Introduction

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Robyn Williams: Now could I invite Ian Wronski to introduce the Deputy Premier, please.

Ian Wronski: First, I wish to recognise the elders and traditional owners and thank them for their especially warm welcome. I also wish to acknowledge the Deputy Premier and Minister for Health, Paul Lucas, and the DG, Mick Reid, our colleagues and friends. JCU is so proud and pleased that the 10th National Rural Health Conference is in Cairns this year. You have made a very good choice of location.

The National Rural Health Conference is the foremost conference on rural health in Australia and JCU, as the principal sponsor, is very proud to be able to provide support to a meeting that has historically been so important to the Australian national scene. Internationally, the health of rural populations remains one of the great challenges of modern development. The issues of access to services and health personnel, health infrastructure and the related issues of disadvantage in relation to education and employment, income, and in some areas even access to basic necessities, such as clean water and fresh food, remain a potent issue in many communities.

In addition, many societies, especially indigenous ones, face very rapid change in patterns of diseases. The sequence of major disease patterns, known as the epidemiological transitions, are accelerated and overlapping. The infectious disease phase overlaps the chronic disease phase, then the cancer phase and so on. What took more than 100 years in Western countries can occur in as little as a decade in many Aboriginal and in many developing country settings, adding tremendous complexity to providing health service infrastructure.

If you take the long, say, 50-year view, at least in the Anglo-sphere countries that we tend to compare ourselves with, there tend to be boom/bust cycles in relation to overall health workforce but, so far, the mal-distributions of health workforce in rural and remote populations have persisted, even in the period of apparent over-supply in places like Sydney and Melbourne.

We have come to know that, as the health workforce tide goes out, first affected are indigenous communities, then rural remote townships, then provincial centres, then it gets to the under-served populations of the capital cities.

So in producing a workforce for rural indigenous or tropical populations, the issue has always been recruiting people from those regions and training them there, or as close to there as possible. Rural kids go rural and rural kids trained in regional settings go rural even more. This creates great challenges for those advocating for rural and indigenous populations and against rural disadvantage.

NRHA and Australia's rural health and medicine movements have played a powerful and progressive role in this. Conference aficionados will know how important organised rural health and medicine has been in propelling the national rural health agenda. Australia has led the development of many innovations in rural health. Just to mention a few: models of distributed clinical placement; tele-medicine; rural medicine as a medical specialty. The notion of rural health is a health specialisation, and the boxes, or the predecessors to the boxes that Joshua talked about in Canada, the RFDS boxes, have been around Australia for at least 50 years, and ours have always contained opiates. Anyway, the list goes on.

So JCU is proud that so many of its academics have played a significant role in many of these developments, and JCU has been a strong supporter of this, institutionally. JCU was established as Australia's National University for the Tropics. Tropical, rural, remote and indigenous Australia is part of our backyard and it is important that we do a good job here.

In the development of the health and medical sector here, we have thought a lot about what type of graduates we are trying to produce and what their skill sets were to be. We have always written our own curricula to make sure that the themes of indigenous, rural and remote were clear in all of our programs, and that our graduates had a skill set that enabled them to work in areas of workforce shortage. We have lined up selection and support systems to take account of rural educational disadvantage so that kids from rural areas could gain access to our most competitive programs, and we are very pleased with the results.

We have around 120 indigenous students enrolled in our health programs at any one time. We do need to do better, but it is relatively good. In addition, a predominance of our students come from rural backgrounds, even in our most competitive programs such as medicine, and return there to work when they graduate. Our health professions rollout started about 20 years ago with nursing and the public health and tropical medicine training program. It has gained quite a pace in the last 10 years and we now have about 13 health professional training programs.

We established Australia's first new medical school in 25 years, first new pharmacy school. We have a near full range of new allied health programs, as well as programs for nurse practitioners and plans for a physician assistant program. We established a new veterinary science program about four years ago, and this year we opened a new dental school in Cairns, focusing on rural, remote, indigenous, tropical, in collaboration with the commonwealth government who provided 50 million, and the Queensland State Health Department who have committed to provide clinical placements for the program. A statistic that still shocks me is that the major reason for general anaesthetic in children under four from the Cape is dental surgical work.

So once again, thank you for bringing this meeting to Far North Queensland. We are proud to have been part of this great movement, and thanks to the Deputy Premier and Minister for Health, and Mick Reid for agreeing to participate. Thank you very much.