Opening address

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Willy: Well, to another politician now. Andrew Laming, who is the Shadow Parliamentary Secretary for Regional Health Services and Indigenous Health, and a very interesting individual he is. He seems like a very, very interesting bloke. And I can't think of another politician quickly who would perhaps be more qualified to be here. Andrew has held the seat of Bowman since 2004. He was born in Hobart but spent his early years in Papua New Guinea before finishing schooling in Brisbane and studying medicine at the University of Queensland. He's also acquired qualifications in ophthalmology, obstetrics and gynaecology, as well as completing a Masters of Public Administration at Harvard, a Masters in Public Policy from Charles Darwin University and a Masters of Philosophy in Public Health through the University of Sydney. How he has done all of these things in so few years is beyond me. He's worked as a GP, as an ophthalmologist in the outback of Australia, as a health planning specialist in East Timor providing medical support for land mine clearing teams in Afghanistan, and he was a health consultant to the World Bank in Washington, DC and medical policy advisor to the former Health Minister Kay Patterson. With all of that in mind, would you please give a very, very warm welcome to Dr Andrew Laming.

Andrew: [applause] Willy, thank you very much for the introduction. That might be longer than my speech. To Jenny, who is now officially a politician as well, I hope you don't mind. To David Plumridge who welcomed us, and to David Fawcett, Senator for South Australia, who was a co-author in the Senate Inquiry into Rural Health Services last year and a linchpin in that report. Thank you for being here, David, as well. To Lesley Barclay, to Gordon Gregory, Marie Lally, of course, the convenor and to the entire organising committee. To Uncle Lewis for his welcome to country, as they would say, money, everything's good, and also to our dancers and to the Tutti choir—in my best Italian accent—for an inspiring performance.

Now could I live dangerously and recognise some of the organisations that make up this extraordinarily diverse conference? And they are obviously the Australian professional colleges of all the clinical groups, most notably, ACRM, NACCHO, AIDA, RACGP, to the AGPN, the ANF, the allied health networks, the RFDS, the physios, the psyches, the physiols, the chiros, the pharmacists, the optoms, the abmos, and the paramedics, the rural nurses, the doctors, dentists, students, health researchers and Aboriginal health workers, to the Australian Health and Hospital Association, SARRAH, Cranaplus, the CWA, Uniting and Catholic churches, ICPA, the Health Consumer Groups, Rural Health Workforce, Rural Health Education Foundation, to the health consulting firms, private sector providers and sponsors. That certainly is an impressive array of providers all in one room.

Look, ladies and gentlemen, this is a perfect weekend to be in probably Australia's most understated city. And I can say that coming from Brisvegas. And it's a fantastic opportunity that comes around only every two years. And many of you in this auditorium will remember 1991 and the now famed and fabled Toowoomba conference. Many here today will recall the work of Col Owen, Bruce Chater and I think Michael as well, who was one of the senior Toowoomba hospital doctors, who's also speaking today, that got things up and running in 1991. I like to remember that as the foundation moment in modern rural original and Aboriginal health, because it brought together these groups for the first time in such a powerful way. And much of that moment and creation can be really targeted back to the Almanac Rural Health Taskforce and the Rural Health Support Education Training Programs that also came out in 1991. Much of that momentum, of course, started and has brought us to here, the 12th meeting. So when you think about the maths since Toowoomba this is the closest thing we get to a 21st birthday. Congratulations everyone. And like most birthdays, I can appreciate that we remember the early ones: Armadale, Mount Beauty, Perth, Adelaide, and Canberra in 2001.

But as you get older you tend to not worry about your birthdays so much. And in the greatest Australian tradition then, let's remember this important milestone since we didn't make last year. At this convention you will see some of the older members of this cohort who were around in 1991, that will be sharing well-worn anecdotes and looking silly on the dance floor, I'm sure. Younger registrants will cultivate new contacts and teach us how to dance. And of course, for the more recent converts to rural remote and Aboriginal health, you'll be celebrating with this sector over the next few days, possibly without fully realising just how hard-won some of the battles have been over the last two decades.

Now '91 was my first year out. I found myself at a Queensland University scholarship that took me to Toowoomba's neighbouring hospital of Goondiwindi, doing one in two 24-hour call and obviously covering munendi [phonetic] during Banty [phonetic] and Saint George. And as things probably should be, it was my medical superintendent who got to go to the then fabled Toowoomba conference, alas he didn't bring me back even a T-shirt. But it's a pretty important lesson, isn't it, that those tiny decisions throughout your career, (Should I go to that convention?) can represent such a missed opportunity that may only come around, in my case, again, over two decades later. Thanks for having me back. The RDAA was formed in that same year of '91. I read about those founders. Many of them are Queenslanders. And I agonised over whether it was too pretentious for a hospital doctor to join. I then moved down to Paul Mara's practice in 1992 in Gundagai. There was very rudimentary education in those days for rural practitioners. We received the occasional pamphlet with multi-choice questions on it from the college. But during that work in Western Queensland and in New South Wales and later in Katharine in 1994, for someone from a RAMA 2 zone, there were some pretty hard lessons to learn.

This was the year of the National Rural Health Strategy. And I was really discovering how relentless and how tiring rural work can be, working with Menzies for a year in Lodgimona [phonetic] in the city desert area outside of Katherine. Look, for those who never work in Rural and Regional Australia you might never know how tough and rewarding that work is. Sure. It's a world unknown to two-thirds of a population. There's not much that escapes scrutiny in the bushes there. Everyone knows someone who knows virtually everyone else. At times, you know, patients stick with you through thick and thin, even when those times come when you think they might be needing treatment somewhere else. We hear about our successes from, unlikely, venues from the RSL and the sideline of the footy field, but also our clinical failures stay with us under our care and management for life.

In 1996, when those University Departments of Rural Health were announced, I recall working in Hobart, in Lismore, getting a real lesson in cross-border issues in different hospital systems, and it really was a firsthand lesson for me. If, for no other reason, all those stand-alone superannuation accounts, that I've now got, scattered around the country. Apparently the Federal Government is sweeping them up now. Well, I say to them good luck! That's better than I ever achieved. And of course, ACRM was established in '97. And I tried travelling across the NT basically looking for trachoma prevalence rates and case finding for the Darwin Hospital. Look, generalism lives on. It lives on in this conventional whole because of the work of everyone here. Many rural practitioners, generals, because you choose to be. Some of you are there because you have to be, because you're filling gaps that no one else can fill. Rural health demands generalism. And this is in a world where, I guess, at best it's undervalued and sometimes generalism is shunned.

Regional Australians we know, from our lived experience, are more likely to travel for their health care, more likely to pay more for it. They're more likely to have authentic relationships with each and every one of you. Look, I can remember in 1999 when the Regional Health Centres were established, the Wagga Clinical School, JCU Medical Schools were announced. And whatever the fashions were at the time, we knew that only a platform of generalism could underpin the care that this nation needs outside of its capital cities.

In 2001 there were the Woolridge reforms, Rural Nursery Entry Programs, practice nurses, nursing scholarships and expansion of the university departments. And I guess each of those reforms by, let me be fair, both sides of politics, recognised the uniqueness of Regional Australia and that we will always

struggle to achieve city-centric health outcomes, but that's no reason never to strive to do it. We need the tailored solutions. It is Australia's unique challenge. I mean, colleagues, this is the second most vastly populated country on the planet, running arguably one of the two biggest health systems in the world. Each of you is the cutting edge of that globally and we face challenges that very other few nations do.

Well, the federal coalition recognises that with its own portfolio of Aboriginal health, knowing that a third of the population receive their health in locations where you can neither see high-rise buildings nor even a set of traffic lights. And many of you have spoken to me about urban primacy, the notion that the really high-profit locations for government, commercial services and even health are in the cities. But keep in mind that the mining sector is changing that, and that, generalisation no longer holds true.

>> Andrew: So Metropolitan supremacy. Sure. It has many masters, but my great concern is a state-sponsored, state-sanctioned and state-perpetuated sense of Metropolitan supremacy. What are those examples that we need to fight at state level? Well, it's the lack of Regional training places being truly accredited. It's the opportunities that are afforded to one profession but not another. The lack of opportunities to start and finish your training in the bush. It seems quite logical. The struggle for rural research and for academic positions to be recognised and, of course, for health departments around the country to recognise the uniqueness of that service. So what's happened, I think, with governments over the last two decades is that we now recognise the true importance. And it's exemplified here today by having professional and consumer groups, because we know that you have the ability to deliver on these reforms that are, of course, dreamt up by government. And many of you who drive these groups, rightly would expect some understanding in return from your Parliaments. You'd expect Parliaments around the country to understand that one-third of Australians are utterly reliant on that primary health care that's received. They don't have the luxury, controversial as it is for me to describe it, of multiple layers of service provision where the greatest challenge is coordination. In many cases they live in areas where there are terrible gaps. You'd expect your Parliaments to prioritise the most extreme health needs, and that is so frequently in the bush. But you'd expect key sectors from fee-for-service, community health, hospitals, private providers to come together and communicate in rational and sensible ways, without developing more authorities to talk to other authorities about talking to each other. You'd understand the difference, you would hope, between an input and an outcome, and you would know that once and for all debt is the conception of trickle-out, where we simply train more people and hope that some of them end up in the bush.

Look, the political challenge will finally is the—most of you work in areas that are not marginal seats. You live in places where your population is largely dispersed. They can't access the media and they can't access the decision-makers. It's utterly self-evident that governments have probably done their best. But sequentially they've really failed to do much more than hand over the problem to a new administration, and there is a really low expectation in many cases that this will be fixed. It's a dead hand of government that, in many cases, just trying to avoid risk and variable outcomes, tends to shackle clinicians and make it unable for them to talk about and to implement what would be better ways of doing things.

So of course, everything could be distilled dollars. Show us the money. That's true. But that compact breaks down potentially when both sides of government don't agree on leaving the budget in an equivalently healthy position for the successor. The other great challenge is, that you need political will within the governments of the day but, finally, and probably more important than those two, is a nuanced understanding of our sector, understanding that there are many professional groups, feel that there is an enormous amount of money moving through the system and that all, virtually every policy, will have unintended consequences of some sort. And we need to understand those before we put out our government press release.

Now, beyond resources then, beyond the will and beyond that understanding of the sector, we also know there are really three topologies going on here. At play, the urban, which I've described, as being

the poorly coordinated multilayered services. In the remote example it's completely the opposite. It's the lack of services with well-meaning committed people doing their best to fill gaps, the workforce challenge. But I think what's missed is in the middle, that third topology of Regional Australia. Predominately a hub and spoke challenge, where too often small communities have to fight for the viability of their health systems when well-meaning regional centres try and sequester those resources in the promise of a better service delivery, which isn't always necessarily the case, and certainly passes more social class on to people living in smaller communities. Now there's really been this relentless and unapologetic folks on chronic care. It's one of the cultural victories in health in most developed economies over the last two decades. As recently as last year Lancet had reported that at the age of 50 about twenty per cent of us have at least two comorbidities, and that twenty per cent increases to forty over the age of 60; sixty at the age of 70, and eighty per cent of us by the age of 80. And that's a rapid curve. So we're looking at where the opportunity is for better health value. Can the dollars be freed up to arrive at where they create the greatest value? That's a great challenge.

The obstacles. I won't lecture you about them. You tell me about them. You've done the reports. You've done the research and you know the data. But we have the negative perceptions about practising in the bush; insufficient coordination, the availability of workforce, the acute infrastructure shortages often aggravated by building substantial edifices in capital cities. We have the misaligned incentives and, of course, the variable quality often that drives from not having enough IT to be able to share information. So every one of us here in this auditorium are here with a small key, trying to open a small door into a big, big opportunity, which is primary health care and monetary disciplinary approach. We are so close to achieving that. But I come here with very, very sincere questions. I need evidence of that impact. I need evidence to convince me to change the way we do things at the moment. The data and the material to support the claimed successes that you'll be presenting this week. I need to know that these approaches are relevant, effective. They can be generalised to other parts of Australia, and that you understand the unforeseen downsides of everything that we attempt in health.

So what does care coordination look like? Is there a risk sharing that goes on between GPs and hospitals? Hospital avoidance sounds wonderful to me. How is it measured? How is it achieved? How do we reward the right service for the right practitioner at the right time and the right place? When, in real time, no one's ever certain what is right. In its burgeoning signs of brief intervention, what truly is effective? And what do we do with impotent interventions? How do we identify them and address them? What about hospitals that are often using their lowest skill medical staff to bulk bill in small communities and yet not share that information with those who provide the community care? How did doctors become so disenfranchised from how the local hospitals work? And how close do we accelerate electronic health, and particularly amongst our specialists who are probably the slowest to adopt that technology?

So I don't want to make any passing observations today about the last five years of health policy. I know there are differences around areas, like Super Clinics, Medicare Locals and the size of the non-service providing health system. But to both sides' credit, investment has been consistent over the decades. But you know there has to be some cautionary notes, also that the challenges we face now are not all that different to what they were five years ago and 10 years ago. I note that many forget that the Regional Health and Hospital Infrastructure Fund, which has made such a difference to Regional Australia, was 100 per cent on and of the 2007 Commonwealth surplus. Now there has not been a surplus since. And that very important fund has done wonderful things over the last five years. But any government that inherits a fund like that is obliged to keep it replenished. And not a cent has been added to that fund, and that's a concern to me. I think when we have moments like global financial crisis and stimulus packages, it is a concern when not a cent of it is spent on health care.

So let's talk about the rest of the world for a moment. Many of our OECD city neighbours are taking pretty bold and decisive steps towards reforming their health systems, and I want to mention a couple. The Netherlands, with their skyrocketing consumer satisfaction, by exceeding everything else in Europe and moving away from it, have really moved on beyond their very passé public-private health debate and

simply set up the Universal Insurance System. Turkey's Health Transformation Program over the last 10 years has used Universal Health Insurance and a quadrupling of their primary health care in investment to treble per capita primary care visits. And above that, to nearly double patient satisfaction rates in a very, very challenging economy of 45 million people.

The US, for all its much maligned social services, are really pioneering remarkable reforms around pay-the-patient incentives for health compliance. And Geisinger, in particular, have achieved a 20 per cent drop in hospitalisation using non-traditional roles more actively, including nurse coordinators and case managers. Chen Med in Florida, risk stratify the patients that they look after, and for those that are at greatest risk offer them free transport and regular monthly appointments. And they've also achieved 20 per cent falls in hospitalisation.

Now, to Spain, and I don't know if I can believe it until I see it for my own eyes, but Valencia, Galacia, and now Madrid providers, are now pioneering SMS engagement with all of their high-risk patients. And their prevention programs include using physicians to work with GPs to reduce referral rates. These regions report almost an unbelievable 26 per cent fall in health costs, 76 per cent increase in hospital productivity, the lowest waiting periods in Spain, and a 40 per cent fall in patient dissatisfaction from 15 to 9 per cent. These health providers bear all the risk and the state has a guaranteed budget for their health system, which never overruns.

Now, of course, I'm not sharing these examples because far out economies from other sides of the world should be telling us how to do things, but by the same token just because it's a very different health system or we're not very familiar with it or we have our doubts about it, is no reason to not look at their lived experience and take the best from what they do and try it, if it's appropriate. I think, you know, just like our sporting club dynasties or our favourite sporting codes. We won't be winners forever. We won't always be winning gold medals or premierships. So as a nation we can't simply trade on last year's results in our health care. We need to keep assuming that we can learn more from all sorts of sources.

Now what will be the big moves in the next five years? Just to finish off. I mean, Australia has this unique and proud, private-public blend of health care, which is actually unique worldwide. We need to use that to build quality and competition between those sectors in a rational way, and stop fighting over whether one system is better than the other. Primary care collapses, and you know that when providers basically practise away and ignore each other. And that's why chronic disease strategies are so important in driving multidisciplinary care. So the 2005 EPC's are important, the chronic disease management items 721, 731 are important. But they still only represent a very tiny proportion of Medicare spending. Now they're going to become increasingly sophisticated over time, I imagine.

We need to hold firm in our commitment to medical research. We need to hold firm to our commitment to the PBS. We can't second-guess or politically interfere in decisions by the PBAC. I sense all of those things have haunted the current administration. And we can improve the care of those with complex comorbidities, by identifying a health home without ever making it mandatory, by promoting and encouraging electronic health records without making it mandatory. None of it needs to be either controversial or compulsory. And personally, I'm really interested in the 18-month to four-year window where health and education have never really spoken to each other. I'm really excited about some of those opportunities with vulnerable children in high-risk school communities, where we have overseas evidence that intensive interventions using our current structures, for a little extra cost, can make a big difference in school attendance, school enjoyment, school completion, crime rates, teen pregnancy rates, odds of getting into university. We've got three decades of that international experience and it's being controlled in Australia right now.

So look, in conclusion, we can aspire to a rural health system where initiative is rewarded, where initiative rewards patients, where clinicians, as I've said, are unshackled, to make changes for the better, where risk is shared, and instead, drive clinicians to work as a team rather than apart, and where local partnerships are supported by governments because that's what we are there to do. And increasingly, we

need to free you up to pursue health value. Now Aussies are living longer. They're expecting more from their health systems every year. And our professions, I know, are up to that challenge, but you have to remain open to some of these new approaches rather than having professional groups make hasty assessments of whether each new change leaves us better or worse off. Like all complex systems, they work better if each of you is freed up to say what you think. Great ideas need to be allowed to germinate, be tested. And the architects of those great ideas deserve some reward for it. For the next four days, well, here is just one of those opportunities. So capitalise on it, seize it. Don't leave a single question in your mind unanswered. If you have one, I'm sure many others share it as well and are discussing the answers. Join the conversation. Talk about it late into the night, because after Wednesday there is always time to sleep.

Thank you.