
**A speech for**
**The Hon. Bronwyn Pike, MP**
**Minister for Health**
**9 am, Tuesday, 8 April 2003**
**Moonee Valley Racing Club**
**McPherson Street, Moonee Ponds**

**(***If quoting from this speech, please acknowledge that it was presented to the **Communities in Control conference, convened by Our Community and Catholic Social Services.)**

**ACKNOWLEDGMENTS**

- Professor Len Syme, School of Public Health at the University of California, Berkeley
- Rhonda Galbally, CEO, Our Community
- Women and men of the Victorian community

I am delighted to be here this morning to **consider the impact on health of communities being in control**.

It is a **special but daunting privilege** to share the platform with **Professor Len Syme**. **Much of what excites me** about communities and good health is **known due to the research of Len Syme and also Professor Lisa Berkman**, who is speaking later this afternoon.

Whenever we talk about the **connections between healthy communities and good health**, we are **building on the work of these two people** and others influenced by their research.

**Another privilege** of this conference is **all of you**. The emphasis over these two days is about communities being in control.

So I **look forward very much to the discussion that will follow** my presentation as a way of hearing from the communities you represent and the community that is developing here.

*(Communities and good health)*

**As I approach this topic** this morning, I have a feeling familiar to anyone who has ever sat any kind of exam. You **walk into the exam** full of dread – and **find that you have been asked the one question for which you were fully prepared**.

That's my reaction to the question that has been posed for me to address: **"Community building – it's good for our towns and suburbs but is it really good for our health?"**

**The answer – obviously and conclusively – is YES.** We have before us a wealth of research results.

**One concise summary** is offered by social researcher **Robert Putnam** in his book, *Bowling Alone*. That book is principally concerned with the collapse of community – social capital – in American life. But **Putnam also examines a wide array of research results about health and well-being**, including work by Professors Syme and Berkman.

His conclusion is unequivocal: **social connectedness is one of the most powerful determinants of our well-being.**

He sums up many studies with this point: **The more integrated we are with our community, the less likely we are to experience colds, heart attacks, strokes, cancer, depression and premature death of all sorts.**

To put it in very graphic terms, Putnam says that, as a rough rule of thumb**, if you belong to no groups but decide to join one, you cut your risk of dying over the next year in half**. If you smoke and belong to no groups, it's a toss-up statistically whether you should stop smoking or start joining.

No wonder Len Syme led a seminar yesterday on whether we should strengthen communities or persuade individuals to stop smoking. As Minister for Health, I find this a tantalising question.

*(The Australian evidence)*
It's all very interesting, isn't it? But as Australians, we always have the tendency to **wonder whether American research can hold true for Australians**.

It's a valid question. Anyone who has lived in America, as I have, can attest to the differences between Australian and American culture.

Some relevant differences might be that we have different ways here of building social capital – does footy fever compare to bowling leagues? We have a different ethnic make-up – more Irish, fewer Germans, very few Africans, for example.

Of course, and thankfully, we have a **different kind of health system – although our Commonwealth government seems to think we would be better served by the American *non*-system of health care**.

But I can assure you that **Australian researchers are finding that exactly the same thing holds true** – social connectedness makes a huge difference to your health and well-being.

Did you notice the statement released by the **National Heart Foundation of Australia** on 17 March? They conducted an exhaustive literature review, including Australian studies.

Their conclusion**? Social isolation, lack of social support and depression put people at significant risk of developing coronary heart disease**, independently of any other risk factors.

The level of risk, in fact, is **similar to standard risk factors such as smoking, high blood pressure or high cholesterol**, and much higher than stress.

So if you want to protect yourself from heart disease, you can give up smoking, take steps to lower your cholesterol levels or blood pressure – or join a group. Maybe you should try doing all of them!

We have other Australian evidence, too. The **Department of Human Services has surveyed 7,500 Victorians each year for the past two years about the state of their health**.

The **recently released Victorian Population Health Survey 2001 demonstrates just how important community and community participation are** for Victorians and our health.

The research confirms the American work. It shows that **people who are well connected** – who have strong and active networks – report that they **are healthier, suffer fewer mental health problems, are less afraid and feel more valued than people who are socially isolated.**

There are **other factors at play, of course**, and some aspects that require more research.

For example, the research shows that **people with higher incomes and people who are in employment tend to have more social networks than those who are unemployed or in lower income groups**.

In the Australian setting, **is it higher incomes or better social networks that produce better health**?

Also, **non-metropolitan people have more robust networks** than those in metropolitan Melbourne and Geelong. But – in this study and in others – **non-metropolitan people report worse health**, a finding we would not expect based on current thinking about the importance of social capital.

This is exciting research, but it is preliminary. The **next Victorian Population Health Survey will examine in more detail what other factors affect people's health** and I'm sure that other Australian researchers will also weigh into this discussion.

So we **might ponder whether building social capital alone will improve people's health**? Much of the evidence suggests that it will.

However, **Richard Wilkinson**, in his work on the **social determinants of health for the World Health Organisation**, lists **10 social determinants** of health. Several of those we would include in our definition of social connectedness – such as social exclusion and social support.

Among other social determinants, he lists **stress, early life** experiences, a sense of having **rewarding work, unemployment, addiction**, availability and knowledge of **nutritious food**, and healthy means of **transpor**t.

His work **supports the high correlation found in the Victorian Population Health Survey between higher socio-economic status and better health outcomes**. He calls this the social gradient and states what should be obvious: **poor social and economic circumstances affect health throughout life.**

He says, however, that **income alone is not sufficient to explain health differences**. Interestingly, death rates tend to be higher in countries and regions where income differences between the rich and poor are larger – that is, **relative advantage is more important than absolute income**.

The **widening gap in income levels in Australia**, as in many other developed countries, may be a **greater predictor of demand for health services** than other factors. This is yet another reason to be wary of the growing gap between the haves and have-nots.

*(Usefulness of these data)*
All of this **data is fascinating**. But for me, as a policy maker, and for you in your various roles in community, the sharp end comes when we ask **how we can make use of this information.**

*(Burden of disease)*
Our **understanding of health inequalities** has been greatly furthered by groundbreaking research done by the Department of Human Services into the **burden of disease**, published in 2001.

The Burden of Disease Study is also proving to be a **great resource for supporting change**. It is being widely used in local government and primary care partnerships – PCPs – across the state.

Some PCPs are putting the **burden of disease information together with their knowledge about the importance of communities** being in control to come up with **new models** of primary health care and prevention.

For example, the burden of disease study showed that **hypertension** was a **serious problem** in the area stretching from Ivanhoe to Kinglake, the catchment area of the **Banyule Nillumbik Primary Care Partnership.**

The PCP **got the community involved** by forming a consumer reference group and surveying people with hypertension.

People said they would attend a program to decrease hypertension if it provided them with certain information – and they were very clear about their requirements.

A series of **self-management classes was designed to meet all the needs expressed by consumers**. They are offered in a variety of places and have led participants to lose weight, exercise more and take other steps that are likely to reduce their blood pressure.

This program **empowers consumers**, both through choice and by **providing relevant information**, and **builds social connections** for people attending the groups.

It's certainly a **different model from distributing brochures on hypertension** in the chemist and the doctor's surgery. Based on the research, I would suggest it will be far more effective.

And it's happening in many places. Our **government spends more than $30 million** on community health services, women's health and primary care partnerships for **doing health promotion using a community building model**.

*(Neighbourhood Renewal)*
As we study the Burden of Disease results, it is clear that **some municipalities suffer much poorer health than others**.

And in municipalities with a high burden of disease, there are **neighbourhoods that suffer even worse health outcomes**.

Remember Wilkinson's list of **social determinants of health** – social gradient, stress, social exclusion, unemployment, social support, transport? **Some of these areas exhibit low levels of every one**, with the possible exception of social support and networks.

To no one's surprise, a **number of these neighbourhoods are in public housing estates**, neighbourhoods where the State Government can make a difference.

In some of these areas, **workforce participation is as low as 5 percent**. Some children do not know any adult who holds a job. The incentive to **stay in school is low**, as is the incentive to **quit smoking, get exercise, or cut back on the grog**.

Hence, through the Office of Housing, our government has started a program of **Neighbourhood Renewal in 15** public housing areas, **with 8 more to come on board** in July.

Neighbourhood Renewal is about raising the standard of the housing. But even more importantly, it's about **improving the health and well-being, the employment levels and the educational attainment of the residents**.

**Community building is at the heart** of neighbourhood renewal. But it also recognises that **we cannot improve** the health, education and employment status of these neighbourhoods **by improving social capital alone. Economic capital is also needed.**

In **Morwell**, for example, residents themselves decided what housing improvements were really wanted.

Then, through the **State's Community Jobs Program, residents were employed** to work alongside skilled tradespeople. They gained skills, self-confidence, a training allowance – and many have moved on to regular employment or full-time training programs.

In **Shepparton**, residents of the **Parkside Estate were so isolated** that they couldn't get to the health services they needed.

Working with the Goulburn Valley Community Health Service, the residents have **brought a range of health services right into their neighbourhood** in a building they call the Meeting Place.

Their **next ambition** is to set up an **op shop** selling second hand clothes for teenagers – and have it **staffed by neighbourhood young people** who would then acquire training in retail.

As you can see from these snapshots, **improving health is not the primary objective of every Neighbourhood Renewal activity**.

But **Neighbourhood Renewal does focus on the fundamental social determinants of health** – employment, education, infrastructure, safety, environment and access to services.

By comprehensively tackling these root causes of ill health – and by emphasising community building – **Neighbourhood Renewal is in a strong position to begin to turn around health inequalities** in the most disadvantaged communities.

*(Conclusion)*
In conclusion, I have used these **examples** to **underscore the importance our government attaches to community building**, a point I know was made to you yesterday by Deputy Premier John Thwaites.

For too long, **health planners and policy makers have overlooked the vital importance of social connectedness**.

We live in a **complex world**.  Much as we might like to find a single answer, I am confident that the **solution to improving people's health and well-being will be as complex** as the world we live in.

The **challenge** that lies ahead - for researchers and practitioners alike - is to **untangle all the important factors** in determining people's health, and **establish the relative importance** of each.

But **until all the factors are better understood**, I'm going to **put my money** on the value of **building community and connections** whenever and wherever we can.

I'm confident that by doing so, **we will also build the health and well-being of our community**.

My thanks to Rhonda Galbally for the invitation to speak today.  I look forward to the discussion to follow and to hearing a full account of this important conference.

**(***If quoting from this speech, please acknowledge that it was presented to the **Communities in Control conference, convened by Our Community and Catholic Social Services.)**