The importance of prevention in rural health

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Louise Sylvan is with us now, and Louise, I apologise to you for Adelaide traffic, and this is maybe news for those of you from other parts of Australia, but Adelaide now has the unfortunate reputation of having the slowest travel times of any capital city in Australia and I can vouch for that. At peak hour, you're very lucky to get out of the city in about 20 minutes. Shocking! Our next speaker, Louise Sylvan, is clearly a very busy person and I'll tell you why. Louise is the chief executive officer of the Australian National Preventive Health Agency. She's been a commissioner of the Productivity Commission since 2008, previously deputy chair of the Australian Competition and Consumer Commission where she was appointed for her expertise in consumer affairs. Formerly the chief executive of the Australian Consumers' Association and president of Consumers International, Louise is well-known for enhancing consumer rights across a range of areas including health, food safety, financial services, and in competition and consumer policy. Louise chaired the ROCD's work on Economics for Consumer Policy and currently serves on the Federal Government's Australian Statistics Advisory Council to the AFS. She chairs the Bush Heritage Australia and serves as a member of the board of the New Social Enterprise Fund Australia. She was formerly deputy president of the Council of Medical Foundation for the University of Sydney and the UNSW Board of Diplomacy and Training Program established by the Honourable Jose Ramos-Horta. She has many other memberships as well, too numerous to mention. Louise has a BA and an MBA from universities in her homeland in Canada and she immigrated to Australia in 1983. Ladies and gentlemen, please give Louise Sylvan a very warm welcome. Louise ...

Louise Sylvan: Thanks very much, Lee, —my apologies for being a bit late this morning but I'm delighted to be here, in fact, and this was a conference I didn't want to miss, not only because I could sense the excitement when I was talking to the Alliance people, but also because I think the time is right now to really tackle some of our rural and remote issues. And we've probably got the capacity to do that in a way we've never had before. So I'm supposed to be heading off to France, I'm on leave at the moment. This morning, I shifted it over to tomorrow so that I could come today and just share a little bit about our new infrastructure, the new agency and get some ideas from you about some of the work that we're starting to do. And it's a great pleasure as well, of course, to be on the podium with Tom Calma, a great honour to be here, and we work very actively in the tobacco space together.

This agency was established in 2011, beginning a year later than was intended, and its purpose is to advise all of the health ministers on preventions. So it's new infrastructure to really try and leverage up the prevention task in Australia. Now, why would you bother to do that? Well, we've been given these three areas as our priorities. It's obesity, alcohol, and tobacco, and here are some of the reasons. Those three areas of course, are implicated as you all know, in particular in three conditions, three preventable conditions by and large, and if you look at that little bottom dot point, approximately 40 per cent of current potentially preventable hospitalisations are associated with these three things. So you can see why governments, around the world actually, not just in Australia, are very anxious to ensure that the issues of chronic diseases are actually tackled, and tackled well.

Now, this is the—if you like—the summary, and I'm going to go through each of these quickly in detail. One thing Gordon asked me to do is set the scene for where we are on these three priority areas that we've been given, and then go through some of the innovation that we're working with. We've worked for a long time in social marketing both as governments, non-government organisations, people in the health field. We're looking to do some—even more—innovation in these areas to try to get us further along in prevention. Now, you'll notice that in fact, those three areas, if you think about it, those are kind of the three sins. They're behavioural areas; we didn't get that wonderful simple stuff like immunisation, simple relative to constant behavioural change. So we got the difficult stuff, very difficult for governments to do well.

So this is the same map, but I've done it regionally for you just so you get a sense of it, and again, I'll pick up each of these in turn and have a quick look at them. But the basic thing I can say is—and you know this—in relation to these three critical areas of prevention, the more rural remote you get, the worse it looks.

So, let me move onto these priorities. Smoking is a huge success story for Australia. We all know that. This is a leadership country in the world in terms of its activities and you can also see—notice that little bump up in the female curve—that's the bottom curve. When governments actually aren't watching carefully enough, and don't quite see what's happening in the market place at this time where we still have the ability in different ways to promote tobacco towards people, that little bump up had to do with the new kind of pack that was available, a little tin pack which came out in quite bright colours and things like that, attracted a lot of women and you started to see the curve go up, until the government came back in and made that impossible for tobacco companies.

But despite that, the curve is a beautiful, beautiful curve and we should be justly proud of that because it's one of the top accomplishments in the world. And without—without, you know, banning, but nevertheless governments taking both fiscal and very substantive regulatory action as well as very, very large investment over time in their social marketing and their messages to people about tobacco.

This is the regional outlook of this. But this is a significant difference between major cities and rural and remote, and it increases the more you go along, and I'll come back to why that might be in just a minute. But that's not the kind of outcome that we want, obviously. Now Tom has shown you these figures, the results still at this stage for Indigenous people are just completely unacceptable and that is logical, as we didn't concentrate on it. We're concentrating on it now, and we hope to see very significant results in the near future.

Now, that wonderful line that we had for tobacco doesn't look quite like that for obesity. It looks, in fact, pretty bad—very steep for Australia—and in particular, the line still isn't updated. We're still waiting for the ACD to update Australia's figures. We hope they're below that little green line which is our current projections. The important thing about this is that a lot of countries appear to be stabilising or moving down or really slowing their rate of growth, and on the projections that were done for Australia that growth line was still heading up. So we're quite anxious to see from the last data where we've ended up in Australia, in that comparative study that the OECD did.

This is what we look like on obesity and overweight. The little yellow ones are a combination of overweight and obesity, and the little blue ones are obesity. In the last national health survey that has just been published, the Australian Health Survey, what happened is more or less the proportion of overweight people stayed the same. The increase is actually in the obesity category, which is quite alarming if you think about it. So that's exactly what you don't want to see. You want to see everything coming down; you particularly want to see obesity coming down.

So I've done it again, here we are on regionality, reasonably significant differences, particularly on the obesity scale, so again, exactly the gradient that we would have predicted that happens when you add regionality and look at rural remote. So again, not a particular direction that we would hope to see. And this is Indigenous again, this is a comparative graph with non-Indigenous people, and as you can see, particularly in the obese category, the critical category are very, very significant differences between males and females, both in general in Australia, and, interestingly, females are not as overweight and obese as males. Males take the cake, females are only 55 per cent, males are up to 70 per cent now. And that is not true for most countries, in fact. So a few other countries look like this but it's unusual to have that particular outcome.

Now, I decided to take a quick look at children for you because it seems to me that that is particularly important. Children in fact, look like they may be stabilising in Australia. They're not going up at the moment as far as we can see. There's a little bit of movement between overweight and obesity but they

are stabilising at very, very high levels. Those aren't levels one would want to have so there's still a big task there to do in relation to children, their diet and their activity.

And here's just a couple of bits of additional information for you. This is from the National Secondary School Survey, Diet and Activity Survey. This was done in Years 9 and 10 and I compared their metropolitan and rural, and you'll notice in relation to overweight obesity, women about the same, young girls about the same. Men not quite, rural men a bit more overweight but this is particularly nice, I think, because it's a good start. So even though on physical activity parameters, you actually have still low rates overall, much, much lower than we would like to see for kids of this age. Nevertheless, in a more rural setting have more physical activity than you do in comparison with the averages for the rest—for the metropolitan. So that's good—a good outcome, I think, and a good start. (Now, I'll just pop over those propagating maps.)

Here's alcohol regionally, and this is a very big difference I have to say. This is a startling difference as you walk through inter-regional, outer regional, and rural and remote. So there's a very significant difference that we think we need to tackle. This is again Indigenous, and Tom made a really important comment there which is that a very large proportion of Indigenous people simply do not drink at all, but when there is drinking, you actually have high risk behaviour or high levels of drinking harmful to their health. Now, these are the regional—this is a map that I gave you at the beginning. This is the sort of regionality across Australia and I put that back up just to make a couple of quick points about it. Even though this is regional, we actually know, and I think a couple of people have mentioned this already, that there are two things operating here. If you look at what's called the social determinants of health, this is really other things that impact on health outcomes. It has to do with income levels, education levels, and so on. There is a combination that goes on here between regional-ness and disadvantage and in fact, shortly coming out will be the COAG report. This is the report of the First Ministers, the Prime Ministers and Premiers on the prevention agreement that they have between them, of which this agency is a part, and you will find that when you do the combination of rural and remote with disadvantage, those are the worst outcomes in the nation, as you might have predicted.

So it has to do with not just tackling health. It's very, very important to tackle tobacco, for example, because that's a significant part of people's incomes going on something that is not particularly useful for anybody, particularly not themselves and their health. So when you tackle that, you're also tackling income problems and people having more income and so on. So that's the quick sort of presentation of the overview and it's both encouraging and discouraging at the moment, and we know that we've got a lot of work to do. And we're trying some new approaches, and I'll just quickly go through those for you, as we do think we need new ways of coming at these quite difficult intractable behavioural issues.

So this is a campaign that we have called, 'Be the Influence'. It's designed to actually speak to young people, because this is part of the government's binge drinking strategy, and we've gone into partnership with 14 sports, some of which had alcohol sponsorship as well. These are the sports where there is most actual involvement by young people. So they're not the sports people just watch, but there are sportswear people most involved. These are the biggest sports in Australia in terms of young people's involvement. So these are the ones that we've partnered with, and we've got this message to them about, 'Be the Influence'. This is a call to their personal responsibility, to their leadership as young people, and of course, sports figures are very influential on young people even when they're not participating in those sports. So here it is on the ground at one of the swimming contests. Here it is in soccer.

[Background Music] Australians sports organisations have made a pledge to tackle binge drinking.

Now, when you watch your favourite sports like football, basketball, swimming ...

Netball and hockey ...

You won't see alcohol sponsorship.

You'll see this logo …

Because the less exposure young people have to alcohol promotion, the better.

We're strong enough to say, 'Enough.'

And you can be too.

Exercise your judgment.

Stand up for what you believe in.

Influence.

So any of you who've got anything to do with those sports will have recognised the various people there, and they're out as ambassadors, and that video shows in the sporting grounds and so on, at half-time. So the message is getting out there really, really strongly. It's a great initiative by the government.

This is something else we're trying at the moment. It's an app. Now, I know everybody's got apps for everything at the moment, but the point of this wasn't actually to give people just an app, though it does have a whole bunch of information in it. It tells people you know, how many milligrams of tar they haven't had, how much they've saved each day. It encourages people to actually set their goals. But the critical thing for me in this app is it's a co-creation application. So people actually—we can't—we can't—you know, governments are way off there in relation to most people's lives. We cannot tell what it is people really need from the point of view of their personal commitment to stop smoking, what will trigger them to not go back and take that cigarette.

So what this app enables them to do is actually have a crisis button. That crisis button can do whatever they want it to do, as opposed to us doing anything for them. So I've looked at some of these—some just go straight to the Quit lines, some call a friend. The one I like best was the guy whose crisis button is a little recording, a little image on his phone of his young daughter, because his goal was to take the kids to Disneyland. This little, I think, probably three-year old child says, 'We're so proud of you daddy. We know you can do this.' And that's his [inaudible]. Now you can't deliver that normally as a health professional, as a government. Only a person can actually co-create that with you. So we're pretty pleased and we've got a whole lot of people using this that we didn't expect and in particular, young women, which we hadn't predicted, so we're pretty pleased with the results of how that's going so far, and the discussion page that accompanies the Quit Buddy app is really amazing to just walk through and read, and the people that have been enabled to quit when they've been smoking for almost 40 years and so on. It's really amazing. This is something else; this is really kind of cutting edge.

Again, Gordon wanted me to talk about the work that was really innovative and different, and useful potentially in rural settings. Artificial intelligences are out there a lot at the moment. In fact, that online assistant for any of you who bank with the NAB online, that's their artificial intelligence assistant. There is not a person behind that that you are talking to or interacting with, that is actually one of their artificial intelligences. The one that you see on the little iPhone is actually the standard, and chartered one for their high-end customers at the moment. The little teddy that you see is one that's being used. It's a talking teddy, highly evolved artificial intelligence; reacts with children and so on in a variety of situations.

The major use of these artificial intelligences has been, to date, probably mental health we've seen the most. There are some trials in dementia. We're looking at this in relation to obesity because a particular difficult task that we've never been able to do from the point of view of assisting people, is actually give them somebody to encourage them on a day-to-day basis. Now if you try to do that from the point of view of a health system and the cost involved in that, you just can't see your GP every day. You can't even see the practice nurse every day, it's too expensive to design that. These are enormously scalable ways of actually providing that psychosocial support, which is so critical for people to maintain the goals

that they have in these difficult areas of either quitting or reducing their weight, or maintaining their weight, or not drinking inappropriately. We literally are trialling these.

The two trials that have taken place so far have been in the United States, at Harvard and MIT on obesity, and you'll be interested to know that the artificial intelligence has worked more effectively than the people, and that's because they're completely non-judgmental in their interactions with people and they can also be evolved to be the kind of friend that people need. Somebody might want a sort of Nancy figure, 'Get out there Joe, you bloody well haven't done your exercise today, what are you doing, whatever in the house.' Mine would be someone that says 'Oh, you've almost got to your 10,000 steps, come on Louise, get out there and have a few more steps.' They literally can be different kinds of personalities. They're avatars basically, but they're avatars that are linked to really substantive and absolutely cutting edge health information for people, to assist them in that—in that day-to-day decision making.

They can link to recipes. They can link to all sorts of things. We're improving the concept at the moment, and I think this will be an enormous support for hard-pressed health professionals if we can make this scalable, at costs that work. Hard-pressed professionals who do not have that constant time to be available to everybody they would like to be available to. They've got some alternatives to give people to help them and in fact, if they get permission, they can actually look how everybody's doing, very easily, without having to see them directly and intervening only when necessary. It has enormous potential, I think, for making our work much more possible and much more effective.

The other thing that we're doing is working with the Medicare locals. You'll all be familiar with these structures, local structures. We've done the usual things you would expect, evidence briefs and so on for them, but the critical thing for us is in fact the prevention grants that are out there. These are the seven grants. Two of them are in regional areas. One of those is redesigning one of the areas of a city entirely so that it becomes much, much more active as a place for people to be, and another one that you might be interested in is the Northern Adelaide one since we're here, which is actually to create a new pathway in relation to asthma and so on.

We haven't just done grants though, governments do that all the time. They give grants, people go, I do stuff, big deal. What we've put together is the practising people in the Medicare locals or GPs, whoever, NGOs that are there, local governments, put them together with the researchers, standing with them to actually look at what works, and giving them a whole set of informational tools to interact with every other Medicare local in the country who wants to follow each of these projects, and implement at that time if they want, or at least see how successful, not successful, what might work for them. We want to kind of stop the sort of duplication, the constant reiteration and over and over learning stuff and actually embed some of this learning into the Medicare locals.

The last thing I wanted to say is, I think, that there's just enormous potential in the rural and remote health professional communities, we think it's a really important group of people that we work with just because of those figures, but also because there's so much enthusiasm and real desire, I think, for outcome, in the people we've met. We look forward to having many more opportunities to work with you. In fact, that artificial intelligence, once we've got proof of concept, the staff has said to me, 'One of the key places that we'll take this very quickly is actually out into rural areas and see how it works in those settings'. I hope we get a chance to do that. Thank you and there's our contact if you need it.

Thank you very much.