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SPEECH TO THE NATIONAL PRESS CLUB
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AMA PRESIDENT DR TONY BARTONE

***Check Against Delivery

Health reform: Improving the patient journey

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

It is a humbling experience to be elected President of such a proud and respected organisation as the AMA.

It is an equally humbling experience to speak here at the National Press Club in Canberra. I thank the Press Club for this opportunity.

I am a GP, and I have been in practice in the northern suburbs of Melbourne for more than 30 years.

Some of you may know that I was inspired to become a GP by watching my own family doctor, who cared for my ill father when I was growing up.

Even now, my mother reflects on the care and dedication my family GP displayed in caring for her family. It's no surprise that he became an early mentor in my professional life.

I have seen it all as I have looked after the health of my community and my patients, including generations of the same families.

I like to think that my experience has given me some credibility in knowing what works and what doesn't work in the health system, especially in primary care.

My overarching concern has always been the patient journey – ensuring that people get the right care at the right time in the right place by the right practitioner.

The priorities for me are always universal access to care, and affordability.

Today, I will share my views on what can be done to make our great health system even better – how to improve the patient journey.

I will also introduce you to some of my patients, and reflect on the barriers in their access to timely care, to further illustrate our concerns.

General practice and primary care reform

On the day I was elected, I made it very clear that one of the hallmarks of my Presidency would be stridently advocating for significant investment in general practice.

This week just happens to be AMA Family Doctor Week – a tribute to hardworking GPs.

GPs of Australia, I salute you. We all salute you.

Your hard work and dedication is highly valued. The AMA will always support you and promote you.

Your GP – your family doctor - will ensure that your health needs are met throughout all stages of your life.

Be it immunisation, preventative health care, age specific medical checks, chronic disease management, or aged care, the life long relationship with your GP underpins continuous and appropriate care.

This is especially the case for patients who are from culturally or linguistically diverse backgrounds. For them, GPs truly are their trusted health advocates.

However, there is something really crook about how GPs have been treated by successive Governments.

They have paid lip service to the critical role GPs play in our health system, often borne out of ignorance and often in a misguided attempt to control costs.

General practice has been the target of continual funding cuts over many years. These cuts have systematically eaten away at the capacity of general practice to deliver the highest quality care for our patients.

They threaten the viability of many practices.

I talk to my GP members regularly, both metropolitan and rural.

The message is simple – some are at a tipping point and have a very bleak view of the future.

They see general practice becoming increasingly corporatised, burdened with more red tape, and GPs are less able to spend the necessary time with patients.

This is not the future that GPs want to see.

This is not the future that our patients want to see.

We can and must avoid these bleak predictions, but it requires significant real and immediate investment from the Government with a clear pathway to long-term reform.

Let me be very clear about this: we must put general practice front and centre in future health policy development.

We have seen too many mistakes. Too many poor policy decisions.

Despite the Government's best intentions - and lots of goodwill within the profession – the Health Care Homes trial and implementation failed to win the support of GPs or patients.

Instead of real investment, the Trial largely shifted existing buckets of money around.

It has fallen well short of its practice enrolment targets, and it looks like only a small fraction of the targeted 65,000 patients will sign up.

There is no doubt that the challenge of transforming general practice was severely underestimated by policy makers. At least with this model.

But general practice still needs transformation and rejuvenation to meet growing patient demand and to keep GPs working in general practice.

The AMA has a plan for reform of general practice and primary care.

It is patient-centred and focuses on better access to long-term continuous quality care and managing patients more effectively in the community.

It takes the best elements of the 'medical home' concept and adapts them to the Australian context.

It is a plan that will require upfront and meaningful new investment, in anticipation of long-term savings in downstream health costs.

In the short term, the AMA plan for general practice will involve:

- significant changes to Chronic Disease funding, including a process that strengthens the relationship between a patient and their usual GP, and encourages continuity of care;

- cutting the bureaucracy that makes it difficult for GPs to refer patients to allied health services;

- formal recognition in GP funding arrangements of the significant non-face-to-face workload involved in caring for patients with complex and chronic disease;

- additional funding to support enhanced care coordination for those patients with chronic disease who are at risk of unplanned hospital admission – a similar model to the Coordinated Veterans Care Program funded by the Department of Veterans Affairs;

- a properly funded Quality Improvement Incentive under the Practice Incentive Program – the PIP;

- changes to Medicare that improve access to after-hours GP care through a patient's usual general practice;

- support for patients with chronic wounds to access best practice wound care through their general practice;

- better access to GP care for patients in residential aged care; and

- annual indexation of current block funding streams that have not changed for many years … including those that provide funding to support the employment of nursing and allied health professionals in general practice.

In the longer term, we need to look at moving to a more blended model of funding for general practice.

While retaining our proven fee-for-service model at its core, the new funding model must have an increased emphasis on other funding streams, which are designed to support a high performing primary care system.

This will allow for increasing the capability and improving the infrastructure supporting general practice to allow it to become the real engine room of our health system.

It is about scaling up our GP-led patient-centred multidisciplinary practice teams to better provide the envelope of health care around the patient in their journey through the health system.

A good example is the Blacktown Hospital Diabetes Outpatient Clinic in New South Wales.

This Clinic has a waiting time of less than a week because the service is distributed to its catchment GPs with the appropriate funding and support for both personnel and infrastructure.

This is a small example, but a significant one when you consider the scale and prevalence of diabetes across Australia, let alone the western suburbs of Sydney, and the average access times for outpatient hospital clinics.

We cannot continue to do things the way we always have.

The bulk-billing rate should not be the metric by which we judge the performance of general practice.

Chronic conditions have become more prevalent in Australia. The ones causing most concern are:

- arthritis;
- asthma;
- back pain and problems;
- cancer;
- cardiovascular disease;
- chronic obstructive pulmonary disease;
- diabetes; and
- mental health conditions.

One in two people now report having at least one of these eight common chronic conditions.

These conditions account for around 60 per cent of the total disease burden, and they contribute to nearly 90 per cent of deaths in Australia.

We must reshape our primary care system to meet these challenges.

We must put in place the funding support that general practice needs to better manage patients in the community - and keep people out of hospital.

Our plan is a smarter and more sustainable blueprint … a better plan for general practice. A better plan for Australians.

Public hospitals

We also need a better plan for public hospitals.

In an election year, voters tend to focus very closely on public hospitals when they are comparing health policies.

Public hospitals are a critical part of our health system. They are highly visible. They are greatly loved institutions in the community. They are vote changers.

The doctors, nurses, and other staff who work in our public hospitals are some of the most skilled in the world.

In 2016-17, public hospitals provided more than six and a half million episodes of admitted patient care. They managed 92 per cent of emergency admissions.

If the state of general practice is crook, then our public hospitals are on permanent code yellow.

Despite their importance, and despite our reliance on our hospitals to save lives and improve quality of life, they have been chronically underfunded for too long.

Between 2010-11 and 2015-16, average annual real growth in Federal Government recurrent funding for public hospitals has been virtually stagnant – a mere 2.8 per cent.

The AMA welcomes that, between 2014-15 and 2015-16, the Federal Government boosted its recurrent public hospital expenditure by 8.4 per cent.

But a one-off modest boost from a very low base is not enough.

I deal with the results of stressed public hospitals every day and manage the impact it has on my patients.

Ollie is a patient with well-controlled Parkinson's disease. He now also has a recently diagnosed lung cancer, which has been caught early, resected, and appropriately managed.

But he has been denied care for his resulting poor control of his Parkinson's disease in the same hospital's neurology outpatient department and referred back to me.

I have been advised that I must source an alternative option for his neurological care.

Another of my patients, **Carlo**, is a victim of the never ending Federal-State buck passing when it comes to health.

Having developed poorly controlled reflux and having been referred to the local hospital outpatient department for a gastro consult, Carlo was referred back to me.

I was advised that I had to arrange a referral at the same hospital's diagnostic imaging service for a possible coordination and swallowing problem, which ultimately proved correct.

He was then referred back to the gastroenterology department to manage his newly diagnosed oesophageal condition.

Barbara is another very common example of the funding chaos.

She is a very active 68-year-old lady who was troubled by severe osteoarthritis of the knee for many years. She was placed on a waiting list for surgery two years ago.

She has had to attend our practice regularly for pain management and supportive referrals for physiotherapy, while I continued to manage the consequences of her inability to lose weight due to her exercise restrictions and worsening diabetes and blood pressure profile.

She has just finally had her knee joint replaced.

These are the experiences of everyday patients.

They underpin the troubling headlines that came from the AMA's 2018 Public Hospital Report Card. Our hospitals are stretched to the limit.

Likewise, the AMA's Safe Hours Audit is a window into the lived experience of dedicated doctors, struggling to deliver quality care in over-crowded, under-funded hospitals.

But instead of helping the hospitals improve safety and quality, governments decided to financially punish hospitals for poor safety events.

There is no evidence to show that financial penalties work.

Health care is complex. Not all patient complications can be avoided.

The 2020-25 hospital funding agreement does little to improve the situation.

Funding levels stay the same, but public hospitals will have to do more with it to help coordinate patient care post-discharge.

The AMA supports better discharge planning and integrated care, especially for patients with complex and chronic disease.

But this will cost money - and public hospitals need extra funding.

The AMA calls on the major parties to boost funding for public hospitals beyond that outlined in the next agreement.

There must be a plan to lift public hospitals out of their current funding crisis, which is putting doctors and patients at risk.

Governments must stop penalising hospitals for adverse patient safety events.

We need policies to fully fund hospitals. We must help them improve patient safety and build their internal capacity to deliver high value care in the medium to long term.

They must link up and work with primary care to deliver better coordinated care.

I note that Labor has pledged an extra $2.8 billion for public hospitals.

I expect that the Coalition will match that as the election draws nearer.

They do not want another *Medi-scare* style campaign.

Medical care for older Australians

Older Australians are voters, too.

Aged care was, until very recently, one of the highest profile segments of the health system – but for all the wrong reasons.

It is now emerging as an area in need of significant reform as the population ages and lives longer.

Older Australians all too frequently do not have the same access to medical care as other age groups - a longstanding result of inadequate funding in the aged care system.

This inequity will likely only grow as the Australian population ages with more complex, chronic medical conditions requiring more medical attention than ever before.

We have witnessed numerous consultations and reviews.

Enough! Now is the time for action.

There is already sufficient information to underpin the final recommendations. It is simply unfair and unjust to delay this any further.

An increase in funding for GP visits to aged care facilities would result in many savings, including from reduced ambulance transfers to hospital emergency departments.

Changes to after-hours care remuneration must consider services that are currently provided under ‘urgent’ item numbers to patients in aged care facilities.

We also need to ensure that the critical role that nurses play in caring for older Australians is recognised in those facilities.

The AMA wants to see Medicare rebates that adequately cover the time that doctors spend with the patient assessing and diagnosing their condition and providing medical care.

We want new telehealth Medicare items that compensate GPs, and other medical specialists, for the time spent organising and coordinating services for the patient.

This includes the time that they spend with the patient’s family and carers to plan and manage the patient’s care and treatment.

There must be funding for the recruitment and retention of quality, appropriately trained aged care staff.

And we must reverse the decline in the proportion of Registered Nurses in aged care.

The AMA Aged Care Survey, released today, shows that AMA members who work in aged care have identified the shortage of Registered Nurses – who should be available 24 hours a day – as the biggest priority for aged care reform.

The survey also shows that one in three doctors are planning to cut back on, or completely end, their visits to patients in aged care facilities over the next two years.

This is largely because the Medicare rebates are inadequate for the amount of time and work involved.

The AMA will ensure that aged care gets the attention and profile it deserves in the election campaign.

Private health insurance:

Private health insurance has been in the headlines for much of the past year – again, for all the wrong reasons.

The AMA has always called for a simpler and fairer private health insurance system.

Without the private system, the public system would likely collapse.

But we cannot expect the private system to thrive – or even survive – if there is not value in insurance policies.

Patients are smart – they know there is no point outlaying thousands of dollars every year if the coverage isn't there.

Affordability means very little without value.

We are clearly at a crisis point in private health insurance. And the Government knows it.

Hence the latest Review, and the recent announcement by the Minister of new categories of policies … and greater transparency.

We support the concept of developing Gold, Silver, and Bronze insurance categories.

We can't expect consumers to understand the many different definitions, the carve outs, and exclusions of some 70,000 policy variations.

Australians want reasonable and simple things from their insurance.

They want coverage.

They want a choice of the practitioner, and a choice of the hospital.

They want treatment when they need it.

We can't have patients finding out they aren't covered after the event, or when they require treatment and it's all too late.

To that end, we have been very clear – we don't support the use of restrictions in Gold, Silver, and Bronze.

Restrictions lead people to believe they are covered, when in reality they are exposed to additional costs.

We don't support junk policies. If a Basic policy category doesn't provide much coverage, that should be made crystal clear.

We don't support dismantling community rating. This must be protected to maintain equity of access to private health treatment.

When the objective is to support a strong private health sector to take pressure off the public sector, it makes no sense to financially discourage the patients who are most likely to need access to private health.

We support standard clinical definitions. Whatever is involved for coverage for heart conditions should not vary between insurers and policies.

I urge the Government to continue to work with the Colleges to ensure that these definitions are robust.

There is increasing corporatisation of private health and the market power is shifting in favour of private health insurers.

Insurers, whether private or via Medicare, cannot determine the provision of treatment in Australia.

They cannot and must not interfere with the clinical judgement of medical practitioners.

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

One area we are disappointed with in the recent announcements is pregnancy cover.

It does not make sense to us, as clinicians, to have pregnancy cover in a higher level of insurance only.

Many pregnancies are unplanned – meaning people are caught out underinsured when pregnancy is restricted to high-end policies.

Pregnancy is a major reason that the younger population considers taking up private health insurance.

They are less likely to be able to afford the higher-level policies. We need to make sure it is within reach.

And having female reproductive services at a different level to pregnancy coverage is, to us, problematic, and will leave a lot of people caught out.

There will be much more to talk about as the private health reforms are finalised and bedded down.

Mental Health

As a suburban GP who sees the whole range of health ailments and conditions, an area of special interest to me is mental health.

I do not think the unique role and special skills of GPs are used enough at the front line of mental health care.

The AMA earlier this year called for a national, overarching mental health "architecture", and proper investment in both prevention and treatment of mental illnesses.

Almost one in two Australian adults – that is more than seven million people - will experience a mental health condition in their lifetime.

Almost every Australian will experience the effects of mental illness in a family member, friend, or work colleague.

The statistics are startling. For example:

- More than half a million children and adolescents, aged four to 17, experienced mental health disorders in 2012-13.

- Australians living with schizophrenia die 25 years earlier than the general population, mainly due to poor heart health.

And yet mental health and psychiatric care are grossly underfunded.

Strategic leadership is needed to integrate all components of mental health prevention and care.

For mental health consumers and their families, navigating the system and finding the right care at the right time can be difficult and frustrating.

There is no vision of what the mental health system will look like in the future.

Poor access to acute beds for major illness leads to extended delays in emergency departments.

Poor access to community care leads to delayed or failed discharges from hospitals.

And poor funding of community services makes it harder to access and coordinate prevention, support services, and early intervention.

Significant investment is **urgently needed** to reduce the deficits in care, fragmentation, poor coordination, and access to effective care.

We have repeatedly called for support for carers of people with mental illness, which is often the result of necessity, not choice.

Access to respite care is vital for many people with mental illness and their families, who are the ones who bear the largest burden of care.

Indigenous health

I am very pleased that one of my first announcements as AMA President was the AMA endorsement of the *Uluru Statement from the Heart*.

The Uluru Statement expresses the aspirations of Aboriginal and Torres Strait Islander people with regard to self-determination and status in their own country.

The AMA has for many years supported Indigenous recognition in the Australian Constitution.

The Uluru Statement is another significant step in making that recognition a reality.

The AMA is committed to improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

It is simply unacceptable that Australia, one of the wealthiest nations in the world, cannot solve a health crisis affecting fewer than three per cent of its citizens.

Prevention

There is not enough time today to cover all the issues I would like to cover in one speech.

I could deliver a whole speech on each of the following topics – medical workforce, rural health, medical research, genetic testing, e-cigarettes and vaping, opioids, medicinal cannabis, scope of practice, asylum seeker health, the NDIS, or palliative care, to name just a few.

I could probably manage a few words about the My Health Record, too. No doubt there will be questions about that.

But I have to talk to you about prevention, if only briefly.

The burden of chronic disease in Australia is significant.

Chronic disease is responsible for around 83 per cent of premature deaths and 66 per cent of the burden of disease.

Chronic disease has a significant impact on the health system, but the reality is that most of these conditions can be prevented.

It simply makes enormous sense to **invest in prevention**.

Taxes collected from tobacco and alcohol excise generate around $16 billion each year for the Government.

In return, total Government spending on prevention is around $2 billion a year, which equates to about $89 per person.

This amounts to a measly 1.34 per cent of all health spending. This is considerably less than comparable countries such as Canada, the United Kingdom, and New Zealand.

If we are to reduce the impact of chronic disease in Australia, all our governments must invest more in prevention.

Tackling obesity is a priority.

Doctors are well placed to identify and support patients who are overweight or obese. Two thirds of adults are either overweight or obese.

The evidence shows that advice to lose weight given by a doctor increases the motivation to lose weight. It also increases engagement in weight loss behaviours.

But the support and advice from doctors can only achieve so much.

Population level measures are needed. We need to see action on a sugar tax, banning junk food advertising to kids, and improving urban planning to help get people moving and active.

Governments have the tools to implement these measures. A sugar tax would be a good start.

In closing, I know the challenges ahead for the health system.

I will dedicate my Presidency to improving health policy so that we have a system that delivers the best possible care to our patients.

The AMA will be a very strong and loud advocate.

There is nothing like a Federal election to help our political leaders share the public's interest in good health policy.

The election will happen within twelve months, possibly this year.

Along with the members of the National Press Club, the AMA will be watching the political events of this weekend and the coming months with very close interest.

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