EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 14 OCTOBER 2009

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 9.45 am

DAUBE, PROFESSOR MIKE
Professor of Health Policy,
Public Health Advocacy Institute of Western Australia,
Curtin University of Technology,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiries into the review of Western Australia's current and future hospital and community healthcare services, and alcohol and illicit drugs. You have been provided with a copy of the committee's specific terms of reference. This committee is a committee of the Legislative Assembly and this hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As a public hearing, Hansard staff are here with us making a transcript of the proceedings for the public record. If you refer to any documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to questions, have you completed the "Details of Witness" form?

Prof. Daube: I have.

The CHAIRMAN: Do you understand the notes at the bottom about giving evidence to a parliamentary committee? Did you read and receive the information for witnesses briefing sheet provided with the witness form today?

Prof. Daube: Yes.

The CHAIRMAN: Do you have any questions in relation to today's hearing?

Prof. Daube: No.

The CHAIRMAN: We appreciate your coming today. If it is okay with you, we might hand the ball over to you and let committee members interject as we have questions for you.

Prof. Daube: That would be great. What I have done, if this is okay, is to prepare no more than 10 minutes' worth that I would like to speak to.

The CHAIRMAN: Without the interjections?

Prof. Daube: I am looking at Mr Watson; I do not think I will survive for ten minutes! I can just run through those comments, but obviously if there are interjections, I will be only to happy to deal with those. As preliminary comments, I would like to say that, first, it is a very real pleasure to be here. I am conscious of this committee's crucial role in the recent tobacco legislation. As you might be aware, the British Parliament followed your example just two days ago. There is good evidence that international precedents help people in those debates. I wanted to comment on that. Second, my focus today is primarily on the role of prevention in our health system. I will not be, in these comments, saying much about alcohol, but I would be very happy to deal with alcohol issues as well because I have a strong interest and involvement in those.

Ahead of my 10 minutes, just this morning I got an email from the Advertising Standards Bureau, which covers advertising of alcohol. I sent them a complaint about a television advertisement on Foxtel in which children in Carlsberg T-shirts are jumping up and down promoting soccer for about 30 seconds. I thought that was an inappropriate promotion. They have just written back saying that

is okay because it was an advertisement placed for soccer not for alcohol. It was okay to have children jumping up and down promoting Carlsberg on television! Maybe we can come to that later, but it makes the point that the system of control of alcohol advertising is broken.

It is probably coincidental that in today's *Crikey* there is a piece—which I did not write—that is headed "Health departments are not equipped for the new focus on prevention". It is quite an interesting discussion on the need for health departments to focus on prevention.

I will make my comments in segments. First, preliminary comments: I want to make the point here that much of this committee's work in discussion on the health system is based on the report of the Health Reform Committee, the Reid report, of which I was a member. All the focus and discussion tends to be on hospitals: Royal Perth, Fiona Stanley and so on—that is understandable—but the first focus of that report was on prevention and health promotion. It was the first of its priorities. The first substantive recommendation is that there be a proper focus on prevention and health promotion, and it is significantly there in other recommendations, including the focus on Indigenous health and mental health and so on. I want to observe that there is also a substantive chapter on prevention and on the importance of chronic disease prevention and so on, so it is important to focus on this area. I will be speaking about prevention. I will not focus specifically on Indigenous health, but I cannot emphasise how important that is, and disadvantage and so on, and that feeds into the areas I will be discussing.

I also want to emphasise that while I will argue for more focus here, Western Australia is not unique in putting insufficient focus on prevention. Our public health system stands up very well in interstate comparisons. We have strong public health leadership. We have here an Executive Director of Public Health who is on the health department executive. That is really important; it does not happen in most other states. We have highly respected groups in areas from environmental health to emergency and disaster prevention; we have a health promotion foundation. There is a lot that is good, and I not want to imply any criticism of them.

My final preliminary point is that we are in a context in which there is an increasing national focus on prevention, as you would be aware from various meetings you have been at. We have the Health Reform Committee and the report of the Preventative Health Taskforce, of which I was deputy chair. I am sure committee members have all read the whole report! It is the heaviest report that I have been associated with. There is also Council of Australian Governments funding, and a lot of emphasis on prevention. The report of the Preventative Health Taskforce did emphasise specific and various roles for the states. The publicity has tended to be about what the commonwealth should do, but there were also recommendations and strategies specifically for the states. I think the impetus is there.

Next are some comments on prevention and funding. By international standards we are a healthy and long-lived community. We also know that so much more can be achieved and how it can be done. The Reid report notes that 50 per cent of cancers, 75 per cent of cardiovascular disease and 90 per cent of type 2 diabetes can be prevented, and there is much more that is preventable in other areas too. The rhetoric is always there. And to be fair to the federal government, now with COAG funding and other areas there is action occurring, though it is still not clear how some of that will happen. The bottom line is still that so much is preventable: the rising tide for chronic disease and so on, but all prevention and public health services still hover around two per cent of the health spend. The Prime Minister described that as crazy, and even in his recent consultations he keeps emphasising that two per cent is not enough. In relation to prevention, the Minister for Health and Ageing, Nicola Roxon, put it even more succinctly when she was asked a question at the launch of our Preventative Health Taskforce report. She said, "By not acting, we are killing people". That was an important way of emphasising prevention. The two per cent is still very generous; it includes mostly services like immunisation and screening, and the definition even includes treatment in areas like alcohol and drug services. So two per cent is a generous definition. We need a different kind of

thinking and funding. I want to emphasise here that it is not that WA is worse than the other states; they all hover around that two per cent mark.

I have not had the chance to look at the most recently tabled Department of Health annual report, which was tabled yesterday; I could not get it online. However, it is pretty much impossible to identify from state reports exactly how much is being spent on prevention and public health, where and when. Budget papers and annual reports all give information in a form that makes it impossible to ascertain just what possible health activities are going on in various areas. I will come back to that. We need a full, accurate report on public health spending for the state.

I then want to move to health system issues. Our record in this state in public health is very, very good. The first legislation on public health was in 1842, when we had legislation to prevent the killing of animals within a town locality, and we have actually had a terrific record. We had a wonderful public health department. The great Jim McNulty, as you may remember, was commissioner of public health, and our longevity is as good as you can find pretty much anywhere around the world, in large part because of that public health basis. We tend to take a strong public health system for granted. For years we were recognised as having the best public health and health promotion systems in the country. But I think there are things that we now need to look at. We need to look at funding and organisational priorities. I looked, for example, at the Department of Health's health performance reports online last night, and I could not see anything about prevention there. That indicates to me that there is not the level of priority there should be. I have a real concern that in some of these areas we are running very, very thin. We have terrific people, but they are a bit like air traffic controllers. If the air traffic controller drops, then we are in trouble, and I think the same thing is likely to occur in our prevention and protection areas. For that reason, it is vital in relation to cuts and savings and so on that all public health gets quarantined as a front-line service, because in my view keeping people alive for 30 years is as important as keeping them alive for three weeks. Prevention is a front-line service and should be treated as such. There should be a commitment that all prevention services will be quarantined. There is a bit of a worry administratively. Prevention services tend to be seen as "Royal Street", and Royal Street comprises administrators. Royal Street is also a place of delivery of absolutely vital front-line services.

I then want to get on to specific proposals. The first proposal is in relation to funding. We need a system that provides transparency in relation to funding; and, second, we need to have a target and work towards it for increasing that two per cent. If that two per cent is real—I think it is slightly exaggerated, not through the fault of people here but because of the way it is put together—we should look at targeting an increase to three per cent within two years. There should be a significant targeting there; not taking money away from other areas in health, but there should be a targeting. Second, in reporting I would like to see a discrete annual report on public health. When there was a public health department the commissioner would produce an annual report. In the great days, in the heyday of public health, medical officers would produce an annual report on the state of the public health, and I would like to see that again for public health, central and regional. Then there are some system issues. I not want to go too deeply into departmental structure, but I would like to see even greater strength for the public health division. I would like to see the maximum possible inclusion of public health services within the public health division, because history tells us that that is when public health is at its strongest. And I would like a more concentrated focus in some areas. Screening, for example, is covered by lots of different parts of the department. You will find that breast, cervical cancer, newborn screening and so on are all in different parts of the department. Those could be brought together in a centre for screening. In public health information, we have great epidemiologists; we have been world leaders. That area may not sound glamorous, but we could usefully bring together something like a public health intelligence group, or something on the basis that they have in Europe or UK of public health observatories that bring together epidemiology, data linkage and so on. We are good in some areas, less strong in others. We used to have strength in injury prevention and violence prevention and so on; not any more. That is an area

that could be bumped up. We have good services in youth and adolescent health. Victoria and other states have a centre for youth and adolescent health. There is mental health promotion. There are other areas in which I think we could raise our game. I would like to see a whole-of-system focus on prevention. We tend to see lip-service on prevention from hospitals, but essentially hospitals are still places where you go to be sick, and may be not to emerge from. There is great opportunity for hospitals to do much more by way of being involved in prevention. I can expand on that if you wish. I would like to see prevention as part of their accreditation process. I would like to see the integration of some public health services within the broader system. It is good in the Country Health Service. It is good in theory, but it is subject to all the usual resource limitations, so there is limited scope to grow, and prevention has to battle against other aspects of funding.

Mr P.B. WATSON: Should not prevention be a priority?

Prof. Daube: Yes, it absolutely should be. I have not focused significantly on the Indigenous health area, but it constantly needs a strong public health focus and application of public health approaches: environmental health, tobacco, nutrition, alcohol, immunisation—immunisation rates among Indigenous people are lower than among non-Indigenous people—and so on and so forth.

The final points are whole-of-government and whole-of-system issues. There is enormous opportunity for prevention, not just within the health portfolio—for good or for bad—but also in education, planning, transport, Indigenous health, local government and sport and recreation, agriculture, training and so on. Why do we still pour money into sports that take in squillions in funding and promote alcohol and junk foods? It would be important to look at what other agencies can contribute. The South Australian government has been looking at a "health in all policies" approach. There have been proposals here for health impact assessments. We have regulatory impact, so why not health impact assessments? Whole-of-government has great potential. There is also a role that we can continue to play nationally. Both the present Minister for Health and present Minister for Mental Health have been very strong in supporting action. WA's record is really good in supporting national action. Folate came in because the then minister, Jim McGinty, felt this was something that he could push nationally. We can play a role and there are areas where we can act by supporting the national prevention agency on food labelling or traffic lights labelling, alcohol advertising controls and so on.

There are some specifics then that I pretty much want to wind up on. The Preventative Health Taskforce set out a blueprint for action, a strategy, and I would like to see this state reporting back on a regular basis on the action that we are taking in response to the recommendations to states in the prevention task force report. The focus tends to be on what the federal government should do, and that is great, but the report very specifically focusses on states. We cannot just leave it all to the feds.

Mr P. ABETZ: Is that the federal report about WA or was it compiled by WA?

Prof. Daube: "Australia: The Healthiest Country by 2020" is the report of the National Preventative Health Taskforce, so it is a national report; and that is the overview. That is the full major report, and then there are three specific technical papers, or reports, on obesity, alcohol and tobacco. The report sets out various areas with responsibility in each of the key areas of tobacco, alcohol obesity and infrastructure, with recommendations not just for the federal government but also state governments, local governments, communities and so on. I would like to see a report back on what this state is doing.

In some of the specific areas, very quickly: tobacco, you have done brilliantly. I think there is still more the government could do—funding. One of the areas in which I would like to see WA take the lead in is litigation. Why is nobody yet suing tobacco companies for the costs that their products incur for the state health system? Some Canadian provinces are doing it. That is something in which there could be considerable scope. There has been very successful litigation in the US, which has reaped billions of dollars in revenue for the states. I think litigation is something in which we can

take a lead. With obesity, we can take a lead providing adequate funding and strong promotion, and with alcohol, which is a major part of the committee's other inquiries, we can do more by way of funding. We can do much more by way of broad policies. We can come to that. I also have a strong view that one of the primary purposes of the liquor licensing control legislation, which looks to the proper development of the industry, is something that in retrospect was a mistake and could be damaging.

In summary, prevention and health promotion was top of the Reid list. They need to stay on top of our action list. We need strong and transparent information. We need more than two per cent funding for prevention, and I would like to see a three per cent target. We need organisational priority and a strong health promotion division. We need to see prevention within the whole of system and for whole of government. The Preventative Health Taskforce blueprint is there. That is something that I think governments could follow and relatively small amounts of funding overall could reap tremendous rewards by way of keeping more people alive for longer, and more disadvantaged people alive for longer.

Mr P. ABETZ: And keep them out of hospital.

Prof. Daube: Absolutely—well, keep them out of hospital for a while. In fairness, we have to say that ultimately a lot of people will end up in hospital, but they can certainly ease the burden of chronic disease; very much so.

Mr P.B. WATSON: I was very quiet there. I only said a couple of words. I got blown away when we were in Tasmania. We had a breakfast meeting with Peter Kennedy and I mentioned the professional CEOs at the private hospitals. He was saying that it will never work, because doctors will not work with them. This is a culture of a doctor saying others would make it too hard for them. How will we ever have a successful health system when the doctors think they know more? They might know more about their patients but not about running the hospital system? We will never ever overcome it when we have that sort of attitude. I hope you are not a doctor.

Prof. Daube: I plead not guilty.

Mr P.B. WATSON: We have to change the whole culture. From what we have been listening to as we go along, the doctors are saying that they do not want someone coming in and telling them what to do. They are saying, "I am a doctor. I know how to look after my patient." I was trying to say to him that he has to look at the overall picture. We have to have someone who comes from outside with different ideas. He said, "No, we won't work with them." As long as we have that culture, we will have the same problems in the hospital system. What is your view on that?

[10.05 am]

Prof. Daube: The reality of the system is that doctors are enormously powerful. When I was in the chair at health, I had my disagreements with them, particularly when EBAs were on the horizon. But I think we can also recognise that they have a really important role to play in making things happen. In this one, particularly in relation to prevention, we are not going to win a war. I think there is a lot of scope to work with them. Prevention is an example—the AMA has been fantastic on prevention; just fantastic. We would not have the measures we want, a lot of them, if the AMA had not been often leading the charge. They have been absolutely and consistently supportive. I think it lies in trying to harness them—trying to work with them as much as possible—recognising, though, that there are always going to be people who are protecting their own patches and so on.

Mr P.B. WATSON: I realise that.

Prof. Daube: But I think, Peter, the answer, given the role that doctors have, the respect they are held in by the community and so on, is that we need to try to work with them as much as possible. The AMA's policies which, again, focus on prevention at a national as well as a state level, are terrific. They are textbook stuff. It is the same with the BMA, and although it is a bit less with the AMA in the United States those issues are still there. I think we need to work with them, harness

them. As far as broader system issues are concerned, hospital administration and so on, I think you are always going to get those tensions. That is often a matter of getting good hospital administration as well.

If I go back years to when I was a hospital CEO, when I became the CEO of Princess Margaret Hospital, the administration and the clinicians had daggers drawn. It was pretty close to open warfare. I found that by working with the clinical association—the chair then was Phil King, who died a few years ago, sadly—the clinicians were actually willing to come on board. I think the adversarial approach probably will not get us anywhere.

Mr P. ABETZ: What do you see as the biggest hole in the preventive smorgasbord of things that is happening? Where is the big gap that you see in the health system's focus on prevention? There is not enough of it everywhere, but are there any sort of huge chunks where we are missing out altogether or not?

Prof. Daube: The most obvious area of failure is Indigenous health. I do not have miracle answers. I see that as the most obvious area of failure. Although it is interesting, when we talk about these areas that I have been involved in, if we just brought Indigenous smoking back to the same levels as smoking in the rest of the community, the life expectancy gap would drop by four years. That is just bringing it back to the same level as the rest of the community. There is huge potential there.

In terms of what the system can do, Peter, getting away from specifics, I would pick three broad areas. The first is having that strong, prominent public health division that is as close to independent as you can make it. I am not advocating breaking up the department, but during the days when Jim McNulty was an independent commissioner of public health, ran his own show and reported directly to the minister, he could take on some of those interests and issues. Those were the days when public health as such was probably at its strongest in this state. I think having that strong, as close to independent public health group as you can get is key. We have an outstanding executive director of public health at the moment in Tarun Weeramanthri. We have learned the lesson when WA tried to scrap the public health division, which was a mistake, and they came back from that. That is one.

The second: there are blunt issues about funding. If public health—which keeps our food safe and our environment safe as well as promotes health—is not regarded as a front-line service and is on wafer-thin funding, I think we have got some real problems. I have to also say that in the areas where we could save most lives, we really put peanuts in. That is a tragedy because people who could be alive are not.

The CHAIRMAN: Mike, I might come in now. You have suggested the strategies for the states. That is something that the committee would be interested in, not just for this report but also as a result of the other commonwealth reports that have come out. If we were to start looking at those strategies and how those strategies could be adopted in WA, you mentioned a public health intelligence group. We are one committee, but would we tap into you as we look at those strategies? When you talk about the public health intelligence group, are there universities that have the data? As a committee we have been very busy with hearings and things over the last few months, so once the committee has had a chance to sit down—we have not, since that has been tabled—we are going to catch up on that. Who would you see as the key players in a public health intelligence group? I know you have said "adopt all recommendations", but once the committee has had a look at each of those recommendations, who would the players be for that public health intelligence group? Who would the players be other than the health department? As you said, in the past they had that presentation of public health. Does D'Arcy Holman? Does Michael Hobbs? Who has preventive health data from research? Is it Fiona Stanley? The first question is about the public health intelligence group, and the second is about what key players are out there, other than the health department, with their reports that we could look at what information they have assimilated?

Prof. Daube: First, in relation to the recommendations specifically to states from these reports, I can get you a breakdown of those, if that would help. We can do that through the secretariat. I can get you a breakdown.

The CHAIRMAN: We will ask for that information from you by way of supplementary information. We ask for a breakdown for the states in relation to preventive health care and future strategies to be adopted.

[*Supplementary Information No 1*.]

Prof. Daube: I will ask the task force secretariat to do that, because I think it will be useful for other states as well. They can read it bit by bit. That would be really helpful. Thank you for that.

In relation to public health intelligence, which I hope is a tautology, I am suggesting that there should be a public health intelligence group or a public health observatory established within the health department that brings together some of these key areas. One of the problems is that in these hard times people tend to look at data collection and so on as being really not terribly important. You mentioned D'Arcy Holman. There was a time when D'Arcy Holman was director of epidemiology in the health department, producing wonderful information that was good not just for public health, but for planning and various other purposes. We have some really good epidemiology people in the department, but I would like to see that lifted. I would like to see a WA public health observatory that brings all those groups together. However, in the meantime: where is the data? Two answers—one is that it is all over the place.

The CHAIRMAN: Before you go onto the data—you have said "bring the groups together from the health department". Which groups? The committee does not know the health department's structure. You probably know more about that. We do have an organisational chart. We could give you the organisational chart. If we wanted to sit at a round table with those people and say, "We've looked at these strategies. What do you think about these strategies? What are you doing about these strategies?", who would the key players be?

Prof. Daube: Without getting too deep into the bowels of the department, I can certainly get you a note of who I think the key groups would be in the epidemiology and planning areas. What I more so think is that we need a higher focus in that area. In terms of where data is, it is everywhere. There are all kinds of people. You mentioned D'Arcy. I think he has presented to you.

The CHAIRMAN: Yes.

Prof. Daube: The first law of public health in this state is that D'Arcy Holman is always right! There are people like D'Arcy, Fiona, me and others who have a lot of that information. But I think what we need, and what I would think that you need in order to be able to make appropriate decisions and recommendations, is information of the kind I have mentioned from the department that is currently lacking—exactly where the money is being spent and how it is being spent. That does not just apply centrally. It applies within the regions, too. You need that so that you know, within your area, how much is actually going into prevention as opposed to how much is going into other services. We probably need to seek the support of the minister and the department in getting you that information in response to some fairly specific questions. That will be hard. That is why I am saying that I think we need a discrete annual report on public health because otherwise it is all mixed in the department's annual report. I am not really giving you a satisfactory answer because I do not think a lot of the information is very readily available. I think it will take quite a lot of work.

Mr P.B. WATSON: We went to a conference in Melbourne. People got up and talked about all these stats and everything like that. I happened to say, "Is there any in regional areas?" They said, "Oh no, it's just the city." These people are getting all this money. They live on the projects they get, but they do a specific area. If they are looking at the overall health system, surely we should be looking at regional and city areas. People come from the regional areas to the city and they go back to the regional areas, so we are missing out on these people. A young girl in Melbourne, who was a

victim, got up at the conference and said, "What you people out there who get paid to do your little projects should be doing is looking at what is best for us street people. You should be doing that rather than making sure you've got money for your projects to get you through the next 12 months." Do you think we are too much "data-ised" and not enough hands-on?

Prof. Daube: I think the answer is probably that we need a better approach to data. We need good data. I have the AIHW report on public health expenditure in Australia. It is done really well; it is the best you can get. The substantive report comprises 13 pages. It does not give you any of the breakdowns that you would want. We need more useful data. There is a problem—a lot of it is research project driven and so on. We are not putting enough into hands-on activity. We need to have prevention activity centrally but we also need good, local preventive services. Yet again, those are the areas that tend to get treated as not being front line.

Mr P.B. WATSON: Do you think sport and rec should be up there? As I have said many times in here and when we have been away, we do not teach kids in our schools, young girls especially, that if they want to lose weight, they can exercise. They do not know that. They go to school and think, "I want to look like that girl on the TV so I'll starve myself." Why are we not out there saying, "If you go for a walk in the morning or do a bit of exercise and cut down a bit on your food, you can be a really healthy person and look like what you want to be"? We do not. So what do they do? They starve themselves, get bulimia or they commit suicide and all these sorts of things. It is such a simple thing to do. We do not have sport in the schools anymore. There are computer classes and all this sort of stuff. That is great. I remember when I was a kid, we used to have probably half an hour to an hour each day of physical activity. You just do not get it anymore.

Prof. Daube: I will ride a hobbyhorse for 30 seconds, if I may!

Mr P.B. WATSON: Sure. I just did!

Prof. Daube: The new education curriculum nationally is being rolled out. The top issues are numeracy and literacy and so on, that is fine. They are the first category. The second category has various things in it. Some months ago, maybe a year ago, the minister for the arts proudly announced that the arts would be on the second tier of priorities. The arts are great. I was listening to Classic FM this morning. I love it.

Mr P.B. WATSON: You have got an opera tie on!

Prof. Daube: Yes. But health and physical education is not in that second tier. I think that is appalling.

Mr P.B. WATSON: I asked Nicola Roxon the question in Hobart. She said that she has now brought sport and rec into her portfolio. That is all right—it is in her portfolio—but she never said anything about putting more money into that part of it. It is just, "We have these strategies." It is very simple what to do.

Prof. Daube: What tends to happen in sport and recreation—that is not criticising the individuals concerned; it is just the way the funding goes—is that there is a lot of focus on high-profile sport, high-performance sport and so on. There is far too little on getting the community engaged in sport. Even community sport may be seen as the local footy team. That is not getting kids active. Given, too, the colossal increase in obesity, we are a really fat country and we are getting fatter. The evidence is that that is on the increase in kids.

Mr P.B. WATSON: I see it when I go to school assemblies, every year the kids are getting bigger and bigger. It is frightening.

Prof. Daube: We need to do more, eat less. The messages actually are not all that hard. There are lots of complex messages around it, but doing more and eating less is not all that complex a message.

Mr P.B. WATSON: It is society, too, because both parents work. They come home, they buy fast food and things like that. I realise that. But if we do not put a system in, what is it going to be like in 20 years? Obese kids become obese parents and role models for grandchildren, who then think it is okay to be obese. We have this terrible cycle and we do not know where it is going to end up.

The CHAIRMAN: WA now, as part of the education revolution, has put so much education back into the curriculum. I cannot remember the exact amount. But I know that came out recently.

Prof. Daube: Our schools are making an effort here and they are doing good things through school canteens and whatever else. I think the point that Peter is making—this is what we tried to do in the prevention task force report on obesity—is that this has to be raised. The priority of this has to be raised. At the moment it is this, this and this, and a bit of physical activity and a bit of information for kids. It has got to be raised as a priority.

Mr P. ABETZ: The term "public health" includes the safety of food inspection and that sort of thing, but does it include preventive programs? It is all termed under "public health", is it?

Prof. Daube: Yes. "Public health" you could categorise as "health protection"—that will be food safety and various other forms of health protection. Years ago, what is now the Environmental Protection Authority used to be in "public health". So there is "health protection", there is "health promotion" and there are other categories, too—for example, how you include data; those areas. "Health information", if you like, can be in there, as well as huge aspects of Indigenous health.

The CHAIRMAN: Can we move to alcohol? You mentioned how possibly as a Parliament we have created a rod for our own backs through the changes made to legislation in 2004 and 2005. Not all members of this committee were members then, so would you perhaps elaborate on that. Are you aware of what is happening in New Zealand? I have my office chasing that up for me right now, but I know that New Zealand is introducing changes because of the alcohol problem they have. If you are aware of what is happening there, maybe you could also give us a brief summary of what they are doing.

Prof. Daube: I am trying to avoid saying that I am not full bottle on New Zealand alcohol!

Mr P.B. WATSON: A case in point!

Prof. Daube: The issues in relation to alcohol—firstly, I make a sort of disclaimer. I chair the board of the Alcohol and Drug Authority, or the Drug and Alcohol Office, but I am not speaking on behalf of those bodies. The evidence on alcohol tells us that price is important and tells us that other things like access are tremendously important. I also have to put in a disclaimer—because I get tired of people saying that alcohol is different from tobacco. We know that. People use alcohol and the aim is not to get rid of all alcohol use and so on, but it is a colossal burden on our community. It is not just a health issue. It is a police issue. Linking it back to tobacco, there is passive alcohol —

Mr P. ABETZ: The collateral damage.

Prof. Daube: That is right. It is just a colossal problem. There are very powerful interests promoting the product. When I looked through the register of lobbyists that you have, I was intrigued to see just how many alcohol lobbyists there are. That is quite apart from the companies. There are very powerful interests there.

The intent of the legislation, which was introduced when Mark McGowan was the responsible minister, was good. It was to get away from Dullsville. It was to beef things up and so on. There were some really good things in it. Previously there were two purposes to the legislation: one was making things run sensibly; the second was—I have not got the phrasing—protecting health, welfare and whatever else. There was a third primary object that went in the new legislation, which included essentially supporting the proper development of the liquor and tourism industries and so on. When you are looking at liquor licensing and liquor licences, if there are those three objects, and they have to be given equal importance, you have a problem. I think that is what we are seeing.

What we have seen through the liquor licensing process is a real concern that that is working its way to undermine some of the public health and other considerations that should be predominant. Essentially what I am suggesting is that that third object should no longer be a primary object. It should go back to being a secondary object.

The CHAIRMAN: Or should it be an object at all?

Prof. Daube: So long as the top two, health and welfare of the community, are above everything else, that is less important. But at the moment it really is inappropriate that the proper development of the liquor and tourism industries are just as important as they are to the wellbeing of the community.

Mr P. ABETZ: Even more. The community is more important than the liquor industry.

Prof. Daube: That is causing major concern to various groups, including various Indigenous communities and people with whom I meet. If you look at what you as a committee can do, just that change I think would make a deal of difference in protecting communities from the inappropriate use of alcohol. Having said that, there are some other things that we can do as a state. We need to see proper enforcement of liquor licensing controls. As I have said, there are various other things, but I will not bore you with those.

[10.30 am]

Mr P. ABETZ: On that particular front, is it Steve Allsop who has done a lot of research in that area?

Prof. Daube: Yes.

Mr P. ABETZ: It would be good for us to get some info on that at some stage.

The CHAIRMAN: We are primarily trying to complete our hospital and health services review, and then we will move on in greater detail to alcohol and illicit drugs. It might be that we invite Steve next year rather than this year, otherwise when we get around to putting it all together we might have lost some things. We might get you back, Professor Daube; we do not know yet.

Prof. Daube: If it would help, through the Public Health Advocacy Institute working with the Public Health Association and various other groups—the Australian Health Promotion Association and others—some while ago we convened a group of about 150 leaders and experts in the area to ask them about their priorities in alcohol, both at a national level and a state level. That was in WA. We had a meeting in Fremantle, and we tried to distil those down into what the experts saw as the priorities for action within Western Australia. We could happily send the committee that, because that might save a bit. You will treat it as you see fit.

The CHAIRMAN: That will be wonderful. By way of supplementary information you will provide us with a summary of the recommendations from the workshop that was held in Fremantle by public health experts looking at the issue of alcohol.

[*Supplementary Information No 2.*]

Prof. Daube: There were two workshops. We also had a workshop of a similar nature on obesity, and that will relate.

The CHAIRMAN: Yes, we will have that too by supplementary information. Professor Daube will provide us with the summary of the workshop that was held on obesity issues.

[*Supplementary Information No 3.*]

Mr P.B. WATSON: Do you want this report back?

Prof. Daube: I think they are my only copies, but if I have a spare set I can ferry them across to you.

The CHAIRMAN: Is there anything that we have not asked in our discussions that you want to flag? I think you have flagged a lot of things for us.

Prof. Daube: The committee has given me ample opportunity and I thank you for your tolerance and listening to me.

Mr P.B. WATSON: It was very informative, Mike.

The CHAIRMAN: Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information on elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript.

Once again, thank you very much for coming. We particularly look forward to receiving information for the state strategies, because we are hoping to start pulling things together in the next month or so and it would be lovely to have that.

Hearing concluded at 10.35 am