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Transcript: AMA President Dr Michael Gannon, National Press Club Q and A, 23 August 2017

Subjects: Private health insurance, doctors' fees, drug testing welfare recipients, NDIS, marriage equality, codeine, palliative care, asylum seeker health, and eHealth

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CHRIS UHLMANN: Thank you very much for that, Dr Gannon. Our first question is from *The West Australian*.

SARAH MARTIN: Hi, Michael. Sarah Martin from *The West Australian*. The Federal Government recently has been talking a bit about a problem of effectively cost-shifting by the States to private patients covered, obviously, by private insurance who are attending public hospitals. How much of a problem do you think this is? And as the States and Federal Government negotiate the next funding agreement, what other issues do you think are going to be in play?

MICHAEL GANNON: The point I made directly to the Minister is that we must maintain flexibility. So we don't want a situation where insured patients are prohibited from care in public hospitals. Now some examples: they might live in a rural area where there's no alternative; no fancy, shiny, private hospital there in the region. It might be the case that a doctor with sub-specialist expertise only works in a public hospital. It may be that they need the intensive care unit that only exists in a public hospital. It may simply be the patient's choice. So, wherever we land, we must end up with flexibility.

One of the problems - one of the things that's led to this problem is the fact that the states and the Territories and the Commonwealth have underinvested in public hospitals. So, the public hospitals are looking for new revenue streams, and sometimes they're a bit too tricky and clever trying to get hold of insured patients when they're not actually providing any greater level of care. A private patient getting Foxtel is not a contribution to universal health care. They might even be taking up a bed that a patient who doesn't have a choice could be in. But I also think this is an area where the private health insurers need to step up to their part of the responsibility. If they've got policies that restrict someone to care in a public hospital, or they've got a policy that has so many exclusions that that's effectively where you end up, they are contributing to the problem. And I'm sometimes surprised at their advocacy that points to private patients in public hospitals as the game-changer in private health insurance. It's not. We need to maintain that flexibility. But within the Ministerial advisory committee, it would be good to pull back on some of the habits of the States and Territories that don't pass the sniff test.

CHRIS UHLMANN: Australian Associated Press.

BELINDA MERHAB: Dr Gannon. Belinda Merhab. Thank you for your speech. You made the point that insurers want doctors to publish their fees and to publish customer testimonials. You described that as dangerous territory. Could you explain why it would be a bad thing for consumers to have more information about their doctors' fees? I mean, isn't transparency a good thing? And surely when we've got this huge issue in private health insurance, shouldn't doctors play their part in ending that blame game to try and solve the problems?

MICHAEL GANNON: Well, if only it was that simple, that we had a ratings website that made it that easy. It is that easy. I've told you today that I can tell you the fee for 88 per cent of

medical procedures, it's zero. And patients are entitled to ask the question: does your doctor participate in a no-gap scheme? Do they participate in a known gap scheme? And that might be enough information. If you know that your gap's going to be less than $500, that might be all the information a patient needs, and they are very much entitled to that.

Five per cent of doctors, therefore five per cent of procedures, therefore, are charged at and above that rate. Now, a clear principle of ethical medical care is informed financial consent. And I think that that should be provided to patients wherever possible. There are some things that you can't predict. So, if you asked me to publish my total fee, I can't tell whether my patient needs the care of an anaesthetist; needs the care of a paediatrician; is their baby going to be admitted to the nursery? So there are limitations to how much information you can give.

Informed financial consent is very important. But I don't trust a website owned by the insurers to produce unvetted information about the quality of the magazines in the waiting room, whether or not the receptionist was rude, and I have great concerns about people not being able to obviously interpret quality data. Please don't publish quality data on doctors and expect them to look after the highest-risk patients. Because if you're going to start to limit care to high-risk patients; so the obese, those at higher risk of blood clots, those at higher risk of complications, those with alcohol and drug problems, we'll end up denying people like that care. So that's why it's a lot more complicated than a cheesy website might appear.

CHRIS UHLMANN: Sky News.

DAVID SPEERS: David Speers from Sky News. The Government today has announced a second trial site for its drug testing of welfare recipients. What does the AMA really think of this? What's the expert opinion of health professionals; bearing in mind your comment in your speech there that tobacco and alcohol do far more damage than ice ever will?

MICHAEL GANNON: Thank you for your question, David. And I remember on Budget night being able to celebrate what I regarded as overall a very good health budget. And if I had to put a nasty star on the Government's last Budget, it was this mean and non-evidence-based measure. It simply won't work. The aspiration of Minister Porter, the aspiration of his Department, I'm sure the aspiration of everyone in this room is for people on welfare to, wherever possible, return to a productive life in the workforce. If you discriminate against them, if you impair their return to full functioning by labelling them as a drug user, then you impair their ability to get their life back on track. That ultimately has to be the aspiration for welfare, to get people back to being productive members of either the workforce, or contributing to our community in some other way. This is not an evidence-based measure which will not help. We don't expect people in most industries to have drug testing before they turn up to work. It's simply unfair and it already picks on an impaired and marginalised group. It's not evidence-based. It's not fair. And we stand against it.

CHRIS UHLMANN: Canberra IQ.

SIMON GROSE: Simon Grose, Canberra IQ. My question is about the NDIS eligibility of people with mental health conditions. Mental Health Australia is keen to expand the range of eligibility. When he was here last month, the Mental Health Commissioner, Allan Fels, argued that because a lot of mental health conditions are episodic, that makes them effectively permanent, therefore should be covered by the NDIS. I note that in the AMA submission to the NDIS transition you asked - you argue for the right balance to be set as far as this issue. Where do you think the right balance is?

MICHAEL GANNON: Thank you for your question. This is going to be a very difficult and vexed issue for governments now going forward. The AMA celebrated the announcement of the NDIS. We applauded the bipartisan support for it. It makes us a better nation that we are trying to take better care of those with special needs and disabilities. And yet the cost of the

NDIS will need to be regulated very carefully to make sure that it doesn't end up consuming the entire Budget. It needs certainty of funding. And on the example you've given, I would probably use the same example I'd use for so many other areas of health care. Talk to the experts. Talk to the GPs, the psychiatrists, the psychologists, the carers who are there providing that care every day. Look at the evidence. Look at what works, and fund it according to what might be expected to work from international evidence, or from talking to home-grown experts here in Australia.

CHRIS UHLMANN: But this is precisely the issue of the NDIS, isn't it? It will be a boundary issue always on what's in and what's out, and there actually will be no end to the demand to get in?

MICHAEL GANNON: Yeah. This will be a very, very difficult area of public policy, not only for this Government but in Governments going forward. We cannot have a situation where the NDIS ends up consuming a third of the Budget. We know, for example, State Health Ministers complaining that health makes up 30 per cent of their budgets and they lament their inability to provide other services. The best answer I can give is to talk to the experts, so talk to the patient groups, talk to the carers, talk to the patients themselves, and we'll try and get those policy settings right. There's no easy answers. But I think talking to people might give us the chance to get those boundaries right.

CHRIS UHLMANN: ABC Radio.

STEPHANIE DALZELL: Dr Gannon, Stephanie Dalzell from the ABC. You back same-sex marriage on the basis that it's likely to reduce stigmatisation. What's your view, then, on the postal plebiscite? Do you give much credence to the claim that the vote could put vulnerable people under even more stress?

MICHAEL GANNON: What I won't do is lecture parliamentarians on legislative approaches. I know that there are many of my members who would have favoured a quicker solution to this. That may well be the mood in this room, looking at the number of nodding heads. There is that risk, there is that risk that the wider discussion on these issues will have mental health impacts on people directly affected by this. Equally, we live in a democracy where people are entitled to have their say. I faced criticism of our Position Statement from within the membership, and I have made it very clear that we, as an organisation, are a broad enough church that we can accommodate different views on this topic, and I am not uncomfortable with the Australian people being given their say. We believe that this is an area of discrimination and therefore does have health impacts. We would like to see it resolved. We would like to see the Government, the Parliament getting on in other crucial areas of public policy, but we are silent on the exact details about how we get there.

CHRIS UHLMANN: John Millard.

JOHN MILLARD: Thank you, Chris. Dr Gannon, you mentioned restrictions on codeine use. There are already considerable restrictions on codeine. To get straight codeine in 30 milligrams, codeine and phosphate, you already need a doctor's prescription. Now, it's true that some codeine tablets mixed with, for instance, paracetamol, can be given across the counter. But they contain other drugs which are likely to restrict abuse of the drug for that reason. Now this would mean people with chronic pain for - might like to see a doctor more frequently. Now, in some areas of Australia, they can see a bulk billing doctor, but in others, in regional areas, in some capital cities, particularly this one, the rates of bulk billing GPs is very low. Some cynics have suggested - and further to that, even, pensioners have been known to be charged - now some cynics, not me, of course, but some cynics have suggested that this necessity to get any sort of codeine on a prescription is just a way of increasing doctors' income. How would you answer such a cynic?

MICHAEL GANNON: Well, thank you for the question. The changes to codeine are not- it's not the case that this is a unilateral AMA statement. This is very much the AMA supporting the Therapeutic Goods Administration, the TGA, in their independent science-based analysis of the issues. Now, many people might not know that there's already 25 countries where codeine requires a prescription. Many people might not know that the science tells us that we all metabolise codeine very differently. So for a significant minority of us, we metabolise it in a way that is extremely potent, every bit as powerful as morphine, and is a common cause of death from opioid overdose. In Australia, more common than heroin overdose. In the United States, less common than heroin overdose, but very much the gateway drug to 140 deaths a day in that country from opioid overdose.

There's another group of individuals that metabolise codeine in a way that it is entirely ineffective and it has no additional analgesic effect over plain paracetamol or a plain anti-inflammatory. Not only have we told the Minister we support the TGA's decision, we are also telling the State and Territory Health Ministers that we do not want to see exemptions from this. That's wading into very, very dangerous territory, when the independent regulator looking at scientific evidence is overrun by an industry that has a different view. And what I would expect to see in line with the evidence is not only will doctors prescribing less and less 4mg, 8mg, 15mg tablets, but prescribing less 30mg tablets. The truth is the evidence shows there are much more effective analgesics that my members should be prescribing.

CHRIS UHLMANN: Radio 2CC.

TIM SHAW: Dr Gannon, thank you so much for your address, and a big shout-out to our doctors and nurses around Australia, doing the great job you speak of today. The *Fade To Black* movie, the life and the death of Peter Strong, a great Australian who came to Canberra and argued for euthanasia bills in legislation. Dr Rodney Syme provided him with nembutol but he never took it. He had to go to palliative care. Seventeen thousand Australians enter palliative care each year, but more than 700 of them die a very, very painful death. I've heard what you said about euthanasia today, but ahead of the Victorian legislation, what will the AMA do to provide support to doctors who may be accused of criminal activity? Or is it good doctoring, which is what Dr Rodney Syme has said? What is the AMA's position on supporting doctors who assist their patients?

MICHAEL GANNON: Well, I'm glad you've raised the issue of supporting doctors, because it might be legislative uncertainty that is stopping patients from getting the care they need. Now, we have inadequate legislation in most parts of Australia to protect doctors acting ethically and lawfully with inadequate doctrine of double effect legislation. So what I said in the opportunity to speak to the parliamentarians in Victoria yesterday, is let's put the horse before the cart. Ninety-nine per cent of end-of-life decisions do not involve requests to die. That is a very, very, very small part of the system. Now, one thing that I hope I've made very clear today is that I have no doubt that those colleagues of mine who would favour a move in this direction act every bit as compassionately and ethically in the care of their patients. But there is the potential in the Bill before the Victorian Parliament to make things more difficult and to impair the care that people get. If they do not legislate for doctrine of double effect, the accusations that we might be dealing with a case of euthanasia, or physician-assisted suicide, might arise.

So, there are so many things they need to fix first. And surely the aspiration of all people, whether they favour voluntary euthanasia or not, is to improve palliative care services. Most people don't even know what palliative care is. Those who have had experience with the system will know how good it is, how brilliant those practitioners are. They know a lot more about pain and suffering relief than codeine and morphine, I can tell you about that. They produce amazing levels of care. So much so that, for palliative care physicians, requests to

them to end patients' lives are incredibly rare, and it's not hard to find palliative care specialists who will tell you they have never received a request from a patient to end their life.

So, the AMA position statement makes it extremely clear that we understand this is a decision for society: it's Parliament's, it's legislators'. The AMA's position is that doctors should not participate in these arrangements. But what I did, when I spoke to those legislators in Victoria yesterday, is said, I know you're very interested in recommendation 49 of your Upper House report, but please, please focus on recommendations 1 to 48, which talk about end-of-life care, which will affect all of us.

CHRIS UHLMANN: Could you speak just a little bit more on the principle of double effect? I don't think that most people actually understand that it's available and actually exists in Catholic canon law, that if someone dies as effect of their pain management being turned up to a point where that's the secondary effect, that's something you can even request in a Catholic hospital. So could you explain how that works and what protections doctors need?

MICHAEL GANNON: One of the things you have to be very careful doing when you're talking on ethical matters is to invoke Catholic canon law, because there are some people who would have great concerns about that. But, Chris, who I know is a scholar in this area, will be able to tell you that this all goes back to St Thomas Aquinas, this is well established in Catholic ethics. And it's a well-established ethical principle which is very much secular as well. But in very simple terms it means that if your primary intention is to relieve suffering, and by secondary effect it has the effect of hastening someone's life, that is ethically, completely distinct from the intention of ending someone's life.

So, if we look at proposed assisted dying laws, the intention is to end the patient's life. If you look at palliative care, the intention is to relieve pain and suffering. The intention is important. I can promise you that palliative care physicians, the nurses who work with them, the teams they work in, they're a great example of multidisciplinary care for all of us, but they work very carefully and compassionately to provide a level of care which is seven levels above the morphine drip that you've all heard of.

CHRIS UHLMANN: *The Guardian*.

KATHRYN MURPHY: Thank you. Hello, Dr Gannon. Thanks for your speech. If we've been controversial enough to deal with Catholic ethics, let's stay with controversy and think about asylum seekers, which you mentioned briefly in your speech. But I want to take you to some remarks you made on radio this morning - on ABC Radio, I believe - where you said that, according to my note, that Border Force has delivered a very high level of care to people in offshore detention. And I think you also mentioned the Government's arguments that asylum seekers get medical care in offshore detention that's broadly compatible with the remainder of the Australian community.

Now, there have been several deaths in offshore immigration detention. There have been documented problems like medical transfers not turning up or being refused, emails not being read by Departmental staff about the health and wellbeing of asylum seekers, there has been people refused treatment and been suggested that they're malingering. There have also been warnings, given that people are a danger to themselves because of their deteriorating mental health. So given what I've just described, how is that consistent with a high level of medical care?

MICHAEL GANNON: One of the interesting things in the area of the health care of asylum seekers and refugees is I don't get often asked to comment on the individual cases of someone having care in Weipa or in Adelaide each day. I will make that point first. The second one is that the ethical principles are very clear. People seeking the protection of the Australian Government are entitled to healthcare standards the same as Australian citizens. So, that's a

matter of ethics and that's a matter of law. What we've developed over the past 12 months or so is a relationship with the Chief Medical Officer of the Department of Immigration and Border Protection, so that when we receive discussions on individual healthcare episodes we are able to talk about them.

Now, again, that requires a number of layers. That requires that patient confidentiality is respected, so it is complex and bureaucratic for us to go back and seek the consent of the patient before we are able to discuss them with the Departments.

I'm aware it is not appropriate for me to go into the detail about the knowledge I have on some of these cases, but the cases of some of the deaths have been subjected to a root cause analysis, so the same level of scrutiny that occurs for an Australian patient in an Australian hospital. I have also received briefings from the private companies providing some of these health services. The interview today with your colleague, Fran Kelly, referred to a difficult and vexed issue where a form of medical care, namely termination of pregnancy - which could relatively easily be provided on Nauru - can't legally be provided because it's illegal on the island. That means that if that cannot be provided, that those patients must be transferred to the mainland. This is a hotly contested political issue. I am not an immigration expert. But I like to think I'm an expert in medical ethics, and I've stated our position very clearly as to the health standards that we would expect. And, where possible, within the confines of patient confidentiality, we investigate them and advocate on behalf of those patients.

CHRIS UHLMANN: Misha Schubert.

MISHA SCHUBERT: Dr Gannon, Misha Schubert from the National Press Club, and a long-time retired former health reporter. I wondered if you could elaborate a bit more on the material you went to in your speech where you described the shift in the private health industry over time from one dominated by mutual insurers to an increasingly for-profit landscape, with shareholders for whom presumably the organisations need to maximise and deliver profits. And your critique of why you don't think that's such a great thing. Can you talk a little more detail about what action you want to see there? You referenced you want to see careful Government action. What does that look like in your view? And can you unscramble that egg after you've established a for-profit landscape, really?

MICHAEL GANNON: Thank you for your question. We are where we are. Don't you love that saying? We have an industry that's now dominated by the for-profits, the mutuals make up a lesser proportion of the market. And the private providers have a fiduciary responsibility to deliver a profit to their shareholders. The AMA doesn't stand up saying legal, lawful industries aren't allowed to make a profit. But what we would say is that those record profits, $1.8 billion, must not come at the cost of a diminishing quality of service. So, we're all in the room together within the Ministerial advisory committee: the insurers, the hospitals, the doctors, patient groups, day hospitals. There's a big group that's there to advise the Minister and see what good policy we can come out of this. But what we must agree on is a basic level of cover, or at least better transparency, so people know what they're covered for. So, the policies that are nothing more than to dodge the tax penalty, they're junk. The policies that limit you to care in a public hospital, I need to be convinced why they're any better than being a public patient in our excellent public hospitals.

Now I don't want to spend my entire life arguing with the insurers. They have a right to make a profit. In fact they've got a corporate responsibility to deliver a profit, but they cannot deliver that profit on the back of diminished services to private patients. And if they don't get it and they don't get it soon, they will drive their industry off the cliff. Because eventually, the number of fairly healthy policy holders will continue to leave. The sick, the chronically unwell, they're not leaving. They're staying in the insurance pool. We need to maintain products so that healthy people see value in the product and when they finally need their health insurance - hopefully for the first time in four and a half years – they think that was a fabulous experience,

that was really good care that I received. But I don't want – I don't want to spend my life criticising the insurers. I want them to work with us and I want them to realise they're driving their industry off the cliff if they don't make some of these changes.

CHRIS UHLMANN: We'll finish with Laurie Wilson.

LAURIE WILSON: Thank you Chris, Laurie Wilson, freelance journalist and director of the National Press Club. I want to ask you about quality of care in terms of e-Health. e-Health of course is – I mean it's starting to pick up some pace under the Digital Health Agency run by Tim Kelsey and obviously it's, I think, generally accepted now that My Health is a great idea. I'm wondering just how active the AMA is in encouraging that take up and also what are the priorities that you see in terms of the application of e-Health to other areas where it can be used clearly to improve that quality of service?

MICHAEL GANNON: So e-Health and the electronic health record are the future. We need to make sure that we get something out of the well-north of $1 billion investment we've already sunk into it into this country. It is the ultimate aspiration that, wherever you're receiving health care, that someone can get an idea about important things about you. So whether they are drug allergies, all the way from the minor all through to a history of anaphylaxis; whether you've got implantables in your body like a hip replacement or something else like that that might go off in a MRI machine; if you've got a serious bit of genetic history or medical history or social history that people need to know; that's the aspiration, that that is available in whatever setting you are. If you're on a caravan driving around – you roll into Katherine and you're sick, that someone can dial up your health record. That's the ultimate aspiration.

It's got a long way to go. I have a regular dialogue with Tim Kelsey and the ADHA. My – some of my members, are a lot more IT literate than me, Laurie, are involved in sinking into the deep detail of getting it right. We have to get it right. But what we need to do is to have all these platforms talking to each other so the GPs can get hold of X-rays from public hospitals, MRIs from private providers, they can get specialist letters in real time. It's an exciting time. It will make health care safer, less drug reactions, less wasteful over-investigation, less duplication of tests, and that will add to more cost effectiveness, greater safety. We've got a long way to go.

CHRIS UHLMANN: Please thank Dr Gannon.

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