needs to be provided. But doctors believe in better stewardship of the limited dollars available. We're calling for better State-Commonwealth cooperation, but even at an individual hospital and area health service level, more can be done. I'd like now to invite Dr Bill Boyd to the lectern to talk about his many years of experience in the hospital system here in Queensland.

BILL BOYD: Thank you, Michael. I certainly have worked in regional Queensland for over 30 years, and I know that we heard Michael saying that we're looking for more funding to make the system work, but we also need a cultural change. We need to include clinicians in decision-making. Up and down the Queensland coast, hospitals are struggling to get junior staff in particular to either be recruited there, or indeed, once they're recruited, to actually stay there. And it's not necessarily about money. It's about training, it's about accommodation, it's about looking after doctors' spouses giving them something to do - an occupation, it's about simple things to keep doctors in the regional centres.

But also a cultural change from their employers. There needs to be an attitudinal change where there is respect for clinical staff. Clinical staff need to feel that they are safe where they are working and that they are working safe hours. We know that a lot of clinical staff - particularly juniors - are working very long hours. We know that if you're driving a motorcar, you're supposed to pull over and rest and tired drivers get into trouble. It's the same with all sorts of professionals, including doctors, that can only work so many hours before they need to rest and that's not happening.

So, a cultural change, respect, include doctors, clinicians, in decision making and certainly look at the funding. But it has to be spent smartly. There has to be smart spending of money. Doctors actually know their job, how about asking them how some of that money should be spent to get good clinical outcomes?

Thank you.

QUESTION: Michael, you would imagine that the Commonwealth Government will say we're putting more money than ever into health. Where's the mix gone wrong?

MICHAEL GANNON: Well, certainly the Commonwealth has provided greater growth in costs than the States and Territories in recent years but these metrics from their own data show that it's not enough. So, what we're asking is that we use every precious cent of funding better and more appropriately. Part of the agreements between the Commonwealth and the States is

how that money is spent. We want to see an end to the games. We want to see an end to the cost shifts. So, for example, the imaginative mechanisms by which the States cleave private health insurance revenue as a cost shift away from their budgets and onto the Commonwealth, that's not helping the system.

We need greater cooperation and we also need to understand that the health system, it's like a jigsaw puzzle, we can't just fix one element of the system and expect that that will take care of everything. Every change to private health insurance puts greater pressure on the public hospital system. The consistent freeze on rebates being paid to GPs and other specialists in the community - which thankfully we're seeing an end to in coming months - but the failure of successive governments to invest in general practitioners is the cause of some of these problems. But even if we fix everything in private health insurance, in prevention, and in general practice, we will always require well-funded well-resourced public hospitals. That's why it's so important that that relationship between the Commonwealth and the States is tidied up.

QUESTION: When you look through that data, where do you see some very significant problems in terms of States, who's really dropping behind?

MICHAEL GANNON: It's possibly not that helpful to pick winners and losers because no one is performing at the level we would like to see. We've seen every State and Territory abandon the four-hour targets for emergency departments. We're not seeing a single State do well when it comes to Category 2 patients getting elective surgery. And what you've heard my colleague, Dr Bartone, today elegantly talk about, is how this has impacts in other areas of the health system. They all blend together. If you can't exercise because of chronic hip pain, you're going to put on more weight, your diabetes is going to get worse, you might have a stroke or a heart attack. All of these things link together. We simply need to recognise the importance of our public hospitals in delivering that caseload of elective surgery and, of course, delivering the services that no other part of the health system can.

QUESTION: What about the suggestion that every State's pretty much doing it but they're manipulating the figures, you have a waiting list to get on the waiting list, then the waiting list is then measured - the second waiting list - do you think they've got to stop that?

MICHAEL GANNON: Well, we as doctors whatever specialty we work in, know all about hidden waiting lists. They are no secret to us. The sad thing is that even with the visible waiting lists the system's not performing that well. But you are exactly right in pointing out the fact that the time it takes to get an outpatient appointment is not recorded in any of this data. And one of the problems we have is the obsession with activity based funding means that hospitals and area health services are providing those services they know they're going to get a dividend from the Commonwealth on. We want to see public hospitals provide all services to all patients according to clinical need. Hidden waiting lists are real. Some patients wait north of two years to even get to a point they might be put on a waiting list; that is simply unacceptable.

QUESTION: If I could speak to Tony, please. Tony, these hidden waiting lists, as you mentioned before, they are causing significant problems. What are the worst cases you've heard where people are literally trying to get a pretty basic sort of appointment but they're waiting?

TONY BARTONE: So, there are examples across a number of different sub specialities. So, if we look at orthopaedics, that's an often quoted one, if we look at urology that can be upwards of 18 months or two years for some assessments in outpatients, if we look at cataracts and ophthalmology that's another area, gastroenterology sometimes scopes in that specialty can take upwards of 12 months or more. So, it's about understanding that really there's a human

side to these numbers. It's not just a knee and it's not really an elective procedure that we're talking about or an elective assessment, because the patient is a whole patient. They have other conditions and as we know, patients are getting older, patients have more chronic and complex diseases and that the interplay of one condition will impact on another condition. So we've got to manage the patient, and we've got to really stop this blame game, stop this cost-shifting, and look at making sure that we can really address timely access because it's about managing the whole patient, managing their condition and their access and quality of life.

QUESTION: Do you think that every State Government is potentially petrified by the fact that if you did put a measure on that waiting time, to get on to that outpatients list?

TONY BARTONE: Look, it's not for me to comment on the degree of fear that might engender. What we really do need is to have visibility and transparency and clarity. We need to measure that. We need to have that out in the open and we need to address it. if we don't know the extent, we can't improve upon it. Performance is only as good as the data that you have and you need to start with the data to begin to improve it. So let's understand it, let's put it out in the open and then we can measure and track our improvement because we need to improve. We can't stand still we can't stay where we are. We're going backwards and that's only condemning our hospitals to a system of failure.

QUESTION: Bill, if we could get the Queensland experience from you.

These figures here show that only 60 per cent of patients going through the ERs are getting - sorry, are being seen and treated within a reasonable time.

BILL BOYD: It's interesting, the 2018 Public Hospital Report, to me, is a bit like the curate's egg. It's excellent in parts. It's not all failure of doom and gloom, but certainly through the emergency departments they're falling behind the targets. Interestingly, they have achieved some good figures for level two surgery. So, as I say, it's not all doom and gloom, but could do better. Again, funding is an issue, but it also has to be the cultural attitude supporting doctors, letting them take the decisions, involving them. We know that in emergency departments the numbers are almost overwhelming and we would also encourage those people who attend those departments to consider going to see their family doctor, rather than coming into the hospital departments and making it difficult for everyone.

QUESTION: What about the waiting times that people are sitting there waiting to get on the list to go and see a specialist about something? How chronic is that in Queensland?

BILL BOYD: It remains a chronic problem and to some extent a hidden problem. The way the figures are compiled and publicised clearly it makes them - it's designed to make them look better than they really are. I know that for some people with some conditions they can wait for a year or more to be seen, and that's before they ever get their surgery.

QUESTION: I've heard the term cooking the books. Do you sort of go along with that perception here - that they're manipulating the figures to make it look better than it is?

BILL BOYD: I think from an AMA point of view we have to be factual and just look at the numbers, whoever might put an interpretation on how they're compiled, and that's up to them.

QUESTION: Queenslanders, are we getting better service this year than what we were the previous year?

BILL BOYD: If you look at the figures on a sort of micro basis, each year it will go up and down a little bit. But I think pretty much it's the same as we go along, if anything, given that the numbers are increasing, the numbers of attendees are increasing. We're pretty much probably going backwards.

QUESTION: So what does that mean for mums and dads who take a child that's sick and head off to an ER?

BILL BOYD: First of all consider whether the child is better seen by a family doctor because depending on - if somebody is very sick and very ill, they will be seen. Somewhere in Queensland they will see a doctor who will look after them. If people go along to emergency departments with lesser - what's deemed to be a lesser condition, yes, they will have to wait and it can be for many hours. So, they have to consider about whether or not to see a family doctor, at the same time, the health services run by the by the government and that has to be - their systems have to improve to be able to minimise the waiting lists in these departments.

QUESTION: When you look at something like category three patients, they're the ones that need something within a year, basically. We've got - I just [indistinct] two hospitals here that I've looked at in Brisbane: one's the PA and one's Logan. At the PA, it's a 171-day wait. At Logan, it's 220. It's only a couple of kilometres down the road. How can we have such a significant difference in a Queensland hospital?

BILL BOYD: Interesting. This report that we've got is largely a nationwide State-based report. I think when it comes down to fine detail, the people running those hospitals would be in a better position to answer those questions.

QUESTION: But it seems crazy [indistinct]. We're the same State, we're only a couple of kilometres apart and yet there's such a dramatic increase.

BILL BOYD: Again, I would say that the people running those hospitals are in a better position to answer those questions.

QUESTION: What do you say to people who are waiting for knees and hips and things like that across Queensland? There's an awful lot of them. Are they in a better position now than what they were last year to getting that surgery done?

BILL BOYD: From year to year, the figures are much the same, but we've probably gone back a bit in Queensland in the last 12 months.

QUESTION: Can it be fixed?

BILL BOYD: I guess it can. It can be fixed by increasing the budgeting towards the services, but also by looking at the way the system is run, including clinicians and physicians - including clinicians in decisions and cutting out a lot of the red tape and compliance stuff that gets between doctors and their patients.

QUESTION: So are people are not being treated as quick because they've got too much paperwork - the doctors and [indistinct] have got too much paperwork to do before they actually do the treating?

BILL BOYD: I think there's not the slightest doubt about that.

QUESTION: Okay. How would describe that to mums at home?

BILL BOYD: There has to be rules and regulations in everything that we do, and the rules and regulations, the ethic behind the rules and regulations, is to try and make everything we do safe. But I would say that it could be looked at and we could cut back some of the stuff that comes between patients and their medical practitioners and the nurses

QUESTION: So, they're being slowed up by having to fill in forms.

BILL BOYD: I think everyone would agree with that. There'd be very few people who don't agree with that.

MICHAEL GANNON: Alright. Thank you again for attending the launch of the Public Hospital Report Card. We will look forward to action from governments at both Commonwealth, State and Territory level, in coming weeks. Use this document as an advocacy piece to help in the care of Australians wherever they live.

QUESTION: Michael, just before you go. Just one more question. Queensland Health today, [indistinct] probably the Minister's going to come out and say: look, this is all wrong, we're actually doing far better than what the AMA is saying. What do you say in response to that?

MICHAEL GANNON: We would say that this is the Commonwealth's own data, and this is the States providing data to AIHW. They could expect nothing less than Australia's doctors to advocate for better treatment for our patients, and if I could pick up again on Bill Boyd's points today. Governments and bureaucracies do best when they involve doctors in decisions about health care. Doctors are the clinical experts. We've got an ethical requirement to be stewards of limited health dollars. We know what works, wherever possible involve doctors at the coalface in those decisions about how we take care of their citizens.

QUESTION: The Minister's likely to come out and say today: look, we've actually improved all of these targets, we're doing really well.

MICHAEL GANNON: It's difficult for politicians at every level of government to find the money for the growth in the health system. The truth is the population is ageing. There's a higher proportion of people living with chronic diseases into extended years. That's something to be celebrated. The things that we can do for people today - the operations that return people to full function, get people out there enjoying their lives - they're to be celebrated. So, increases in health budgets year on year aren't bad news, but it's our job to call governments to account and to remind them about those basic health services that Australians without a voice would expect us to call for.

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