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Transcript: AMA President, Professor Stephen Robson, answers questions after his address to the National Press Club, Wednesday, 14 June 2023

Subject: Health worker burn-out, Medicare complexity and compliance, One Health approach, bird flu, GP workforce, rural health, vaping and sexual assault health effects.

LAURA TINGLE: Thank you so much. That's a very comprehensive survey of the landscape. If I could just start at that level of people. During the worst days of the pandemic there were lots of stories that my program and others did where we were documenting just the absolute exhaustion of hospital workforces. We hear a lot of anecdotal stories about people just leaving the system because of that exhaustion and the trauma associated with working through that period.

Can you give an audience who doesn't see the hospital system up close a sense of where it's ended up now? Is it sort of more or less back to functioning, albeit with all of those existing problems it's got? What's the state of the workforce? Have they been able to recover? Obviously there are shortages but what's the sense on the wards?

STEVE ROBSON: Laura, it's a fantastic question. When I was driving home one night this week, I was listening to ABC classic, and Slava Grigoryan has just released an album - I don't know if people know. It's been devoted- he's written guitar music about the experiences of healthcare workers. I was driving home and they played a piece called Winter. It was about a healthcare worker - or how Slava thought a healthcare worker would feel driving home at the peak of the pandemic, looking forward to going home to bed after just exhaustion and being overwhelmed.

It was a beautiful guitar piece and it actually made me emotional, because I remember what things were like at the peak of the pandemic. Now, I'm a pretty resilient person. I can only imagine what all of my colleagues, whether they are nurses, whether they're doctors, whoever it is working in our public hospitals - the fact that you cannot have been through that and not have both had a sense of exhaustion, that to me makes me emotional, down the track, listening to a piece of guitar music, because that's what it's about.

But it made many, many of my colleagues' question: “is this really the right thing for me?” Because I don't think anyone, when they trained, really knew that they'd be training into a pandemic and what that would mean, in many cases the resource sacrifices that they'd need to make. I think we have seen this reflected in the health workforce, a lot of people have moved out of health. We've seen high levels of burnout and stress in the health work force. So, I think it has ongoing implications moving forward and that makes it very difficult to build a new workforce.

A lot of the young people, whether they're nurses or doctors who trained during the pandemic, training was really hard - they didn't get that experience. I think, I predict it will

have an effect on the health workforce for another decade to come. I think it will be very difficult for Australian healthcare workforce to get over what they've been through, Laura.

LAURA TINGLE: To what extent is there a trauma element involved in that? I mean, before vaccines came along in particular, people were going in to work and having to make decisions about whether they'd go home or not at the risk of exposing their families.

STEVE ROBSON: I think we- many, many people in healthcare experienced this moral injury from the peak of the pandemic. I had exactly the same thing. I have young children here, and they probably remember we had discussions at home. If I came home from working should I actually stay downstairs? We've got bit of a granny flat area, and dump my clothes at the door and just stay down there and try and keep away from the family before vaccines. When we were seeing images from - I'm sure the kids were happy not actually having me snooping around, so it was not all downside for them but it was a big thing for the family.

I think that's a thing that people - at nursing school, medical school or whatever - never really envisioned having to deal with, and I think it affects how you see your profession and what you want to do. If you really want to work part-time and so on. So they're really big issues and it's great to hear someone acknowledge that from the workforce perspective. Thank you.

LAURA TINGLE: Julie Hare has a question.

QUESTION: Julie Hare from the Australian Financial Review. Thank you very much for your speech. It was reported in the AFR today that GenesisCare Australia, Australia's largest cancer care company, has filed for bankruptcy in the US. It's also been discovered that the company had a malfunction in its buy now-pay later services for cancer treatments. How often does Medicare fraud, if I can use that word, happen as far as you're aware in corporatised health? And, do you anticipate any changes to cancer care after the uncovering of this- billing problems and the bankruptcy of the company?

LAURA TINGLE: Yeah. Look, another very good and topical question. And as you know, as I took over as the AMA President, there was a very big public media discussion about how, in particular the Government investment in healthcare is managed. My own personal sense has always been to be a good steward of the health system but I recognise that may not be universal.

Minister Butler called a review and Dr Pradeep Philip reviewed the system. I guess the first comment is that, many of the claims that were in the media at the time weren't supported by Dr Philip. He did report that there was a wide confidence interval but some significant amount of money, that it's difficult to say how it was spent in the health system.

But he acknowledged a couple of really important things. One is that the overwhelming majority of doctors are very, very good, thoughtful and mindful stewards of the healthcare budget. In fact, that coincided with research that had been going on of for a couple of years from one of the Sydney universities that found, in fact, GP's were so terrified of getting an audit they were probably under-billing to the tune of half a billion dollars a year just so they didn't trigger an audit. So, there's a high degree of concern about the systems in place.

Medicare is unbelievably complex. It has close to 6000 individual item numbers with complex rules and descriptors. In my own practice, it had the example or experience of

ringing the Medicare helpline and getting, what is the right thing to charge? You're getting one bit of advice one day, a conflicting bit of advice the next day. So, there's enormous complexity. I think there's no doubt when there's complexity, there's the potential - I think Dr Philip himself said, there's the potential for fraud if this isn't managed well.

The AMA's spent many, many years working – and I've been involved this -- we meet with the Health Department, look at data and try to work out, does this really reflect what we'd expect expenditure to be in the health system? And I was part of the MBS review where we try to simplify all of this.

So, what's my answer to your question? It's an incredibly complex system. Any complex system is potentially susceptible to mis-use, I absolutely concede that. I think anybody who wilfully misuses public funds like this needs the book thrown at them. I have no sympathy and I think action should be taken. But I think, at the end of the day, a lot of these things are symptomatic of the complexity in the system, and trying to resolve that is the way to ultimately make sure we are all good stewards of the health system.

LAURA TINGLE: Simon Grose.

QUESTION: Simon Grose, Canberra IQ. Your talk and paper you put out today is about a strategic approach to optimising the spend, the health spend. Like, another angle on that is the One-Health paradigm which is, human health is a part and parcel of animal health or- animal health, that they're part and parcel. Now, so my question is about biosecurity. Indonesia, about six weeks ago, declared FMD as endemic. We've got swine fever in Timor and PNG I think, varroa mite's coming in. And both sides of politics have been on to this over the last two or three years, but these things are pulsing across the Arafura Sea and the Torres Strait. So, how do you assess our biosecurity effort and would you do anything different?

STEVE ROBSON: Yeah, another great question. I think one of the things the pandemic has taught every single person around the globe is that we are not isolated from the rest of life on this planet. And the One-Health paradigm, for those people who don't know, is that we need to look not just at human infection, for example, but consider the ecosystem around us with animals and look at potential threats to human health. We know that it's very likely that COVID, for example, came from animals in a wet market and crossed over.

I think many, many people around the world are anxiously looking at bird flu at the moment, which seems to be teetering on the brink of moving to humans and if it does it's going to be a catastrophe. I think it's actually symptomatic of a broader issue that, as humans, we are bespoiling the planet. And I think it's absolutely clear that human action is affecting ecosystems to the point where it's a threat to human health and existence if we do not manage it well from this point forward.

Biosecurity, I'm no expert in biosecurity. I used to be in the navy, I was a navy officer, so I have some experience of issues in the region. I think getting the settings right on this is difficult because there are many groups who would like to make sure there are fewer, I guess, restrictions on the ability to trade across borders. But getting that advice right is hard.

I think I'd go back to the principle that I think is really important for a lot of things we do, listen to the experts, keep the politics out of things. And I think if we do our best to follow the expert advice, not put too much of a political angle on things, I think we're likely to be

able to steer the most appropriate course. But I stress, I'm no expert on biosecurity but I acknowledge just how important it is for all the reasons you articulated there.

LAURA TINGLE: If I could take a slight careering off the path about that. One of the things that sort of strangely happened in the pandemic was that we actually saw, both extraordinary scientific breakthroughs, medical breakthroughs, but also this deterioration in confidence in expertise. What's your feeling about the extent to which that actually now is influencing the public debate from everything from funding medical research through to the way we fund our health system?

STEVE ROBSON: Yet again, I think that's an absolutely important thing. And I think everybody who approaches the responsibility of care or looking after the community and tries to make decisions based on good science is challenged by this. And we're seeing ideas that really have no scientific basis at all but take hold and take root.

And I think one of the big things that happened is social media allows these ideas to spread rapidly. When you study social media as you would an infectious pathogen, you find that misinformation and disinformation spreads more rapidly than accurate information. It's quite extraordinary when these things are studied.

So I think it makes the policy environment incredibly difficult and I think a lot of people are also victims of algorithms that allows you to see what you want to see. So in the old days someone would pick up a couple of newspapers and read them, whatever. Now, people don't do that so much. They have a device that will deliver up to you, based on an algorithm, something they think you will like - so it tends to be very self-reinforcing.

I think I we have to deal with it. I don't know how to do it but I agree with you, it is a major threat not only to health policy but to good public policy generally. It's a threat and we're looking at these existential threats at the moment, aren't we? We're looking at pandemics, and we're looking at climate change, we're looking at AI and the Pentagon is looking at UFOs.

[Laughter]

STEVE ROBSON: There are lots of things that potentially threaten us as a species in a way that we haven't faced before. I know my own children face an environment that's very different to the one I faced when I was their age. Dealing with it has to be a high priority if we are going to get good public policy and good government - not only here but around the world, Laura.

LAURA TINGLE: Tess Ikonomou.

QUESTION: Thank you very much for your time today. The number of graduate doctors choosing general practice has plunged to record lows. What needs to be done to attract more doctors to general practice?

STEVE ROBSON: Well, it's a critical question. I think Mark Butler, the Federal Health Minister himself, has acknowledged this is just such a key issue for the country. So when I was a medical student, I admit this was a long time ago, general practice was really seen as a great place to be and to build a career. There was a gentleman in Brisbane who billed himself as Dr Warwick of the AMA and he was your family doctor. And people would ring the radio

and talk to him and get advice. It was really seen as a fantastic career. And I had the luck of doing my GP placement with him, with Warwick, and it was great.

But over time I think we have seen a number of forces at play that have made it a less and less attractive career option. And you're right, we're now seeing training places for GPs, despite the number of medical graduates, not being filled. When you survey young doctors who've recently graduated, yeah, general practice, maybe not for me. Only a small proportion think it might be the right fit for them, which is terrible because it can be an extraordinarily fulfilling career.

So I think we're looking at how we can build this up again and make it a great career destination for people. We have to say we value it. And I think one of the messages that successive governments have delivered to GPs is: we don't value you. And I think people want to be part of a team that's valued. I think part of that is the funding model and I know that Dr McMullen, my Vice President, has spent an enormous amount of time on the strengthening Medicare task force, working directly with the Minister has spent an enormous amount of time getting these settings right. How do we rebuild a funding model that actually makes it attractive to people? And it should be attractive to lots of people. And I think making sure that our jobs are not in a situation where, to actually turn a living you've got to see patient, after patient, after patient, after patient, but funded in such a way that you can actually sit down and spend time with a patient.

You know, people have complex conditions and mental health issues, and this is almost a gender thing. I think there is evidence that female GPs like to spend more time with patients, so it's a gendered response as well, to make sure that they are resourced and funded to provide the care that the community needs. Not a model from 40 years ago that is now, you know, turned into a churn to just to keep the doors open. So I think there are lots of things you can do, but acknowledging the problem is the critical step.

LAURA TINGLE: Could I- once again, I'm just taking.. So where is that process up to? There's been the Strengthening Medicare Taskforce, there were measures in the Budget. What's the next step for you and the Government?

STEVE ROBSON: So, the Strengthening Medicare Taskforce, of which Dr McMullen was such a key player in this, has set some very high-level directions. It's said that we can't do this fee for service model that rewards things as the only way forward for general practice. We need to build a funding model that's sustainable in the long-term that appropriately rewards practices for keeping the doors open and makes it viable, but also looks at the change in the way patients have conditions now as compared to the past. People have an overlay of mental health conditions, several chronic conditions, they're having trouble getting into public hospitals. GPs need to be funded appropriately to do all of that.

So I think that's been acknowledged in the Strengthening Medicare Taskforce. And to the Government's credit, I think the budget from a few weeks ago sent a very strong signal to the nation's general practitioners: okay, we get it. We think the time is now to move forward. I think that signalling is really important. We're very keen to move forward with the Government and help them and look at the next steps.

There are lots of challenges as I ran through here. Nothing is unsurmountable, but I think acknowledgement of the problem has now been largely done and we want to work with the Government and say what is going to deliver a health system? What's going to make

general practice healthy for Australians? Because it's much cheaper to be managed by GP than have a hospital admission and see someone like me at the end of an admission at a public hospital.

LAURA TINGLE: Nic Stuart.

QUESTION: Thanks for a terrific speech. And if you want to respond appropriately you might say my question is terrific as well.

[Laughter]

QUESTION: More seriously though, you've looked at productivity gains and that's something that you, with your economic background, has brought forward. And yet the big productivity gains you've indicated are, for example, stopping vaping, stopping- I think that you've tweeted recently about the need to reduce sugar.

STEVE ROBSON: Yeah.

QUESTION: But these are political blockages. Firstly, what can we do to actually get the politicians to actually improve our health? What will get their focus on to this sort of thing? And secondly, if I can, you've also mentioned the- you were very effective in talking about GPs and specialists and all the other- the myriad of elements that make up the healthcare focus. How is it that that we can get all those amounts working better together?

STEVE ROBSON: Well, that really is probably the best question that I have ever actually been asked.

[Laughter]

STEVE ROBSON: And I agree that it's perfection. That's a question I want to applaud..

[Laughter]

STEVE ROBSON: We'll put our hands together for that question, thank you very much.

[Applause]

LAURA TINGLE: Outrageous.

STEVE ROBSON: I think you're absolutely correct. At the end of the day, we have a political cycle. I spend a lot of time talking both one on one or sitting in a party room with people, our political leaders and politicians, and the fundamental thing, at the end of the day, is they need to be re-elected. So we have to make sure that when they go to their constituencies in their electorates they're talking about things that are important to people.

Now, when we survey people, we actually know that health is really important to people, so it should be an easy sell. And I think one of the things is we've got to say: Well, what really is the thing that is important to our constituents? Not to necessarily big business lobbies or whatever - what's actually important to people, and build a narrative around the fact that actually everybody agrees. If somebody comes to you and says: Look, is your health important to you? Absolutely. These are things we're thinking of doing that might make either you or your family or your community more healthy, and I think doing it that way is the way to move forward, and putting in perspective all these other interests and managing conflicts and- from lobby groups, you know? I represent one.

[Laughter]

But we all understand the role of lobby groups, but I think at the end putting health at the first part of this.

And the second part of your question is about all of the moving parts, and I often think of healthcare as a helicopter. There are all of these things that are constantly in motion - you have a main rotor and a tail rotor trying to work against each other to keep the thing stable, and somehow a helicopter flies. I think we need to think of the health system like that helicopter and make sure that we do have these opposing forces but they're all working toward the common goal, and that is to give us a healthy country because we know a healthy country is an economically prosperous country.

QUESTION: Best answer ever.

[Laughter]

STEVE ROBSON: Thank you.

LAURA TINGLE: Maurice Reilly. Hopefully he isn't going to be quite so self-indulgent.

[Laughter]

QUESTION: I'm asking this question for Tim Shaw. Tim Shaw asks…

STEVE ROBSON: Oh, okay. Hi, Tim.

QUESTION: Rural and remote communities are seeing some of the biggest issues to getting access to health services. What can governments do to bridge the gap, and what can the AMA do in supporting that?

STEVE ROBSON: Tim, that is a fantastic question.

[Laughter]

So I grew up in a small town called Mundubbera. I went to school in a place called Toowoomba. My family are in all of regional Queensland. I get completely just A: how difficult it is to access health services in regional areas, but how critically important it is, too. And we have multiple groups. We have the Rural Doctors groups here, who are working furiously to come up with a plan. But I think at the end of the day one of the paradigms that is difficult and makes it difficult for communities is a kind of fly-in, fly-out workforce, and I think that while that may solve some problems in the short term, the long term is saying what can we do to make it viable and attractive for a health workforce who want to stay and establish and put roots down in a town? And I don't just mean a doctor, I mean everybody involved in health - nurses, midwives - we're seeing around the country major problems in rural maternity services. And one of the key things that people want to do is have their family where they live. Correct me if I'm wrong, Peter[sic], with any of these things, but yeah, I agree. 25 per cent of Australians live outside of urban areas. There is no reason they should have any lower or any different expectations to people who live in a place like Canberra. But we have to make it attractive because this is part of our rural ambition. It's one part of the rural ambition that if you want to stay in a town, you know that your children will be educated, that you'll have a good job, you'll have access to healthcare services and things like that that are affordable. So I think that's probably the very next step. We've looked at general practice in general. We need to look at how we can make health services sustainable in the long term and appropriate for rural Australians. Peter, are you happy with that? [Laughs] Thank you.

LAURA TINGLE: Julie Hare has another question.

QUESTION: Thank you. Your document here today is- talks about moving from sick care to healthcare. There's a third wing of this, which is the wellness industry, and I call it an industry because it's worth about $10 trillion nationally. There's a thing called wealthy wellness, that only the wealthy can access a lot of these treatments, services, ideas. It's an unregulated sector largely. But on top of that, there's a quote that I came across this week that said: We're at an inflexion point in history where only the wealthy can afford to be well and that the poor will be the only people who carry chronic diseases. I'm just wondering if you can talk to me, talk me through sort of where the wellness industry sits with the healthcare sector and a sick care sector, and just the division between rich and poor and access to services and good health.

STEVE ROBSON: Okay. Well look, the questions are going on, so I'm cancelling my oxygen therapy session that I was booked to go to straight after this.

[Laughter]

I think it's a really good point, but this is not new. If you go back to ancient Rome, a lot of the writings are about exactly what you talked about today. All of these wellness things that people even in those days wanted to indulge in. And we know that in Australia, for example, more is spent out of pocket on things like vitamins and supplements than on prescribed medication. It is a big thing. It's a profitable thing. That's fine, that will drive marketing and people are very interested.

I think one of the key things that separates or makes other therapies non-part of the paradigm attractive is time. If I go to my GP, they're normally frazzled, they've got a full waiting room. They know they've got to see a lot of patients and they will deal with quickly. A lot of these wellness people will sit down with you and really take their time going through all of your problems, and you really feel heard. And that's a thing that's incredibly satisfying to people. If I go somewhere and they just listen to me talk about my problems for ages and take them really seriously, I'm happy to pay you for that. That makes a lot of sense to me. So I understand the lure and the attraction of all of these things.

I think it's important that we always approach them from the perspective of saying: What does the evidence tell us about these things? What does the evidence tell us about the effectiveness of what you're spending your money on? I don't know. It's a difficult thing to manage. I'm not running down the wellness industry in any way whatsoever. And in fact, I'm saying I understand why it's so attractive to people and why people are so attracted to it when they perhaps have some experiences of underfunding and undervaluing of the health system here. But I think if you look at that gap between rich and poor and their health - I actually was invited to the Economics Society of Australia here in the ACT a few years ago to talk about our genetic future. And I think the next big thing as we understand more and more about human genetics, we understand a lot of our health is programmed in our genetics. And I think the big divide is going to come when people use technologies like IVF, select embryos that have genetics which reduce the risk of disease, and that is the basis of the next generation. We're seeing this in America at the moment and some places overseas. And the cost of IVF and the cost of that technology will leave a generation of people alone, so we'll have genetic haves and genetic have nots, and I think that's the next frontier. And I share your concern. I think if we get to that stage as a society, we're in big trouble.

QUESTION: Thank you.

LAURA TINGLE: Simon Grose.

QUESTION: Let's talk about vaping and prohibition. I think two days ago we reported that the TGA had fined a Sydney mob over 500,000 for bringing in almost 400,000 vaping products. And every now and again we see out in- normally rural Victoria, people are busted for growing hectares of tobacco dobbed in by their neighbours. I have a friend who is a vaper. He gets his gear from somewhere in Western Sydney. He also gets packets that look like Marlboro, 15 bucks for 20. Prohibition creates a black market, creates profits that people take the risks that I'm talking about, but all you and the governments do is carry on the same we're going to stamp this out, blah, blah, blah. Can we get some insight? Can we get cleverer?

STEVE ROBSON: Okay. Again, a very. very hot topic. And it's a hot topic with a lot of the people I deal with. About a month ago, just before the Budget, when the Health Minister announced that they were going to move to a prescription-only model for all e-cigarettes, I got a call the next day from a school principal that I know, and he was almost in tears of gratitude. Because we'd talked about vaping and he said, I cannot thank you enough. I want you to pass on to the Health Minister from me how grateful I am as a teacher for my colleagues that someone is finally acknowledging this is a problem and doing something to help settle it down. So e-cigarettes were invented about 20 years ago, and they were initially invented by a pharmacist as a way to perhaps replicate those hand mouth movements that came with tobacco smoking that were very, very difficult in other methods of giving up tobacco smoking. A lot of the evidence initially was promising, but of course, they have been supplanted as a recreational thing. So we have a small proportion of e-cigarettes that are prescribed at the moment as one of a suite of things that can help you give up smoking. But a massive market in vaping e-cigarettes, some of them disposable that befoul our societies with all of this ecologically catastrophic thrown away vapes after a single use. And most of the vapes that people inhale have virtually no quality control at all. Even though they're sold as non-nicotine, they commonly have nicotine in them. Even if it's not tobacco smoke, they have things like nail polish remover that you're inhaling into your lungs.

And they are, for the first time, being associated as a gateway to smoking for a generation who'd given up smoking. So they are a big problem. I think everybody acknowledges that they're a major problem, and I completely acknowledge the issues around the black market. I get it completely. I know that kids can join a Facebook page and someone will ride up with the motorbike and give them e-cigarettes and things like that. But we have to start somewhere. I think we probably are at a point where we have an opportunity to do something as a first step and build on that. I think the idea of saying; oh, just bugger it. Just let it run and make some money out of it, as I hear some people taking is the wrong approach. And if again, as I said earlier on, we take the approach of what the evidence tells us, the evidence tells us that e-cigarettes are not good for you. And even if you get off a tobacco cigarette, there's no pathway to get off of a vape. So we think making sure that the people who are trying to give up cigarettes work with the health care professional to help them, is important. And people who don't, or take them up purely for recreational purposes, particularly kids, particularly- vaping is a thing of young people. We need to send a strong signal that it is harmful, that we don't want the next generation-

QUESTION: [Interrupts] But kids are going to do stuff they're not supposed to do. That's psychology.

STEVE ROBSON: [Talks over] Yeah, look, we all get that. But I don't think it's a time we just roll over and say I give up. And I think that's the thing. I think we're getting a signal now that says we take it seriously. When teachers are ringing me in tears, not saying my kids have misbehaved, for a change, but saying we're worried about vaping, then I think they're the calls I like to get.

LAURA TINGLE: Finally, if I could ask you, you're a bit of a mad tweeter. And amongst…

STEVE ROBSON: [Talks over] Oh no. Much to the annoyance of the comms team.

LAURA TINGLE: Well, you know, you tweet pictures of Roy Kent, so that's only to be endorsed. But on a more serious note, a few days ago, you tweeted that: 'I speak as an obstetrician gynaecologist who's been involved in the care of many victims of sexual assault. Why in God's name would any woman now come forward to report these crimes after seeing the current media horror.' I just wondered whether you could reflect on what the outcome of the current media horror might be in a health sense?

STEVE ROBSON: A lot of people have read different things into that, but I want to bring my perspective to that. As an obstetrician and gynaecologist who works in public hospitals, over the years, I have been called to treat some of the most appalling, appalling injuries. I'm not even going into things that I've had to treat and manage for women because it will be triggering, and I would feel like I'm betraying some women I've managed. But even away from that, so often I try to help and treat people and it comes out that they have been a victim of sexual assault. And many of them just find these discussions so triggering. And when we're in an environment where - and I know some of the players involved in the whole thing we're talking about here - we're seeing some of the discussion, not just the reporting, but in particular the comments that seem to come with the reporting and the things on social media about this. I cannot imagine how triggering this would be for the tens of thousands of Australian women who have been victims of assaults and never told anybody. Kept it inside. And I think we need to be incredibly careful in our discourse about this, because it may play politically one way or the other, but by God it is harming a lot of women. And if a young woman sees this dissection of events in the media, is she really going to say, wow, I want to go and report this immediately? I think it's a terrible disincentive. And I think my reflection is that many of the women I treat would just retreat further into this shell and not want to report what should be a reportable crime to bring the perpetrators to justice.

LAURA TINGLE: Professor Steve Robson, thanks so much for talking to us.

STEVE ROBSON: Thank you.

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