Australian Medical Association Limited
ABN 37 008 426 793

42 Macquarie Street, Barton ACT 2600: PO Box 6090, Kingston ACT 2604
Telephone: (02) 6270 5400 Facsimile (02) 6270 5499
Website : http://www.ama.com.au/

Transcript: AMA President, Dr Tony Bartone, Q&A Session, National Press Club, Wednesday, 24 July 2019

Subject: Medicare, Informed Financial Consent, Australian Health System, Investments, Newstart, Private Health Insurance, Egregious Billing, General Practice, Preventive Health, My Health Record, Federal Election

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SABRA LANE: Thank you very much for your speech there, Dr Bartone. I'm going to kick off with: if Medicare was a public patient, would it be in intensive care right now, or sitting on a trolley outside accident and emergency?

TONY BARTONE: Medicare is certainly in dire need of significant attention, it needs care. It may not be in intensive care just yet, but that is where it is heading. We need to ensure that there are appropriate funds invested- for investment in all parts of the health system, not just one part, not just some parts, but all the parts.

And to do that, especially with scarce health resources, we need to ensure that there is a cohesive strategy that underpins and underlines that also, that it's all working seamlessly in a coordinated and correlated fashion to ensure that the patients are getting the best for their certain care and needs.

SABRA LANE: Simon Grose.

QUESTION: Simon Grose from Canberra IQ. I'd like to ask a question about the Informed Financial Consent project that you launched yesterday. At the doorstop, Minister Hunt talked about how it would enable people to compare plans, compare gaps, compare doctors. So he paints the picture of the sanguine patient who can just work the market, but I figure that this is an area where swapping doctors or comparing doctors is constrained by both loyalty and timing, and I raise the example you raised yourself. Because you had a tooth out on Friday [sic]. And you said that they told you what the cost was going to be, the anaesthetist, this, that and the other. Now, how likely would you have been if they had said, like an over-the-top kind of cost, take the bib off, here's the shades back, I'm leaving now, and I'll go and shop around. I figure that would be a pretty small chance. How much is it about comparing doctors and comparing costs and services, and how much is this service going to be about putting in a kind of transparent downward pressure on costs?

TONY BARTONE: What this guide that was launched yesterday is all about is empowering patients with information, so that they understand their health journey. Now, obviously, in an emergency situation, that journey is somewhat compressed in time, but it's still an important part of that journey. Understanding where the costs come from and what are the drivers behind that is an important part of understanding your care and how it's delivered.

Certainly, most people that complain about their unpleasant experience is because of the surprise shock at the end of the process, which happens many weeks after the event, when they go to make their claim at their health fund. That's not acceptable in our current system.

It is about ensuring that there is information parity on both sides of the buyer and the seller, and so that the journey then becomes about 'let's concentrate on the clinical care, rather than worrying what is this actually going to cost me, because I have no idea where it's all going'.

SABRA LANE: Sue Dunlevy.

QUESTION: Dr Bartone, Sue Dunlevy from News Corp papers. There's a lot of scary rhetoric in today's speech, which we're talking about the life expectancy of Australians about to be in decline. We've heard a lot of this sort of talk from AMA Presidents over the years, yet bulk billing continues to increase. We don't seem to actually see any of these threats played out in the real world. AMA Presidents, both yourself and those past, for almost the last decade have been talking about the need to reform general practice, to fund a different model of care through coordinated care. Yet, every time governments come up with a solution - such as the Healthcare Homes or Kevin Rudd's plan for a similar idea in diabetes care - it's rejected by the medical profession.

And again today, you are calling for this, but you don't provide any detail. You keep rejecting the plans the government comes up with. Exactly how does the AMA see this working? How much should doctors get paid to provide this type of care? Should patients have to enrol with a single GP to get access to it? When are we going to see you put some close on these generalisations, something that the Government can negotiate on?

TONY BARTONE: And thanks for your question, Sue. There are many parts and I hope I can address them all succinctly. But essentially, the bulk billing rate should not be used as a measure of quality and care delivery in the system. It certainly is part of the access that Australians have come to appreciate and treasure as part of their Medicare system that we have. It underpins that universality of access that I spoke about in the speech. But clearly, what we've done for many, many years is exactly as you say, we have just kicked the can down the road. We've not addressed the issues. We've not addressed the drivers in a meaningful way.

And that is why you can have a conversation that says, we've got record spend on health care, but waiting times for care, for meaningful interventions, is actually increasing. That's why you can have a situation where there is even more pressure on patients for that hip pocket contribution. As I clearly pointed out, that contribution to their care isn't really happening in the areas of non-referred medical services. It's- there are so many other parts of the health system which are blowing out as part of that patient journey.

So, we've got to have a really coordinated strategy. And I know that- you could say that's just words and no strategy, no substance. But we remain ready and committed to work with government to ensure that there is a pathway forward.

The Government's now got three years ahead. It's got three years with the benefit of many years of reviews and task forces, committees, submissions, inquiries, call them what you want, the evidence is all there. We can now move to an implementation phase, and we stand ready to work with Government in that respect.

Anything, however, that is not engaging with the clinical profession in terms of the changes required, is not going to have the buy-in and we need to work together. Now all of the stakeholders need to be present at that table, including the consumers, and we are ready to do that right now.

QUESTION: But how much do you want to get paid? What's the detail? What is your ask of the Government?

TONY BARTONE: Sue, look, it is not up to us to really say- specify a specific quantity. There is obviously a schedule of fees that has not been indexed for many years, either partially or fully. Over that 30-year gap since 1 February 1984, that gap has gone incredibly so large, it's not even relevant in some- and in particularly, in aged care facilities. It has no sense of the cost of providing that care. Now, we need to have a sensible conversation about bringing value back into the schedule, into the rebates that provide certainty and outcomes for the Australian population.

SABRA LANE: I just want to touch on- you've got the awards here today, the Dirty Ashtray Award and the trophy for the Government that's done the best. There's been a lot of focus recently on companies that have had- and organisations that have had investments in things some people believe are bad. You know, the sin taxes, tobacco companies, alcohol and pokies, and coal, more recently. I just want to be sure, does the AMA have any interests in those things? Have you divested yourself of those things?

TONY BARTONE: We have taken a serious approach and look at this as legitimately as possible, as I can give you an undertaking today, absolutely no is the answer.

SABRA LANE: To any of those?

TONY BARTONE: To any of those.

SABRA LANE: Alright. Marnie Banger.

QUESTION: Thanks, Dr Bartone. Marnie Banger from Australian Associated Press. As you would know, there's been a lot of talk lately about whether there should be an increase to the Newstart payment for job seekers. I wonder if you thought raising that payment might have a benefit for the health of Australians? And does the adequacy of welfare payments generally need to form part of the Federal Government's long-termed preventative health strategy?

TONY BARTONE: So the Newstart allowance falls slightly out of my particular purview, but what I can say is that obviously, people on that kind of allowance are experiencing significant stresses, significant issues. And that must have a health impact on their wellbeing. So, clearly, if they are struggling, clearly if it's insufficient to meet the needs, well then certainly we would- from a health perspective, it makes sense to increase that.

Now, I'll leave that to the appropriate Health Minister and the Parliament to have that conversation. But, clearly, we need to ensure that how we treat those who are disadvantaged or

in unfortunate circumstances doesn't increase their likelihood of developing poorer health outcomes.

SABRA LANE: For someone who has got a chronic condition, how do you reckon they would go on living on $40 a day?

TONY BARTONE: Well, clearly, that would be a very, very significant stretch by any sense of the target.

SABRA LANE: Could you not?

TONY BARTONE: I certainly couldn't, no.

SABRA LANE: Steph Dalzell.

QUESTION: Hi, Dr Bartone. Steph Dalzell from ABC News. You've called for the Government to look at the cap on private health insurance rebates, but others argue it already spends 8 per cent of its entire health budget on those incentives. They say the Government would be better off putting that $6.5 billion into the other things that you have called for, in terms of primary health care. Do you think the answer here is greater incentives for private health insurers?

TONY BARTONE: The cost of providing the care that is required to transfer that entire load from the private health care system into the public system is significantly more than the numbers that have been mentioned in the various reports. And that is clearly part of the conversation.

I mean, it's fanciful to think that overnight you could suddenly transfer the majority of elective surgery into public hospitals. There simply isn't the infrastructure there or the capacity, and then what are you going to have? A reverse contract negotiation of using redundant facilities?

We've got a really good system here now. It is working and it has worked well in the past, it gives Australians the option of care and at a time and a place of their choosing, it gives them the choice. Why not let those that can afford to contribute a bit extra more to that have that opportunity and provide that, as I said, that access to the universality of care that is what we are most recognised for in our health system?

If we suddenly transfer that load into the public system overnight it would be, you know, a calamitous situation, as I said, and just haven't got the capacity or the ability simply on the current numbers to fund that, going forward. It would require a significant change in all levels of that health portfolio spending.

QUESTION: Do you acknowledge that if private health insurance was good value for money, there wouldn't be a problem in attracting customers and retaining them?

TONY BARTONE: Absolutely. So yeah. Clearly, we've always said that it's a falling appeal of the product because of lack of value, and lack of what it provides as a product. Australians

are very clever. They certainly realise when they are being sold a dud and that's why they're dropping out.

And, so, if you bring value back to the system, if you bring transparency, if you bring certainty of experience, people will start- will retain their health insurance for that opportunity of ensuring that either the option of choice, or having a much more expedited process through the system.

SABRA LANE: Dana McCauley.

QUESTION: Thanks, Dr Bartone. Dana McCauley from *The Sydney Morning Herald* and *The Age*. I've got a question for you about out-of-pocket costs. You've previously said that between one and two per cent of specialists are egregiously billing patients. Should these specialists who charge egregious fees be penalised under medical malpractice rules as the Chief Medical Officer is considering? Should they be deregistered?

TONY BARTONE: So, the issue of egregious billing, just to be very clear, is something we do not support. We've called it out significantly time and time again. Now, as an Association, we have limited scope to actually implement any measures to bring that level down, but what we've said is that if you improve the system, if you bring back the investment into what created a lot of those gaps in the first place, if you bring back that investment and bring back the clarity and the transparency and give consumers the information, the marketplace will single-handedly expose them for what they are.

And that's part of that conversation of health literacy. It's what I go through with my patients every day in the consulting room. It's not just care, but it's giving them a further understanding of their condition, of their access, of their journey through a very complex system.

Give them the opportunity, give them the information, give them the smarts and I'm sure the Australian public will make the appropriate call.

SABRA LANE: Do you need to do what you've done today with the governments that are doing good things on tobacco and say that, you know, the doctors that are charging too much: you guys are duds, patients beware?

TONY BARTONE: The Colleges are already having conversations out in the public space about what they can do in that respect.

But I think if we just shine the torch on that, the Australian public will easily make that distinction. When they compare and look at fees that are many multiples the times of what other people are charging, that'll be simply a no-brainer, as I've said before.

SABRA LANE: Nic Stuart.

QUESTION: Thank you for a terrific, if somewhat frightening, speech. The common aspect in all of this seems to be GPs. They're the first line of assault and yet you've pointed out, for example, that obviously because they're working for companies or working in private practice, they can't do things like transfer leave entitlements and other arrangements like that.

Is there some way that we can actually get to actually fix the conditions of work of GPs and how much of a difference will that make?

TONY BARTONE: So, clearly, access to training is an important part of building a new workforce of general practice. Now, if people are making that option of being part of that, they're graduating with significant HECS debts at a very crucial time in their life. It's a time where they're setting down families or other- you know, buying a house, all the other things that go with that. They need to really realistically look at what is the options ahead.

Now, if you're comparing two things on an equal passion meter level, and one is significantly less funded than the other, it's a no-brainer unfortunately, and that's not acceptable. We need to ensure that choice becomes about passion, about dedication and want and desire to practise in a certain health craft, not because of what the remuneration is.

Now, clearly, the portability of leave entitlements is a significant part of that equation, but besides that, there is a genuine significant disparity between what a GP registrar can hope to begin on in general practice versus what their counterparts are earning in the hospital system and that's simply not acceptable.

SABRA LANE: John Millard.

QUESTION: Thank you, Sabra, and thank you, Dr Bartone, for such a wide ranging address. Some commentators, not just journalists but also respected medicos and academics, have suggested that private health fund subsidies should be withdrawn and contributed instead to private- sorry, to public medicine, hospitals, or whatever. Apart from possibly starting a medical World War III, could this perhaps be Economics 102 and if you think it could be, what's the AMA's view?

TONY BARTONE: I'm sorry, the exact question there? Sorry. I missed that? The world war ...

QUESTION: I mean the total withdrawal of- or partial withdrawal of public subsidy of private health funds and putting that directly into the public system.

TONY BARTONE: I think that's a question that follows along the lines of what was previously asked, and I'm sorry to miss your question in the first place, sorry about that. But let's be very clear. The withdrawal of those subsidies will not be sufficient to replicate what is required in the public health system, right? So we'll need more.

Now, we had a battle, we've had an election contest. It was fought on increased amount of funding in public hospitals, for example, and clearly the Australian public already made a decision on that one already, so we need to have a different approach for understanding how we actually use the health resources more wisely, more efficiently and more appropriately.

So, it's not about doing stuff for the sake of doing it, it's about that we're using- we're bringing efficiencies. Now, we've had conversations before that talk about wastage in the system, duplication of costs, the, you know, perennial lack of information transfer that is the journey of the patient through the system. We can talk for days. I mean, every day my general practice,

there is a hold-up for some reason or another in the care of that patient, what is that costing us? And, you know, there's no significant numbers that have been put out on that, but it runs into the many billions.

Let's have a conversation that brings back the appropriate funding to the system and then look at where the utility to the economy and where the utility to the Australian public might be had.

SABRA LANE: Mark Metherell.

QUESTION: Thanks for your speech, Doctor. The head of a health fund this week has suggested maybe the abolition of Medicare and the mandating of private health insurance. Can I have your response to that suggestion and also, do you think private practice is part of the DNA of a typical Australian doctor?

TONY BARTONE: Australians love their Medicare and the public health system. They do not want a US-style system. We know that that will bankrupt - it's almost on the throes of bankrupting the US economy, God forbid what it will do to ours. And seriously, you know, that's probably one of the more left-field suggestions I've seen for a long while.

So, let's be very clear. We're not about trying to dissuade the Australian public from the universality of access. As I said time and time again, this is what Australians value about their health system. This is what other countries are envious of when it comes to our health system. Why would we try and reduce that and put that at risk?

Let's look at what are the fundamental issues and drivers of the disparity. Let's ensure that both are funded appropriately and effectively and efficiently, and let's have that conversation about the mix perhaps. But certainly, we couldn't support that at all.

SABRA LANE: Getting to some of the other points in your speech, let's just do it with a tax on soft drinks, restrictions on junk food advertising, volumetric tax on alcohol. There is a noted group of conservatives within the Government who would say, instantly, what you want is a nanny state. How do you convince them that this is the way to go?

TONY BARTONE: When it comes to the information and the health literacy that underpins what we're calling for there, I'm sure that the majority of Australians would have a different view that a nanny state is being imposed.

But notwithstanding that, I mean, we've got to be realistic. We can't expect the health system to continually get us out of a pickle because we've played in gay indifference to looking after ourselves, looking after our bodies, doing a moderation of exercise and food appropriately, a diet appropriately, and then expect that some wonder drug will get us out of there.

I did make the point that if you look at average life expectancies, it's consistently gone up for many, many decades now, but it has started to flatten out. The rest of the world has caught up to Australia, you might say, and we've started to stagger. That's because we were so far ahead because of our prevention strategy on tobacco. We were world leaders and, guess what, that's what gave us that little bit of extra impetus, extra advantage, but that's narrowing down.

And so, we can't expect a wonder drug, a wonder procedure, or that the health budget is going to be infinitely deep and sufficient to keep getting us the expensive care we need so that we can do with gay indifference.

SABRA LANE: Tony Melville.

QUESTION: Tony Melville, Director of the National Press Club. A subsidiary question: North Sydney Council last night banned smoking in the CBD. They won't be fining people straight away. It'll be a sort of a self-regulated thing. Do you think that's a good idea - I assume you do - or would it just push smokers underground?

Now, the main question is: the hot story last year was My Health Record, and the AMA negotiated a lot of protections on that, but I still have friends vehemently opposed to it, sharing their data with, you know, up there. Have your protections worked? Have you got any good news or bad news stories about how My Health Record has been working?

TONY BARTONE: Yes. My Health Record, thank you for that.

[Laughter]

So, almost a year on from that debate, we've seen the introduction and the legislation has passed, and certainly, 90.7 per cent of Australians now do have a My Health Record. But that's only part of the conversation because that record doesn't mean anything if there's nothing in it.

So, we need to look at how we're using it, and at the moment, there's just not the information being shared between all parts of the system in a meaningful manner to allow that utility. Now clearly, protection of privacy is fundamental and something we took very seriously then, we take very seriously now, and we will continue to ensure remains very, very significant.

The protections about the secondary use of data on this system have been well and truly documented. It was one of the key issues that we brought to bear because of the momentum that was public opinion at the time.

So, it's about more a conversation of maturing that health record and giving Australians again - I'll come back to that word - the health literacy to use their record effectively and efficiently for their own purpose. Take control. In a previous version, it was controlled - the Patient-Controlled Health Record - giving the patient the power to use it to expedite and assist in their care journey through a very complex system.

SABRA LANE: Misha Schubert.

QUESTION: Misha Schubert, a Director of the Club. Dr Bartone, thanks for your address. You were remarkably polite in response to Mark Metherell's question about - let's put in on the record - Mark Fitzgibbon, the managing director of NIB Insurance this week, who called for the abolition of the beloved Medicare system, as you described it earlier, and wants private health insurance to be made compulsory with some kind of arrangement for government to take over subsidies for people at the lower end of the income spectrum.

Can I invite you to be a little bit more colourful, perhaps? How would you characterise those remarks? And do you think that shows that some in the private health insurance industry are spectacularly out of touch with the views of Australians and how they feel about Medicare?

TONY BARTONE: Look, I'll say it again. Australians put a value on their Medicare card that is fundamental to their health journey. They particularly value it and they will not see that- and many governments have tried to change that in the past, and I think everybody now recognises that it's here and part of our health fabric. So, trying to change that as a solution to a problem that is very urgent is extremely bemusing, to say the least.

Let's be very clear. The private health system has significant overheads in running their insurance scheme. If you look at private health insurance and the cost of running Medicare, it's significantly more. Now, you might say that's economies of scale; the Government's got an advantage; but it's still significantly less. Why would the Government transfer funds from the public sector to the private sector wholly, and then impose a certain level of additional expenditure? It doesn't make sense. As I said before and I'll say it again, let's address the issues underpinning the reasons behind why the insurance is not being taken up.

Let's even be further clearer than that. Young people realise the value - or lack of value - that they're getting. They know that the product has not provided them with the care at the appropriate time that they thought they were getting, or the cost coverage that they thought they were getting.

So, we need to improve the value. We need to improve the product. We need to improve the affordability of premiums so that then people will make the appropriate decision when and if they can afford to make it, and allow those who have no other option, no other access to health care other than through the public purse, to have that access that, as I say, the Australian system is so famous for.

SABRA LANE: Sue Dunlevy.

QUESTION: Dr Bartone, just a few weeks ago, we came out of an election which, more than many in recent history, was all about health. We had one of the major parties offering massive increases in Medicare rebates for cancer patients, a big increase in hospital spending. Voters didn't go for that. Are you making a case here today for something that people aren't interested in clearly because they didn't vote for it at the last election? What's your reading of what the election result means for health?

TONY BARTONE: The Australian public are particularly interested in what it means for them and their hip pocket. Now, you need to communicate a value proposition. If they understand the value proposition for a certain proportion of the Budget being spent on access to the healthcare system, then that's a conversation that they want to be part of and engaged in.

Consumers are part of the stakeholder group that comes to the various many forums and submissions and reviews. And clearly, we need to have, again, I'll come back to that word, that literacy, that understanding of the health system, and understanding that the health system is

not a cheap product. It's not a cheap supply option that can easily be funded through minimal amounts of taxation.

The parts of the health budget that are dedicated to health have been on a significant decrease over the last decade. Something like 18 per cent almost a decade ago to 16 per cent 'til now of the health budget, of the federal Budget, is on health.

Now, that's a conversation that clearly, maybe, the population want to have a view on. But they didn't- even though cancer was a very emotive topic, a topic which touches a significant number of millions of Australians, it didn't look at the whole picture when it comes to health. And that's why I say: you can't just fix one part, you need to fix all of the parts and you need to communicate a vision.

Let's have a conversation with the Australian public. I'm sure it will be more than up to the task of helping the Government to set that vision, that agenda.

SABRA LANE: Ladies and gentlemen, please join me in thanking the President of the AMA, Dr Tony Bartone.

TONY BARTONE: Thank you very much.

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CONTACT: John Flannery 02 6270 5477 / 0419 494 761
Maria Hawthorne 02 6270 5478 / 0427 209 753

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