

# “Do I see a demand?” Getting rural health on a national agenda

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Reading all what I found on the Internet about this 10th National Conference on Rural Health and about the National Rural Health Alliance and its partners, it is clear to me that I should be learning from you instead of being here to present! It is obvious that the Alliance and its 28 member associations, and the Friends of the Alliance, have created a very rare success story: linking across a huge and often unfriendly geography unusual suspects—health executives, nurses, women’s associations, churches, consumers groups, parents, students networks, physicians, indigenous health workers, every possible health care professional organizations including your famous Royal Flying Doctors Services. The common cause of these unusual suspects: *equivalent health and well-being in rural, regional and remote Australia by the year 2020*. This is quite an achievement. I can only say: thanks for this invitation!

We both live in some of the largest countries of the world—Australia and Canada—yours being the 6th biggest land mass and mine, the 2nd biggest. But we fall way behind in world ranking when considering our population numbers. Yours is concentrated along the eastern and south-eastern coasts, and in Canada, 90% of the population lives in the south, within 160 km or less of the US border.

This Canadian 90% bordering the United States also includes rural communities; the figure we usually quote to quantify rural Canada is 20-22% of the population while yours is 30%—a very significant difference, for 30% represents “a critical mass” in political science, while a lesser figure falls in the category of being a “token” player with all what that means. I will come back to this later.

This Conference wants to address the health needs of a widely scattered and quite diverse population, including, like in Canada, a great number of Aboriginals<sup>1</sup>, a diverse population facing some serious challenges, the most obvious being isolation, distances and transportation, extreme weathers, as well as major cultural differences. Like most of the planet you suffer of climate changes, Australia herself being the driest country of the world. Last year, the “Big Dry”—the worst drought in a century—exhausted the land in entire regions, forcing some herds to be whittled down. The extreme lack of rain also killed off some of the Outback’s hardest tree species. I am told that this year is not any better. As I read, the availability of water is now a determining feature of country communities. On top of that, infrastructure is in poor shape, and workforce shortages persist.

Although Australia has had a history of droughts through the centuries—droughts appearing at times in every State, even in all of them at the same time (1918-1920)—individuals and communities living through them must repeatedly find in themselves the resources to adapt and survive. Besides family and business income loss, marital breakdowns, food price increases, various hardships become powerful stressors contributing to mental health problems. Australian research as well as the New South Wales Farmers Association for example, have established that in the recent drought deaths from suicide of male farmers and farm workers are double that of any other group in the male population.<sup>2</sup> The severe and ongoing drought has highlighted a range of problems with the current mental health system and services across NSW.

People in the rural, remote and isolated parts of the Canadian provinces or in the Arctic live extreme weather conditions and many hardships, but nothing comparable to the droughts in Australia. To be frank, rural health is not a theme or an issue that would spontaneously come to mind in Canada. I can’t even recall having heard of it, except sporadically in research at the Canadian Population Health Initiative<sup>3</sup>. Our

rural or remote populations are aging, they have to do long distances to get to a family physician and much longer ones to see a specialist. They enjoy poorer health with specific health vulnerabilities, have shorter life expectancy and higher infant mortality rates. Rural economies range from mixed to single-economy communities. The latter would depend solely on agriculture, forestry, fishing, hunting and trapping, oil and gas, mining or tourism. But this is never discussed on public platforms even at electoral times.

I assume that most Australians, although enjoying a privileged link to the awesome natural environment which is theirs, see themselves as urban people and never think of, and probably don't even truly know, rural and remote Australia. The question for you then is not how to get on the national agenda—you managed it with success for a decade—but to get what you need out of the current national health reform agenda. You don't want a generic set of reform proposals for the whole country, rural and isolated areas lumped together with everyone else. No. It is about much more than being part of the package; it is about being recognized as having distinct needs calling for innovative and tailored solutions, timetables and budgets. It is about promoting holistic traditional approaches for indigenous health. There are no simple, interchangeable, recipes, but there is an accumulated knowledge about how changes occur in society. Let me share with you some of these observations.

## The problems and the objectives

The invitation to this Conference is straightforward about its objectives: *to put our issues clearly before the public and the decision makers.*

If we go back to the core value—itself a fundamental objective—of the National Rural Health Alliance *All Australians should have equitable access to appropriate health services, regardless of where they live. The diverse communities of rural and remote Australia should be healthy and health-promoting places in which to live and work,* we will of necessity address differences in health status.

Above all, the biggest challenge for Australians regarding health status and well-being is that of their indigenous populations. In Australia, as in Canada, the lack of health equity unfortunately applies in a dramatic way to Aboriginals. Simply relying on the crude indicator of life expectancy at birth, the Aboriginal populations of Australia live 17 years less than the rest of Australians (2007), a much greater gap than for Canadian Aboriginals, who live between 6 years less for Status Indians and 12 years less for Inuits (2001).

On many indicators of health conditions—circulatory system, diabetes, communicable diseases, renal failure, cot death, mental health, cataracts, respiratory, etc.—indigenous populations of Australia score between at least twice to four times and more cases as for the rest of Australians. Their inequality in life expectancy results from:

- poverty
- insufficient education
- substance abuse
- for remote communities, poor access to health services
- for urbanised Indigenous Australians, cultural pressures which prevent access to health services
- cultural differences resulting in poor communication between Indigenous Australians and health workers.

Unfortunately, the same list of indicators and of causes would apply to Canadian indigenous people. Finally, Australia is guilty of “the Stolen Generations” as we are in Canada for the “Residential Schools”, leaving scars still being battled by the victims, their families and the community.

The work of the recent WHO Commission on which Fran Baum and myself sat confirms the role of these factors and shows how lesser education, high unemployment, social exclusion, lack of or difficulties of accessing appropriate health services, isolation, bad stress, and many more factors play negatively on both individual and collective health, both between countries and within countries. Within such way of thinking about the problem, the health care system (doctors and hospitals) is only one factor affecting your health. We absolutely need these services, but alone they are far from being enough. The other causes of poorer health have also to be addressed by different Ministries at the various levels of government.

Two more points come out of the report of our Commission: health status is a matter of social class and it shows from top to bottom of society, and the gap between the top 20% wealthiest and the bottom 20% poorest is both shocking and widening.

More and more we now have ample evidence to demonstrate the differences in health status not only for the vulnerable sub-groups of the population, but within each society, we know that health status is also graded according to social classes.

No country can discuss health inequality without addressing health inequity. Inequality in society, as well as health inequality, refers to an observable, often measurable, difference in (health) status between individuals or between groups, whatever its cause. On the other hand, inequity (of health or otherwise) is a moral category rooted in values, social stratification, embedded in political reality and the power relations.

This is what we should be aiming for. But let us not kid ourselves: significantly reducing health disparities would require profound structural changes, including income redistribution, in most of our contemporary societies. The question then becomes: how much do Australians, how much does Australia, value an egalitarian society?

## Communicating the message

Let me insist as a first point, almost trivial but critical, on how you communicate your issues to the various levels of government, especially to Canberra. I recall Cabinet discussions on this or that when one Minister elected and living in, not the far north, but just the northern part of Ontario or British Columbia, or any other province, would repeatedly make the point that we were forgetting the ways of life in that part of Canada. He or she would add that the decision about to be made would be a disaster, etc., for them and their communities. We, the rest of Cabinet, did not understand what exactly was at stake, although most of us had travelled the country at least a few times. But just passing by does not tell about ways of life. So that colleague became a bit of a bore and we made at times some stupid decisions. My conclusion: you will never be blunt enough and passionate enough in your messages to get across the sound barrier. Not just blunt but expressing what you want both on good evidence and in a way that speaks to the imagination to all those of us—civil servants, politicians and the general population who lack the imagining of your ways of life. The importance of human stories is also proven.

What would mobilize Australian public opinion best? You have two concepts to play with so to speak: the social classes one or the gap between top and bottom. The question is as I just stated it: how much do Australians, how much does Australia, value an egalitarian society? The first notion refers to the gradients in health status, how each 20% of the population, from top to bottom, enjoys an optimum health status with a longer life expectancy, or a much less good one with often 10 years less of life expectancy

depending on where they fit on the social ladder. The other concept which can mobilize public opinion is that of the gap between the top 20% to the bottom one, usually a very shocking state of affairs.

Keeping the situation of indigenous people in mind as the single most dramatic and urgent reform to achieve for both your country and mine, it seems to me, on the other hand—and I know this may appear paradoxical— that the rural health constituencies of Australia want to move from the plural to the singular, from a coalition of places and stakeholders to an integrated approach of “the” rural health community of Australia. I know that local needs differ to an extent, but the core problem is the same: being forgotten, lacking health professionals human resources, not even receiving the 30% of health and related budgets corresponding to your 30% of the national population. For example, I noticed that the report, *Health and community services labour force 2006*, states that Australia’s health workforce increased on the whole by 23 per cent between 2001 and 2006—but that the remote health workforce decreased by 346 workers per 100,000 people. Nation-wide, in 2006 there were 2,649 health workers for every 100,000 people, compared with only 1,379 per 100,000 in very remote areas.

I mentioned as a positive element the fact that rural health represented 30% of Australians and referred to 30% as a critical mass. That concept comes from the physical sciences and is now used in social sciences. One way of looking at it, coming from feminist research of women’s importance in Nordic parliaments<sup>4</sup>, is that when the individuals belonging to any regrouping or institutions reach the magic number of being 30% or more of the place, they are in a relationship of power and they can change things. To the contrary, those who are just a few, or less than 30% from the numerically dominant group, are considered tokens. They don’t count really. It could be viewed as follows: moving from a small minority to as large minority, which has the power of changing substantially the group dynamics.

Rural health as one single powerful sociological entity should be “in the face” of Australian public opinion. Although in practice needs will probably be treated in and by silos, one by one, based on their nature as seen by bureaucratic structures, at the political level, you have to be perceived as one important single issue: Australia’s rural health.

## How does social change occur?

This takes me to the title of this presentation “Do I see a demand?”... It refers to a lesson in Politics 101 that I learned in Cabinet in 1978 when I first presented the case to create the Child Tax Credit<sup>5</sup>— a reform particularly dear to my heart. (At the time existed only a relatively small universal monthly family allowance paid to all mothers for each child below 18 years of age. We wanted to add a legislation targeted at reducing children’s poverty by an annual important payment to mothers for each child of families below a “decent” poverty line, including working poor families, to be sent by mail through a very simple income tax delivery mechanism—no question asked!) Still a relatively new Minister, I knew my dossier inside out and presented it, I thought, brilliantly. Suffice it to say, in respect of Cabinet confidentiality, that when the discussion was over, a most senior Minister turned to the Prime Minister and simply said: “*Do I See a Demand?...*” Not another word was said, but the proposal died there immediately. What a catch 22 situation, for Cabinet documents cannot be discussed outside! (By the way, changed circumstances gave me another opportunity later that year to present and to see the proposal approved.)

In following years, I always made sure that what was needed for the common good and supported by the population across the land locally, but silently, was seen as beneficial by decision-makers at the top, either for their own re-election or for that of the government as a whole. In the case of finally winning Cabinet approval for the *Canada Heal Act (1984)*— a Bill banning all extra-billing, charges and user fees to patients—this meant exposing the public support as “in the raw” as possible.

On April 9, 1984, after four and a half years of very public discussions, negotiations, disagreements between Ottawa and the provinces; active hostility and the most aggressive and dishonest media campaign from organized medicine; as well as heated debates and opposition in the House of Commons, the *Canada Health Act (CHA)*<sup>6</sup> was unanimously adopted on third reading by all parties. The Act became law on April 17, and was first applied in July of the same year.

The only pressure groups in existence were rich and powerful—and opposed the legislation. There was no association of patients or former patients, survivors networks did not exist yet, and our consumers associations lacked resources. We needed to counterbalance the system of interest groups, hence these community public forums.

Social change usually occurs both from the bottom up and from the top down, in that the demand must come from groups and constituencies, be perceived by all, and then, find a champion from the top.

This brings us to a discussion of advocacy. I found the following an exemplary way of describing what needs to be done:

The essence of (public health) advocacy is spreading the word—spreading the word to members of one's community about ways to protect and promote health, and spreading the word to decision-makers about health policies that need to be enacted. (...) Health problems force us to quickly understand that our health is both personal and political.<sup>7</sup>

Continuity of action is the one key ingredient of advocacy. I regularly refuse to sign petitions, even letters-to-politicians campaigns. In itself these techniques are of not much use. Such approaches are taken by politicians as bad storms to weather through, and forgotten the day after when things get back to normal. But not if there is perseverance and continuity of action.

Other conditions for success lay within the government and you want to make sure these are in place. This applies to all levels of government involved in health care. You want to see:

- Continuity of committed leadership in the Department of Health: the classical turnover after 1.5 or 2 years of Ministers and Deputy Ministers changing to other portfolios cannot go on.
- Strong support signals from the top: the Prime Minister; the Premier. As we said in our international Commission, the Prime Minister, the Premier, must agree to become the champion of that not insignificant policy and political cause.
- Development of an intersectoral or whole-of-government approach and mechanism.
- Adoption of a social determinants of health focus instead of health promotion focus.

This last point is important and not always obvious, because many of you do health promotion and prevention within a broad understanding of upstream causes of bad health including societal factors. However, the temptation is always great in any government to address the individual life-styles when implementing health promotion, forgetting the socio-economic dimension of many impediments to optimum health. Focussing on negative individual life-styles themselves, perceived as easier targets with good mid-term results, also lead to blame-the-victim approaches when it is society structures that should be challenged.

Let me borrow the words of Dr. Margaret Chan, the Direct General of WHO, at the launch of our report: "Addressing the "causes of the causes" is arguably the most efficient form of prevention".

To conclude in keeping with the theme of advocacy and social change, I would like to ask you if you have considered broadening your National Rural Health Alliance to include natural and possible allies in the

Australian society completely outside, so to speak, of your concerns and preoccupations in order to aim for a vast rainbow coalition.

You are the natural allies, those here today—public health professionals, primary care workers, family medicine, nurses, health policy professionals, community representatives, volunteers—all of you present here. Most if not all of you have a direct connection with the rural health of this vast country. You remain however within the health sector broadly defined, and that is great. But is it enough? More and new players from rural and isolated Australia could probably be reached out and invited to join: farmers associations, vets, are the first coming to mind. And what about the national scene? All those involved in social and other types of community services are also concerned by what they see as workers on the front line. They should be involved as well, in the same way that NGOs fighting poverty and pushing for more simple justice are. Teachers would be great supporters. We can think of others who would join, including businesses and corporations. The challenge here is to be innovative in developing linkages and networks of groups who never see one another, who are like individual planets. Two more constituencies can, in turn, play an important role: that of women and that of seniors.

## Conclusion

You find yourselves in the middle of the turmoil of federal health reforms and I understand that the government proposals will be released in June, a few weeks from today. The pace of social change being what it is, politicians being what they are, and politics being the art of the possible, you will win some but you will lose some. I assume you have determined what is non negotiable for Australia's rural health at this point in time, including the must for indigenous health in 2009. I wish you maximum success.

Let me remind you that, at the end of this Conference, your job will only be beginning anew. I would like to leave you with another quote from the same two authors of earlier on:

The essence of the work is social change. We've got to be in it for the long haul. Advocacy is not for the person who needs to see the world change drastically in 20 years. We are all part of a large continuum of change, and the work is evolutionary. It keeps changing. Our work is to set change in motion, and if we're doing our jobs right, then we've also set up a forum, a space, and a community to help nudge that change along after we're gone.<sup>8</sup>

## Presenter

A sociologist in applied social sciences research, **Monique Bégin** served as the Executive Secretary of the Royal Commission on the Status of Women in Canada (1967–1970) before becoming the first woman from Québec elected to the House of Commons (Liberal, 1972). Re-elected in 1974, 1979, 1980, she was appointed Parliamentary Secretary to the Minister of Foreign Affairs (1975–1976) by Prime Minister PE Trudeau. Sworn in as Minister of National Revenue (1976–1977), she was then twice appointed Minister of National Health and Welfare (1977–1984). Besides creating the Refundable Child Tax Credit (1978) (now Canada Child Tax Benefit), she remains best known for the *Canada Health Act (1984)*.



She left politics in September 1984. A university professor since, Monique Bégin was the first holder of the Joint Chair in Women's Studies at Ottawa and Carleton Universities. Dean of the Faculty of Health Sciences at University of Ottawa (1990–1997), she also co-chaired the Royal Commission on Learning of Ontario (1993–1994) and was a member of the International Independent Commission on Population and Quality of Life (1993–1996). A Visiting Professor with the Health Administration Program at the Telfer School of Management, University of Ottawa since 1998, she was appointed a member of the WHO Commission on Social Determinants of Health (2005–2008).

She is a Fellow of the Royal Society of Canada (1996) and has received 15 honorary doctorates in recognition of her contribution to human rights and to public policies. In 1998, she was invested as Officer of the Order of Canada.

## References

<sup>1</sup> Australia counts around 500,000 resident indigenous persons, about 2.4% of the total Australian population. The figures for Canada (First Nations, Inuits and Metis) are respectively 1.3 million persons corresponding to 4.4% of the Canadian population.

<sup>2</sup> Sartore GM, Kelly B, Stain HJ, "Drought and its effect on mental health--how GPs can help" in *Aust Fam Physician*. 2007 Dec;36(12):990-3

<sup>3</sup>Public Health Agency of Canada (PHAC) and the Centre for Rural and Northern Health Research (CRANHR) at Laurentian University. *Canada's Rural Communities: Understanding Rural Health and Its Determinants*, Canadian Population Health Initiative, 2006.

<sup>4</sup> Drude Dahlerup, "From a Small to a Large Minority: Women in Scandinavian Politics" in *Scandinavian Political Studies*, Vol. 11, No. 4, 1988, pp. 275-298.

<sup>5</sup> Now called Canada Child Tax Benefit and its National Child Benefit Supplement.

<sup>6</sup> A legislation deemed necessary to clarify the five program criteria mandated by the federal government as the basis for its transfer payments to the provinces towards hospitals and physicians services costs, and to ban institutional user fees and physicians' extra-billing which might have lead to a two-tiered health care system.

<sup>7</sup> Bylye Avery and Samiya Bashir, "The Road to Advocacy—Searching for the Rainbow", in *American Journal of Public Health*, August 2003, Vol 93, No. 8, p. 1207.

<sup>8</sup> Idem, p. 1210.