PLENARY 3
SUNDAY 2 MARCH 2003
1.30 PM – 2.25 PM

Vivian Schenker, Conference Chair

If everybody can take their seats … It’s nice to have you all back. Hope you all had a pleasant morning, enjoyed your first Concurrent Session and had a good lunch, a good and sustaining lunch because we have got an intellectually challenging, but I hope not too challenging, afternoon.

Can I just say a couple of things before we start? Some people are apparently still using that slim coloured Program that was actually printed six months ago or more. I think you will have more success if you use the Handbook that is in your satchel and you update it by having a look at the Program and noting the Program changes that are marked in green that I told you about this morning at the top of the stairs where the Program is printed. Because there have been a few changes made but there have been an awful lot of changes made since that first Program was printed six months ago so you will find it a lot less perplexing.

You will note for example that Kay Patterson was initially supposed to be speaking in this session here. As soon as we heard from the Prime Minister however that he wasn’t going to be available to open the Conference, Kay Patterson stepped in to the breech; so she was always going to be speaking yesterday and you will note if you saw the Program changes that Nigel Stewart will be speaking in that slot in a few minutes’ time. So that means, you might also have noticed that the choir performance that was scheduled initially for right now is also not going to be held, which is a bit of a shame really, and we have considered community singing for a little while. We thought karaoke might be a possibility but I think it is a little early on in the Conference. We might save the karaoke for Tuesday.

However, it has been brought to my attention by a very zealous member that one of our delegates from the University Department of Rural Health in Tamworth in New South Wales is having a birthday today. So on behalf of the Conference I thought we could all sing “Happy Birthday” to Tony Smith. What do you think?

(Singing)

Happy Birthday Tony. Twenty-one is a lovely age. Can I also point out that last night somebody lost something very important here in the Concert Hall—a blue “Juice” brand baseball cap that is apparently much loved so if anybody finds it could they please return it to the registration desk immediately and there will be a very grateful delegate waiting to claim it.

Okay on that note; let us get on with the show. Ladies and Gentlemen—Sue Moss, local Performance Poet from here in Hobart!
Artival One

**Sue Moss, Performance Poet**

Bebopabebopaloolabopopbrrr!

Well, good afternoon and welcome all you interstate delegates to this wonderful Conference. This story will familiar to you. Hope your memories are good. If you do remember this it will be very good indeed.

(Performance)

**Vivian Schenker, Conference Chair**

Well if you haven’t had enough you can see more of Sue. I think she is running one of the Symposums that starts straight after this Plenary Session.

Well our first Keynote Speaker this afternoon is a woman who will be familiar to most of you. If you haven’t met her you will have most certainly have heard her distinctive Canadian accent on the radio or on the television. Her name is Louise Sylvan. She is the Chief Executive of the Australian Consumers’ Association so she is an expert on everything from bank fees to washing powder, as well as more complex issues like the effect on us all of globalisation.

Louise is also the elected President of the World Federation of Consumer Organisations, Consumers International, and has advised governments in a variety of areas over the years. She is here to give us the benefit of her advice now — Louise Sylvan.
KEYNOTE 4—COMMUNITY PLACE
Consumers, community and social capital

Louise Sylvan, Chief Executive, Australian Consumers’ Association

Thanks very much Vivian and thank you for your invitation to join you at this 7th National Rural Health Conference.

I am always really pleased to be back in the health arena. Vivian didn’t mention but I think a number of you know that I was the Founding Director of the Consumers’ Health Forum and that is really the first time I worked in the health arena and really loved it in the health arena. So, it is nice to think about some of these issues again and I am particularly pleased at the timing of your invitation because I am very grateful to you for giving me a respite from financial planners—from whom I do need a respite!

I want to start briefly by just talking a little bit about ACA and Choice and of course most of you know us by our brand name, which of course is, originally, Choice Magazine, and now has a whole lot of things under it that we offer consumers. We are quite an old organisation and you can see our Mission Statement there “to test, inform, protect and to empower consumers to enable them to be empowered”.

We have got a really strong focus on understanding what is actually happening to consumers—whether that is in the marketplace, whether it is as a result of interactions with governments, whatever it is—actually finding out what goes on. So even though obviously there is a lot of theoretical underpinning to the work that we do—whether it is competition policy or whatever—what we want to know is what is happening to the consumer.

Here is a little ad for the website: www.choice.com.au We think it is a terrific tool not just because it gives consumers access easily anywhere they happen to be in Australia. The thing that the website enabled us to do, which is in our original founding Mission Statement, which we have never really been able to do successfully, is to really use it as a tool to enable people not only to personalise what they are doing individually in terms of their choices in the market but to actually use it as a tool to enable people to have their own voices heard on issues that are of importance to them. So when we are campaigning on an issue we almost always use that website to enable people to come on to actually send their own letters to Ministers if they want to do that, send their own complaints to companies and so on, and it enables us to do something that, in terms of trying to resource individually and help people individually, having “people resources” to do that we have never quite been able to accomplish.

One thing that I will mention, because it is really important to us, I think it is really important increasingly now in Australia: the ACA has always chosen to be completely independent and by that we mean that we don’t accept any advertising in any of our publications as you have probably noticed. We don’t accept any products or services. We buy those in the marketplace just the same way that a consumer would when we are testing them. Nor do we accept any government money. We have chosen to do that because it is an association that, in our view, needs to belong to the people and we want no leverage by anybody else in a sense on that organisation including
governments of any complexion. So we keep that independence and I think it enables us to speak very strongly because nobody has got any levers that they can pull in relation to what we say and what we research.

We have four key policy areas and health is one of them. Now I am talking about social capital and I put social capital into the four capitals. Some people are offended by the use of that terminology I gather, people who don’t like to think about relationships, trust and so on in the same way that you would think about our produced and financial capital for instance. I actually think it is useful to look at it that way, in part because just the use of the term capital might get the attention of the pointy-headed economists and Treasury who aren’t paying attention most of the time on these four issues.

So there are the four definitions. The definitions that I have used are in fact the definitions that are used by the Australian Bureau of Statistics. Social capital as we know builds community. You have an excellent paper I heard I think in the 5th Conference from Fran Baume on social capital and I am going to use the term just the same way that everybody else does—which is connectedness, trust etc. There are typical indicators there. I just sound a little bit of a warning and anybody who has worked with social capital (which is still, I think, a very amorphous concept, not yet totally well defined). Just a little word of warning: some of these measures are typical indicators like knowing your neighbours, trusting others, social attachment, which uses those indicators, for instance, the divorce rate—we have to be really careful about how we use those. It is not necessarily a positive to have a really low divorce rate when that means that people are trapped in abusive relationships and can’t get out of them. So we need to be careful about what these things mean and how we interpret them. I don’t take a romantic view about social capital and what it means. I just think it is useful to have these concepts and the debate that we have got. I use it more to mean two really, I think, critical things for us both in terms of health and also in terms of the nature of the society that we are creating. I use it to indicate ability of people to influence and I think that is how Putnam was actually using it originally in his Italian study. Those people who were participating in local government weren’t simply participating from a sense of a civic engagement—engagement was important—but the point was that they were involved in a partnership or in a process of local government that had quite embedded within it a very serious influence of the people who were engaged in it. So it wasn’t a pseudo-consultation where decisions had already been made or decisions were, in fact, going to be made by others without recourse to the kind of input these people were giving.

And the other thing that I think I use it much more perhaps than other people who use social capital do is in relation to trust—trust for those who are unknown to you, people who are not known, again making sure that connectedness between people isn’t exclusive of others, and also trust in those with decision-making powers (and I will come back to that in just a moment as well).

So social capital in health... The evidence, I think you will probably know, a lot of you much better than I do since I don’t work in the health arena any more but, having read the papers over the years as they have emerged and a new term has emerged, which is social epidemiology, that where certain behaviours are basically equal—smoking, diet exercise and so on—you nevertheless get an independent influence on health outcomes from social cohesion factors, and most importantly from my point of view,
from inner quality. So we are not talking about social and economic standing per se; we are actually talking about another factor: influencing.

Now, one of the things about inner quality as we all know—I think the Head of the World Bank for a while was saying, the rich have gotten richer and the poor have gotten poorer, but in fact if you look at the global information on this that is probably not true—in fact everybody has gotten a little bit richer depending on what period of time you are looking at. Incomes have in fact lifted for many people throughout the world. The key difference has been in things like executive powers, the level of executive salaries and so on. So, if you like, the boats have all risen but some boats rose much, much more substantially than others, and that is having an effect on our sense of cohesion as a community—it weakens the social glue that we have had with each other in the past.

In order to talk about social capital and consumers and community and that complex topic reasonably I have got to go back a little bit to, in fact, two key trends over our lives—trends that in a sense we have not been in any way in control of either as consumers or as citizens. The probably major key trend has been the ascendancy of the market. It is much more dominant in our day-to-day life. There are often no relationships—this is a long-term trend, you know, 80, 90, 100 years—no relationship between the consumer and the person supplying the product—more so of course a relationship for a service provider. A lot of our relations are now much more market-based than they ever used to be and that goes from carrying activities, to utilities and so on. And there has been a corporatisation of what I would have called community—in sports for example; farming, which is becoming increasingly corporatised or contracted to corporate entities. You remember when the really big forum that the Rabbitohs had in relation to their exclusion from being part of the competition—a lot of that outrage that you heard from people that were demonstrating, people who were supporting the legal case, was not even so much outrage at complete exclusion—they were outraged about that—but real outrage at the fact that a corporate entity could do this; that it was just corporatised; that a community sport, the community group that they had supported. So I think that is just happening increasingly. So there is this shift because a lot of this is driven by economics to the individual.

The other key trend has been what government has done almost simultaneously. There has been a trend to smaller government as it is called—it hasn’t actually happened but that is what is said—a lot of moving aside, government moving aside for the private sector and private sector interests to be able to flourish, sale of assets by governments (not necessarily a bad thing), deregulation of a whole lot of things that the governments used to do for us, so not intervening in a sense in that marketplace relationship and broadly what is called the new “neo liberalism”. So there is a strong shift away from collective and public and you can see how this starts to impact seriously in relation to health.

The other things that I would say are really critical, globally, because we can’t actually do this globally, is that we are in a period of absolutely massive economic transformation because of the technologies that are changing around us. And as that was happening (which is dislocating to societies in its own right) as that happened governments did financial market liberalisation, which coincided with enormous computing power and it coincided with instantaneous communication, so we have had what we have never had in the world before: the ability of essentially private
investors to rock a quite major economy—as they did to the UK, as they did during the
Asian crisis. We have got liberalisation of trade, products and services—something the
consumer movement obviously supports but it required microeconomic reform at the
nation-State level. We had the rise of intellectual property rights or the rise of rights in
abstract things increasingly. We have had a globalisation of rule making—our nation’s
States are in a sense through consensus processes nevertheless saying that the global
rules supercedes those that we might want to put into place for our own people—the
world matters much more. And of course we have had a concentration of corporate
power.

Now here are the effects I think of those global changes generally: in health it has
reinforced a quite simplistic notion of health—the economic model of the consumer
buying services. We have seen it come through very strongly over the last twenty
years or so. We have had improved standards of living, as I mentioned, but those have
been highly unequal in terms of how that has been distributed. We have huge levels of
uncertainty in our people that we have never had before, particularly about their job
security because that is what has been particularly affected by globalisation and I
think we have had a serious reduction in “trust” in our societies—a serious reduction
in trust in the corporate sector, a serious reduction in trust in government and, equally
important, a reduction in trust in our own democracy. I think democracies are very
fragile anyway so that is a serious outcome for us.

If you look at something like the World Economic Forum, that forum of the thousand
largest global corporations in the world that takes place, the meeting takes place, each
year in Davos—if you look at the survey that they did for their meeting in Davos in
January you will see that democracies have fallen in terms of our trust and our sense
of them down to the level of the global corporate sector, which I think has never
happened before. So that is serious for our societies.

Just to finish that off in terms of what that has done to us as a Community. What that
has done is strained our community capacity to cope: there has been enormous
pressure on people, on communities and thus on our social cohesiveness. And the
irony of that from my perspective is this has been largely brought about by our nation-
States seeking to co-operate more fully at the global level.

So let me come back now to the topic—having set that context—let me come back to
the topic of social capital in health. I actually think in health we have accomplished a
lot in relation to social capital. I see it all through the elements of this Conference—
there is a much more consultative approach to health, particularly in relation to health
promotion, much more involvement of consumers, of community members through to
community control, in some cases by the people who are most affected by health
related projects. And we have seen good data on that about the efficiency and the
effectiveness of the outcomes for health and the way of doing that actually increases
social capital for communities. That is true whether it is a project that we are doing in
a developed country or a developing country, so the methodology if you like holds
good across both types of nations.

The other thing that I think is important is that there is a rural and regional advantage
in relation to social capital. There is a much stronger sense of community and
partnership and sometimes inclusion as well of all peoples. The disadvantage is of
course in relation to service access, infrastructure like transport facilities,
communications and in relation, potentially and in some cases reality, to economic growth.

So what we haven’t when we look at that picture, or when I look at that picture—we have accomplished the narrow framework in relation to social capital—what we haven’t accomplished is I think the broader framework and that is putting health policy within a social framework that doesn’t let economic ideology dominate. We actually understand it, very many people understand it, we just don’t seem to be able to deliver on it.

So my final one-liner just to try and summarise that very big picture is that we need to understand that you cannot build a strong economy on a weak people and that means that government’s investment—I don’t call them expenditures; I call them investment and I think that should be recorded in the accounts as investments—in health, in education, in infrastructure and so on are critical in terms of building a strong people. You can’t sustain a strong people on a weak society even if economically you have brought them up. If the society is unconnected, not cohesive, distrustful you will nevertheless not have the lift that you expected as a society. And finally “What gets measured matters” and I think it matters a lot—the numbers become the reality. If you watch our Treasurers out there responding to the New York ratings agencies about how wonderful they have been in terms of their fiscal discipline and their GDP growth—you will see that what matters to those people is in relation to things that don’t necessarily entirely matter to us. Economic growth is important but all four capitals matter to a people.

So the key task I actually think—and I think it is a key task for this Century; for all of us who are concerned about these sorts of things—is to actually ensure that we switch around the way that we think about markets and societies. It was pointed out about fifty years ago now that the danger of unfettered markets that were not under the discipline of their societies would be that they would tear their societies apart. Now the point of economic growth for me and I think for you and its corollaries of liberalisation, of actual financial capital and so on, the point of all of that was to enhance people’s well-being; it wasn’t to get economic growth per se, which is what it has become. So our key task I think in this Century in relation to how we govern ourselves is to put the market back within the discipline of our society. That implies also a much more sophisticated understanding of what government is and what it should do; a much more sophisticated understanding about markets—what they can’t and can do—and in a sense, to use a health phrase, to take some “evidence base” to these things and to evolve some social and economic policies and long-term policies that really make sense for people. Thank you.

**Vivian Schenker, Conference Chair**

Thanks Louise. We are glad we could take you away from some of that financial planning—it’s always a nice relief.

Our next speaker, who is also probably known to many of you, he is one of the men in green, is Nigel Stewart, the Chairperson of the National Rural Health Alliance. You have probably heard already from his accent that Nigel spent his formative years across the Tasman. He studied and worked there until 1993 when he moved to Port Augusta in South Australia. At that time he was the only Paediatrician. He was
carrying out Clinics in Port Augusta, in Port Pirie, in Whyalla, in Roxby Downs, Coober Peedy and Ceduna. A second Paediatrician, a Registrar, a third Paediatrician and then a Nurse are now part of that Northern Regional Paediatric Unit of which Nigel is the Director. He is particularly interested in childhood disability and child protection; he has four young kids of his own, and he is taking time off from his family and all those other interests to speak to us now—Nigel Stewart.
KEYNOTE 5—MAINTAINING THE MOMENTUM IN RURAL HEALTH

Nigel Stewart, Chairperson, National Rural Health Alliance

Megan McNicholl, who is a Council Member is going to join me in this presentation. Yesterday I jokingly suggested that eventually I would be Minister of Health but I didn't know you would be getting me to step up so quickly to replace her but I appreciate the opportunity!

We have been talking over today and yesterday about some issues, and I prepared this beforehand but they seem to be the right issues so I am going to work my way through them.

It has been an interesting week or two in health and I think we should reflect for a few minutes on how we see things …

HEALTH IN OUR NATION

The treasurer suggested this week that defence is the highest priority of this land and nation at this time and that if necessary funding cuts in health would be necessary to maintain expenditure in this area. The treasurer may have credentials to manage Treasury. The treasurer and Treasury have minimal credentials to manage health. We strongly support Senator Kay Patterson in defending her portfolio and the monies that are required for provision of excellent and efficient health care. We fully support the people with expertise in health who currently manage it. Management of health by Treasury will be a disaster. We only need to look at that small nation of New Zealand across the water that enjoyed many years of Treasury managing all government departments. At the end of the day the people of New Zealand needed to make huge reinvestments in health and education at the end of the Treasury cycle. Our message would be to not go down this road.

RURAL HEALTH

Rural health is on the map and has enjoyed growth in recent years. Rural health however is still fragile. The infrastructure is there but needs bedding down and needs continued investment. Any threat to the overall health budget is likely to result in disproportionate reduction in rural health monies and threat to rural health.

THE DROUGHT AND ITS ONGOING CONSEQUENCES

This country is coming out of a long and severe drought that has affected at least 4 states being Queensland, New South Wales, Victoria and Western Australia. Many of these states are not used to such a long and severe drought. While there is happiness at the breaking of the drought, it will be a long time of recovery. As with most stressful events, people actually survive the acute crisis well but often show signs of
stress and distress in the recovery phase. There is going to be a huge need for support of rural communities and rural people over the following 1–2 years as the consequences of the drought continues to have financial and psychological effects on families. Families will still be dispossessed of their land and it will be found that some farming units have become unviable and unable to recover. This will bring stress to men, women and children of rural communities.

PRIORITIES

This is a time of seemingly increasing external crises to Australia. It is therefore easy to look outwards and to forget the vast interior of Australia and the people who live there. It is important that those people are acknowledged for their great economic contribution and their social and political contribution. The cities of this nation ignore that at their own peril. Increasing disaffection will bring its own trauma to the people of Australia. It needs to be acknowledged that while some gains have been made in recruiting health personnel, rural people, not least the Indigenous rural people of Australia, still continue to enjoy very poor health and disease. There are still high rates of Indigenous infant mortality, shortened life expectancy for the adults and there are still high rates of mental health problems and adult male suicide in all rural communities. The effort needs to continue.

Vivian Schenker, Conference Chair

Thank you Nigel. Thank you everybody.