



Well, ladies and gentlemen, it gives me enormous pleasure now to welcome to the lectern Mike Daube, professor of Health Policy at Curtin University of Technology. He has come an enormous way and he is going to talk to us about making a difference in the work we do. Please welcome Mike Daube.

Making a difference: getting the health and health services we need

[Mike Daube](#), Professor of Health Policy, Curtin University of Technology

Thanks very much indeed, Julie. If there's one thing I have learned today about what will improve the health system I think it is if we just transferred Julie's energy and dynamism into running the health system we would have finished all our problems by lunch time.

I am going to speak about some aspects of rural health services. But, as you'd expect from my background, I place a lot of focus on the importance of prevention for the general community and specifically for Aboriginal people. Just briefly on my background, I should let you know that I spent some years running a state health service, which is why I am grey, and one of the things I want to talk about is where rural health currently sits on the political agendas.

I wish I could tell you that it's up at the top but it isn't. Political and media noise are almost entirely about big picture and city focused issues, emergency departments, elective surgery waiting lists and so on. But I can tell you from my own experience that the day to day pressures on people running health systems are almost entirely about the metropolitan areas. Unfair? In WA the country health service is the best run part of the system, but that's the reality.

But there are exceptions. In late 2003, before WA was in boom time and had become the capital of Australia, the Government was facing huge budget pressures. Some budget commitments were deferred, including one to rebuild the hospital at Moora. The shire and community in Moora decided to run a campaign pressuring the Government to putting funding back on the front burner. They were up against all kinds of odds, budget pressures, a strong Minister and Moora isn't in the metro area.

So, the Moora shire took their case to parliament and to the media but they did more than that. They turned their campaign into something of an icon by coming up with a brilliant marketing strategy. Their form of peaceful resistance was to show up at all kinds of events where the Premier of the day was performing and they presented him each time with a brick from the hospital to demonstrate its run down state.

Now, that attracted enormous coverage and attention and even affection, even if people didn't agree with them. They presented the bricks good-humouredly and persistently and even managed to have them tabled in the parliament. Now, what Government could resist and after a few months the announcement was made that Moora Hospital would be rebuilt at a cost of \$7 million. So, the point I want to make is wherever you are, good, professional, well run advocacy campaigns work.

You don't need vast resources or to come from a big city. You can be a small community but handle the media and the politics right and country advocates get good results. Let me give you another example in which I was involved directly. The town of Wiluna is 966 kilometres from Perth. Soon after I became Director-General of Health in WA I was briefed about the sewage ponds in Wiluna where I hadn't been for some years. In poor condition, on the edge of the town, about 80 metres from the school.

They were adjacent to the classroom where the school provides breakfast for the children and where teachers and children conduct cooking classes. The pools in the surroundings areas had been dilapidated for years, fencing was primitive and broken, kids played in the area. If they kicked their footies into it they'd collect them from and play in the raw sewage.

Responsibility for action was with the water corporation which was always about to do something, planning was always in hand but nothing was actually happening because it would have cost them a few million bucks to stop kids playing in raw sewage. So, I tried to generate action within Governments, so did Ministers. Talk of action, of course there was, but no action.

So, time passed and I moved to an academic role and still the ponds remained. I made repeated inquiries, so there's the ponds again. When it had been raining you can see the overflow and it goes into the roads and so on. So, I decided to go public. I wrote a long piece for the West Australian newspaper which ran some related coverage and I noted that this was discrimination against country people and against Aboriginal people. It was acceptable for kids to play in raw sewage 1000km from Perth, can you imagine that being tolerated for more than 30 seconds in the kind of inner city suburb where people like me lived.

So, that put the matter well and truly on the public agenda and we kept it there with the help of the Governor-General who made some scathing remarks when he visited Perth and thanks eventually to the intervention of the Minister for Water, action was taken and the sewage ponds have been moved. So, the lesson again is you can get action on country health issues if you're determined and focused and willing to work with the media.

So, where should you be looking to make a difference. I want to comment very briefly on Andrew Podger's proposals this morning. Andrew is a vastly experienced Canberra bureaucrat who gives a wonderful Canberra perspective on how our system should be different. Health services are under pressure, Federal and State and Territory Governments need to work together better so the Commonwealth should take over the system lock, stock and barrel. Problem solved. It's a wonderfully seductive line.

I'll just, in the interests of time, keep my responses very brief just to say that I think that's simplistic. There's not a scintilla of evidence that that kind of restructure would make any difference but there is masses of evidence that restructures don't solve problems, they usually cause chaos. I have lived through ten in the Western Australian health system. We don't need more restructures. What we do need is some more funding and from Canberra's perspective a \$10 billion surplus is a pretty good place to start.

So, let's not talk about restructure, let's work to improve the system as best we can. It's actually not a bad system, we can fine tune it. So, where else should we focus? Well, many of the problems that cause us most concern and cost us most are amenable to prevention. Between them, cancer and cardiovascular disease cause 70 per cent of our deaths. More than half of cancers, more than half of cardiovascular disease, more than 90 per cent of type1 diabetes are preventable.

They're all broadly amenable to the same messages, not smoking, eating sensibly and exercising and the many problems attributable to alcohol abuse are amenable to relatively simple messages about avoiding inappropriate use of alcohol. Here from today's Australian you see, "Better prevention could be expected to save the country about \$4 billion a year," and then they gave you some estimated health cost savings from the Productivity Commission about how much we could actually save if we did something about prevention.

So, how does rural and remote Australia fare in the light of the challenges? We're making progress in tobacco around the country and not before time but alcohol problems which were plateauing are getting worse again as is obesity. We're all fat and getting fatter. So, how does rural Australia face? This slide probably won't come up very well so let me just make the point that in terms of the way Governments handle prevention, at the moment 2.5 per cent of all Governmental expenditure goes on prevention and if you want to know how seriously the Federal Government takes prevention, all its health promotion campaigns together they spend less on than McDonald's spend on advertising.

So, somewhere along the line we have got our priorities just a little bit wrong. With rural health it is probably not readable so let me just tell you that country people do worse with circulatory disease, injury, various cancers and so on and coronary heart disease. In terms of some areas, you eat four or more serves of vegies a day better than cities but unfortunately you also seem to eat more. Perhaps counter-intuitively you exercise less and some of you are more sedentary.

You're more likely to be overweight and obese. We will get these slides put up on the website. You smoke more, more of you drink to risky levels and the further you are from the metropolitan area the more likely you are to drink with a range of consequences including road crashes and deaths and, in



passing, the same applies to illicit drugs. So, messages about prevention which struggle to be heard in any context are having an even harder time in rural Australia.

Now that's, in a sense, good news because I think it offers you great scope if you take up the challenge of prevention. There's nothing that would make more difference to the health of rural and remote Australia than promoting prevention. But it needs action. It requires that when you lobby and pressure Governments you put as much emphasis on prevention as you do on the provision of services.

The media campaigns which we know to be effective, largely by-pass rural and remote areas. You're hard to reach but that just means that Governments should put more money into reaching you. My experience, I can tell you, in 20 years in Government is that I can recall any number of representations from country people and areas about the provision of health services. Letters, calls, visits, delegations, bricks, you name it.

But I would be hard pressed, apart maybe from a few comments about screening – I would be hard pressed to think of a single occasion when we were lobbied for more support for prevention in the country and yet that is an area where the country does notably worse and has great potential.

We should learn from experience elsewhere. In 1972 the Finnish Government established a remarkable program called the North Karelia project. North Karelia is a remote and sparsely populated part of Finland. The project began following a petition from provincial representatives who had learned that their province had very high rates of cardiovascular disease. The story goes that when people were asked, "Have you had a heart attack," the answer would be, "Not yet."

It was a locally run program with a large number of community representatives that involved health service staff at all levels, voluntary organisations, many other individuals and groups, sports organisations, to farmers, all the health professionals and so on. A huge range of activities. Even cholesterol lowering competitions between villages and youth and school projects and so on. Now, the results were remarkable. There were dramatic changes in all the key behaviours, from smoking to fruit and vegetable consumption, to use of butter, even to changes in behaviour by the food industry.

And by 1995 even the annual mortality rate of coronary heart disease in North Karelia in the working population as you see had fallen approximately 75 per cent compared with the rate before the project. Why hasn't that been replicated here? Maybe it's because it's a rural and remote project. Governments haven't seen fit to fund something of that nature and rural health activists haven't lobbied for it.

Now, in my last, I think, two and a half minutes, Julie, I just want to talk about Aboriginal health. The greatest single injustice, and you have heard this, in Australian health is the Aboriginal life expectancy gap. Life expectancy at birth in Australia is 81 years. We rank only behind Japan but by contrast, an Aboriginal child at birth in Australia can expect to live to about 63, 18 years less. And Aboriginal people are disadvantaged from the start.

Infant mortality is declining but the decrease is slower for Aboriginal people. Andrew Podger pointed out, in quoting Ian Ring, by contrast, the life expectancy gap for Indigenous people in New Zealand has halved and is down to ten years, and it is down to less than three years in North America. It should also be technically feasible to halve the life expectancy gap here over ten years.

Well, we have heard lots of outrage. If rhetoric were going to solve the problem the Aboriginal health problem would have been solved decades ago but we haven't got to grips with the life expectancy gap. What would make a difference? I mean, here you have a sort of campaigner and administrator's point of view.

First, we must ensure that health is a priority, not only for health departments but for all Government agencies at all levels. Public health legislation should give heads of health the power to direct other Government agencies when there's a public health crisis. If that had happened we would have got rid of the sewage ponds in Wiluna years earlier. Second, we must apply what we know. We do not need repetitive research to show that Aboriginal health is poor. We know that. Research in Indigenous health should focus on informing the policy process and how we make the changes we need.

Third, we need a single approach. There at least I agree with Andrew Podger, even if my answer is a bit different from his. In this complex area we should end the current confusion of Commonwealth/State duplication. The left and right hand work together but it would help if they were working to the same brain. There's a huge amount of duplication and, in my view, all State and Commonwealth funding for Indigenous health should be pooled and administered by State and Territory departments.

Why then not the Commonwealth? First, Indigenous health must be linked with broader service delivery. Second, the States have experience of direct service delivery and third, and crucially, State Governments are more amenable to local pressure. State premiers and cabinet read and react to local papers every morning, Canberra has other priorities.

My fourth point is that we should do more to investigate and learn from the experience of other countries, such as the US Indian Health Service. If they brought the life expectancy gap down to less than three years, there may be some answers there. Fifth, Aboriginal communities face enormous behavioural problems.

Now, that's not cause for victim blaming, the causes range from the history of disadvantage to the ruthless promotional activities of tobacco and alcohol junk food producers. But the bulk of a life expectancy gap is now related to personal behaviours. Aboriginal people still smoke at levels the rest of the country left behind decades ago.

Add to this, poor nutrition, alcohol, injuries and no one should be surprised at the life expectancy gap or the chronic epidemic diseases such as diabetes, which is rampant and getting worse and a serious threat to health budgets. And, of course, we also have problems with behavioural diseases such as sexual transmitted diseases. So, we have got to be aware that we must focus on behavioural problems too.

Sixth. Any new programs and behavioural change need more than exhortation and funding from Governments. They require a partnership with the community and support through advocacy and example from community leaders. Seventh. Governments should provide clear strategies and measurable targets that are clearly and publicly reported. Their response to Aboriginal disadvantage should be judged on whether their plans and actions address the challenge of reducing the life expectancy gap.

That is the single greatest disadvantage and injustice we have in Australian health. We should judge them on how much progress is being made towards halving the gap over a ten year period. Why do that over a ten year period? Because it is not fairy floss. We know it has been done in New Zealand and it has been more than done in other countries. So, it is our continuing shame, not if Governments don't do it, but if we don't hold them to the public glare for their failure to do it.

So, there you have a public health campaign as I view it and in summary my themes are, recognise your strengths. You can make a difference if you go about it astutely. Next, don't waste time on Commonwealth/State debates. They'll still be around when our grandchildren are in their bath chairs. But also don't believe for a nano-second that a takeover by the Commonwealth will solve any problems.

There are issues in terms of administration that we shouldn't be telling the Commonwealth and the State Governments how they should organise themselves, the challenge to them is to get it done between them. Above all, I would argue, look to see where you can make a difference. You can make a difference if you focus on prevention and this is an area where rural Australia has been very poorly served.

Whether it be in the big killers and social problems, tobacco, alcohol, obesity or in relation to Aboriginal health, we actually do know what needs to be done. We just need it to happen. We need to spend more than 2.5 per cent of our total health budget on prevention. We need to spend a bit more than McDonald's do. We need our own North Karelia projects. We need the community and political focus on prevention that will allow rural and remote Australians to live as long and as healthily as the rest of the country. Thank you.



JULIE McCROSSIN: Mike Daube, thank you very much and because he is not in your printed program, I will just repeat Mike Daube, professor of Health Policy at Curtin University of Technology.