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## **Across the great divide: health in rural Victoria**

Inaugural Violet Marshman Oration  
La Trobe University, Bendigo

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## 1 Introduction

'It was the best of times, it was the worst of times, it was the age of foolishness', and the antonyms continued. So begins Charles Dickens' famous *Tale of Two Cities* (Dickens 1859). Tonight I'm going to tell you a tale of two places: the city and the bush.

When I grew up, Australian history was all about the famous white male explorers; indigenous Australians were neglected at best and often denigrated (Macintyre and Clark 2004). The tales at that time were about the white male explorers crossing the Great Dividing Range, opening up more land for white occupation and farming. Crossing the Divide transformed the Australian economy, and over the next 150 years agricultural production and exports expanded and the rugged rural macho myth became embedded in the Australian psyche.

Today regional Australia is still an export powerhouse, albeit now mainly from extractive industries in specific locations, but the people who live in regional Australia are falling behind their city counterparts on a range of measures of health and well-being.

In this Oration I will present some data on the health of people in regional Victoria, compared to Melburnians, using previous published sources and an analysis of data from the Australian Bureau of Statistics. These data have been specifically extracted for me and this analysis sees the light of day for the first time in this Oration.

In order to address a problem we need to understand the dimensions of the problem. Measurement is crucial. This has

been expressed in many contemporary aphorisms, 'you can't manage what you can't measure' being just one. I'm attracted to a beautifully expressed summary, in poetic 19<sup>th</sup> century language, by the famous physicist and engineer William Thompson, better known to us as the inventor of the Kelvin temperature scale.

In physical science a first essential step in the direction of learning any subject is to find principles of numerical reckoning and practicable methods for measuring some quality connected with it.

I often say that when you can measure what you are speaking about and express it in numbers you know something about it; but when you cannot measure it, when you cannot express it in numbers, your knowledge is of a meagre and unsatisfactory kind: it may be the beginning of knowledge, but you have scarcely, in your thoughts, advanced to the stage of *science*, whatever the matter may be (Thomson 1891).

Fortunately our knowledge of rural health issues is not of a 'meagre and unsatisfactory kind'. We have measurement aplenty. The Australian Institute of Health and Welfare has been publishing specific information about rural health for more than two decades, with the latest information being online rather than in the book format of the previous millennium. The National Rural Health Alliance publishes fact sheets; and there has been a journal specifically devoted to rural health issues – the *Australian Journal of Rural Health* – for a couple of decades too.

One article in that journal, co-authored by Professor John Humphreys who was based here in Bendigo, compiled a table of the many academic studies which had identified rural-urban differences in health status (Smith et al. 2008). In the early 1990s the National Health Strategy devoted a 117-page background paper to improving Australia's rural health and aged care services (Reid and Solomon 1992). What we know from this work is that people who live in rural and remote Australia have worse health outcomes on practically any dimension you care to measure.

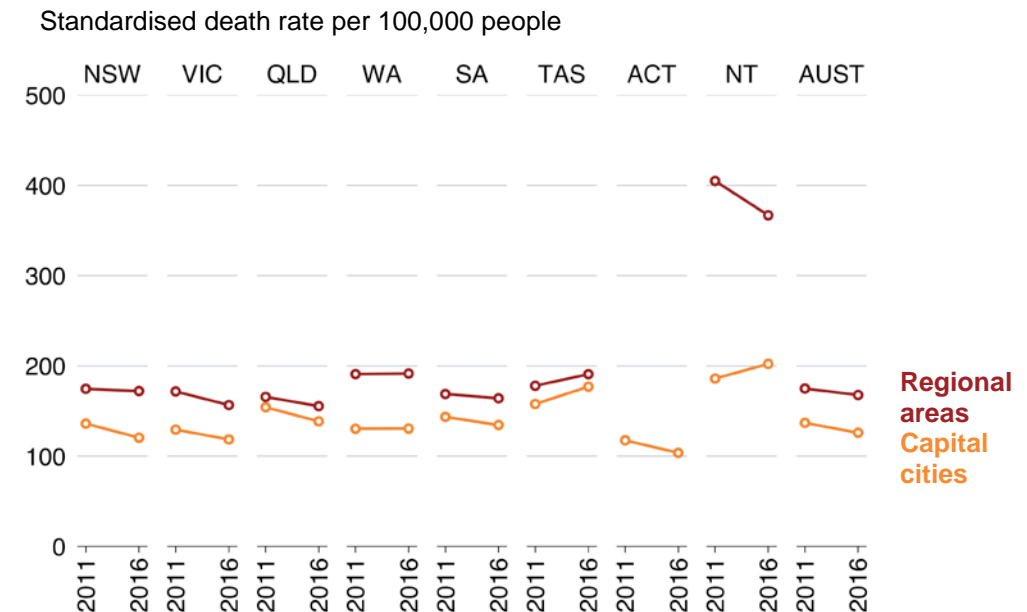
## 2 Comparison of avoidable mortality

In this Oration I will report on an analysis of avoidable mortality. This is a measure which classifies causes of death according to whether the cause could have been prevented, or whether the likelihood of death could have been reduced through the efforts of the healthcare system, a measure called amenable mortality. There are of course causes of death which both might have been prevented, and might also be amenable to intervention by the healthcare system. The formal definition of avoidable mortality, which combines preventable and amenable, is 'deaths from conditions that are potentially preventable and/or treatable through existing primary or hospital care' (Olatunde et al. 2016). For most causes of death it only includes deaths under age 75, but there are lower age cut-offs for some specific causes.

In Grattan Institute's 2018 Orange Book, which compares state government performance across Australia, we used avoidable mortality as a measure of state health system outcomes, albeit recognising that responsibility is somewhat shared between the Commonwealth and the states (Daley et al. 2018).

What we showed is that rates of avoidable mortality – remember this is mortality the incidence of which could have been prevented or reduced through the intervention of the healthcare system – was greater outside capital cities than in the capital city (see Figure 1). The good news is that rates of avoidable mortality in all areas are decreasing.

**Figure 1: Avoidable mortality has similar patterns across Australia, with higher rates in regions**

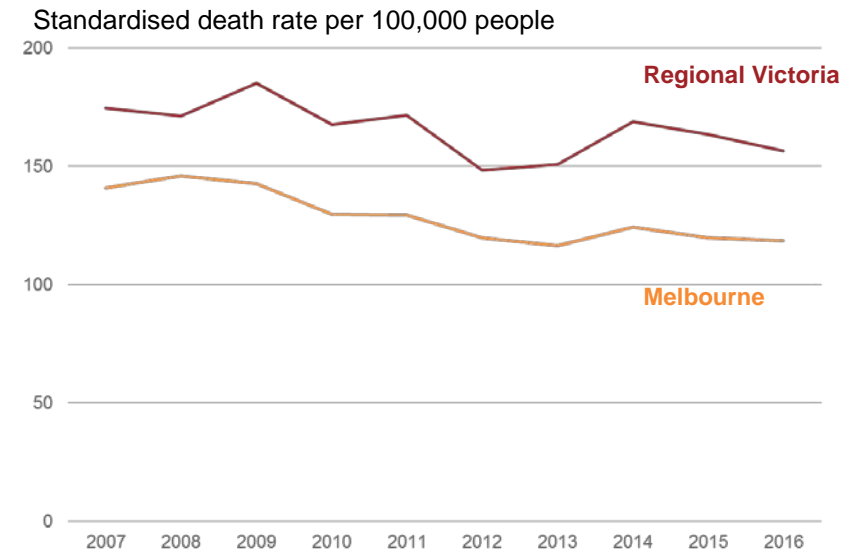


Source: Daley et al. (2018).

If we turn specifically to Victoria, over the past decade we have seen a significant reduction in avoidable mortality in both regional and metropolitan areas ('greater Melbourne' is how the ABS describes it). In my new analysis we still see that avoidable mortality at 157 per 100,000 people in 2016 is about 38 per cent higher in regional Victoria than it is in Melbourne, where the rate is 118/100,000 (see Figure 2). What is worse, the improvement in

avoidable mortality has been greater in Melbourne than in regional Victoria. Avoidable mortality in 2016 in regional Victoria is 10 per cent lower than it was back in 2007. This is of course a cause for celebration. But avoidable mortality is 16 per cent lower in Melbourne than it was a decade earlier.

**Figure 2: Victorian avoidable mortality has declined faster in Melbourne than outside Melbourne**

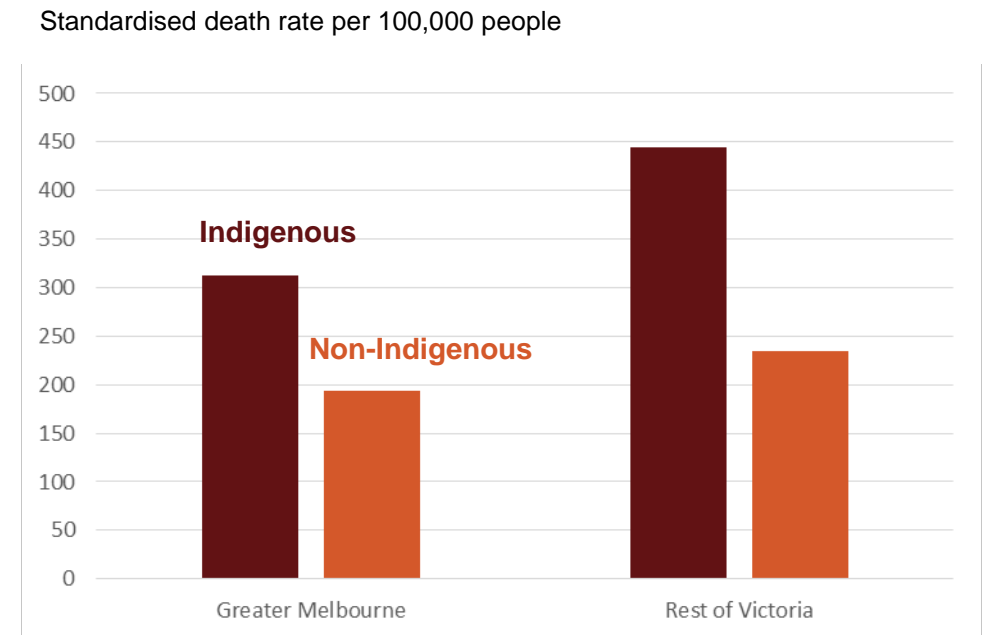


Source: Grattan Institute analysis of Australian Bureau of Statistics (2018).

This invites the question: why has there been greater improvement in Melbourne than across the Divide (with apologies to Gippsland for this geographical inaccuracy)?

When I started this speech I made an acknowledgement of country, recognising the Dja Dja Wurrung and the Taungurung peoples of the Kulin Nation. Those acknowledgements of country should not be something we do simply as a feel-good custom, without thought, reading our autocue rote-like.

**Figure 3 Aboriginal and Torres Strait Islander people have higher avoidable mortality rates, wherever they live**



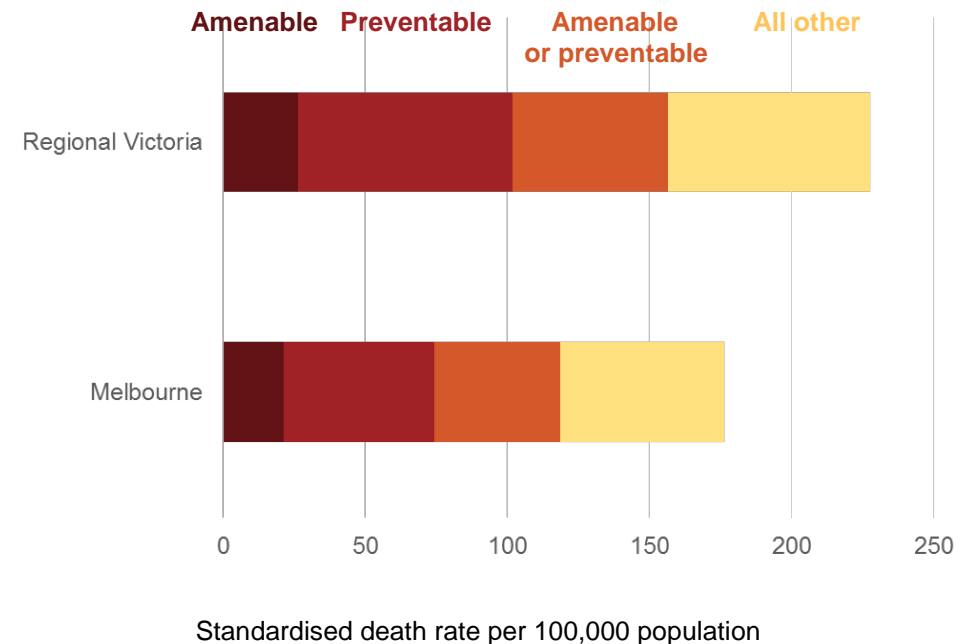
Source: Grattan Institute analysis of Australian Bureau of Statistics (2018)

We should remember that the effects of Aboriginal dispossession are seen today in almost every statistic about health status that we examine. Indigenous Australians have a life expectancy about a decade shorter than non-Indigenous Australians. We see the difference too in avoidable mortality. Both Indigenous Australians and non-Indigenous Australians who live in regional Australia have higher rates of avoidable mortality than people who live in metropolitan areas (see Figure 3). But rates of avoidable mortality for indigenous Australians are about one-quarter to one-third higher than for non-Indigenous Australians wherever they live.

The difference between regional and metropolitan avoidable mortality is not explained by Indigenous status, at least in Victoria, but what we do see in these statistics is the starkly worse health outcomes for Indigenous Australians in both regional Victoria and Melbourne.

‘Avoidable mortality’ can be decomposed into that which is amenable to healthcare interventions, that which is preventable, causes of death which are in part both amenable and preventable, and all other causes (see Figure 4). For all Victorians, whether in the city or the bush, more than two-thirds of their mortality risk is avoidable mortality.

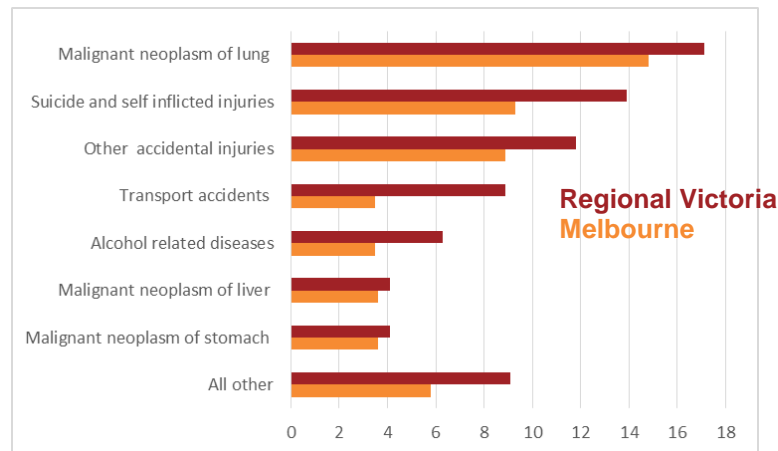
**Figure 4: More than two-thirds of mortality is potentially avoidable (2016 data)**



Source: Grattan Institute analysis of Australian Bureau of Statistics (2018).

It is instructive to look at the preventable subset of avoidable mortality, causes of death such as lung cancer (see Figure 5). There are a significant number of deaths for these conditions each year.

**Figure 5: People who live in regional Victoria have much higher rates of preventable deaths for each of the leading causes (2016 data)**



Source: Grattan Institute analysis of Australian Bureau of Statistics (2018).

What we see here again is that for preventable mortality, people who live in regional Victoria have higher mortality rates for each of the leading causes of preventable mortality. If regional Victoria had the same death rate as metropolitan Melbourne, 800 fewer people would have died in 2016 in regional Victoria.

Now remember, this is preventable not amenable mortality. This is not mortality where the incidence might be reduced because of better access to healthcare, or better treatment generally. This is

not therefore mortality where one might say that more services are needed to address the problem.

We can see that the leading cause of preventable deaths is lung cancer. We know the antecedents of cancer, particularly smoking, and we know that Victoria has led Australia in tackling tobacco-related illnesses. But still we see 15 per cent higher rates of lung cancer mortality in regional Victoria compared to Melbourne.

The second-highest cause of preventable death contributing to the significantly higher rate in regional Victoria compared to Melbourne is accidental injuries, including from farm accidents.

The point I'm making here is that these causes of death are regarded as preventable, or at least the incidence can be reduced with good preventive action. This is not about needing a cardiologist on every street corner of every tiny rural town. This is about systematic prevention occurring right throughout Victoria. There is no excuse along these lines: 'economies of scale mean that we cannot afford to provide high-tech services everywhere'.

We *can* act to affect these rates independently of service provision issues, although that is not to say the health system doesn't have a major part to play in leading the charge on some of these preventable causes of death, a matter I'll return to later.



### 3 The social context of avoidable mortality

I have talked so far about mortality rates and the health system as if they existed in some sort of vacuum, independent of a social context.

What we know about Victoria – and Australia generally – is that incomes and other measures of socio-economic status are lower in regional areas compared to the capital cities. I will highlight just a couple of examples here.

On a range of key indicators, regional Australians fares worse than people in metropolitan areas. There are higher levels of unemployment, for example, in regional Australia. Unemployment is particularly high in some pockets of regional Australia (and, to be fair, in some parts of metropolitan areas).

These socio-economic disparities have implications for healthcare. Smith and her colleagues highlighted the impact of socio-economic status or social determinants of health on health outcomes for people in regional Australia:

Evidence that rurality contributes to health indicators in ways over and above socio-economic factors is not consistent. Several studies have found little or no rural–urban variation in health status for particular diseases and conditions after controlling for variables relating to socio-economic status.

Others have found that the effect of socio-economic deprivation is more strongly associated than rurality with higher rates of suicide and undetermined deaths at all levels of population density and across all age groups, and that much of the variation between rural and urban health status could be explained by socio-economic factors affecting the use of health services (Smith et al. 2008).

My own view is that reality is closer to the last clause of that excerpt.

Research shows the same pattern in the United States. A recent paper compared mortality rates in rural and urban counties in the US and showed the familiar pattern: mortality in rural counties was worse than in metropolitan areas. But this study then corrected for socio-economic characteristics and showed that the rural environment was in fact protective. Indeed, after taking into account the socio-economic environment, including race, outcomes in rural counties were better than in urban counties (Spencer et al. 2018).

The implication of all this is that we need to look not only at the medically-defined causes of death, such as lung cancer and accidental injuries, but at the *causes* of those *causes* – the social determinants of health (Galea and Link 2013; Putnam and Galea 2008). Healthcare interventions should aim to shift the overall pattern of poor outcomes, or the mean of the distribution of ill-health, as well as looking at the health of high-risk individuals (Rose 1985).

So any analysis of rural-urban differences in health status and mortality must start from this analysis of the broader economic environment within which people live their lives and in which the health system is situated. This is an issue to which I will return later.

But I also want to highlight that, as important as socio-economic factors are, they do not explain the fact that regional areas have fallen behind on improvements in avoidable mortality. That is, socio-economic status can be used to explain the starting point of higher rates of avoidable mortality in regional Victoria back in 2007, and to some extent in 2016, but it does not explain why metropolitan Melbourne has had faster reductions in avoidable mortality than regional Victoria.

What we see on cross-sectional analysis, a single point in time, is that parts of regional Victoria certainly have significantly higher rates of unemployment than the Melbourne average.

What Grattan Institute work has shown is that, contrary to the popular perception, regional Australia is generally not falling behind metropolitan areas on most of the key indicators economic performance and socio-economic status (Daley et al. 2017). For example, patterns of change in unemployment do not show that regional Victoria is falling behind.

Similarly, there are areas of high income growth in regional Victoria, although as with all statistics there are distributional issues within these geographic areas and indeed some of the areas with the highest incomes tend to be the most heterogeneous, the most unequal.

If there is no evidence of a marked worsening of the average socio-economic position in regional Victoria, why then has avoidable mortality worsened in regional Victoria relative to metropolitan Melbourne? This reflects a failure of policy and priorities, again an issue I'll come back to.

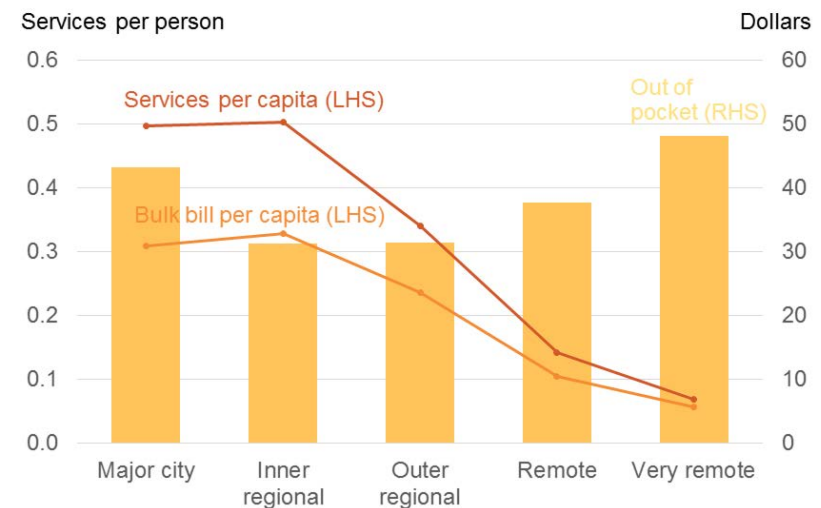
## 4 Health care in regional Australia

I have talked so far only about outcomes, specifically avoidable mortality. But of course it would be remiss of me not to point out the differences in provision of healthcare. If we look at general practice for example, what we see is that measures of GP services, such as attendances per head of population, are much higher in major cities but also regional areas, compared to remote and very remote areas (see Figure 6). The rate of bulk billing is also lower the further you get from metropolitan areas. As a result, out-of-pocket costs are higher in remote and very remote Australia than they are in metropolitan areas.

These figures are aggregated up to the five big geographical classifications used by the Australian Bureau of Statistics in their analyses. This aggregation disguises within-area differences, so one part of one remote area might have good access, while another part of the same remote area has very poor access, and the average works out as not too unreasonable. We need to be much more nuanced in our health workforce planning and policies.

My overall point is that there are inexcusable differences in rates of primary care provision. What I haven't shown is the heavy reliance on International Medical Graduates to prop-up services outside the capital cities. This poorer provision, lower bulk-billing rates and reliance on International Medical Graduates represent a failure of policies on access to primary medical care in regional Australia.

Figure 6: There are lower rates of general practice visits in outer regional and remote areas, but both higher rates of bulk billing and higher out-of-pocket costs for those not bulk billed



Source: Swerissen et al. (2018).

Essentially, we have seen a dramatic growth in access to medical schools – both more medical schools and more places in medical schools – leading to an increase of more than 50 per cent in the number of new medical graduates each year (see Figure 7).

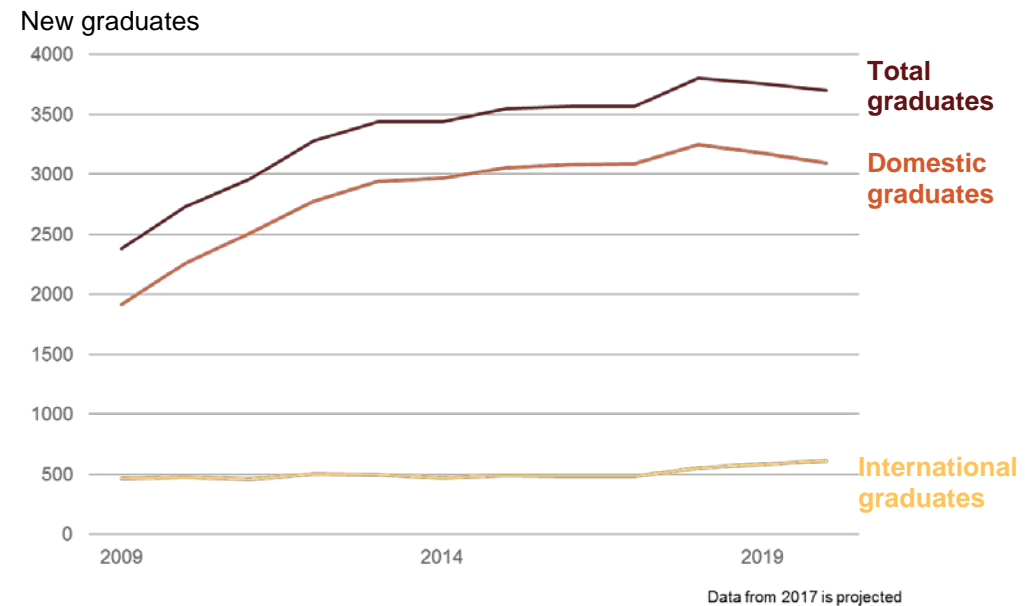
This has been done with a naïve belief in trickle-down medical education policy, where pumping out more medical graduates from city-based medical schools will somehow, by policy magic, improve access to health care in rural and remote Australia. Sure these policies have included financial incentives for graduates to relocate, and new graduate location appears to be affected by these incentives (Yong et al. 2018), and there has been an improvement in per capita provision of medical care outside the cities (see Figure 8). But if only a fraction of the expansion that has occurred in metropolitan areas had been diverted to regional areas, there would now be equality in per capita access.

Over the period 2006-2017, GP supply in major cities increased by more than 8,000 full-time-equivalents. In very remote areas, GP supply increased only by 358, and in remote areas by 232. Shifting the work destinations of a handful of people would address geographical barriers to access.

This expansion of medical training is a gross failure of policy, kowtowing to the rent seekers of the major metropolitan medical schools, and it has left people who live outside the comfort of metropolitan areas with continuing poor access to GPs.

We should learn from the experience of James Cook University in north Queensland. It shows that rural medical schools – where students can do all their training in rural settings and where the priority of the medical school is rural practice and so rural practice is valorised – have the biggest impact in terms of producing graduates who want to work in rural settings.

**Figure 7: There has been a 50 per cent increase in the number of medical school graduations over the past decade**



Source: Medical Deans 2016 – 2017 Student Statistics Report  
<https://medicaldeans.org.au/md/2018/07/2016-2017-Student-Statistics-Report.pdf>

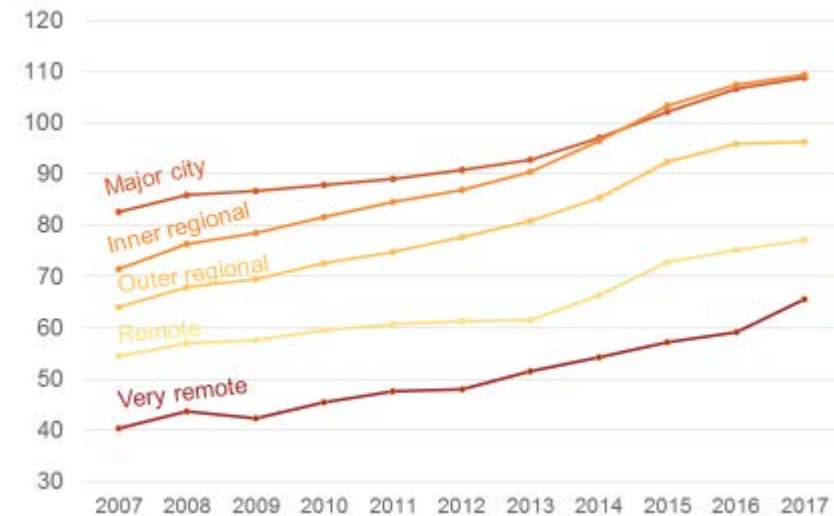
Medical graduates of James Cook University are 16 times more likely to intend to work outside capital cities, and four times more likely to intend to work in smaller cities (of less than 100,000 people) (Sen Gupta et al. 2013). And those intentions get converted into reality. James Cook University medical graduates are 10 times more likely to take their internship outside a metropolitan centre. And if you take your internship outside a metropolitan area, you're more likely to practise outside a metropolitan area. (Sen Gupta et al. 2014; Woolley et al. 2014).

Some of this is explained by where students lived when they applied to enrol: rural location on application is associated with working in rural areas as a health professional after graduation. So is whether you identify as Aboriginal or a Torres Strait Islander.

But I think it's also strongly about the ethos and culture of the University. The message sent to students throughout their course at James Cook is that rural and tropical practice is really complex, really interesting, really valuable and really challenging. James Cook students are not sent the implicit message that the best doctors are sub-sub-sub specialists who work in an arcane field, with a lab filled with pink and blue bottles, and seeing the rarest patients in the biggest cities in the largest hospitals in the state.

It is about time Australia admitted that our existing policies on the medical workforce are failing to respond to needs. We should rearrange medical education places, or change the nature of incentives for new medical graduates, or a mix of both.

**Figure 8: There has been an improvement in the number of full-time-equivalent GPs in all parts of Australia over the past decade, but access is still worse in regional Australia**



Source: Swerissen et al. (2018).

I am aware that the Government announced some expansion of rural provision in the recent budget, but I am sceptical about whether it will achieve the changes that are required.

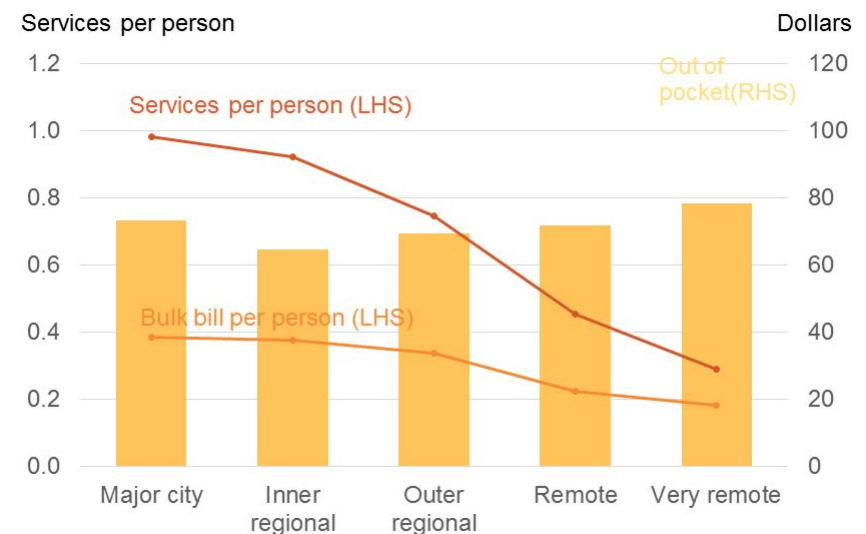
We need to improve the availability of specialist medical education in rural areas (May et al. 2017; Sen Gupta et al. 2018), and make it harder for new graduates to put out their shingles in metropolitan areas, especially the nice parts of the cities. This will

require us to take the bold step of tightening controls over access to Medicare billing. Perhaps in the first instance, new provider numbers should be restricted to those who have worked in higher-needs areas for an initial period, with a provisional provider number issued to every newly qualified graduate but with billing available only if a high proportion of their patients (say more than 80 per cent) in any week are resident in areas of high need.

Obviously we have to ensure that there is adequate supervision and mentoring for new doctors (Moran et al. 2014). But it may surprise you to know that even in rural Victoria people have access to the Internet, and that remote supervision and mentoring is always possible. I will turn to other aspects of workforce reform and primary care in regional areas later.

It would be remiss of me in a place like Bendigo, and in an event sponsored by La Trobe University, not to mention Allied Health. Unfortunately we see with Allied Health exactly the same problems as we see with GPs: that is, services per capita are lower outside capital cities than in metropolitan areas (see Figure 9). Bulk billing, to the extent it is available under Medicare for Allied Health services, is again lower outside metropolitan areas, and so out-of-pocket costs are higher.

**Figure 9: Fewer Allied Health services are used in very remote areas, and the cost to the patient is higher**



Source: Swerissen et al. (2018).

## 5 Failure of policy

I have so far presented a litany of problems. Admiring the problem is good, but doing something about it is what policy should be all about.

The good news is we've had a National Strategic Framework for Rural and Remote Health since 2011 (Standing Council on Health 2011). It is a grandly entitled document, and presumably because it pretends to be oriented to action, it is not produced as a glossy brochure but as a rather plain, pedestrian, document.

It is interesting to look at this document, which articulates five broad goals (See Box 1). What is stunning about this is that it is primarily not about rural and remote health, the title of the Framework, but rather about rural and remote *health care*. It also totally and completely ignores the social and environmental context that I have highlighted, although to be fair there is a hint of this issue buried in the discussion of better planning.

There are probably a number of reasons for these oversights. The people involved in producing the document may well have been from health services and so more comfortable talking about services rather than *outcomes*. But it may well be that, like the Rawlsian veil of ignorance (Rawls 1999) which helps us work out what an ethical distribution of resources might be, the writers of this document have cast a 'veil of denial' across the policy landscape, wilfully ignoring the causes of the causes.

### Box 1: The five broad goals in the National Strategic Framework for Rural and Remote Health

Rural and remote communities will have:

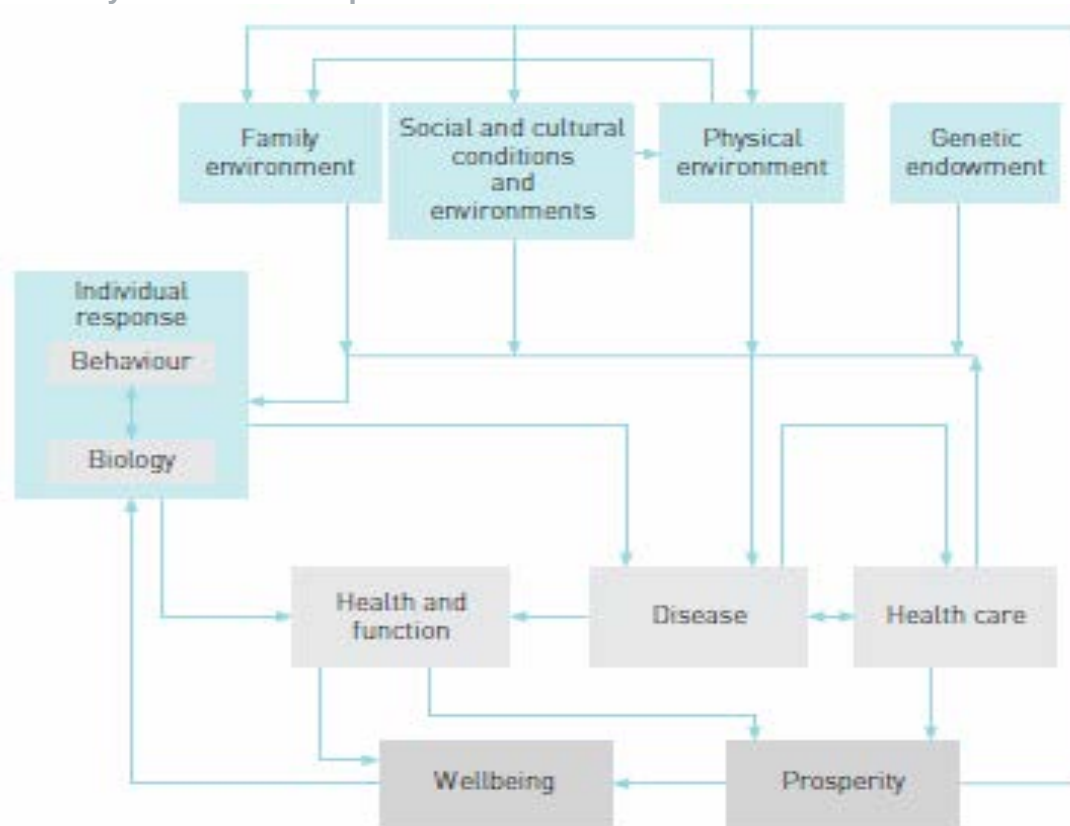
- Improved access to appropriate and comprehensive health care;
- Effective, appropriate and sustainable health care service delivery;
- An appropriate, skilled and well-supported health workforce;
- Collaborative health service planning and policy development;
- Strong leadership, governance, transparency and accountability.

*Source: Standing Council on Health (2011).*

We know that the creation of ill health is affected by a number of factors: family environment; social-structural conditions and environments; physical environment; and genetic endowment (see Figure 10). Only a person's genetic endowment has an independent and direct effect on an individual.



Figure 10: Many factors affect a person's health and ill-health



Source: Figure 2.13 in Duckett and Willcox (2015), drawing on Evans and Stoddart (1990).



Each of these four factors can have an impact on individuals, creating a direct biological response (an illness or disease) or a change in behaviour (including health-related actions). For example, the physical environment can have a direct impact on an individual, with early exposure to ultraviolet radiation acting as a trigger for the development of melanoma.

However, Jackson (1985) has drawn attention to the limitations of the mono-causal paradigm, pointing out that health is not simply caused by a single factor in the environment or a single behaviour impacting on health. She also argues that conceiving of the creation of ill health as being simply a combination of multiple independent factors, such as the environment, behaviour and hereditary or genetic factors, is inadequate. Rather, health problems are caused by a complex interaction of environmental factors and individual behaviour. These factors are interdependent, as families and the socio-economic environment shape behaviour, and the impact of the physical environment is mediated either by the socio-economic environment or the family. For example, the physical environment may determine food choices, but these are generally mediated through culture and family.

This means that recommendations to deal with obesity by suggesting people simply push back from the meal table – as then Deputy Prime Minister Barnaby Joyce suggested in response to our 2016 report (Duckett et al. 2016) proposing a tax on sugar sweetened beverages – are naïve, are part of the veil of denial which prevents sensible discussion of obesity policy, and indeed add to the problem of obesity. (As an aside, I wear Barnaby's

description of our proposal as 'bonkers mad' as a badge of honour.)

The individual's response to factors in his or her environment may lead to diseases and could also have an impact on the individual's health and function. Environmental factors also shape how an individual responds to illness and disease: whether they will take action and, if so, what type of action.

My point here is that there is a complex interaction of factors involved in the creation of health and disease. This in turn means that attempting to reduce the prevalence of disease is complex, and needs to recognise these causes of causes – the social and cultural context, the family environment, and the physical environment. But for some reason, we don't seem to do this. For some reason we deny this and keep designing programs which assume that disease is principally caused by individual behaviour, unaffected by the individual's context and environment.

If we are to see serious improvement in avoidable mortality and the health status of people in regional Australia, we need to confront this veil of denial head-on. We need to recognise that health programs have to address the causes of causes, the socio-economic factors which contribute to higher rates of avoidable mortality and poorer health status generally.

This is not a new challenge. Some 150 years ago the German father of social epidemiology, Rudolph Virchow, wrote that:

Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out

problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution...

Although he refers here to the politician, I think he equally means and would refer today to any local leader, including leaders of hospitals and health services and, dare I say it, Primary Health Networks.

Virchow then goes on to a statement which could well be adopted as a motto for the Grattan Institute generally and its Health Program in particular:

Science for its own sake usually means nothing more than science for the sake of the people who happen to be pursuing it. Knowledge which is unable to support action is not genuine – and how unsure is activity without understanding...

It is all very well admiring the problem, it is all very well describing the problem, as we have done for too long in the case of the relatively poorer health status of regional Australians. But if we are to move ahead, if we are to address these problems, we need to do more than talk. We need serious action, and that means action at local levels as well as trying to improve the broad economic indicators.

Virchow sets out a challenge for what he calls ‘medicine’, but today we would call ‘healthcare’:

If medicine is to fulfil her great task, then she must enter the political and social life... The physicians are the natural

attorneys of the poor, and the social problems should largely be solved by them.

Unfortunately, addressing social problems is not easy, as Virchow himself found. He did a famous study of a typhoid epidemic in part of Germany and identified the social antecedents which contributed to the epidemic. This did not go down well with the powers that be, and his career suffered as a result. I’m not saying that all of you who take on this challenge will so suffer, but I am saying that one needs to build a coalition – because makes singling out and vilification that much harder.

I started this Oration with a focus on measurement, and that is appropriate in a university setting. Often action on improvement is not taken because decision-makers don’t know there is a problem. In my view this is not where we are in terms of rural health disparities. As I said at the start of this Oration, we have measurement aplenty.

It might also be that decision-makers know there’s a problem but don’t know how to fix it – or probably more accurately, don’t know how to fix it in a way which does not challenge the established order. All we can legitimately do in terms of policy solutions, therefore, is to provide more services, or at least talk about providing more services. In some cases more services may be necessary, and I do not deny the stark reality that access to healthcare is worse in regional areas than it is in the cities, as I have shown earlier.

But how do we explain the continuing failure to recognise and address the causes of causes of poor health status in regional

Australia? We talk a lot about rural health issues, but we are doing little to build an employment base in regional centres, and to build connectedness in those regional centres and small rural towns (Holt-Lunstad et al. 2015).

Of course, it may also be that decision-makers know there's a problem and don't want to fix it. This might be because of cost – although I don't think that is the issue with rural health – but it could also be that it never gets high enough up the political agenda. This may change as rural independents flex their political muscle. But it may also be that powerful interests do not want to destabilise their advantage, or, finally, it might simply be policy inertia.

## 6 Policy proposals

Grattan Institute did a report a couple of years ago looking at those areas in Australia which had very high rates of potentially preventable hospital admissions over a very long period of time (Duckett and Griffiths 2016). We went into that report thinking we could identify a few areas which accounted for major problems. And to some extent we did. But what we found was it was not as simple as that. Yes, there were areas with very high rates of potentially preventable hospital admissions over very long periods of time, but the science of what to do about that was not clear.

This challenged me to work out what our recommendation should be. It seemed outrageous that there were parts of Australia where the rates of potentially preventable hospital admissions were 50 per cent higher than the rest of the state and had been so each year of the past decade. This drew me to consider that there might have to be a trade-off between outrage and evidence.

In my view it was morally unacceptable not to intervene, not to attempt to improve health outcomes, and not to make recommendations in our report in the face of this outrageous inequity. We argued the size of the problem and the evidence threshold should be related, inversely. We recommended that in the case of egregious inequality, additional investment should be made to tackle it, even if there was only a weak evidence base, provided that investment contributed to building an evidence base.

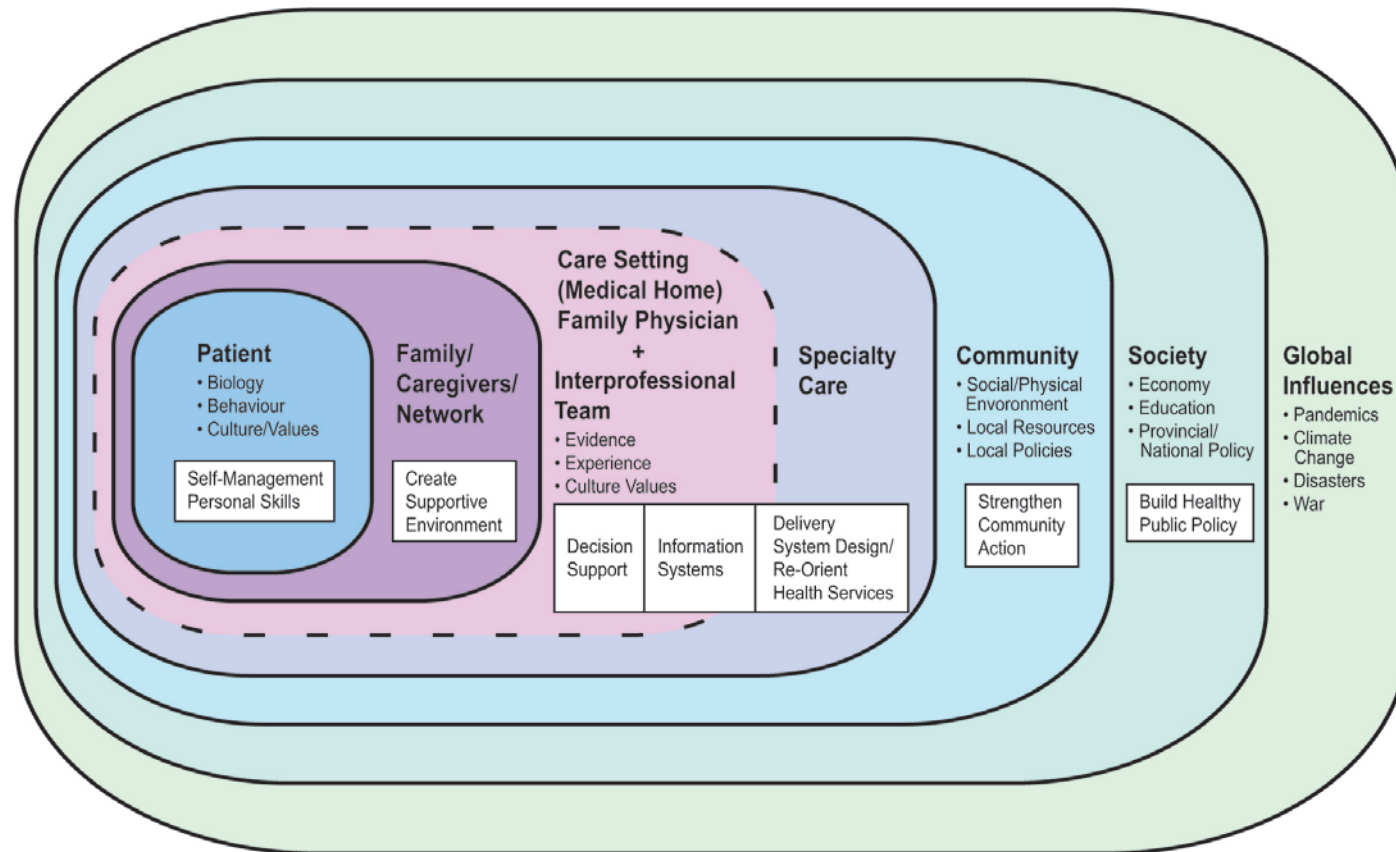
We also showed in that report that the nature of the problem was quite different in different locations. This meant that solutions to

the problem needed to be tailored to the specific situation and underlying causes. In some cases a few patients were the cause of high rates of potentially preventable hospital admissions because those few people had very high rates of readmission. In other cases the problem was spread more widely (Duckett and Griffiths 2016).

So to an audience comprising mostly health professionals, it is appropriate to challenge you to think about how healthcare can contribute to improving avoidable mortality. You might think the answer is obvious. What health professionals do every day is address the presenting problems, manage ongoing chronic conditions, and cure acute illnesses.

But as I have stressed earlier in this Oration, people exist within a social context, and so does healthcare. Working with an individual, a patient, a client, involves what I like to think of as the multi-layered onion of healthcare (see Figure 11). If we are to have a truly person-centred health system, we must put the person at the core of our thinking and do everything we can to support them to manage their condition (Duckett 2012: 77).

Figure 11: Putting the patient at the centre of the health system



Source: Duckett (2012), page 77.

We need to support their carers to help them. We need to strengthen the social supports that support the carers. It is only a few layers out from the core of the onion that we would begin to recognise the role of the formal healthcare system, including the primary care system.

The primary care system needs to be supported by specialists, obviously, and we need to do quite a bit of rethinking about the model for specialist medical care in Australia, something a future Grattan Institute report will tackle. Suffice it to say now that access to specialist medical services is not adequate, many people face high out of pocket expenses, and waiting times for outpatient services are unknown in some states and unacceptably long in others.

But as I have stressed in this presentation, the health system sits within a social context, influenced by social factors, including broader environmental factors such as climate change. The challenge for healthcare workers is how to incorporate this perspective into their everyday practice.

One slogan I have kept in my mind is that 'every good curative intervention has a preventive component'. This might be called developmental casework, or developmental service provision (Jackson et al. 1989).

As a health worker works with an individual, they might also be thinking about whether the individual's problem is shared with other individuals, and whether there might be opportunities for mutual support. Might this person's presenting problem be

influenced by an underlying problem of social disconnectedness? Might an individual's goal to lose weight be easier to achieve if they joined a walking group? And here we might ask why is it easier for a doctor to write a prescription for a drug than to write directions for how to join the local walking group?

And then you might say, whose job is it to create those walking groups? Whose job is it to tackle some of the bigger issues that might be causing health problems, including lack of employment opportunities?

In my view it is legitimate for local health bodies, such as hospitals, health centres, and Primary Health Networks, to join campaigns with local councils and other groups to address the causes of causes, to try and change some of the factors which contribute to ill health.

In turn this means that local health services need to work with their communities on setting priorities for what needs to be addressed. Too often our 'consultation' processes are not really consultations at all. They are simply people in power telling people with no power what is going to happen, at the 'inform' end of a spectrum of public participation (International Association for Public Participation 2007).

With broader local participation and local involvement, we can begin to build social movements for change.

Yes, you might cynically sneer, this thinking is so 1970s. And maybe it is: the social movements of the 1970s led to substantial change in society and in health systems, opening up new

opportunities and new ways of thinking (Baum et al. 1992; Broom 1991; Crouch and Colton 1983).

The 1980s and subsequently saw the de-legitimisation of this approach to change. 'There is no such thing as society' we were told (McSmith 2010). The neoliberal agenda stole power from community groups, transferring it to contracted-out, marketised services across a broad range of the public sector (Cahill and Toner 2018). Community health services with a local identity, named so you understood who and what they were, were replaced by larger corporations, with reduced local involvement, and names that read like brands of soap powder.

We need to recover that dynamism and activism of the 1970s, and as part of that we need to rethink about what is the role of the local hospitals. Victoria is unique and much derided for having so many autonomous hospitals. I have in fact never been in favour of closing local hospitals. My view back then was that the political pain of closure was not worth it. The big money, in terms of savings, is in the big hospitals.

Rather than benign neglect of local hospitals, my view has shifted over time to believing that we have to reconceptualise the role of local hospitals.

Many of them have changed their corporate name to 'local town' health, or 'local region' health, even though the principal building is still the hospital. The name changes should signal a much bigger shift in thinking than people have hitherto contemplated. Health services in rural Victoria provide many more services than acute healthcare. They need to be explicitly and overtly engaged

in the development of their community. Already many of the better health services are. I've heard from Professor Mandy Kenny, for example, of health services which have created community gardens.

This means that the role of the local chief executive officer is not simply managing the books of the hospital, and ensuring appropriate clinical governance. It is also to be out there in the community, building links and strengthening the community. And the good news is that many of them are doing that already.

Local hospitals need to take a lead in innovative models to attract and retain GPs. Again, some are already doing this, such as Swan Hill. And all of this can be done while still maintaining rigour in clinical governance, as we suggested in our Targeting Zero report (Review of Hospital Safety and Quality Assurance in Victoria (Chair: Dr Stephen Duckett) 2016).

The hospital should not be the only engine of change. Primary Health Networks – PHNs as they are abbreviated – also have a critical role. At the moment PHNs are micromanaged creatures of the Commonwealth, and this despite the fact that they are all incorporated as independent companies. If you look at a PHN logo, it has in fine print 'an Australian Government initiative', with a capital G, rather than the small g it should be.

PHNs were created to strengthen primary care. They will not be able to do that if the Commonwealth government continues with a head-in-the-sand, veil-of-denial proprietary attitude to the PHNs.



The Commonwealth, as difficult as it will be for them, will have to realise that they are not the only game in town. State governments exist, and the Commonwealth needs to work with the states to improve and strengthen primary care, as we have argued in Grattan Institute reports on primary care (Swerissen and Duckett 2016, 2017; Swerissen et al. 2018).

Many health professionals argue that two levels of government being involved in healthcare makes good governance and improvement impossible, and creates problems with continuity of care. That is not my view.

The public well knows which government is responsible for what. In last year's Victorian election, the parties made competing promises about expanding public hospitals and school dental services, for example. There were no promises about expanding the Pharmaceutical Benefits Scheme. Voters know who is broadly responsible for what.

That doesn't mean we can't improve coordination. Australia's health system exhibits the most complex form of coordination issues that there is (Thompson 1967). The outputs of state-funded health services are the inputs of Commonwealth-funded services, and vice versa. If the Commonwealth fails in its obligations in primary care, some of the consequences are borne by the states through increased potentially preventable hospital admissions. And there are a host of other examples.

In addition to getting the funding incentives right between the two levels of government, we need to look to PHNs. In my view PHNs should become a neutral ground, accountable to both the

Commonwealth and the state, and be used by both governments to improve health and healthcare.

In several Grattan Institute reports we have argued for tripartite agreements between Commonwealth, state and PHN to set local priorities, which might include for example goals to reduce potentially preventable hospital admissions. This would have financial benefits for both Commonwealth and state, as well as obvious community benefit through reduced unnecessary hospital admissions. But to achieve this we will certainly need change in accountability and governance arrangements.

All this will not be achieved without workforce reform. We have to recognise that there are fewer GPs in regional areas, as I have shown earlier. And I suspect the shortage is worse than the raw numbers display. There is anecdotal evidence which suggests that new services and new GPs are less involved in local hospital on-call rosters than they used to be, which threatens the viability of local hospital services.

As I have argued here, existing trickle-down policies are not working. And as Albert Einstein famously said, if you continue pursuing policies that don't work, you better get a new job. (I might add that there is no evidence that he actually said that (<http://quoteinvestigator.com/2017/03/23/same/>, accessed 21 November 2018), but I saw it on the Internet so it must be true.)

Workforce reform needs to involve workforce substitution, using the existing skilled workforce and supplementing it with people who can take on some of their tasks.



We have argued in a Grattan Institute report that using pharmacists' skills better, including empowering them to do immunisations, can free-up GP time and help improve access (Duckett et al. 2013). I'm pleased to say the Queensland government has picked up on that suggestion. We went further though and proposed that, with the agreement of GPs and patients, pharmacists should be able to provide repeat prescriptions to people with simple, stable conditions. They should also be able to provide vaccinations and to work with GPs to help patients manage chronic conditions. Using pharmacists in this way would free-up scarce doctor time to allow them to treat more complex conditions.

I want also to return to the issue of aboriginal health. It is a disgrace and an indictment of us all that the health status of aboriginal people is so poor. The issues of the social determinants of health which have been a theme of this Oration are writ large in the case of aboriginal health.

The antecedents of poor Indigenous health status reflect the dispossession of prior generations and are not going to be addressed quickly or simply. The solutions include putting more authority into the hands of Indigenous communities to manage their own health services, to set their own priorities and to work in culturally appropriate ways.

But improving aboriginal health is not simply a matter of more doctors, even more services, and more Aboriginal Controlled Community Health organisations, as important as they may be.

Judith Dwyer and her colleagues have shown that:

Australian research on differentials in care has established that systemic racism is real, with damaging effects on access and quality (Dwyer et al. 2016).

Mainstream Australia condemns the most egregious aspects of overt racism. But the evidence about the way Indigenous Australians experience healthcare cannot be dismissed as a random artefact; unconscious racism may be at play. This may be as simple as well-intentioned people thinking that treating Indigenous Australians equally is sufficient, when contemporary ethics acknowledge that unequal need warrants unequal care. That is, equal treatment is not enough to overcome Indigenous disadvantage; additional care is required. It is also important that health professionals 'see' the ways in which access to and quality of care are affected for Indigenous patients by the practices and policies of health care organisations.

A key way to address racism in healthcare, whether unconscious, systemic or institutional, is to call it out and ask health professionals to take additional action to overcome the bias. For this reason, I have argued that the medical profession's code of conduct needs to direct medical practitioners' attention to unconscious bias, and to the steps they need to take to redress it (Duckett 2018).

We also need to recognise the importance of the development of aboriginal community controlled health organisations, which are culturally safe and locally accountable. These are the same principles that I suggest ought to apply to the whole health system.

Finally, I'd enter a plea to be bold. We need to recognise and name the issue of social determinants of health. We cannot be bullied into denying that ill-health is created in a social environment. Nor can we sit idly by, awaiting a revolution which will fix all problems. I have a secret to tell you: that's unlikely to occur in the near future.

What we have to do is build coalitions, work with local communities to identify local problems, and mobilise to address them. This is long and slow work. It is not about simply calling a meeting, but involves starting with people in developmental casework or developmental service provision, and starting with communities with the worst health outcomes.

A key theme of what I have been saying is about local solutions, empowering local organisations to work creatively to tackle health problems beyond the bounds of health institutions. We need to give greater flexibility to our local services so they can foster and encourage innovation to help address the manifold causes of the poorer health status in regional Australia.

And this brings me back to where we started this evening, with Vi Marshman, whose first career was as a nurse in rural Victoria. In her day the healthcare problems were different from today, with more emphasis on acute care and less emphasis on chronic illness. So too treatments were quite different. But what we had back then was a strong sense of community in those small rural towns.

The Violet Vines Marshman Rural Health Initiative is a really important development which offers the opportunity to address

some of the problems I have sketched out in this Oration. I understand that part of the requirement of the grant is that La Trobe University and Professor Kenny will work closely with local communities to do two things.

Firstly, to identify and improve health services in those communities, working with rather than imposing on the community (Farmer et al. 2017). This will help to build authentic solutions along the lines that I have argued for. Secondly, the Initiative will help to reconceptualise how we think of rural health issues, evaluate solutions, and contribute to the knowledge base so that others, internationally, can learn from what is happening here, as we learn from them.

I'd like to thank my friend Ian Marshman, and the whole Marshman family, for generously endowing this Initiative; my friend and colleague Mandy Kenny for inviting me to give this Oration; and you for patiently listening to me tonight.

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## **The Violet Vines Marshman Rural Health Initiative**

Violet Vines Marshman (1917-2014) was born in the small rural town of Branhholme in western Victoria and trained as a nurse. She devoted much of her life to improving the health and wellbeing of people living in rural and regional Australia.

Ten years before her death, Violet established the VV Marshman Charitable Trust, with her sons – Ian, Neil and Ken – as three of its Trustees. The \$3 million investment in establishing the Violet Vines Marshman Rural Health Initiative at La Trobe University is the Trust's largest investment.

The research program of the Violet Vines Marshman Rural Health Initiative is focused on how primary health research, innovative health services, and contemporary workforce approaches can be combined with integrated knowledge translation to maximise healthcare outcomes for vulnerable rural people and ensure the delivery of place-based, exceptional rural health care. Community members and other key stakeholders are explicitly involved in the research program because they bring unique expertise, including knowledge of the context, and they are important in rapidly translating evidence to policy and practice. Key lessons are rapidly diffused and disseminated as knowledge is produced, using a variety of intensive methods of communication tailored to the target audience.

The program provides a blueprint for Australian health reform, demonstrating how community-driven health service redesign can address major access and equity issues, and how an agile,

interlinked and self-improving system can be achieved at a practical place-based level.