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/

PRESIDENT'S ADDRESS
Dr Tony Bartone

2019 AMA NATIONAL CONFERENCE - #amanatcon
Sofitel Brisbane, 24-26 May 2019

***Check Against Delivery

I acknowledge the traditional custodians of the land we are meeting on.

I acknowledge their elders past present and emerging, and respect their continuing culture and the contribution they make to the life of this city and this region.

I would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending this Conference.

It has been another very busy and productive year for your AMA.

The past six weeks tell it all.

We have had a five-week election campaign, and all that it entails for a leading advocacy and lobbying organisation like ours.

We produced our election manifesto – Key Health Issues for the 2019 Federal Election.

We launched our Public Hospital Report Card, which made headlines and created political headaches at the start of the campaign.

We released our Rural Health survey.

We issued around 20 media statements on health policy.

I delivered a keynote speech on private health.

I was on a panel at the AMSA Leadership Seminar.

We witnessed an election campaign that saw the Coalition Government returned, much to the surprise of many of the pundits and the pollsters.

And during this campaign our hard-working Secretariat has managed to put this Conference together while all that was going on.

Well done, team.

Fellow delegates we have a lot of important work to finish with presumed Health Minster, Greg Hunt.

In the 12 months since you elected me President in Canberra, it has been non-stop action and persistent endeavours.

We have achieved a lot.

I said on day one of my Presidency that general practice would be a priority for me, and it has been.

And it has paid dividends.

GP and Primary Care

We have had some significant wins on this front.

Over one billion dollars in funding for general practice was announced in the 2019-20 Budget and MYEFO – one billion dollars of funding that both sides of Parliament agreed to fund.

This was no accident or lucky occurrence. We put this on the agenda.

Meeting after meeting, submission after submission, consultative forum after consultative forum, Departmental briefing or MP briefing, absolutely everyone was informed on the pivotal nature of the GP.

We reminded them all about the considerable ratcheting down of funding to general practice over the last decade or more.

We told them all that significant funding was needed urgently, or the cornerstone of our health system would be under accumulating threat.

The AMA has for years pushed for genuine reform to the way that general practice is funded.

We have advocated for a model that will allow for coordinated, patient-centred care, which maintains GP stewardship of the system.

We have now finally seen real funding for this with the $450 million announced in the Budget for GPs to assist the coordinated care for people over 70.

This is a good first step, but this policy approach must be expanded.

We will be pushing the Government to introduce funding for coordinated care for all Australians with a chronic illness.

Funding that will sit alongside fee-for-service, which will still remain the core of general practice funding.

Colleagues, our advocacy led to the bringing forward of the lifting of the five-year freeze on Medicare rebates for GP items by one year to July 2019. This is worth $187 million.

While we want funding for better models of care, we also want to make sure the foundation of the system is sound.

This is also why we called for the split Level-B item to fix the system, which currently does not encourage hard-working GPs to spend more time with their patients.

Our advocacy for more support for GPs to visit Residential Aged Care Facilities has been heard.

The Government increased funding for GPs visiting Residential Aged Care Facilities and retained the Aged Care Access Incentive.

This means that visiting patients in aged care facilities remains a viable proposition for GPs who conduct these visits.

However, there is still much more to do on this front to ensure that a patient in a registered facility retains the option of being able to have choice as to which GP they see.

We also worked hard to make sure that new programs and initiatives would not negatively affect our members.

The Government delayed the implementation of the new Workforce Incentive Program by six months to 1 January 2020.

It is our view that implementation arrangements should allow for a reasonable transition period to give practices time to adjust to any changes.

The commencement of the Practice Incentive Program (PIP) Quality Improvement (QI) Incentive was put back to 1 August 2019.

This means that the Asthma Incentive, the Quality Prescribing Incentive, the Cervical Screening Incentive, the Diabetes Incentive, and the GP Aged Care Access Incentive will continue through to 31 July 2019.

The Government will also provide $200 million in additional funding to support the PIPQI Incentive.

But we are also concerned about the future of general practice, not just for we GPs who have seen practice costs continue to rise while our rebates have stalled, but for the next generations of GPs.

GP training places have remained undersubscribed for two years running.

This is extremely worrying and an ominous sign. It is further evidence of the declining appeal of a General Practice career for an ever-increasing number of graduates.

We have called for a review of the employment models for the GP training program. This will be one of the first things to discuss with the newly elected Government.

Public Hospitals

Another priority will be public hospitals.

Our Public Hospital Report Card showed clearly that the public hospital sector is not in good shape.

Doctors and nurses are doing more than their fair share – they are having to do more with the funding they have.

When governments underfund, they are making a choice to constrain the supply of public hospital services.

The consequences are significant. They can include increased complications, delayed care, delayed pain relief, and longer length of stay for admitted patients.

In other words, denial or delay of access to public hospital services not only puts the safety of patients at risk, it also undermines a key plank of our universal, world renowned health system - Equity of Access.

Let me be clear. Public hospital capacity is determined by funding.

Public hospitals can't provide faster access to elective surgery unless they are funded to pay for extra theatre sessions, extra ward beds, extra nurses, and specialists.

Ambulance ramping and long waits in emergency departments will not be resolved unless public hospitals have enough money and ward beds with appropriately skilled staff to accept seriously ill patients.

We can't have a hospital system that is stretched so tight that scheduled elective surgery is cancelled because ward beds are needed by seriously ill patients who unexpectedly present in emergency.

We can't have a hospital system that is so under-resourced that GPs cannot find a hospital bed for their patients who need elective surgery.

Our public health system should be better than this. It is unacceptable that our public hospitals have been reduced to this.

Commonwealth contributions to public hospital services is in large part determined by the current National Health Reform Agreement.

Under this Agreement, Commonwealth funding is indexed at a rate that reflects public hospital input cost increases, offset by efficiency gains.

But since public hospitals are service organisations, staff salaries account for a large proportion of total input costs.

Nurses, for instance, comprise about 41 per cent of total hospital staff.

The annual rate of price indexation applied to Commonwealth funding is trending at 1.6 per cent per annum.

But public hospital nursing salaries are rising at the rate of 2.5 to 3 per cent per annum in most jurisdictions.

The greater the magnitude of difference between the annual 1.6 per cent price indexation compared to annual hospital input cost increases, the greater the pressure on public hospitals to make up the funding gap via efficiencies.

The AMA is not opposed to the pursuit of public hospital efficiencies, provided they do not drive staff burnout or reduce the quality of care that our hospitals can afford to provide.

Efficiency is when patients are seen in ED within clinically recommended timeframes.

Efficiency is when patients are admitted for elective surgery within clinically recommended timeframes.

Our public hospitals are struggling and require new funding to be better tomorrow than they are today.

We have an ageing and sicker population. Demand for public hospitals is not going away and public hospitals need the resources to improve their capacity, their capability, and their output.

There was an opportunity in the election for a genuine contest between the parties to show their commitment to better support our vitally important public hospitals.

To fund public hospitals to be better, not just busier.

To help our public hospitals improve the quality of their care, rather than just the quantity of work each staff member must carry.

And to support our medical and health staff with the resources they need, so they can care for all of us.

Our hard-working doctors, nurses, and health professionals, like all Australians, do not deserve anything less.

Our advocacy for greater funding will continue.

Private Health Insurance

The other side of the equation – private health and private health insurance – is also unfinished business.

It was impossible for consumers to understand the multiplicity of carveouts, restrictions, and exclusions of the 70,000 variations of policies that made up our private health insurance system. Something had to change.

We backed the intent of the Government's reforms, including the concept of developing the Gold, Silver, and Bronze insurance products.

But the Government reforms do not address affordability in an enduring way – this problem is starkly obvious, even with the slightly smaller 2019 round of premium increases.

Yes, the rate of increase in premiums has slowed, but still outstrips inflation and, more importantly, far outstrips wages growth.

How much longer can private health insurance stay affordable with increases in premiums averaging 4 to 5 per cent a year, when wages growth is firmly stuck around 2 per cent?

And, as we can see in the latest figures, private health insurance coverage is declining, with a dozen or so successive quarters of decreasing coverage to 44.6 per cent. Change is needed and it is needed now.

There is increasing corporatisation of private health and the market power is shifting in favour of private health insurers. Insurers should not determine the provision of treatment in Australia.

They should not interfere with the clinical judgement of qualified and experienced doctors.

Australians do not support a US-style managed care health system, and neither does the AMA.

The AMA believes that the next round of private health reforms needs to focus on protecting the independent clinical decision-making by clinicians, who are chosen freely by the patient.

And poorly indexed, differential insurance rebates must be abolished so that patients can understand what they will receive as an insurance rebate, regardless of the State they live in or the fund they insure with.

Out-of-pockets

With the election over, it is time for an honest discussion about patient out-of-pocket costs.

Out-of-pocket costs are negatively affecting consumers' view of the value of having insurance.

As a profession, the AMA realises we have some heavy lifting to do on this.

The AMA has been vocal. We do not support egregious billing or the use of administrative and booking fees. They are unprofessional, inappropriate, and unacceptable.

Let us be clear about what constitutes out-of-pocket costs to patients.

It must necessarily include the other components of payment from the Medicare Benefits Schedule (MBS) and the health funds.

This is not a conversation that can be limited to what doctors charge.

Minister Hunt announced the development of a specialist fee transparency website.

The AMA agrees – patients want to know what their out-of-pocket cost will be for a health procedure.

But a website that only shows doctors' fees will not deliver this.

To determine an out-of-pocket cost, patients need to know what rebates they will receive from their health insurers – and some are certainly far better than others.

We must be honest about the reasons why out-of-pocket costs arise.

There has been a five-year freeze on the MBS rebate – a rebate that was inadequate to begin with.

And this freeze has been mirrored in the rebates paid by many health insurers. But our practice costs have not been frozen.

From 2010 to 2018, PHI premiums increased by a cumulative 49 per cent – compared with the health CPI cumulative increase of 40 per cent.

By contrast, doctors were faced with a paltry 5.7 per cent increase in the Medicare rebate and the same or similar level for PHI rebates.

We must do better.

We cannot scapegoat one group and expect the problem to be resolved.

If we can simplify the private health insurance products, we must be able to make rebate transparency possible as well.

Mental health

An important area of health was neglected during the election campaign and has been neglected for some time.

I am talking about a framework and funding for mental health care.

With the election out of the way, I will be spending much of the second year of my Presidency talking about mental health. Not just talking. I will be demanding action.

The election – and indeed the past decade or more – has been frustrating from an AMA perspective.

Despite hundreds of millions in additional funding thrown at mental illness, we still see massive inconsistencies in responsibilities for mental health services.

There are huge service gaps, lack of access for many, as well as overlaps and duplication of services.

Governments have been unable to address the many gaps that exist in mental health.

These gaps are the result of the Commonwealth and States being responsible for different aspects of health; as well as gaps created by the public and private system and between acute and community-managed care.

Overarching cohesion and responsibility are lacking.

These structural and financial divides and divisions are historic and require a massive overhaul of how mental health services are understood, planned, funded, and delivered.

The AMA has made submissions, and I have raised our Position Statement and recommendations at every opportunity.

But we are yet to see reforms of the mental health system or reforms outside of health care – such as in workplaces, education systems, commitments to social justice outcomes, affordable housing and social services – which we know will improve mental health and economic participation.

We have seen some smaller worthwhile commitments made during the election campaign, but what I want to see are plans that address the issues facing GPs, Emergency Departments, doctors, and psychiatrists.

This is primarily about access and pathways to appropriate care.

Properly funding mental health has been historically neglected. The AMA will be putting the spotlight on mental health.

Indigenous health

Big picture policy and funding for Indigenous Health have been similarly neglected.

The AMA Report Card on Indigenous Health continues to be a leading advocacy document.

It is significant that the issues the AMA has campaigned on – such as ending Rheumatic Heart Disease, increasing investments in legal services and justice health outcomes, developing an Aboriginal and Torres Strait Islander Mental Health Plan, increased funding for Close the Gap programs, and promoting healthy choices - have been supported.

This year’s Report will be on dental and oral health. We will, I hope, also see significant investment to address another area of underfunding and disadvantage.

Prevention

Similarly, we must revive the government focus on preventive health – from all levels of government.

Prevention receives a paltry amount of the total health budget. This completely misses the point of preventive health care.

The AMA has been vocal in calling for the release of the National Alcohol Strategy and a National Obesity Strategy.

These are two public health issues that cost lives and are a huge impost on the health budget.

Family and domestic violence

An area where the AMA has raised its profile is addressing domestic violence.

The AMA's push for increased supports for victims of family and domestic violence has achieved results.

It has been an important part of the reason that has seen the major parties finally start to address this most horrific and unacceptable situation.

Measures such as paid domestic violence leave and financial support for women and children forced to flee their homes are all positions the AMA has been strongly pursuing.

We have been working with other stakeholders to achieve these measures.

We're a long way off seeing the cultural changes so desperately needed to prevent violence against women and other forms of domestic abuse, but I am proud of the work the AMA has put in thus far to achieve these reforms.

Rural

We have also had successes with rural health.

There was a very welcome additional $60 million in funding to fast track the National Rural Generalist Pathway in the Budget.

The National Medical Workforce Strategy was also announced.

Both of these measures will help deliver much-needed doctors to rural and remote communities, but they won't be able to deliver for years.

The results of the 2019 AMA Rural Health Issues Survey paint a picture of a rural health system being propped up by hard-working doctors.

It shows that we need investment in resources and staff right now, not in ten years' time.

Rural doctors work longer hours and they treat sicker patients. They often do it without the resources or infrastructure city doctors take for granted.

Despite this, these same doctors told us that they love rural medicine. They love the work. They love their patients and their communities. But they just want more support to keep doing it.

Rural Australia spoke up very loudly in the election. We will help rural Australia get and keep the health workforce they need and deserve.

Gender equity

At last year's AMA National Conference, the AMA supported a motion to develop strategies to drive cultural change within the profession and workplaces in support of equal participation across gender in the medical workforce.

This led to the AMA Gender Equity Summit in March this year in Sydney - the first of its kind for the Federal AMA.

It provided a forum for the medical profession to discuss the cultural and practical barriers to achieving gender equity in the profession.

It produced practical recommendations to address the underlying systemic and cultural barriers and contributors that impede our progress towards achieving gender equity in medicine.

Cultural change is particularly important if we are to achieve a level playing field for both men and women in the medical workplace.

Equal access to parental leave and flexible work arrangements should be available in all environments.

We want to ensure that all doctors can fully participate in the medical workforce and are guaranteed access to a range of flexible employment, return to work, and training opportunities.

Gender-based workplace discrimination and bias are also significant issues for female doctors.

While the representation of women on the AMA's Board currently sits at 40 per cent, it is much more variable among our Councils and Committees, with some doing well and others not so well.

The AMA has work to do to improve the representation of women on its Councils and Committees.

We have more work to do to support more women to take on leadership roles both within the AMA and the broader profession.

At the Federal Council meeting held only yesterday, Federal Council supported a motion to adopt a target of 40 per cent women, 40 per cent men, and 20 per cent flexible for all AMA Councils and Committees.

We recommend that the AMA Board adopts the same, with a gender diversity target of women holding 50 per cent of Federal AMA representative positions overall, for attainment by 2021.

This is the first step in the AMA demonstrating its commitment to improving gender diversity in its representative structures.

We have a breakfast session on Sunday looking at how we can support women to take on representative roles within the AMA. I encourage you to attend that session.

Doctors' health

The health and wellbeing of the profession is a high priority for the AMA.

We have led some innovations recently including national funding of health services to doctors and medical students through our subsidiary, Doctors' Health Services Pty Ltd, with funding from the Medical Board of Australia.

Advice and referral services are available to doctors and medical students no matter where they live.

We are developing a package for educating doctors to treat doctors and medical students.

This will improve our profession's capability to respond to and manage the health-related issues of our colleagues.

With a grant from the Department of Health, we will be establishing a telehealth service for doctors and medical students.

Some of you may remember that the Government announced during our 2017 National Conference that it would provide funds to support mental health and reduce suicide in the health workforce.

One of the initiatives that flowed from this funding was a national mental health and suicide framework for the medical profession.

The AMA has participated in this initiative.

The framework is being finalised. It will be important that the profession comes together to ensure that there is continuing momentum for improving doctors' health and wellbeing.

Despite these welcome initiatives, addressing the individual and organisational issues that can harm doctors' physical and mental health remains a challenge for our profession.

The rate of suicide among medical professionals continues to be a blight on our profession.

Most doctors have been touched by the loss of a colleague during their careers.

Shortly, we will have the privilege of hearing our international guest, the distinguished advocate for physician health, Dr Michael Myers.

He will present a keynote address on how we can protect doctors and their families.

In closing, let me outline the immediate road ahead for the AMA and my Presidency.

As you may recall, last year, upon election, I gave you three broad undertakings:

- Strong advocacy on patient access to primary care, to mental health and aged care, to in-hospital care and for our Indigenous people, as well as those in rural and regional areas.
- Work on improving the collaborative relationships between the Federal and State and Territory AMAs.
- Ensuring steadiness, security, and confidence in the Federal AMA Secretariat amid a period of external and personnel changes.

I believe we have made significant progress but there is more to do.

Let me add two further promises to you today for the next 12 months.

One, vigilance on private health care - I will ensure the AMA resists any threats to the sustainability of private health care and patient access.

It is this access that fundamentally helps underpin access to our universal health system.

Two, doctors' health and wellbeing. This will include continuing strong action on mandatory reporting, which will involve cooperation between the Federal and State AMAs.

The AMA staff will be overjoyed, no doubt.

It has been a very busy and difficult time at HQ with policy, Position Statements, publications, reports, submissions, speeches, hearings, meetings, and the daily business of being one of the most successful and respected lobbying groups in the country.

Throw in National Conference and the Federal election lobbying, and it all adds up to stress and pressure and long hours.

But our Secretariat has stood up to the challenge and worked tirelessly and professionally under the leadership of our acting Secretary General and the Directors to support me and Federal Council and the Committees and the Board to deliver results on your behalf.

To borrow a turn of phrase…….. how good is Secretariat?

The Board is on the verge of appointing our new Secretary-General following an exhaustive, robust, and transparent process by the Board. This should take some of the pressure off and help us set a course for the way ahead for your AMA.

You can be assured that we will be doing all in our power to report an even more successful year of achievement at National Conference in Canberra in 2020.

Thank you.

---

24 May 2019

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

Follow the AMA Media on Twitter: http://twitter.com/ama_media
Follow the AMA President on Twitter: http://twitter.com/amapresident
Follow *Australian Medicine* on Twitter: https://twitter.com/amaausmed
Like the AMA on Facebook https://www.facebook.com/AustralianMedicalAssociation

Sponsors

MAJOR SPONSORS

Australian Government
Australian Digital Health Agency

My Health Record

Avant mutual

Leadership Development Dinner

HESTA

Best Practice

Leadership Development Dinner

CONFERENCE SPONSORS

Learning

13SICK NATIONAL HOME DOCTOR

Doctors for the Environment Australia

RACMA
ROYAL AUSTRALASIAN COLLEGE of Medical Administrators

ELITE

uno.
The online mortgage broker

VSO

MediRecords