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Transcript: AMA President, Prof Brian Owler, National Press Club Q&A, 22 July 2015

Subject: National Press Club Q&A

LAURIE WILSON: Thank you, Brian Owler. Let's move to questions. Now, let me ask the first one. Perchance I happened to be chairing a health care conference in Brisbane last night and one of the speakers' opening remarks went to the audience and he asked them to put up their hands, those who thought that the meeting in Sydney between the various political leaders, the State and Federal leaders, would actually achieve a positive outcome, and not one hand went up. Now, that generated a little laughter but it's not a laughing matter. You've urged the leaders to, in your own words, sort this mess out. But how confident are you, I mean you talk to State and Federal leaders, your organisation does, how confident are you that there is in fact a genuine commitment to achieve some sort of breakthrough?

BRIAN OWLER: Thanks, Laurie. Well, to answer the question, I'm not very confident at all, but we've only had to listen to the comments that various State leaders have been making this morning. But what I do welcome is the fact that health has been seen as a priority and there is recognition that health funding, particularly for our public hospitals, must be placed as a priority. It's not up to the AMA to say whether it should be through GST or other income measures or taxation measures. There is clearly a revenue problem. It's not an expenditure problem. At the end of the day, we need to make sure that there is sufficient funding for our public hospitals. Now, as part of this debate, of course, we have a debate about Federation and the roles of the States, and that is an interlinked conversation.

I have a lot of concerns about pushing responsibility away from the Commonwealth and back to the States. Those larger States have well-developed systems and they will be okay. But I really worry about some of our smaller States and Territories, where the systems are not as strong, where they certainly don't have the flexibility in terms of their revenue to cope if they are suddenly presented with a problem. And I think already in this country, we have a problem with equity in terms of the service and access to services that patients in different States and Territories experience. And I think what we should be doing is trying to make sure that wherever you live in this country, no matter what State or Territory, you get access to the best quality health care services in a timely manner.

LAURIE WILSON: Question now from Andrew Tillet.

QUESTION: Andrew Tillet from The West Australian. Professor Owler, you just said that you're not going to say - the AMA's not going to say whether it thinks - how to approach the funding issue. I'm going to ask you anyway. Would you support an increase to the Medicare levy, to - particularly if that money was hypothecated - to the health system or would you support a broadening or increase to the GST to do so? And in particular, what about extending the GST to removing the exemption - sorry removing the exemption for healthcare in the GST?

BRIAN OWLER: Well, let me address the last point first. Clearly, the AMA does not support including health in the GST, nor does it support including things such as fresh food. I mean, I've just been talking about, you know, prevention and making sure that we actually have a healthier society and so slugging fresh food with a GST is obviously going the opposite direction. We also have an issue about the affordability and access to services and we want to

make sure that we're not going to add a 10 or 15 per cent extra cost on the top of accessing healthcare services. Now, I mean, one of the things that this discussion is not really addressing is what happens to the money that might be raised. So whether it's through a Medicare levy, whether it's through the GST, whether it's through income tax, it's still all going to the Federal Government. The issue is actually how we allow States to actually share in that revenue, and even actually allow them to raise the revenue themselves. I think that is really more of the question that we should be talking about.

Now, the Medicare levy - I mean people are under the impression they pay their Medicare levy and it covers the costs of health. But the Medicare levy raises about$10 billion. The cost to the Federal Government alone for health is about $60 billion. So it goes nowhere near covering the cost of health and to actually get anywhere near what is needed, it would have to be a much more substantial increase than, say, to 2 per cent. There are issues, obviously, with GST being a regressive tax and we have issues about how it might affect disadvantaged people in our community, but as I say that sort of tax policy is not necessarily for the AMA to say. Suffice to say that the money needs to go into the public hospitals at the end of the day, and make sure that we stop this blame game between the States and the Commonwealth about where the money comes from.

LAURIE WILSON: Sue Dunlevy.

QUESTION: Sue Dunlevy from News Corp. Dr Owler, the Pharmacy Guild has been the one group in the health sector that's managed to get an increase in pay out of this government. I'd like to know what you think the AMA could learn from their tactics… and also, I would like to know how you would feel if the Government decided to apply any savings from its Medicare review to cover the black hole it's got in its budget as a result of not going ahead with the increase in the pharmacy co-payment.

BRIAN OWLER: Look, the Pharmacy Guild, I mean, we support pharmacists to be pharmacists. And we recognise that there's an important role for pharmacists to play and they need to be supported to actually provide medications for patients in a timely and safe and effective manner. Now, the Pharmacy Guild are a strong lobby and good luck to them, they've negotiated strongly with the Government. The problems that we have with the latest CPA is really in relation to the roles of pharmacists and what they might be paid to do in the future. And I think we need to get back to recognising and respecting everyone's roles within the health system, what their training, what their education actually is and what it actually prepares them to do. And so, the only problem that we have in terms of the pharmacists is when we start talking about them taking a much more active role in doing some of the roles where it is really the GP's role.

Now, as I said, we support pharmacists to be pharmacists. We have a proposal that is there with the Pharmaceutical Society of Australia that is there about having pharmacists and GPs work together. There is a role for them to play, a non-dispensing role in general practice that allows them to actually do that patient education. And actually the evidence is that there are savings that can be made through that. Now, as far as the MBS review is concerned, we've said all along the MBS review cannot be a cost-cutting measure. Now, if there are clearly savings that are identified and the evidence is there that supports those savings, then fine. But we also need to make sure that we have the ability to introduce new items onto the MBS.

This cannot be about just taking items off. There are a lot of things that are not covered by the MBS at the moment that should be covered. Things that should be better recognised, and better valued. And the process for getting those numbers on at the moment is very costly, it's very lengthy, and so what we need to do as part of this review is ensure that we can actually add new things on and make sure that we do actually come up with a modern MBS.

If we get the sense that this is a cost-cutting exercise, given the assurances of the Minister time and time again, then as I said, the AMA support, and I suspect the support of the whole medical profession, will be jeopardised.

LAURIE WILSON: A question now from Sarah Whyte.

QUESTION: Hi Dr Owler, Sarah Whyte from Sydney Morning Herald and The Age, you talked about Medibank and I'm wondering, are we heading toward US-style system, that they're not going to cover women who die during childbirth and other complications? Where do you see the future with private health insurers and what kind of regulation were you speaking about before?

BRIAN OWLER: Well, this is the concern, that we are heading down that system and Medibank Private have actually made no secret of the fact that they want to have a much greater say in the payment to providers, whether it be hospitals or doctors or anyone else. We don't want to go down a road to a system whereby an insurer can be basically dictating what doctor you can be referred to, what treatment you can have. They need to be able to cover the procedures that are approved for patients, they already go through that process of AMSAC, they are already there.

So a US-managed care system is a system that places an enormous administrative burden on the patients and on the practices. It actually increases costs and, at the end of the day, the only one that wins is the insurer. We don't want to go down that system. As I said, we actually have an excellent private health insurance system, and it has many features that I think we should be very proud of. I am concerned that as Medibank Private, given its float and given its new, I guess, direction, that we are slowly heading towards that direction. Now, I've got to say, the private health insurance sector is not uniform. We also have the mutual funds, who are there to benefit their members, and this is a very different approach - particularly in dealing with them as the AMA has experienced.

And so we need to make sure that the constant cost-cutting that we see Medibank Private doing does not undermine the ability of the other private health insurers to actually maintain their level of services and their level of coverage.

LAURIE WILSON: Primrose Riordan.

QUESTION: Hi there, it's Primrose from The Fin Review here. I was wondering, the AMA talked about … Doctor, you talked about abuse of trainees in doctors. I was wondering how many cases you were aware of, of legal action against senior doctors accused of bullying, and what measures does the AMA support to protect trainees?

BRIAN OWLER: Look, I can't put a number on the number of legal cases, but we are aware of a number of cases where there have been complaints and where issues have been raised. And certainly, what is more concerning to us is the number of cases that actually never get to that point because people are too afraid to speak out, because they're worried about their careers. Now, as difficult an issue as this is for the medical profession, what we did do was get all of the leaders of the Colleges and a number of Specialist Societies together in Canberra. We held a roundtable. And we have a plan that we're trying to work through to confront this issue.

I think what we need to do is make sure that the policies and procedures are in place. They vary right across the country. For many of our junior doctors, the employer is actually the Department of Health, it's actually not the College or their senior doctor. So they need to make sure that those procedures are set up right across the country, and we're working through AHMAC to make that happen. The Colleges also need to make sure that their processes are in place as well. I applaud the work of the College of Surgeons, their expert committee which is

currently doing its work to actually come up with a process that I think everyone should then replicate.

Then we need to make sure that it is safe for people to actually come forward without fear of reprisal, without fear for their careers. Finally, I think the most important thing is that we do need to change the culture. I've got to say that the vast majority of senior doctors are very supportive of junior doctors but we know that that is not always the case. So where we do see a problem, that is why we need to speak out and make sure that we don't allow that to happen. And as leaders, as senior doctors within the profession, the responsibility is on us to make that happen.

LAURIE WILSON: Belinda Merhab.

QUESTION: Hi Dr Owler, Belinda Merhab from AAP. We've had a lot of talk recently about how we can raise more money for the health system. But I'm wondering if there's a better way to spend the money we already have and wondering how we can actually find those efficiencies given that every time a suggestion is made, we do have outcry from various stakeholders.

BRIAN OWLER: Well, reducing expenditure and trying to rein in any inefficiencies of course is part of the responsibility I think of those working within the system, but also those in charge of the system, and certainly our politicians. But sometimes it also needs some investment. And that's why I was talking about the importance of our IT systems. Unless we have that sort of infrastructure that is being developed that reduces the waste, that reduces unwanted clinical variation, then we are always going to continue to struggle.

One of the visits that I had to the US last year was to Chicago and to Washington, and the amount of IT infrastructure that they have allows them to do things like predictive analytics. So they can actually predict for a patient with certain characteristics, what should be done to prevent that patient from developing a disease, or they can predict if that patient is likely to get into trouble within the next few months. And so they're more pro-active about trying to intervene.

That's the sort of direction, that's the - I guess the smarter way that we need to be heading. I've also got to say that as I mentioned last year, this Government did do away with the incentives around activity-based funding. Now, activity-based funding has its own sort of problems, and it was never going to fund an open-ended activity. But what it did do was force departments and individual doctors to actually focus on their practices, and actually look at the costs of the health care that they were providing for particular conditions against a benchmark.

I think we need to be doing more of that, so we don't have variation in our hospital stays from one hospital where it might be seven days to another hospital where it might be four, for instance. So we need to get that unwanted clinical variation out of the system, and make sure that people still have some ability and flexibility. But where there is waste, that we cut it out.

LAURIE WILSON: David Sharaz.

QUESTION: David Sharaz from SBS. You mentioned in your speech that compromising the rights of asylum seekers and the doctors who treat them could open itself up to risks. I was just wondering what those risks are.

BRIAN OWLER: Well, we shouldn't do it. I mean, there is a clear ethical and moral obligation for people to be able to speak out when they see a problem. And the reassurances that have come subsequent to this Act going through Parliament have done nothing to appease doctors, because, at the end of the day, why have the Act in the first place? To us, it seems like the

Government is trying to intimidate those doctors and health workers that do have genuine concerns about asylum seekers, not only in terms of the healthcare provision that they're receiving, but also on the effects that detention is actually having on those people.

So you start to do these things as a society for one group, but where is it going to stop after that? Is there another group that might be there somewhere in the future that we might place the same sort of law around? I just don't think, as a society, this is an acceptable avenue to go down.

LAURIE WILSON: Michael Keating.

QUESTION: Professor, Michael Keating from Keating Media. I might follow up a bit on what my colleague's question - Belinda - was. You said that IT and technological change is a key efficiency that can be made in the health system and you've outlined some of the ideas that you've had. As you know, it's quite difficult to change across an entire department, let alone across every GP in Australia. The Australian Government has got the e-health system which they're promoting at the moment, but how do you think, in practice, those efficiency gains will be made in IT, and have you had a conversation with the Minister suggesting some of those ideas?

BRIAN OWLER: Look, doctors have embraced IT in practices, particularly our GPs. I mean, you don't go to a GP, or very rarely these days, without a computer being on the desk, the prescription being done electronically, and pretty much everything that the GP needs is on their desktop. The problem is that all of these systems have been built up as silos, rather than allowing people to communicate and talk to each other. And there's been some of that developing, but it's mainly within private practice, within GP surgeries. What we need to do is develop the ability to link that IT with the hospital.

Now, the PCEHR was the sort of grandiose plan and it got bigger and bigger and bigger as more and more people wanted more and more features. And in the end we weren't able to deliver on that grandiose plan. But I think what we need to do with the PCEHR is scale it back, allow it to be the vehicle that allows us to do what we need to do - provide the clinical information between doctors, allow that doctor-to-doctor communication, so that we can actually know what people are saying to each other. That's the sort of direction the PCEHR needs to go down.

Now, there's no reason why, in a country of 24 million people, we can't do this. There are regions in the United States where they have systems that cover a population that's larger than that. So there's no reason why this cannot be done. It just needs some resolve, and it needs to focus on what we need to do to make the system work.

LAURIE WILSON: Sophie Morris.

QUESTION: Sophie Morris from The Saturday Paper. Further to your concerns about the Border Force Act, given the risks of prosecution if medical practitioners and others working in detention centres are found to have spoken out and breached this Act, would you be advising doctors not to work in the detention centres under those conditions, or do you consider that the welfare of the people within those detention centres outweighs the risk to doctors and that they should take that risk and see what happens?

BRIAN OWLER: Wouldn't matter what I said, I suspect, I think doctors would vote with their feet and they would go and provide health care to asylum seekers because that's what they do. We're not going to be able to stop people from doing it. There've been talks from some groups about boycotting detention facilities. Doctors are never going to do that, because doctors will always go and look after the patient. And they will put their own interests second. We've

already seen that. I mean, people have suffered for speaking out already. They've been intimidated and we've seen that happen.

So I don't think that … it wouldn't matter what I said. I would never advise that anyway, but doctors are always going to go and look after their patients and it's the health care of the patient and asylum seekers, as I said, are patients just like any other, and they deserve the best quality healthcare. I mean, I've got to say that some of the comments about, well, you know, they should get the sort of standard health care that's available locally and that's the same as what healthcare is provided to some remote Indigenous communities. Well that's more an indictment on the healthcare for our remote Indigenous communities than it is an excuse for the healthcare that's provided to asylum seekers.

LAURIE WILSON: David Speers.

QUESTION: David Speers from Sky News. I should acknowledge a bit of self-interest with this question. It's in relation to Medibank Private. I was on the phone to them the other day trying to book in a tonsillectomy for one of my kids and they said we're ending our contracts with Calvary John James here in Canberra. So it's timely you have a go at them today. I guess in one sense, hasn't the horse already bolted on this? Medibank has been sold off. What are you actually proposing here, that the Government should intervene and say you need to have contracts with certain providers in certain parts of the country?

BRIAN OWLER: I think that's one option, but I think we also need to be talking about these issues. The problem is that people look at the glossy ads on television, they look at the hype, they look at the extras that they might get for their coverage, they go on websites that compare the premiums one against another. But at the end of the day we've got to start talking about the value of the health insurance product that people are buying. And if they start buying products that doesn't allow them to get admitted to the private hospital, or they have products, for instance, that we've referred to as junk products, where you're only covered to be a private patient in a public hospital, don't have any access to a private hospital, those products are not worth anything.

And so, it's no point having those sorts of products or people thinking that they've got coverage and buying them. We need to make sure that the public is much better educated about this. We've also seen other aspects such as reducing the coverage for pathology and radiology by Medibank Private in certain hospitals. And that means that people are going to be shocked when they get home and they see a whole range of bills for out-of-pocket expenses that they wouldn't otherwise have gotten if they were with another fund.

These are the sorts of issues that people need to be much more aware of. It needs to be brought out into the open. Rather than having these sort of discussions and negotiations between closed doors, I think a bit of sunlight on these arrangements is in order.

LAURIE WILSON: Andrew Tillet.

QUESTION: Andrew Tillet from The West Australian. A bit of a left-field question. Medicinal cannabis. New South Wales is spearheading a trial about its use. I was wondering what your thoughts are. Is it something the AMA would support, given that the body of research out there on its use and the benefits of it, do we actually need a trial and perhaps we should move straight to making it available to Australians? Should there be any restrictions on who has it, should it be limited, for example, just to the terminally ill, and should it be subsidised by taxpayers?

BRIAN OWLER: The issue of medicinal cannabis is, I think it should be treated like any other medication. We actually use all sorts of medications, morphine is another form of heroin, for

instance, we use that. It's not about the fact that it's cannabis. It's actually about the fact of how effective it is. Now, when you say that there's evidence there, the evidence, I've got to say, varies depending on the condition. There are some conditions where it clearly may be beneficial, and perhaps we don't need to have an in-depth trial on those sorts of indications but there are clearly others where the evidence is actually not there.

And those are the sorts of things that we need to have proper trials of, and regulate it as a medication just like any other medication that we use to treat patients with a terminal illness, with epilepsy or any other condition. So it's not about trying to deny access of the drug to people, but we also want to make sure that we don't do any harm. That we want to make sure that people are actually getting the drug for the right reasons and that it's actually going to benefit them in the future.

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