

Official opening

Paul Lucas MP¹

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Thanks very much, Ian. First of all, can I acknowledge the traditional owners on the land on which we're meeting today, Senator Judith Adams—a senator from Western Australia, Owen Allen, and Jenny May, the National Rural Health Alliance chairperson.

This is 13 days away from winter at the moment, for those of you who come from down south—just thought I'd make that observation—and Brisbane isn't too bad at this time of the year either, though it's not as good as here. I'm delighted to be here today to say a few words to you. The Premier apologises. Cabinet meets on Monday so she's down there with our colleagues dealing with matters of State, and I'm up here dealing with what is the most important area of interface that I think a state government can have with its citizens because, if you're like me and passionate about the right of employment, the right to give people an education and a job, you can't do that unless you've got health. And you are at the forefront and the cutting edge of that.

I've had a look through the various topics that you'll be discussing and they're very, very interesting. I must commend the conference organisers on the breadth of the topics that you're covering. I did like the Donald Rumsfeld one though: what we know and what we don't know. And, as you know, sometimes you don't know what you don't know, as Donald Rumsfeld said, but you'll be knowing what you do and don't know as a result of listening to that seminar a little bit later on in the course of the conference.

Queensland—and I don't want to get into a contest about who's the most regional and remote of the states, because we are—but, obviously, in a state like Queensland, both our strong regional and rural economies, remote economies, mean a lot to us, and it means a lot to everybody in Australia because you all have your own challenges and different ways. We have a lot of remote communities. But, significantly, probably differently from most other states, we have very strong regional communities as well. And, in fact, I think that is a significant opportunity for us here, but a challenge as well because, if one is committed to a hub and spoke model, the hub and spoke just does not mean what happens in the south-east corner in Brisbane; it means what happens in our regional hospitals and then how they service the rural communities that are in their service area. So, if you like, you've got two hubs and multiple spokes as part of that. And that's why I would like to acknowledge the federal government contribution in the recent budget to significant funding for a number of our regional hospitals to allow them to grow and develop even further, matching, of course, our \$2.5 billion we're spending on rural and regional health service this financial year.

The other thing that I should point out—I was talking to Senator Adams just before—I think that it's really important for governments to have an inclination and orientation towards understanding it is not just about what happens in their major population centres. In my state, in this state, our first university was called the University of Queensland. Like in Western Australia, their first university was called the University of Western Australia. Our principal state orchestra is the Queensland Symphony Orchestra, like in Western Australia. In Sydney, it's the University of Sydney and the Sydney Symphony Orchestra. In Melbourne, it's the University of Melbourne and the Melbourne Symphony Orchestra. The point I'm simply making is for a long time it has been very important to us in the larger states to understand that we do not begin and end in our major population centres. It is very, very important that in large and remote states, in particular, you understand that you have to have that commitment to what happens outside the population centres.

You would have heard before that we have significant challenges in the comparative health of people in remote Australia. We have the great boast in this country of having the second longest life expectancy on earth—the second longest life expectancy on earth—yet, if you're an Aboriginal male, it's 18.7 years less than everybody else. And that can't continue. And, indeed, if you have a look at remote life expectancies, it's 5.6 years lower, and I suspect that is largely in part due to the scandal in terms of indigenous life expectancy. And, clearly, that is a major focus of what you are doing at this conference and a major focus of what we are doing as a government as well.

In fact, in terms of rural health workers, I am delighted at the significant increase, in recent years, in terms of indigenous health workers. And it is very, very gratifying, when one is in a rural or remote hospital and you see many indigenous faces as patients, it's also very, very gratifying to see an increasing number of indigenous health workers there as well across the broad gamut of those professions.

Our most senior indigenous nurse presented a paper at the International Nurses' Day breakfast the other day, and I forget what university it was but I think—was it USQ this year that has got 25 per cent of its nursing students intake indigenous? And that's just outstanding, and congratulations to USQ if that's you. If it's not, sorry about that—you got congratulations anyway—and I apologise to who I should have congratulated.

Ian mentioned before—and I would also like to compliment the universities generally on the increase in offerings, not just in medicine but in the allied health areas and nursing as well, that has happened—really the explosion in recent times in training, not just, of course, in the big capital city, you know, first universities, but in other universities as well. It seemed for a while that everyone did what my profession did—churned out lawyers, because lawyers are cheap to educate actually and everyone wanted to have lawyers, you know. And lawyers are great people to have. We've got the gift of hindsight, but we need a few people who have a few gifts of foresight as well and so that's why we need some nurses, doctors and allied health professionals graduating as well.

I'm very proud of Queensland's rural generalist medical program which is unique in Australia. It's about giving more remuneration to doctors from internship onwards if they're interested in rural practice and giving them those unique skills that one needs for rural and remote practice. We've got 50 rural generalists and over 100 doctors in training, and we worked with the Australian College of Rural and Remote Medicine to do that. In addition, we have 235 bonded graduates from Griffith University, or who will come from Griffith University, for remote practice as well. And you heard the good news about what's happening at JCU there as well.

I suppose we've got—society has changed a little bit in terms of what is the scope of practice in many rural and remote locations, and I think for a significant period of time what we did was retreat in and provide less services—the same people who would have, in the past, provided more complex things and, of course, insurance and patient safety and all those things which are, of course, critical. Perhaps what governments did in the past was just say, "Okay, we'll just cauterise things more and more." I think now what we are doing is working it again, thanks to the federal government for their commitment in terms of midwives and nurse practitioner MBS funding—is actually say, "Well, can we start to look at what more we can do now? Can we again look at what more we can do with appropriate training and support?"

A large proportion of our rural and remote nurses are aged over 55 in Queensland. We have decided that—like everything in Queensland we always use "Q", you know—so we've got "Nurses on Q", and that will provide our own agency service for the provision of nurses, particularly in locum and relief situations in rural and remote Queensland. Because they'll be our own, notwithstanding being

provided in a locum sense, that will also ensure that they are familiar on a broad scale with the policies and practices of Queensland Health as well.

In many places we are reliant upon locums, and they do a great job, but the more that we can ensure that we can provide that continuity of training, the better it is. Similarly, with the challenges for doctors in rural and remote practice in getting appropriate relief, I think that must be the most challenging thing of all. If you are a sole professional in any of those communities, to actually not ever be able to, you know, have a glass of sauvignon blanc or whatever you want to drink, or a beer, because you're always there and you're the only person who is there—and people are entitled to a life. And the more that we can provide those sorts of support to enable people to actually get the many benefits that are part of being in rural and regional Queensland, but also trying to eliminate some of the negative aspects of it.

We do have to change. We spend \$8.35 billion a year in Queensland health. That's about double what we spent five years ago. Why do I say that? Well, because, if we increase at that rate, in 20 years' time we'll have no money left in the state budget for police, teachers, roads, railway lines. So we can't continue to increase at that rate. We have got to do what we do better. We have got to actually look at what offerings we provide and how we can do things more efficiently. Of course we'll get the funding growth that comes with an increase in population in a state like Queensland, as we will in other parts of Australia as well, but we also need to look at things differently.

I'm currently reviewing a hospital in remote Queensland called Aramac. It has two nursing home residents who are unable to walk, and they're very important to us—very important—but it has, I think, 21 staff positions, and a doctor who's there not very often because it's difficult to staff that. I'd actually far rather focus, not on what sort of bureaucracy we have, but on how many people I can have delivering services into those communities. And that's why, again, I would acknowledge the commonwealth government's work in multi-purpose health centres. And we need to work out how we can actually better provide those services into the future. Just as the drugs, just as the surgical techniques, just as the practices have changed over 100 years, we also need to ensure that the fabric of what we deliver them in and the method in which we deliver them has to change as well. To do other than that is not acting in the best interests of people in rural and remote Australia.

I mentioned before the exciting announcements in the budget in terms of nurse practitioner funding and also MBS funding for midwives. That I think will offer us again significant opportunities to increase not only the services in more remote and regional communities but also, in fact, to also have a significant improvement in quality of care as well, because you'll be able to have those people qualified on the ground there all the time.

I think one of the areas that is probably the most exciting—or what I think is one of the areas that's probably the most exciting—is the ability for future improvements to be driven off technology. I was in Thursday Island recently speaking with a group of doctors there at the hospital and I said, “Look, what's the most important thing for you here? You know, what's the biggest annoyance that you have?” And they said—and I expected they might say, “Oh, look, you know, we're short staffed,” or those sorts of things, and they said, “Look, we need clerical assistance. We need assistance to actually help us manage the paperwork that comes from servicing all of those outer islands that one does in the Torres Strait.” So it's not actually necessarily in every instance to have more people in service delivery. It's people assisting people. I don't want nurses mowing the lawn, you know. I don't want physiotherapists out doing the banking. You know, we need to understand that it is also, in appropriate places, making sure that you have the support staff in place for those people.

And one of the interesting areas that I've noticed that I think that we are doing a fair bit on but can do even more on, is in the area of tele-health in a number of ways. A number of our hospitals now, in their emergency cubicles, or in some of them, have cameras and screens in them, and that gives the opportunity for whoever is attending to the person who has been injured or ill the ability to go down the internet and have someone at a larger hospital look at them. And, in fact, that works in many instances, not only, of course, to places, for example, in remote areas of Queensland into Townsville or into Cairns, but, at the same time, from Cairns or Townsville for them to look remote to the people in Brisbane as the case may be. And I think the burns people, in particular, do some of that work as well. So does the state-wide paediatric network. And what does that do? Well, what it actually does is provide services to people in communities that can be as distributed as possible, which I think is an important thing to do. It also supplies the mentoring that one sometimes needs to actually improve your ability to have that confidence in what you're doing.

I know in the legal field, which is my old field, it is very difficult sometimes, as a sole practitioner, so the ability to actually have those mentoring supports is important. Similarly, people have pointed out to me you don't just want to rely on tele-health as the be all and end all, because it is also important to actually encourage ongoing face-to-face contact because, as you know, it is not until you know someone personally, face to face, that you are then in a position to make sure that you can communicate with them with a full gamut of human emotions that come from actually knowing someone personally than if the only time you ever know them is over the phone or down the line.

So I have been very impressed with some of those opportunities. The federal government have announced \$42 billion. I'm here singing their praises. I'm going to give them a bit of, I think, an area of homework they need to work on. They announced about \$42 billion for their IT rollout throughout Australia. I would have thought one of the first priorities for that is to invest very, very heavily in IT services into health in rural and remote Australia, because that is actually where it really, really will matter. And the more that we actually have those services being able to be delivered in those areas better, without the shuttered screen or something that's really just a normal fact of life in terms of e-health, the better it will be. The better it will be for people who do not have the opportunity or the alternative to walk down the road for the consultation with a specialist that people in my electorate, for example, in urban Brisbane take for granted. So that will be a key priority for ours.

I just should say one other thing about tele-health—is it provides, I think, an exciting avenue of increased equity in the future. I spoke about equity in terms of where you live. I also think of equity in terms of your ability to participate in the workforce. By that, I mean this: there are many people in the health profession, and many of them, indeed, medical specialists, who decide, when they want to have children, they may wish to have a period of time in which they're not in the workforce or not totally in the workforce. If you can deliver tele-medicine to a very remote part of Australia with the appropriate bandwidth in place, you can also service it from someone's home. So I might be someone who's on paternity leave, for example, and a very skilled person who—we're losing my skills for a period of time whilst I'm on that leave. We might be able to then offer the opportunity for that person to still participate in the workforce by doing a list or by doing consultations while sitting at home with the kids running around doing what kids normally do. All I'm saying is this: that it does give the opportunity to empower a whole lot of people and so I am very—I've set a task for my department to take the issue of tele-health very, very seriously.

So, again, thank you very much for inviting me to say a few words today. You are very important for that statistic that I gave you before—that we do not have the same conditions for people in remote Australia in terms of life expectancy as we do for people in urban Australia. Whilst we still do have the second longest life expectancy on the earth, and that is great, we need to do more in rural and remote

Australia and you people—you people are at the forefront of doing that. You people are the people who see people every day, develop the policies that make people better and keep people well. So whether you're in any aspect of delivery—and, in particular, I wanted to acknowledge our indigenous health workers—thank you very much for your contribution.

