Opening address

Andrew Laming MP[1]

[1]Federal Member for Bowman, Shadow Parliamentary Secretary for Regional Health Services and Indigenous Health

Thanks Leigh for kicking off Plenary One 'Shaping a Bright Rural Future'—I hope as a warm-up act, Jack Snelling and I do ok. Thanks to this year's conference convenor Marie Lally, to your Conference Advisory committee and the Organising group. And of course the Tutti Choir for your inspiring intro.

Distinguished guests, Jack, South Australian Senator David Fawcett, to Australian professional Colleges, most notably ACRRM, NACCHO and AIDA and RACGP, to AGPN, ANF, Allied Health networks, the RFDS; the physios, the psychs and the physios, the Chiros, Pharmacists the Optoms, the Ambos and paramedics, the Rural nurses, Doctors, Dentists, students and health researchers, to the Australian Health and Hospital Association, CRANAPlus, the CWA, Catholic Health Australia, ICPA, the health consumer groups, Rural HWorkforce, and RH Education Foundation, to the health consulting firms, private sector providers.

What a perfect weekend in Australia's most understated capital city, we are celebrating the work of rural, remote and Aboriginal health professionals.

For many of you, rural health's watershed moment was 1991. Many here today recall the Toowoomba Conference when 'modern' rural health was born. You'd agree it provided the foundation for what has been two-decades of uninterrupted advance in the status of (and investment in) rural, remote and Aboriginal health.

Much of that momentum creation can be traced back to the AHMAC Rural Health Taskforce AND the Rural Health Support E&T program.

Given this is a two yearly event this 11th meeting is as close as it gets to a 21st birthday for rural health.

Like most birthdays, we made a fuss over the early ones at Armidale, Mt Beauty, Perth, Adelaide, and Canberra 2001. But as you get older birthdays are something many of us hope others don't notice.

In that great Australian tradition, let's celebrate our 21st with:

- the older generation sharing well-worn anecdotes
- younger registrants cultivating new contacts
- our more recent converts celebrating our sector without perhaps fully comprehending the hard-won battles of the last two decades.

1991 was my first year out, so I have keenly followed our profession's achievements ever since.

Back then, a Qld Health scholarship took me to Toowoomba's neighbouring Goondiwindi Hospital as a PGY2 RMO on 24 hour call and providing GP relief cover in nearby Mungindi, Dirran and St George.

As it happened, it seemed only right that my Med Super Dave should go to the now famed 'Toowoomba Conference.' Alas, he didn't even bring me back a tee-shirt.

It is a pretty important lesson in life that a seemingly trivial question (like whether to attend a conference on a weekend) can represent such a missed opportunity that doesn't come along again for two decades. Thanks for having me back today.

The RDAA was formed in that year of 1991 and I recall reading about the founders (many from Qld) and agonising over whether it was a bit pretentious by half to join up before heading south to co-manage Paul Mara's thriving Gundagai practice in 1992. Accessing continuing education was pretty crude in those days. The College would send out pamphlets of multi-choice questions.

In 1993, while I did my DipObs, the GP Rural Incentives Program and National Review of Nurse Education was announced. I saw little need for incentives at the time; you were either cut out for bush work, or you weren't.

Doing that rural work in western Qld and NSW then Katherine in 1994 delivered some pretty blunt lessons for a AGSC-RA 2 kid. It was the year the National Rural Health Strategy was endorsed, and I was discovering how relentless and exhausting this work could be. In 1995 was a year working with Menzies in the semi-desert Warlpiri community of Lajamanu.

Those who don't like hard work rarely end up in rural, remote and Aboriginal Health jobs. It is a world unknown to most in the city, where small local populations expropriate your essential services into their lives, but in most cases, pay you back a thousand times in friendship.

That was a lesson about relationships; operating in a world where everyone knows someone who knows everyone else. There isn't much which escapes scrutiny working in the bush. Patients stick with you even when you are certain they might be better off somewhere else. We hear about our successes from a multitude of sources; we manage and carry our clinical failures for life.

In 1996 when University Departments of Rural Health were announced, I took on rotations to Hobart and Lismore, offering a handy lesson in comparative State hospital experience. I still have stand-alone superannuation accounts littered around the nation. Apparently the federal government sweeps them up these days. Good luck to them. It is something I never managed to do.

ACRRM was established in 1997 while I was travelling to every top end community NT doing case finding and trachoma screening for Royal Darwin.

Generalism lives on in this auditorium because we know from first-hand experience that few rural areas possess all the pieces in the puzzle necessary for integrated care. Many rural practitioners are generalists because they want to—or have to be; being called upon to adapt and fill changing gaps and over time-whether you like it (in some cases) or not. Rural health demands generalism in a world that at best undervalues it and at worst, shuns it.

Regional Australians are more likely to pay for and more likely to travel for their health care. They are more likely to have deeper and more authentic relationships with their care team. I remember the excitement in 1999 when regional health services centres, the Wagga Clinical School and JCU Medical Schools were announced. Whatever the fashions and fads are in health care, we know that only a platform of generalism can serve our rural communities.

In 2001 while I worked in East Timor, I recall the range of Wooldridge reforms including rural nurse re-entry programs, practice nurses, nursing scholarships and expansion of University Departments of Rural Health.

Those reforms recognised that regional Australians have always struggled to achieve city-standard health outcomes. But it is no reason NOT to strive to eliminate those gaps. It recognised that tailored responses were required. That colleagues, ***is Australia's unique challenge***; we are one of the two most sparse populations in the world, running one of the top two health systems globally; high quality medicine in the remotest of contexts. In that supreme challenge, many of you in this room are globally at the cutting edge.

The federal Coalition recognises this with a specific 'regional health' portfolio, because a third of Australia's population face these health challenges which in a developed context, are fairly unique worldwide.

Like you, I have spent most of my career watching rural health emerge from the shadows to be recognised for its ***distinctiveness and diversity***. It is only by spending years in the job, that you come to learn how complex the issues, how ephemeral the solutions and how hard-won the advances have been.

Many of you have spoken of urban primacy; that these areas are the high-profit locations for government and commercial activity. But the mining sector is transforming parts of our nation's heart, making it impossible anymore, to generalise about rural decline.

Metropolitan supremacy mindset has many masters. My concerns are those mindsets that are State-sponsored, sanctioned or perpetuated by the State. These include:

- regional training places that should be accredited
- opportunities afforded to one profession denied to others
- lack of opportunities to start and finish training in the bush
- struggle for rural research and academic positions
- recognition by health departments -of the uniqueness of rural conditions.

What has changed in that time is that government of all persuasions now recognises the importance of involving and locking in national associations of professional and consumer groups because we know they have the ***capacity to deliver***. In return, many of you who drive these groups rightly deserve some assurance that our Parliaments:

- understand that 1/3 of Australia gets their primary health care from where there are neither high-rise buildings or even traffic lights
- prioritise the most extreme health needs; multiple overlapping poorly coordinated urban services are a concern, but it's trumped by the absence of services for parts of our population
- key sectors (FFS, Community health and hospitals must work together) but progressively commissioning larger authorities to get other authorities talking to each other, isn't the answer
- understands the difference between an input and an outcome
- concur that the ***Trickle out model*** long discredited. Large investments in last decade's strategies which barely worked then, are unlikely to deliver different outcomes now
- political challenge, that rural health is too often in non-marginal seats, where population is dispersed, poorer and less able to access media and policy makers.

It is self-evident that successive governments dutifully hand on the workforce challenges to their successors. There appears little expectation the challenge will be fixed. The dead hand of government, fearful of sporadic localised failures, too often shackle clinicians with reporting, and make doing their work even harder.

It is true that political commitment can be distilled to dollars; the expression 'show us the money.' But that becomes increasingly challenging when one team spends down and the other side bails out.

Beyond resources, stakeholders like you are looking for:

- political will (seniority of the Health Minister in the Cabinet is a reasonable indicator) and an open door to government when needed
- a nuanced understanding of our sector (and its multiple stakeholders, competing interests and significant financial flows). Otherwise bright ideas on a press release operationalised, leave us no better than before we started.

There are increasingly three typologies in primary health care provision:

- the ***urban challenge*** is dominated by parallel, overlapping and non-communicating service provision
- in ***remote Australia*** of course there are the dedicated few endeavouring to keep gaps as small as possible
- and in between, we have the hub and spoke challenge of ***regional Australia***, dominated by small communities defending the viability of their health services against efficiency raids from major centres, which claim better outcomes, but so often sap capacity and transfer social costs onto patients and families in the process.

There is now a relentless and unapologetic focus on chronic disease and inappropriate use of hospital resources. Scottish (Lancet) 2012 research shows that at age 50, 20% of us have 2+ co-morbidities… and that jumps by 20% each decade through to be 80% at age 80.

Health value created will increasingly determine where health resources flow. Risk-averse splintered service provision which inevitably ends on hospital admission must become a thing of the past.

Lets 'out' the obstacles to a clearer commitment to primary care:

- negative perceptions; including the preference for a quick acute care intervention
- insufficient co-ordination, patients become lost in the hospital system
- low prestige of rural work and availability of workforce (global challenge)
- massive acute infrastructure spends leaving crumbs for PHC
- misaligned incentives- leading to hospital use over primary care
- variable quality; due in part to under use of health technology in remote care.

We are all here with small keys hoping to unlock big doors into a better health future for our communities.

To do that, we need evidence for impact, we want data and material to support the claimed success, and demand that new approaches are relevant, effective and can manage the unforseen downsides.

- What does care coordination look like?
- Is there any risk-sharing between GPs and hospitals?
- Hospital avoidance sounds great, but how is it measured, let alone achieved?
- How do we reward the right service from the right practitioner going to the right person at the right place and time, when no one in real time actually ever knows what is 'right'?
- Science of brief interventions, what is effective, and how should we respond to failed interventions?

- Why are hospitals using lowest-skill medical staff to bulk bill patients and not share health information with their community care providers?
- Why is community health operating in isolation?
- How did doctors become so disconnected/disenfranchised from local hospitals?
- How do we accelerate adoption of electronic health information systems by specialists?

I make only a passing observation upon the last five years of health policy. Sure there are differences around SuperClinics, Medicare Locals and the size of the non-service providing health system. But to both side's credit, investment in rural infrastructure and health workforce has been sustained over the last decade.

As a cautionary note, my sense is that our health system bears pretty much all the same challenges that it faced back in 2007:

- jurisdictional divisions
- struggles with rural retention
- overlap of organisational activity
- gaps which are perpetuated by first-mover disadvantage
- everyone working in isolation to keep people out of hospital except the hospital itself
- a lack of risk-sharing.

I also note that many forget that the regional health and hospital infrastructure fund was established entirely out of the 2007 Commonwealth budget surplus (the last time we had one) and not a cent has been replenished to that fund since.

Ambitious infrastructure programs are only assured, where governments care capable of balancing budgets and accruing surpluses. In the spending down of those surpluses during the GFC, not a cent of the stimulus package was spent on health care. That I believe was an economic opportunity our nation passed up.

In contrast, many of our OECD neighbours have taken bold and decisive steps to reinvigorate their health systems:

- The Netherlands with their skyrocketing consumer satisfaction has completely sailed past the public private debate to universally insure their entire population.
- Turkey's Health Transformation Program has used universal health insurance and a quadrupling of PHC investment (2002-10) to treble per cap primary health care visits and nearly double patient satisfaction rates.
- The US are pioneering remarkable workplace-based 'pay-the-patient' incentives for health compliance, and Geisinger has achieved a 20% drop in hospitalisation using non-traditional roles like nurse co-ordinators and case managers. ChenMed in Florida risk stratifies then offers free transport and monthly consultations to also report 20% falls in hospitalisation, readmission and cholesterol levels compared to national averages.
- While in Valencia and Galacia, providers are pioneering sms engagement, compulsory enrolment of at-risk patients in prevention programs and the use of physicians to work with GPs to reduce specialist referral rates. These regions report an almost unbelievable 26% fall in health costs, a 76%

increase in hospital productivity, the lowest waiting periods in Spain and a 40% fall in patient dissatisfaction. These health providers bare all the risk and State investment is fixed.

Of course sharing these examples is not to say that we should be leaping onto every fashionable health reform from distant economies which don't share much in common with us. But just like sporting Club dynasties in our favourite codes, our health and hospital system won't always win premierships or gold medals. As a nation we can't simply trade on last year's results. We must never assume that (just because we may not like the look of another health system), we can't learn deep, valuable and transformative lessons from their international experience.

Our generation-long public private health care debate is also increasingly become passé. The jury was out, came in, gave a verdict and has left the building. Both public and private provision play a vital role.

What will be the big movers in the next five years?

- Australia's proud and unique balanced private/public model offers hitherto un-capitalised opportunities to drive quality and value, with the insured and uninsured accessing both systems at various times.
- Primary care collapses when providers ignore each other. That is why chronic disease strategies were so important in driving multidisciplinary care. That includes the advent of the 2005 EPCs for multidisciplinary care planning and their successors; the Chronic Disease Management (CDM) items (721-731)—these are likely to become increasingly sophisticated as they drive better results for patients.
- We need to hold firm in our commitment to health and medical research and Defend and sustain our PBS from political second-guessing of PBAC approvals- both of which have haunted the current administration.
- We can improve care of those with complex co-morbidities by identifying a health 'home' without mandating it, by incentivising a EHR without mandating it and by risk-sharing between hospitals and community providers. None of that is controversial.
- Personally, I am interested increasingly in the opportunities in the 18month to 4year old space to identify and support vulnerable children in high-risk communities using our current structures and better understanding of social determinants. Decades of International evidence now informs a number of trials around the nation.

We can aspire to a rural health system:

- where initiative is rewarded and where that initiative rewards patients
- clinicians are unshackled to make the changes for the better
- where risk is shared and incentives drive clinicians to work as a team rather than apart
- where local partnerships are supported by government departments
- where dollars are increasingly freed up to pursue health value.

Australians are living longer and increasingly expecting more from their health services. Our professions are up for that challenge, but we must remain open to new approaches rather than performing hasty assessments of whether each of us as providers are better off or not.

Like all complex systems, they work better if those within are freed up say 'I can see a better way.' Those great ideas must be allowed to germinate and be tested and their architects deserve reward and recognition. These next four days offer just such an opportunity. Seize it, capitalise on it, don't leave a

question unanswered. There are plenty of intellects struggling with those very same conundrums. Join that conversation; have them late into the night; there is plenty of time after Wednesday, to catch up on sleep.

Thank you and good luck.