

## Public health in the bush

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Professor Mike Daube is Professor of Health Policy at Curtin University and Director of the Public Health Advocacy Institute and the McCusker Centre for Action on Alcohol and Youth.

Before moving to Curtin in January 2005 he was Director General of Health for Western Australia and Chair of the Australian National Public Health Partnership. He has played a leading role in public health, health policy and health advocacy in Australia, the UK and internationally since 1973. He has been a consultant and adviser over many years for the World Health Organization, the International Union against Cancer, Bloomberg Philanthropies and governments and NGOs in some 30 countries, as well as an author or co-author of many major reports. He is a regular commentator in the media on health issues.

Professor Daube recently completed his second term as national President of the Public Health Association of Australia, and leads the PHAA in WA.

He is currently also President of the Australian Council on Smoking and Health, President of the WA Heart Foundation, Chair of the National Alliance for Action on Alcohol, Chair of the WA Alcohol and Drug Authority, Deputy Chair of the Federal Government's Preventative Health Taskforce and a member of many editorial boards and other committees including the NHMRC Prevention and Community Health Committee and the Heart Foundation National Board.

He has received awards for his work from organisations including the World Health Organization, the Australian Medical Association, the National Heart Foundation, the Public Health Association of Australia, Healthway, ACOSH, Curtin University, the Australian Red Cross, the Global Flour Fortification Initiative and the Thoracic Society of Australia and New Zealand, and is a White Ribbon Ambassador and a Count Me In Ambassador.

I'd also like to acknowledge the Noongar people, the traditional owners of this land, and I'd like to thank James for introducing me as tall. The Trade Practices Act will be after you, but I've always wanted to be introduced that way. I'm a campaigner by nature so I want to focus on preventable health and death and disease. I won't focus specifically on Indigenous health as Tom and Colleen are pre-eminently qualified to speak in that area.

As you all know, many of the problems that cause us most concern and that cost us most are amenable to prevention, yet prevention over all attracts only two per cent of health expenditure—national, state, country, metro. Between them, cancer and cardiovascular disease cause about 70 per cent of deaths, more than 50 per cent of cancers and cardiovascular disease. More than 90 per cent of type 2 diabetes cases 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.

We know what's needed to prevent many of our health problems, with tobacco showing the art of the possible. Indeed, smoking alone is the cause of the deaths of 20 per cent of Aboriginal people. We know what needs to be done. There have been reports telling us what needs to be done. So how do rural and remote Australians fare in the light of these challenges?

Even over and above Indigenous health disadvantage much of the news isn't good. You smoke more. More of you eat four or more serves of vegetables a day but, unfortunately, you also eat more. You exercise less. Some of you are more sedentary. You're more likely to be overweight and obese—and when I say "you" I don't mean you individually; I mean everybody else out there. 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 drug use. So messages about prevention which struggle to be heard in any context are having an even harder time in rural Australia.

So what are the implications of this? As you've heard from Judith, we need more resources for the bush—staff and building—of course we do, but we also need more advocacy to improve the state of health itself, to deal with the issues and conditions that cause preventable conditions such as heart disease, cancer or diabetes. So I believe that we also need a specific program to focus attention on country public health, to develop country-

specific programs rather than relying on the backwash from metro-focused campaigns. There are precedents. There are exciting precedents.

As far back as 1972, the Finnish government established and funded a remarkable program called The North Karelia Project. North Karelia is a remote and sparsely-populated part of Finland but, following an independently-run locally-led comprehensive program, including health service staff at all levels, opinion leaders, voluntary organisations, local media, schools, many other individuals and groups, the results were remarkable. There were dramatic changes in all the key behaviours. And even in the first 20 years, there was a 57 per cent reduction in cardiovascular disease and mortality in men. Now, the North Karelia Project wasn't perfect but it did show the art of the possible—what can happen when a non-metropolitan community gets hold of an issue and runs determinedly with it.

And there are other examples of programs and campaign for prevention, whether about behaviours or resources. When Colleen was talking movingly about her father in Wiluna, I was reminded of a very modest advocacy program I had the privilege of being involved in a few years ago. You may remember Colleen, the sewage ponds were essentially abutting the school in Wiluna and the water authorities weren't willing to do anything about it, so there were kids playing in raw sewage. And that was an absolute disgrace and we managed to get action in that area. So you can achieve action through advocacy, both in terms of behaviours and in terms of specifics.

So, after that, what are my main messages about public health in the bush? Rural and remote populations are affected even more than the rest of us by preventable mortality and morbidity. Those of us working in public health need your support in the campaign to get more than two per cent of health funding allocated to prevention—two per cent for prevention. We also need to ensure that health is seen as a responsibility for all government agencies, not just health departments. We tend to focus on health departments but there are so many other government agencies that have a role there, whether it's education or housing or whatever it may be.

There's a major role for campaigning, advocacy, call it what you will, to ensure that, in addition to funding for services, there's support for public health activities and programs. Tom and I are working closely together on the campaigns and activities in terms of tackling Indigenous smoking where Tom is leading the program nationally—a huge, dramatic, I think, program that's going to have a major impact over time on the single largest contributor to the life expectancy gap. We need more of that and we certainly needed it before now.

So there are good precedents for all manner of action from overseas programs, such as North Karelia, to local action, such as some of the measures taken to address alcohol problems in the Kimberley. We need strong public health in the bush, but that will only come if there's as much pressure for this as there is for bricks and mortar. It's not a case of either/or. We need the services but we also need the actions and resources we know can help enable rural and remote populations to live longer, healthier lives, and that will only happen if there's advocacy—pressure on governments to make it happen. The alternative is that rural and remote populations remain as disadvantaged as they now are, not only in health resources but also in health and in life expectancy.

Thank you.

