



TRANSCRIPT

Opening Plenary: Driving change in our region

Wednesday 15 July 2009, 1.30pm

A/Professor Libby Kalucy:

It gives me great pleasure to welcome you to this first opening plenary of this conference. My name is Libby Kalucy and I am the Director of the Primary Health Care Research & Information Service which is convening this conference for the Australian Government together with AAAGP, the Australian Association For Academic General Practice and APHCRI, the Australian Primary Health Care Research Institute. My next duty is to point out the exits which you can see lit up as it's the first time we have been in this room, so those are the fire exits and use them if necessary. The next pleasurable task I have is to introduce to you the Wurundjeri Elder, Auntie Dianne Kerr who is going to perform the Welcome To Country.

Auntie Dianne Kerr, Wurundjeri Elder: ***Welcome to country***

Good afternoon everybody. I would like to pay my respects to my elders, my elders past and present, my elders who are here today and elders of different Nations that are here today. I am both proud and honoured to stand here today on the traditional country of my grandmother and mother and ancestors to welcome you all and I hear that you are all the big guns, that you are all policy and researchers. It's awesome to have everybody altogether and to share information and get to know different communities and what they do. I am an elder of the Wurundjeri Tribe and an elder in my family, I am one of the eldest left, I am a young elder, there is no one above me and I live in the community of Dandenong and we have quite a lot of Aboriginal families that live there and I am at that sort of age where I start to worry about my community and its good to actually speak to people doing research and looking at peoples health as we have really poor health and a lot of other people do but we seem to be struggling very very hard in this modern world and I worry because I am 55 years of age and I am at that age where I have to count every day and its really sad to be wondering if you are going to be around for the next 10 years. I am not political, but the Government has just made the retirement age 67, we don't get there, it's really sad to think that most of us won't retire. I also notice a lot of you are on your computers out there, have some time out and rest. You really do need some time out because you people are important people, so take your shoes off, feel the earth, smell the roses, just do that and take some time out, its really healing to put your feet on the earth and take some time and listen to each other because if we listen to each others story we start to understand each other and we will get a lot further and if we can live in peace and harmony everybody else can and its part of that holistic healing, its very powerful, holistic healing and that's how we live and I thoroughly believe in it and spiritual, altogether. I would like to offer you my hand in friendship; in friendship and as a symbol of reconciliation so that we can walk together in peace and harmony, may Banyule my creator

surround you and keep you safe on country. On behalf of my elders I say Wonun je ka, Welcome. I wish to welcome you from the tops of the trees to the roots in the ground and if you look after the country, it will look after you. Thankyou.

Libby Kalucy:

I think those are words of great wisdom, particularly the ones to listen to each other and learn to understand each other is good advice at the beginning of a conference and take time out. It's now my great pleasure to welcome the Honourable Mark Butler the parliamentary secretary for health who is representing Minister Nicola Roxon on this occasion to open our conference and to launch our Snapshot.

***The Hon Mark Butler MP, Parliamentary Secretary for Health:
Launch of Snapshot 2009***

Thankyou very much Libby and can I thank Auntie Dianne for wonderful Welcome to Country and pay my respects to the traditional owners of these lands and their continuing attachment to the land around Melbourne. Also can I pay a particular welcome to our international guests, Dr Tikki Pang from WHO, I am not sure whether Professor Sullivan is here yet, but it's wonderful to have the benefit of international guests at such an important conference. Can I also thank the organisers, particularly Libby whose daughter was consistently the smartest kid in my class at high school back in Adelaide, not that I harbour any ongoing resentment or bitterness for that matter, which you can pass on with my tongue in my cheek Libby. But particularly to you guys who have come from all the different four corners of Australia to be at this very important conference. Times are very tough in all sectors of the economy and society and taking the time out and making the decision to spend the funds that are involved in coming over to this conference is a particular contribution to your field of research and practice so I thank you for doing that. Thankyou for your welcome Libby, the Minister for Health & Ageing, Nicola Roxon is, as Libby has said unable to be with us this afternoon and she sends her apologies and obviously her best wishes for a very important conference. I personally am very excited to be here, I have only been the parliamentary secretary for Health for four weeks or so and I am very happy that one of the new responsibilities I have been given in this role is NHMRC so I have a particular interest in research, including research in the area that you guys practice in. I am not telling this audience anything new when I say that primary health care is the front line of the Australian health care system and primary health care research is essential to inform us how to make that care better. The work that you undertake as researchers or research sponsors is therefore of great interest and importance to a Government that is undertaking the most ambitious and broad health reform agenda in several decades as our Government is. Last year in a recorded message to your conference Minister Roxon outlined the reform processes which the Rudd Government planned or had underway at that time, and in very broad terms what we hoped to achieve from them. A year on, a lot of hard work has been done in preparing for reform, culminating in the delivery of a number of reports to the Government. I am sure you are all familiar with these major reform processes, the National Health & Hospitals Reform Commission, the National Preventative Health Task Force and the National Primary Health Care Strategy. I understand that on Friday afternoon you are going to have representatives involved in all three of these reform processes as well as the Deputy Secretary of the Department speaking at a plenary session and each of these people have made a significant contribution in developing the reform agendas that I have talked about and they will have far reaching implications across the entire health system so I encourage you to stick around for that session if you can. In addition to these processes there are other significant reform processes underway. We are currently working on the first National Men's Health Policy and an updated National Women's Health Policy. We also had the 2009/2010 budget which made important contributions to health. In spite of very difficult global economic conditions the Government invested across all parts of the health system including

measures to boost the health workforce, reforms to maternity services and a major investment in building and upgrading health and medical research and training facilities across the country. All of these reform processes are separate but they are interdependent. The major theme of all of them is to reorient our health system from the treatment of episodes of serious illness in the acute care setting to better management of conditions in the primary health care setting and more prevention and patient centred care. Hospitals are an essential and very high profile part of our health system obviously but primary health care is just as, if not more important to our overall health and well being in our ability to participate in work and community life. International research shows that health systems with a strong primary health care sector are more efficient; they have lower rates of hospitalisation and mortality and deliver more equitable health outcomes. In Australia more effective and accessible primary health care will be absolutely critical to meeting the major health challenges that we face in the 21st Century. These challenges include an ageing population, rising rates of chronic disease and the health needs of rural and remote and Indigenous communities who are currently falling behind the rest of the population. Compounding these challenges are workforce pressures, a lack of continuity and patient care, and issues of safety and quality in practice. Primary health care must lead the way in tackling these challenges and research into improving practices and services plays a vital part in meeting those challenges. The need to make these major challenges in health has been acknowledged not just by the Rudd Government but by all Australian Governments. COAGs National Health Care Agreement, the new agreement on Commonwealth State Health Funding announced in November last year affirms the agreement of all Governments that Australia's health system should do a number of things. Firstly it should be shaped around the health needs of individual patients, families and their communities. It should focus on prevention of disease and the maintenance of health, not simply the treatment of illness. It should support an integrated approach to the promotion of healthy lifestyles, the prevention of injury and diagnosis of the treatment of illness across the continuum of care and it should provide all Australians with timely access to quality health services based on their needs not their ability to pay regardless of where they live in the country. The National Health Care Agreement also sets the policy direction for better connecting hospitals to primary and community care in order to meet patient needs, improve continuity of care and importantly to reduce demand on hospitals. This is, of course, why in June last year Minister Roxon announced that the Government would develop Australia's first National Primary Health Care Strategy with the assistance of an external reference group Chaired by Dr Tony Hobbs. For those who don't know Dr Hobbs, he is a GP Obstetrician in Cootamundra in NSW and the immediate past chair of the Australian General Practice Network. The other members of the external reference group offer a range of perspectives on primary health care. They include a pharmacist, a midwife, a physiotherapist, a psychologist, a birth reform advocate, a general practice nurse, a consumer representative, primary health care academics and general practitioners including those who work with Indigenous and rural and remote communities. Australia's first National Primary Health Care Strategy will provide a systematic plan to tackle the challenges in primary care. The Minister asked that the strategy give priority to these areas. Better rewarding disease prevention, promoting evidence-based management of chronic disease, supporting patients with chronic disease to manage their own condition, supporting the role that GPs play in the health care team, addressing the growing need for access to other health professionals and encouraging a greater focus on multi disciplinary team based care. The drafting of Australia's first National Primary Health Care Strategy has provided us with an opportunity to consider the strengths of our current primary health care system that we can build on, to identify the major pressure points and to canvass new approaches to meet future needs. The Government asked for a draft strategy by the middle of this year, and I am pleased to say that it has very recently been received. I can't reveal too much today as the strategy is being carefully considered by the Minister and others in the Government, together with the recommendations of other key reform processes. However, I can say that the draft reflects extensive consultation and feedback. In fact there were more than 260 submissions in response to the National Primary Health Care Discussion Paper that was released around October 2008. Those submissions were received from

State and Territory Governments, professional groups, individual GP Divisions, consumers, health care practitioners, public and community health services and special interest groups. The Minister has also received the reports of the National Health & Hospitals Reform Commission and the Report of the Preventative Health Task Force which will also be very relevant to the future of primary care. As I have said the Government is in the process of considering all of these reports which will be released in the very near future.

Research and reform go hand in hand. They are two sides of the same coin; one can't succeed without the other. Primary health care research is different to some other types of health researching that it deals with the real world of what happens within the primary health care setting. This makes it even more relevant to health reform. Your research provides the sound evidence base for new practices and policies for health practitioners which in turn in many cases will demand changes to the system in which they operate. Improving the real world of primary health care to improve services and outcomes for patients is a core objective of the Governments health reform agenda. That's why the Government intends to harness the power of your research more directly through a slightly amended brief for the Primary Health Care Research Evaluation & Development Strategy. PHCRED has received more than \$100K from the Australian Government since 2000. The Rudd Government will be continuing that funding for a new phase of the strategy which will see its research initiatives aligned and integrated with the reform agenda in the National Primary Health Care Strategy. We also want to see a greater exchange of knowledge between researchers, practitioners and policy makers because as I said research and reform need to work together for either to be successful. On that note I am very pleased to launch the 2009 Snapshot of Australian Primary Health Care Research. Like the first Snapshot last year, this cross section of projects funded through PHCRED shows the quality, the diversity and the potential for advancement offered by Australian Primary Health Care research. As I was reading the Snapshot over the weekend I was struck by a few recurring themes. One of the themes that jumped out at me was the importance of continuing education and training for our front line GPs and that had particular resonance for me as I chaired elements of the South Australian Mental Health Review a few years ago when I was a member of the Social Inclusion Board and there were two critical findings out of that review. In addition to quite a stark absence of step up and step down facilities in South Australia, GP training was identified as one of the very important ways in which we could deliver immediate improvements to mental health and depression care in South Australia. That sense that I had from that experience was reinforced by the reorder study in your Snapshot program but the importance of GP training also comes out in the research project that identifies or leads to greater identification of benign skin lesions and also the analysis of GP errors. The second recurring theme that came out to me in reading the Snapshot over the weekend was the importance of trying to improve the directness and the timeliness of access by patients to care and I was particularly struck by this when reading the lifestyle plan to reduce type 2 diabetes, also the finger prick test for blood lead levels in children which led to an increase in the willingness of parents to bring their 0-5yo children along to that sort of testing but also the GP based testing for diabetic retinopathy, if that is the right pronunciation for that difficult word. The third thing that really came to me was the effectiveness of multi disciplinary teams and that came out of the research into the results of Your Defiant Child program for rural families, but also in a couple of the studies in the Snapshot of chronic disease management plans in GP settings which I thought was very instructive as well and last and certainly not least the innovation in some Indigenous health services that is included in the Snapshot is of particular interest to the Government in our attempt to close the gap on health outcomes and life expectancy between Indigenous and non Indigenous Australians. Innovation that ranged from early childhood health in an urban setting to the links between ischemic heart disease and depression to the very innovative way in which IT was being used in very very remote settings in Western Australia. It really is a wonderful snapshot of some very important pieces of research in your sector. These projects are very inspiring but I have no doubt that it is just a snapshot, there are many many others which could equally have been

featured in this publication. The bottom line of all these projects and indeed of all good research is innovative thinking informed by the best evidence. I know that's your aim and its certainly our aim to promote and encourage that with such a big reform agenda, in fact the Government is relying on it and we need more of it. Best wishes with your conference for the rest of the week and can I thank you for the opportunity to be with you this afternoon.

Libby Kalucy:

Thankyou very Mark for those two speeches, the opening and the launch and certainly as somebody who has been involved with the rest of the PHC RIS team in putting together the Snapshot together with our excellent advisory group, its really nice to see it come to fruition and to see what those Snapshots represent and I thank all the contributors from the audience who have taken part in this. It is now the time to introduce our first key note speaker, Dr Tikki Pang. He is currently the director of the Research Policy & Cooperation in WHO Geneva. Prior to joining WHO, Tikki was Professor of Biomedical Sciences at the University of Malaysia. Tikki told us last night how he saw the light after lots and lots of biomedical science as an immunologist and thought well does he keep on publishing more papers or does he do something more interesting and in fact he took this big change, and changed his career. He is, as well as being very eminent in his field, he is currently Secretary of the WHO Research Ethics Review Committee and Secretary of the WHO Advisory Committee on Health Research. He has many research interests in epidemiology and pathogenesis and particularly now in health research policy systems, development of research capabilities in developing countries and the linkages between research and policy all of which are dear to the hearts of researchers here, even though the immunology side is maybe a little bit more distant in our priorities. Tikki I would invite you to come to the stage. Thankyou.

Dr Tikki Pang:

Responding to the challenge of health security

Thankyou very much for your kind introduction. It's always a great pleasure to come back to Australia. I spent 11 years of my life here, and really owe this country the education I was fortunate to have at ANU and am very pleased to be back and to share a few ideas with you on this topic of challenges to health security. I think Mark gave a wonderful summary about the very exciting things that are happening within Australia. I am going to take perhaps a more global view of primary health care in relation to health security challenges with a particular focus on the developing countries but before I begin I would really like to thank the organisers and especially APHCRI for enabling me to come here as one of their International Visiting Fellows. Let me begin firstly by just asking what we really mean by health security and I guess what I am talking about here are the health components of human security and the ultimate aim is perhaps a world that is safer from the various traps that threaten global health security and many of you know there are whole range of these, ranging from infectious diseases to chronic diseases to unsafe food and water. Importantly more now, health risk associated with climate change events, I think that is becoming very important. Last but certainly not least is this whole issue of inadequate and also inequitable access to basic health care services. So this frame work of global health security if you like is really what guides the World Health Organisation and its core mission is really the attainment by all peoples of the highest possible level of health. The emphasis there is on the word all. So I think some of you may know, I was very pleased earlier when I was looking at the posters, that at least one of you in the audience has actually heard of what's going to be on the next slide, and that is the work of the WHO and of the United Nations system in general is guided by this Global Compact agreed upon by all members of the United Nations in the Year 2000 and its called the UN Millennium Development Goals with a target of achieving these goals by the year 2015 and as you can see these goals here, 4, 5 and 6 are very much health related although you could also argue that the others are important as far as health is concerned. So the work of the

WHO and the UN system and all the other organisations are essentially focussed on the achievement of the MDG's as we call them and I will come back to these goals as I go through my presentation. I am going to divide my presentation into two parts. First to describe to you in a bit more detail what are the various threats and challenges and in the second part to actually focus on the role of primary health care in particular as a critical response to overcoming some of these challenges. So if I begin with the threats to health security I think this clearly is on everyone's minds. I was invited to the ABC studios this morning for an interview and I was hoping to be able to talk about primary health care but all they wanted to know about was swine flu. So I guess that's topical and clearly it's on everybody's minds and Australia of course has some serious concerns about some severe cases overnight in young people. The latest figures nearly 100,000 cases with 430 deaths worldwide but I don't want this presentation to be focussed on swine flu. I would just like to remind you that it's not the only problem that's facing us. In our part of the world for example, I am just picking examples randomly, very recently there is a concern with hand food and mouth disease and this has been a problem in Australia in the past and certainly in South East Asia and western pacific many countries deal with this and you hardly hear about it. Going a bit beyond this region, cholera continues to be a huge problem in parts of Africa. Many of you know the problem in Zimbabwe which is associated with instability in the country. Another huge issue and many people in public health will tell you that this is the single and most serious threat to global health and that is antibiotic resistance and this is not restricted just to the developing countries. If you see this graph on extensively drug resistance tuberculosis you can see it's global. These are strains of TB that are completely resistant to all known antibiotics. But of course on a more global scale beyond the developing countries you have problems with MRSA in hospital settings. So antibiotic resistance and of course there are problems with resistance to malaria in many parts of South East Asia and more recently, just from last week the appearance of H1N1 pandemic strains, resistant to Tami flu so at the end of the day the bugs are always going to be faster than us. So that's antibiotic resistance for you. This is a very interesting slide. Katie Jones last year looked at 335 incidences of emerging infectious disease over the last 40 years and found that about 60% of these are linked to wildlife and as you know influenza for example is linked to wild birds. SARS that happened in 2003 was linked to some wild animals, Civet cats in China. 20% was linked to drug resistant pathogens a 20% is to vector borne pathogens. This slide also shows you where the hot spots are. Where did this happen and once again if you take some of these diseases, the one in particular, this part of the world, tropical Asia is a real hot spot and clearly Australia is as close as you can get in terms of a developed country in this part of the world. So it will continue to be a problem, we need to continue to be alert. I want to move on to highlight some other threats. This one is well known to many of you. In a sense just focus on the broadening of the blues. I think everybody is basically with the fact that many of the problems are now not so much with the communicable diseases but more and more shift towards non communicable diseases and accidents as causes of death. In 2005 for example there were about 58 million deaths globally, 35 million out of that is due to chronic diseases, cardiovascular disease, diabetes, cancer etc and 34 million of those 58 million deaths due to chronic diseases, of that 34 million, 80% of them are in developing countries. So its no longer true to say that heart disease is a rich mans disease. The developing countries are facing now what everybody knows as a double burden of both infectious disease as well as non communicable diseases and as you know in terms of health care its a lot more expensive to look after the complications of diabetes than to treat an acute episode of infection. Another issue related to chronic disease is health effects of tobacco and if you look at the eight leading causes of death world wide, of those 8 causes about 6 million deaths are actually attributable to tobacco use. So there are very important risk factors which are very global in nature, alcohol is another example in this category. As we all know we are dealing with an ageing population, I think Mark referred to that in his presentation that in both developed and developing countries the percentage of the population aged 60 and over is going up and these are forecasts. Once again the majority of those will be in the developing countries. I want to move on now to a threat to global health which is related to the forces of globalisation. This is of

course a very misused term but I want to illustrate a few examples of globalisation that has a direct impact on health and clearly climate change is foremost on everyone's mind, many people consider this to be the biggest health threat and inter governmental panel on climate change is saying that its going to go from bad to worse. This slide from the recent article in The Lancet tries to link increases in global average temperature to health, to coastal environments and to food and you can see that the direct effects are quite clear and quite a lot of good evidence for it. This slide, change distribution of some disease factors, I think its very clear that malaria and dengue for example are going to see changes in distribution as a result of global warming. But increasingly people are beginning to be aware of the indirect impacts like if you have crop failure, you are going to have increase burden from malnutrition, diarrhoea and other infectious diseases. Also extreme weather events like heat waves and flood and even natural disasters and eventually also burdens on health services and although it focuses on health clearly it's also linked to other impacts of climate change. This is another interesting figure, if you look at the parts of the world that are responsible for greenhouse gasses you can see where they are, its of course the industrialised countries, Northern America, Western Europe and also China. But people who die from the increase in greenhouse gasses, where are they? They are in Africa, in South Asia and parts of South America. There is a huge equity problem. It's not the countries that are producing the gasses that are being affected in terms of deaths linked to global warming. Another example of globalisation which I think needs to be mentioned because it has tremendous impacts on global health issues is of course the ongoing financial crisis. The first example that I am going to tell you about is the food security. This is another very topical area that clearly is very important for developing countries. This report just a few months ago from the UN Standing Committee on Nutrition basically said that if global growths falls by 2 or 3 percent as a result of the crisis and agricultural investment falls by 20 percent you will see an increase by 30 percent in cereal prices and after that you will see 60 million more children going into a state of malnutrition and the projected price of maize over those sort of scenarios you can see it going up and in parts of Africa of course this is the main staple food. So that's the impact or the financial crisis on food security but there is another more direct impact on health especially in poor countries and that's the reality because the financial crisis started in the rich countries, the rich countries now have less money to disperse through their overseas development aid programs. Italy and France have been accused very recently of reducing their support for Africa including for health system strengthening and sustaining and importantly also the major foundations, the philanthropies, you can think of the Gates Foundation for example have also been effected by this. So you may think how does that effect health in developing countries and this slide, a lot of people are quite surprised when they see it. In many countries, the low income countries, and many of them are in this part of the world, external resources for health as a percent of total expenditure is very high, so in other words 66% of the health budget comes from outside of the country. So clearly if overseas development aid for health falls these countries are going to be very severely effected in terms of being able just to maintain basic health care in their own settings. So this allows me to segue into a topic which is very central to this presentation. I am very happy that Mark mentioned that really health systems are at the core of all this and the reality is that many health systems in the developing world are essentially in a very fragile very precarious state and some are not functioning at all. I just want to highlight to you what some of the problems are. The first one is the obvious one. Health workers. You can see here that Africa which has 25% of the global burden of disease has only 2% of the global health workforce. You go to North America which has about 10% of the global burden of disease it has 37% of the health workforce. Once again this issue of gaps and inequities. Financing. I am just using one example here. China is struggling with this huge issue of increasing amounts of out of pocket payments. People are having to pay out of their own pockets for health care because there is no universal coverage and in many of the situations ending up with what is known as catastrophic expenditure. Households are just essentially plunged into bankruptcy and poverty to the extent that many people especially in the rural parts of China actually don't go and see a doctor because they know if they do so they are going to end up

bankrupting the whole family. So financing, your ability to afford basic health care is now a big problem with many of these health systems in the developing world. Third one, the central most important criteria for a good health system is basic reliable information across morbidity, mortality, number of doctors, number of hospital beds etc etc. Basic health information is a major challenge in developing countries. For example in developing countries on average 40% of births are unregistered and in the least developed countries 71%, this is talking about basic birth and not even categorising numbers in various disease categories. So human resources financing information are some of the real problems. There is another even bigger problem and this is one that comes from the outside. Many of you will know that in the last decade or so huge amounts of money have been going into developing countries particularly Africa from the rich donor countries of the industrialised world. Many of you will know the global fund to combat AIDS, TB and malaria. The global alliance for vaccines and immunisation. In America the Presidents emergency plan for AIDS relief. You are talking huge money here. 22 billion dollars in 2007 alone. They are going into countries by and large they are focussed on specific diseases, HIV, AIDS, TB, Malaria make up about 70% of all those initiatives. Importantly they are going to countries which cannot absorb; they do not have the capacity to absorb this kind of aid. What happens? You end up disrupting the whole health system. You divert scarce resources from primary care into treatment of lets say high profile diseases. Agencies go in there because they want to see results quickly and they want to tell the tax payers in three years we will reduce the number of tests in HIV AIDS from such and such to such and such. So it's done in sort of lets say ignorance of the needs of the country and the next slide is very recent from analysis that Chris Murray did on this so called health initiatives. A is what Cambodia wanted. You give me money this is what I want to use it for. Primary health care, equity funds. B is what Cambodia got. You can see it wanted 40% in primary health care. Instead it got 60% for HIV AIDs, STD's and infections diseases. So there is a huge problem here in terms of what's happening in these countries. The aid completely well intentioned of course, is totally ignoring the health system that needs to be strengthened across the board not just for specific diseases. So what's the impact of all these sort of fairly grim scenarios that I have been mentioning to you and once again I will go back to the slide of equity. Once again a very telling slide which outlines the use of basic maternal and child health services across income. So you look at antenatal care all the way to users of modern contraceptives including the presence of skilled attendants at delivery and you can see No. 1 the access in some of these are fairly low, not even 30% in this case of medical treatment of diarrhoea but what's even more striking of course is that if you are poorer you are much less likely to access it than if you are rich so there is once again a big equity gap here and what I want to mention in particular this issue that is very much a priority with WHO that of maternal mortality. About 530,000 women die every year mostly in Africa during pregnancy and childbirth. The tragedy of course is that these are deaths than can easily be prevented with basic obstetrics care. So that's a real tragedy and if I link it back to MDG5, the one that says reduce maternal mortality by two thirds by the year 2015. What's happening here, this plot here tells you in South Asia you need a 5.4% reduction annually to meet MDG5 in other words in 2015 75% reduction of maternal mortality. What's actually happening is maybe by the year 2076 we will reach that particular MDG. Of all Mug's 4,5 & 6 this is the one that's really far behind and even the other two are not as dramatic as this but really it seems to be a bit of a pipe dream and of course the inequity goes beyond developing countries. I think this audience doesn't need to be told about the situation in Australia. This is a study done by Alan Lopez's group In Queensland and very recently highlighted in The Lancet just two or three weeks ago and the disparity in the health of Indigenous Australians compared to the Australian population in general in very well known in terms of cardiovascular disease in both men and women and in really right across the board across all these other diseases. So it's a problem that exists even within developed countries so clearly there is a fairly obvious problem here. It's staring us in the face and the American's call us what is the elephant in the room. The Canadians I believe say what is the dead moose under the carpet. Now one of the benefits of my 11 year stay in Australia was my growing interest in Australian slang. So I guess in Australia what you would say is even blind Freddy could

see it or it sticks out like a country dunny. Now in the original version the dunny is something a little bit more crude so I changed it slightly. But clearly if you reflect on what I have just said, the elephant in the room is clearly about getting the health system in good shape and once again this is where when I hear Mr Gates talk, and I happened to hear him in Geneva about a month ago, I get very worried, because he has the attitude that money will fix everything and its all about more technology. You talk to him about health systems and he basically rolls his eyes and says well I give you money and you develop the best and just go and deliver it. It doesn't occur to him that it doesn't work that way. So the elephant in the room is the health care system basically and having said that, what do we do now, and in a sense I will try to summarise what I have said in the first part of this talk. Clearly there is a huge series of problems which I have just called the unfinished agenda which is treatment of common infections, better nutrition, breast feeding, the interventions are already there, its simply not being delivered, its unfinished because the health system is incapable of delivering them. The emerging problems like the non communicable disease issue which I have highlighted and there are the whole series of challenges associated with globalisation including climate change, including the spreading of harmful lifestyles, Libby was telling me about her visit to Samoa, and the increasing of obesity as a result of spreading of the fast food culture would be one example and of course emerging new infectious diseases are also linked to globalisation, increased trade, increased travel etc etc. So in overall terms we are seeing inequities and gaps, as I said MDGs are not going to be reached, health systems are in disarray. Importantly I think the problems go beyond the health sector and if you reflect back on the issue of poverty, level of education, number of children in the family, the social determinants of health are absolutely critical. So the future I believe is where primary health care has a very important role. I don't need to tell this audience of the three pillars of primary health care which is participation, intersectoral collaboration in inequity. It really them becomes the heart of the health system. I think those of you who do follow the developments in this field will know for example that WHO last year convened the Commission on Social Determinants in Health. Professor Fran Baum from Flinders was a member of this Commission, so Australia did make a major contribution and those of you who know Fran will realise just how much of a contribution she made. Once again it highlights the inequities then concludes that equity is strongly influenced by the way health systems are organised and financed, importantly champions primary health care as a model for health system acts on this underlying social, political and economic causes of ill health. Just before the release of the report of the Commission we also released another report but in relation to this our Director General had this to say. That health systems will not naturally gravitate towards equity. Left to its own devices. So unprecedented leadership is needed and primary health care which integrates in a sense health in all of Governments policies is the base framework for doing so. So what we are saying here is that primary health care should actually be the framework for a health system and this is what is the focus of the report that many of you know about, The World Health Report in 2008 which was entitled Primary Health Care, it basically focuses on the fact that the current problem with primary health care is very much centred on tertiary care, commercialisation and a fragmented approach and what should be happening is through a series of reforms to sort of move back to what's the principle of Alma-Ata more than 30 years ago in terms of health for all. Of course this is the crucial issue here, what are these reforms that we are talking about. Its reforms that will achieve universal coverage improving service delivery which is people centred and importantly of course, public policy reforms informed by evidence and leadership reforms in terms of the health authorities. So these are the reforms that are needed and this allows me to segue into the second part of this presentation and that is the whole notion that primary health care is a critical response to those challenges that I have outlined. In terms of what is needed, if you want to drive change and facilitate these reforms, in my view it is four main areas, more research on primary health care in low and middle income settings, evidence for policy, commitment to systematic evaluation, and of course beyond evidence and science the consideration of the political forces and the ethical impurities because clearly this is a field which goes beyond the health sector and there are many other forces that one needs to be aware of.

Why is evidence so important especially in a developing country setting? Hassam Mschinda who runs the Ifakara Centre in Tanzania had this to say. If you are poor actually you need more evidence before you invest rather than if you were rich and clearly in terms of financial crisis that becomes even more important. Barbara Starfield in a very recent article in the Canadian Medical Association Journal articulated what evidence is needed to achieve these PHC reforms that we talked about. I think her first point is an important one and she basically stated that evidence-based goals are needed to address both systemic and clinical aspects of primary care. In terms of the systemic aspects what she is referring to are issues of equitable distribution of resources, universal financing or coverage, low or no core payments and comprehensive coverage. On the clinical side I think this is very familiar to all of you and I think Mark has referred to some of these comprehensive integrated services, I believe there is this idea of having super clinics being developed as part of the primary health care reform. What I want to mention at this stage is that when I was preparing for this presentation I quickly realised that the issues around primary care which are of concern to the developed countries are quite different to those issues which are of concern to the developing countries and without generalising too much the developed countries are focussed very much on the clinical aspects and as I was looking through the brochure 50% of the abstracts at this meeting are around clinical practice whereas in developing countries the interest and need is much more on the systemic infrastructure so forgive me if I am just going to concentrate on this one and just highlight to you a few examples. So I will highlight a couple of examples related to systemic needs for reform as well as what are the challenges around those needs. Some good examples around more equitable distribution of resources. This is a project in Tanzania where it is really a community based participatory research for more equitable distribution. It was done in the district of Tanzania not in the whole country so it is focussed very much at a district level. The research was designed with the policy makers, the district health authority right from the beginning. The background of this is that 40% of the deaths that occur in that district occur at home so the Government and hospital statistics are totally unreliable. So they did this house to house survey to get the true burden of disease. What children and people were dying of and as the result of the research they then adjusted the district health budget to be more commensurate with the real disease burden. Between 1997 and 2005 they saw a 52% decline in under five child mortality. That is very impressive and at the rate they are going they are going to reach MDG5 well before 2015 and in fact they have already done so. That's an example of the kind of research that actually informed policy and importantly was implemented by the district health authorities and had a pretty dramatic outcome. This is another example, in Africa where a strategy to deliver drugs to treat river blindness was extended to also include a broader package of interventions so instead of just ivermectin for river blindness they included Vitamin A, they included Betnets for Malaria, they included medications for tuberculosis. So this is the idea of community based integrated sort of delivery of basic health care services. Moving onto universal coverage, I think this is clearly very important point and I would like to highlight here the Thailand 30 Baht universal coverage scheme. The background was Thailand had a very fragmented public health finance system which led to a lot of inequities. In 2001 the Government decided to provide universal coverage where everybody pays 30 Baht and accesses all the services. It covers both preventive and curative care, it shifted resources to primary care and included private providers. Very strong evidence-base the Thai health systems research community is very very solid and competent. The evidence was synthesised from both international and importantly domestic studies because that's what policy makers want to know and it was very effectively communicated and I think this is another important issue when you talk about evidence to policy. To the political parties by the researchers through brief concise papers importantly suggesting that that coverage was feasible with existing resources, not about asking Government to increase taxes to raise more revenue and its now been implemented and it covers 80% of the population and the reports that we are hearing so far is that its been remarkably successful. Another very similar scheme in Mexico, once again very much like the Thai scheme to deliver health insurance regular and preventive medical care to 50 million uninsured Mexicans. It started a little bit later than the

Thai's, 2004, a huge effort to get consensus across political parties and different groups, once again this idea of getting consensus is absolutely critical. Once again informed thoroughly by evidence and the last one is very important and this really is what I want to emphasise. Right from the beginning systematic evaluation was included so a rigorous independent scientific assessment of the program, did it really actually work, did it really make a difference and the first assessment was actually published three weeks ago. Its a randomised assessment of the Mexican universal health program, a lot of people will say its probably a bit premature, its only been rolled out in 2004 but at least the idea of assessment and evaluation is part of the program and just to highlight one finding, this finding actually showed that there is a reduction from base line in catastrophic health expenditures, whether this will be sustained over the next five to ten years who knows but I am just illustrating the principle and importance of evaluation. Much of the examples that I have mentioned so far and in fact in this whole field of primary care research and reforms, a lot of this is anecdotal, case studies, published paper here and there and the more systematic analysis has been lacking until very recently last year Simon Lewins group attempted to basically summarise the evidence of systematic reviews relating to governance financial delivery arrangements as well as implementation strategies that can improve primary health care in the low and middle income countries. They did not address the specific clinical or public health interventions perse but focussed really on the health system arrangements and the implementing of the strategies which support the delivery of these interventions and I think in a sense that's breaking new ground because a lot of the literature is focussed really on oral rehydration therapy or on measles vaccine so this takes a completely different tack so I just want to summarise what they found from this huge exercise of many many systematic reviews. That financial incentives can be used to influence both provider and patient behaviours, that user fees reduce the use of both essential and non essential health services although they also found that the removal of user fees has to be done very carefully. Task shifting I think where you delegate some tasks to lay health workers or to nurses can expand coverage and address workforce shortfalls. I think that's a particularly important finding. Integration of primary health care services has not been adequately assessed and that tells you that there is a big resource gap there maybe when you say OK integrate services, that sounds like a good idea, but the truth is the evidence hasn't really supported that so it needs more study and quality improvement strategies I think that was mentioned earlier, can have important although modest effects on phc quality. So I think those are some important advances in the evidence base along these ideas. In terms of the challenges I think this whole area is full of theories and research studies. I think many of you know the literature is filled with ideas about the knowledge pyramid, you do a basic theoretical methodological innovations, you publish it in your papers and your reports, you do systematic reviews and then you present it to the policy makers and everything is fine. It doesn't work that way. Then there are very nice studies that tell you what do policy makers need. Clear translation accessible use of information relevance to policy context. That's all been well documented. This one is slightly more interesting because it was based on a systematic review. What things facilitate policy makers use of evidence and Andy Oxman and his colleague found it was personal contact, timely relevance and inclusion of summaries with policy recommendations to make it easy and the barriers are opposite of those but also this issue of basic distrust sometimes between researchers and policy makers and the reality of power and budget struggles. So that's the theory. Huge literature in this area. What actually happens in practice? Somebody said that against the advice of experts I made a decision to cull 1.5 million chickens in order to control an epidemic. This decision was based more on faith in my own personal experience than on solid scientific evidence. Who said that? No less person than my own Director General. So that's the reality and as John Maynard Keynes once said "there is nothing a politician likes so little as to be well informed it makes decision making so much more complex and difficult". To be less facetious and perhaps the reality is probably better captured by Sir Michael Marmot who said that "scientific findings do not fall on blank minds, science engages with busy minds that have strong views about how things are and ought to be". To quote someone nearer this part of the world "to a policy maker research evidence has to be able to answer three

questions, can it work, will it work, is it worth it". And if the evidence doesn't help him, in this case Dr Suleiman who was a former Director General of Health in Malaysia, then he loses interest. So the responsibility of researchers is to try to at least address these three questions. There are big problems here in terms of the evidence itself, e.g. there is lack of systematic reviews which are relevant to phc priorities for developing countries, many of the interventions reviewed are simply not implementable in poor countries. Limited amount of research done, poor quality and lack of the impact of the research on policy. If you look at the Cochrane Database of Systematic Reviews, just across the board from 1997 to 2007 around 10% only of those reviews involve authors or co-authors in developing countries so it's very much cued towards systematic reviews of health issues in the developed world. John Lavis also did a review of systematic review production in 22 low and middle income countries in Asia and Africa and Latin America. It was highest in Asia and America and much lower in Africa and some of these countries produce no systematic reviews indicating very limited capacity to do these reviews and interestingly only 10 of these reviews actually address governance, financial and delivery issues within health systems. The large majority are about interventions as you well know it really focuses on randomised controlled trials etc etc. This is another interesting paper which tells you that the research base itself from which you can then do the systematic review is also very biased in terms of its content. This was a paper published which analysed the research funding patterns of more than 100 major research agencies and tried to link it to the impact of the number of child deaths. And this is what we found. 90% of these grants were for developing new technologies. Great it can reduce child mortality by 22%. However if instead the research were done on how to fully utilise existing technologies the reduction can be 66% but everybody wants to develop new technologies, everybody wants to do molecular biology, nobody wants to do health systems research. So the evidence base itself is lacking and importantly I think this lack of assessment of the impact, and I was particularly pleased to come across this report in terms of attempts to provide a framework address questions, indicators of how you address the impact of primary health care research and I am going to use this occasion especially knowing that Mark is here to say that based on the experience of APHCRI and PHC RIS and many of you in this room that Australia has a very important role to play as a global health citizen to better support evidence based primary care reform and through various ways about sharing knowledge and as Dianne said just now its all about sharing knowledge and understanding from each other. It's not just that the research and experience in Australia can be useful for developing countries but also the other way around. To help build capacity through technical workshops in doing systematic reviews. I am in touch with Sally Green in the Cochrane Centre in Melbourne. We have started to work with her to build capacity for doing systematic reviews amongst developing countries and advocacy. I was telling Bob Wells and Libby last night the obvious follow-up to your conference is for Australia to take the lead in convening an international conference on primary health care reform in developing countries. Going beyond your shores. I believe you have a very important role to play and I really hope that WHO can look forward to some stronger ties. I had a phone conversation this morning from Jim Tulloch from AusAid and I think they are particularly keen to develop the health systems part of the program. In terms of what WHO are doing I just want to mention one activity which is something called the Evidence Inform Policy Network that we have set up to promote systematic use of evidence and partnerships at country level. Basically what we do is we establish country teams and regional and global support structures. We do research synthesis and policy briefs, help the countries do that, we develop capacity and empower the countries. These country teams are formed entirely by the countries not with any direction from us. We facilitate safe harbour country dialogues between the policy makers the researchers and civil society. We do the monitoring and evaluation of the impact of this idea of having a country team to link researchers and policy makers and also the development of new methodology. I just want to give you a map of where we are active. Cambodia, Vietnam and Laos are three countries for example. Many countries in Africa and also in Latin America. One example of a workshop, we got policy makers and researchers from 9 low and middle income African countries and there were many more policy makers than researchers at this

meeting. Before the meeting they agreed that what they wanted was a policy brief on how to support wide spread use of combined chemotherapies to treat malaria so they set the question it wasn't WHO or the researchers. So basically it also includes the health system side not just the clinical side. Before the workshop we helped them identify the relevant reviews and importantly the relevant national research which is sometimes hard to get as well as the disease burden data. During the workshop they were asked to identify at least three policy options for the policy makers and then to be further examined and discussed between each other including equity and then finally after the workshop to finalise the policy brief and present it to the Ministry of Health. To cut a long story short, in one year Burkina Faso has now got that policy into the national legislation and more importantly its got 20 million dollars from the global fund to support the implementation of that policy. So we are very excited about this but once again as part of this also have an evaluation program so maybe in five years we will know better that it has really worked equally across the board. In conclusion I think the evidence that is needed to drive primary health care reforms and change in developing countries is still very limited especially on the system aspects, although things are changing. It is critical to systematically evaluate the reforms and strategies more than anything else to further build the evidence base. I think the limited capacity to do the research as well as to access manage analyse and synthesise the evidence to policy makers is clearly a major problem and finally I think strengthening the linkages between research and policy development is a high priority and I think structures and mechanisms are needed which are part of the health delivery programs. It's not something that you do on an adhoc basis when you have a problem. This is the experience that we have learned. It's got to be part and parcel of the programmatic implementation. If we succeed in establishing these kinds of structures and mechanisms I think we would have discovered that there is a pathway from good science to publication to evidence and to programs that work. In this way research becomes an inherent part of problem solving and policy implementation, that's from Julio Frenk, former Mexican Minister of Health and it really encapsulates that entire spectrum. However if we fail in doing this, we will then be reminded of the words of Paul Farmer to whom I give the final say. The divorce of research and analysis from pragmatic efforts to remediate inequalities of access is a tactical and moral error. It may be an error that constitutes in and of itself a human rights abuse. Thankyou for your attention.

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