Minister for Health and Aged Care - speech - 3 November 2023

Read Minister Butler's speech at the Whitlam Institute to celebrate the Whitlam Community Health Program

Thanks Fran.

Can I begin by acknowledging the traditional custodians of the land on which we meet, the Burramattagal people of the Darug Nation.

I pay my respects to Elders past and present and extend that respect to any First Nations people here with us today.

I'd also like to acknowledge the work of Whitlam Institute Chair, John Faulkner.

A Labor loyalist and true believer, John was never afraid to speak according to his conscience and his principles, but he also remained steadfast in keeping another's confidence.

John, of course, can't be here today due to the state funeral for former Labor leader and Governor General Bill Hayden. Someone who will rightly receive many words of reflection today.

Thank you also to Vice Chancellor, Professor Barney Glover AO, for welcoming us here on this significant occasion, to recognise the 50th anniversary of the introduction of Gough Whitlam's Community Health Program – or CHP.

The legacy of the Whitlam Labor Government in the health of Australia is difficult to overstate.

But while much has been written and said about Medicare and its precursor, Medibank, the contribution and the legacy of the Community Health Program is less well known.

Indeed, the CHP would likely have faded into obscurity, were it not for the work of Professor Fran Baum and the team at Stretton Health Equity at the University of Adelaide, who have spent many years documenting and cementing its legacy.

What I'd like to do today, is to provide some of my own reflections on the lessons of the Whitlam's CHP, and outline how the Albanese Labor Government is integrating those lessons into our reforms to strengthen Medicare.

As Professor Baum outlined, the CHP was a recommendation of the National Hospitals and Health Services Commission in 1973.

The Commission produced two major reports around that time.

One report handed to Social Services Minister Bill Hayden recommended the creation of universal health insurance scheme to be known as Medibank.

The other report handed to Health Minister Doug Everingham recommended the creation of the Community Health Program.

Before they entered politics, Bill Hayden was a Queensland cop and Doug Everingham a Queensland doctor.

It's hard to find two men with a greater legacy in health than Bill and Doug.

Together, they planted the seeds of a policy that would grow into the oak tree of universal health insurance – a visionary and nation-shaping policy that faced a savage assault when they tried to introduce it.

Medibank was a universal insurance scheme to provide low or no-cost access to a private industry of medical doctors providing mostly episodic treatment on a fee-for-service basis.

The Community Health Program's remit was very, very different.

Doug Everingham called it "community health care rather than sick care" that aimed to proactively improve the health of the local community, and not just those individuals who sought – or could afford – care.

This meant a greater focus on health protection and prevention, providing treatment programs and health promotion in areas like drug and alcohol, mental health and reproductive health.

Underpinning the CHP was a comprehensive model of health that looked beyond the narrow medical reasons for episodes of illness, towards a greater understanding of the social determinants of health.

In contrast to the private primary care industry, services at community health centres were free and universally available, without referral.

They were provided by multi-disciplinary teams of nurses and allied health workers, sometimes operating alongside or in partnership with local doctors.

CHP projects were locally-driven and community-controlled interventions designed to meet the health needs of local residents, particularly amongst marginalised groups and poorer households in regional areas or the fast-growing outer suburbs.

The CHP was there to fill a gap that Medibank couldn't, particularly for people in places with little access to – but a lot of need for – good quality primary care.

Because underpinning every part of the CHP, was the foundational Labor principle of equity.

That principle saw the funding of more than 700 projects around the country, from community health centres to women's refuges, family planning services to Aboriginal community health services.

Instead of a uniform model of care imposed from above, the CHP funded states, local councils and community groups for a wide variety of projects in a truly bottom-up and iterative approach to policy formation.

The CHP let more than 700 flowers bloom.

The idea was to see what worked and then replicate and innovate.

But - as is so often the case with visionary and nation-shaping Labor health reforms in Australia – the Community Health Program was opposed by a self-interested cabal of doctors' groups and the Liberal-National Coalition.

Spurred on by the Australian Medical Association and the General Practitioners Society, the incoming Fraser Government ensured that those seeds of reform never took root.

The Fraser Government dismantled Medibank and defunded the Community Health Program, ripping Medibank from the soil and leaving the CHP to wither on the vine.

And wither it did.

Slowly in some states, and quicker in others.

After another long winter of cuts and neglect to healthcare, the Hawke Labor Government was elected and immediately restored funding for community health.

But while the funds flowed to the states and territories, it was without the overarching ethos and drive of the CHP, as Bob Hawke and Neal Blewett instead focussed their attention on the restoration of universal health insurance.

Medicare took root, but the CHP did not.

50 years on from Whitlam's visionary reforms and Medicare is now an oak tree of health policy in Australia: impossible to uproot.

Which is not to say the Coalition hasn't tried, many, many times.

The father of the modern Liberal Party, John Howard, called bulk billing a "complete rort".

And when he was Health Minister, Peter Dutton, lamented that there were - quote - "too many free Medicare services".

That other Queensland cop then tried to do away with bulk billing altogether, by introducing a GP tax on every single patient every single time they fronted up to a doctor.

When Labor and the Parliament blocked that vandalism, Peter Dutton and the Coalition froze the Medicare rebate for six long years, ripping billions out of primary care.

Thankfully, Medicare withstood successive Liberal Health Ministers hacking at its branches with nasty cuts and callous neglect.

The report that landed on Doug Everingham's desk calling for the creation of the CHP, paints a picture of Australia not so different to the one we know today.

An Australia with differences of degree, not of kind.

Doug's report talked of rising rates of chronic conditions and mental health disorders, of lifestyle diseases that cannot be cured with a one-off course of treatment or by a single doctor working alone.

It talks of confusing and inefficient fragmentation in the health system, of gaps between primary care and hospital care and a lack of clarity after discharge.

It talks of the need for multidisciplinary team-based care and better coordination between doctors, nurses, and allied health.

In fact, so much of the report that landed on Doug's desk reads just like the report that landed on mine in February, some 50 years later.

The 2023 Strengthening Medicare Taskforce report and the 1973 Hospitals and Health Services Commission report share much in common, particularly in the problems they identify and the opportunities they see for reform.

But where the 1973 report called for a principled program of health delivery to sit alongside Medicare, the 2023 report calls for Medicare to be strengthened by integrating many of those same principles into Medicare itself.

Principles…
of equity and of universal access,
of community involvement and of team-based care
of proactive health protection
and of care that looks beyond the medical to the social determinants of health.

It is through integrating the principles of Whitlam's CHP that we will strengthen Medicare.

At this year's Budget, that is exactly what we began to do.

We are strengthening Medicare by listening to communities and putting patients at the centre of healthcare.

Patients have too often been locked out of decision-making and so the Budget allocated $13 million to strengthen the capacity of the Consumers Health Forum and seed the creation of a new body for Culturally and Linguistically Diverse Australians.

Two new national mental health consumer peak bodies will also be established, to ensure that consumers and their carers have a say in mental health policy.

We are strengthening Medicare with a new rebate for GP consultations longer than 60 minutes, to give GPs the time they need to provide better care for patients with complex needs.

That new rebate took effect on Wednesday this week, along with the single largest investment in bulk billing in the 40-year history of Medicare.

The tripling of the bulk billing incentive will begin to restore equity and universal access, by making it easier for 5 million children and their families and 7 million pensioners and concession cardholders to see a doctor for free.

After nine years of cuts and neglect that saw bulk billing decline sharply, GPs are calling this investment a game-changer, saying it will help them maintain and even shift back to bulk billing those who need it most.

We are strengthening Medicare by fostering the kind of multidisciplinary team-based care that the CHP envisioned.

This starts by giving GPs the support they need to grow their nursing and allied health teams, by increasing the Workforce Incentive Payment Stream Payments by up to 30%.

This has provided a much-needed boost to the more than 5,800 practices that receive this incentive, helping them support over 21 thousand health practitioners, including:
16 thousand nurses,
4 thousand allied health practitioners, and
500 Aboriginal Health Workers.

Smaller practices that do not have the means or market to bring on permanent staff will soon be able to call on the services of allied health practitioners, through a 77 million dollar program of PHN commissioning and practice support.

We are strengthening Medicare by supporting every health professional to operate at the top of their skills, training and experience.

Professor Mark Cormack's Unleashing the Potential of our Health Workforce Review will find the opportunities for everyone in our highly educated health workforce to provide every ounce of care that they can.

I'd like to see every health professional work to the top of their scope, but we particularly need to break the glass ceiling that has held back our highly-educated nurses.

The first batch of consultation took input from across the health sector and closed last month, with more consultation opportunities next year before the final report is delivered in October.

We are strengthening Medicare by addressing the gap between hospital and primary care, with 58 Medicare Urgent Care Clinics rolling out across the country.

As of this week, 35 Urgent Care Clinics are now open to patients, with the remaining 23 to open in coming weeks and every clinic to be open by the end of the year.

This is a model of care that is pretty common overseas, but rare in Australia.

These clinics provide free urgent care for patients, without a referral or appointment – all you need is your Medicare card.

They have already seen more than 52 thousand presentations across the country, saving public hospital emergency departments an estimated 14 million dollars in avoided patient episodes.

In keeping with the ethos of Whitlam's CHP, Urgent Care Clinics are tailored to local context.

In the ACT, for example, the Territory Government already had a well-established network of nurse-led clinics that we will now support and extend, as part of the Urgent Care Clinic network.

We are strengthening Medicare by going beyond fee-for-service, with the introduction of the new MyMedicare program.

MyMedicare is the foundation upon which a stronger, more personalised Medicare will be built.

Patients will get more tailored quality care from their regular general practice, doctor and primary care team.

Practices will get better information about their registered patients.

MyMedicare will help Medicare go beyond the limitations of fee-for-service, with a range of blended funding packages to help practices tailor their care to patients from priority groups, like frequent hospital users and aged care residents.

The first of those packages will come available in the middle of next year, but already nearly 200 thousand patients and 4,500 practices have registered for MyMedicare.

And the benefits of this system-wide reform will grow over time, as more patients and providers join.

We are strengthening Medicare by growing and supporting the Aboriginal Community Controlled Health Sector.

As Professor Baum has often remarked, ACCHOs remain one of the few modern examples that fully embody the promise of Whitlam's Community Health Program.

I couldn't agree more.

The work ACCHOs do isn't just a model for First Nations health, it really is a model for the whole health sector.

Since coming to government, we have invested nearly 970 million dollars to improve First Nations health outcomes including over 700 million for additional programs and infrastructure upgrades to strengthen and support the community-controlled sector.

Through all of this work to deliver a stronger Medicare, our north star has – and always will be – patient benefit.

Putting people before profit.

The Albanese Labor Government will always make the tough choices and face down any opposition in the service of patient benefit.

Whether that be in providing health and hip pocket benefits from 60 day prescriptions … or in squaring off against Big Tobacco, as we reignite the fight against nicotine addiction.

It was Labor Health Minister Doug Everingham who first took a stand on behalf of patients and against Big Tobacco profits, by restricting the advertising of tobacco products for the very first time.

50 years on and other Labor legacies like our world-leading plain packaging reforms have seen real progress and saved countless lives.

But there remains much to do, after another decade of Coalition negligence.

We were once a world leader, we are a laggard, today.

Tobacco use remains the leading cause of preventable death and disability in Australia.

50 Australians die every single day from it.

Strengthened legislation is before the Parliament while we also invest in community-driven initiatives, like the renowned Tackling Indigenous Smoking program.

At his 1972 Labor Policy speech, Gough Whitlam said that “health is a community affair”.

This remains true today.

As we look to the role that Primary Health Networks might play in a more community-oriented primary care, we need to ask ourselves:

How can weave the principles of Whitlam's CHP into the PHN network and ethos?

Healthcare is stronger when community is involved.

It follows that Primary Health Networks are stronger, when they have community representatives on their boards.

And community advisory committees need to be fully engaged, and engaged with fully.

But even as we strengthen Medicare with the principles of Whitlam’s CHP, Medicare’s underlying architecture remains a universal health insurance scheme for a private industry of medical practitioners.

And we need to be clear sighted about the strengths and limitations of that purely private market model.

Nowhere are those limitations more evident than in the thin markets of regional, rural and remote Australia, where general practice closures are sudden and GPs are harder to come by.

In 1974, at the opening of the CHP-funded Maroondah Social Health Centre in Melbourne, Gough Whitlam said:

"It is equally wrong that people in some areas should have available a more than sufficient number of doctors to provide medical treatment while people in other areas suffer a shortage of doctors."

Whitlam's attempt to right that wrong was the CHP.

The Albanese Government's approach is to strengthen Medicare and pilot innovations in service delivery that go beyond the private fee-for-service model.

Innovations like the Single Employer Model trials that are being progressively rolled out across the country to explore new employment approaches GPs-in-training in areas of workforce need.

These trials will help attract and retain the next generation of GPs by giving trainees increase certainty as they accrue employment entitlements.
This model improves access to primary care and maintains public hospital services.

It also gives trainees experience working in general practice so that we can build the pipeline of medical graduates wanting to work in primary care.

We also need to lift the status and availability of nurse practitioners.

When I was last in the health portfolio, there were around 2,000 nurse practitioners in Australia.

Ten years on, and there are still around 2,000 nurse practitioners.

In the Budget, we committed to raise the Medicare rebates for nurse practitioners by 30% and remove the collaborative arrangements that have restricted their autonomy.

We are also investing in innovations like the Nurse Practitioner and Team Based Primary Care Pilot in Western Australia, which will see up to 20 nurse practitioners deployed to general practices or ACCHOs in that state, to diagnose and treat a wide range of conditions, at no cost to patients.

The WA Department of Health, in partnership with the local PHN, received 35 applications from nurse practitioners and placements will be finalised this month.

The May Budget also included $27.0 million for piloting interventions in thin markets around Australia.

My Department is engaging with states and territories, PHNs and Rural Workforce Agencies to define what we mean by a 'thin market' and what effective, community-based interventions in these under-serviced communities look like.

Thin markets aren't just a problem for rural and remote Australia, they also affect outer suburbs and regional centres.

They usually occur because we have few policy levers to ensure our workforce is distributed equitably and effectively.

That's why the Government is reviewing those levers.

'Distribution Priority Areas' and 'District of Workforce Shortage' policies were created at a time when we had a surplus of medical workforce – something very few countries have right now.

We can't kid ourselves: the global medical workforce shortage is an issue that won't be solved overnight.

We need new, transparent ways to distribute workforce equitably, as well as innovative, localised interventions to address the health needs of Australians in thin markets.

Pilot interventions will take place in sites like:
The Cassowary Coast in Queensland;
Northern Tasmania; and
The Eyre Peninsula in South Australia.

Underpinning all of this work will be the power of Australia's world leading health and medical research sector.

In the lead-up to the Budget, I announced a $50 million research initiative from the Medical Research Future Fund to drive innovation in primary care.

The fund will supercharge innovation to benefit all Australians, but particularly for groups who have poorer access to healthcare.

The first grant opportunity has already opened and will provide up to $42 million for research and medical innovation projects that aim to transform primary care.

As we near the end of a big year of delivery in strengthening Medicare, the Albanese Labor Government hasn't wasted a day in building on the legacy of the great Labor governments that came before it.

From Curtin and Chifley's Pharmaceutical Benefits Scheme, to Whitlam's Medibank and CHP.

Next February will mark the 40-year anniversary of Medicare.

40 years of universal health insurance in Australia.

A visionary reform that has endured, despite decades of nasty cuts and callous neglect from the Coalition.

We know that there is more to do, as we build a stronger Medicare for all Australians.

Strengthening Medicare for the next 40 years will mean reviving the principles of Whitlam's other foundational health reform, the Community Health Program and weaving them deep into the fabric of Medicare.

To ensure that Medicare is more than just a safety net, as so many of those in the Coalition would like to limit it to being.

By weaving the ethos of the CHP into Medicare, we will strengthen Medicare beyond its health insurance roots:

From universal health insurance … to universal health care.

Or what Doug Everingham would have called: "community health care, rather than sick care".

Thank you.