



Wonky Health by Dr Tim Senior

A compilation of columns investigating **health in all policies**. Thanks to all those who helped to crowd-funded this series.

Wonky Health is a column where Dr Tim Senior investigates the health impacts of policies (including within the health sector but mainly outside of the health sector).



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Wonky Health reveals how co-payments will increase the health gap

The impacts of a Medicare co-payment would be far-reaching, including increasing the health gap between wealthy and poorer areas, and making it harder for general practices to survive in disadvantaged areas.

MPs (and others) wanting some evidence-based insights into how the co-payment would affect people and general practices across electorates are advised to dive into the first edition of Wonky Health.

Tim Senior writes:

For my first Wonky Health column, I'm going to start very close to home with the Medicare co-payment. **You may have heard of this.** There's a lot been written about it.

We already know that it **makes health care more expensive**, that it **keeps people struggling to afford it away** (so that richer people can **get appointments more easily?**) and it's **pretty unpopular**.

But don't worry, say advocates of the co-payment. It's a price signal that's too small to operate as a price signal, it's a policy designed to keep people away from the doctor that won't keep people away from the doctor. It will make the budget more sustainable by paying doctors more, building up a big research fund and contributing nothing to the budget bottom line.

That's a magic pudding of a policy. Or perhaps just a **normal pudding**.

What we haven't heard much about is the way the co-payment policy systematically takes money away from where it is needed.

It's as if those responsible for the policy had read Julian Tudor Hart, who worked as a GP in a Welsh coal-mining village, on **the inverse care law** - and said "that sounds like a good idea." (The inverse care law holds that *"the availability of good medical care tends to vary inversely with the need for the population served"*.)

If I were to write the Ladybird book of Medicare Co-Payments, the introduction might go something like this:

- Not everyone lives in North Sydney
- Wealth is not distributed evenly across Australia
- People without much money tend to live in the same areas, and people with lots of money tend to live in the same areas.
- People who can afford to pay for appointments and prescriptions tend to live in the same areas
- People who struggle for these tend to live in the same areas, and so go to the same General Practice.

In the follow-up volume “Inequality for Dummies,” I might add:

- Poor people have worse health than rich people
- A strong general practice and primary care sector **can help** with this health problem, and keep people out of expensive hospitals.

For people to whom this is new information, I’d then invite them to consider that many practices who bulk bill people need to bulk bill almost everyone – in a particular area, if one person can’t afford to see a doctor, most people can’t afford to see a doctor.

I’d then invite them to understand the nature of general practice in these areas. Let me introduce you to the next generation of Julian Tudor Harts, led by Graham Watt, Professor of General Practice at the University of Glasgow.

They call themselves **GPs at the Deep End**, and they serve the 100 most deprived practices in Scotland. **Through their meetings**, we heard that “there are no easy cases.” They describe the multiple conditions their patients have, and the complex social and mental health problems.

“Social and medical problems are often not differentiated by patients who look to GP practices for help,” they say, analysing the gatekeeper role of GPs in accessing a range of important services. They identify one of the most crucial factors: “The most important barrier to addressing the inverse care law remains the shortage of time within consultations.”

They recognise the importance of a sequence of face-to-face contacts in tackling these problems. They talk about multi-morbidity, barriers to patients engaging in their own care, and high practitioner stress. In short, it is difficult work.

But hang on! These GPs in Scotland are describing my work in an Aboriginal Medical Service in south-west Sydney. In fact, it sounds very similar to the description of **consultations described** in several Aboriginal Medical Services – longer consultations, more problems managed in each one, more health professionals seen each visit.

I would even go so far as to hazard a guess that GPs working in any deprived community in Australia would recognise this pattern. This includes many rural communities, and would include all the Aboriginal Medical Services I know.

So let’s look at how Medicare supports these practices to provide longer consultations to deal with these complex problems. And how this mechanism attracts doctor to work in these underserved areas.

Um. Well. There are GP Management plans for chronic disease and their reviews, which have limits on the number of times they can be charged.

And there are health assessments, which **probably don’t work**, and certainly **don’t attract people who need them most**. And then there are the routine Medicare attendance items, which encourage 6-minute medicine, where the financial incentive is to see a lot of people quickly.

So if you spend the time required on the complex problem, the practice earns less, which means fewer or lower paid practice staff.

Of course, privately billing general practices will earn significantly more than bulk billing ones, because they set their own fees. If you want to repay the debts you built up as a medical student, you're not attracted into working in deprived areas, clearly. And privately billing GPs won't be affected by the co-payment (though their patients will get \$5 less back from Medicare).

If the co-payment comes in, practices will be able to choose to ask people for the co-payment of \$7 (and will get a pay increase of \$2 for each patient they see). However, most of their patients won't be able to afford \$7 in these areas (remember, we don't all live in North Sydney) and will choose optional discretionary spending like food or electricity or rent that week.

So many practices will waive the co-payment, because they need to if they actually want to help people, resulting in \$5 less from Medicare, \$2 of the co-payment less from the patient and loss of the low-gap incentive for pensioners and children. And this happens with almost every patient, because we don't all live in North Sydney.

So the result is less money for the practices that need longer consultations for all their patients.

Meanwhile, the AMA says the policy will encourage **4-minute medicine**. And it does – mainly in areas that need longer consultations for more complex consultations. The other thing that will happen is fewer practice staff. But not in North Sydney, where we can privately bill.

Currently 20% of Medicare GP services are privately billed and **80% of services are bulk-billed**. It's important to point out, though, that this 80% figure is an average. "Never walk across a river with an average depth of 5cm" I was once told – you don't know how deep it goes!

Interestingly, there are some data hidden away on the **Department of Health website** that show the bulk billing rates for each electorate so we can find out the range around that 80%.

Rosie Williams, over at **InfoAus** has put these figures into her online database, so you can all go searching for **your own electorates**, or those of your favourite MPs.

Step forward GPs in the electorate of **Chifley**, who manage a bulk billing rate of 98.9%. Perhaps Rooty Hill will be significant in another general election campaign fought on the co-payment!

The lowest bulk billing rate is 45.8% – in the seat of **Canberra**. I'll leave others to theorise about the impact of this on MPs' experience of co-payments for health care.

Clearly, there are some electorates that will be much more affected by the co-payment than others. You can see how they are **distributed across parties here**. We can also add in the measures of deprivation (the SEIFA scores) to the bulk billing rates and – lo and behold – there is a correlation.

I've deliberately presented this by electorate, as this brings the issue directly into the eyesight of our elected members in a way that other figures might not.*

The implications for your electorate are this: If you are in a well off area, with low bulk billing rates, you are unlikely to be affected by the co-payment very much. If your bulk billing rates are high in your electorate, then the co-payment will hit your electorate hard.

If you are in an area of economic disadvantage, the co-payments may well be waived and you will find it harder to sustain successful general practices in your area.

The removal of health resources from deprived areas happens just at the time that a **BMJ paper from the UK shows that providing extra funding to areas of deprivation reduces mortality**. Oh dear.

This analysis doesn't even mention the potential of Medicare Locals to support practices in deprived areas and provide and link to those social and community services that were so important to the GPs at the Deep End. New organisations will need to find their feet very quickly across many localities to support this.

This recent paper shows how, with really good co-ordination, a universal network of primary care services (through something like a Medicare Local) can reduce cardiovascular mortality in a deprived area. It took about 10 years. We might be starting again, from scratch. Oh dear, again.

The conclusion to my Ladybird book might go something like this:

Current policy removes resources from the primary care sector in deprived areas, just when the evidence shows doing the opposite can improve health.

It might be time for everyone to move to North Sydney.

*Meanwhile, over at the **National Health Performance Authority website** there are similar figures about Bulk Billing rates by Medicare Local, as well as figures about the number of people who struggle to pay for care. There are also stats **here** showing the deprivation index for each Medicare Local, and one day I'll put these together.

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Wonky Health: It's just not fair!!

In the second edition of Wonky Health, Dr Tim Senior explains why Health Minister Peter Dutton should be telling his Cabinet colleagues that they are making his job much harder – Budget policies that promote inequality are also likely to be harmful for the community's health.

Whether politicians are as clever as children, who grasp the basic concept of fairness from about age three, is another matter...

Tim Senior writes:

Listen! That strange clanking noise you can hear around the budget is the changing of gear.

Instead of debates about how many promises were broken, or debates about whether there really is a budget emergency, the real discussion now is about fairness.

In a country whose unofficial motto might be “A fair go,” much of the unpopularity of the budget is because people think it is unfair. Last week Joe Hockey tried to **defend the budget on the grounds of fairness**.

So, if the federal budget has achieved one thing, it has **got us all talking about fairness**. We are all 70s class warriors and socialists now, it seems – charities, welfare agencies, the Australian Medical Association and even ex-liberal leaders John Hewson and John Howard are talking about fairness.

But, really. Be honest now. Does it really matter whether the budget is fair or not? We can moan, it might offend us, those at the bottom will struggle.

We might get away with a lack of fairness if we could just hide away and ignore those people who are affected. We could just get on with our own lives.

But what if it wasn't just individual policies that had an effect on health care? It's fairly easy to see how a Medicare co-payment might affect health, or making people live without any income for up to 6 months will make people sick.

But could the overall shape of the budget – where the richest incomes fall by 0.2% and the poorest by 2.2% – affect Australia's health?

Let me introduce you to Richard Wilkinson and Kate Pickett. They are UK epidemiologists who have spent a lot of time asking just this sort of question. Their book **The Spirit Level** is a highly readable introduction to their findings (and the graphs and updates are available from **Equality Trust website**.)

They looked at developed countries and ranked them by the gap between richest and poorest – a measure of inequality – then looked at a **range of health and social issues** to see if they were correlated. They then did the same looking at states in the US.

They found that there was a clear correlation between health and social outcomes and inequality. Societies that were more unequal had worse health problems than more equal societies. Countries with larger differences between the richest and the poorest, had worse physical health and worse mental health.

I hope you are all chanting at me now “correlation doesn’t equal causation.” These findings don’t show that inequality causes poor health. It doesn’t prove that taking action to reduce economic inequality will improve people’s health.

Subsequent efforts to show that inequality causes ill health have had mixed results – which is what you’d expect for such a complex concept. It would be very difficult, though, to claim the opposite – that doing what this budget appears to do in worsening inequality will improve anyone’s health.

On the other hand, there is some evidence that people who move from an unequal to a more equal society do better than those who move in the opposite direction.

Economic inequality is also tied up with inequality in status, culture and ethnicity, and there is evidence that these play into the health outcomes too – for example, in Japan it has been pointed out that social status might be more important than income, which is why it is an outlier on some of the statistics.

Here in Australia, the obvious example is of Aboriginal and Torres Strait Islander peoples’ health, where colonisation and dispossession result in social exclusion, all of which have health consequences, and also contribute to inequality of opportunity.

Many of the Budget’s policies show a lack of understanding about what it is like to struggle to pay rent, fuel or medical bills. There is a lack of empathy and imagination; it seems as if those now making policy have some idea that poverty just means less opportunity to buy expensive designer goods.

Poverty **changes peoples’ decision making**. People make decisions for the now, not the future when they don’t see a future. This is the reason people smoke (“It’s my only pleasure, doc”) or don’t take on debt to study.

We can wish it wasn’t so all we want, but fundamentally, if we really believe in the right of individuals to make decisions for themselves, we may have to understand this.

As Joe Hockey said, “Our duty is to help Australians to get to the starting line,” as he stamped on the toes of those already struggling to reach it.

While it might be interesting to debate the research findings on whether inequality causes poor health (and I do find it interesting!), there are policy decisions being made now.

Doing nothing while waiting for an answer to questions about the precise relationship between inequality and poor health outcomes is not doing nothing – it’s maintaining the status quo.

Putting policies in place that preserve income for the richest and remove income for the poorest will have consequences.

Restricting access to quality education to those who can afford to pay top dollar for it has an effect on social mobility and inequality. It’s fairly simple to predict from what we know that the effect won’t be to improve anyone’s health.

Meanwhile, **Oxfam show** that the richest person in Australia owns more than the bottom 10% of the population.

One of the striking findings in the Spirit Level was that everyone's health is harmed by inequality – it's not just those at the bottom, though clearly, they lose out most. The health of everyone is worse.

So, if you want more people to reach the age of 70 so they can retire;

If you want more children to survive their first year;

If you want fewer people to suffer with depression;

Then you'd be at least careful about making Australia more unequal with these budget measures.

Of course, you might not be interested in these health outcomes – especially if you're not the health minister.

A budget sets out the sort of country we want to be, and the government may think that inequality is the necessary engine that drives economic growth. But the evidence for this is very frail.

It looks more likely that inequality acts as a drag on economic growth – like a tax, if you will. You also create a society that has higher rates of homicides and robberies. Children score lower on reading and maths tests. Even levels of trust are lower in more unequal countries.

We are entitled to ask “Is that the sort of country we are aiming for?” Seen in this light, health outcomes are a marker of a society not functioning at its best, rather than a collection of diseases people suffer from.

If I were the health minister, I'd be going round to all my Cabinet colleagues telling them that their budget is making my job harder.

The redistribution of wealth from those at the bottom to those at the top, the limiting of educational opportunity and the reduction in social mobility will harm people's health in multiple ways, both because of specific budget policies, but also because of the reverse Robin Hood.

We all need to talk about inequality. It won't make you into a 70s Class Warrior. It will, however, put you in line with everyone from Jesus to **John Rawls**.

It may be hard to explain to Cabinet ministers. But most children grasp the concept of fairness from the age of three.

Perhaps we need to treat our politicians like kids. “Now, listen...”

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Can an “Infrastructure Prime Minister” be a “Health Prime Minister”?

The third edition of Dr Tim Senior’s crowd-funded **Wonky Health column** investigates five ways that transport policies affect health.

He says: “I am questioning an unthinking devotion to the car, at the expense of a transport system that enables all groups in a society to join in and contribute to that society.”

Tim Senior writes:

Tony Abbott said before the election that he **wanted to be the infrastructure Prime Minister**. And, in what is quite a tightening of the dictionary definition of the word, infrastructure now means roads.

Tony Abbott wants to build roads. Public transport can be left to the state governments. This has been less controversial than many other proposals. Nothing to see here, everybody move on.

But what if the way we move ourselves and our goods around has health consequences?

Perhaps our decisions to build roads, tax petrol, construct cycle paths or increase the cost of train tickets have bigger implications than just time spent in a traffic jam.

Transport often comes up as an issue for Aboriginal Medical Services, usually in terms of accessing appointments. I know many of my patients walk everywhere, some cycle, not as a form of fitness drive, but because they have no other choice, no way of getting around.

Could our decisions about transport have **effects on our health**?

There are five ways in which transport affects our health, all of which have impacts whatever individual choices we make about how we get around. They also impact us differently if we are children, elderly or where we live. These are:

- Accidents and injuries
- Air pollution
- Physical activity
- Social connectedness
- Noise levels

Don't get hurt – Accidents and injuries

Travelling by car is the most risky form of travel there is, with 40% of those involved not being in a car. Particularly at risk are cyclists, pedestrians and children. We routinely discount this risk – every morning our transport news on the radio will tell us of delays in the city because of a vehicle accident. Imagine our horror if we heard about an aeroplane crash just because it delayed someone else's flights. The relationship between more roads, more cars and more accidents is more complex, however. Most accidents happen in built up areas, comparatively few on motorways. Those on motorways, however, are more likely to be serious, because of the higher speeds involved. In fact, there is a dose-response relationship between speed and likelihood of accidents – each reduction in speed of 1km/h reduces accidents by 3%. Certainly, preventive policies such as drink-driving legislation and seat belts do a lot to reduce the numbers of accidents, and the effect of them when they do happen – examples of the nanny state not often criticised nowadays! The likely effect of building more roads is to have more cars on the roads, which results in more accidents overall. Those traffic bulletins will be getting longer.

Don't breathe in – Air pollution

Cars produce air pollution, in the form of tiny particles, which we all inhale, ozone, NO₂, and carbon monoxide. (Of course, they also produce carbon dioxide, which contribute to climate change, and affect our health too.) Though it's not entirely clear what ingredient in this cocktail is responsible for what, we do know that exposure results in more asthma attacks, more hospital admissions, and a short term increase in cardiovascular deaths. Perhaps surprisingly, it seems that those who get the most polluted air are those inside the cars – not the cyclists or pedestrians outside them (or indeed those on the train!). Living near roads with heavy traffic also puts you at higher risk – especially if you are a child. Policies to restrict emissions levels in new cars – that nanny state again – can keep air pollution levels from rising, but ultimately, increasing the number of cars on the road is a good way of delivering air pollution into populated areas at nose height.

Don't just sit there – Physical Activity

It's become common knowledge that sitting around is not good for you. We've become accustomed to the solution to this being gym memberships and exercise equipment at home. We've also become accustomed to failing. Physical activity has become an optional extra, a commodity to be sold, but not part of everyday life. At the same time, we are using petrol to fuel our activity, instead of our metabolism. **What if we used walking and cycling as part of our routines to get to work?** There is reasonable evidence that doing this has a good impact on health outcomes, such as risk of diabetes. However, it's not an easy thing to do. It's only practicable to walk or cycle for shorter journeys, not the traditional city commute. It requires infrastructure, such as safe cycleways and footpaths, bicycle parking. It may also need public transport – **as people have to walk a bit at either end** – that is convenient and cheap, and takes bikes. At least currently the nanny state is not telling people to exercise more. Instead it's shouting at people to get in their cars, **loudly encouraged by some media!**

Don't go out and play – Social connectedness

Transport is mostly a means to an end. It is what gets you to a place to do something you need to do – work (or find work), see friends, buy food. It is also what gets the tools you need for your work, the coffee you share with friends, and the food you buy, to the places you go to. Overall, transport should improve our social connectedness. However, the car has moved from a social enabler, to being an isolator – allowing us to move to suburban areas without social centres. Small towns are created around the car, with large shopping centres out of town, few footpaths, and no schools, community centres. Traffic volumes and speeds in an area actually affect the number of friends that people living there have. In areas with high speed or high density traffic, people keep to themselves, and stay away from the roadside, using it only briefly, with no social contact. Local transport density also affects the outdoor play of children, such that they spend less time outside, with less physical activity, and less time socialising with other children. It seems a little odd that a nanny state might be a more effective nanny for our children.

Don't whisper – Noise

Those who seem convinced, **despite all the evidence**, that wind farms are bad for our health, should perhaps stop tilting at windmills, and look at transport where there is evidence that noise – proper noise, not infrasound – can have adverse effects on health. Noise can cause annoyance, aggression, poor sleep and impaired communication. Its effect is particularly strong in the elderly, those already hard of hearing, and those used to a quiet environment.

Don't care – equity

Though we are all affected by these issues, we are not affected equally. It's usually the case that well off suburbs don't end up with new motorways built through them, and that high volume traffic areas do not have high house prices. Public transport is often geared to the commute, and so serves the Central Business District and other well off areas best. Poor public transport in less well-off areas of a city can exacerbate other equality problems such as food security, or the ability to travel to look for work. Groups such as children are particularly vulnerable to quite a few of the health issues driven by transport.

Don't get ill – the solutions?

Thinking about the health consequences of transport policy is an unusual thing to do, and perhaps slightly strange. It's very easy to deposit the whole issue into a large too-hard basket. We're not used to thinking that non-health policies have health effects – that choosing to build a new road might result in higher hospital costs. It's also an area where the health effects are complex, and thinking about just one outcome can adversely affect others. I may have come across as being anti-car. I'm not – my family has 2 of them – but I am questioning an unthinking devotion to the car, at the expense of a transport system that enables all groups in a society to join in and contribute to that society – perhaps a workable definition of infrastructure. The evidence is not clear enough to say exactly what needs to be done. If we wait for sufficient evidence, however, we've either done nothing at all, or carried on with policies anyway in the absence of any evidence. This is where values come in.

I'm thinking of Sydney now, and imagining a transport system where most people choose a frequent, convenient and cheap public transport system, perhaps funded by those willing to pay for the privilege of travelling in their own metal box on clear roads. (We already have tolls on many of the major roads into Sydney. And the London Congestion Charge has been a controversial success.) I'm imagining social communities walking and cycling safely to socialise with each other.

None of this may be appropriate. I'm certainly not an expert in transport. But in the midst of all this complexity, the final message is simple.

Consider health outcomes in the cost benefit analysis. It leads to better decisions for all of us.

Further Reading

I have drawn mostly on two reports looking at the evidence on transport and health.

The first was written by the WHO. Though it concentrates mostly on European data and outcomes, the conclusions are more broadly relevant:

http://www.euro.who.int/__data/assets/pdf_file/0003/87573/E72015.pdf

The second is a UNSW report looking at the evidence in an Australian context:

http://hiaconnect.edu.au/old/files/Impact_of_Public_Transport_on%20Health_in_Australia.pdf

Here's an example showing it can be done for a particular road project in Australia:

<http://onlinelibrary.wiley.com/doi/10.1111/j.1753-6405.1995.tb00385.x/abstract;jsessionid=2F4300D1F-326CE2F083F2CC9E3B341AB.f02t01?deniedAccessCustomisedMessage=&userIsAuthenticated=false>

It's also been done in Edinburgh:

<http://www.sciencedirect.com/science/article/pii/S0033350602000021>

And in London:

<http://jech.bmj.com/content/58/3/169.full>

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How inequality creates complex health and policy challenges

In the fourth edition of his crowd-funded Wonky Health column, Dr Tim Senior examines evidence from around the world about the health needs of disadvantaged peoples, reporting that poorer people tend to develop more complex medical problems and at a younger age than richer people.

While this is a critical area of policy that needs addressing, he cautions:

“... the solutions may not be the ones we think they are. If we’re making policy, we’re employed with a computer on the desk in front of us, and another one waiting for us at home. We have a high degree of choice in our lives and usually aren’t confronted with as many mental health, drug and alcohol problems and chronic pain as those we need to be thinking about.”

In other words, the solutions we come up with are those that would work for us. These may be not just the wrong solutions, but solving the wrong problems.”

Tim Senior writes:

If you’re worried about the aging population, and what that means for our health system, then you need to be worried sooner about inequality. Here’s why.

It’s generally recognised that as people get older, they have more medical conditions, and together these are more complex to manage. They require more services and more professional help.

Our health services (not to mention social services) will have to work out ways of providing this. And as a society we will have to work out how to fund it.

In the field that I work in, Aboriginal and Torres Strait Islander health, we recognise that on average people have more medical conditions at a younger age. Often Aboriginal and Torres Strait Islander people become eligible for services for older people from the age of 55, where it is 75 for non-Indigenous people.

The reason for this is not that they are Aboriginal. **It is not due to genetics.** It is due to the fact that Aboriginal and Torres Strait Islander people are over-represented in those sections of our communities who have been excluded from the main workings of our society and do not have access to social goods.

There are specific historical and cultural aspects to our society’s exclusion of Aboriginal and Torres Strait Islander people, but just the fact of exclusion has an effect.

A team of health researchers in Glasgow have done a lot of work in this area. **They show** that while multimorbidity is more common in those older than 65, more than half of those with more than one medical condition are younger than this. What’s more, they show that the poorest group in society has 2 or more medical conditions 10 to 15 years earlier than the richest group.

So while we are grappling with the complex services required for the elderly, those in underserved communities will need these services 10-15 years earlier. A rough guess might suggest that time is now!

Certainly, **evidence from this research group** and from Aboriginal **Medical Services** in Australia shows that the effect on primary health care is that longer consultations are required dealing with more problems at each visit. More professionals are involved for each patient.

But it's not enough just to think that not having money is just the same as having money without the designer goods. For example, offering everyone health checks (leaving aside the fact **they don't work**) is a nice middle class solution that attracts middle class people to health services they can already access. It **doesn't attract those who might really benefit** from preventive care.

Three recent papers put some interesting meat on this. First of all, the same group of researchers showed that not only did the presence of multimorbidity come in at a younger age for the socioeconomically deprived, but the **types of conditions they suffered from were different**.

There was much more anxiety, depression and drug and alcohol problems in deprived communities, which is perhaps unsurprising. There were also higher rates of chronic pain – think on that! – as well as dyspepsia, coronary heart disease and diabetes.

You can imagine from this the sort of services that will be required in these areas. Drug and alcohol and pain clinics aren't very sexy, though, and rarely get people out on sponsored fun-runs. They are also treatment areas that don't provide simple solutions.

It's easy to think people should just make more sensible choices about their lifestyle. **Another recent paper** looks at preventive advice and activities in lower-income compared to higher-income individuals.

The survey was done in Canada so some of the findings may have not translate directly to Australia, though personal experience would not suggest it is hugely different here. They found that preventive health advice, such as smoking cessation, dietary changes, and exercise were offered equally by health professionals regardless of income.

However, they found that people on low-incomes were less likely to stop smoking, and less likely to have a cholesterol or glucose test. The reasons for this were more often due to extrinsic factors beyond the person's control in lower income individuals, such as cost or availability. Higher income individuals were more likely to say it was due to personal choice.

The **third study** comes from America and looks at the use of e-health activities. They found that the biggest predictor of whether someone used e-health or not was their socio-economic status.

Older men and those on low incomes or lower levels of education were less likely to use the internet to look for health information, or to find or communicate with a doctor, let alone use computers to track their own information. Again, this is America, but there is **evidence of a digital divide in Australia**, and I'd be surprised if these findings were completely different here.

Policy implications

What does this mean for the development of policy?

First of all, it means that the multimorbidity and need for complex services that we are expecting as the population ages is already here for the worst-off sections of our society.

Second, it means that the solutions may not be the ones we think they are. If we're making policy, we're employed with a computer on the desk in front of us, and another one waiting for us at home. We have a high degree of choice in our lives and usually aren't confronted with as many mental health, drug and alcohol problems and chronic pain as those we need to be thinking about.

In other words, the solutions we come up with are those that would work for us. These may be not just the wrong solutions, but solving the wrong problems.

Fortunately there is some more evidence for an age-old remedy that works – engage! **This paper** looks at health reform in Australia and suggests that if we want equitable health care in Australia – and I would firmly suggest we do – then we need to think about equitable governance. This is policy-speak for involving those who need the service in the planning and running of the service.

Clearly, Aboriginal Community Controlled Health Services show a way of doing this in Australia. They have **demonstrated excellent outcomes** in populations that are often described as difficult, high risk and hard to reach. That's only true when you ignore their needs!

The paradox here, of course, is that while the health sector worries about an aging population, the Aboriginal health sector is seeing too many people die before they reach retirement age.

There really is no time to lose for any of us.

First published at Croakey on August 3, 2014

Wonky Health: What might public health advocates learn from reading Rob Oakeshott's new book?

The interests of cashed-up industries are routinely put ahead of our health.

That's hardly "hold the front page" news for those in the public health field, so it's perhaps surprising we don't hear more public health advocates calling for action on systems of political governance, including political donations.

The malignant influence of cashed-up political donors is highlighted in a [recent article](#) by former independent MP Rob Oakeshott, who argues strongly for reform of the laws around donations to political parties.

"The commercial influence on public decision-making is more important than anything else right now. Australia is losing its future unless we change," he wrote in *The Saturday Paper*.

So what pickings does Oakeshott's new book, *The Independent Member for Lyne*, offer for those with an interest in public health advocacy?

The Independent Member for Lyne by Rob Oakeshott

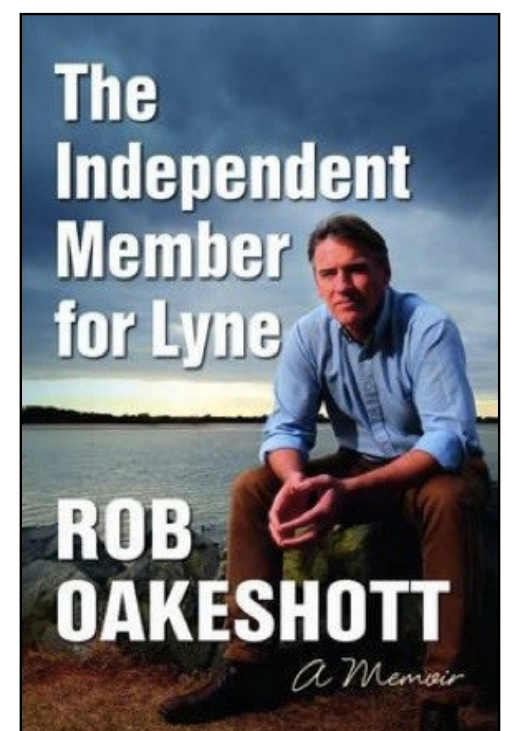
Reviewed by Dr Tim Senior

Early in this political memoir, Rob Oakeshott describes seeing a book on Tony Abbott's desk during the negotiations which will determine which party will get to form government after the 2010 election. "It is a book I remind myself I should read," writes Oakeshott. "I suspect it holds some wisdoms that Abbott is relying on."

It is in this spirit that I read *The Independent Member for Lyne*. Could this insider's description of the 43rd Parliament of Australia hold some wisdoms about effective political advocacy, especially for someone naïve to the process like myself?

Rob Oakeshott, as you will remember, is one of the independent and cross-bench MPs who kept Julia Gillard's Labor government in power from 2010 up to the 2013 election, and it's impossible to read his memoir without the benefit of hindsight on current political personalities.

I'll leave the political analysis to others – after all, it will be what most people read the book for. There are effective sideswipes at all sides of politics, all of which have the ring of truth about them, and leave one feeling a little disillusioned about party politics.



Oakeshott says towards the end of this book “I’m a policy wonk at heart. I like thinking about policy, but tire of the inevitable politics that comes with the territory.”

I was a little surprised to read this, because, with a few exceptions, much of this book is about the politics, rather than the policy – who discusses what with whom and why, the annoyances and loyalties that come with intense contact over time. In the end, the value that Oakeshott seems to appreciate most is the art of compromise. Both the Greens and Tony Abbott are derided on this.

I am being slightly unfair. The three policy areas Oakeshott is most committed to are Indigenous affairs, the National Broadband Network, and action on climate change. When he writes on these he is at his most knowledgeable and most interesting. It is these issues that have decided his allegiances, both with the National Party and on who to support in government.

Oakeshott is worth reading on Indigenous issues. One of the best sections is the appendix where he reprints the speech he made to parliament in Dunghutti language. Elsewhere he describes the process of discussion with local Elders that led to this, and describes often the importance of Indigenous languages. There’s also an interesting discussion on Noel Pearson’s arguments that reform on Indigenous affairs needs to come from the Conservative side of politics.

Oakeshott’s writing makes clear that much of his passion on Indigenous affairs is personal for him (he’s married to a Dunghutti woman, and the book is most emotionally engaging when he writes about his family).

In contrast, he emphasises that the importance of action on climate change comes from listening to, and understanding, scientific perspectives on the issue, and he is dismissive of those that don’t.

A recurring theme in the book is the concerted and co-ordinated lobbying by the rich and powerful. We meet James Packer ensuring his casino profits aren’t disadvantaged by government policy. We hear about the pressure applied by News Limited and shock jocks for decisions favouring money and power.

We discover the “Kochtopus” referring to the US Koch brothers using their influence across media, think tanks, academics and astroturfing to push their interests, especially against effective action on climate change. (It’s worth noting on passing that GetUp are also not mentioned with any sympathy, either.)

What would an advocate for public health learn from reading Oakeshott?

Health as a topic is notable for its absence. Hospitals are mentioned a few times, once in a discussion on the potential risks of public-private partnerships in financing. The health consequences on the immediate health of schoolchildren in an area of coal mining are mentioned as part of Oakeshott’s decision. But that’s it.

Interestingly for the health sector, where health service provision in rural areas is a major part of our thinking, one of the most prominent recent advocates for rural Australia has very little to say in this area. I don’t think that’s Oakeshott’s problem. I think that’s ours.

There are other areas of the book where the absence of discussion is instructive. Apart from the coal mining example mentioned above, health policy and health effects of other policies doesn't get a look in. Broader consequences of policy areas go unmentioned – for example there's strong advocacy for action on climate change, but I didn't get the feeling of why we need to do this, apart from saying “the experts say so.” I think we'll need more than that.

There's the same in advocacy for improvements to the Pacific Highway, which just sort of needs doing. Big issues, such as marriage equality or constitutional recognition for Aboriginal and Torres Strait Islander Australians are needed to make Australia better.

I'd clearly agree, but would wish for the reasons to be clearly articulated. I didn't hear any of the voices who would be affected by policy. Australia would be better, but this was quite abstract. The people we do meet in this book were mainly related to the work and lives of those closely involved with Oakeshott. He meets a lot of constituents, but we don't get to hear from them or have a sense of how they might be affected by policy.

I don't doubt for a minute that these positions are sincerely held and thought about by Oakeshott – indeed, he comes across as a man of integrity and thoughtfulness, who takes his role seriously.

For someone who calls one of his chapters “Questioning the norm,” the views come over as conventional (small-c) conservative. He takes a default market-based position on most issues, without tipping over into market fundamentalism. He takes a conventionally progressive view on social positions, such as inequality, and argues these well, especially on the ways lobbying occurs for the rich and powerful.

However, parts of the book are instructive in that there is no reflection on the way these inequalities come about. We hear about members of Oakeshott's family and in-laws who “joined the world of politics in their own ways.” Several times, someone in a meeting is discussed in the context of relatives whom Oakeshott knows, or known about from university or school rivalries. These relationships, of course, disadvantage those more recently arrived in Australia, those without relatives in power, and those who haven't formed networks with them at school and university.

You won't find mention of that here – not because Oakeshott doesn't care – I suspect he cares more than many – but because this is one of the ways Australia does business. This is not Oakeshott's fault – he is merely reflecting mainstream Australian values, serving as a representative. I may be hoping in vain that someone who says they are “questioning the norm” would wonder about this.¹

What are the lessons for those involved in health advocacy?

Rob Oakeshott comes over as someone who takes his role as an elected politician seriously, and wants to get policy ideas right. He's not alone in this among our elected representatives, but the personal toll is significant.

1 Perhaps more insidious is that someone arguing in favour of marriage equality is still able to thematically group same-sex marriage and the Royal Commission into child sex abuse. He genuinely doesn't conflate these as being linked, it's just that in a book organised in chapters grouped by policy area, I found this conjunction jarring. Elsewhere, Oakeshott writes “I kissed Tim Mathieson [Julia Gillard's partner] last night” which shouldn't need to be followed up by “Relax, it was just a peck on the cheek; nothing more.”

However much they (or we) might like to think differently, Parliament probably does reflect a version of our national values, beneath all the spin and colour. (Reading about the binge drinking culture in the NSW Parliament, made me think that effective alcohol policy starts with a direct disadvantage right there.)

In explaining and advocating for health policy, and particularly in public health, we need to start from scratch – assume no knowledge – and make clear the effects on their constituents, their friends and their family.

There are plenty of reasons to read The Independent Member for Lyne, but if you want to learn about effective health advocacy, read it with one eye on what isn't there, as much for what is.

First published at Croakey on August 20, 2014

In which Rob Oakeshott responds to a Wonky Health review of his book

In his recent Wonky Health column, Dr Tim Senior reviewed a new book by former MP Rob Oakeshott, *The Independent Member for Lyne*.

The review noted that “health as a topic is notable for its absence”, and also suggested the book would have benefited from a deeper analysis of the root causes of inequalities and power imbalances.

Below is the author’s response, in which he explains why rural health did not feature as prominently in the book as many would have liked, and also reflects upon the challenges of seeking a fairer distribution of power.

Rob Oakeshott writes:

I love the [crowd-funded journalism project](#) undertaken by the [Public Interest Journalism Foundation](#). Even when it hurts!

It was with surprise that I awoke this morning to find [an article](#) from Dr Tim online that undertook a review of my book, *The Independent Member for Lyne*, through the specific lense of rural health advocacy.

Despite years of public criticism about many things, one never quite gets comfortable with the nakedness of being ‘reviewed’ and ‘critiqued’. So, once again, as I sat down to read, I felt myself putting the battle-suit of democratic participation back on, in preparation for emotional scars to be picked. It was time to read what the thoughtful Dr Tim had to say.

He doesn’t actually score me out of ten, but I am left thinking I got about a six – maybe a six and a half at best!

He is right to pick up that rural health as a standalone topic doesn’t exist – well, it does – but not in the book. It died a death in the editing process, and sits in a red folder in my garage. I look at it now and think I should give it to Dr Tim. He could review the ‘uncut’ version.

As a revealing joke on myself, when I was tasked by the publisher to write 80,000 words on my time in politics, I got a bit carried away and gave them 200,000 words. My great life challenge of ‘wordiness’ reared its head, and more than half a book lies dormant amongst kids’ bikes, a lawnmower, and the home of a visiting dog.

So I can only apologise to Dr Tim, as in my world, rural health does matter, and did matter greatly when in office. It just ended up as off-cuts for the prime beef story of raw politics in the minority government of the 43rd Parliament.

That it was rural health that was cut is the valid conclusion that Dr Tim himself concludes.

Therefore, fair criticism 1. I concede.

There is another really important point that Dr Tim makes as part-critique. He comments on the social networks that I own and expose throughout the book – friends from university, from school, and family.

He describes them as examples of access to power that I don't reflect on at a deeper level. He seems to want a demonstration that I have thought about this, and is disappointed I don't articulate my views on this if I have.

Can I assure Dr Tim and readers of his article that this exact point is a life's work in politics for me, and is at the heart of my political journey. I thought it was obvious through my actions how I dealt with existing power structures, but obviously not.

So two points on this.

Firstly, the broad point for all of us to think on. Social learning theory is critical to where our politics in Australia has landed.

How we all perceive what power is, and who should hold it, was tested like never before when Australia had its first female Prime Minister, and she emerged from, a somewhat ironically named, 'hung' Parliament. This challenged a lot of Australia's social learning structures – what we are all bought up to believe and are 'culturally comfortable' with.

I discussed this last Saturday night with Mary Delahunty as I interviewed her for an audience interested in her new book 'Gravity', which looks at this in relation to Julia Gillard, from a specifically gender politics perspective.

Gender and sexualisation in politics was never something I placed much weight on until the 43rd Parliament, and it was only then that I heard so many men, and women, describe their politics in raw sexual terms:

"Grow some balls and call an election" was what I was repeatedly told.

"I mightn't agree with Gillard, but gee she's got some balls", was how she was described when she kept smiling and working through the most vicious attacks.

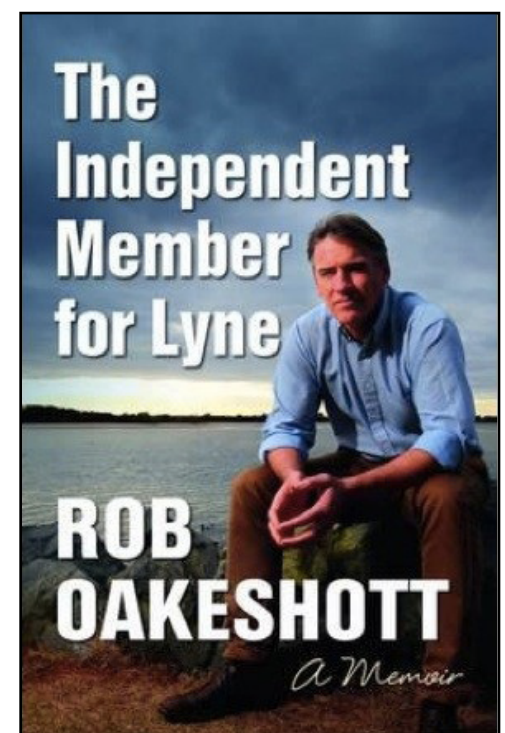
Balls = Power?

Since when?

So yes, Dr Tim, you are right. Social learning theory, and what we have all learnt to accept as 'cultural norms' played an enormous part in the noise of the recent Parliament, and we all have some reflecting to do on this.

And then secondly, there is the personal response to these power networks that I have been bought up with, and have used, and have challenged.

What I often think about today, in private, is if I had just 'shut up' and played the game as a good political party boy, I would have had a successful career in the traditional sense of power in Australia. My 'old school tie' network would have assured this. My access to power was strong, and my path to more power was clear.



It was through my own belligerent actions that I disrupted this.

My journey is a lived example of not just the strength, but also the pitfalls, of standing up to power.

I was once a ‘golden boy’ of those power structures, with lots of excitement about a bright future. I was ‘going places’.

Because I chose my own way, and chose to actually stand up for some values and some people without power, I am less ‘going places’, and now more ‘tolerated’ by this same network. I am now positioned as a ‘good fellow who lost his way’. A black sheep of Australia’s power elite.

There is no question I had power at a very young age. But my choice was to try to distribute this power to others – like rural health networks – and to embolden them and give them access to real power in our country.

And while this may have worked for three years at the sharp end of power in the 43rd Parliament, and while this may have been a political model that I promoted for my entire 17 years in public life, it is a model not without pitfalls.

Because the more I tried to distribute power the more I personally fell away from real power. This remains an unresolved issue in my own mind.

I inadvertently ‘cashed my political chips’ on you, Dr Tim, and others like you.

In a way, I handed in my old school tie, and the access to power that comes with it. Even today, I am not sure I did the right thing in doing so, but I did so because I do think the accumulation of power in the hands of a few is an enormous problem in modern politics – and frankly, I did enjoy challenging this, and trying to reverse this, while I had the chance.

No matter how big the punch in the nose in reply, it was fun to poke power in the eye.

So again Dr Tim, it is very astute of you to pick this up, and I was remiss not to reflect on this in more detail in my own words.

Therefore, fair criticism 2. I concede again.

Finally, in stating the obvious, I remain a lover of all things rural and regional health. The Port Macquarie Base Hospital extension opens shortly, and there is great excitement about this \$110 million upgrade.

Kempsey Hospital begins soon, and there is similar delight in this \$80 million upgrade. These were just two of the 105 regional and rural hospital upgrades negotiated by Julia Gillard, Tony Windsor, and I in those heady 17 days in 2010.

Likewise, the \$20 million Joint Health Education campus, a first of its kind in Australia, is about three-quarters complete, and is a very exciting model to be looked at by other regional communities.

I am looking forward to sitting up the back at a few of these ribbon-cutting ceremonies soon, and doing nothing other than smiling.

Thanks Dr Tim for taking the time to read my book, to reflect on it, and to expose holes through thoughtful review. I give your article an eight out of ten.

First published at Croakey on August 22, 2014

Is this just another privileged white man writing about Indigenous affairs?

Recent articles at Croakey have highlighted efforts to decolonise **healthcare practice** and **HIV research**.

How might policy-making be different – in both process and outcomes – if efforts were made to decolonise what remains a heavily colonised system?

This and other questions are raised by Dr Tim Senior's sixth Wonky Health column, which examines the **Forrest Review into Indigenous Jobs and Training**.

He suggests that non-Indigenous Australians "need to talk about how our own cultural world-views are constant re-colonisers, stamping all over any good intentions we had".

Tim Senior writes:

We need to talk about Twiggy. He recently published his report into Indigenous Jobs and Training, known as **The Forrest Review**. He **tells us** that if "Implemented in full, it will end the disparity between Indigenous Australians and other Australians and comprehensively build our society."

I must say, that's pretty impressive. Surely, on that strength alone, this is a must-read document that tells us something crucial that we've been missing. What has Andrew Forrest seen that no one else has?

Despite Andrew Forrest warning against cherry-picking parts of the report, **Tony Abbott hasn't taken up the invitation to implement it in full**. It would presumably be quite easy to point to all the evidence and previous projects that make the case for this supreme confidence. **Eva Cox, Professorial Fellow at Jumbunna IHL, University of Technology in Sydney, makes a compelling case** that the report doesn't even take a peek at the evidence.

Health, and particularly, disability arising from poor health, is both a cause and consequence of unemployment and welfare and limited training opportunities. Would implementing the Forrest Review "end the disparity between Indigenous Australians and other Australians" in health outcomes?

The recommendations, **summarised here**, go from the uncontroversial support of early childhood and pre-school, to the much discussed (and outside the terms of reference) Healthy Welfare Card.

All the recommendations are supported by a website, **Creating Parity**, for reporting outcomes. The other recommendations routinely talk about incentives and the obligations of job seekers to do what they are told to do by Centrelink, Government and businesses, with the removal of discretion and exemptions from the system (which in other circumstances might be called flexibility).

What sort of evidence might we draw on in developing policy on training and employment if we want to improve health outcomes?

It turns out that **insecure or precarious employment** has a range of adverse health effects, including higher mortality. This is particularly true in Anglo-Saxon countries, like Australia. There is also some evidence that **welfare policies have effects on health**, which, though complex, tend to show that generous welfare policies might improve infant mortality or old-age mortality figures.

It's difficult to find evidence, though, as to whether these particular recommendations will have a positive benefit on health. The best we can do is work from principles about what we know works.

There's a useful comparison, perhaps, in the only other major document that sets out a comparable goal: "to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by the year 2031." That's the **National Aboriginal and Torres Strait Islander Health Plan**.

The plan was developed as a partnership between government and Aboriginal and Torres Strait Islander peak health bodies, through the National Congress of Australia's First Peoples National Health Leadership Forum. Since then, while Andrew Forrest is asked to write a report on Indigenous training and employment, the Congress has been **notified it will not receive further funding**.

The two documents are working towards slightly different goals, both have a recognition that the ability to make choices about healthy lifestyles has a profound impact on other choices you get to make about the way you live. There's a general agreement on the importance of antenatal health, early childhood impacts and education. Acting effectively at these points in life is pretty uncontroversial.

On the face of it, there's also **agreement** that "These reforms will work only if first Australians themselves are involved in the design and implementation of the reforms" or "There is a full and ongoing participation by Aboriginal and Torres Strait Islander people and organisations in all levels of decision-making affecting their health needs."

Fine words like that need to be backed up by the way you work. Those are easy words to type out, but over 200 years of history tells us they are hard to do.

Aboriginal and Torres Strait Islander people can be forgiven for rolling their eyes each time they hear this in a report and then see how, for example, the Northern Territory intervention was (and is) implemented.

I know people who will open the Forrest Report with a sense of trepidation – "will this be another non-Indigenous person who thinks they have a solution to which we are the problem?" It's the same feeling many Aboriginal and Torres Strait Islander people have seeing a health care provider!

It's not too hard to read a report like this and work out whether First Australians have been "involved in the design of the reforms." Who are the people and organisations in the submissions? Who is thanked in the acknowledgements? Who is quoted in the report?

The submissions to the Forrest review are handled quite well. We get a breakdown of Indigenous people and organisations by number and a breakdown of submissions by geography. Marcia Langton is thanked in the acknowledgements, with more mentions going to the big banks, the Department of Prime Minister and Cabinet and Fortescue Metals. The majority of quotes seem to come from Andrew Forrest himself.

The summary of “**What First Australian leaders told us they should do**” quotes Fiona Stanley, a fine advocate, but not an Indigenous one.

We are told that Indigenous Australians used words like “idleness” about their young people. Perhaps I’m speaking to the wrong people, but I hear words like “racism” mentioned much more often than “idleness.”

I even had some fun counting the number of times these words occurred in the Forrest Review and the National Aboriginal and Torres Strait Islander Health Plan – yes, it’s a crude measure!

Word	No. times in The Forrest Review (246 pages)	No. times in The National Aboriginal and Torres Strait Islander Health Plan (66 pages)
Culture (or derivative)	57	96
Racism	6*	23
Partnership	18	40
Idle/Idleness	4	0

*(5 relate to “racism of low expectations”)

It may be that Andrew Forrest is right in his solutions, though I’d argue that using pejorative terms, such as idle, don’t help the working-in-partnership that he’s trying to promote.

Reading the report, it looks to me like a fine example of a rich non-Indigenous entrepreneur philanthropist being unable to see beyond their own cultural worldviews – or indeed that they even have a cultural worldview. The world of health and medicine has been grappling with mixed success with this for a while, and it is currently expressed in terms of **decolonisation**.

This worldview does (at least) two things. It looks at Aboriginal and Torres Strait Islander people as being “other” – those strange people over their possessing culture, in the form of dot paintings and corroborees. Meanwhile, it views “us” as being culture-free, operating in the world as it is – in this case, that’s the world of business and markets.

In this mindset, it is up to Aboriginal and Torres Strait Islander people to do all the changing, without any examination of what non-Indigenous institutions might be doing to keep people away. Those changes usually require people to become just a little bit more like “us”. You can make your own decisions, as long as it’s the decision I would have made. (We see this play out in terms like “poor choice,” “better choice,” and “rational choice.”)

It also means you can do culture, as long as it’s out of hours. This makes the mistake of understanding culture as cultural artefacts, rather than as the way life is lived. This attitude can lead to some profoundly silly statements that slip by, until you realise how culturally based they are.

Examples in this report include:

“For readers about to leap on the argument that first Australians need to preserve their culture through their language, let me remind you that the quickest way to lose language is to be unable to record it.”

This might be news to the many Indigenous people who lived across the land we now call Australia for 60,000 years before colonisation.

“...only employers and the market can deliver real jobs.”

This might be a surprise to those people employed in all those pretend jobs in the police force, the armed forces, state schools and health services – especially as health services are the **largest employer of Aboriginal and Torres Strait Islander people**. (Yes. Larger than the mining sector.)

It’s as if the report exists in a vacuum. There’s no mention of Gonski or Constitutional Recognition. Throughout the report, we see the assumption that people make decisions about alcohol, gambling or drugs based on ignorance of a particular set of facts, which completely misunderstands the effects of poverty on being able to make choices about your future, **even when given appropriate advice**.

We see no appreciation of the social circumstances that determine people’s behaviour, just a mentality that wants to tip their decisions in a different direction, not through discussion, not through an understanding of their circumstances, but through a technological solution, the “**Healthy Welfare card**.”

There’s no **discussion** as to whether the amount on the card is sufficient, or any appreciation that people may need some cash to get on a bus or buy a stamp to actually get a job. There’s only a celebration that people with the card can’t get cash or porn or go gambling, even if this wasn’t something they were going to do anyway.

There’s also not any appreciation that there may even be **unpleasant historical parallels** for those using the card. You just don’t know if you don’t ask those affected by the policy.

So I think Andrew Forrest is completely wrong to say this is the solution that will end the disparity in Australia between Indigenous and non-Indigenous Australians. It’s not that there are no good ideas there. It’s not that there is nothing worth discussing. There may be.

It’s that, once again, a rich non-Indigenous person has demonstrated pretty conclusively that they don’t get it – that real engagement with Aboriginal and Torres Strait Islander peoples is about recognising our own cultures for what they are, and wondering if there might be other ways of doing things.

“The situation is so awful, we need to do something,” people say. That should be an argument for not doing the wrong things, the things that makes it worse. I think a prime non-Indigenous cultural methodology is diving in with solutions at the expense of ever listening. I try to acknowledge and correct for that in my work.

So when I say we need to talk about Twiggy, keep in mind that I have so much in common with Andrew Forrest. We are both white male Australians. We both earn above the national average, we are both in very privileged positions. We both work in Indigenous affairs in some way, and neither of us are anthropologists!

Like me, I suspect Andrew Forrest is absolutely genuine about wanting to improve the lives of some of Australia’s most deprived communities.

We need to talk about how our own cultural world-views are constant re-colonisers, stamping all over any good intentions we had. That's what non-Indigenous Australians need to talk about.

First published at Croakey on September 2, 2014

The complex and changing world of GP training

In the wake of the federal budget, uncertainty about the future is facing many areas in the health sector – and GP training is no exception, writes Dr Tim Senior in his latest Wonky Health column.

Tim Senior writes:

The last ever **GP Education and Training (GPET) Convention** was held recently in Brisbane, and there was a **lively Twitter stream** – #GPET2014 – from an enthusiastic crowd.

If you fancy dipping in to this timeline, you may be confronted with a string of acronyms and abbreviations making your Twitter stream look like you've just spilled alphabet soup on your computer.

Before getting in to the conference itself, here's an outline of GP Training in Australia.

General Practitioners (GPs, also sometimes called Family Practitioners or Family Physicians) are medical specialists.

Their speciality is human beings – the symptoms they get which might indicate nothing or serious disease, and the ways of managing this safely. They have expertise in early diagnosis, undifferentiated symptoms, co-morbidity, and chronic disease. They have expertise in the dynamics of a consultation between a doctor and patient, and develop long term, trusting therapeutic relationships with their patients.

In short, General Practice is easy to do badly, and hard to do well.

For this reason, there is a training program for doctors to become fully qualified GPs. A medical student will train at university for anything between 5 to 7 years, then do an intern year as a junior doctor in a hospital, and go on to do further work as a Resident Medical Officer in hospital. During this time, they gain a broad experience working across many in-hospital specialties, such as emergency, paediatrics, medicine and surgery.

Over the last few years, some doctors in these hospital positions had the opportunity to do a short placement in general practice under supervision. This program was called the **Post-Graduate General Practice Placements Program** and you'll hear it referred to as PGPPP.

The idea was to give junior doctors some experience and understanding of general practice, otherwise the only opportunity they have is when they choose it as their career! The PGPPP **was defunded** in the last budget and is not continuing.

GP training itself consists of a year as a Resident Medical Officer, followed by two years in various general practice settings. At this stage of their career, doctors are called GP Registrars. They usually rotate through several different practices, which may include an **Aboriginal Medical Service**. There are also opportunities to do extra training in particular areas of interest, such as obstetrics, anaesthetics or paediatrics. Some registrars work part time in a university setting on a research project – **an academic term**.

In total, training is a minimum of three years (including that hospital year) and is completed after passing the **Fellowship of the Royal Australian College of General Practitioners exam** (FRACGP). Some registrars in rural areas do an extra year of training to gain **Fellowship of the Australian College of Rural and Remote Medicine** (FACRRM) or the **Fellowship of Advanced Rural General Practice** (FARGP) from the RACGP.

Once a doctor has either FRACGP or FACRRM (or both), they are deemed competent to work unsupervised anywhere in Australia, and they are entered on to the Vocational Register with Medicare (or a VR GP).

The curriculum for training and the standards for training posts are set by the Colleges – the **Royal Australian College of General Practitioners** (RACGP) and the **Australian College of Rural and Remote Medicine** (ACRRM).

The bulk of the training occurs in general practices across the country provided by an experienced GP Supervisor. Other training occurs in Aboriginal Medical Services, in sexual health clinics, in prisons, and in academic GP Units. The training is co-ordinated by one of 20 **Regional Training Providers** (RTP), under contract to **GPET**, a wholly owned government subsidiary.

Into this mix are all sorts of representative organisations. The **GP Registrars Association** represents GP Registrars, the **GP Supervisors Australia** represent GP Supervisors. Medical educators are GPs employed by RTPs to provide and co-ordinate out of practice teaching.

So, to the Convention. The budget in May announced that **GPET would be dissolved** at the end of 2014 and its functions taken in to the Department of Health. The number of staff involved would be halved.

On top of this, the RTP roles will cover a larger geographic area (so there will be fewer of them). They will be put out to tender during 2015. It is possible that a range of organisations will tender, including current RTPs, Universities and Medical Schools, private companies or even Medicare Locals will tender for the new organisations.

The sense of uncertainty about the future was a constant presence at the conference – while GP training will be happening, no one knows what structure it will have.

Into this uncertainty strode the opening keynote speaker, **Robin Youngson**, founder of **HeartsinHealthcare**. He acknowledged the uncertainty and set the tone for the conference, eloquently setting out a call for compassion in health care.

“Remember,” he told us, “that it doesn’t matter what structures are around you, you can always care.” This message was well received by this group, who generally are motivated by the idea of producing good, compassionate doctors, not just knowledgeable mechanic ones.

Though Youngson was to some extent preaching to the converted, there was a sense that this message needs to be heard. There was evidence presented that a health system that is built to enable compassion results in better health outcomes across a range of conditions, and is also cheaper. This is a message that should be heard widely among policy makers, but is always at risk from the gravitational pull that looks like efficiency.

We heard impressive evidence that compassion from the doctor results in biological and chemical changes in the patient, though this is perhaps a very anaesthetic take on what could be conceived as a moral issue. If treating people with compassion is the right thing to do, does it matter that a gene is upregulated when it occurs?

John Launer, a GP and Family Therapist in London, gave a complementary keynote. His talk was about using narrative techniques in clinical care and teaching. He contrasted a narrative approach with the conventional approach taught to doctors.

At its purest, the medical model assumes there is a set of facts held by the patient about their condition, which the doctor uncovers using a set of questions. While no GP worth their salt uses this approach exclusively, the techniques of doctor and patient jointly build a shared understanding of the patient's experience of illness.

Themes that overlapped in both keynotes were the importance of being fully present and emotionally available in consultations, and John Launer touched on ways of teaching this too. Perhaps ironically for a conference celebrating GPs as Superheroes, this approach is really about two flawed human beings in a room.

A regular highlight of GPET Conventions continued this year – the imagination of the participants. This ranged from the fancy dress costumes for the dinner, to the **flashmob singing**, to a session devoted to a series of paper presentation limited to 3 minutes each and a paper outlining the benefits of GP teaching while out walking in the Southern Highlands of NSW – simple and genius!

With a high proportion of young GPs among the delegates, there was a large social media presence, resulting in the conference **trending in Australia**.

There was little certainty about the future of GP training, but neither was their pessimism. As Professor John Murtagh, the elder statesman of Australian general practice, said: “GP training must continue.”

There's a committed cohort of GPs who want to do the job well and train others to do it well. Like caring, the structures will change, but the work will continue.

• *This is the first of a two-part Wonky Health series; the next instalment will investigate the impact of planned changes to the higher education sector for the health workforce.*

• *Declaration: Dr Tim Senior received complimentary registration to the conference as he was covering it for Croakey.*

First published at Croakey on September 22, 2014

Wonky Health asks: will deregulation of higher education be a nightmare for the health sector?

As suggested in the tweet below by AMA vice president Dr Stephen Parnis, there are widespread concerns about how the Federal Government's proposed deregulation of higher education will affect the health system.



Meanwhile, in his latest Wonky Health column, Dr Tim Senior says that making university education more expensive will have wide-ranging implications for our health. Indeed, he suggests, it will be something of a nightmare.

I have a recurring dream. I dream that I am back at my interview to get in to medical school.

“Why do you want to be a doctor?” I am asked. My eyes moisten, and I give the answer thousands like me are giving across the country. “Because I want to help people,” I say.

Then, from behind the desk, up pops Christopher Pyne. “Help people?” he screeches at me. “Help people?”

“The only reason for getting a degree is to line your own pockets. I cannot conceive of any other reason for wanting a degree. You want to make money! I am not going to support you to make a packet off the back of hard working people like Gina Rinehart.”

I always wake in a cold sweat, before I realise that this is a dream, with no basis in reality.

Christopher Pyne, the Education Minister, clearly wants a higher education sector that is high quality, saying “If we don’t act, and act now, we risk (the) system falling into a downward spiral towards mediocrity.”

This will be achieved, he tells us by “set[ting] our higher education providers free.” So what are the changes that will achieve this?

- HECS-style loans expanded to higher education courses other than degrees, and to institutions other than public universities
- Increasing the interest rate on HECS-HELP loans
- Deregulating the fees charged by Universities.

- Reducing the contribution of government to Universities tuition fees by 20%

For a policy that is supposedly focussed on quality, it seems very well disguised as a policy focussed on costs.

The argument goes that those with a University degree are more likely to be employed and earn more than those without so they can afford to pay more. (There's a really good [ABC Fact Check](#) on the different ways of calculating the pay difference of graduates and non-graduates. It's broadly true, and some measures agree with Christopher Pyne's statements.)

But taking on this debate assumes that the only person to benefit from someone's degree is the graduate herself. Every time you drive over a bridge without it collapsing under you, every time a child is taught in a school, every time you successfully send a text message, speak to someone by phone, or even watch The X Factor, you are benefiting from a string of university graduates who made that possible for you.

I suspect there is a very strong argument to be made that nurses (and teachers) benefit society a great deal more than they get in salary. Many of those working in the health services are graduates, including nurses, physiotherapists, speech and language therapists, occupational therapists, pharmacists and, of course, doctors. Also many of the managers, public health practitioners and health policy experts are graduates.

In claiming that those without degrees don't want to subsidise those who get them, we are also claiming that those without degrees don't want there to be trained health professionals available when they need them. I don't see anyone making this point.

Would making degrees more expensive, both as a result of universities charging more and students being asked to contribute more, have an effect on our future health workforce?

I'm going to follow the old rule of "write what you know" for a moment, and follow this train of thought for medical degrees, just because that's the one I've got, and that's where most of the evidence is, as far as I can tell. (Please do write in the comments if you have views on the effect of this policy in other health professions, too. There's some [excellent information here](#) on the likely cost increases of different degrees, including health related degrees).

Medicine is one of the most expensive courses, partly because it takes anything from between 5 and 7 years to get the basic qualification. It does result in higher income than many other professions, too.

In 2010, Melbourne University created some controversy with a Medical Degree which bypassed the government's ban on charging full fees with a [4 year graduate entry MD](#) program costing \$204,000 in total. [Bond University charges \\$331,280](#) for its Bachelor of Medicine, Bachelor of surgery program if you enter next year. If you plug in medicine into [the website](#) (run by Greens Senator Lee Rhiannon) then it claims a total cost of \$355,548, taking more than 50 years to pay off.

There are two crucial decision points potentially affected by these costs. The first is what specialty junior doctors choose; and the second is whether to enter medicine at all.

In theory, having high levels of debt should lead medical graduates to choose medical specialities that will earn them more so they can pay off their debt more quickly.

The best evidence on the earnings of different medical specialities comes from the **MABEL** (Medicine in Australia: Balancing Employment and Life) survey. Their report showed that overall, GPs earned 32% less than specialists. This might be important, because, **as Barbara Starfield showed**, employing more primary care physicians decreases mortality, whereas employing more specialists is associated with increased mortality.

Could it be that the suggested university funding policy will worsen population health? (People might be interested in subsidising population health, if so.)

The evidence is a bit mixed, but it looks like **future earnings do influence career choice**, and **that those with higher debt are influenced more**, and are more likely to choose based on earning potential. (**We are already seeing this**, with the number of GPs being static, while the number of specialists is rising.)

The MABEL survey also broke down different work and geographical factors and how they related to pay. GPs in regional and rural areas earned more than other GPs, so, conceivably, the policy may be good for these areas (though that would be a very broad brush to solve a workforce problem).

However, it would be most likely make recruitment of GPs into **Aboriginal and Torres Strait Islander Health**, which we keep telling ourselves is a priority, much harder. Areas such as the **outskirts of Sydney would also struggle to recruit much needed GPs**.

It's also possible that high debt would make doctors increase their fees, **resulting in a more expensive health system**.

Would high fees and the prospect of high debt put people off applying to do medicine?

The evidence here is less clear, I suspect because it's easier to survey those who already got in. **One large study in the UK** showed that debt does not affect the choice to go to university, except for those in lower socioeconomic classes.

In other words, higher student debt will restrict entry to health careers, especially medicine, to richer families even more than it does already. Given the **well known relationship between poor health and low income**, this will put **further distance and between doctors and many patients** resulting in misunderstandings.

The particular needs of Aboriginal and Torres Strait Islander people becoming doctors (and other graduate health professionals) warrant a special mention. It's generally agreed that we need to **increase the numbers of Aboriginal and Torres Strait Islander people in the health workforce**, and the **Australian Indigenous Doctors' Association** has done great work on this in medicine.

With many Indigenous doctors going in to medicine later in life, and having significant family and cultural obligations on them after graduating, the likely debt will put many off (*Note from Croakey – see **recent comments** by AIDA president Dr Tammy Kimpton raising similar concerns*).

Making medical degrees particularly expensive may well stimulate other policy options in the future, such as increasing GP income relative to specialist income, relying more on less expensive non-doctor workforce for many tasks, shortening medical training, or financial incentives for working in particular areas or fields. There are no major proposals for doing any of these things, though (with the possible exception of increasing the amount done by non-medical workforce) and there's not much evidence for any of these.

So it seems entirely plausible that the proposed university funding policy will have the effect of confining medicine to a well-off section of the community, encouraging people to work in high paying specialist fields, reducing the number of people working in low-paid “priority” areas.

Perhaps it may ultimately even increase early deaths for Australians. We can only hope that it all turns out to be just a bad dream.

First published at Croakey on October 9, 2014

Ideological warrior takes on the Harper review of competition policy: Wonky Health in action

In his latest Wonky Health column, Dr Tim Senior investigates the implications for healthcare of the Harper Review into competition policy.

He examines the ideology and the evidence that motivates both proponents and critics of competition in healthcare, and concludes “to continue pushing an agenda in the health system promoting choice and competition is done despite the evidence, not because of it”.

He says: “We know that competition in health services doesn’t increase choice in what matters to people, it just chases the money.”

Read on to discover Senior’s own ideological stance...

Tim Senior writes:

What’s the worst insult you can throw at a policy? Perhaps “**Ideological**”. This description has been used to dismiss the **Renewable Energy Target review**, the **curriculum review** and the **whole budget**.

I am old enough to remember when ideology meant “a system of ideas and ideals, especially one which forms the basis of economic or political theory and policy” **and dictionaries still believe this**. In the current political climate, though, ideology is one of many synonyms that means “disagrees with me,” it is only ever possessed by opponents, and it’s only ever a really bad thing to have.

So it must have been with a sense of trepidation that the **Harper review into competition policy** published its **draft report**. This review was set up by the Prime Minister and the Minister for Small Business in March 2014. Its scope was “in regard to achieving competitive and productive markets throughout the economy, by identifying and removing impediments to competition that are not in the long-term interest of consumers or the public interest.”

It’s a wide ranging review, applying competition principles to almost every aspect of Australian life, including supermarkets, energy and human services. The panel is headed up by Ian Harper, an economist “whose career spans government, academia and advising business,” who now works at Deloitte Touche Tohmatsu. He is joined by Peter Anderson, “a national business leader,” Su McLuskey, CEO of the **Regional Australia Institute** and Michael O’Bryan, a barrister in competition law.

Peter Anderson, one of the panel members, gets their defence in early, telling us reassuringly in a nice video **that his aim is practical not ideological**.

I’m not having any of it. Calling a policy ideological is not an insult, it’s just a way of failing to recognise your own ideology (which ends up with you **writing something like The Forrest Review!**).

Ideology is the values and assumptions that guide you in deciding what questions you will ask and where you'll find answers. In short, the Harper Competition Review is highly ideological. That's not an insult. It should be ideological, in that it should have a guiding vision about what makes a better world.

So let's look at what it says about health, and see where our ideologies clash and where they agree.

Even to look at what it was that the Harper review was asked to do, it to peek in at a different set of values. The panel's view is that competition policy should:

- make markets work in the long-term interests of consumers;
- foster diversity, choice and responsiveness in government services;
- encourage innovation, entrepreneurship and the entry of new players;
- promote efficient investment in and use of infrastructure and natural resources;
- establish competition laws and regulations that are clear, predictable and reliable; and
- secure necessary standards of access and equity.

In the health system, many of us would feel most at home with that last statement on access and equity. It's difficult to disagree with efficient use of infrastructure and resources, though there can be profound disagreement **about what that looks like**. Making markets, choice and entrepreneurship an end in itself in the health system starts to sound like a different ideological tune.

What ideologies would I like to see?

I'd like to see a focus on health outcomes for the users of services – which is not the same as responsiveness. I'd like to be confident that we are doing what we know works because we've learnt from the evidence.

Let's play! We dive straight in to section 8.4 on *Professional Licensing and Standards* – bear with me, it's really exciting! Some submissions raise concerns about the reduction in competition from Medical Colleges restricting entry, and the reluctance of the AMC to accredit new specialisms. The Panel hedges its bets, saying some regulation is necessary for health, and some impedes competition.

This is fine if competition is the end you are trying to achieve. But what if a healthy population is what you are trying to achieve?

And, God forbid, what if you wanted to use some evidence to try and answer that question?

You'd be hard pressed to go past Barbara Starfield's work showing that **the health of populations improves with more primary health physicians** (and better access to them). And population health gets worse by employing more specialists.

You might wonder if the deregulation of entry in to specialist medical colleges, or the creation of new specialties would increase the number of specialists, increasing competition while worsening public health.

You might also be forgiven for observing that deregulation and competition in medical specialities encourages **people to go where the money is**, in both speciality and geography, **especially if university fees are deregulated**. While equity and access are there in the panel's principles, it seems to be trumped by competition.

Even if you want "more efficient use of resources," the **evidence from the US** seems to indicate that health systems become more expensive outside the public health system, and that **physician fees are the main reason for this**.

Moving on to section 8.10 headed *Private Health Insurance*, and we learn that 47% of Australians have Private Health Insurance, and find the Panel recommending they be allowed to cover primary care.

The only evidence cited for this is the **Commission of Audit** report in May. It's not that hard to call on the expertise in the health system to wonder about the effects of this – in fact **Croakey managed to do exactly this** just a few weeks ago.

You'd think that if there was strong evidence that extending insurance into primary care improved health, we'd be hearing quite a lot about it. Sadly, the comparisons from the **Commonwealth Foundation** don't suggest that this is the case.

We get a much more nuanced discussion in Section 10 on *Human Services*, which explores competition policy in aged care, disability care and health services. There's an acknowledgement that "A consumer choice model is not the right one for all services," which didn't appear in the earlier discussions.

Having said this, the report then looks admiringly over at the UK choice agenda, and uncritically argues for increased diversity of providers of human services, including for-profit, not-for-profit and mutual or co-operatives.

Where's the evidence?

If this was a very good idea, we might expect to find the literature littered with examples of increased choice and competition improving the quality of health services. But that's not exactly the case.

In **an analysis of the UK experience** of increasing competition, there was some improvement in speed of treatment and convenience, but no change in quality of care. **Other research** backs up the finding that you get minimal change in outcomes for a huge effort in change, often at the expense of **huge opposition from health professions**.

More worryingly, there is **some evidence** that increasing competition between hospitals results in **worse mortality**. It may result in lower costs, but **even that is not clear**. In General Practice more competition results in **more prescribing for the elderly**, and in **worse quality**. (A focus on the patient relationship improves quality, though. When will we see a report suggesting that?)

Perhaps things get better if we focus on patient choice, rather than competition. There's not much evidence on this (if you know of any, please comment below) partly because it's such a complex area. Choice depends on information (**and pretty colours**), with **price (and out of pocket expenses) being a large driver of choice** (not a bad thing, though it may leave people uncovered for particular conditions).

However, it doesn't need much experience with reading **nutrition labels** or choosing **phone plans** to realise that **providing information** that **matters** to **enable choices** that are meaningful is **not easy**.

We are currently in a position where the information we make publically available **doesn't help people make choices and doesn't improve health outcomes**. Marketers, of course, are way ahead of us on this, **finding ways of manipulating our decisions**.

Which leaves us where, precisely? Well, to continue pushing an agenda in the health system promoting choice and competition is done despite the evidence, not because of it.

Denying that there is ideology behind this agenda means that there can be nothing at all behind it – if not ideology, then what? Denying any underlying ideology also forgets that the policy is contestable, and that health professionals with a different (non?) ideology **based around collaboration, not competition**, will continue to oppose the proposals.

So, let's all acknowledge and celebrate our ideologies.

The Harper review panel can be safe in the knowledge that they are working in the dominant ideology of competition and choice.

But in the health sector we can be proud of having a different ideology. It's one that says health outcomes are important. Every day we meet people who struggle in their daily lives because of sickness or disability. Every day we meet people whose contact with health services is in their caring functions, not their share price. And every day we use the evidence about what works because we don't want to keep on repeating yesterday's failed experiments.

We know that competition in health services doesn't increase choice in what matters to people, it just chases the money. And we know, from the current UK experience, that if we are forced to work in a system whose values do not match ours, there is no smooth transition, only battles and misunderstanding and anger.

So my ideology is no niche historical ideology.

It is an ideology that asks "What works for all of us, not just the lucky few?" It is an ideology that wants to create healthy communities for all of us, not healthy bank balances for the few.

Being ideological isn't an insult, it can be something to be proud of and worth fighting for.

You can make a submission to the Harper Review [here](#). The closing date is 17th November

Further reading – three more takes on the Harper Review

[Lesley Russell on the Harper review at Inside Story](#)

[Paul Smyth](#) and [Gerard Brody](#) over at Power to Persuade look at different professional and consumer perspectives.

First published at Croakey on October 27, 2014

Wonky Health asks: Who are you prepared to sacrifice to climate change?

The health sector must keep talking about the dangers of climate change and highlighting the wide-ranging risks, according to Wonky Health columnist Dr Tim Senior.

The aged, children, big-city residents, and the poor are among the groups most at risk of the health impacts of climate change, but no-one is immune, he warns.

Tim Senior writes:

I shouldn't have to write this post. Even after the recent G20, where our government's efforts to **keep climate change off the agenda failed spectacularly**, the obvious still needs saying often and loudly.

Destroying our climate destroys our health.

This link, between destabilising our climate and destabilising our health, is well established.

It's been **discussed frequently in the medical literature**; the **Lancet** has had a **special commission**; in Australia, it's been a **focus of the Climate Commission**, and the formation of the **Climate and Health Alliance** and **Doctors for the Environment Australia**. Croakey has been **covering this for a while**.

There's even a **brand new book just published** on climate change and global health (which I'm using as some of the sources here).

So why write about it?

Because it still needs saying. It's not often spoken about in health circles, apart from a few cranks like me.

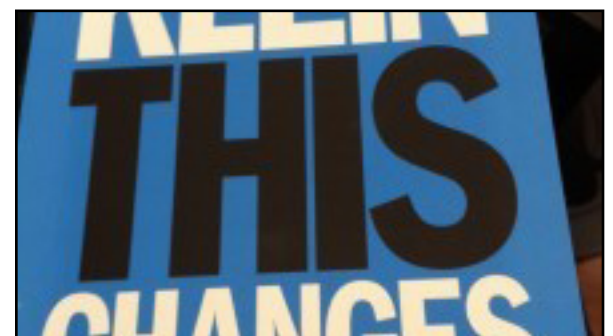
It's become a depressingly stupid debate in Australia about the price of electricity, rather than about keeping our only home habitable. And, perhaps worst of all, we have a Government that is clearly not interested in taking any action on this, indeed, they seem to be rushing headlong in the opposite direction.

Health, though, is valued by people. Any project that looks like it will pollute our air or poison our drinking water will meet with strong resistance. It is easy to understand the anger that arises when fracking threatens our water supplies or agriculture, or when a **mine fire burns for weeks**, making it unsafe for children to play outside.

Even those who don't like wind farms know **that attributing every conceivable health problem** to wind farms can scare people.

The only way to maintain the extraction and use of fossil fuels is to choose someone and somewhere to sacrifice.

"Sacrifice zones" is the memorable term popularised by Naomi Klein in her new book, **This Changes Everything**. (And if you haven't read this book yet, stop reading me now, and **go** and **buy** a **copy**. I'll wait....).



Most of the sacrifice zones involve less powerful or vulnerable populations away from population centres, but this becomes harder and harder, such that now even Andrew Forrest, presumably happy to dig where he is not, **objects to living in a potential sacrifice zone.**

If we're really not willing to act properly on climate change – **which means cutting fossil fuel emissions to zero by 2100 according to the IPCC** – then who and where are we willing to sacrifice?

Wide-ranging risks

The risks affect everybody, but they aren't evenly spread. Are we willing to sacrifice people to the direct effects of heat extremes? The elderly and children are particularly vulnerable to both heat waves and cold snaps. Neither of these groups would be electorally popular groups to sacrifice!

The heat sink effects of cities makes urban rather than rural populations suffer more in heat waves, and there is evidence of poverty making people more vulnerable because of problems affording air conditioning in summer and heating in winter.

For the economically minded, the effect of increased hospital admissions during temperature extremes is expensive on governments, but there's also under-reported evidence of reduced productivity during temperature extremes, too.

Much less predictable is where your sacrifice zones will be when disasters hit. Climate change results in more frequent cyclones and hurricanes, hail, bushfires, and floods. Many of these will occur mostly near coastal areas.

The health system will be at the forefront of any response to disasters, and good preparedness can hugely mitigate the effect of any individual disaster. However, if there is one thing that climate change teaches us, it is that we need to be prepared for complex combinations of causes and effect, with pre-existing vulnerability and combinations of events leading to unpredictable consequences.

The impact of disasters on infrastructure and health programs can have a huge impact on the ability to prepare for and manage health risks due to changes in the climate.

Secondary health effects of climate change result from changes in the distribution and lifecycle of mosquitoes, ticks and other animal hosts of diseases. These include conditions like malaria, dengue, lyme disease, and parasites. The changes, though are complex – you don't get to choose your sacrifice zones, some areas will be better off, some worse.

Perhaps more pertinent in Australia is the evidence emerging that climate change will have an effect on allergies due to differing levels of pollen. It may sound trivial, but allergies can have a profound effect on quality of life and productivity. Combine this with air quality, too, and you have more respiratory problems, especially asthma, and I'm sure I've already started seeing patients with asthma worsened by weather patterns.

Impacts on our food supply

There's a third set of consequences from the effects of climate change on food production – plants, animals and fish. Drought, floods, cyclones and ocean acidification will all affect these in complex ways, though we already know enough about the health effects of malnutrition.

Natural disasters will affect food prices (Remember the **price of bananas after cyclone Yasi?**) but so will decisions we make to mitigate the other effects of climate change, such as growing biofuels.

As people across the world **struggle to afford food**, or to grow their own, we'll see more headlines about Melburnians **concerned about the price of coffee**, which doesn't really count as part of the **real food security problem in Australia**.

Ultimately, the problem is that we don't live on the environment, separate to it, but in the environment, part of it.

Describing pre-colonisation Australia as “**nothing but bush**” manages not only to be **wrong and offensive** about Australia's Aboriginal and Torres Strait Islander history, but betrays the thinking that pristine bush has no value and needs to be removed for development.

There is nothing we can do in life that doesn't depend on the planet as our life support system in some way (and shown by the relation of a **healthy environment to mental health**). It doesn't matter where you are on the political spectrum.

If you eat food, drink water and breathe air, you depend on the environment. If you believe that **lack of equality causes social and economic problems**, that depends on sharing environmental resources fairly. If you believe in giving business certainty, then you could do without floods, fires, and cyclones. If you believe in low taxes and small government, then **Garnaut** and **Stern** tell us we need to act on climate change as soon as possible. If you support our armed forces, if you want **less conflict in the world**, if you want **insurance to remain a viable business**, then you'll need to advocate for action.

Action? Of course, action means taking whatever steps possible to reduce the emissions of greenhouse gases. Those of us concerned about health must continue talking about this, in the same way that we advocate for other policies that keep people healthy, such as tobacco control and junk food.

Healthy lifestyles have environmental benefits

At a personal level, the advice is exactly the same advice we've been giving on healthy lifestyles for years.

We need to be more physically active – which means walking and cycling and using public transport more. We need to eat food that is less processed, and from closer to home – which means less fossil used in its production and transport. We need buildings that need less power to run heating and cooling, which also results in less respiratory disease.

Effectively, the health consequences we see of our current lifestyle is that of substituting and supplementing our own energy with that of fossil fuel – in food, in transport in energy and in waste. In the current system, that is how we keep creating profit.

Currently, our economy only works if eventually we all agree to live in sacrifice zones, to be sacrifice zones. I am more optimistic than I've been in a while. Our Government was isolated on the issue at the G20, and need to say soon what their future carbon dioxide reduction targets will be (and how Direct Action could possibly get there).

Pressure is mounting globally for action, which will only be heightened in Australia by another **angry summer**. Average temperatures and CO2 are hard to imagine, but health isn't. People do care about their health and the health of those they love.

That's why the most important action the health sector can take is to keep talking about the damage we're doing to the climate and how we can prevent this. This is not about electricity prices or tax rises or markets.

This is about who and where you are prepared to sacrifice first to maintain a way of life that will eventually get us all. And that, we certainly should talk about.

First published at Croakey on November 20, 2014

Wonky Health has found new jobs for Tony Abbott, Joe Hockey and some of their Ministerial colleagues

Inspired public health leadership is hardly the hallmark of the Abbott Government. But if the Government wanted a “complete health makeover” (and even some of its own MPs seem to favour this), then Dr Tim Senior has some ideas for a political revolution – to be lead by a Prime Minister for Health.

His latest Wonky Health column, outlining a whole new way of conceptualising the Federal Ministry, exemplifies his call for more imaginative approaches about how we might do policy differently “and not be bound to a narrow conception of government as managers of an economy, and ourselves as consumers”.

Tim Senior writes:

You call that a reshuffle? THIS is a reshuffle!

If I’ve sounded a bit grumpy over the last eight months or so at Wonky Health, this might reflect the number of unpleasant policy surprises that have been sprung upon us.

Before the Federal election, I had thought there was a **unity ticket on Gonski**, and I had **looked closely** at the Liberal’s Health policy before the election. In short, I was expecting a range of policies, some with a beneficial effect on health, some not.

Then the budget came along. Without warning, there were suddenly **co-payments**, **university deregulation**, the **abolition of GPET**, a **mining magnate’s report on Indigenous disadvantage**, and a **general encouragement of increasing inequality**. That’s a lot of policy with potentially poor health outcomes.

But there are alternatives, if we imagine them. They can be difficult for politicians to grasp, but there are examples of policy that promotes health. South Australia is leading the way with their **Health in All Policies** approach.

Another attempt at a similar idea was the **Wellbeing Manifesto**. The WHO has given **guidance for governments** on tackling these, led by Professor Sir Michael Marmot, the British public health physician.

Famously, during a visit to Sweden, Marmot asked the Swedish Prime Minister, “Who is your health minister.” “We are all health ministers,” came the reply.

In this spirit, let’s wonder what would happen if all our current cabinet ministers were health ministers. (I’m using current ministers as examples, but if they were really promoting health, we might see a bit more diversity in the cabinet – perhaps as a result of a reshuffle coming soon).

The Health Services Minister

Sussan Ley's role would be renamed "The Health Services Minister" and would be responsible for organising the health system to get the best health outcomes for users of the service (and one of her KPIs would be making the services accessible for those who would benefit from using them, but don't). She would get no extra marks for making the service cheaper if it didn't also improve health. That is not what sustainable means!

Minister for Health (Environment)

Greg Hunt would primarily be responsible for ensuring that Australia worked to prevent climate change, and brought other countries along with them, too, emphasising the likely devastating health effects. He would also ensure that other threats to health and the natural environment were minimised, and that everyone had access to areas of natural bushland.

Minister for Health (Economy and Funding)

Formerly known as the Treasurer, Joe Hockey would be responsible for monitoring and reporting on inequality as a key cause of poor health, a recommendation which could come from a recent [Senate inquiry](#). The tax system would be measured on its fairness, and used to make it easier for people to make choices about their own lives, especially those whose lack of income normally prevents them making choices. He would ensure that everyone was paid a living wage.

Minister for Health (Law)

George Brandis would no longer be the Attorney General, partly to do away with confusing plurals. His responsibilities would be to ensure that everyone had the right not to be hounded by bigots, and that human rights (including a right to free speech) applied to everyone, not just those with newspaper columns or those rich enough to afford lawyers.

Minister for Health (Immigration)

Peter Dutton would have to ensure that those under his guardianship were treated in a way that was not detrimental to their future health. While this includes drowning at sea, it would also include death by murder, death by delays to routine medical treatment, and death by a life so awful it forces people to self-harm. He would promote inclusion of asylum seekers into Australian communities to improve everyone's health. The Minister for Health (Law) would constantly be in his ear to prevent him from putting at risk community inclusion.

Minister for Health (Education)

Christopher Pyne would have responsibility for ensuring that all children were literate, and would engage families of all backgrounds in doing this. He would be responsible for ensuring especially that every child had the chance of a good education wherever they went to school, whatever their income, and that university was an option for them, if they wished.

Minister for Health (Employment)

Eric Abetz would devote his time to ensuring that all those capable of working were able to do so, and that they had secure employment. Those not in work would not be treated punitively, but helped to develop skills for both job-seeking and subsequent work. Adding to their stress through punitive measures and low income only causes ill health.

Minister for Health (Aboriginal and Torres Strait Islander Affairs)

This minister would have a slightly changed remit. She (because all the others seem to be he!) would be responsible for ensuring that Aboriginal and Torres Strait Islander people had easy access to other ministers to ensure policies that affected Aboriginal and Torres Strait Islander people included them in policy making.

Some new ministers would also be created!

Minister for Health (Transport)

Nominations are open for this minister who will work with state counterparts to develop active forms of public transport. Roads would become clearer as more people moved to convenient, cheap, clean public transport and cycleways in all major cities and urban centres.

Minister for Health (Food)

There would be a dedicated minister for ensuring that everyone across the country had access to affordable, healthy food, and the means and knowledge to prepare it. This minister would have to think about health implications of policy, and would be specifically mandated to challenge big food companies to be transparent on their labelling. They may also want to consider price signals on unhealthy foods.

Minister for Health (Maternity and Early Childhood)

As this is where so many of the health gains are to be made, why not have a specific minister to co-ordinate policy across government? They would ensure there was support for mothers during pregnancy, in establishing breast feeding, and in pre-school literacy and education. This minister would have the power to influence other Health Ministers, such as Economy and Finance, Health Services and Education to ensure appropriate services were developed and funded.

Overseeing all of this would be the Prime Minister for Health, Tony Abbott, to ensure that the various other health ministers worked collaboratively with each other and with the States and Territories and local councils to improve the nation's health.

It may be that this all over-emphasises health at the expense of other outcomes. But an understanding of health as not being **merely an absence of disease** (or the community focus of the **Aboriginal definition of health**) shows that health outcomes are a marker of a functioning community, one that we have measures for.

Surely if government are there to do anything, they are there to produce functioning communities, which produce healthy people as a by-product!

I don't expect any of this to appear in the next budget. I don't know how I'd implement it, or even pay for it in the short term (I think there would be longer term benefits on health expenditure and improved productivity, but that's an arguable point.) ‘

What I do value is imagination – imagination about how we can do policy differently, and not be bound to a narrow conception of government as managers of an economy, and ourselves as consumers.

This is a starting point for ideas about new policy and new ways of administering policy. Because the alternative makes me and everyone else sick.

Further reading

The ideas for these policies are all based on ideas and evidence from the following documents. None of the documents recommend implementing it in the way I've suggested!

The Social Determinants of Health: The Solid Facts (PDF) 2nd Edition; By Richard Wilkinson & Michael Marmot. WHO Europe

South Australian Health in All Policies Case Study (PDF)

The South Australian Model of Health in All Policies

Health in All Policies: Framework for Country Action (WHO)

The Wellbeing Manifesto

And when you've read all of that, Evelyne de Leeuw puts the whole thing in a **single tweet!**

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Wonky Health goes out with a bang. And an investigation of Evidence-Based Voting

It is a truth almost universally acknowledged that the state of Australian politics is deeply unsatisfying for those who care about evidence, outcomes and fairness.

Perhaps it is time for a novel concept, Evidence-Based Voting?

In the final instalment of his crowd-funded Wonky Health column, Dr Tim Senior investigates what difference it might make if your How to Vote card came with the results of a PubMed search.

Tim Senior writes:

How to really scare politicians: Evidence-Based Voting

I like my politicians to be connected in some way to the real world. They can believe all they want that the sun sets in east, or that grass is purple, or that the earth is flat, or that global warming isn't caused by humans.

But making policy based on these beliefs ends up harming all of us, through ridicule, opportunity costs and inept policy making. What connects us to reality is evidence.

In medicine just making up facts is frowned upon. Where it's possible to find out whether a treatment does more good than harm, it's a good idea to ask the question.

I have carried over this naïve belief into asking whether government policies have effects on health. It's why dismissing criticism of government policy as “shrill” or “electronic graffiti” might work as a rhetorical flourish in the school debating society on a bad day, but is no substitute for understanding the effects of policy in the real world.

What if I apply the same principle to my vote? Is there any evidence that health outcomes are better under a particular political tradition?

It's a dangerous question. It might even lead to accusations of bias. But if we actually want our vote to make a difference, surely finding evidence on outcomes that matter to us is a better way than the usual approaches – which turn out to be height, a mellifluous voice and baby-kissing ability!

The biggest study to look at this question looks at OECD countries in Europe and North America, and classifies their predominant political ideologies between 1950 and 2000 into one of four categories:

- Social democratic
- Christian Democratic (conservative)

- Liberal
- Authoritarian conservative (dictatorship)

This is how the countries were grouped, and their characteristics.

Type of government	Countries	Health and welfare systems	Average public spending as % of GDP	Average public spending on health as % of GDP
Social democratic	Sweden Norway Denmark Finland Austria	Universal health, generous social benefits. Encourage women into workforce (Austria less so)	30%	7.2%
Christian Democratic	Italy Netherlands West Germany Belgium France	Generous benefits for elderly. Universal health care	28%	6.4%
Liberal	UK Ireland Canada USA	Universal health care (except USA) Means tested benefits.	24%	5.8%
Authoritarian conservative	Spain Portugal Greece	Little welfare state Poor public services	14%	4.8%

Their analysis shows that countries with pro-redistributive governments are correlated with having populations with lower infant mortality. In other words, children die less.

Already, I can hear the election strategists firing up their focus groups to test slogans such as “Save the Children. Vote 1 Redistribution Party” or, more likely perhaps, “Vote for us or the children get it”.

Of course, it would have to be countered by the qualifier, “Correlation NOT Causation.” There is a similar, but weaker correlation of redistributive policies on adult mortality rates, too.

(Actually, the **government’s response**, and opposition silence, to the **Human Rights Commission report into children in immigration detention** doesn’t give me much confidence that the future health of children is a current priority for either party. But I digress.)

It is not the political party elected that matters, but the degree to which they implement redistributive policies. So better health outcomes were obtained by having long periods of policies promoting full employment, regulated labour markets, and public health expenditure.

Another study indicates that it is not just the presence of egalitarian parties, or the proportion of votes they get that determines population health. Unsurprisingly, they have to implement policies of universal public health systems (particularly) and welfare systems (in general) to realise the benefits to child health.

Another study looks at health inequalities, showing that “Late Democracies” have worse inequalities in health, particularly for women. (This paper looks at mainland European countries, so late democracies are represented by Spain and Greece, which no-one is holding up as a role model right now!)

A systematic review (**with a title worth remembering** – it begins “Epi + demos + cracy...”) cautiously concluded 4 things:

- The transition to capitalism in Eastern European countries probably worsened education-based health inequalities
- Market-oriented reforms worsen health inequalities
- The welfare state makes a small improvement in health inequalities
- The health of particular groups is improved by particular policy attention.

This last one is especially important in improving Aboriginal and Torres Strait Islander health, where improvements can be made, **but go backwards if policy attention wanes**.

As you’d expect with something as complex as politics, the answers may not be simple. This research is suggestive, but not conclusive.

There is a suggestion, too, that **Australia may be an outlier**. Despite Australian governments of all persuasions adopting neo-liberal market based policies, our health outcomes are among the best in the world.

So, what are we left with? It’s possible – perhaps even likely – that we maximise health outcomes by voting for parties with more redistributive policies and higher spending on health and welfare.

If we want to improve Aboriginal and Torres Strait Islander health, we need to vote for parties that commit to focussed policies over the long term. It’s becoming harder to find a mainstream party who will openly admit to policies like that.

The principle of Evidence-Based Voting doesn’t need the outcomes to be health outcomes, either. There’s no reason why looking at outcomes like housing, employment, transport and climate protection couldn’t be subject to a hunt through **Google Scholar**.

Imagine a future where your How to Vote card come with the results of a PubMed search. We could all be more confident of outcomes we cared about, and be given the ability to vote accordingly.

There would be nothing more likely to strike terror into the heart of a politician than that.

This is my final Wonky Health column for now (you can read the previous columns here). I would like to thank profoundly all those who contributed to the Crowdfunding campaign.

You have made an experiment in health writing work, and made the clunkily-named Social Determinants of Health have a broader audience. That is important work to which you have contributed.

Thank you to everyone who has read, commented, tweeted, e-mailed and discussed ideas here. You are proof that social media can work for discussion of complex ideas.

And finally, thank you to Melissa Sweet, never daunted by my strange idea and adding “Yes, why don’t YOU do it!” All the columns have been improved by Melissa’s encouragement, ideas and editing.

If you want more ... watch this space...

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