

**SPEECH TO ADELAIDE PRESS CLUB
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PRESIDENT OF THE AMA, DR KERRY N PHELPS**

****CHECK AGAINST DELIVERY****

"A BED! A BED! MY KINGDOM FOR A HOSPITAL BED!"

Good afternoon, members of the Adelaide media, medical colleagues and other guests.

It is a pleasure to be here in Adelaide, the City of Churches, and quite appropriate, too.

We should all go out and visit each and every one of your churches to say a prayer for the state of the health system in Australia.

Divine intervention is needed.

And nowhere are the problems more evident than here in South Australia. Even your Human Services Minister, Dean Brown, has had cause to be openly critical of his coalition colleagues in the Federal Parliament over their failings in regard to health policy.

It is sometimes said that journalists spend their time chasing ambulances looking for a story.

Well, if you were an Adelaide journalist, you'd be hard pressed to get your story written because the ambulances never stop.

From what I hear, the ambulances drive around and around in the search for a hospital bed for emergency patients.

They get turned away not only from public hospitals where it has become a national pastime, especially in the capital cities, but the new thing is seeing private hospitals having to go on bypass too.

This is not a sign of a healthy health system.

In fact, I hear the ambulance traffic has meant that many Adelaide residents are beginning to think that the Grand Prix has returned to their city.

If Bosworth Field was in Adelaide today, the call from Richard the Third would be "A bed! A bed! My kingdom for a hospital bed!"

Dean Brown's recently announced Health Complaints Commissioner will certainly have his or her work cut out for them when appointed.

In its Budget Submission for 2001-2002, the AMA in South Australia has estimated that at least \$160 million extra is need to meet the basic needs of the South Australian public hospital system.

At the end of September 2000, there were 1534 patients on waiting lists for more than 12 months – up from 601 in March 1999.

There were 228 accident and emergency diversions between September 2000 and January 2001 – this number is on the rise.

Not a pretty picture for South Australia, but the same problems are being felt in the other States and Territories.

It is an enormous national problem.

The underfunding impacts, layer upon layer, on patient care. Morale in our public hospitals is as low as I have ever seen it.

There is a brain drain from the public to the private sector as conditions get harder and harder, and more and more frustrating as senior specialists struggle with limited budgets, outdated equipment and the daily agony of deciding which patients will get care to fit into artificially tight budgets rather than community needs.

Once, only a few short years ago, senior specialists would not dream of working only in the private sector. Now it is becoming more and more likely to hear of talented surgeons, obstetricians and physicians walking away from the public hospitals because it is just too hard. This is a tragedy which may take generations to turn around, if ever. We do not want to see a two-tier health system... one for the "haves" and one for the "have-nots".

There are no hospital beds for emergency patients.

The ambulances are doing laps of the city.

Aged care services are at breaking point.

And, as already mentioned, there are waiting lists of more than a year for elective surgery.

Add to this the broader problems of an outdated Medicare that is failing doctors and patients, the creeping corporatisation of medical practice, and medical indemnity, and it is clear we have a few problems.

Add in unnecessary meddling by the notorious ACCC.

Then there are the moves from certain quarters to embrace things like blended payments and fundholding, and you can see all the signs of managed care – and the problem grows.

Then throw in a Health Minister who has filed the Relative Value Study (RVS) in his bottom drawer – a Health Minister intent on causing divisions in the medical profession – and we have a huge problem.

The Federal Health Minister has said - and I think he was trying to score points - that he is not the Minister for Doctors.

Well, at the risk of stating the obvious...you can't run a health system without looking after the interests of the doctors and nurses working in it.

They tried that in the UK and now they are finding that they have run short of doctors to the extent that they are having to offer big incentives to retired GPs to go back to work, and trawling the colonies for doctors to make up the shortfall. The other obvious issue is this...who is the Minister for Patients? The two issues go hand in hand.

The AMA supported the Government's support for the private health system. Not only did it encourage choice but it has the real prospect of eventually relieving some of the pressure on the public system. But the public system still needs a lot of catch-up funding.

Our health system has the basic fundamentals pretty right, but it is in need of renovation. Not a patch-up job covering the cracks, but some serious policy work and substantial funding.

The Australian people are not interested in band-aid solutions when corrective surgery is needed. But that's all we've been getting – band-aids.

And we are not even talking about quality band-aids. They are the cheap and nasty ones that look like they might work but peel off very quickly, having done nothing to help heal the damage underneath.

One example of this band-aid approach is last week's 50 cent Medicare rebate top-up from a packet of band-aids called the MoU or Memorandum of Understanding.

The song and dance made of the 50 cents was remarkable considering that this was money that belonged to general practice patients from last year's Budget that was underspent.

I will explain why this little exercise needs to be renamed the MoM...the Memorandum of Misunderstanding.

Why Misunderstanding? Because the Minister is talking to the wrong organisations about GP financing.

Dr Wooldridge has made much of the liaison between the three MoU organisations who are fondly referred to in AMA circles as the three MoU sketeers, and used their involvement in discussions on GP financing as a claim that he has the support of the profession in this exercise.

To test this notion, the AMA conducted a survey last week asking GPs - members and non-members, urban and rural - who they wanted leading any discussions with government.

The MoUsketeers scored 5.8% for the college of general practitioners, 3% for the Rural Doctors Association and a massive 1.2% for the Australian Divisions of General Practice.

In contrast, the group excluded by the Minister from discussions on general practice - the AMA - scored over 80%. THAT's what I call a mandate. And THAT's why the Memorandum of Misunderstanding is a cynical exercise.

The only solution is for the MoUsketeers to decline any further involvement in the exercise and insist that the wishes of GPs are honoured – that the AMA lead discussions in consultation with the other GP groups.

Until that happens, the MoM exercise is nothing more than a band-aid.

And this is why the AMA will continue to push for real and lasting solutions to the crises facing the delivery of quality health and medical services in Australia.

We will continue to support the RACGP in its proper role in dealing with education and training. We support the role of the DIVISIONS in GP education and service delivery and we will continue to work with the RDAA on important rural health issues.

The Relative Value Study – the RVS – is at the top of the list of AMA priorities.

We will push for implementation of the RVS in the May Budget.

The RVS has been an exhaustive seven-year study started under the Labor Government and continued under the present Coalition Government.

The RVS is really the Medicare survival kit.

It is the first comprehensive review of the Medicare Benefits Schedule of fees – the MBS - since its inception nearly thirty years ago.

The AMA has been saying for some time now that the MBS is grossly outdated. Because the entire system of health funding, both private and public in this country is based on the numbers in the schedule, then you can see how important it is to get it right.

The RVS is about long term solutions, not short term fixes – not the band-aid approach.

The AMA sees implementing the RVS as fundamental to the survival of the Australian health care system for at least the next 20 years or so. Doctors, like any workers, want adequate remuneration for their efforts. In fact 'adequate' is just not good enough.

For a GP or other specialist to reach the stage in their career where they can practice independently, it takes six to eight years of university study, at least two years basic hospital training, and then four or five years of advanced training.

Throughout their postgraduate training, the hours are long, the work emotionally and physically tough and the responsibility for human life immense.

The RVS is not just about remuneration for doctors.

It is about maintaining high quality accessible and affordable health care for all Australians.

It is about rejecting the American system that you see on shows like **Chicago Hope** every week.

In effect, the RVS means Medicare and the preservation of Australia's universal health care system – access to quality, affordable health care regardless of means.

It will provide security and certainty for doctors and patients well into the future. It is the best chance we have – for the foreseeable future – to put some science into working out where the MBS should be.

If the RVS is ignored in the May Budget, we will push all the way to the next election and beyond.

As the AMA is the only truly independent voice for doctors in this country, we have a considerable voice in the community and we have the best sources of information about the state of the health system – doctors and patients.

The doctors in the suburbs and the country towns, in general practice and in hospitals, the specialists, the students, the researchers, AMA members and non-members, are all telling us the same thing – the health system is sick and it needs help.

Doctors are being forced out of general practice by rising costs and falling incomes. Many are looking to the corporates, others are leaving the profession altogether.

These are all good people committed to their patients who find it is just getting too hard to keep their practices viable to provide the level of service that patients want and deserve.

Like the banks, the post offices, the government agencies and Telstra jobs before them, the traditional Australian family practices are disappearing from the landscape.

It is the result of a health system in trouble, a health system in urgent need of a check-up and revival.

Any prescription should have discussion of the full and immediate implementation of the RVS at its heart.

So far there has not been any serious response by the Minister to the findings of the Relative Value Study. The cone of silence has descended.

What we can expect to see is some cherry picking of a few items here and there. But this approach will not be accepted by the profession.

The Government used the AMA's goodwill to bring the Study to a premature conclusion and to reach compromise positions on a large number of matters and to leave others matters in the 'disagreed' basket.

Now, after four months of silence, it is clear there was no goodwill on the Minister's side.

If the AMA had not compromised and the Consultants were allowed to come to conclusions on disagreed matters, a 15 minute GP consultation could have come out at around \$57.00 - not the \$44.00 we have discussed.

Since the Government won't reconvene the Medicare Schedule Review Board to finalise these matters, the AMA has decided to reconvene its representatives on the Board to finalise them.

We need an outcome that is realistic for all medical services and which moves extra money into the consultation based parts of the Schedule, and the government must respond to this so that patients' gaps do not blow out.

The AMA believes the implementation of the RVS is essential to the future of Medicare.

It can't be done with just words. It needs money and whichever party is in government after the next election, they cannot afford to ignore it.

As I said, the Government last week announced a 50 cent increase in the MBS fee for a Level B consult the other day and increases in the after hours rebates. There is no doubt that the after hours increases are welcome, but it is simply returning some of the funding that was stripped out of after hours rebates years ago, which was largely responsible for GPs giving it up after-hours work.

We could have told them that would happen at the time – in fact, I think we did! And the money was owed to GPs because the budget had been underspent.

This is just fiddling at the edges. And, it was all brought about because the volume of services is temporarily relatively flat.

If the volume of services picks up under the Memorandum of Misunderstanding there will need to be cuts in rebates.

When this happens, one assumes the Government will not announce that decision as triumphantly.

Of course the three medical organisations which have signed the MoU will be required to stand beside the Government to announce any rebate cuts just as they

have stood by to announce the increases.

It will be interesting to see how their members judge them then. In our fax poll, around 95% of doctors want the RVS implemented. They want recognition of their work. They don't want the scraps from the table.

Speaking of scraps from the table, I'd like to return now briefly to the public hospital issue.

Public Hospitals

According to the Prime Minister, what to do with public hospitals is one of the most difficult public policy issues he has confronted.

Down here, it would seem that private hospitals are getting closer and closer to the policy 'too-hard basket' as well.

We don't have a national policy on public hospitals in Australia. There is no national set of standards for our public hospitals.

Each state funds its hospitals differently. Each state funds its hospitals at different levels. They are organised differently. They count things differently. They report differently, they give access differently, and they cost shift and blame shift differently.

They have different beds per population ratios, different waiting times and numbers, and different admissions per population.

The Senate Community Affairs References Committee looked at this problem. It recommended that governments tackle these difficult issues and come to some resolution.

Several of their recommendations suggest that the Australian health care agreements should be broadened out to cover other health programs and that representatives of health professionals, for example, should be included in the discussions.

It also recommended that an extra \$450 million a year be injected into the public hospital system to offset the serious underfunding which they observed – half the cost to be borne by the States and half by the Commonwealth.

Looking at the South Australian wish list, that \$450 million will not go very far nationally.

We need national standards against which the performance of the public hospital system can be judged. And so that the States are accountable for the health funding they receive under the Federal State agreement... or perhaps a better description is the Federal State Disagreement, because every time there is a problem each blames the other for the shortfalls.

And we need better ways to integrate the private hospital system into the overall health picture.

It is obvious that public hospitals will be a major issue in both the Federal election and the South Australian election. The AMA will be lobbying for responsible policies for the long term in this area.

Medical indemnity

An issue that has been prominent in the eastern States is the number of doctors suffering under the weight of medical indemnity insurance premiums.

The full magnitude of this problem has not been felt here yet. There are some protections for country doctors, I believe, but city doctors are starting to come under more pressure.

The AMA in South Australia has made calls for tort law reform, something that the Federal AMA and AMA (NSW) have had success with in negotiations with the NSW Government.

We hope the other states will follow suit and that the NSW initiatives lead to further reform.

The blowout in premiums is being driven by relatively few but an increasing number of very high cost awards – some over \$10 million – which the system just cannot afford.

However, often plaintiffs get nothing or very little, and legal costs absorb over half most awards.

Only one-third of doctor indemnity premiums go to compensation awards to patients injured by negligence. The rest goes to lawyers and administration.

The system is slow, costly, unpredictable and frequently unfair to the patient, the doctor, or both.

Because of this situation, some areas of Australia are seeing not just services disappear, but doctors too.

At a Federal level, we are pushing for a system of structured settlements for indemnity cases to allow periodic payments to replace lump sum awards.

This involves relatively easy change to the taxation system.

As we speak, officers of the AMA are speaking with the Federal Government about this very issue.

In the time I have left, I'd like to touch on some issues that are great threats to the unique nature of our health system.

Managed care

The Chicago Hope-style of medicine – otherwise known as managed care - is of enormous concern to the AMA and should never be allowed to gain a foothold in Australia.

The hospital is called "Hope" because in the USA if you get sick you just have to "hope" your health insurance is paid up.

Managed care is an example of outside influences placing undue pressure on the doctor-patient relationship.

In Australia, we don't want US Supreme Court decisions like the one reported in *The Australian* on Monday - and originally in the *Medical Journal of Australia* - in which the court ruled that a doctor's obligation to making profits for an employer is more important than a patient's wellbeing.

This is what managed care is all about. Telling doctors to meet targets and ration treatment to deliver the best results for the shareholders, not the best outcome for the patients.

This is not good for Australia. This approach has to be rejected at all costs.

Australian Governments must be convinced to go down the RVS path, the preservation of Medicare path.

Protections against US managed care in Australia - such as a universal and accessible Medicare – with a strong public system parallel to the private system - are being worn down.

The Medicare Benefits Schedule is increasingly capped and more and more restrictions, hurdles and bureaucratic obstacles are put in the way of patients receiving the care they need.

In the US, six giant health insurance companies now dominate the health insurance marketplace. If a doctor doesn't have a contract with one of these companies, he or she is out of business.

These organisations could not even be described as health insurance companies. They dictate the level of care a patient can receive based on cost.

Doctors and patients are in a take it or leave it situation. The company's imperative is to cut costs and boost profits. The doctor's is to deliver high quality care. It is an inevitable collision course.

Restrictions on care are not transparent to the patient and the doctor is in breach of the plan requirements if he or she advises the patient of these restrictions.

All the talk in the US is about a patient Bill of Rights to counteract this.

Surely it is not necessary for us in Australia to go down that path before we realise it is too late to turn back.

The fundamental transaction in the health system is the relationship between the doctor and the patient.

The more we interpose payers, Governments, bureaucrats, red tape and restrictions on the relationship, the more we diminish it with inevitable consequences.

The AMA believes in the fundamental doctor-patient relationship. It is worth fighting for. We have and will continue to fight to defend it.

This will take vigilance over the behaviour of the Health Insurance Fund and vigilance over the activity of the growing corporate medical entities.

Something else the AMA is vigorously defending doctors against is the unfair application of the Trade Practices Act by the ACCC.

Competition policy

The Chair of the ACCC, Mr Fels, has accused the AMA of running a scare campaign of misinformation to rural doctors.

The only people scared are the doctors who have to become trade practices experts if they are to work cooperatively with colleagues on rosters, work sharing, negotiating with hospitals or determining which patients to bulk-bill.

The Trade Practices Act was designed to control large corporations, not discriminate against individual doctors, and the ACCC simply does not understand how medical practice works.

Why is it corporate practices can vertically integrate and set their own fees, but a group of individual doctors working as associates in the same practice sharing premises, staff, even a computer system are not allowed to even discuss their fees, and a group of doctors in a country town can't get together to discuss rosters, share workloads, or negotiate with hospitals without risking breaching the Act?

That is why the AMA and the Rural Doctors Association of Australia are calling for an independent inquiry into the impact of the Trade Practices Act.

Last week Mr Fels told a Parliamentary committee in Canberra that country doctors should seek authorisations when setting up work rosters.

But a separate authorisation would be need for every specific situation. Each authorisation costs, conservatively, \$25,000 when you include legal fees.

This is a very time consuming and costly process that ~~would be time consuming and~~ would have little chance of success in easing the overall burden on doctors. It could even exacerbate their problems.

The ACCC says it does not operate by threats. They say they haven't prosecuted any rural doctors...yet! This is all very reassuring.

Meanwhile, behind the scenes they tell groups like the AMA in Western Australia that if they try to represent doctors in their negotiations with rural area health services they will be taken to court to test crown immunity.

The AMA in WA is already up for several hundred thousand dollars in legal fees and is now facing a fine of up to \$250,000 for trying to assist the State Government to attract doctors to a peripheral hospital by negotiating an acceptable contract for specialists.

The problem is that part way through the process the hospital was privatised and crown immunity ceased – so they got them on a technicality.

Our rural doctors are up in arms. We are told of situations like the doctors in the NSW Riverina who are too intimidated to turn up to meetings to discuss the problems in their health system for fear that there will be a conversation about rosters or fees or contracts and they will be prosecuted by the ACCC.

They cannot ask the AMA to represent them as a group unless they pay for one of Mr Fels' authorisations or risk a prosecution.

The Trade Practices Act is an unnecessary burden on many facets of the health system.

Conclusion

I hope I have made it clear to you today that the Australian health system is at the crossroads.

Here in South Australia, you are seeing clearly all the evidence of a system in trouble. It is the same all across the country.

It needs national solutions. It needs long term solutions.

The AMA has presented its case to the Federal Government, to the Opposition, and to other parties.

We will continue to do so all the way to election day.

We can only hope that whichever party is in Government after the next election that they are committed to building a health system that best serves not only this generation, but the next, and is prepared to listen to the real experts – the doctors, nurses and health care workers. And, most importantly, they must listen to the patients.

We need a health system that works in the best interests of all Australians. A healthy nation is a productive nation.

Thank you.

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