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**Transcript:** AMA President Dr Tony Bartone, National Press Club Q and A, 25 July 2018

**Subjects**: Public Hospital Funding, My Health Record, Aged Care, International Medical Graduates, Gap Fees.

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**STEVE LEWIS:** Thank you, Dr Tony Bartone, for that pretty robust diagnosis of the health system. I was going to visit you for my annual health check, but I am too intimidated now.

[Laughter]

You mentioned in your speech that Labor's committed an extra $2.8 billion to the hospital system, which the Coalition's yet to match. And, then there was a fairly- not very subtle warning, I would say, that they don't want another Mediscare campaign, the Coalition, the Government, which of course was very effective at the last campaign. Is that the AMA putting the Turnbull Government on notice, that it needs to match Labor, or the AMA, and its constituency will campaign at the next election in favour of that additional funding? Please.

**TONY BARTONE:** And, thank you for that question. We're clearly on the record, and our Public Hospital Report Card shows the extent and the stress that the system is under when it comes to public hospitals. The $2.8 billion announced by Labor in the terms of their policy is a significantly better place than the current funding agreement has alluded to. But we're clear about that really, there needs to be significant investment. Both sides need to do better. But clearly, when it comes to the election, as we do every time, we will put our own report card on all the parties' health policies. We will do our rating, and we will assess them according to the metrics that we will be outlining very clearly in the lead up to those elections.

**STEVE LEWIS:** Thank you very much. Our next question is from Angus Livingstone.

**QUESTION:** Thank you very much, Doctor, for your speech. You mentioned the My Health Record rollout, which you probably were expecting a question on this today. It's obviously proving controversial. There's concerns about data security. There's concerns about police getting access to data without a warrant. Greg Hunt says there are policies around that prevent police getting access to the data. But then Bill Shorten is saying that he thinks the rollout should be suspended until privacy concerns are dealt with. Do you support the calls for a suspension and do you think GPs should refuse to use the service until those concerns are dealt with?

**TONY BARTONE:** And thank you for your question, and there's a number of parts to that question. So, please bear with me, while I address all of them. The My Health Record, or previously known as a Personally-Controlled Electronic Health Record, has had a very difficult inception over many years. The consultation and the advocacy program started well back in the last decade, and that was seeing an enormous amount of goodwill of all the various healthcare organisations, including ours, involved in the setup, in the contributions to help set up what we feel is a very useful clinical tool and one that will ultimately aid the patient journey in a complex medical system, especially as patients become more mobile and especially as patients become more aggregated around the country.

In terms of the current discussion around the warrant and the access to security, let me make a couple of observations. The AMA holds the privacy and security of its patient medical records in the most paramount and highest esteem and seriousness.

Anything that will compromise that will not be withstood by our members. I have sought assurances from both the Minister and from the Department, the head of the Authority, that this

is not the case. They have given me written undertakings that, without a court order, without judicial oversight, there is no way of access to the system for anyone other than the nominated people by the patient. However, I will ensure that any ambiguity in the differences between what the legislation says and what is the practicality of the interpretation, including the assurances, are crystal clear and there can be no ambiguity for our members or for the public going forward. And I think that there was another part of the question.

**QUESTION:** [Inaudible]

**TONY BARTONE:** I think, as I said, it's been a very difficult birth and transition over the course of the journey. A lot of time, a lot of effort, a lot of goodwill has been expended in setting up this system as it currently stands. It's not the best possible system as it currently stands, but that's because there have been so many barriers, so many issues, regarding interoperability and barriers to- including access to broadband, including the state of IT in our hospitals and other parts of the health system. The utility hasn't been there and so people haven't been able to access any reliable information. We've come to a tipping point. We need to grow the system to a point of maturity so it can develop and become more robust, more informative, more about the patient and allowing them to control their health journey through this very complex system. And until we have enough people on- with the record, and until we have enough providers uploading information, and enough developers with the necessary tools to actually increase the utility, to increase the performance, it's going to be stuck- too little too late.

Many, many patients tell me: “Doc, have you got my records for my recent inpatient stay?” And I say: “no, I haven't got them yet. I haven't. Don't you get that automatically?” To the average patient or punter in the street, they think that we're all connected. They're surprised to hear that we still fax off referrals to the outpatient clinics. Fax in this day and age. Patients often say, can I email you? I say no, we don't have a secure messaging environment to facilitate that. So we need to move well into the 21st century and we need to ensure that we've got the enablers. The My Health Record isn't the answer to everything. It is part of a wider solution. It's one of the enablers to allow that to occur.

**STEVE LEWIS:** Thank you. For the younger viewers, we might have to explain what a fax is.

[Laughter]

Next question from Dana McCauley.

**QUESTION:** Hi, Doctor. Thank you. Just another My Health Record question. Just following up. You mentioned that the Minister has given you a written undertaking that information won't be passed on to police. Given the way that the legislation is drafted and those reassurances, wouldn't it make sense for it- for the laws to be tidied up so that patients are protected? And you know, given the amount of opposition at the moment, you mentioned wanting to have larger numbers enrolling, wouldn't that help to push the program forward? And the other thing I wanted to ask was, I know some doctors have raised concerns that they might be held liable for data breaches and just wondered if there's anything you can say to address that? Thanks.

**TONY BARTONE:** I'll reiterate what I've just said before, and that is that anything which impairs or creates ambiguity between what the legislation says and the assurances that I've received in writing, which I'm happy to acknowledge at a subsequent time, must not be allowed to occur. And I've made it clear that I will be wanting to seek a meeting with the Minister in the coming days to ensure that any ambiguity is put to rest and whatever measures need to be done to ensure that that is once and for all put to bed.

And in part of the data breaches, privacy- there's nothing more personal, nothing more important than a patient's medical condition and their medical record. We, as medical practitioners, all have strict obligations in the Privacy Act in terms of the curation and maintaining of that. And anything which interferes with that will obviously be an issue. Now

again, the same process, in the same fulsome discussion with the authority, with the Minister, I'll make sure that that again is put to bed.

**STEVE LEWIS:** Sue Dunlevy.

**QUESTION:** Dr Bartone, the clearest way of making sure that your health record is not handed over to the police is to change the legislation so that that provision is no longer in the legislation. Will you be asking Health Minister Greg Hunt to change the legislation, so Section 70 is reformed?

**TONY BARTONE:** Sue - and I'll be very clear about this one more time - I will do whatever it takes to ensure that the ambiguity and any discrepancy between the legislation and what currently is the standard practice of what we all practice under, is removed and put to bed once and for all. Whatever it takes.

**QUESTION:** That includes changing legislation?

**TONY BARTONE:** Sue, whatever it takes. Whatever it takes.

**QUESTION:** Isn't that what it takes?

**TONY BARTONE:** Well, I'll be having a conversation with the Minister and if it means that we have to go to there, that's where we'll go.

**STEVE LEWIS:** Do you think the Government would be amenable? Have you had any- have you heard suggestions? Have there been any signals from the Government that it would be prepared to consider legislative amendments, as Sue suggested, to remove that ambiguity and to improve public confidence in My Health Record?

**TONY BARTONE:** I am sure the Government is committed to a successful rollout of this, and anything which gets in the way of the trust, of the faith in the system by doctors, will be seen as a deal breaker in terms of the successful rollout, and that will be dealt with accordingly and appropriately.

**STEVE LEWIS:** The next question is from Phoebe Bowden.

**QUESTION:** Thank you for your speech. You say the AMA is going to make aged care an election issue, but it is an area where the people impacted are often voiceless, and as the AMA has found in its most recent research, people- or doctors are turning their back on the sector. How do you put that firmly on the political agenda?

**TONY BARTONE:** Thanks for that question. There have been countless reviews and inquiries over the last 12 months. There's been a number of taskforces that we've also contributed to personally, and with submissions. In my dealings with the patients that I visit, with the families that I look after, aged care is becoming increasingly an area of distress for them. The access, the care, and the ability to have the reliable treatment is a concern. Our members want to, and I repeat, want to get involved, and they would, they would, but the financial disincentive to actually providing care is enormous. Some still do it because they've got a relationship with the patient. But because of the way the nursing home facilities are becoming distributed further and further out in suburbia and at the fringes, and traffic being what it is, the time taken to get to these things is considerably prohibitive in terms of the management.

So, we need to look at ways that we can improve that and that's what these submissions and taskforces are all about. It's about getting the right people. It's about getting the right investment and creating the opportunities. Now, I've mentioned about telehealth. There's a lot of non-face-to-face work that goes into an aged care patient. That could be done without the doctor leaving the surgery and could be done over the phone or through the online portal, back to the theme. At the moment, I'll go and visit a patient in the nursing home and then I have to go back to the surgery and rewrite up my notes because my program won't interact with the provider program at the facility. So, it's double handling. I need to write the scripts up at the surgery and take that away and print them out and send them off to the chemist. Because we're

still trying to get to one source of truth and having the patient chart being the actual prescription as well. There's so much that needs to be done to improve the areas of inefficiency. If we can get that done we'll get more care, and it's about ensuring that that becomes an area that we keep a metric on for both parties.

**STEVE LEWIS:** Our question from Phoebe Wearne.

**QUESTION:** Thanks very much for your speech, Doctor. You spoke about the critical role of GPs like yourself. I am interested in your views on one of the biggest budget savings from this year's Budget, which relates to cutting the number of overseas trained GPs that are able to work in our cities. Are you convinced that this measure won't cause further GP shortages in regional areas?

**TONY BARTONE:** Medical workforce and the distribution of that workforce has been a significant problem for a really long time and a lot of parts of the department have been working on this over the course of the journey. We now are finally reaching a stage where, after the disbandment of Health Workforce Australia, as one of Abbott's first announcements that we're getting, through the National Medical and Training Network, we're getting data, collaborative data, from colleges and from parts of the workforce in terms of mapping out the current supply and demand and the projections for the future. So, a number of specialties have already come online so we can map out the demand.

Now I'm getting to your question, I know. So, once we understand what the needs of the medical workforce are, we can then start to actually distribute that population accordingly. It makes no sense when we've been training medical graduates at a rate of three times more than what we did more than a decade ago, and to have- still importing doctors to provide the really good care that has really been the backbone of care in a lot of rural and regional Australia. But it makes no sense while we're ramping up on this side to continue doing what's on that side. We need to- we're producing enough doctors of our own. We need to get the infrastructure, the training environment to support the programs, to train them in rural and regional Australia and develop the linkages and then set down roots there. That's what it's going to take and we have to start it in a coordinated fashion. It's not fair to bring people in if we're going to be pushing people out there.

**STEVE LEWIS:** Next question is from Paul Karp.

**QUESTION:** Paul Karp from *Guardian Australia*. You've addressed the issue of police requiring a warrant. But I want to take you to the breadth of the grounds on which the Digital Health Agency can release records. One of those grounds is to protect the public revenue. Could I please ask, is this too broad and is this one of the ambiguities that's going to need to be fixed when you discuss the health records with Greg Hunt, because the AMA's ethical guidelines say that compelling doctors to disclose medical records can only be done when it's overwhelmingly in the public interest?

**TONY BARTONE:** The entire- that entire section of that legislation, which I know has been promulgated around on social media and various other forums, will be a subject of the conversation. It will be important to understand exactly the where and where not, and it must be clearly in the public interest, it must be at the same level that exists currently now. That is, a court order or a judicial oversight that warrants us to release those records. The security and privacy of those records are tantamount to us as an organisation for our members providing care to their patients.

**STEVE LEWIS:** Can I just ask you to clarify because I think there's been a lot of questions on this issue - My Health Record, are you saying that without changes to the current scheme, legislative changes and other changes, that the AMA will not support My Health Record?

**TONY BARTONE:** No, I'm not saying that. I'm saying that we need to clear that ambiguity and any confusion in that area to ensure that what exists now in a practical aspect, continues to be the same level of oversight and care and minimum requirement before we release our records, and I am sure we can get that done.

**STEVE LEWIS:** Thank you. Our next question from Simon Grose.

**QUESTION:** Simon Grace, Canberra IQ. You talked about adverse safety events in hospitals. It reminded me of a time when the fax was a relatively new and exciting technology.

[Laughter]

**STEVE LEWIS:** You are showing your age, Simon.

**QUESTION:** Yes, I am showing my age. When I was a trolley boy at RPA emergency theatre in Sydney and there'd been an operation and I was encouraged to take the patient back to the ward as quickly as possible because if he died in the ward it was easier in terms of administration than if he died in the emergency sector. So, hospitals have risk management systems at the micro level like that, and the macro level. You talked about you don't like financial penalties as a way to discourage or respond to adverse safety events in hospitals. But you didn't outline any mechanisms, either carrots or sticks, that would be better than financial penalties. How would you better manage or reduce the incidence of adverse safety effects and incidences in hospitals?

**TONY BARTONE:** Education and best practice guidelines need to be front and centre of any process to ensure that we all lift the various parts of the health system up together. Understanding that they're under stress, understanding that there are underfunding issues, and not penalising them for the things that are exactly the cause of the stress that they're under there. Penalising them in the underfunded situation is only going to create a further and further spiral, or a list of unintended consequences because they're going to push people that are too risky out of the system because they can't deal with that. They don't want the risk. Education must be the core. Getting them to a point where they want to be able to play, with their other colleagues, with their other representatives around the table, to ensure that best practice becomes the spire, the goal to which to target to achieve. And if it can be shown that hospital A is actually doing better by doing this process - well, it's actually going to mean better health outcomes. So why wouldn't they come along?

**STEVE LEWIS:** The next question from Nic Stuart.

**QUESTION:** Thanks very much Tony. Congratulations on your recent appointment. I was going to take you to this issue that we keep on going back to, the My Health Record. And ask you why you are defending this, when it's actually something that the Government has pointed out, is progressing with? And secondly, ask you about Section 70, of the Constitution, because although we know a lot about Section 40, of the Constitution, journalists don't know anything about Section 70, at the moment. But the other thing that I wanted to ask about was the sweet spot. You talked about taking on big sugar. And, that's something that really we need as a society to do. How serious are you, about actually doing that?

**TONY BARTONE:** Thank you, Nic, and thank you for your note of congratulations. I appreciate that a lot. Let's take it in reverse order, just to break up the- no, we'll do the My Health Records. Look, I'm not a lawyer. And drafting legislation is not my forte. But ensuring that a patient's security and privacy is protected is.

The reason you might think I'm actually the front man for the Government on their promotion and communication campaign is because it's been done so poorly. And this is a clinical tool which we believe has clinical merit. So let's start from there.

Privacy and security issues aside - if we can bed that down and assure ourselves that that is under control and will be under control and completely remove any ambiguity in that space, it's about clinical tool and clinical outcomes. Our members have been very vocal over the journey about the benefits of My Health Record or the PEHO in its previous iteration. Our patients have wanted that. Consumers have wanted that. So we don't want the last 10, 12, 15 years to be all in vain and completely go out. So yes, that's why we're having a conversation.

Now, the communications strategy by the authority probably leaves a lot to be desired. And so yeah, hence we're filling that void. Not because we've been asked to, but because we still see

that there is utility in the product. There is utility in the system. After so many barriers, so many pitfalls, so many issues, there comes a time where we actually- especially with the legislation as it is in terms of opt-out, we have to ensure that we get the best utility of the system going forward and help us, as doctors, manage the care around our patients and ensure that they've got a portable record, which they're controlling. That's why it's called My Health Record. They can control the access. They need to set their security code right upfront when they do activate their file, so that they regulate who will and won't get in there. But all of this will take time, it will take effort, and there needs to be an acknowledgement of all of that process in the journey. But, it's a start of an even longer trek, you might say. It's not going to be solved overnight.

In terms of big sugar and the sweet spot, well look, basically, yes, I've been ridiculed and I've been called many things about my continual advocacy on this front. I'm not going to stop. For the two years that I'm President, it will be front and centre and part of my advocacy. I'm sure that the next President will continue that advocacy until it actually becomes part of our health policy. The research and the findings from overseas are very clear. Where it's been introduced, there have been some positive benefits, some positive outcomes. We can't be dictated, especially when two-thirds of the population are obese or overweight, with the chronic disease bill going where it is, with health resources being so scarce. With everything being so overstretched, we can't just put our head in the sand and say that's okay. We need to- you know, the sugar tax won't fix it all. But it's a bloody good start, pardon the French. And it will get people focused on this journey as we go forward as part of a multifaceted program. Public education, prevention, resources to help our patients. But health literacy, and that's another one of the areas that I didn't talk about today. When it comes to a person's own health literacy, we have so much to do in this country about that, about understanding what are the things matter and don't matter and how we can become more empowered to take control of our own health destiny.

**STEVE LEWIS:** Thank you, our next question from Jon Millard.

**QUESTION:** Thank you Steve. Jon Millard, freelance. Thank you very much, Dr Bartone, for your very wide-ranging address. Some doctors, not all of them, have come under criticism for their charging practices, charging fees and so-called gaps far in excess of either Medibank or private health insurance rebates. And here, I'm not referring to hardworking GPs like yourself, and neither to hardworking physicians, and I naturally have no experience with obstetricians or gynaecologists, but I'm certainly talking about some procedural specialists. Your predecessor has noted in this place that this can give the profession, generally, a bad name. Do you think that possibly the overall cost to the taxpayer of medicines in Australia could be significantly reduced by reducing these fees, perhaps seven or eight times the Prime Minister's salary?

**TONY BARTONE:** I think I've got the premise of your question, Jon.

[Laughter]

But, let me say this, when it comes to out-of-pockets, this is an area that really focuses the attention of all the patients and the surprises that they get. Three points. APRA data clearly shows that nearly 88 per cent of all procedures are performed at no gap. No gap. Another 7 per cent at a known gap that's less than or equal to $500, but it's identified upfront when the patient joins that health insurer. So nearly 96 per cent of episodes of care are at a no, or known gap. So that clearly we're not talking about those instances. We're talking about 1 or 2 per cent of people, perhaps, that are egregiously billing. We have publicly called them out. We will not defend them. We will not condone what they do when it comes to this. We really need to basically be very sure about this. We don't support egregious billing, we don't condone it, we don't defend it.

But the other factor that you must bear in mind when it comes to out of pockets is the reason that underpins it. You have almost decade-long non-indexation or appropriate indexation of either the Medicare schedule or the private health benefit schedule that underpins those rates

that they pay. They have not kept pace with inflation, they do not bear any relationship to the cost of provision of good medical care, and the gap has just widened and widened, not because of any egregiousness, or jealous nature on the part of our professionals involved in that area. So there's many reasons for that and we need to make sure that that is clearly understood when it comes to out of pockets.

**STEVE LEWIS:** Tim Shaw.

**QUESTION:** Thank you Steve. Doctor, Tim Shaw from Radio 2CC in Canberra. Thank you so much for your address. The Governor-General of Australia recognised a remarkable Australian doctor yesterday with the awarding of the Star of Courage and an Order of Australia medal for Dr Richard Harris. He worked together with the team of professionals to effect that extraordinary rescue out of the Thai caves. Can I draw the parallel - isn't it time that health professionals that you lead, and right across the spectrum, start working together, rather than just reliance upon government? I'm shocked to learn that some doctors in bulk billing GP practices are trying to see six patients an hour. But if you're a patient with a mental health issue, surely there's not a GP in Australia that can truly affect effective treatment in that 10-minute meeting. Can you tell our audience watching right around Australia, with one in two Australians suffering from a mental health issue, and I know that that's a very key issue in your own personal practice, how can pharmacy, how can professionals outside of that standard GP experience help those one in two Australians? Whether they be young children ages 4-17 and whether they be older Australians. Do we need some kind of co-joint meeting with the GP, with a family member and the patient? What's your recommendation, because this is a spiralling and deeply concerning problem? I don't think that Dr Harris was bulk billing for his service in Thailand. You know he wasn't. What can you, the actual practitioners, working together with the rest of our medical professionals in Australia, don't rely on a data record, don't rely on a government, they come and go. You're here to stay. What can the doctors, the nurses and the professionals do right around the industry to make Australians healthier in this journey forward? Thank you.

**TONY BARTONE:** Thank you for your question, Tim. There are many parts to that, but essentially, it really comes down to coordination, linkages between the various parts of the system. Ensuring that there is good communication and flow of information between the various parts. I talked about the long-term structural reform that we're looking towards in primary care and general practice. It's about having spec-ed up teams to deal with problems in a coordinated fashion. The GP will be at the head of that team, but be using all of the other multidisciplinary and allied health providers to their best advantage in managing the care around the patient. And that care is going to follow the patient. The patient will be at the centre of that care, whether they're in our practice, whether they're in the hospital or whether they're out in the community. We need to be coordinating that care. That's what's really important about the future evolution of general practice. We're going to do more coordination, more linkages, more bringing the various disparate parts of the health system together. Sure, the My Health Record might be one of the glues that helps that conduit of information. But it's not going to solve that. But we do need to use technology to improve and ensure more efficiency and more effectiveness. And the practice team will be front and centre, part of that solution. And yes, mental health, I can't say it enough, mental health is a significant part of my day. Patients don't come in to talk about their conditions in six minutes or less, we need to have a system that facilitates and allows that to ensure that that is the default situation.

**STEVE LEWIS:** Ladies and gentlemen, we might conclude on that note.

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