PLENARY 1
SATURDAY 1 MARCH 2003
5.00 PM OPENING SESSION

Opening Ceremony

Featuring the Tasmanian Aboriginal Health Service, arts performers, incorporating video clips from 2001 Conference and community video

Nikki

ya pulingina. My name is Nikki and I’m from palawa people of Tassie. I am just going to say a few words before we start our performance. With the people that we have up here on stage this is just a part of our talent here in Tassie. We are here today to share with you our stories, our language, and our history and tradition, through celebration in song (and) dance of our people, our past and, importantly, the strength in our future as proud palawa people.

We are featuring traditional Cape Barren Island music with a young girl who plays the fiddle. Our Elders are sharing their stories and traditions. We have some dancers, Illakawara, dancing a song about the muttonbird, which is a really big cultural tradition that we still practise today. We have got our children sharing our language and our palawakani with our land. Our youth are inspiration for our people and the foundation of our voice for our people and our lives. Thank you.

(Music, song etc)

Auntie Eva

ya, I am Auntie Eva. I have twined this pile of rushes from the Tasmanian bush. This now becomes the centre of our Conference story mat. We invite you to visit the Arts Space while you are attending the Conference. Take some time during the Conference to sit, yarn and weave with other delegates. Bring along a piece of string to be included in the weaving, or come along and we will teach you to make some string. Our contributions of string and chord and twine will be woven alongside the Tassie bush-fibres: mat rush, native flax, spark brush and cumbungi.

As a token of the part a few play in promoting rural health with us all, I will be working in the Conference alongside Gwen Egg, and I invite you to come up Gwen please.

Gwen Egg

Thank you Auntie Eva. Hello, I am Gwen. I live at Carlton Beach, East of Hobart, and I weave with fibres collected from the bush. In the Arts Space we are going to use
country know-how to weave something of what you have to say into our story-mat representing the diverse experience of the people who are here.

Your contributions will be joined together by a continuous coil of buttonhole stitches. Maybe you know how to make a simple blanket stitch, a half hitch or a buttonhole stitch or maybe you will come and learn for the first time. It’s a very versatile invention. It may protect the edge of a blanket from fraying or it might just temporarily hold a rope. It is at the heart of the ingenious and elegant basket weaving of Indigenous technology in many parts of our continent.

Half hitches that may circumnavigate the buttonholes on your shirt are a treasured example of your great grandmother’s embroidery. During the Conference we are going to make a multitude of half hitches, circling our shared experience. Join us in the Arts Space anytime throughout the Conference.

At the last rural health Conference, delegates recorded their stories on postcards, the heart of the matter. We will pick up the threads and continue the story. Thank you.
Welcome to all participants

Shelagh Lowe, Convenor, Conference Organising Committee

I would like to thank the palawa people for their gracious welcome to us all and for enabling us to participate in their land. My name is Shelagh Lowe and I am currently the Deputy Chair of the National Rural Health Alliance and the Convenor of this Conference and I would like to welcome you all here.

It gives me immense pride and pleasure to welcome you to the 7th National Rural Health Conference and to Hobart in what has become my “home state” since I came here to work in 1983—just prior to the Ash Wednesday bush fires. I came originally to work for 12 months and was married off to a Tasmanian which what I believe is the ultimate retention strategy for rural health workforce.

There is something very unique about the rural and remote health workforce and the community in which they serve. A shared bond, a feeling of family and a passion about where they live... and it creates a special fabric for the life that we all enjoy. In the last few months this has been severely tested across our great country: by fire, by flood and by drought. And I notice over the last two or three days, those of you who have been here for a few days will have noticed that Tasmania has turned on most of that in heat and in snow and in rain.

To those of you who have never attended a rural health conference before, and to those of you have, I hope you make the most of the opportunities that you have here to create, renew and refresh your passion for what you do and for where you live. A varied and comprehensive program has been put together—to stimulate, to educate and to entertain you.

I would like to take the opportunity to thank the very professional Conference Organising Team and the Conference Organising Committee for the dedication and commitment they have put into making this the best Conference that you will ever have yet been to.

And I would now like to make the opportunity to introduce you to Nigel Stewart who is a paediatrician from Mount Gambier in South Australia and who is currently the Chair of the National Rural Health Alliance.
Welcoming address

Nigel Stewart, Chair, National Rural Health Alliance

My name is Nigel Stewart and I live in Port Augusta, South Australia. As I look around this room and realise that more people will gathered in this room than live in many of the small towns I service, it is all a bit overwhelming.

Firstly I would wish to acknowledge the local Indigenous people who are the original inhabitants of this land. I thank them for making us feel welcome.

Secondly I wish to acknowledge not just the important dignitaries who are here, who I will come to in a moment, but those of you who are the heart and soul of rural health in Australia who have made the effort to be here. I also acknowledge those who for many reasons are not able to be here. Looking around the room I see Indigenous health workers. Their load is great and their importance to their communities is great. I welcome you. Looking further, I see the young fresh faces of students, new graduates and the young people who are committed to rural health and have much more energy than those of us who are getting a bit older or are just plain old. I next see the many middle level practitioners who carry out much of the service delivery that is required to bring our sophisticated services to rural communities. I see nurses, doctors, allied health staff, mental health workers, pharmacists and a host of professions that make up our rural teams. I also see the managers who dispense money, write our employment checks and more importantly manage and plan and have a critical role in advocacy and development of services in our regions. I also see the many people from the cities who are our friends and are involved in rural health either for a long period of time or a short period of time and can make critical difference to the development of policy, the instigation of programs and the advocacy that we need within state, territory and Commonwealth capitals.

I am very pleased that we are here in Hobart. I have been to Hobart before and I am sure that the friendly and welcoming nature of the people of Hobart and of Tasmania will make for a great conference. Our roots are really in rural Australia and Hobart and Tasmania have a great affinity with that. Enjoy the amenities of Hobart and your time here. Listen to the many and varied speakers we have, contribute to the development of new directions for rural health and the National Rural Health Alliance. The voice of rural health throughout Australia needs to be strong at this time, it needs to be coherent and it needs to be unified. I wish all of you well in your colleagueship, deliberations and thoughts. There is a lot of fun in the next few days but there is also a lot of work to be done to continue to advance rural health. I have some more serious comments to make but they are for tomorrow, not today.

I would like to welcome some of the important dignitaries who are here today including Senator Kay Patterson who is the Minister of Health and will shortly open the conference. I very much appreciate her efforts to come and spend a little time with the rural health people of Australia. This is an important validation of our importance and our contribution to the vitality of Australia. I particularly welcome Dr Manguyu, paediatrician from Nairobi and Kenya. I am always pleased to see a colleague within child health and I am pleased to see that children’s health is receiving an international
perspective and priority within our conference. I would also welcome the Lord Mayor of Hobart, whose community are going to make us feel so welcome and make for such a great conference. I would finish by making you all welcome as Chair of the National Rural Health Alliance on behalf of myself, the excellent staff and the full council and the member bodies who have contributed to the National Rural Health Alliance.

Have a good time, do lots of work and remember that our mission is to advance rural health. I would now hand over to …
Welcoming address

Vivian Schenker, Conference Chair

Thanks Nigel. Your confidence is very reassuring. Let me also acknowledge the palawa of people of this country and thank them for their fabulously warm welcome and the way they brought us all on to this stage—even if nobody seemed to want to take me, I don’t know why, they all seemed to have Rob Valentine in this, I am not quite sure why, maybe they know something I don’t know yet.

Anyway, let me also add my warm welcome to this wonderful Conference. I am sure we are going to have an extraordinarily interesting and challenging few days together. I am going to be with you throughout the Conference. I will be introducing some of our esteemed guest Speakers and I will also be helping you work out where you are supposed to be when. So I want you to feel you can look to me for guidance although I suspect you might be better off seeking out one of the army of people who you will see around the place in bright green t-shirts—they are probably better equipped. And can I start—it shouldn’t be necessary but—can I start by reminding people to turn off their mobile phones before they come either to plenary sessions or to the individual sessions during the day. It will only embarrass you when they go off, so if you can try and remember to turn them off that would be terrific.

I am not sure exactly how much guidance I can offer our first panel of dignitaries. I suspect that as politicians they get quite enough guidance from their colleagues and their minders. But it is my pleasurable task to introduce them and invite them to say a few words.

On behalf of the Tasmanian government we are privileged to have with us this afternoon David Llewellyn, the Minister for Health and Human Services. They work them hard here in Tassie. I think David’s also the Minister for Police and Public Safety, and the former Minister for Primary Industries, Water and Environment. Please make him welcome—Mr David Llewellyn.
Welcome to Tasmania

Hon David Llewellyn, Minister for Health and Human Services

Well, thank you very much Vivian, and I certainly wish you all the very best as Conference Chair during the next few days. Can I also recognise the palawa people and the land on which we stand, and to say to them what a wonderful exhibition this afternoon with the singing and so on. It was really wonderful.

My federal parliamentary colleague, the Honourable Kay Patterson—welcome Kay, once again to Tasmania. I know that you are actually a regular visitor here to Tasmania and we welcome you sincerely. To the Lord Mayor Rob Valentine and to the NRHA Chairperson Nigel Stewart, and also to the Convenor of the Conference Organising Committee Shelagh Lowe. Shelagh actually, she said that she had come from afar and that she was captured into a rural setting and she is the ultimate in retention and I am very pleased about that because she has been retained in an area where actually I was born and is part of my electorate on the north-east coast. So, well done Shelagh.

Distinguished guests, and Committee, Speakers and participants. On behalf of the Tasmanian government I would very much like to extend the very warmest of welcomes to you all to Tasmania. We are very proud of our State and as the former Minister for National Parks and Heritage, together with those other areas that were mentioned, I can say that beauty abounds with both our States natural and our built heritage. And I hope at least some of you will be staying after the Conference to have a look around.

The government is proud of its achievements over the last five years. We have seen some very substantial improvements in our economy. Our unemployment is now reducing and our population increasing for the first time in a decade. We are also leading the nation in terms of business confidence and productivity, and exports per head of population is the greatest here in Tasmania and that is probably something that very many of you are not aware of. And I think that there is an air of confidence amongst our community.

Some of you would have travelled to Tasmania on one or other of the new fast ferries which are now bringing into the State over a hundred thousand more visitors, and many of which have discovered Tassie for the first time and they have been, I have got to say, furiously buying up all of our coastal real estate and pushing prices up and creating a problem for me with affordable public housing—because I am also Minister for Housing.

Despite the optimism, we still have our problems, particularly associated with the delivery of services into our communities. Tasmania is the most population-dispersed of all States with half of our population living outside our major cities and that is more than in fact double the people living outside the capital than in New South Wales or in South Australia or Western Australia and Victoria, and more than Queensland as well, but not quite that much because they are fairly diverse as well.
For the delivery of health services that means that we need on a population basis very many more health centres. We have smaller hospitals and nursing homes in those centres around the State and certainly that compares in that adverse way I guess with other States. Tasmania has very many more people with low incomes and very many more older people than other States as well.

The area that I was mentioning about a moment ago up the East Coast—twenty per cent of the East Coast community is over the age of 65. And that is another trend that we have noticed with the fast ferry—there seems to be a lot of people coming here to retire and that is going to actually increase our age profile a little bit more too. So that is another little problem that we have got. Lower socio-economic circumstances, high rural and regional populations and an ageing population create real challenges for the delivery of health services. Particularly if we are to assist people, and we should, to live in their own community and to live there as long as possible.

So, in order to achieve those outcomes that are positive in the face of the challenges that we have before us I think what we all must do is to work together. And the Tasmanian government for the last five years, starting some five years ago, began that process through a process called “Tasmania Together”. Tasmania Together is based on community involvement and community ownership. Tasmania Together has delivered a vision of the Tasmania that Tasmanians want to 2020 and beyond. Through its consultative arrangement the Tasmanian people have told us quite clearly where our focus should be in the areas of health, education, community safety, job creation and so on. Now I know when I was looking through your agenda and I think on Monday there is a segment on Tasmania Together, in fact, so I am sure and I hope that will be of interest to everyone.

Over the past five years the government put considerable emphasis on forming partnership agreements also with local government. We have had a focus also of moving the Cabinet around the State and talking with people on a very regular basis. I guess in some respects that is an advantage of being a small State. It makes it easier to work across levels of government, in local communities—pooling resources to give local communities a say in local solutions to local needs. And certainly I have got a very genuine resolve and look forward to fostering a much closer partnership and arrangements with all levels of government and particularly the federal government as well, Kay.

A health system does need reform and a lot can be done without the need for large amounts of additional expenditure and I think all of us, as State Ministers, are wanting to get down and look at what we actually can do. Particularly since we have been given I think a focus and direction through a lot of hard work from a lot of people to try to resolve those sorts of matters.

I am sure that all of you here today will make an important contribution to that process over the next few days, and I certainly look forward to hearing about that progress that I am sure that you will make.

So can I just say that I hope that you get some time to sample some of Tasmania’s delights and that you don’t work too hard in a sense but that you do take that time off to look around the State after the Conference and I am sure that once you do that you will feel compelled to come back again soon. So I wish you all the very best for the
Conference and as I say I certainly will be looking forward to the outcomes of it here. Thank you very much.

**Vivian Schenker, Conference Chair**

Thanks David. I must say that certainly for me one of the big attractions of this Conference, and I am sure for many of you as well, was an opportunity to visit Hobart—surely one of the most beautiful of all our capital cities. I have got a special soft spot for Hobart. I have been here for many an ALP Conference, as a journalist I might add—not a delegate, and more poignantly perhaps it was the place I waved goodbye to before leaving for Antarctica a couple of times and the first place I saw on my return.

Alderman Rob Valentine is well aware of the city’s virtues. He is the Lord Mayor of Hobart. Please make him welcome—Alderman Rob Valentine.
Welcome to Hobart

Alderman Rob Valentine, Lord Mayor

Well thank you very much. And can I say firstly a welcome and a recognition of the palawa people, the Aboriginal Elders that are here today and that wonderful welcome that we had. I mean what a wonderful welcome with the children doing their thing and the voice, that singer, wasn’t he fantastic? Absolutely! And those dancers. I think it was just terrific to see our Indigenous people welcoming us in that way.

May I particularly welcome Senator Kay Patterson, Commonwealth Minister for Health and Ageing, the Honourable David Llewellyn, the Minister for Health and Human Services and most other things it seems, Nigel Stewart, the Chairperson of the National Rural Health Alliance and of course Shelagh Lowe, Convenor of the Conference Organising Committee and Deputy Chairperson of the National Rural Health Alliance. And what a wonderful job to get 880 delegates here and participating, so thank you very much Shelagh for the work that you have done there. And of course the Conference Chair Vivian Schenker—we do welcome you as well. And, particularly Dr Florence Manguyu who is a Consultant Paediatrician in Clinical Practice from Nairobi.

Ladies and Gentlemen, firstly the city of Hobart, as it always does on occasions like this, wishes to recognise and acknowledge the history of this land and its Indigenous people. The city recognises that we are meeting on the country for which the Mohini people were the traditional custodians and on which the palawa people and their forebears have performed age-old ceremonies and who have a continuing association with it.

As I said before, 880 delegates and we welcome every one of you to this wonderful capital city of ours and we would hope that you go away a convert and that you say “Hey you’ve got to go and visit Hobart when you go out there” because we have got fast ferries that can bring us here now and we would hope that you go out and that you tell your families, your friends what a wonderful time you have had and hopefully we will be overrun by visitors. Another 200,000 perhaps a year instead of 100,000. So, thanks to the fast ferries, and congratulations to the government on that.

There is a lot to see, a lot to do in Hobart, if you take the time, but of course you are here to Conference and to talk about those things that matter with regard to rural health. And they are very, very important issues. I grew up in the country myself, Dunalley, which is not far from here, probably half way between here and Port Arthur. And indeed services to country folk and those that are in more remote communities are very important services when it comes to health. Never underestimate that and I am sure you don’t.

The Conference is going to be held from the 1st to the 4th of March and continues a series apparently that began in Toowoomba where the first National Rural Health Conference was held in 1991. Since then it has been held in Armidale in 1993, Mount Beauty 1995, Perth 1997, Adelaide 1999 and Canberra 2001. And apparently each of the Conferences have come forward with initiatives and policy developments, and I am
sure it is Conferences like these that help to guide governments that are out there trying to make a difference in this world of ours.

The 7th Conference will focus on all sectors that can make a major contribution to the health of people in country Australia. Now can I say, Hobart is the capital city of Tasmania but it is a capital city with a regional feel and make no mistake: we definitely appreciate the work and effort that goes into being able to deliver health services in regional locations, more effectively and more cost-effectively and more expertly and professionally as we go by and, indeed, we do appreciate the work and the effort that goes on at Conferences like these. And we congratulate you for bringing yourselves together to talk about issues that certainly do affect us. So thank you for the time that you have put in for helping the people of Australia in more remote communities. And particularly it will widen the rural and remote health community to include people involved in education, the environment, economic development, transport and the arts.

… Ladies and Gentlemen enjoy yourselves while you are here in Hobart. It’s the late nights that catch you. Just beware: there are plenty of live bands and hotels that you can sort of secrete yourself in after the main events are over for the Conference. Just make sure that you have got enough money left over for a taxi to get you back to your hotel. Enjoy the time, thank you.

**Vivian Schenker, Conference Chair**

Yes, and as the Chair of this Conference can I point out that we have very early starts in the mornings so be careful what you do at night. Well, I think we now all feel very welcome so it’s time to get this show on the road. To officially open this 7th National Rural Health Conference please welcome Senator Kay Patterson, the Federal Minister for Health and Ageing—Senator Patterson.
Official Opening

Hon Kay Patterson, Minister for Health and Ageing

Thank you very much. To the Elders and families from the Tasmanian Aboriginal Centre, I apologise that I wasn’t here for your welcome.

To David Llewellyn, the Health Minister, had I actually come on the fast ferry I might have got here faster than the plane I was on, which was delayed with a thunderstorm at the airport. And of course all the staff evacuate off the tarmac and then we had a technical fault so I spent the whole afternoon in the plane. I would have rather come by ferry. I think I should have left last night. With regard to the price of housing going up just remember all those stamp duty increases you get and you should be in there fighting for health!

To Alderman Rob Valentine, Nigel Stewart, Shelah Lowe, Vivian Schenker and distinguished guests Ladies and Gentlemen: it was very interesting as I sat with a number of people coming to the Conference at the airport this afternoon and one of my former students came up and gave me some details about some work she was doing in Stawell. Having taught in Health Sciences for eleven years in Melbourne and many of the students were from Tasmania because physiotherapy, speech therapy, occupational therapy, podiatry, medical record administration etc, were not taught here in Tasmania. I think I have taught about seven and a half thousand allied health professionals. When I became Health Minister many of them came out of the woodwork and wrote to me and said (e.g.) I am the Director of Nursing at Alice Springs. You taught me in first year. I know a bit about Aboriginal Health. If you need a hand let me know”. And it was tremendous to have that sort of feedback and I have caught up with many of them. I don’t think I can go to a hospital in Victoria where there isn’t somebody I have taught and that has been a great joy for me as Health Minister to see students I have taught being able to teach me a few things.

So, I guess I come with a strong background in health and real commitment to co-operation between medical fraternity and allied health professions. That is the only way we are going to achieve outcomes in health, but particularly in rural health, if we have that real working partnership. I am particularly delighted to have been asked to open the 7th National Rural Health Conference. I wish you an enjoyable time over these three days.

You can do nothing as a politician without people knowing. I thought I had crept down here quietly in January, paying my own fare David—just make sure I would get that on the public record—for my Christmas holidays and David tells me he knew I was here. I was hiding I thought with a hat and some disguise, but you can’t do anything. It is evident you couldn’t have an affair without anyone knowing. Some people have found that out I suppose.

There isn’t another Conference which really brings together so many people, not just from diverse regions but from diverse occupations, all with the absolutely same goal of improving rural health outcomes. On my travels since I have been Health Minister, as well as doing all the other things you seem to have to do, it is really important for a federal Health Minister to be out and about. I did a major trip through central
Australia, up through the top end of the Northern Territory, across to far North Queensland and down the coast and then another through the Kimberleys and Pilbara.

I got to Urapuntia for example, to Urapuntia Utopia Clinic and there was sister Lynn Ritchie, Ken, Mavis and Lyndsay and they took me through their patient record system. Under the toughest of conditions they were maintaining continuity of care for their community and I wished my GP in downtown Melbourne had the same sort of patient record. Then I met Jack Little and the Katherine West Board where they are just so enthusiastic about the progress of the Primary Health Care Access Program where we rolled in PBS and MBS and Territory money delivering a tremendous program out there and now they are and assisting Katherine East achieve the same outcomes. They were so keen to tell me about what they were doing they decided that they would track me down in Darwin and spend Sunday afternoon with me telling me what they were doing in Katherine West.

In Palm Island I met a young Indigenous doctor, Tony Grogan, who was telling me that his family was living on the mainland. He was working on the Island and he wanted to ensure his island people had access to the essential medical care that he could provide. And when I said to him “How do you feel about being away from your family?”, he said to me “Well Senator Patterson that is what people in the Navy do, that’s what people in the armed forces do and I am dedicated to doing something for my people and that’s what I need to do.”

Or the nurse that I met in one of the remote Aboriginal communities had been teaching in Queensland for twelve years, teaching about remote and Indigenous health and thought that she needed to update. Her family had grown up, she had talked to her husband and she had taken a year off, left him back on the East Coast in Queensland, had gone to work back in an Aboriginal Health Service, to actually get first hand experience so her teaching would be relevant and would be up to date. That is the sort of dedication, that is the sort of commitment that I have seen and admire when I am going around as Minister for Health and it has been absolutely inspiring.

I could go on all night but I won’t do with stories of the enthusiasm and dedication I have witnessed on many trips that I have made—not just into remote communities but in rural communities as well.

This Conference will provide a welcome chance for people working in isolated areas to maintain that passion by sharing their experiences, hearing the experiences of others, cross fertilising each other with ideas and working and meeting with people who face similar hurdles. I don’t think anybody understands the difficulty, unless they have been and visited, the difficulty that you face, the decisions you have to make, sometimes without the support of other health professionals and other colleagues. I think sometimes that is forgotten by those of us who live in the city. But it is a good reminder that in the end improved health outcomes rely on people and people delivering services in local communities. I know that many of you here are trailblazers in establishing new pathways for improved health in your communities.

The Howard Government has made a real commitment to rural health and has introduced a large number of programs, of which I am particularly proud. Despite the achievements there is still a lot we all need to do. We have established a solid foundation in the key areas of quality education and research since 1996. We have
spent about $2 billion dollars on targeted rural health and aged care in this time—quite apart from spending in the Medicare and Pharmaceutical Benefits Schemes.

If I can just run through a few of the things. There have been over 2000 health scholarships available now compared to 150 in 1996. I was delighted last week to be able to announce the Allied Health Professional Scholarships to be awarded on a merit-based application for allied health professionals to update their qualifications or extend them, if you are interested you need to be aware they close in April. We have seen an 11.4% increase in the number of rural doctors over the past five years. The sorts of reforms: about 14 programs we have put in place to encourage doctors to go back into rural areas are just beginning to have an effect. Some of them will take a while to wash through. We have now got 25% of young people in medical schools from rural areas—when it was 8% when we came into government. As I said some of those things that we have been doing will take quite a while to work through the system.

We have got a total of 124 Regional Health Services operating this year to support local solutions to primary health care priorities. There are 76 Multi Purpose Services operating across all States with further communities undertaking MPS planning to have Commonwealth and State funds pooled to provide flexible aged care and health services. That is where you can really see the Commonwealth and the States working at that level when you get the “argy bargy” of the health care agreements out of the way—there is still a lot that can be done with good co-operation between the Commonwealth and the States. I can still sit on the platform with David and I know that we will be working at that next level down, really working on some of the things—like we have just rolled out a Healthconnect program here in Tasmania which will have an enormous impact on patients being able to have access to their records wherever they go.

One of the other things, and I think as an educator and a health educator in particular, that has thrilled me are the nine Clinical Schools and the ten University Departments of Rural Health. I was out at Bendigo Hospital yesterday presenting them with their accreditation certificate and to see their excitement—they are just about to commence the building for the Clinical School—to see the integration of what can happen there with people who are out there already, being able to use their skills as teachers and mentors. To see young people coming to Bendigo and surrounding areas and doing their clinical placements whether it be in medicine or whether it be in OT or podiatry or whatever. Going back into those rural communities and wherever you go, for example to Broome, you see the work that is being done with these initiatives. It gives me great heart what is being done in the Greater Green Triangle between South Australia and Victoria with the initiative at Deakin at Warrnambool. That is an exciting development—they are all still fairly new but making a tremendous impact.

We have actually had significant funding for practice nurses and allied health professionals in general practice. We have got the Medical Specialist Outreach Program to get specialists out into areas where they haven’t been before. We have got a program funding arrangement to support pharmacies in rural areas. We have got the Rural GP Service, Women’s GP Service, which some people call the “Fly in, fly out” but some of them “Drive in, drive out” service where there is no female GP this service provides regular female visits to rural communities. Then there is the mental health initiatives with tele-psychiatry—not always easy to get some of the health
professionals and doctors out into rural areas. Psychiatrists are one group where we know from evidence that teleconferencing is effective if you have face to face contact on a regular basis. To increase access for rural people we have now got tele-psychiatry MBS rebate so that people can have better and more frequent access. We have got the Mental Health Three Plus Plan through GPs and we are seeing a large number of GPs signing up to that despite some groups saying it mightn’t work. But it has been working. Doctors are participating and bringing into that program other allied health professionals and psychologists to actually work with them on that program — to deliver better mental health services to people in rural areas.

I could go on. There are many more. I sat with Emma Handyside, one of my staff who helps me in this area and is with me today and said “What else can I say?” and she said “Well don’t go on for too long about too many of them”. But when you go through them they are all initiatives which are making enormous differences in delivery of services into rural and remote areas.

The momentum that is developing is evident in the enthusiasm I have witnessed among the members of the Rural Student Network. Now I sing their praises all the time. Being with them at their annual conference at Port Arthur last year gave me a real hope for rural health in the future under their leadership. I mean Rural Network students are the leaders of the future. The thousands of students doing dentistry, medicine, nursing all the allied health professions are an enormously enthusiastic group. If you haven’t made contact with them make sure you do. If you have got a local council what they should be doing is encouraging young people who are studying health sciences to come back to attend a civic reception when they come back at their Christmas holidays — everything should be done to make them feel that they are a significant part of your community, that they are valued, that you are interested in how they are going. Not just you as a health professional but the whole community is interested in how they are progressing and wants them to come back. Now the Rural Student Network supports them when they are undertaking their studies through the rural clubs but they also need support back in their local communities. It is a very good network and I am glad that some of them are here to infect you with their enthusiasm at this Conference. They are the future.

An important part of any discussion of rural and remote health services involves Aboriginal and Torres Strait Islander health. It is totally unacceptable that we have people in our community, a minority in our community, who die twenty years earlier than Anglosaxons, or people who have come from overseas. And as I said I made it an early priority as Minister for Health to visit communities and people in the Northern Territory and Queensland. You may be interested to know that Phillip Ruddock has initiated a regular meeting of all Ministers whose portfolios impact on Aboriginal and Torres Strait Islander peoples, from David Kemp in the Environment — environmental health obviously is an important one from my perspective right through to Amanda Vanstone in Family Services. We meet on a regular basis. Our Heads of Department now meet on a monthly basis which has never happened before. And what Phillip has done is also allocate to each Secretary of Department an area for which they are responsible to make sure we have an integrated whole-of-government approach. Now it is a nice bit of competition that has been introduced because you could imagine no Secretary of a Department wants their area to do worse than another. So I think it is very clever on Phillip’s part to do that, but of course then the Minister gets involved in the area they are responsible for and our area is the Pitjantjarra Lands and of course
my Secretary has been up there twice now and coming with me again in May. So it has focused attention and you will see a lot more emphasis on a whole of government approach—on education, on environment, family and community services, health etc—to try and drive this issue further and that is what we really mean about practical reconciliation.

I have been pleased to sign two framework agreements for Aboriginal and Torres Strait Islander health on behalf of the Commonwealth—one for Western Australia and another one for Queensland which will drive not just the Commonwealth whole-of-government approach but across jurisdictions. As part of our long-term strategy we have increased our investment in Indigenous health. In fact we have increased it in real terms by 89% in the last 6 years—to actually pursue a two-pronged approach to improve accessibility and responsiveness of the mainstream health system and invite complimentary action to Indigenous specific health programs. I have to say that we have seen some tremendous examples—as I mentioned Katherine West whereby pooling all the resources together. We had some resistance from the local non-Indigenous communities who then have had to eat a bit of humble pie and say they are getting much better primary health care than they were before. This is fantastic in terms of being able to use that information to roll out similar sorts of primary health care projects in Western Australia and other areas.

I have concentrated on rural and remote health obviously because that is the challenge that is facing you all. But in health portfolio there are issues which impinge on both urban and rural health and one of them is the sustainability of the PBS which has gone from one billion dollars in 1990 to 4.8 billion dollars last year. If it continues to grow at the rate it is growing it will be 7 billion dollars in 2007. Now the Commonwealth commits at the moment 31 billion dollars a year in funding to health. 7 billion dollars—when you take that as a proportion is enormous so we really all have a responsibility to make sure that PBS is sustainable.

The other thing that I think is important is the need to focus on prevention. I think a lot of our health policies—it doesn’t matter which party you come from—have been very much directed towards treatment. When you look at Peter Costello’s Inter Generational Report, which was part of our Charter of Budget Honesty, means any government of any persuasion every five years will have to demonstrate, given the current policies, what the budget outlook will be in 10, 20, 30, 40 years ahead. We are not doing too badly for about the next 10 years and then it all gets terribly awful. And we are the people who have to make (I am talking about “we” meaning “you”) David, all of us, are the ones who have got to make a difference to make what we use work harder and smarter to make sure we don’t leave a burden for the next generation—that is intolerable. When you look at that Inter Generational Report, other countries are a bit further down the track than us. They are at where we will be in 10 years time. We have to make sure that we put in place programs and practices that actually sustain health and also, not just a treatment, but prevention if we are going to actually afford the sort of health we now have, or the sort of health services we now have with an ageing population.

Workforce issues are another. The difficulty and challenges of delivering health across jurisdictions are enormous and we have just had a small glitch in that over the last week. I was very glad to hear David say they could do a lot more without lots more money—it wasn’t what I was hearing last week—but anyway, David, I will hold you
to that later on. But I think he is right and in some States we have been able to go a long way. For example with three of the States that we have initiated a program with pharmaceuticals—the terrible situation where there was a bit of cost-shifting going on, patients were leaving hospital with either no medication or two days medication. Now I have agreements in three States that they will receive medication under the PBS. It means it saves us the cost of a visit to the doctor and the pharmacists’ dispensing fee, as the patient actually goes out and doesn’t have to struggle in their dressing gown to the pharmacy which is what has been happening. So despite the “argy bargy” at the public level we do have a lot of things going on in the sorts of reforms that have been talked about in the discussions we had last year. But there will always be, when there are agreements irrespective, whether it is disability services, housing or health, unfortunately there will always be an “argy bargy”. All that aside, I know that we can achieve some quite significant things when agreements are under consideration.

So they are the things that keep me awake at night: pharmaceutical benefits scheme, prevention, the jurisdiction issue, workforce (how we are going to get more nurses, more doctors).

One of the other things that I have been able to achieve is when the Health Ministers told me they were very concerned that the AMWAC data for doctors wasn’t as accurate as it might have been and we needed more doctors, I was able to work with Phillip Ruddock. Having been Parliamentary Secretary to him meant I knew about the immigration system. In October I said to the Department “We need to change the rules, we need to allow students who have studied here and paid for their medical courses to do their internship in Australia”. It looked as it mightn’t be possible because after you need a year’s lead time. They said “When do you want it done?”, I said “Next week so we can tell them so they can stay in January”. Well there was a sort of slightly horrified “this is courageous minister” look but we have done it. We now have 93 doctors that we wouldn’t have had now in our hospitals as interns relieving the pressure on other young interns who have not been having to stay 24 hours a day, six days a week to do their residency. So hopefully I have been responsive to the Health Ministers looking for ways that we can actually solve problems. That was one opportunity I had to do something immediately and hopefully while we address the issue of the workforce.

Our overall investment in rural and remote health forms a long-term strategy that will not be fully realised for some years. I have got great hope for the University Departments of Rural Health and Clinical Schools. I think they will give their communities new perspectives as education-based centres. But what this Conference shows is that improvements come down to the people on the ground delivering health services in their communities and that is why we are working hard to both increase the numbers of health professionals and support you in these roles. We can only achieve this through all rural health partners working together and I believe the Conference demonstrates great enthusiasm among everyone here to do just that.

I am delighted to open the Conference and wish you all well with your work in rural and remote communities and wish you all well with your work in helping rural and remote communities to achieve better health. Thank you for your commitment. I hope, and I know you will have a fantastic Conference but take some time to enjoy beautiful Tasmania. As a Victorian senator I still think this is a pretty fantastic place. Thank you.
**Vivian Schenker, Conference Chair**

Senator thank you. Isn’t it a pleasure to see State and Federal Health Ministers together in the same room! Can we all thank again Senator Kay Patterson, also the Tasmanian Minister David Llewellyn, the Lord Mayor Rob Valentine and Shelagh Lowe and Nigel Stewart from the National Rural Health Alliance. Thank you very much.

Well, Ladies and Gentlemen we are extremely fortunate to have a remarkable woman with us this evening as our first Keynote Speaker. Florence Manguyu is a Consultant Paediatrician in Clinical Practice in Nairobi in Kenya. She is the past president of the Medical Women’s International Association and she sits on several international and national boards dealing with policies in health. Now I am just going to list a couple of her remarkable achievements. In 1994 she chaired the incredibly influential NGO forum of the UN International Conference on Population and Development in Cairo and she was a member of the World Health Organisation’s Global Commission on Women’s Health. At home in Kenya through her work for the health and well-being of children and youth she has become a pioneer in the development of the first comprehensive Children’s Act, which was enacted only last year. Florence is perhaps already known to some of you here. She was the hit of the WONCA Conference they tell me in Australia last May, and she joins us again now – Florence Manguyu.
KEYNOTE 1
People, poverty and prosperity in health

Florence Manguyu, Consultant Paediatrician in Clinical Practice in Nairobi, Kenya

Thank you very much for those kind words and thank you everybody. Honorable Minister, the Lord Mayor, Nigel, Shelagh and Vivian. I am glad to be here and I am sorry that the boys and girls have already left. But I was overwhelmed by what they did and it is really wonderful to be back in Australia in less than a year.

These little ones give me a great deal of joy. Just before I came I had to reschedule the appointment of one of them because I was coming and she asked me “Where are you going?” so I said I was going to Hobart. She says “Where is that?” and I said “Tasmania” and she said “Where is that?” so I took her to the world map and showed her where Tasmania and Australia was. She didn’t want to ask any final questions. But she said “Take them something nice and good from Kenya”. What a challenge. So I arrived yesterday in the morning and I brought you some rain.

Good health of every human being is a human right and the right of everyone. Let me tell you Vivian that I cannot speak as fast as the Australians so please take that into consideration for your timing. Many advances have happened in the field of health and as a result the quality of life has improved for many people. Many people in developed countries can now live a long live. Healthy long lives which used to be a privilege of just a few people is now the prospect of many. Many indicators of health such as infant mortality rates and life expectancy have improved. Infant mortality rates going down and life expectancy going up. However, these advances in health have eluded many people in developing countries so whilst some people in a country like yours can expect to live long, healthy, protected lives, in a country like mine many people go through their entire life without ever having enjoyed one day of good health.

The world is becoming increasingly urban and this slide shows how urbanised we are and are going to be. The green bars show how urbanised we were in the year 1950, the purple ones in 1990 and the others show the projection of what will be in 2030. The first set of bars are the world projections here and this second set of bars are what is happening in Africa and the last ones, which I can’t get to, are what is happening in countries developed as yours.

There is nothing wrong in moving from the rural areas. It is the trend and the trend in Africa has been very fast in the last two years. Those lines show what has been happening in our population. The last two decades we have really increased in number totally and also we have become more urbanised—the lower line, the cream one. That again is okay but can we manage that? We cannot. Because when we grow at such a rate this is where we go to live. Let me tell you that in the world about 160 000 people move out of rural areas into urban areas—cities and towns. Put another way: if 160 000 people were to be moved out of Australia every day it would take only four months to empty the whole of Australia. These people who move to urban areas are young, they are poor, they are looking for jobs and they are driven by poverty. In Africa when this was happening the population was growing at a rate of 4.7% per
year. That is 1970–1995 when this growth was greatest. But our economic growth was dropping at the same time. The gross domestic product was dropping at a rate of 0.7 per year. When people live in an area like that, what you are seeing, social services are difficult to provide, including housing (the kind of housing you want), the sanitation and the health services are difficult to provide.

Further on this kind of living, it is no longer (as) temporary as we used to think. Slum areas have become permanent features of African urbanisation. Therefore when we are planning our health services we dare not, we must not ignore the people who live in slum areas. Because they are many as this slide shows, the heading shows. Fifty per cent of us in Nairobi and we are three million in Nairobi, live in such an area. And that kind of area occupies only 5% of the residential area in Nairobi. That is like saying twice the population of Hobart lives in an area like that. That is unacceptable.

People who live in such areas have very unique health needs. Infant mortality rate is a good indicator of health and those bars compare the kind of rates we have in infant mortality. The red bar showing what it is in slum areas as compared to the rest of Nairobi, the second bar, and the rural areas and the total of Kenya and other urban areas. It is terrible to live in an area like that and easy to understand why.

In this study that was done in the year 2000 they also looked at the prevalence rate of diarrhoea or diseases in children between the ages of 0–35 months and again we found the same trend. Poverty is a killer, although it is not a disease as such. The number one enemy of health in poor countries is poverty. It is a major handicap to development. We are now about 6.2 billion people in the world and about half of us live on $2 USD, $3 AUD or less per day. But even, if we go deeper into that 3 billion 1.2 of them live on less than $1, but the sad thing is that 70% of them are women and girls. So the worst of the poor’s health is concerned are women and girls and that is terrible.

One of the features of people of poverty and people who live in poor countries is their life expectancy. Life expectancy in poor countries has now dropped to 49 years, in fact the latest figures are 46 years. And one child out of ten in those countries will die in their first year. In fact for many of them life begins and ends in the first week of life. Compare that with the rich countries: life expectancy, 77 years and the infant mortality rate is 6 per 1000 live births.

Let me tell you what the figures are here. Well these are estimates so you may have even more recent ones. Life expectancy in Australia is 76.4 for men and 82.0 for women. In Kenya it is 48.7 for men and 49.9 for women. I should be dead. The infant mortality rate for you is not high; in Kenya it is 70 per 1000. But there are worse figures in other countries, like in Rwanda which is not very far from home, it is 146 per 1000.

Another indicator of health that still remains very, very shameful as you look at between the rich and the poor is the maternal mortality. It is very risky to be pregnant. There are risks even in developed countries but the risks are much higher in a developing country. And those figures there speak for themselves. Yet being pregnant and having a baby is the same physiology really wherever you are. But if you are in Angola you have many more chances of dying. If you are in Switzerland, which would be the same for here, you probably would not need to die. That is really sad and the figures are even worse in places like Afghanistan, Bosnia some years back, and also in places like Cote d’Ivoire which is in West Africa.
Over the last few years the world has looked at certain diseases which affect the poor more and they have called them the diseases of poverty. These diseases of poverty—the three major ones—one of them is caused by a virus and that is the HIV virus causing AIDS; the other one is a bacteria, tuberculosis; and malaria caused by a parasite. Of all the new cases 92% of HIV is in developing countries; tuberculosis about 84% and nearly all the malaria is found in developing countries.

Since I come from that area where HIV is so high let me show you the latest estimates. By the end of two months ago in December there were 42 million people living with HIV and AIDS. Of that the majority, 29.4 million, were in Africa—not the whole of Africa, only sub-Saharan Africa. That 29 million is only in about 600 million people. You are doing very well: 15 000 people are estimated to be in New Zealand and in Australia. Of course you are a much smaller group and these are just estimates, total figures in regions. Let me put this figure another way. That is where we are, in Africa, the red bar, compared to you, can’t even be sure, that is the end there, the last bar 15 000 and that is what you were at the end of the year 2000. You are doing very well but be warned. That is what we were in the year 1980 and we thought we were doing well and now we break the record. Let me tell you while I am there the highest figure, the highest prevalence rate is in Botswana with 39% of the people of others being infected, not sick but being infected. In Botswana, life expectancy, because of that has dropped to 34 years. That is frightening.

But over several conferences that have been in the last decade, from 1990, in the 90s the world leaders have come together and developed what they call the UN Millennium Development Goals for Human Development, so the world is not quiet at this issue. And out of those eight human development goals, three of them that I have underlined there deal directly with health. And nonetheless each one of them reinforces the other and together they work for human development. There is a global response to this. The goals are for human development and reduction of poverty because of what poverty means in development but nevertheless they affect health as we see them there.

So what is our response in health? Let me give you a little personal experience to show that health must be accessible to everybody. Some years back when I was on a call one day I was going to see a new born baby who had pneumonia. Before I went into the room the nurses called me aside and they said “You must speak about family planning to that family”. That baby was their seventeenth baby. I said “I am not going to talk to them. If this is their seventeenth baby, the chance of having another baby is zero, unless it is a miracle”. They insisted anyway so I went in and saw the patient and the patient wasn’t very bad and there was this couple, the parents, looking quite old but I couldn’t talk about family planning, so the nurse kept on digging me in the ribs so I started saying something and I stumbled a bit and the way they looked at me, wanting to laugh at me, she looked at me like I was an alien from outer space and she said “Doctor, where were you when I needed you?”. That was the end of my family planning lesson.

But at the same time I went to another clinic.

… We were feeding this baby, tube feeding, and the baby was ready to come out of the incubator. The people who visited this child every day were a couple, a man and a woman and a little girl of about twelve, so since now they could come into the room. I told them “Come in” but I told the little girl, because we don’t allow them in such a
ward, to wait in the office. So I took out the baby gave the baby to the lady and I told her “You can now breastfeed”. And she looked at me and she said, “No, I will not. I am not the mother. That little girl who you said should wait in the office is the mother.” At that time I did not need the nurse to push my hand. I talked to that girl about everything and she didn’t talk to me, this was over several days, but I could hear her saying, wanting to tell me and to ask me “Where were you when I needed you?”

So accessibility is important and you can live in a city like Nairobi and still health is not accessible to you. And you may if you are in a village have to do that. That is a lady in Ghana about to deliver, being transported in that manner. Let me tell the gentlemen who are here if you don’t know, it is very, very difficult, impossible to walk five miles when you are in labour. Just in case you think that that is an African way of doing, transporting people, I have that picture which is from Nepal, doing the same thing. That is what we do when we are poor.

But poor people, if you invest in them, they will tell you what their needs are. Women were asked in this study what they needed in health, what their priorities were in health, what did they identify? They identified toilets, provision of drainage, water and then health services can come and could we tackle the HIV, AIDS disease. So the poor know their needs and they need to be involved. In the rural areas, in towns and in slums they know that environment is so important. And I can tell you after being in this profession for 30 years I know the best medicines are three: adequate food, clean water in a safe environment with good sanitation.

I will quickly show you what the Ugandans did when we invested in their poor. It is a neighbouring country. In 1992 the prevalence of HIV for women attending antenatal clinics was 29.5%. They worked together and they reduced it and are still reducing it so that in the year 2000 it was 11.25%. We cannot wait for people to be rich in order to do something to help them. Sri Lanka … and Cote D’Ivoire… have the same poverty or the same richness, the same gross national product at 750 dollars and their maternal mortality was about the same before they started doing something. When they did what they did their maternal mortality went down to 70 in Sri Lanka, remained high in Cote D’Ivoire and is higher now that they are fighting. But what did they do, what did the Sri Lankans do? They introduced universal education so that literacy rates now are about 93%. They improved and uplifted the status of women and they formed partnerships and everybody was motivated and they said “No, we are not going to have any woman dying in the process of giving life to our children”. So we need to have a global partnership, a partnership also of the local communities, the poor, the professional, different organisations and indeed everyone.

I joined the weavers for a while and I was able to do this much but not much else and it reminded me of a saying we have in Kenya that if spider webs unite they can tie up a lion. And we have a big lion in front of us. But if we work it together we could overcome.

One other people we forget to include in our partnership are the private for profit people. That slide was taken to show the economic activities that go on in that slum area. It is the same slum area I showed you. Now I want to ask you. What moral right do some rich people have to do their business and sell a bottle of one litre Coca Cola costing more than those people earn in one day? When I showed my husband this he said “But they buy it. They must have the money”. And I told him “Yes, because that
one bottle of litre you will divide it in 200 mls, that’s five people buying a loaf of bread and that is a meal.” So if I want to do any partnership I would include the Coca Cola people or any other … as they pour their drink could they also pour their money.

I also had the opportunity to listen in a workshop to the Indigenous group and I got the sense that you think of your ancestors and you talk to their spirits or you hear their voices. I come from also a very traditional part of the world and I right now as I close my eyes I can hear the voices of the newborns—the women who have died in childbirth, the young boys and girls who are dying of malnutrition in those slum areas and … diseases. The many men and women who die needlessly and they are all asking the same question: “Where were you when I needed you?”

So let us join together and go to the community place where they are and let us listen to their voices, let us share the know-how that we have between the rich, the poor an the community and we will overcome. Ladies and Gentlemen, thank you for being here.
Vivian Schenker, Conference Chair

It is very hard to know what to say after that, isn’t it? I am still getting over that figure that average life expectancy in Botswana is down to 34 years of age. Well that certainly stirred things up and introduced an awful lot of the themes that I think we are going to be hearing lots more about over the next few days. Let’s keep the blood circulating and the adrenaline levels high with a performance I think now from the amazing “Shouting Choir”. Are they here? I hear no shouting. Can anybody hear shouting? Possibly they have become the whispering choir. We just can’t hear them. Here they are.

(Shouting Choir performance)

Vivian Schenker, Conference Chair

Ladies and Gentlemen the amazing Shouting Choir – the love bond is broken. Dear, oh dear, oh dear.

Well that ends this formal part and I don’t know really if that is so appropriate now anyhow — that ended the formal part of tonight’s proceedings. To help us get a bit better acquainted you are invited now to move to the Welcome Reception which is going to be held in the foyer of Level 1 here at the Grand Chancellor Hotel and in the Federation Ballroom. And you might notice while you mingle and soak up the atmosphere that the Conference Exhibition is on in the same location so feel free to have a look at the 35 stands that there are this year. You are welcome to have a look at any or all of them at anytime during the next few days. Make sure you get a chance to get to them all in the next four days. Go and have a drink and I will see you back here bright and early tomorrow morning for an 8:30 start.