



TRANSCRIPT OF PROCEEDINGS, E&OE

NATIONAL RURAL HEALTH ALLIANCE INC

PUBLIC SEMINAR: HEALTH AND WELLBEING IN REMOTE AUSTRALIA,

CANBERRA, 1 NOVEMBER 2005

QUESTION AND ANSWER SESSION:

SENATOR BARNABY JOYCE

PROFESSOR JOHN WAKERMAN

MR ANDREW PHILLIPS

FACILITATOR: Sue McAlpin

SUE McALPIN: I wonder if we could have the three speakers up the front for people - John, Barnaby and Andrew. And questions? Just here.

ROBERT BAIN: My name is Robert Bain. I'm an agricultural economist who's become involved with Health Workforce in recent years and I wanted just to address a question to Senator Joyce. You made some comments about overseas trained doctors which I think most people here would agree with both in terms of qualifications and experience and where they come from. The advantage though of overseas trained doctors is they can be required to work in areas of workforce shortage as part of the immigration and visa arrangements and I wondered what you would do if you no longer had the OTDs that were required to work in areas of workforce shortage, how you would actually go about getting doctors into these areas?

BARNABY JOYCE: Thanks for that, Robert, and as an accountant, still with an accountancy practice, I am aware of your work in the past, which it's good to actually put a name to a face.



It doesn't remove us from the moral responsibility that we have. If we take in an overseas doctor to fulfill a domestic requirement of Australia, we nonetheless leave a hole from wherever that doctor came from. And I imagine if we have doctors coming in from possibly the United States or England or countries which have a well developed medical system, the argument could be posed that the effects on the country from which we take that service are not detrimental in general to the people.

But if you take a doctor from South Africa - and some very good doctors come from South Africa - that position will be filled, it will be filled with a doctor from Rhodesia or Zimbabwe or Namibia or wherever. Ultimately you have to follow it down the tree and find out that you are taking a resource from an area where they don't have the capacity and then you have a moral justification argument about what you've just done. And is it fair that for the sake of filling domestic requirement in Australia that you increase the child mortality in some town in Zimbabwe. I don't think that's a fair outcome for those people.

We must acknowledge the consequences of what we are doing and how it affects the wider world that we live in. Obviously we are only putting a bandaid on the problem. The problem is we don't have enough doctors, especially doctors in regional areas, especially doctors who are culturally attuned to specific areas in those regional areas. It's always a shame with my own brother who became a doctor at the age of 26. Prior to that, I can assure you, he was a drover on a stock route and he had 787 cattle at one time and he used to break horses. Now, he would be a good doctor to have out west. In fact I think he'd be a terrible doctor to have where he is. I remember seeing him shoe a horse, and I hope he works on people a bit better than he can shoe a horse!

But we have to fix our problem up within Australia. We have to probably maybe recut the whole way we go about creating doctors, and nurses, and maybe there is a wider aspect for nurses. It's great today, with the discussions, in indigenous areas, especially when you get out west, there are nurses who specifically have a quasi-medical role. And it is happening now and maybe we should expand that role somewhat so that we get a wider involvement of directors of nurses who go out and take on these roles.

We have to also utilise, in the telecommunications area, they're one of the things - prior to the sale of Telstra, one of the big attributes was to make sure that we could get tele-medicine out



west and to get the referral basis. But to get tele-medicine out in an effective form we must have optic fibre to the hospital, to get the five to 6000 megabit download speed, to be able to get that sort of continuum of it. There's some incredible number, it's like 600 million or 60 million consultations a year that go on in Australia - I don't know the number, it's a massive number - and the capacity for us to make remote areas, for specialists' work, connected into the hubs of the Canberras and the Tamworths and the Dubbos and the Sydneys and the Brisbanes, the Perth, the Alice Springs and the Darwins, is there now with the technology we've got.

Ultimately, when we look down the track, you know that with keyhole surgery and the use of robotics, we don't know where this may end, but it could well end if we had the technological capacity for operations to be started, to be commenced remote. And people say, "Well, that's in the never, never". Well, not really, we're heading in that direction now.

So to answer your question, we must, no matter what happens, always acknowledge the consequences of where we acquire our doctors from. If we are going to acquire doctors, we must be aware of the ramifications to the country we take them from and make sure that they're not too onerous, that we are not just basically exploiting a resource from a country that can't afford to give them up.

Secondly, we must fix the problem up in Australia and cut the area back down to its basics and start looking at wider roles for probably nurses and also how we train our doctors. And, as given during the speech, we must make sure that we keep our development of regional medical facilities or the regional training areas for doctors, that is absolutely essential. So maybe in the future the roles for Charles Sturt and New England Universities, even though it's expensive to develop medical skills, is a clear example of how we can actually do it. We have had a great success from having clinicians or clinical schools in regional areas and we must continue down that process.

Finally, we must be fully aware of the technology that we have around us, especially the telecommunications technology, which has already been brought up. Be aware that this is the technology of the future. It gives the capacity for people in regional areas to have access to the best in the field, the best in the country right at their fingertips. And we must - well, we did, it was one of our predominant things with the Telstra legislation, why we kept on going back and saying, "That's not good enough", "That's not good enough", "That's not good



enough, we don't get more, we won't approve it", until in the end we did the very best deal we could but we also have the capacity to have money aside, \$3.1 billion put aside, another 340 million in the year 2008, with the deeming rate that we got on the \$2 billion. That's the sort of money you need aside to actually roll out the optic fibre and it was after lobbying from people such as the AMA that was a predominant driver in how we made that decision.

SUE McALPIN: Thank you, Senator Joyce. Any other questions.

JOHN WAKERMAN: Could I just add something to that?

SUE McALPIN: Yes, John.

JOHN WAKERMAN: I just wanted to add a couple of points. Look, I absolutely agree with everything you said about that. I just wanted to add a couple of points. I agree with you totally, it's not just about doctors, it's about the team. And there's a lot of discussion at the moment about inter-professional education, new categories of health workers and so forth and I think we're, by necessity, with the sort of workforce crisis that we're facing, we're going to have to consider those things.

The Alliance has got a position on education of doctors and that is that we should be a good global citizen and produce not enough just for ourselves but perhaps consider the needs of our region as well. And the only other point I wanted to make was that Andrew put up a graph about the origin of medical students and the increase in the numbers coming from rural and remote areas after the government invested in things like rural undergraduate medical scholarships. And we know that the best predictor of where someone is going to practice, the best predictor of rural practice is rural origin. So if we can encourage more students, not just medical students but others, dentists and others, from rural and remote areas, then our return is going to be relatively high on that investment. So I think we need more of that.

SUE McALPIN: Any other questions? Yes.

MARTINA STANLEY: I'm Martina Stanley from ARRWAG, the Australian Rural and Remote Workforce Agency Group. We represent rural workforce agencies who are responsible for recruiting doctors for rural and remote areas, and I'd just like to comment on Senator Joyce's comments earlier on.



There seems to be a perception that we're taking people out of Third World countries and I think if we were doing that, that would be a really bad thing to do because obviously we're disadvantaging those communities. But I think there's another side to it too in that those people are exercising their choices to come to this country in the same way that I did and many other people in this room did and we actually have no control over those people who choose to come here for reasons of their own.

Certainly when it comes to recruiting from those places we have codes of ethics that we adhere to and those state very clearly that we cannot recruit from countries in the developing world, we are restricted to recruiting from places like the UK and Canada and some European countries. And so it's not as if we're going out there actively recruiting from those countries.

Of course there are exceptions and I'm sure there are recruiters out there who are doing that but I think we need to be careful that we balance some of that discussion with some more positives.

SUE McALPIN: Any other comments, questions? Yes.

QUESTION: I'm I just want to fire a question to Andrew. Why is it difficult in your work? You kept saying it was difficult to get to know indigenous people

ANDREW PHILLIPS: Okay, just to - for example, with almost all of the data sets we have - let's say for example with the mortality data set, to use an example, we might have for one year 128,000 people recorded on that database. All of the individual identifiers have been stripped off, but there's one that says, "Was this person indigenous" and there's some sort of code there, it might either be a - generally it's a number. I think zero is non-indigenous and one is - and I think in some states seven is and whatever, but there's some sort of marker. But what we know or what the Bureau of Statistics have spent a lot of time researching is that quite frequently, when there's a zero there, like when that person is identified as a non-indigenous person, they actually are.

So, for example, let's say we count - let's say for every 100 deaths of indigenous people in Australia, we would know about 60 of them. We don't know about the other 40 because they're like invisible to the system. And what we want and what we need is to have all of



those incorrectly labelled records correctly labelled so that we can come up with a valid rate. What we know is that as you move into more remote areas, it's more likely that an indigenous person who dies will be recorded as indigenous. So if we calculate rates of death for indigenous people across areas, what we'll tend to find is that the rates will increase simply because the identification is better. It may also be that the rates of death are actually higher too.

But we actually spend a lot of time talking with some indigenous organisations about or people representing indigenous organisations and that the bottom line was, if you can't do it properly, best not to do it at all but at least draw attention to the situation for indigenous people in Australia generally and at the same time try to do something about - or try to encourage others to do something about better identification. And I think in pretty well all the publications that we've produced now, at the beginning we've said stuff like, "Identification needs to be improved. Those organisations responsible for collecting need to try to do something to improve that".

But it certainly would be one of the things we would love to do from many different perspectives, to describe what's happening for indigenous people in different area in an accurate and valid sort of way. I hope that answers your question? Okay, yes.

SUE McALPIN: Barnaby has to go to the House, so we'll have to excuse you and thank you very much for your contribution and particularly for staying on and contributing to the discussion. I think you've really set the scene for dynamic discussion, thought provoking and we look forward to your career with interest and what you might be able to do for the people of rural and remote Australia. So thank you once again.

It's now morning tea, so those people who might have a question of John or Andrew, please feel free to have some discussion with them over morning tea. So I'd also like to thank John and Andrew for their contribution as well.