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**SPEECH TO THE NATIONAL PRESS CLUB  
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 AMA PRESIDENT DR TONY BARTONE**

\*\*\*Check Against Delivery

*Enough Talking – Time for Action on Long-Term Health Policy Vision*

I acknowledge the traditional owners of the land on which we meet, and pay my respects to their elders, past and present.

Thank you to the National Press Club for the privilege of speaking to you here today.

On November 22<sup>nd</sup> last year, I was in Brisbane visiting an Aboriginal Health Service. I was there to launch the AMA Indigenous Health Report Card.

On the same night, my elderly frail mother fell at home and was admitted to hospital. This was another one of her many falls during recent years on a high-level home care package.

She has not been able to return home since that night. She was eventually admitted to an aged care facility.

There was nothing I could do to meaningfully assist my Mum’s journey that night. My anguish was palpable and abject helplessness very real.

It gave me, as AMA President and a community GP, an unwelcome front row seat to the care journey of a loved one in our health system.

Unfortunately, my mother’s story is not uncommon. It is the same story for many patients in our health system.

Patients with complex chronic care needs being managed for many years by their GP. Then an intervening significant event. Then a transition in care, which requires a new management plan for them, often coordinating many other healthcare workers.

These patients are all mothers, fathers, grandparents, brothers, sisters, or children.

For many of them, the story is one of delayed access to care, elective surgery, and long public queues.

For others, it is dealing with the ongoing complexity of chronic disease. For some, it’s the challenge of managing issues with their mental health.

All these challenges are even greater for patients in rural and regional Australia.

I gave my first Press Club speech a year ago, and raised similar issues.

Last year, I spoke about Mrs B, who was waiting for knee surgery. She has since had her knee surgery, but her rehabilitation remains problematic because of the delay in her care.

I spoke also of Mr O, a patient with Parkinson's disease, which was diagnosed along with lung cancer. One year on, he still has frustrating issues with coordination of his Parkinson's and lung cancer outpatient services.

These experiences illustrate some of the problems with our health system, and remind us why we need health advocates like the AMA.

The past year for the AMA has been, at times, indeed challenging and difficult, but always busy and rewarding.

It was a year that saw a significant start made in addressing the decade-long underinvestment in general practice.

It was a year of a Royal Commission into Aged Care, on the back of many harrowing stories of neglect and a system in crisis.

It was a year with new private health insurance policy classifications - Gold Silver, Bronze, and Basic.

It was a year that saw an election with health a clear central battleground for votes.

The AMA repeatedly said throughout the campaign that health reform must be the Government's highest priority.

We saw the Coalition returned to Government.

However, two months on from the election, the need for significant health reform remains - and it must still be the Government's highest priority.

Our world class health system is simply groaning under enormous and ever-increasing stress.

Underfunding, under-resourcing, poor access, waste, inequity, and inefficiency are commonplace.

From maternity services to primary care, prevention to public hospitals, private health insurance to the Medicare Benefits Schedule, mental health care to Indigenous health to aged care, there are problems everywhere.

All the parts are connected. You can't just fix one, and ignore the others.

Our population is growing rapidly. It is ageing and the mix of disease is becoming increasingly more chronic and complex. This trio of drivers means that we need to improve and change our system - and change it fast.

That is why we need an overarching vision for our health system – innovation, clever thinking, and commensurate funding to set us up for the growing patient demands coming in the decades ahead.

We did not see such vision in the election campaign.

This is the challenge that the Morrison Government must take up and deliver on.

So, my message to Health Minister Greg Hunt is a simple one - and I have already raised it with him.

The time for talk is over. It is now time for action.

Otherwise, Australia's increasing rate of life expectancy will most definitely reverse its trend for the first time in the best part of a century.

Otherwise, many hundreds of thousands of Australians will be added to growing public waiting lists.

Otherwise, private health care might really become the exclusive domain of the very elite in our community.

Otherwise, the equity and access that underpin our system will become a distant memory.

Today I will outline some of the key areas where our policymakers can build a visionary health policy platform.

As this week is AMA Family Doctor Week, our tribute to all of Australia's hardworking GPs, let's start with general practice.

### **Primary care and general practice**

We know primary care is the most cost-effective part of the health system. But our GPs are working under increasingly enormous pressure.

Genuine, targeted investment in this area can and will reduce downstream health costs by improving access to high quality GP-led primary care services.

We know that people in communities with more GPs live longer than those with access to fewer GPs.

Currently, general practice services represent around just seven per cent of total health expenditure from all levels of government. This translates to \$382 per person annually.

For comparison, \$2,606 is spent per person on public hospitals.

This disparity exists even though, every year, around 88 per cent of Australians see a GP.

And 90 per cent of the health problems that are encountered in general practice are managed in general practice.

We must start planning for the new primary care environment now.

The Government has asked the AMA to help develop and implement a 10-Year Plan for primary health care and general practice.

As a start, the Government has finally lifted the Medicare indexation freeze.

It has also made a down-payment with new policies and funding to improve continuity of care for patients over 70.

There is also new investment for quality improvement within general practices through the Practice Incentive Program.

But we need to build on these measures, and this must include additional funding models.

Fee-for-service funding is the predominant funding model for general practice. It works well for most patients. It provides autonomy and choice, but it is more suited for treating acute health issues.

The AMA believes that a more blended funding model is needed. Such a model would support general practices to continue to deliver safe, innovative, high-quality, accessible care in a more complex and more demanding primary care world.

The Government's proposed 10-year plan must be about:

- improving access to high-quality, GP-led primary care services;
- ensuring adequate spending on general practice, correcting Medicare rebates, and
- improving the confidence of medical professionals in general practice, thus encouraging more doctors in training to pursue a career as a GP.

It has been argued that the Federal Government should increase the proportion of its health budget spend on general practice. Other jurisdictions are already legislating targets.

More investment would equip general practice for seamless care-coordination - genuine holistic care.

It's about, as I often have said, improving the infrastructure, the capacity, and the capability of general practice.

To correct the fee-for-service model that underpins GP funding, general practice needs more investment, not a redistribution of existing resources.

Current remuneration structures do not value GPs' time or the significant complexity of their work. Instead, they reward volume over value.

The introduction of an extended Level-B – the most common GP consultation – would be the first step. This would support GPs to spend more time with their patients.

Expanded funding for coordinated primary health care through general practice would be next.

Carefully working with the profession to design the new system of coordinated care payments to recognise the significant amount of non-face-to-face work that GPs undertake.

It is essential that all payments for these programs are indexed to keep up with the cost of running a practice.

This should also include the introduction of specific Medicare rebates for nominated GP telehealth consultations.

The same applies to the Workforce Incentive Program.

The goal to support the employment of nurses, pharmacists, and allied health professionals in general practice will fail if the payments remain capped at current levels, which have not changed since 2012.

These reforms can only succeed with a highly trained GP workforce in enough numbers to meet future need.

This will involve improving GP-registrar working conditions, and making general practice a viable career path for Australian-trained doctors.

GP training has been undersubscribed for two consecutive years. This is concerning, particularly as we are graduating doctors at the highest rate in the OECD.

GP registrars are paid significantly less than their non-GP registrar counterparts. They are unable to transfer leave and other entitlements as they progress through training. These are major issues.

We want a review of employment arrangements for the GP training program, including the consideration of a single employer model for GP Registrars.

The AMA also wants maternity care, mental health, and rural health to be core considerations of the 10-year primary care plan.

### **Private Health Insurance**

The unique balance between the public and private sectors makes the Australian health system one of the best in the world.

This balance and harmony allows universal access to health care. This is a key and vital feature of our world-class health system.

Just as we need to ensure our public hospitals are funded and supported appropriately, the Government must ensure that the private health sector remains efficient, robust, and productive.

The private health insurance industry, which facilitates access to private health care, has been under the microscope.

In fact, private health insurance is currently in trouble – real trouble.

There have been 15 successive quarters of decreasing coverage despite a comprehensive Government review and the transition to the new policy structure.

But the situation is even worse than these figures portray.

There is a reality that we must all face here right in front of us.

We see increases in premiums averaging 3 to 5 per cent a year, when wages growth is firmly stuck at around 2 per cent.

But premiums are going up because an ever-increasing number of younger and healthy Australians are opting out of insurance.

This is leaving a higher proportion of older, less healthy, expensive-to-insure patients in the system - and there are more of these joining every day.

This, in turn, causes fund outlays to go up - and round we go again. This is clearly unsustainable.

Sooner or later, the number of people with private health insurance will fall further – and dramatically.

This would mean the option of private hospital access would be unaffordable for many Australians.

The burden would then fall calamitously on the already stressed public system.

We are truly on the precipice of the possible demise of a system that provides for the majority of elective surgery in Australia.

The notion of free and affordable universal access in this country will simply evaporate overnight.

We need a private health insurance system that continues to offer affordable, transparent, and appropriate cover.

Reform of private health insurance needs to also address indexation of rebates, variation in rebates, and insurer contracts.

This reform needs to start now – we can't wait for another dozen quarters of decline. The death spiral is already underway.

We need to look at all the reform options, including the Government's current private health insurance settings and investment.

Whenever private health affordability is debated, it is inevitable that the issue of out-of-pocket costs will arise.

Let us be crystal clear about why we have out-of-pocket costs in the first place.

The three contributors to out-of-pocket costs are the doctor's fee; the Medicare rebate; and what the health fund will pay.

Let's also be clear that 87 per cent of services are billed under a no-gap arrangement.

But the proportion of our health expenditure paid as out-of-pockets by individuals is not growing.

Australian Institute of Health and Welfare figures show that the proportion of health expenditure funded by individuals – not by government or insurers – has remained at around 16 or 17 per cent for the last 10 years.

Importantly, of that 17 per cent, only 10 per cent is spent on non-hospital referred medical services.

Most individual expenditure is on dental services and pharmaceutical products and other medications – 20 per cent and 37 per cent respectively.

So, what are the reasons behind out-of-pocket costs?

Gaps can be caused by:

- the very wide variation of rebates from funds;
- or a lack of appropriate insurance coverage;
- or whether a hospital has a contract with a specific insurer.

MBS fees, and therefore insurers' rebates, have fallen well behind the true cost of providing quality health services to the Australian community.

Each insurer sets the rebate amount that they are willing to pay. If the insurer's rebate is low, the out-of-pocket cost to their customer can be high.

Out-of-pocket costs can vary by thousands of dollars because of the variation in what the insurer chooses to pay as a rebate.

And yet we have only seen a 0.6 per cent decrease in the number of services provided at the no gap or known gap rates in the last 12 months. This is testament to the restraint of doctors.

The Government was saving money through the Medicare rebate freeze, but in doing so passed the growing gap between the rebate and the doctor's fee directly on to the patient.

Let me be clear. The AMA supports and actively encourages full transparency of doctors' fees.

We unreservedly condemn egregious billing, which occurs in a very small percentage of cases.

In fact, the AMA is taking extra steps to help patients understand medical fees.

Minister Hunt yesterday launched an Informed Financial Consent (IFC) information guide produced by the AMA with more than a dozen other medical organisations.

The guide explains to patients that the same doctor performing the same procedure can be paid significantly different rates by each fund.

This is often the untold story behind patient out-of-pocket costs, and one that is hidden by high levels of no gap and known gap billing statistics.

This is another important step in improving health financing literacy.

We want to provide patients with more information to give them the confidence to ask questions about their fees.

We want to empower patients to be equal partners in fee conversations with their doctors.

The guide is on our website and there are copies in the room today.

The Government's proposed fees website needs to also list what patients can expect back from Medicare and their private health insurance fund.

Patients want to know what their out-of-pocket cost will be for a health procedure. A website that only shows doctors' fees cannot deliver this outcome.

We remain in discussions with the Minister's office about this issue. We need transparency all round.

### **Public Hospitals**

Another sector of the health system in need of major funding and reform is public hospitals. But this is a subject for an entire speech on its own at another time.

There is so much to say, and so much to do.

The 2019 AMA Public Hospital Report Card is a story of public hospitals that are over-stretched, and over-stressed. I recommend you go to the AMA website and read that Report Card.

It is a most distressing story.

### **Aged Care**

And so is aged care.

Aged care systems and Australia's older people are suffering from a lack of Government support and resources.

The Aged Care Royal Commission will continue to uncover shocking stories and poor management practices and will report with significant recommendations.

The AMA believes that there are practical and achievable changes that can happen immediately to improve aged care.

Not in October. Not in April 2020. But right now.

We support the introduction of an appropriate minimum staff-resident ratio that aligns with the level of care needed in each residential aged care facility.

This will ensure 24-hour, on-site registered nurse availability.

The proportion of registered nurses in residential aged care facilities is in decline, which is the exact opposite of what Australia's older people require today.



Registered nurses are the only aged care provider employees who can truly provide frontline, timely clinical care within their scope of practice.

Older people who require aged care need registered nurses to safely administer medicines, and to help prevent medical issues such as pressure sores and fractures.

Meanwhile, doctors are decreasing their visits to aged care facilities, partially due to a lack of financial support from Medicare.

Almost 100 per cent of GP visits to facilities are bulk-billed.

But the current fees for GP attendance at aged care facilities do not come near covering the additional time and complexity compared to a GP attendance in their own consulting rooms.

Medicare rebates need to increase by at least 50 per cent for aged care facility visits.

The Government provided funds in the last Budget to help in this regard. But this is nowhere near enough to turn the tide of doctors who are reducing aged care facility visits.

Meanwhile, more older people are choosing to stay in their own homes for as long as possible. This has a range of benefits, including being significantly cheaper and desirable.

But there are just not enough home care packages.

There are currently more than 129,000 older people waiting for their approved and appropriate home care package level.

According to Royal Commission data, 16,000 people died while waiting for a home care package. Let me repeat that number - 16,000 Australians.

This is simply unforgivable in 21<sup>st</sup> century Australia. It is totally unacceptable.

## **Indigenous Health**

The ongoing failure to address Indigenous health is also unforgivable and unacceptable.

There are immediate things we can do to turn things around.

The AMA supports the Uluru Statement from the Heart. The Australian Parliament must make this a national priority.

Giving Aboriginal and Torres Strait Islander people a say in the decisions that affect their lives would allow for healing through recognition of past and current injustices.

It would underpin all Government endeavours to close the health and life expectancy gap.

We need to also look at and address the broader social determinants. This requires cooperation and unity of purpose from all relevant Ministers and portfolios.

We must take out the politics and fearmongering. We must do the right thing by the First Australians.

The AMA welcomed the stated intent of the Minister for Indigenous Australians, Ken Wyatt, to hold a referendum on Constitutional recognition for Indigenous peoples.

It is time for unity. Let's build on that.

### **Mental health**

Meanwhile, big picture mental health reform remains the hardest area of health care for governments to get right.

The continued investment in current mental health services is not producing the outcomes the community needs.

The Report on Government Services (ROGS) tells us that there has been a modest increase in overall expenditure on mental health in Australia, from \$275 for every person in 2006-07 to \$354 in 2015-16.

We want to see innovation in mental health – multi-agency and multi-dimensional approaches and investments in psychosocial rehabilitation.

We want funding to be based on sound research with input from clinicians, and from consumers and carers.

Critically, we are calling on the Government to fund and resource a properly skilled mental health workforce. This is a priority.

The growing role of GPs in coordinating mental health care must also be recognised and formalised.

Patients now see their GP for mental health reasons more than any other health issue.

But very little funding has been directed to general practice to allow GPs to provide mental health services in a primary care setting.

The reforms we support should start in the community sector - and use the evidence which shows that integrated interdisciplinary care works.

We could also learn from the New Zealand model, where they put frontline mental health staff in primary care clinics working as part of the GP-led team.

We must also address how people with mental health care needs are not being properly looked after under the National Disability Insurance Scheme (NDIS).

The AMA strongly supports the NDIS, but there are problems. For many people with episodic mental illness, it is a mess.

Fixing the NDIS must be a priority for the Government.

## **Prevention**

And so must prevention - a pet subject of mine and the AMA.

Investing in preventative health measures reduces the rate of chronic ill health and improves the health and wellbeing of all Australians.

Investment in prevention will give the Government the long-term savings it wants in the health budget.

We need an overarching obesity prevention policy. This must include a tax on sugar-sweetened beverages, and restrictions on junk food advertising to children. Let's just do it.

We need a new National Alcohol Strategy, including measures such as a volumetric tax and front-of-packet warnings on alcohol products. Let's just do it.

We need a dedicated preventative health promotion agency. Let's just do it.

Australia has shown it can be a world leader in preventative health by the way we have approached tobacco control and stopping people smoking.

Plain packaging was a huge move. But the tobacco companies still seek ways to promote their killer products.

All our governments must do more to continue the momentum on smoking cessation.

This is the 25<sup>th</sup> year that the AMA and the Australian Council on Smoking and Health – ACOSH – have highlighted the best and worst government efforts to cut smoking.

We have judged the Queensland Government as the best over the past year, and it wins the National Tobacco Control Award.

The Northern Territory has won the Dirty Ashtray Award for the poorest record in tobacco control. This is the fourth year in a row, and the 13<sup>th</sup> time in 25 years.

These Awards are on show in the Club here today.

We all need to do a lot more on preventative health to get Australians making healthier choices and staying fitter.

The Federal Government must once again take on a greater leadership role in tobacco control and reinstate the National Tobacco Campaign, with additional and sustained funding.

## **Conclusion**

I have today outlined what all health consumers, members of the medical profession, and the wider health workforce all know to be true.

Health care is Australia's largest employer. It employs 14 per cent of our total workforce. It is a significant economic generator.

Investing in health care offers a unique return on investment.

It would offer a necessary stimulus at this uncertain time for our immediate economic future.

Driving economic activity through our largest workforce sector would also add extra capacity in general practice, hospitals, and other frontline areas.

It would increase clinical infrastructure, capacity, and workforce.

It offers the prospect of a significant increase in GDP by investing in the health of the workforce.

This would deliver increased productivity and significant additional work years through better health outcomes as a direct result of spending on chronic illness prevention.

Surely, this is a no-brainer. I may not be an economist, but this is simple Economics 101.

Ladies and gentlemen, the time for talking about improving our health system is long past.

The time for action is clearly now.

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