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Transcript: AMA President, Dr Tony Bartone, ABC Radio Sydney, *Focus with Cassie McCullagh,* Wednesday 30 May 2018

Subject: AMA Presidency

CASSIE MCCULLAGH: Well, the Australian Medical Association has a new President. Victorian GP Tony Bartone was elected by his peers at their National Conference at the weekend. Having been Vice President to the outgoing Michael Gannon, he comes to the role at quite a critical time with a Federal Election looming in the not too distant future. And the peak doctors group itself has a battle on a number of fronts, all kinds of issues from public hospital funding to low Medicare rebates for GPs. At the same time, the membership of the AMA itself has been falling, and that provides a challenge as well.

So, who is Tony Bartone, and what are the key things on his list of things to do? Let's find out. Dr Bartone, thanks for being with us and congratulations.

TONY BARTONE: Good morning, and thank you.

CASSIE MCCULLAGH: Now, can we start with the, well, the relationship with the Health Minister Greg Hunt. It was reported when he came to the portfolio that the first phone call he made was to the AMA, which is a great sign of respect. Have you had a chance to catch up with him?

TONY BARTONE: Yes, we've had the opportunity to catch up with the Minister and also the Shadow Minister. It's been straight down to work ensuring that the message from our conference and the message to the delegates is clearly communicated at this, as you say, very crucial time in our positioning towards the next Federal Election.

CASSIE MCCULLAGH: So, off and running. Tell us a bit about yourself. How did you come to be a doctor, where did you grow up?

TONY BARTONE: Look, I was born in Essendon, Moonee Ponds, in Melbourne, and basically lived there all my life essentially, and then set up general practice in the Northern Suburbs of Melbourne, and essentially have been in one or other general practice environments for the majority of that time, save for going back to university and doing an MBA, and then I got very, very involved and interested in medico political affairs and advocacy on behalf of my patients, and well, that's all led to today.

CASSIE MCCULLAGH: You said Moonee Ponds, is that what you said?

TONY BARTONE: Yes.

CASSIE MCCULLAGH: Yeah, yeah. And I'm just saying from your surname, is it an Italian family?

TONY BARTONE: Yes. So, my parents were both born in Italy and came out in the '50s as part of that large-scale European migration that has made Australia the multicultural country that it is today.

CASSIE MCCULLAGH: And how did you choose being a doctor, what was the spark for you, was it someone in the family kind of suggesting it to you or did you have a good doctor yourself?

TONY BARTONE: Well, you're absolutely on the money there. Our family doctor growing up was a very important member of our community, very important member of our family in terms of the access that my mum and dad in particular required at various parts of our growing up. So, with four children in the family, mum or dad needed to attend regularly there. But it was really when my dad was confined to bed, and my family doctor was coming out to see him on a regular intervals to get him through a long period of infirmary, and basically it was that dedication, that attention to detail that really motivated me to get involved in medicine in the first place.

CASSIE MCCULLAGH: Wow, what a great story. And what did you experience yourself as a GP, what's kind of- the hard part of that job?

TONY BARTONE: Look, the hard part, you might say is about, especially nowadays, is navigating a very complex system when it comes to accessing care on behalf of our patients. Patients who are becoming increasingly an older age group, becoming increasingly subject to a number of chronic illnesses. And really when it comes to accessing care whether it be in the public hospital system, in outpatients, or in allied health services, or in the amount of paperwork, or you know, accessing various programs, it's becoming increasingly more complex and more detailed and, you know, care coordination now is such a large component of what we do today in general practice. Something that really wasn't part of the equation 10, 20, 30 years ago.

CASSIE MCCULLAGH: Yes. There's so many tentacles to the job, so much paperwork and, I guess, you're dealing with problems all day long and really serious ones in many cases, and probably getting a bit annoyed by the ones that aren't so serious as well.

TONY BARTONE: Look, we- our patients come to see us when they're in need and we understand the issues that cause them to feel vulnerable and need to access health care. Need to understand that it's an opportunity to not only deal with the immediate concerns, but also to look at preventative care, develop a lifelong trusting relationship that allows them to ensure that they are comfortable about when and if they need to access care they've got that established underlying opportunity to really share that, even if it's not sometimes in a face to face manner, but it's over the phone. We've got that familiarity with their condition, that familiarity with what really causes them to be concerned. And each time they walk into the surgery we can see their manner. The way they even walk in, the way they come in, they sit down. It tells us a story and that's an ongoing lifelong journey and that's the part that I really appreciate.

CASSIE MCCULLAGH: Yeah, I guess that would be also very rewarding when you see people get better, or you just see that the difference you've been able to make while they do go through an illness can be. So yeah, I guess that is a big part of it and why so many GPs stay in the system when in fact the funding through Medicare for GPs has been an issue for some time. It was frozen for how many years was it?

TONY BARTONE: Well essentially the back half of 2013 and it's been frozen. Until then, there was a very, very tiny increase in uplift this time last year in July, but essentially the consultation freezes unfreeze in 1 July this year. So really, it's been a long time, a long time, a long burden or long constraint on the funding side in general practice and not only just through indexation freeze, but through a number of other sustained small and additional cuts or removal of funding along the way, which has created that complexity and that tightness and that

vulnerability in terms of the sustainability of some of our practices around the country, and that's what one of the messages that I'm clearly trying to relay to both sides of government to address in the lead up to the next election.

CASSIE MCCULLAGH: I know that the rate of GPs not becoming members or leaving the AMA - the Australian Medical Association - has been one of the bigger areas of the falling membership. Do you have a feeling of why that might be?

TONY BARTONE: What we know about member associations right around the world is that in this age of connectivity of being able to access more through different channels, different media, different networks, what's in it for me, the value proposition has to update and has to change and we need to see how we can become more relevant to more of the doctors out there in terms of the ones who aren't currently members and also the ones who are, to maintain that association. So clearly, it's becoming- as with all the associations of whatever profession we're talking about around the world, it's becoming a much more difficult task, but that just means we have to be a lot more strategic, a lot more understanding, a lot more aware of our members' needs and the opportunities to attract non-members.

It's often said, however, that everyone is a member of the AMA, it's just a proportion of the profession decide to pay for it.

CASSIE MCCULLAGH: I see. Okay. Now, to some of the things that you see as challenges that lie ahead, we saw on Four Corners on Monday look at the way that private insurance works and also this sort of gap between people's expectations of what their cover is going to be and what it actually is. Sometimes enormous figures that we saw people having to shell out after having an operation and thinking that they would have cover. What did you think of that?

TONY BARTONE: Look unfortunately, it was a very narrow look at what is a much more complex and much more nuanced area. So there's a number of quick points to make. Private health insurance, we've already had long discussions and long conversations out in public about the complexity, the lack of transparency, the detail, the knowledge that you need to have to try and navigate the various tens of thousands of policies that are out there. There are a number of exclusions, restrictions, which really put a barrier to value to care, to the opportunity to use the insurance product when you need it after being a member for many, many years. So that's one issue to understand.

The second issue is that the- when it comes to out-of-pockets, there are a number of drivers that really underpin the widening out-of-pocket gap that is occurring, and largely you look at both the frozen Medicare rebates, particularly in the last five years or so, but really the widening gap between what is the schedule and what are the costs of providing good quality health care, and if we look at over a 30-year margin, we've nearly seen a 2.5 times divergence of the appropriate fee for that surgery intervention, whatever. And so really it's understanding that both the Medicare Benefits Schedule and the private health insurance rebates for that intervention have largely not kept pace with the cost of providing care. So that's another point to make.

CASSIE MCCULLAGH: So what you're saying there is that while we're pointing the finger at the health insurance industry for not providing enough coverage, in fact it is the funding of the Medicare system and the public hospital system itself that is creating the shortfall, which patients are then having to pick up.

TONY BARTONE: Not so much the public hospital system, but in terms of the Medicare Benefits Schedule, and so the private health insurance funds rebates [indistinct] for any episode of care are based as a component- based on that scheduling. So really, when you're looking at a base that's already totally inadequate - and are now tying yourself to that in a way -you're essentially still going to have a situation which is not recognising the true cost of care. But the other thing to very quickly mention is that nearly 89 per cent of all private health procedures are performed by our surgeons, by our specialists, in hospitals, private hospitals, at what we call known gap. So that's on a zero cost- zero out-of-pocket and another approximately 7 per cent, so bringing the total up to 95 per cent have their procedures done at what we call a known gap - a predetermined set amount that's agreed between the insurer and the patient when they sign up for that policy.

So 95 per cent of private hospital procedures are being performed at zero or a known gap, a gap which has a maximum usually of around $500 as an actual out-of-pocket cost. The problem comes- it's all the episodes of care leading up to the private health episode that actually aren't covered by the insurance. The visits, the tests- the pathology tests, the radiology…

CASSIE MCCULLAGH: Specialists.

TONY BARTONE: …Imaging, all of those other things along the way before you actually get to have that procedure, they're not covered by your private health insurance and of course they contribute- you know in the totality of that episode of care and [indistinct] and because of the divergence, the disparity between schedules and between the cost of providing quality health care in our society, that's where a lot of the out-of-pockets is also driven.

CASSIE MCCULLAGH: So maybe the system needs to recognise that the costs can be cumulative as you're going through procedures and not just coming from one source. Just finally, Tony Bartone, what's your first port of call? What's on the top three of your list to do?

TONY BARTONE: So, just very quickly, in terms of the top three, we're looking at all the issues around access to health care in our community so be that public hospitals, be that variability of access to care in rural and regional Australia; be that in access to quality aged care facilities or in home care packages for our elderly population; be that in services for patients with mental health issues, or be that to- obviously, the inequities confronting our Aboriginal and Torres Strait Islander population when it comes to their health care. So, access number one. And general practice, I've already alluded to and that's a really significant one as well. We've talked about private health insurance, but the other area that I want to spend a large proportion of time on in the next two years is trying to get consistency and clarity around a robust training plan. So, our training pipeline is clearly under-resourced at the moment. We have been calling for a national medical workforce strategy, which basically utilises the very large and growing graduate population of new doctors coming in through the system, through the large increase in students over the last decade, by giving them the opportunity to have structured and quality training programs. And then also having the opportunity to train in rural and regional locations with the appropriate infrastructure, to allow them to become part of the workforce solution.

CASSIE MCCULLAGH: Plenty to do Tony, yeah. Busy times ahead.

TONY BARTONE: Absolutely. Looking forward to it.

TONY BARTONE: Well good luck and we'll be watching with interest as these issues develop. Thanks very much for talking to us and letting us meet you this morning.

CASSIE MCCULLAGH: It's been my pleasure, have a good day.

TONY BARTONE: Thank you. That's Dr Tony Bartone, the new President of the Australian Medical Association with what's on his agenda and some of those challenges.

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30 May 2018

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