

*College of Health and Biomedicine Dean's Lecture Series*

**Thinking beyond the "system"**

**How can we put consumers at the centre of health care?**

**Speech by The Honourable Nicola Roxon**

**Chair of the Sir Zelman Cowen Centre, VU**

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Acknowledgements – traditional owners of the land

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Thank you for that introduction and for the invitation to deliver the Dean's lecture.

As mentioned, I very much enjoy my role at the Sir Zelman Cowen Centre, keeping in touch with my legal background and so many cutting edge community issues in the law – working with Islamic communities to assist them with a deeper understanding of Australian law & considering the opportunities technology provides for dispute resolution are just some of the great projects Professor Laster has introduced as the Director of the Centre.

Outside VU, I'm still very involved in health – as a Director of Bupa (the health insurer and health care company) and as Chair of Cancer Council Australia plus I do quite a lot of tobacco control advocacy around the world, for the WHO & Blommborg, so I have some perspective of other health systems as well. In fact, I am heading to Canada in a fortnight to try and assist their new government in introducing plain packaging as well.

I must emphasise, however, that the views I express today are decidedly my own.

I tell you of these other roles for two reasons – firstly, so that other organisations cannot be held accountable for my personal views but secondly,

as my comments stem from a broad understanding of the health system, not just my perspective gained in politics.

Australia's health system is the envy of the world. For all the noise and anxiety, we are impressively cared for & generously supported by our fellow taxpayers. We have amazing quality of life and long life expectancy.

Much, although not all, of this is due to our quality health care system - we are also blessed by good weather, lots of fresh produce, clean air, high standards of safety in our workplaces and roads, good sanitation and a strong obsession for sport. (Although arguably we could do more on the playing, rather than just watching, of sport!)

These natural advantages have been enhanced over many decades by the development of well-educated health professionals, effective immunisation programs, strong public health regimes, funding for world class medicines and technology – & all these play an undeniable part in helping us achieve great health outcomes nationwide. Undeniably as well - our universal Medicare system has helped to ensure everyone, rich and poor, can or should get quality medical care.

Given things are so rosy in comparative terms, shouldn't we just keep doing what we are doing already?

Personally, I don't believe we can. We must take care to cherish the good components of our health care provision but we must constantly be on guard for advances. We must understand and deliver those improvements by constant learning, and by listening more to patients. So many patients and their families feel poorly treated or ignored, inequities are rife & the costs to consumer and government alike are potentially unsustainable. There is no point being proud of a system if we won't be able to find ways for it to continue to deliver.

I want to ask - what role does the next generation of health professionals play in battling these problems and shaping the future?

Its wonderful to be asked to give a lecture like this at VU – where the University's vision for health is developing as a key part of its Centenary celebrations and plans for the future.

It allows us to reflect on the role institutions like ours can play in giving the next generation staff their fabulous professional and technical skills, but also our obligation to give them the ability to think about the context they work in, the big picture.

For example, I can confidently assert that surgeons and physios and occupational therapists are not trained in media or public health campaigns – but they feature in TAC ads because they are well aware of the health consequences of car accidents. Every day they are exposed to the consequences of poor driving or dangerous practices. Although they want to care for those injured, those health professionals also want to help prevent harm in the first place, and be part of educating or changing the broader community - not only through their technical skills applied to individual patients.

This is just one example of thinking beyond current patients, more broadly to all those who might in the future become patients – it's a small example that provides a window into a bigger discussion: asking whether we need to train our health professionals more about the context and community they work in?

Once we look more critically and more deeply at our system we see those national statistics, which we are rightly proud of, hide a different story. In truth, the story is unbearably patchy – if you are indigenous, if you live in a small regional town, if you have a disability, if English is not your first language, if you are poor – your health outcomes are still so much worse than the rest of the country's.

And this is with all our natural benefits and a system committed to delivery universal high quality to care at no cost or minimal cost to the consumer.

In some cases these different outcomes are so devastatingly bad, that our results rank us amongst those in developing & low income countries. Did you know, according to the Heart Foundation, indigenous Australians are 19 time more likely to die or acute rheumatic fever and chronic rheumatic heart disease than non-indigenous Australians? Can't we do better than this?

The fact is, that we are both incredibly well served by our health system and that it has some catastrophically unfair gaps.

So my speech today tackles the questions of why, when there is so much good in the system, we can't provide a better experience for patients? And why is it that we fail to reach all groups? Given that there have been so many attempts over the years to reform "the system" in both big and small ways, do we actually need to approach this differently?

My hypothesis is, if we go back to the basics of asking what delivers better care and outcomes for patients, we will resolve more of our problems. But it takes listening to patients and insight to act on it. And it will take health professionals to truly decide it is also in their interests to advocate for patient benefit – a focus which will be beyond merely their own conditions or particular professional considerations.

With that sort of introduction, you might expect my speech to circle around the perennial health debates – doctors v nurses, public vs private, states & territories v commonwealth, government funding v charitable funding v no funding, medicare v insurance, hospitals v primary care, Liberal v Labor, House v Senate, big parties v independents ....interesting as these conflicts often are, I want to step beyond all of these and try and ask a more fundamental question:

- How can we ensure patients get a better deal?
- How do we listen to them more & learn?
- If we do this properly, can we get better outcomes & spend our health dollar more effectively?
- What can health professionals do to make this happen?

My topic, hopefully appropriate given I am addressing a school responsible for training top quality health professionals, is to ask how to we put the patient/ the consumer in the centre of all these discussions?

If we always try to solve the problems from the system perspective, rather than the consumer perspective, it is impossible not to be swayed by those substantial stakeholders other than patients. The patients, with a few exceptions, find it very hard to be heard within our health system and health debate.

I want to explore these issues through three examples:

- (1) How health professionals use evidence, research and data (or don't, as the case may be) and keep this base knowledge up to date throughout their working lives, so patients get best practice care
- (2) How we can improve outcomes by listening more to patients (and whether technology can turbo charge this?)
- (3) The great opportunity that exists for health professionals to play a leadership role in tackling some of the perennial problems in our health care system.

I hope that through these examples – just a select few of what could be many more - health professionals will see the unique possibility they have to help shape an even stronger and more effective health system for patients. Indeed, I hope to urge health professionals to see the unique responsibility they have to help break the deadlocks that so often occur in our system.

(1)

Health professionals, while they are studying, are heavily focussed on learning – what the evidence shows, how procedures work. Very focussed on this while studying, but I believe it is fair to query whether we are teaching them, or equipping them, with the skills and built-in understanding that such study will be constantly required. That evidence will change and grow – that best practice will be updated and in order to be the best professional, giving the patient the best, you will need to keep learning too.

We all know the example of the nurse or physio saying casually to a parent or grandparent in rehab after knee or hip surgery, “Oh yes, surgeon X’s patients always recover more quickly.” Not just a passing comment, as it turns out, because the data shows there is vast variation in recovery times for hip surgery done the new or old way, but who knew? The staff know. The insurers know. Anyone paying for large numbers of surgeries can see the variation.

In this example, there are surgeons persisting with older practices that they know well, although they have significantly less desirable outcomes for the patient. Why does this continue? Is there any way for a patient to know & choose?

Surely we as patients are entitled to know this before, not after, our surgery? How do the GPs find out – the people we so often trust to guide us through the system? Why couldn't this data be available? Or the best/ updated practice be understood and implemented?

Notions of privacy seem to stop this information being released. There is reticence for non-professionals to make this clear. Perhaps there are even financial incentives for some facilities to keep this quiet, as they get paid for the longer periods a patient is in rehab care.

I can't see why we prioritise protecting the surgeon's privacy (in terms of not releasing data) rather than the patients' outcome – and indeed how are longer recovery times good for the patient or the taxpayer? If you are not a health professional, it can be difficult to have line of sight & if you are a health professional, you may feel under pressure or with an incentive to keep the system as it is.

A cancer case study shows both the strengths and inequities of the system. The example is courtesy of the work of Professor Sanchia Aranda, CEO of Cancer Council Australia.

As many of you would know, cancer outcomes in Australia are amongst the best in the world. BUT, it is still a lottery.

The upside of our story is that Australians have a 67%, five year survival rate, stabilising incidence of cancer and we are reducing mortality.

That is - unless!

- you are aboriginal
- you are poor
- you live a long way from a tertiary treatment centre
- you have a rare cancer
- you have lung cancer

Consider this interesting piece of research. NSW has conducted detailed work to show the link between outcomes & volume, if you need complex surgery for two rare types of cancers, oesophageal and pancreatic. The first report in 2011

showed better outcomes when surgery was conducted at hospitals where there were higher volumes of such surgery.

It is clear that the idea of making such surgery available at more places, closer to people's homes, is not delivering better outcomes for patients. Here, we are failing the individual patients who get less optimal care – although it challenges the notion of access and availability, matters we rightly care about too.

Is it right for patients if the system supports or encourages access to such surgery in more and more places, even if their outcomes are likely to be worse? Are the health professionals really putting the patient first in such situations? Would the GP refer to these staff or hospitals if they knew this data? Is the patient being asked?

Such research is vital – it can provide health professionals and consumers with better information and help us all make better decisions about our treatment choices, which give us better outcomes and which have an impact on the effective use of scarce resources. Perhaps, for some, being close to home really matters, but one could guess the weighing up of options for most patients would be very different if this outcomes data was up in lights.

Some of the cancers with the poorest outcome have the lowest investment in research and service delivery models. Much of the variation in outcomes relates to system factors including clinical variation – so how we educate our health professionals to access research as it becomes available is an ongoing challenge.

And if a whole group of professionals look to be wilfully ignoring such evidence – surely we need to say something? Do something? But what?

An example was revealed in media coverage in June this year showing the extremely high cost of non-evidence based prostate cancer surgery. The Sydney Morning Herald reported “Cancer patients are being charged exorbitant out-of-pocket costs for “flashy” surgeries by doctors who are not disclosing the full financial burden or equally effective alternatives in the public system, cancer experts say.”

The most brazen example quoted by Professors Currow and Aranda in their

research was the use of robotic surgery for prostate cancer (with out of pocket costs to the patient of around \$10-15,000) but no evidence of better outcomes than a standard prostatectomy. They published an article in the MJA looking at “financial toxicity” which flows from such choices being pushed on patients, and is well worth a read.

I noticed there was a separate, but almost identical, patient story from Queensland in the papers just this week.

This is not only failing to keep up with good evidence & data, not only failing to inform consumers properly and making significant financial gain for continuing to ignore such evidence – but I would argue it is also highly unprofessional conduct.

Can we train our health professionals to look out for and avoid such behaviour? Who are the people that can speak out and change this?

To know that some consumers are taking drastic action, like mortgaging their houses to pay thousands of dollars for particular surgery, yet not be told that, although your doctor might be recommending it, there is actually no evidence to show this costly procedure is not superior to more affordable alternatives, is pretty terrible. I’ve seen families put in similar overwhelming financial stress trying to pay for medicines that have not yet been shown to be effective.

It becomes a big challenge to you – as next generation health professionals or those training them – to think how you will shape your vital community role in this regard. How will you treat the patient to the best of your ability, keep up to date with data, communicate honestly about interventions, their cost and their likelihood for success.

Training people to both work effectively in the system and be able to think what needs to change in the system can be very tricky. But I would argue it is worth the effort.

To date we have seen health professional bodies, largely regulating their own professions, are mostly unable or ineffective at stamping out such behaviour. If the consumer lens were used more often, the right course of action to take would be much more obvious.



It isn't a surprise to me that it is often nurses, and non-medical health professionals, who are the ones who identify many of these issues, work to devise better solutions and regularly speak up about problems.

We need to ensure we equip all our new health graduates to do this well, and not be afraid of any power structures which might try to impose a professional hierarchy beyond what is truly needed to manage care well. A more appropriate hierarchy is to put the patient at the top, and identify the need to speak out and speak up for patients.

(2)

The next area to explore – which has a huge impact on how we train health professionals - is how we can improve outcomes for patients, by listening more to them.

End of life care is an extremely important, topical and sensitive example of the system spectacularly ignoring what so many consumers clearly want.

Leaving aside the more vexed question of euthanasia, we see the most basic preferences of families & loved ones being routinely ignored or overruled – ironically, to both the annoyance and despair of families and at great cost to the “system” and the community.

This must be a no-brainer – why can't we change the focus here?

Australian Centre for Health Research (ACHR) has done some brilliant work in this area. Their research shows that although 70% of Australians express a preference to die at home, only 14% actually do. This is a big gap! This gap is too big to be explained away by some unique or particular circumstances and indeed is an obvious trend that we don't provide well at all for consumer choice in this area.

Given that deaths of younger people are now relatively rare (2/3rds of Australians die between 75-95) we know most deaths are expected – yet we haven't found a way to help people die well in terms of “dignity, choice and support to address their physical, personal, psychological, social and spiritual needs.”

ACHR is exploring some novel ways to successfully promote this discussion – through things like their campaign to “Death over Dinner” – a consumer movement to help people talk, over the comforts of dinner, with family and friends about this very taboo subject. Consumers and families are trying to drive this change – but health professionals, lawyers and the system can often work against this.

On a financing front, Medicare doesn’t even have an item number for End of Life Care conversations.

In our education, query whether we teach health professionals how to have these conversations appropriately – this takes skill and practice and sensitivity, but these are all things that can be learned. They can be learned, of course, provided we think it is important to teach it ...

The ACHR report quotes Dr Ashleigh Witt, a doctor in our region training at Western Health to be geriatrician who says’

“Palliation is hard for many doctors because they like to fix things. They like cures. [my aside, this could be said for governments too ...] They are excellent at saving lives, but struggle to accept they cannot save everyone. But death is natural. Death of old, frail people is very natural. We aren’t supposed to live forever and having a peaceful death with family present is a wonderful thing. A good death is as important as a successful resuscitation.”

This is a community issue as much as one for the health system – but health professionals of all types do need to be able to grapple with it. They are centrally placed to add maturity and content to the conversation.

As Health Minister I heard many anecdotes about doctors who don’t want to be the ones “to destroy hope” – but often they, inadvertently or not, instead misled people, gave them false hope, prevent them & their families from being able to plan & care properly for those precious last days or months.

It may seem cruel to “destroy hope,” but I would argue it is also cruel to give people false hope – to leave families feeling they are making terrible choices (sell their house for an expensive speculative treatment), when really the options have little if no prospect of success.

Another example of trying to build better services around people, not to just fit within “the system” is one I have been proud to observe at BUPA, with the model of care embedding doctors within an aged care facility (now in around 30 homes across the country). This is showing really promising signs of the benefits for the quality and consistency of care, at a time when residential aged care patients are coming into care often older and sicker (many with dementia, making their care at home extremely difficult).

Yet funding is not really designed to encourage this, in fact it is moving the other way with a push to pay less for those with very high needs. If there is less quality care easily available in homes (whether through nurses, doctors or other skilled professionals), we know the risk of needing to send residents to hospital is higher – we know the cost of ambulance and hospital care is higher to the community, and most importantly, is often far less comfortable and convenient for the patient or the family.

If we listened to consumer, or looked at outcomes for resident and patients – this is a good type of care. Overall, there are also benefits to the system – but the existing programs are a clumsy way to deliver it and it is difficult to find out how to tap into it properly. It is one of those challenging areas where the patient experience is not always considered first in the health care debate, because it falls into the federation vortex – a saving to state hospitals, but a cost to the Commonwealth through aged care ... a common recipe for inertia.

Similarly, I love the idea of a “living laboratory” at VU, the Centre for Chronic Disease Prevention and Management, trying to conduct research right in the community with high rates of chronic disease, looking for solutions that are about solving the real problems in this community, right now.

We also must not underestimate the strategic advantage we have with a very diverse student base and surrounding community. Patient driven care requires deeper sensitivity to diversity – and VU’s ability to use this diversity of background and life experience to produce health professionals with the ability to think outside the square is crucial, and exciting.

I am also convinced it is the consumer that will drive the biggest disruption in health care – and that technology is likely to turbo charge this effect.

This is not to downplay the amazing breakthroughs in technology providing potential for remote diagnosis, consultations, medication compliance supervised over skype, treatment and movement monitored at home and the wonder of what virtual reality might deliver in nursing homes.

At the very least, today's health professionals must be trained and ready to cope with change and learn how to be comfortable with and early adapters of new technology to ensure patients gain the full benefit of these breakthroughs. Health professionals mustn't feel threatened by such change, but rather ready to be an enabler to help support better outcomes.

But, ultimately, the most disruptive technology will be that which is giving the consumer something they want and can't currently get.

As my case study here, I'd like to take the time to discuss Whitecoat – a website & app established by the insurer, nib, to explore where the consumer movement, backed by technology might take us. Its an interesting innovation – best described as a type of TripAdvisor for health professionals – it provides consumer information and moderated consumer rankings for a growing number of health professionals.

This started as product of NIB – but I should declare that BUPA (and HBF) have also recently announced they will be part of this website, although the data and information that I am using is based on NIB experience and what has been in the media, mainly from their CEO Mark Fitzgibbon.

Anyone can consult the website, which provides contact details and cost comparisons for about 40,000 healthcare providers in Australia.

As nib describes it "Every time an insured customer visits an extras provider and we pay a claim, we send the customer an email and asking them to give us feedback on our experience. That feedback will be put through a robust moderation process, but about 85 per cent of the comments end up on the Whitecoat website." The ratings will be moderated according to guidelines set and monitored by the NIB in order to safeguard healthcare specialists.

It is probably easiest to quote Mark Fitzgibbon from the AFR to explain further:

“There's far too much evidence of avoidable hospital admissions, unreasonable costs, "out of pockets" and unwarranted variations in treatment. Our chances of having a major joint replaced can vary for no reason other than where we live and the doctor we choose.

The most significant factor behind this inefficiency is the weak position of healthcare consumers compared to sellers. In most other markets as a consumer, I generally have as much information about my needs and preferences as the seller. Healthcare is very different. Typically, I'll simply defer to whatever the doctor or dentist proposes, acknowledging their superior knowledge of the condition I have and treatment options. Economists describe this as "information asymmetry" – lay people call it "doctor knows best".

Tackling information asymmetry, and putting relevant information on consumers' desktops or mobile devices has led to a digital platform and directory [we call "Whitecoat"](#). Not unlike Trip Advisor, it allows consumers to search, find and book a clinical provider as well as review and share their experience. Already it hosts over 40,000 providers (thus far mainly allied providers such as dentists) and shares 250,000 patient reviews.

It's an overdue win-win-win for the three "Ps" – patients providers and payers. “

You may be disappointed, but probably not surprised, about the predictable, initial objections almost immediately from dentists, doctors and others – howling that consumers are not health specialists, so how can they fairly rate professionals, why should their rankings matter etc etc. There were loud and immediate objections from the AMA & ADA in 2011 & 2013 and again this year as Whitecoat gradually grows bigger and reaches further.

Surely the professionals are forgetting some basics here? Patients can easily, accurately and appropriately rank them on many things – the cost of the service, delays getting an appointment or on the day, style of communication and much more. Mark Metherell of the Consumers health forum notes "it has been very hard to bring providers in the health sphere up to the same level of transparency on fees that we expect in every other occupation group."

Consumers are the ultimate experts in all these matters and health professionals are slow if they think they should not have to cope with this sort of assessment.

And there is now ample evidence that the level of consumer comfort and the consumer experience can actually have a positive health impact – not least because people more readily comply and attend as needed!

There has been strong praise from the little heard Consumers Health Forum. (It would be a nice research project to compare the finances available for the ADA or AMA or ANF for advocacy, lobbying or media, compared to the consumer forums. Its is easy to see who has more resources, but perhaps technology will change this as sheer numbers deliver a different impact. Of course, that means consumers must engage. )

Of course we know some objections are real – people with problems complain more than those who are happy with service – just ask any restaurant or hotel. But unlike restaurants and hotels, health professionals have a good alternative here. They could advocate for the release of rigorously measured and collected performance data that Medicare and health insurers hold (as do many hospitals & other large service providers). To date, they have vehemently opposed the release of materials, whether de-identified or not.

This is part of a larger problem about lack of transparency, not just for professionals, but for institutions too. Its hard to drive effective reforms for consumers when so much information is behind closed doors. This was a component of my thinking when we established the *National Performance Authority & National Pricing Authority* which I noticed are due for the chop as part of the current Omnibus measures before the Parliament. Although I don't like it, I do understand why governments consider cost savings by cutting institutions, rather than services, but I would hope care is being taken to keep undertaking the valuable work itself and look at how to use it even more for the benefit of consumers and taxpayers.

Luckily, we are seeing many allied health professionals, embracing this more consumer facing approach. As the app has had more coverage, we are also reportedly seeing some doctors bucking the trend and willingly signing up.

Again, what this underscores in terms of training of next generation health professionals is that other skills matter – communication, running a business, explaining costs and processes is all part of being a competent health professional.

And, really, we must embrace the obvious concept that consumers are entitled to know and share information about cost, relative cost and their opinion on value. Technology is making this easy and convenient to access. I truly hope Whitecoat or other such initiatives can make it clear that this level of transparency is unavoidable and valuable for the patient.

(3)

So:

- if we embed the lessons from research properly into our systems of care, and remember to continuously refresh this, we will improve the situation for patients
- If we listen to patients more – we will deliver better care by respecting their choices. In many instances, this will better meet their needs and be a less intrusive and less expensive level of care.
- If we are unafraid to transparency and feedback, we will ultimately lift standard of care

So if we do manage to train our health professionals to expect and embrace ongoing learning and the value of listening to patients, will this be enough to drive change to the system?

In my opinion, there is another remaining layer – and that is for health professionals to understand how the payment systems and costs work across the system. This is a big ask – let me explain what I mean because it adds a layer of complexity.

The health professional is trained to do their best and want the very best for that individual patient in front of them at the moment that they are treating that person. In the same way, if any one of our children was sick we want the

absolutely rolled gold best care for them. Health professionals are brilliantly trained to always strive for this for their patient.

How do we ask them to have this focus day after day after day, yet also the mentality to learn from these experiences? How can we teach them to be able to gain sufficient wisdom from this and then use it to think about the system as a whole? How can they be assisted to keep some perspective about what treatments and interventions do the most good for the most people? How to ask them to give best service to patient and see the big picture too?

And even to ask them to go a step further and be engaged in that process – possibly even against their short term financial interests?

It is fair to ask if perhaps this is not the health professionals' obligation? Maybe this is the role for health administrators and governments? Can they do it?

Does your opinion on whose obligation this is change if it is taxpayers who fund the health professionals? Are their obligations not just to the patient, but to the funder, in this case the broader community?

It seems a lot to add on the plate of a busy paramedic, nurse or registrar. But if they don't engage in this debate, who else will? And if we don't equip them to do it effectively, what then?

We know our politics struggles to deliver such leadership. Reformist attempts are often two steps forward and one back (& occasionally the other way round!!)

But instead of despairing at the blunt state of politics (whether you think the Government was too clumsy in its Medicare freeze or whether you think Labor was too political in its campaign against it) it is possible to see the current balance of power politics not as too messy, but as a golden opportunity for influential professional groups to get organised and to make an impact.

Usually the debate around "influence" is also blunt – it is seen through the prism of lobby groups like the Minerals council running an expensive campaign to stop a government initiative, or the AMA running hard to object to a particular change that affects them. But it doesn't have to be – thoughtful actors outside the parliament can have enormous influence, and health



professionals are in a wonderfully trusted position to drive change. But they need to think and act big picture to have this impact.

Instead of limiting their influence to protecting the industrial interests of their members, professional groups could also use their considerable knowledge, experience and resources to identify a few genuinely creative solutions to some age-old problems. If they did, they would be jumped on immediately by political leaders and through our parliament in a flash. Truly.

But there is a proviso here – the public, not to mention politicians, can smell self-interest a million miles away. So these solutions need to actually solve problems for consumers – not just benefit or protect the particular interests of one professional group. This is hard for membership bodies to work through – although the long term interests of their members are served by a more stable, effective, sustainable system – their immediate interests often dictate for the line to be defended each day.

I see signs of change. After the AMA vociferously opposed Medicare Locals and GP Superclinics, I now see the College of GPs welcoming the pilot of the next iteration “Health Care Homes.” Good on them! Although this is not a new concept, the Age noted that the “plan also demanded a fundamental cultural shift, where patients would cease to be passive consumers and accept more responsibility for their healthcare as active members of a multidisciplinary team.”

The College President Dr Frank Jones is quoted as saying "We can either struggle with a 1980s health system that does little to confront the realities ... or take concrete steps towards driving changes that reflect 21st century knowledge and healthcare management and information technology." said RACGP president Dr Frank Jones.

Similarly, any of you my age or older might occasionally reflect with bemusement that the same AMA representing doctors which is currently in a tooth and nail fight to protect Medicare – is the same organisation that not many decades ago campaigned fervently against Medicare, even taking it to the high court, and argued that Medicare was socialising medicine and would be the end of private practice .... *(at least this took a few decades – my colleagues in law tell me every proposal to change the practice of law is either*

*a scandal or a tradition, with often not even a year in between it going from one to the other!)*

Medicare started as relief for patients who were being declared bankrupt or sent to jail for failing to pay medical bills, but it is now also an income system for doctors. As I said at the beginning, this has had an overwhelmingly beneficial impact for patients and is rightly loved by consumers. However, it means that doctors have become gate keepers for what can be reformed – I can only wish they would use this position and influence to drive some serious change. Other health professionals are excellently placed to urge them to take this role seriously and to help identify change that could benefit the patient and the system as a whole.

My past interactions as Health Minister highlighted the problem if professional groups protect a few outliers – those charging exorbitant amounts, pushing the boundaries of ethical behaviour or benefitting in a way which wastes resources that could be used elsewhere. Even if they are doing the wrong thing, professional groups have had a dubious history of protecting members no matter what. Professional indemnity insurers can conspire in this. So it is very hard for there to be visibility of bad behaviour or outrageously high fees.

When Governments by good luck or good management stumble upon these, they get attacked and pilloried for taking action (and then the community wonders why reforms are not embraced!!).

I cannot miss the chance to share the example of the doctors and ophthalmologists on this front. Some of you will remember my attempts to reduce the Medicare schedule fee for cataract surgery, now the process is so much faster and benefits from the new technology. It was regarded at the time as an open secret that the old rate was being severely rorted, but the Government was hard pressed to find a single professional group who would support our moves or speak out to explain our actions were justified and eventually only a minor change was made.

The real kicker in this story is the huge number of people who have since told me that I was absolutely on the right track and they were cheering me on (but obviously only quietly in their bedrooms!).

I guess this is small fry in the scheme of things, but it is illustrative of the need to find a way for professional groups to honestly identify issues and work with governments to fix them – it gives them more headroom to then deliver in important areas that are being neglected.

When directly engaged in treating the patient a health professional has one very clear role – & when being advocates in public debate through professional groups and others, there must be a big picture. This is even more so if government of the future won't ever have majorities - they need trusted professional groups to work with them on the big picture, informed by work with individual patients, but with a larger perspective.

Health professionals have real power to bring about change – provided it is clearly driven by consumer benefit, not merely professional advantage.

For health professionals, I could sum up the lessons in the following way:

- (1) If you beef up your fundamental commitment to be driven by the evidence and keeping yourselves up to date, this will benefit consumers and make you a more skilled professional
- (2) If you listen to consumers & get comfortable with feedback and transparency, this will also lift standards and contain costs of care
- (3) Speaking up for patient interests will benefit not just that patient, but the whole system
- (4) A consumer centric health professional, comfortable with technology and change, will be the one in most demand in the future
- (5) A health professional that can translate their experience into the big picture, is a trusted resource. Using that trust and those valuable insights, can help improve our whole health care system.

I hope this presentation presents you with some thoughts from a different perspective and challenges you to think about the role VU can play in helping equip the next generation of health professionals for the future.