PLENARY 2
SUNDAY 2 MARCH 2003
8.30 AM – 9.40 AM

Opening Video—video clips from previous Conferences and images of rural and remote health

Frank Meany

Opening of Day

Vivian Schenker, Conference Chair

Good morning. For those of you who were not here yesterday, I am Vivian Schenker. Welcome back to this first full day of the Seventh National Rural Health Conference. I hope you had a pleasant evening last night and are ready for what looks like being a pretty full day today, but a pretty interesting day, too, by the looks of things.

Now, I have got a few housekeeping matters to get under way before we go. The message board: Now, that is located near the Registration Desk, which is just at the top of the stairs. Most of you, I think, have been to the Registration Desk. Can you check there every day, even a few times, if you walk past and tell anyone you know who might have a message there.

Also, any changes to the program in your handbook, those changes will be marked in green on the program which is on display boards at the top of the stairs outside this Concert Hall. It might pay you to check there every morning as well. Now, a question you are probably asking yourselves is; how on earth are you going to find the concurrent session rooms? Well, there is a map, a plan, in the front of your handbook, which I am sure you all studied last night.

There is only, I don’t know how many pages, 199 pages of it. In case you missed the map, there it is on the second page. It has all the venues marked and you might, again, want to check those. All the rooms that you are meant to be going to are marked on the program in the handbook as well.

Just one final matter: The Speakers. Could all Speakers please call into the Speakers’ Preparation Room at the top of the escalators. Now, that is important even if you do not have any audio/visual material, we need to check you off. If you can bring your presentations, if you have them, at least two hours before your session then they can
be tested as well. Before we start the proceedings proper, Nigel Stewart, the Chairperson of the Alliance wants to say a few words.

**Nigel Stewart, Chairperson, National Rural Health Alliance**

I would just like to welcome those people who were not able to come to the fantastic opening last night and just make a few comments about that. The Tasmanian Aboriginal Centre gave us fantastic performance in welcoming us and, once again, I acknowledge the palawa people on whose land we are meeting today and their welcome to us is very important.

I think Florence Manguyu gave us a very humbling speech which represented the spirit of the children and women of Africa very eloquently and very well. I think when we look at the problems we have in rural Australia and we hear her speech it makes us see things in perspective and that international perspective is very important.

However, we have much work to do in also continuing to advance rural Australia and while most of us do not live in the environment that she described, and we need to contribute to helping people in that world, there is still much work to be done and there will be some Australians who do not live that far apart from the environment of which she has seen. If you did not have the opportunity to hear Florence, but you have the opportunity to talk to her today, I would very much emphasise she represents the spirit of, broadly, Africa and also that spirit of women and children and rural issues that we try to capture so well. I really thank her for her talk last night, and I will stop now.

**Vivian Schenker, Conference Chair**

Thanks Nigel. Well, as Nigel just said, the National Aboriginal Perspective is indeed important and our first speaker will help elaborate a little on that. He is the Deputy Chairperson of NACCHO, the National Aboriginal Community Controlled Health Organisation. Henry Councillor is also Director of the Kimberley Aboriginal Medical Services in the glorious town of Broome, truly one of the most beautiful places on earth, and he is going to talk to us today about the relationship between health and Indigenous history and culture. Please make him welcome—Henry Councillor.
KEYNOTE 2—INDIGENOUS PLACE
Healing the divisions

Henry Councillor, Deputy Chair, National Aboriginal Community Controlled Health Organisation

Thank you for that warm welcome. Yesterday we had a symposium, an Aboriginal symposium, which I think was a brilliant turnout. I think that the discussions and the issues that were raised at the symposium was very important and I think there has been some sharing in key areas of Aboriginal health and the linkages between Aboriginal health and mainstream Australia.

First of all, good morning ladies and gentlemen. I would like to thank the traditional owners for allowing me to speak here today. It is a great honour for me as a Jaru man from the Kimberleys to be standing her today in another brother’s country to be able to have the pleasure to speak to you and my fellow brothers and sisters. It is also a great honour to be here today to talk to such a large gathering. We normally talk in small gatherings where we seem to get the message across a lot quicker, but sometimes they have to be larger than expected.

As you will see in your program, this session was basically was going to be done by the Chairperson, Ms Pat Anderson. Unfortunately, Pat had to decline that offer. But what she wanted to let you know is that the National Aboriginal Community Control Health Organisation, NACCHO, represents over 100 Aboriginal medical services across the country. She does appreciate and thank the organisers for allowing NACCHO to be part of this discussion today.

What we have found is one of the key tasks of our Chair is to build relationships across this country from a national perspective dealing with policies, health policies and health issues. But also to share our determination to radical health improvement for Aboriginal people. This is an approach backed and supported by all of the NACCHO Board Members and membership across the country. As you will see in the next few days we will hear much about the appalling health standards across the country to rural remote and urban settings, and the health statistics about all Aboriginal people.

It is, of course, due to some of the poor Aboriginal health that I am here to talk to you about. There are a couple of things that I would like to raise with you here today. One of them the high proportion of our people living in rural and remote areas other than urban areas. The other is the fact that Aboriginal health is dramatically worse than our non-Aboriginal counterparts in all locations. In fact, a preliminary analysis done by NACCHO accounts for over 50 per cent of excess mortalities in these areas of Aboriginal people. Early death confronts us every day in our communities across this country.

It is really rare to live in an Aboriginal community, particularly in the rural and remote, without bumping into somebody who is either coming or going to funerals. Which is a sad event, particularly for us as we struggling not only just with our poor health status, but our economic status, our environment and most of all our lifestyle.
Our lifestyle has changed over the 50-odd years. We also want to enjoy healthy life. So what has gone wrong? That again is a question that we believe that many answers lie in many places. NACCHO views there has been a fundamental failure in the health service delivery nationally. This include in the national and redevelopment of the national health strategy.

Of course, some of the enormous health differences is due to the fact that outside of the health system, housing, poverty, lack of education, but the health system can be made far better towards the contribution. It has been particularly unsuccessful in addressing Aboriginal health as a priority because of its minority. It has also failed to take effect of that Aboriginal Community Control, talk effectively to Aboriginal Community Control Health Services and engage Aboriginal people in the planning process about their own health. We only have to look at some of the figures from other countries and other Indigenous people to know that this is the case.

For example, in the 1940s and early 50s in the United States Native American life expectancy improved by about nine years. The increase in life expectancy about 12 years in New Zealand for the Maori people over the past two decades. So let me make this clear; when we are given the power to design and control our own health services we do make a difference. And that’s our sole belief and our philosophy. This is a lesson that we have learned over the past 30-odd years in the establishment of Aboriginal medical services across the country. And, sadly, we know that others still have to learn this and respect it.

We believe the failure to talk to Aboriginal health organisation has resulted in little attention being paid to Aboriginal health by a number of host of key areas of government. There are a number of simple steps that can be taken to reach the solution. I would like to outline some of those areas, just a couple because of my time-frame. All rural health programs need to be accountable as to the impact on Aboriginal health. The reporting criteria to ensure that access of our services and Aboriginal communities in such programs should be made mandatory. Benchmarks need to be set. For instance, in light of the excess mortality in rural and remote areas attributed to Aboriginal population, a minimum benchmark should be set for expenditure on Aboriginal health.

Perhaps maybe 50 per cent of all rural health expenditure should be targeted on Aboriginal population and Aboriginal Community Control Health Service. Of course, this will vary from region to region depending on the proportion of the population that is Aboriginal. I understand that the Northern Territory Rural Workforce Agency is well in excess of this target. Within mainstream programs we also believe that Aboriginal health services should get a loading. This would recognise the extra and the workforce difficulty that these services face today.

The Aboriginal population and Aboriginal Health Service are excluded for many a wide range of special programs and initiatives that are available to improve health status in rural Australia. Putting things simply, this should not continue. It should change as a matter of urgency. I would like to acknowledge the General Practice Partnership Council for the work I understand that it will be doing over the next coming months to identify the Rural General Practice Programs. It could be extended to urban Aboriginal health services and urban communities. There are a range of workforce issues where benchmarks need to apply.
NACCHO has welcomed a number of recent commitments flowing out of the Health Ministers’ Council in recent times. However, this simply does not go far enough. One is the decision to review the impact of the mainstream workforce program and support training, recruitment and retention of health professionals within Aboriginal primary health care services. This should apply to all programs. There is a need for re-examination of the rural and remote classification system. For instance, it makes no sense to classify Darwin as a capital city. It is our firm belief that the government needs to make a fundamental commitment to equity in the areas of workforce benchmarks.

I am sure no one in this room would argue with me that all Australians should have equal access to doctors, nurses, specialists and allied health services. This should apply no matter who you are or where you live. It should happen no matter what the circumstances may be. As a first step, the current national average of medical practitioners per head of population should be taken as a minimum workforce benchmark to be provided in rural and remote areas. NACCHO believe this could be applied over a realistic timeframe. I propose that this would be proposed over the next five years so things can happen. It is our view that needs-based grants should be employed to assist in meeting these benchmarks.

They can be structured to fit needs accordingly; urban, rural and remote locations. Within that time-frame work must be done to establish need-based workforce requirements. The reason is simple; the high burden of disease suffered by Aboriginal people. The benchmarks are also vital to ensure proper access to hospitals. I believe they require to measure the transport, including type and time. The difference and difficulty between transport in rural, remote and urban. Hospitals should also be required to develop good partnership with Aboriginal communities in open discussion for a range of cultural barriers.

I am talking here about hidden racism and poor service delivery to poor people, irrespective of who you are. There should also be a monitoring of Aboriginal access to tertiary care in light of recent finding that the Aboriginal patient received less procedures in hospitals than non-Aboriginal counterparts, despite a much larger burden of disease. A final point I would like to make related to the partnership; meaningful, ongoing and lasting partnership. This is a key way forward for our sectors and mainstream agencies.

Let me use some of the division as an example. Some members services have a positive partnership with their local divisions. Their local division providing direct, meaningful and ongoing support. This demonstrates that we can have informed positive partnerships which benefit all. However, many do not. It takes time to build this partnership. Mainstream agencies need to understand that it takes time to build trust, given the history of the marginalisation, the oppression that we are all experiencing.

We also are pleased, at the national level, to be developing such a partnership with the Australian Division of General Practice. We hope this will provide greater impetus for divisions in our service to engage with each other at our local level as well. Divisions have expertise in accreditation and implementation of chronic disease initiatives, and implementation of enhanced primary care. Items that can benefit all sectors. We ask divisions to direct more of this expertise towards the Aboriginal sector in providing their own form of assistance. We also are pleased to be working in partnership with
other bodies, such as the Chronic Disease Alliance, the National Rural Alliance and the general practice organisations.

A good example of this is the product of the training videos and the Well Person Health Check. We accept that mainstream agencies can play a key role in assisting us in our struggle for better health. In return we ask mainstream to accept that Aboriginal Community Control Health Services has the backbone of primary health care delivery to our Aboriginal communities. We ask you to respect that most of the pressing health issues our Aboriginal people are facing today; alcohol abuse, violence, discrimination and the need for a healthier lifestyle are not going to be solved by Medicare. To address these issues requires community action—advocacy. By definition this community action must be controlled by the community itself, of ownership.

We need a mainstream health system to support and nurture that approach. We need to come together. I hope in this time that I have spoken to you that I have given you some food for thought for the next couple of days. Listening to yesterday’s symposium was a great honour because I could see there is a lot of commitment in this room, and there is a lot of good that people want to do. It is no good just cleaning your front yard, you need to look at your backyard as well. And that is a very important aspect of our environment today.

So in saying that, I thank you all for taking the time and trouble to listen to me this morning. There will be no doubt that there is a lot of work ahead of us today, and in the next few weeks, and in the next year, irrespective that we may be involved in war. As I said at the start, NACCHO want to build this partnership, develop alliance and look at Aboriginal health holistically, together, with you. We know we cannot do this alone. And neither can you. We need to walk hand-in-hand and develop policies, procedures and programs so that we can overcome some of these meaningless diseases and illness.

We must heal the divisions in the partnership where they are broken down. We have no choice. It is there and we need to work with it. Many lives depend on it. The well-being of our brothers and sisters must be a common goal. NACCHO will work with any individual or any organisation to the commitment to this goal. I thank the organisers for the opportunity to speak to you here today and wish you all the success from this conference in the next coming days. Be well. Thank you.

**Vivian Schenker, Conference Chair**

Thank you, Henry. Well, as Henry has pointed out so eloquently, health is not something that exists in a vacuum. You cannot even look at health issues in isolation and expect to have any effective impact, or even any effective insight. Our next Speaker knows that only too well as well. He is the President of the Australian Local Government Association, as well as President of the New South Wales Shires Association. Now, he is also a farmer and a grazier, when he gets the time, and he lives with his young family in Moree, which is in New South Wales. Of course, when he is not travelling around the country representing the LGA. Please welcome now Mike Montgomery.
KEYNOTE 3—ENVIRONMENT AND POPULATION
State of the regions: environment, population and health

Mike Montgomery, President, Australian Local government Association

Thank you very much, Vivian. I, too, would like to acknowledge the traditional owners of the land on which we meet today. Nigel Stewart, Delegates, Distinguished Guests—can I say from the outset that the Local Government Community throughout Australia certainly cherishes the work that you, the Rural Health Community, do for rural and regional Australia. So many of you go far beyond the normal call of duty to care for the millions of Australians who call the bush their home. I am one of those. Keep up the good work.

My task today is to do two things. Firstly, to provide you with an overview of the social, economic and environmental health of regional Australia. And this, I hope, will provide some context for your deliberations over coming days. Of course, as we know, health is closely linked to the socio-economic status and poorer regions will have poorer health outcomes. My second task is to outline the Australian Local Government Association’s intention to play a more active part in the growing campaign to improve access to health care in regional Australia.

In that context, I would like to take a look at some of the emerging workforce issues. Firstly, to the state of our regions; we hear an awful lot from governments, both state and federal, about their commitment to regional development. Much of that commitment is real. There is significant programs that are assisting our regions to grow and prosper. But at the end of the day we are still largely a capital city centric nation. The current economic orthodoxy shuns true nation building in favour of market driven outcomes. This trend has led to regional inequality, and the problem is getting worse, not better.

The ALGA, for the past five years, has worked with the Melbourne-based Economic Consultants In National Economics to assess the state of our regional well-being. Our annual State of the Regions report is one of the few documents that provide a comprehensive stock take of the economic well-being of our regions and their prospects for economic development and employment growth. The latest report released in November of last year gives local government cause for serious concern. It shows that the equality of regional incomes has drastically worsened since 1998. Australia has very few regions that are highly competitive in the modern global economy. And, not surprisingly, it is these highly competitive regions that capture a large share of Australia’s economic output and income.

The regions covering 20 per cent of the Australian population with the highest level of incomes now earn over 30 per cent of all income, and have claimed more than 43 per cent of the increases since ’99. While overall equality of employment has improved, the regions covering 20 per cent of Australia’s population with the worst employment received only 11.6 per cent of the new employment created since 1998. But the most dramatic trend in regional equality has been the change in the value of housing stock;
with regions covering 20 per cent of the population with highest values of housing now owning over 34 per cent of the entire value of housing in Australia.

In short, the rich regions are richer and the poor are getting poorer. For example, the lowest levels of unemployment are once again in Sydney, with four of Sydney’s seven regions occupying the top four places in Australia with unemployment rates between two and four per cent. At the other end of the spectrum, in regions in central Queensland, here in Tasmania, northern Adelaide, the Northern Territory, northern New South Wales and Gippsland, where the unemployment rates are between 14 and 25 per cent there are other disturbing trends. The 2002 report examines issues of inequality among the young and old between Australia’s regions.

For younger Australians the statistics are striking. Young people aged 15 to 34, it does not include me any more, unfortunately, young people aged 15 to 34 are almost three times more likely to earn $50,000 a year in the core metropolitan regions as those who live in Australia’s lifestyle, rural or production zones. As a result, younger skilled workers are leaving the disadvantaged regions for the core metropolitan areas. At the same time, older less skilled workers are leaving the metro regions for lifestyle regions, such as the New South Wales North Coast.

This aged migration phenomenon is partly in response to low incomes and weak employment opportunities for the over 55-age group in our inner cities. The impact of these changes, of course, is reflected in the number of people in lifestyle regions now on the disability support pension. Lifestyle regions have experienced an 80 per cent increase in disability support pension recipients since ’91, while growth in the core metro regions has been less than 30 per cent. As national economics points out, benefit reassignment continues to be a strong indicator of the failure of economic policy to address growing regional inequality.

So we have the situation where some regions are doing well, but many others are being left behind. And the situation becomes worse when you add the impacts of environmental factors such as drought, fire, salt and flood. The impact of salinity, for example, is profound. Across the country some 2 million hectares are now affected by salinity, and this could rise to 12/15 million hectares unless we do something about it. The sustainability of many rural industries is at stake through the loss of farm and grazing land to rising salt. The loss of agricultural production is some $130 million a year so far, and one estimate has put the value of land lost at almost $700 million.

More than 400 urban and rural local government areas are now affected by dry land salinity in some way, and the problem is projected to get worse before it gets better.

Salinity reduces the lifespan and increases maintenance costs of roads, bridges, footpaths, ovals and sports grounds. It lowers property values, which impact upon rates. It causes the loss of areas suitable for residential development, and it downgrades town water quality and water supply infrastructure. The impact of salinity on urban infrastructure is not confined to a few isolated areas. Salinity is having a big impact on cities like Wagga Wagga, Albury Wodonga, Forbes, Bendigo and even parts of western Sydney. So the drought is also having a profound impact on many regional communities.

The nation’s winter crop was the worst since ‘94/’95. The summer crop is forecast to be the worst since ‘82/’83, and while the National Climate Centre believes there is a strong chance of higher average rainfall from March to May, and there has been some
relief on the east coast of the mainland, the drought is likely to wipe 80 per cent of the 2001/2002 net value of farm production from 10 billion down to 2.2 billion. A huge impact. Almost 5000 farm families are now receiving federal drought aid, with more than 66 million already spent. In New South Wales alone, there has been an increase in farm families receiving interim income support of more than 25 per cent.

In Queensland the number of farm families receiving interim relief has almost doubled, while in South Australia and Western Australia farm families receiving the assistance has increased by more than 100 per cent. The effect of drought has a multiplier effect, of course, hitting farmers, their families and the businesses in the towns that service them. Some have predicted that the impact of this drought will still be with us in five years time, if those communities can recover at all.

So I have painted a fairly gloomy picture of the current developments in regional Australia. But, look, I would like to add that there is a great deal of resilience and determination and enterprise in our rural communities. They are strong communities and they have got big hearts. The LGA believe that we need to have a completely fresh look at regional development and to start a substantial investment program to help regional leadership, co-operation, strategic planning and infrastructure development. Major regional investment is needed along the European and American models if we are to tackle growing regional inequity and disadvantage.

What we really seek in regional development is sustainable communities, and we live in a society and not an economy. We need policies that address the triple bottom-line—social, environmental and economic. And that is why Local Government is not just concerned about economic outcomes in the community we serve, but also about health outcomes. In particular, we have been worried about access to primary and acute health care in regional Australia. We are acutely aware of the impact of shortages of health professionals and rural health workers in the regions. We know that there is a critical shortage of nurses nationally. We know that more than 22,000 nurses will leave the workforce over the next five years.

There will be 31,000 nursing vacancies between 2001 and 2006, about three quarters of which will be created by nurses leaving the profession. We know that we are facing a problem with pharmacists. Only recently a study commissioned by the Pharmacy Guild of Australia found there will be 3000 fewer pharmacists than we need to meet community demand within eight years. 3000 fewer. We know that the Australian Competition and Consumer Commission, ACCC, last month warned that there could be a severe shortage of surgeons in the coming years. And we know that where national shortages of health professionals occur the problems will be most sharply felt in rural areas.

It seems to me that as a nation we lack the ability to effectively plan for our future health workers needs in accordance with community needs and priorities. I want to focus on just one shortage area, general practitioners, as a case study. It’s been 10 years since the Commonwealth began the rural incentives program in a bid to keep rural GPs in the bush and to swell their thinning ranks. But a decade, and millions of dollars later, serious shortages persist in rural and remote Australia. Today, equally serious shortages are emerging in outer urban areas, such as the western suburbs of Sydney and Melbourne, making it even harder for the bush to compete for doctors.
GPs are closing their lists and are no longer taking new patients, reflecting the increasing workload they face. Rural communities and local government bodies, some of which are offering packages worth hundreds of thousands of dollars, to obtain doctors for their towns are growing increasingly frustrated at the lack of access to medical services. Why is it that after all these years we appear to have made so little progress? Consider the following: An Access economic study commissioned by the AMA last year found the national shortfall of GPs to be between 1200 and 2000, with at least 700 more needed in country areas.

The study said nearly half of the rural population lived in areas of severe GP shortfalls. The Rural Doctors Association estimates that we need more than 1000 additional GPs in rural and regional Australia to address the shortfall. Health outcomes continue to be worse in rural and regional Australia. Death rates for males under 65 in rural and remote areas are 10 to 20 per cent higher than for those in major cities. For females the figure is 10 per cent higher. Why have the problems persisted after a decade of so called political action? Well, it seems to me that four factors affect the size of our GP workforce remuneration, and clearly GP incomes are not what they used to be. But that reflects the number of GPs who are no longer bulk billing. So, remuneration, and the number of medical students who graduate each year, the number of doctors who undertake GP training and the number of overseas trained doctors we bring into Australia.

All four are controlled to a greater or lesser extent by the Federal Government. For the past decade the government has maintained there has been a surplus of GPs in Australia. Not a shortage, a surplus. The only problem was that there were too many in urban areas and not enough in the bush. Or we are told it was a problem of maldistribution, not of quantum. In 1992 the Labour Health Minister, Brian Howe, announced a series of measures designed to curb increasing Medicare costs. The strategy was designed to, and I quote:

Improve access when necessary at the same time as reducing the growth rate in the number of general practitioners.

In other words, they wanted to keep the lid on doctor numbers. For example, the number of overseas trained doctors permitted to sit a medical entrance examination was capped at 200 a year. By the mid 1990s the Commonwealth was moving to restrict access to Medicare provider numbers. Now 10 years on the orthodox view of our medical workforce is being seriously questioned. Most surprisingly the AMA, of all organisations, is leading the charge for change. AMA and Access Economic Researchers suggest that we had an overall shortage of GPs in 1998. Not just a rural shortage, but an overall shortage. Today they say the overall shortage is around 2000 GPs. If this is the case then it is little wonder that bulk billing is disappearing from regional Australia.

Little wonder that GPs in places like Ballarat are closing their books to new patients. Little wonder that we hear reports of women turning up at country surgeries with sick kids before they even open on the off chance that there will be a cancellation. If that is the case, why has this been allowed to happen? Why haven’t we been able to forecast this shortage and planned to increase our GP numbers. Delegates, nothing less than a National Inquiry is needed to assess the adequacy of Australia’s medical workforce planning processes and to see if we can put better mechanisms in place that can better meet the needs of regional Australia in the future.
The ACCC has also bought into the debate about how we determine doctor numbers. Four weeks ago it proposed reforms to the training and assessment procedures for surgeons. In its reform paper it was critical of the body that advises on medical workforce issues, the Australian Medical Workforce Advisory Committee. It said that the methodology used by AMWAC to determine surgical training number targets needs to be improved. It said, and I quote:

Simply to work on the basis that projections should be aimed at ensuring the ratio of surgeons to population is kept stable, rather than assessing whether the ratio is appropriate in the first place, would be to avoid dealing with the most fundamental issue a workforce advisory committee would address.

It strikes me that now would be a good time to take stock and see if we cannot come up with a better system of planning our medical workforce. I also think we need to look beyond medicine and have a look at our overall planning mechanisms for the entire health workforce. We already have an Australian Health Workforce Advisory Committee, which is co-located with AMWAC. But why cannot we have one overall workforce planning body that can fairly and impartially assess, as the ACCC says:

Appropriate ratios of health professionals and health care workers and anticipate changes in demand.

An overall body would be able to look impartially at issues such as engaging nurse practitioners in areas where doctors cannot be found. That said, I think there are some hopeful signs. The number of students studying medicine has been increased, although this will not translate fully into fully trained and independently practicing doctors for another 10 years. There has also been some easing of restrictions on overseas trained doctors. GP training has also been restructured with a much greater emphasis on equipping GPs for work in rural areas. Kay Patterson, Senator Kay Patterson, the Federal Health Minister, says that GP labour supply in rural and remote Australia increased by 4.7 per cent between 2000/2001 and 2001/2002.

While that is welcome, the rural doctors point out that this represents about 160 new rural doctors. A far cry from the 1000 or so they say are needed in the bush. So what do we need to do? A number of suggestions. We should also be increasing the number of medical graduates by at least 300 a year. We should be dramatically increasing GP training places from 450 to at least 600 a year. We should be breaking down entry barriers for appropriately qualified doctors who have trained overseas. We should be considering the introduction of differential Medicare rebates, with higher rebates in regions with significant doctor shortages, particularly rural and outer urban areas. We need to consider how we can stop the loss of procedural GPs from regional areas and we need to fund nurse practitioners to work in areas where no doctors can be secured.

For its part, the Local Government Association of Australia has called on the Federal Government to provide more assistance to rural and remote councils to recruit and retain medical practitioners and medical services in small rural towns, especially those towns that do not have infrastructure such as housing and surgical facilities. Local Government is doing a great deal to attract doctors and other health professionals in regional areas, particularly by making lifestyle packages available, including accommodation, travel and assistance with locum relief. Some are even providing education for the GPs children. But more could be done with direct Commonwealth support.
Clearly, there’s plenty of goodwill around to address the problem of not just doctor shortages, but regional shortages of all those engaged in health care delivery. I look forward to working with all of you to achieve some further positive changes for the communities we serve. Thank you.

**Vivian Schenker, Conference Chair**

Thanks Mike. Can I make a final appeal; I am going to have to make it every day by the sounds of things, about mobile phones. Now, I am actually going to try a different tack today, if I cannot convince you to turn them off because you cannot even bear the idea of being out of communication for a couple of hours every day, what about turning them to vibrate? It has a double advantage; nobody else has to hear it and you get a little thrill in the middle of one of the speeches. A little wake up call. As opposed to what you get normally, that is right. There are lots of thrills in the speeches we are hearing today. Could you perhaps try that? Fiddle with your phones in the tea break and see if you can find the vibrate function. Okay.

Well, we all know that conferences like this do not just happen. They do require an enormous amount of planning and work and they could not happen at all without the support of organisations like Telstra. Telstra was also involved in our last conference in Canberra and the Regional Managing Director of Telstra Country Wide for the southern region, Lawrence Paratz, joins us now. Perhaps he can help you with the vibrate function on your phones. Please make him welcome. Lawrence Paratz.
Formal opening of the Exhibition

**Lawrence Paratz**, Regional Managing Director, Telstra Country Wide, Southern Region (Victoria and Tasmania)

Thank you very much for that. The last time I had an introduction like that I had about 1200 people bring their mobile phones over and say, “Now where is the function?” So I might have to escape quickly. Look, it is a real pleasure to be here this morning and to be part of the early phases of the Conference and, of course, to give the level of support that Telstra and Telstra Country Wide have given to the Rural Health Conference, not only this year, but also previously. I guess the story of Telstra Country Wide is really very compatible to, I guess, the plea that we almost heard from the previous Speaker. It has now been more than two and a half years since Telstra Country Wide was created, and that was done with the intention for Telstra to gain a better understanding of regional capabilities and opportunities and to support our customers and communities throughout Australia including, importantly, outside the main metropolitan areas.

A key component of that was 35 locally based management teams, very senior people, placed and developed in regional Australia enhancing our relationships and our understanding of the geographic and sector specific needs across Australia and thus enabling us to develop targeted plans, targeted products and to work with communities and groups and better allocate our resources. And, of course, an important part of that is the facilitation of access to quality health services and leading edge health services for all Australians no matter where they live, no matter where they are, no matter where they are educated. That is one of our very strong priorities founded on regional knowledge.

The ability of our telecommunications infrastructure to transmit images, voice, and data between health units is facilitating today: diagnosis, clinical advice, consultation, education, training services and valuable medical information across vast distances. And I guess also importantly it is improving the liveability for medical professionals throughout Australia as well for their families to be educated, to live, to develop and enjoy lifestyles in regional Australia.

I am pleased that through the work of Telstra Country Wide over the past two and a half years we have been able to expand the reach and the quality of advanced telecommunications infrastructure to more Australians. The potential of this infrastructure to expand and improve the equity and availability of access to health services in rural and remote communities is very exciting. And it requires, in addition to infrastructure, imaginative responses to develop and build on the possibilities of that infrastructure. I am delighted to see, right across Australia, that response, that imaginative response coming from people like the people here in this room, building on that infrastructure.

I would like to share with you this morning some examples of how innovative customers, like yourselves, are using our infrastructure to the benefit of both patients and health care professionals and particularly including remote areas. Let us look now at…
…conjunction with an innovative management software that they have developed to link patients and health care providers in remote locations with clinics, hospitals and reporting specialists across Australia.

Of course, the slide is a very complex one, I am sure most of you will not absorb it at that range. But through RRRA’s intelligent auto-routing software medical images are automatically delivered to the most appropriate medical specialist anywhere in Australia. And that is done based on the skill and availability of that medical professional improving the timeliness and accuracy of reports.

A further example: the New South Wales Rural Doctors Network is using Telstra Big Pond Broadband two-way satellite to link 50 remote clinical practices to the latest research information, clinical diagnosis data bases and on-line education and training. This same satellite broadband network enables doctors to keep in touch with the progress of patients in remote locations and to manage their patient records more effectively.

The benefits, of course, are improved patient treatment and care, as well as helping to attract and retain GPs in rural and regional communities. But perhaps one of the most practical and pervasive applications of technology in recent years has been the ability to bring patient and doctor together via video conferencing, allowing face to face diagnosis and even medical intervention across distance without either party having to travel.

The introduction of tele-psychiatry to Medicare in October last, means that people living in rural and remote areas can now claim for consultation with a psychiatrist via video conferencing. Video conferencing has also emerged as a tool for visual collaboration between colleagues, speeding up the decision-making process and assisting in both the formal and informal education programs necessary for professional development in these areas. The pipes which deliver these things, whether it is confer-link video or the other examples, include things like ADSL and ISDN and I know all of you will be interested to say, “Well, that is nice to look at these examples, but are they available? Can I use them?”

Well, these things are now available in 96 per cent of the population, ISDN in particular, and that reaches customers up to 18 kilometres from an exchange, and with the satellite that fills in the other four per cent. So high speed internet and data capability is now pervasively and universally available. Let us put that into more concrete and succinct terms. In remote rural towns such as Tibooburra, Menindee, Wanaaring in New South Wales or in Boulia, Burketown, Doomadgee in Queensland and all the other places like that.

These all have ISDN infrastructure. If the existing potential were to be realised, the further the rural or remote patient would ever need to travel to see a doctor is to their nearest town, and that’s talking about some very small towns here, to use a very cheap video conferencing facility, like the one you saw earlier.

In Victoria, a partnership between Telstra, the Department of Human Services and Tele-Health Victoria is providing video conferencing to around about 145 sites. I am particularly pleased that this partnership between business, government and the non-
profit sector has resulted in us being able to offer an amended and reduced ISD and tariffing model, which provides up to 25 per cent reduction in the underlying costs. And of course that is all extremely positive for the whole program. We are also working at the very cutting edge of satellite internet applications providing point to point and multi-point video conferencing over our two-way satellite internet service.

This has had tremendous implications for the more than 3000 customers in the most remote parts of Australia who took up an extremely attractive offer of Big Pond two-way satellite, and that offer was made possible partly as a result of Telstra winning a very significant $150 million contract for provision of advanced services into the remotest areas of Australia. These customers now enjoy faster, more reliable internet and this opens up possibility even for more possibilities for tele-medicine applications and education into the most remote parts of Australia. And the graphic you see behind me is not hyperbole, but reality.

Sitting on top and alongside all of this, mobile technology continues to improve a pace. Through our terrestrial CDMA and GSM digital networks, both digital networks, and via the new Telstra Mobile Satellite Service this has tremendous application for rural health. The CDMA network covers around about 14 per cent of the land mass, the Telstra Mobile Satellite Network, which you can see outside later, covers every inch of Australia and out to sea as well. The Short Message Service, SMS, and we have just had warning about the mobiles, but the SMS to mobile phones is finding a whole range of uses.

I guess we hear a lot about it being used for social purposes amongst teenagers, but the sort of uses that we are seeing emerging include reminding patients to take their medicine, providing rostering information to medical professionals, alerting doctors to medical conditions and providing remote data access. Some diabetic patients in Wollongong, for instance, are involved in trials where they regularly send their monitored data back to medical staff using data services over the mobile network. Telstra’s new hand-held mobile satellite phones are generating a lot of interest from rural community services and particular nursing services for staff safety and communications when out on home or community visits.

Recently, we donated a Telstra mobile satellite phone to help around about 10,000 remote and rural health workers in Australia get timely access to the Council of Remote Area Nurses of Australia Bush Crisis Line, CRANA. This is staffed by three psychologists who work from satellite offices in various parts of the country. The 24-hour confidential telephone service provides debriefing and support for remote health practitioners and their families. The psychologists are now able to take emergency calls on their Telstra mobile satellite phone even if they are out working or travelling in areas beyond the coverage of the extensive digital CDMA network.

Looking now to the future I am extremely enthusiastic about Telstra’s future in delivering quality health services to all communities. We certainly have the latest telecommunications infrastructure and there are a growing number of applications to realise and build upon its potential. Furthermore, we are actively supporting new health applications through the Telstra Broadband Fund which we introduced in February 2002 to stimulate and fast track the development of new applications and technologies. Health Share Pty Limited is one of four health related projects targeted for the first round of funding under this fund.
Using ADSL technology the company is developing an automated system that uses collaborative video conferencing platform for consultation, program sharing, scheduling, billing, messaging, and greatly improving clinicians’ communications with each other and their patients. We are also working with partners and health sector customers to develop a unique privacy, security and authentication package for electronic health records, known as EHR. This will improve efficiency, safety and quality of care over remote and paper-based systems.

So it is a story of innovation. With a continent comprising some 7.6 million square kilometres we have overcome tremendous challenges to bring telecommunication services to all Australians. I invite you to explore some of the technologies that can connect patients and health care providers across large distances on show outside at the Telstra Country Wide exhibit in the hall. Furthermore, I invite you to look at the very wide range of innovations available from all of the exhibitors out in the hall and take the opportunity to view the offerings from a large range of companies and organisations, government departments, instrumentalities, to improve health care throughout the vast continent.

There is certainly plenty to look at. On our own stand you can look at the Telstra mobile satellite that I have spoken about. You could have a look at long-range cordless telephones. You can have a look at Blackbury devices that keep you in touch. And we will have staff out there right through the Conference to assist you. You could even look at a device that allows you to take phone calls from your aircraft.

In closing, I would like to wish you all the best for a very successful Conference. Just looking at the energy and enthusiasm around this morning, I think that is almost a foregone conclusion. We, in Telstra Country Wide, are delighted and pleased to be able to support the Conference because we recognise the importance of the work that you do in supporting our community. Thank you very much for your attention.
Preparing for concurrent sessions and evaluation

Vivian Schenker, Conference Chair

Lawrence just whispered to me that he was only kidding; he would be very happy to help anybody with any of their mobile phones anytime they see him around in the next couple of days. Is that not what you said, Lawrence? Absolutely. And can I encourage you, as Lawrence did, to have a little look at the exhibition outside. There is actually an incentive and for somebody like me who is not used to this sort of thing because I come from the ABC where they give away nothing, there is in fact a competition with prizes.

I do not know if you have seen this yet. If you had a good look at your handbook last night, as I am sure you all did, you will see it in there on page 40. The gist of it is that you take out the business card holder, which you got when you registered, and you collect business cards, and if you collect business cards from, I think it is 20 of the exhibition booths, then you are eligible for big, big, big prizes.

All you have to do is hand them in. Now, where do you hand them in? You hand them in at the Registration Desk for checking and if they are correctly completed your name will be placed in the Exhibition Incentive Competition Box. And do you know what the prizes are? Well, you get your registration back and $500 in cash. So I reckon it is well worth doing, and at the same time Lawrence can help you with your mobile. It is a double whammy, is not it? So what more incentive do you need?

Well, that is the last of our Keynote Speakers for this morning. This is the point at which you move into your Concurrent Sessions. And perhaps to tell you a little bit more about how they will work, seeing as we are about to move into the first of them, here is Gordon Gregory.

Gordon Gregory, Executive Director, National Rural Health Alliance

Thanks Vivian. First, a word on recommendations. We are very interested in all of the recommendations that are generated. We have made a start by collating those that were included in the contributed papers. We want to add all the recommendations, which emerge during the course of the Conference. To become involved, what you do is to put your recommendation into writing, legible writing. It has to be signed by at least two people.

The other way, of course, in which recommendations will be generated is through the Concurrent Sessions. If you have a recommendation which emerges let your Chairperson know and the Chairperson will write it down and present it to the Recommendations Committee.

If you have your own recommendation, sign it, two people, put it in the box, or boxes, which will be on the Registration stand. So boxes for recommendations on the Registration stand. You will be hearing a lot more about recommendations through the course of the Conference and in particular on Tuesday.
To the Concurrent Sessions, we try to run the whole Conference on time. When we do not, when we move to the Concurrent Sessions we do not take time off the Concurrent Speakers and we do not collapse the five-minute gap between the Concurrent Speakers. So what we are asking you to do, the practice we are asking you to adopt, is as follows.

When Vivian winds the whole Plenary Session up and says, “Go”, look at your watch and we then have five minutes. Five minutes after Vivian says, “Go”, we start a Concurrent Session and the first paper runs for 20 minutes. And then there is a five-minute gap in all Concurrents at the same time, we hope, so that people can swap from one to the other.

Then there is a whole 20 minutes again for the next paper-giver and then there is a five-minute gap, not this morning because there is only two this morning, but usually there are three. So there would be a five-minute gap and then 20 minutes. So we do not take time off — look at your watch when Vivian says, “Go”, and the first session in concurrence begins five minutes after Vivian says, “Go”.

So hopefully it will work. We do not want people to have come all this way and to have gone to all the trouble to present papers and then for them to be squashed for time. Thank you.

**Vivian Schenker, Conference Chair**

Do not go yet. Do not go yet. I have not said “Go” yet. Ralph McLean, I think, wants to talk to us briefly as well about how you can go about evaluating the Conference — Ralph.

**Ralph McLean, Conference Evaluator**

Thanks Vivian. It is lovely being here, not as a bureaucrat, not as a manager of a health service in rural and remote Australia and not as an academic. My role is very simple. It is to listen to you in the next three days. It is to listen to the Conference. It is to make observations. It is to give an evaluation, which is not just the old boring, staid, quantitative evaluation. For those of you who know me, the odd few hundred, I think it is also a good example of Gordon Gregory’s sense of humour making sure that I do not speak in public for three days. Thank you, Gordon. And I look forward to meeting every one of you.

**Vivian Schenker, Conference Chair**

Thanks, Ralph. We will have to talk to you individually, I think, rather than hearing you en masse. Now, this is where we do move to the first of those Concurrent Sessions.

Can you note as well, before you go, that there will be a session on the revised Healthy Horizons document from 11.15 to 12.15 today. And if you are interested in that it will be held in the Woolstore, which is around the back. Across the road and round the back of the Hotel Grand Chancellor. I think you have your morning tea here and then you go across the road.

Okay, ready, set, go! See you back here after lunch.