The Tasmanian Government's Submission

Parliament of Tasmania

Joint Select Committee

Preventative Health Care

March 2013

Tasmania
Explore the possibilities

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1 Introduction

Health and wellbeing underpins the quality of life of Tasmanian families and communities, the strength of the economy and the amount of pressure placed on the health care system. Governments are increasingly examining the balance between investment in preventive health care, other care services in the community and acute health care.

The fundamental causes underlying Tasmania's health issues and disparities are the social determinants of health, and these are being impacted upon by socioeconomic circumstances and demographics.

The past century has seen a dramatic improvement in the health of our population, including reduced infant mortality, massive declines in deaths from infectious diseases, and major increases in average life expectancy at birth.

Many different aspects of prevention in the form of organised public health action to protect and promote health have contributed to the improved health and wellbeing that are enjoyed in Tasmania today. These include what could be regarded as 'classic' public health strategies, such as: improved sanitation and hygiene; immunisation programs; maternal and child health programs; improved environmental controls; injury prevention; needle and syringe programs; and many other interventions that are now well embedded in our social systems.

The community is now facing new and quite different prevention challenges. These new challenges are arising in part from a major increase in the prevalence of chronic conditions such as obesity, diabetes and cancers at the same time as the population demographic is changing and people are living longer. There is an urgency to improve the sustainability of current systems of care and the best way to do that is through preventing, or at least delaying, the onset of many of these conditions that ultimately require significant care and support structures for affected individuals.

Better knowledge of the impact of the social determinants of health and how 'social gradients' and disparities in these determinants can in themselves adversely affect health outcomes, is shifting the prevention focus from changing health risk factors alone, towards more effective approaches that also take into account the deeper causes underlying health behaviours.

Improved access to data about the health and wellbeing of Tasmania's population would make it easier for government departments and other agencies to plan for the most effective strategies based on knowledge about the problems affecting the communities they serve.

Strategies for action on the social determinants, as outlined by the WHO[1], include:

1. improvements to daily living conditions,;
2. tackling the unequal distribution of power, money and resources; and
3. measuring and understanding the problem and assessing the impact of action.

While all of the WHO recommendations are broadly supported by the information provided in this submission the third may provide the greatest opportunity for immediate action in Tasmania. Actions for measuring, understanding and assessing the problem include:

- monitoring and surveillance systems (or health intelligence);

[1] WHO, *Closing the Gap: Policy into practice on Social Determinants of Health,* World Conference on Social Determinants of Health, 2011 WHO. Access at www.who.int/sdhconference/Discussion-Paper-EN.pdf

- education and awareness;
- health equity impact assessment; and
- intersectoral mechanisms like shared budgets and interdepartmental committees.

This thinking is aligned to what is termed a 'Health in all Policies' approach.[2]

Examining and implementing a preventive health approach that takes into account the social determinants of health involves consideration of a highly complex set of problems. Tasmania is uniquely placed to take a proactive and whole of jurisdiction approach and can be at the forefront in Australia through a combination of community based and coordinated government or 'Health in All Policy' approaches.

1.1 Definition – Social Determinants of Health

The social determinants of health (see Figure 1) play a major role in influencing both the health of the Tasmanian population and the degree to which inequities are experienced within and between populations. The social determinants of heath are those conditions of daily living that determine a person's chances of achieving good health: the conditions in which people are born, grow, live, work and age.

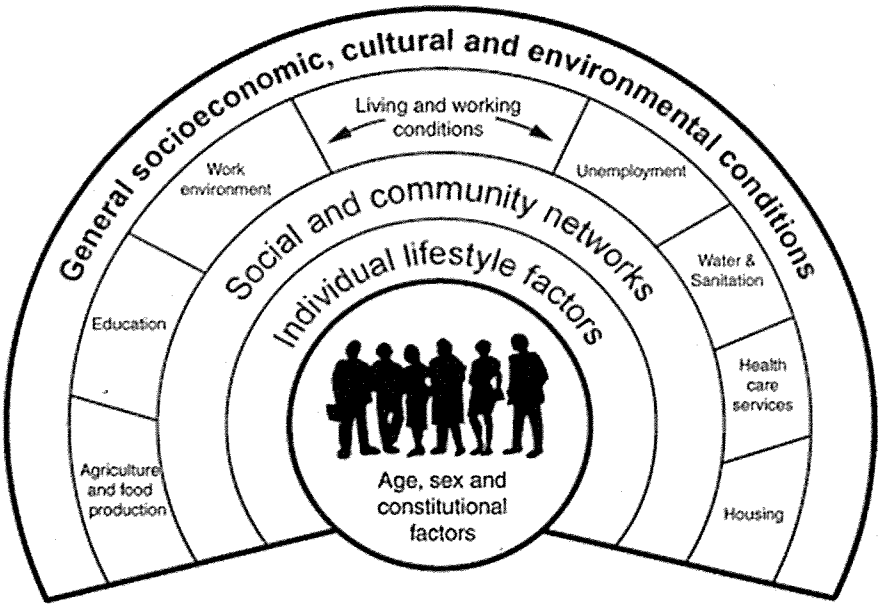

Figure 1. The Social Determinants of Health (Dalgren and Whitehead, 1991)

Also known as the 'causes of the causes,' they are the socioeconomic factors that influence health outcomes. In 2003, the WHO identified ten key socioeconomic factors understood to have the greatest influence upon health[3]:

[2] The Health in All Policies or HIAP approach as termed by the WHO refers to the use of a broad suite of actions and strategies. The same term has been applied to the name of the Tasmanian community network - the HIAP Collaboration - whose focus is on governance and structure. This issue is further elaborated on in Section 2.3.1 under Other Opportunities.
[3] World Health Organization (WHO). *The Solid Facts: Second Edition.* Edited by Richard Wilkinson and Michael Marmot. Geneva, WHO: 2003.

1. the social gradient[4];
2. stress;
3. early life;
4. social exclusion;
5. work;
6. unemployment;
7. social support;
8. addiction;
9. food; and
10. transport.

In other words a safe environment, adequate income, meaningful roles in society, secure housing, higher levels of education and social support within communities have all been associated with better health and wellbeing.

The social determinants of health are important because they underpin the life experience and outcome for every Tasmanian. The health care system has an important role in making improvements to hospitals and other health services, including access to quality primary care. The social determinants of health – where and how people are born, grow, live, work and age - lie outside of the health care sector, so to must the solutions. Improving population health and reducing health inequity will be achieved by influencing the factors that determine health and wellbeing. Factors like education, employment, transport, social inclusion, food and social supports.

No one organisation or sector can achieve this working alone. Working across sectors of government and the community (known as 'inter-sectoral action') is an important strategy to improve outcomes for Tasmanians.

A plain English glossary of the terms used in this submission is included in Attachment 3.1.

1.2 Whole of Government Approach

The Tasmanian Government recognises the difficulties that arise when addressing complex problems and has developed a number of tools and projects to assist state agencies in this respect. There is substantial interest and support from within the Government agencies for a collaborative approach to the challenges that will not be solved by any one department working alone.

The Government's Policy Framework is a critical guiding document that reflects the Tasmanian Government's priorities for 2013-14. Two further important whole-of-government projects that seek to improve the basis upon which decisions can be made are the Collaboration Approach and Stats Matter.

The Government's Policy Framework

The Giddings Government Policy Framework 2013-14 was released by the Premier in December 2012 (Attachment 3.2). The Premier stated that her Government's agenda is about giving all Tasmanians the opportunity to get a job and get ahead in life and that her aim, as Premier, is to dedicate the Government's energy to reducing inequality in our society.

[4] See Glossary at Attachment 3.1 for definition.

The Policy Framework sets the Government's higher order priorities against which policies, programs and initiatives can be guided. It identifies the three areas of priority: Jobs, People and Opportunities with three objectives listed under each area. All nine objectives in the Policy Frameworkare relevant to the Terms of Reference (ToR) of the Joint Select Committee Inquiry.

Overlaying the Policy Framework is the need to observe sound financial management and ensure agency and program budgets are appropriate, efficient and sustainable.

The Government has released its package centred on jobs. Further action on the remaining two areas for priority – people and opportunities – will be forthcoming in 2013.

The Collaboration Approach

It is clear that government agencies need to work together effectively and efficiently to solve complex problems – and even more so in the current constrained budget environment. The 'Tasmanian Government Approach to Collaboration' (the Collaboration Approach) was launched in October 2010to encourage a culture of collaboration across Government.

The Collaboration Approach provides a best practice framework to assist agencies to work better together on complex policy and service delivery issues in order to deliver better outcomes for all Tasmanians. It is also a guide to assist in identifying policy issues that could benefit from adopting such an approach and the critical factors for success. These include leadership, trust, shared aims, accountability, membership and information sharing.

While the Collaboration Approach focuses primarily on collaboration between State Service agencies, the approach can also be applied to, and acknowledges the importance of, collaboration with external stakeholders including non-government organisations. It also highlights the importance of developing a culture of collaboration internally within agencies, as a building block for broader collaboration.

Stats Matter

Stats Matter is a long term strategy to strengthen the Tasmanian Government's statistical assets and capability to enhance decision making – It is about the government and community making effective decisions based on sound statistical practice.

The Stats Matter project has acknowledged the clear need for the Tasmanian Government to focus on statistical practices, capability and evidence-based decision making. Using a statistical or scientific approach to investigate available evidence can lead to decisions that are more effective and result in better outcomes for the community.

Stats Matter will support Tasmanian Government agencies in developing sound policies, delivering targeted services and enhancing performance accountability.

These three initiatives (the Policy Framework, the Collaboration Approach and Stats Matter) apply across Government and are relevant to all agencies. They encourage and support collaborative, evidence based decision making. These are critical elements in addressing complex problems, including considering investment in preventive health and addressing the social determinants of health.

1.3 Terms of Reference and This Submission

It is noted that the Inquiry's title and ToR focus on 'Preventative health care' which implies a clinical base or setting. A greater part of effective prevention effort in the community occurs

outside of the direct influence of the health 'care' system and is driven very much by the social determinants of health. Accordingly this aspect represents the primary focus of this submission.

The focus of this submission is also on health inequity rather than health inequality (see Glossary in Attachment 3.1 for definition). It is generally accepted that equality in health outcomes is not achievable due to a range of factors that cannot be influenced including genetic or biological factors. As a result this submission focuses in addressing inequities – those factors (or social determinants of health) that can be changed.

While this submission outlines the key inequalities in the social determinants of health for Tasmanians and discusses the work of the Tasmanian Government in addressing the avoidable inequities, it must be acknowledged that these issues cannot be solved by the State Government acting alone. As well as the importance of work by other spheres of government (both Commonwealth and Local) and sectors, Government responsibilities need to be complemented by enabling measures that support local action in and by communities.

The WHO Commission on Social Determinants report *'Closing the gap within a generation'* was a landmark report that has elevated awareness of the social determinants of health worldwide. As the Commission has developed its work, some countries and agencies have become partners and sought to frame policies and programs, across the whole of society, which influence the social determinants of health and improve health equity.

This is an approach that has become known as Health in All Policies. Those countries that have moved to implement a Health in All Policies approach are regarded as at the forefront of the global movement on social determinants.

Significant groundwork and progress has been achieved in Tasmania already. The Tasmania Health Plan 2007 was a response to the changing health and health care needs of the population and included a strong focus on improving pathways and linkages between services provided by the State, local or Commonwealth Government, and services provided by the community or not for profit sectors. The 2008 *Tasmania State of Public Health* report identified that health inequities are a significant reason for the challenges facing Tasmania, and that this would need to inform service re-design and reform.

Making progress to improve outcomes for Tasmanians also depends on the contributions and actions of the Commonwealth Government, Local Government, non-government organisations, research organisations, business, community groups and individuals. Not only does the Tasmanian Government need to work together internally to make progress, collaboration is also required and sought with other relevant organisations to ensure the most appropriate partnerships, strategies and actions are implemented.

Interest in the social determinants of health and health inequity has grown in Tasmania, both within and outside of government and was strengthened with the launch of the Health in All Policies approach of South Australia in early 2010.

The Tasmanian Government initiated the *Fair and Healthy Tasmania Strategic Review* in 2010 in order to find the best ways of improving health outcomes and reducing avoidable health inequities in Tasmania. Concurrent to this the Health in All Policies Collaboration, and more recently a Social Determinants of Health Advocacy Network has been established in the community sector that are active in raising the profile and interest in action on the social determinants of health.

Towards the end of 2011 the Tasmanian Government responded to the findings of the *Fair and Healthy Tasmania Strategic Review* with the release of *A Healthy Tasmania: Setting New Directions for Health and Wellbeing* (A Healthy Tasmania).

A Healthy Tasmania is the Tasmanian Government's strategic policy direction for a fairer and healthier Tasmania. It is a long term approach for building good health and wellbeing in collaboration with communities. A Healthy Tasmania is about keeping Tasmanians healthy, well and in control of what matters to them.

A Healthy Tasmania also acknowledges that the daily conditions of living that determine a person's chances of achieving good health and wellbeing in the first place – such as education, employment, transport, poverty, early childhood – lie outside of the control of the health sector.

As with all the biggest policy challenges facing governments today, health inequity is a 'wicked issue' - complex and cross cutting. It cannot be addressed by one part of government acting alone. What is required is the active collaboration across governments and the community.

Key Themes

The social determinants of health are those conditions of daily living that determine a person's chances of achieving good health. This includes factors like housing, education and social support. They are important because they underpin the life experience and outcome for every Tasmanian. While the health care system has an important role, addressing the social determinants of health cannot be achieved through the health care system alone. As the social determinants of health (where and how people are born, grow, live, work and age) lie outside of the health care sector, so too must the solutions.

The following key themes have arisen in preparing this submission:

- preventive health is much broader than health care and the whole of government has a responsibility to act on the social determinants of health;
- policy responsibility for preventive health is blurred between the State and Commonwealth Governments;
- intersectoral action is critical to reducing health inequities and must incorporate the Commonwealth Government, state governments, non-government organisations, the community sector as well as the individual;
- preventive health is a long-term agenda with no single solution. Investment in primary prevention, especially in the early years, is important to achieve the greatest financial and social benefits;
- financial constraints need to be considered including rising health care costs, Tasmania's demographic circumstances (with an aging population), and the limited capacity for state governments to raise revenue relative to the Commonwealth Government;
- to improve the health outcomes and quality of life for Tasmanians everyone needs to be involved in responding to local needs and building resilient communities;
- information systems are required to collect population and social health data. Mechanisms to make this information broadly available to inform policy responses and service planning is also necessary;

- it is critical that other existing bodies of work already underway in Tasmania be considered by the Joint Select Committee including the work of the Health and Wellbeing Advisory Council, the Commission on the Delivery of Health Services in Tasmania and the State of Public Health Report Tasmania 2013; and
- the findings of the national Senate Inquiry into Australia's Domestic Response to the World Health Organisation (WHO) Commission on Social Determinants 'Closing the Gap in a Generation' Report will also be relevant to the Inquiry.

Examining and implementing a preventive health approach that takes into account the social determinants of health is an area of growing significance and one that the Tasmanian Government is actively supporting through important initiatives such as the Health and Wellbeing Advisory Council.

This submission shows that Tasmanian Government is actively engaged both in actions to support the provision of preventive health care and actions to address the social determinants of health.

2 Response to the Terms of Reference

2.1 Terms of Reference 1

(1) The current impact of inequalities in the major social determinants of health on the health outcomes, including mental health outcomes of Tasmanians and including current evidence describing social gradients in health, and the capacity for health and community services to meet the needs of populations adversely affected by the social determinants of health.

This ToR can be considered in two parts, the first focusing on the current statistical evidence underpinning the discussion on the social determinants of health in Tasmania and the second examining the service capacity to respond to identified areas of need.

2.1.1 Tasmania's Health Status

The State of Public Health Report is provided to the Tasmanian Parliament every five years as required by the *Public Health Act 1997*. The *State of Public Health Report 2008*[5] provided an analysis of the impact of social determinants of health in Tasmania and highlighted the role that governments must play in reducing health inequities.

The State of Public Health Report 2013 and its companion document Health Indicators Tasmania 2013 are currently being prepared. The data sources informing these documents include:

- the 2009 Tasmanian Population Health Survey[6];
- the National Health Survey and Australian Health Survey[7];
- the National Drug Strategy Household Survey[8];
- the Australian Secondary Schools Alcohol and Drug Survey[9];
- the National Secondary Students' Diet and Activity Survey[10];
- the Survey of Disability, Ageing and Carers[11];
- Births and deaths data; and
- Tasmania's own databases such as the Tasmanian Statewide Hospital Morbidity Database and the Cancer Registry.

The above sources have also informed this section, which provides an overview of Tasmanians' current health status including mental health, the inequities in health, and the social gradient.

There are several ways to depict this gradient, and these are often dependent on the types of analysis available from the various sources of data. Household income is one simple measure that is used due to its association with a range of other social determinants. Using census data the Australian Bureau of Statistics (ABS) regularly constructs more sophisticated Socio-

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[5] Access via http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0020/60095/State_of_Public_Health_Report_2008.pdf
[6] Access via http://www.dhhs.tas.gov.au/pophealth/epidemiology
[7] Access via http://www.abs.gov.au/websitedbs/D3310114.nsf/Home/Australian+Health+Survey
[8] Access via http://www.aihw.gov.au/publication-detail/?id=32212254712
[9] Access via http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/mono58
[10] Access via http://www.cancervic.org.au/module_research/module_research_projects/secondary-students-diet-nassda.html
[11] Access via http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0

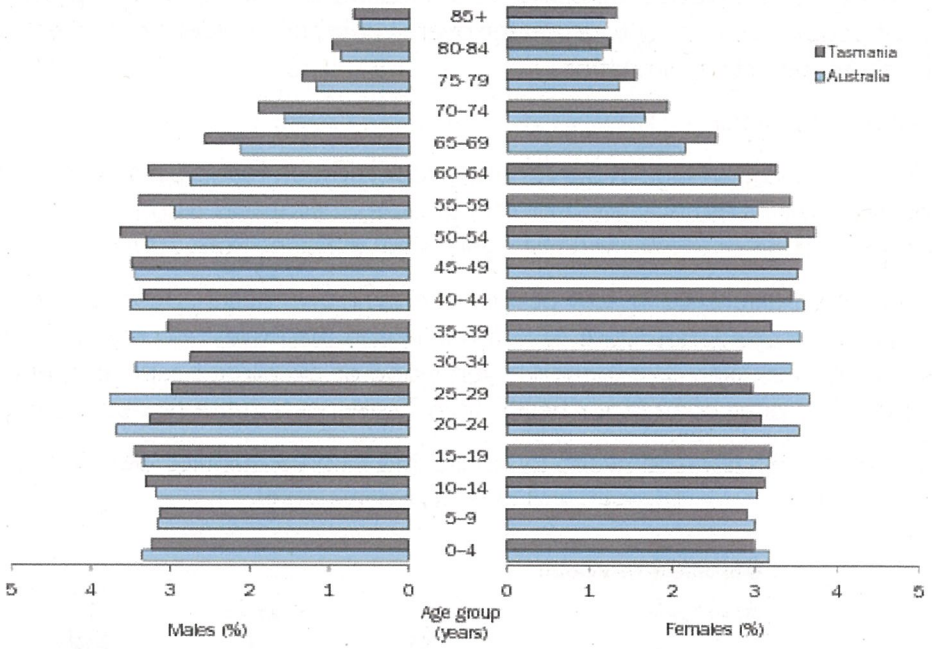
Economic Indexes For Areas (SEIFA) that summarise a range of socio-economic variables associated with disadvantage. These indexes are compiled at the Census Collection District (CD) level, and may be used to rank CDs. Also highly relevant to interpreting health data for Tasmania is another type of ABS classification that divides Australia into major cities, inner regional, outer regional, remote and very remote categories (Tasmania does not classify as having a major city).

Age and Sex Distribution

The age distribution of Tasmania's population at June 2011 was characterised by a lower proportion of people aged 20 to 44 years than the total Australian population (Figure 2). As a proportion of the Tasmanian population, 20 to 44 year olds made up 31% (down from 34% in 2001) compared to 36% for Australia as a whole. This in part reflects a net outflow of young adults from Tasmania to pursue education and employment opportunities interstate.

Tasmania also had a higher proportion of people aged 45 years and over (44%, up from 38% in 2001) than Australia as a whole (39%). This partly reflects a trend of adults in this age group moving to the State.

Figure 2. Age and Sex Distribution (%), Tasmania – 30 June 2011



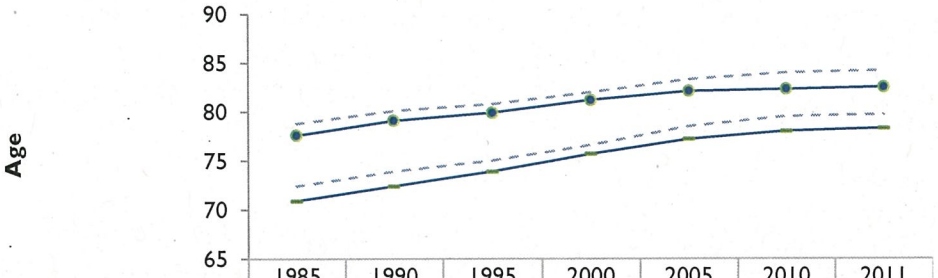
Life expectancy

The health of Tasmanians is generally good and improving with longer life expectancy and good self-reported health.

Life expectancy has steadily improved over the 25 year period 1985 to 2011. The Tasmanian male life expectancy in 2011 at birth was 78.3 years which is 8.4 years higher than it was in 1985, compared to an additional 4.9 years for females with a current life expectancy at birth of 82.5 years, narrowing the life expectancy gender gap by about two years.

However, Tasmania continues to have one of the lowest life expectancy of all states and territories. The life expectancy gap between women in Tasmania and Australia as a whole has widened, by half a year since 2005 (now 1.7 years as shown in Figure 3).

Figure 3: Life expectancy at birth, Tasmania and Australia 1985-2011



	1985	1990	1995	2000	2005	2010	2011
Tas Males	70.9	72.4	73.9	75.7	77.2	78.0	78.3
Tas Females	77.6	79.1	79.9	81.2	82.1	82.3	82.5
Aus Males	72.4	73.9	75	76.6	78.5	79.5	79.7
Aus Females	78.8	80.1	80.8	82	83.3	84.0	84.2

ABS, Deaths Australia 2011, November 2012

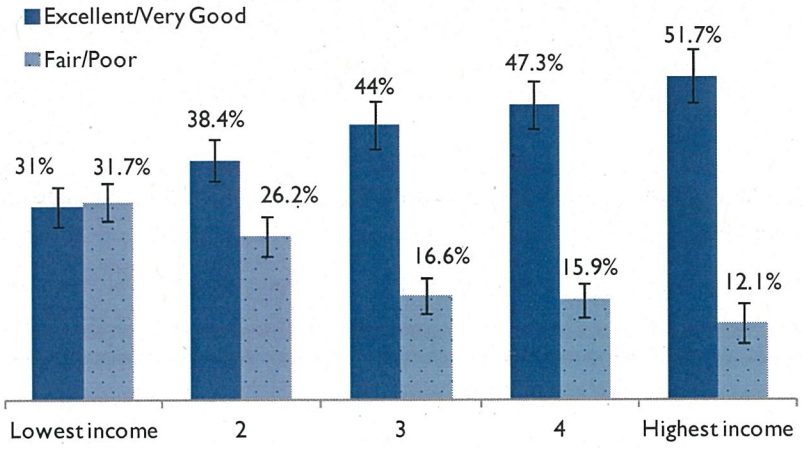
Most of the life expectancy increases in Australia have been in 'healthy' years, plus years lived with some disability, with only a small component of increased years of life associated with profound disability. However, the ageing of the Australian population and the increasing longevity of people are leading to a greater overall number of older people with disability and severe or profound activity limitation.

Self-assessed health status

In the 2011-12 Australian Health Survey, the proportion of Tasmanians aged 15 years and over who reported their health was good or very good/excellent was 81.6%, slightly lower than the Australian proportion of 85.6%, and not significantly different from 2007-08.

There is a marked difference in how people rate their own health, depending on their household income category (Figure 4). Tasmanians in the lowest income household group were significantly less likely to experience very good or excellent health and reported significantly higher rates of fair/poor health than Tasmanians in the highest income household.

Figure 4: Self-assessed health by household income quintiles, population 18 years and over, Tasmania 2009



Tasmanian Population Health Survey, 2009

Mortality and cause of death

While prevention and health care are driving mortality rates down, Tasmania's mortality rates remain significantly higher than the national average. Tasmania's age standardised mortality rate in 2011 was 6.5 deaths per 1000 population, down from 7.6 in 2001. The Australian standardised mortality rate was 5.6 deaths per 1000 population in 2011.[12] Tasmania's mortality rate in 2011 was the highest of all jurisdictions apart from the Northern Territory (7.3).

In 2010, the most common causes of death in Tasmania were cancer (28.3% of all deaths) and ischaemic heart disease (15.6% of all deaths).

Tasmania's age standardised mortality rates are higher than Australia's for a number of conditions. These include cancer, diabetes mellitus, ischaemic heart disease, strokes and intentional self-harm.

The Tasmanian age-standardised mortality rates for ischaemic heart disease and cerebrovascular accident (stroke) have declined by approximately two-thirds for both males and females between 1978 and 2010.

The very substantial decline in coronary heart disease death rates is attributable to a number of factors; prominent among them are declining levels of tobacco smoking and the availability of better primary health and hospital care. Evidence from other countries attributes improvements in risk factors and treatments in about equal proportions.[13]

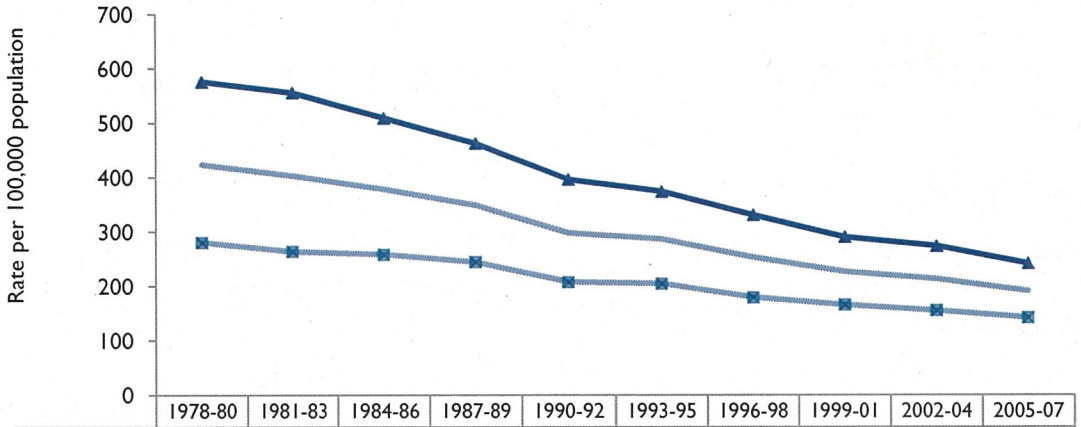
Potentially avoidable deaths

'Avoidable mortality' refers to causes of death before the (arbitrarily chosen) age of 75 that could potentially have been avoided or delayed either through effective prevention or treatment of specific diseases. This concept is helpful from a prevention perspective in monitoring health outcomes for conditions that are amenable to prevention and treatment, and there is a nationally agreed approach to the calculation of avoidable mortality rates.

Over the period 1978 to 2007, there has been a steady decline in potentially avoidable deaths by approximately 55% (Figure 5).

[12] Australian Bureau of Statistics. Deaths, Australia, 2011 (cat. no. 3302.0), November 2012.
[13] Australian Institute of Health and Welfare 2011. Cardiovascular disease: Australian facts 2011. Cardiovascular disease series. Cat. no. CVD 53. Canberra: AIHW.

Figure 5: Potentially avoidable mortality, population 0-74 years, Tasmania, 1978-2007

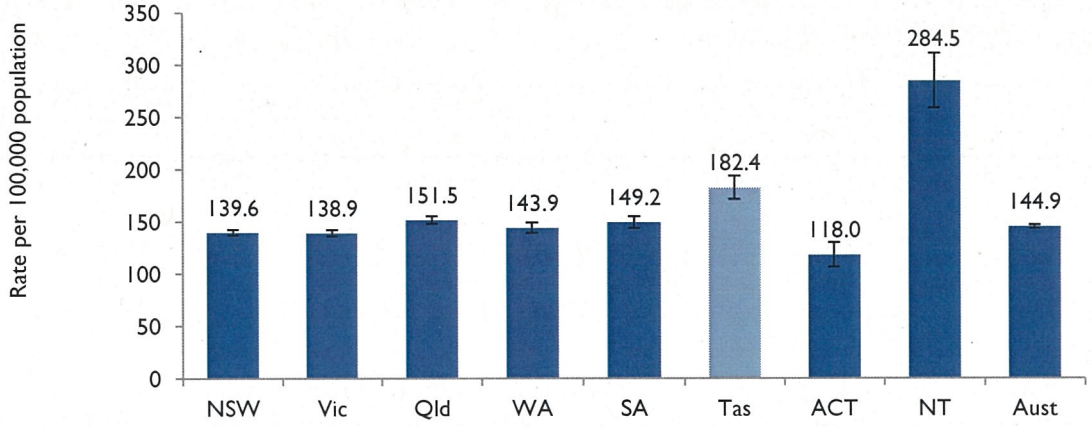


	1978-80	1981-83	1984-86	1987-89	1990-92	1993-95	1996-98	1999-01	2002-04	2005-07
Males	575.9	555.6	509.1	462.3	395.9	373.8	330.6	290.2	273.3	241.4
Females	280.4	263.6	258.2	244.3	207.5	204.8	179.4	165.6	155.0	141.8
Persons	423.6	402.7	378.3	348.5	297.6	286.5	252.7	226.5	213.2	190.8

Notes: 1. Rates are age-standaridsed to the Australian 2001 population. 2. Avoidable deaths were estimated using disease codes developed by the New South Wales Department of Health (2010). 3. Average annual percentage change for males: -3.3% (P<0.01); for females: -2.6% (P<0.01); for persons: -3.0% (P<0.01).

However, Tasmania still has significantly higher rates of potentially avoidable deaths than Australia. In 2009, there were 182.4 per 100,000 population compared with 144.9 for Australia as a whole (Figure 6).

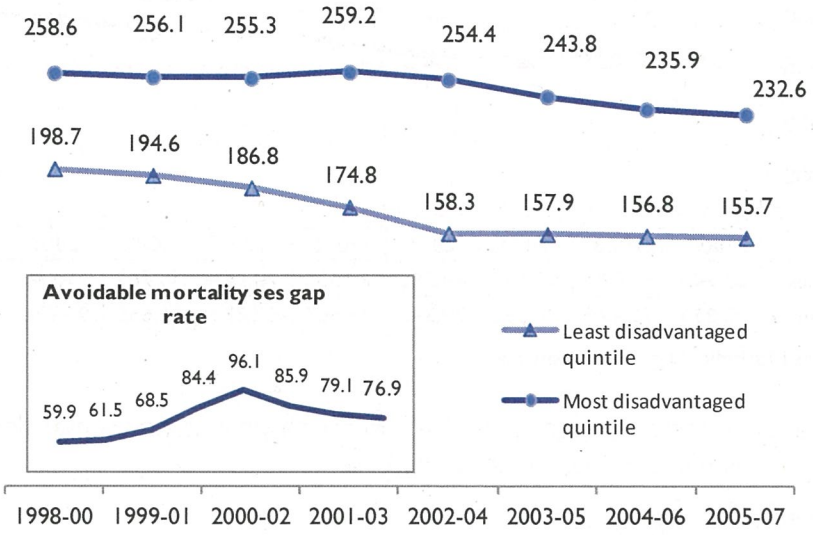
Figure 6: Potentially avoidable mortality from all-causes, under 75 years, Australia, 2009



Notes: 1. Rates are age-standardised to the Australian 2001 population. 2. The error bars represent the 95% confidence intervals of the rate.. 3. COAG Reform Council 2012, *Healthcare 2010–11: Comparing performance across Australia, COAG Reform Council, Sydney.*

Avoidable mortality rates by socio-economic status are a good measure of health inequities. Figure 7 below compares avoidable death rates in people living in the highest SEIFA quintile areas in Tasmania, with those in the most disadvantaged quintile. While rates have improved in both groups, greater improvements have occurred in the high socioeconomic group.

Figure 7: Avoidable mortality by socio-economic status (SEIFA), age 0-74 years, age standardised rates per 100,000 population, Tasmania 1998/00 – 2005/07



DHHS, Epidemiology Unit Rates age standardised to the 2001 Australian population

The infant mortality rate in Tasmania was 4.5 deaths per 1000 live births in 2011, and over time has consistently remained comparable with or better than the Australian rate.

Hospitalisations

Hospitalisation rates are increasing, but progress is also occurring through prevention and early disease detection with low rates of potentially preventable hospitalisations, as well as high levels of participation in cancer screening and primary care consultations.

Hospitalisations data are an important health status indicator, but should be interpreted with caution. Hospitalisations refer to hospital separations or episodes of care in a hospital. A person can have more than one separation per hospital visit and more than one separation per year.

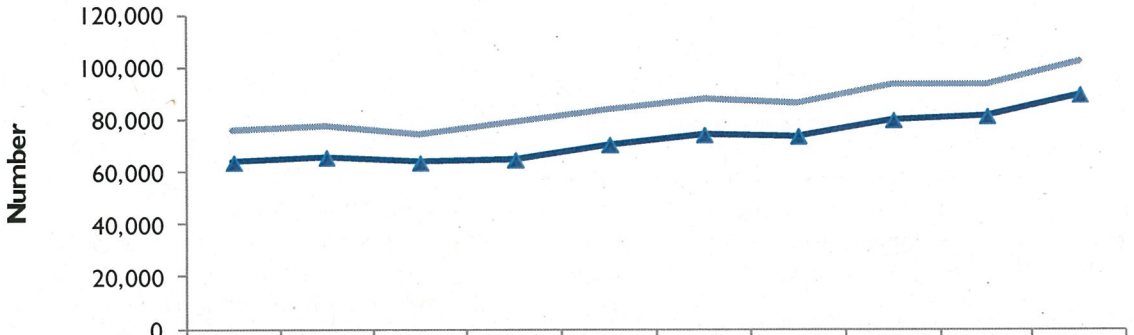
In 2011 there were approximately 191,449 hospital admissions to Tasmanian hospitals. The number of patients being treated in both public and private hospitals each year continues to rise, at a significantly higher rate than the percentage increases observed for the Tasmanian population overall during this time period.

From 2002 to 2011, hospitalisations due to all causes have increased by 25,766 separations (40%) for males, and by 26,036 separations (34%) for females (Figure 8). Hospitalisation rates in females were higher than in males between 2002 and 2011.

Hospitalisation rates are increasing for diabetes and arthritis/musculoskeletal conditions.

A significant component of the overall increase in hospitalisations has been in the number of hospitalisations in persons aged over 65.

Figure 8: All-cause hospitalisations by sex, Tasmania, 2002-11



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Males	63,788	65,704	63,684	64,798	70,556	74,346	73,762	79,948	81,444	89,554
Females	75,859	77,479	74,093	79,345	83,906	87,881	86,659	93,724	93,697	101,895

Statewide Morbidity Database, Tasmania.

The likely impact of Tasmania's ageing population on hospitalisations is that demand for hospitalisation in Tasmania will continue to increase.

Potentially preventable hospitalisations

'Potentially preventable hospitalisations' are conditions where hospitalisation is believed to be avoidable through the primary prevention, early detection and the provision of timely and adequate primary care for established conditions.

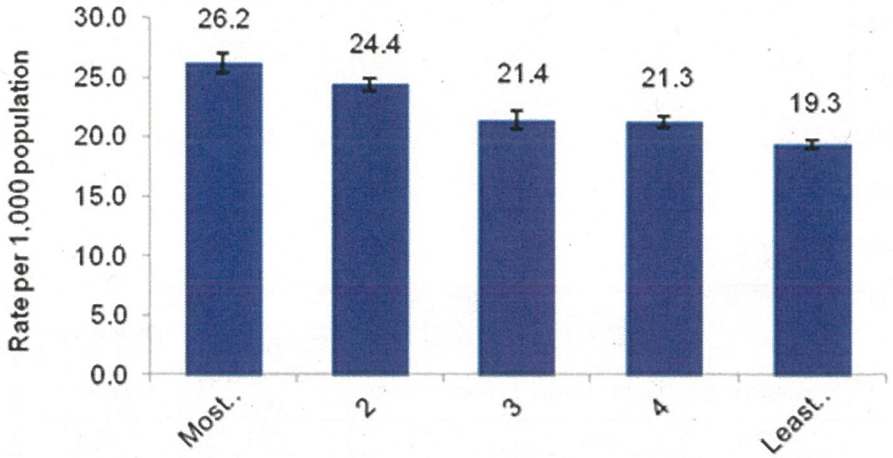
Potentially preventable hospitalisations have not increased over the last decade and compare favourably with the rates of other jurisdictions. From 2010-11, only 6.7% of all hospitalisations in Tasmania were potentially preventable and Tasmania had the second lowest rate of such admissions of all the states and territories, with a rate of 20.2 compared with the Australian average of 27.7 per 1 000 population.

It is important to note that the definitions used for calculation of preventable hospitalisation rates take into account only some of the factors that underlie hospital bed utilisation or demand. Beyond access to primary health care, strong influences on rates of hospitalisation include socioeconomic status, age, ethnicity, comorbidity, continuity of care, rurality and mental health problems.[14]

However, potentially preventable hospitalisation rates for the most disadvantaged SEIFA quintile (26.2 per 100 000 population) were almost 30% higher than for the least disadvantaged quintile at 19.3 per 100 000 population, with a clear gradient across quintiles (Figure 9).

[14] Katterl R, Anikeeva O, Butler C, Brown L, Smith B, Bywood P. (2012). *Potentially avoidable hospitalisations in Australia: Causes for hospitalisations and primary health care interventions.*
PHC RIS Policy Issue Review. Adelaide: Primary Health Care Research & Information Service. July 2012.

Figure 9: Potentially preventable hospitalisations by socio-economic status (SEIFA), Tasmania 2009-11



Notes: 1. Rates are age standardised to the Australian 2001 population. 2. The error bars represent the 95% confidence intervals of the rate.

Chronic conditions prevalence in Tasmania

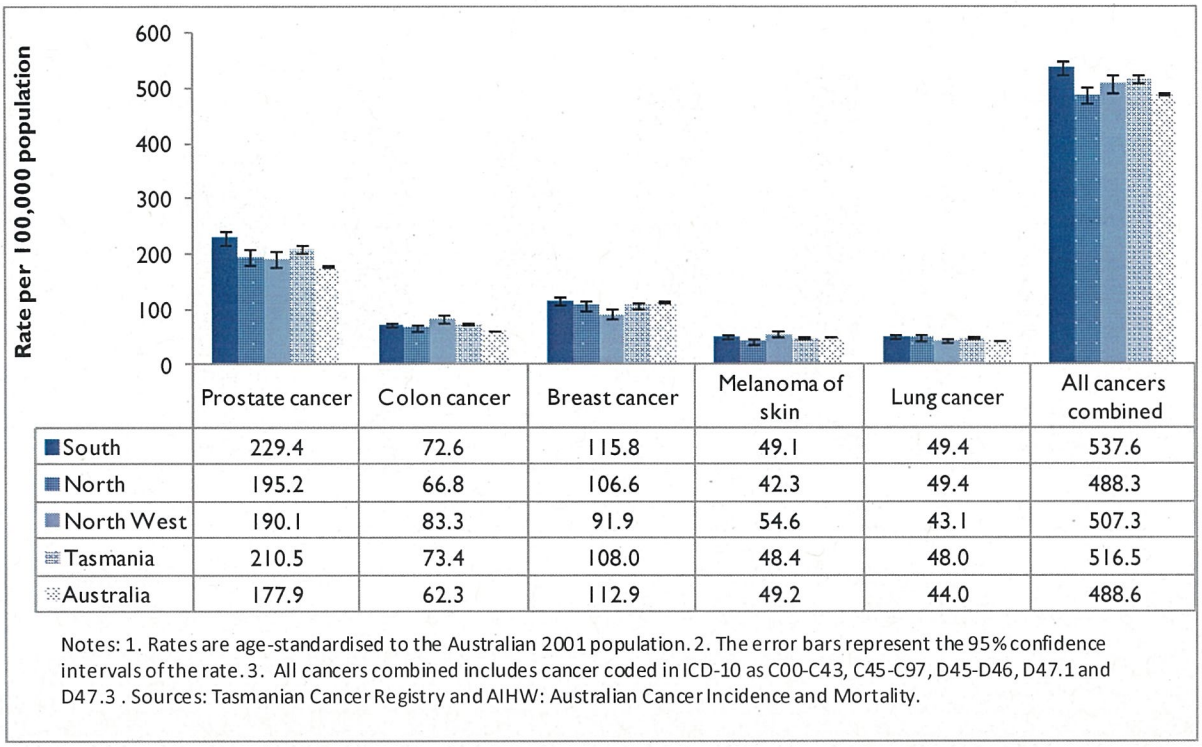
The growing prevalence of chronic conditions reflects Tasmania's ageing population, although better prevention and health care is driving mortality rates down. There has been a downward trend for hospitalisations and mortality for a number of chronic conditions such as strokes and ischaemic heart disease, while hospitalisations have increased for diabetes and arthritis/musculoskeletal conditions.

More than three in ten Tasmanians are affected by arthritis or some other musculoskeletal condition, and more than one in seven is diagnosed with hypertension (13.6%).

There is a statistically significant difference in age-standardised cancer incidence rates between Tasmania and Australia, when all cancer types are combined. As shown in Figure 10 there is also a significant difference between Tasmania and Australia for three of the five top cancer types: prostate, colon and lung cancer.

An increase in cancers will likely become particularly noticeable in Tasmania due to the sharp increase in cancer rates that occurs in later years.

Figure 10: Age-Standardised Incidence Rates for top five cancers in Tasmania and Australia, 2005-09



	Prostate cancer	Colon cancer	Breast cancer	Melanoma of skin	Lung cancer	All cancers combined
South	229.4	72.6	115.8	49.1	49.4	537.6
North	195.2	66.8	106.6	42.3	49.4	488.3
North West	190.1	83.3	91.9	54.6	43.1	507.3
Tasmania	210.5	73.4	108.0	48.4	48.0	516.5
Australia	177.9	62.3	112.9	49.2	44.0	488.6

Notes: 1. Rates are age-standardised to the Australian 2001 population. 2. The error bars represent the 95% confidence intervals of the rate. 3. All cancers combined includes cancer coded in ICD-10 as C00-C43, C45-C97, D45-D46, D47.1 and D47.3 . Sources: Tasmanian Cancer Registry and AIHW: Australian Cancer Incidence and Mortality.

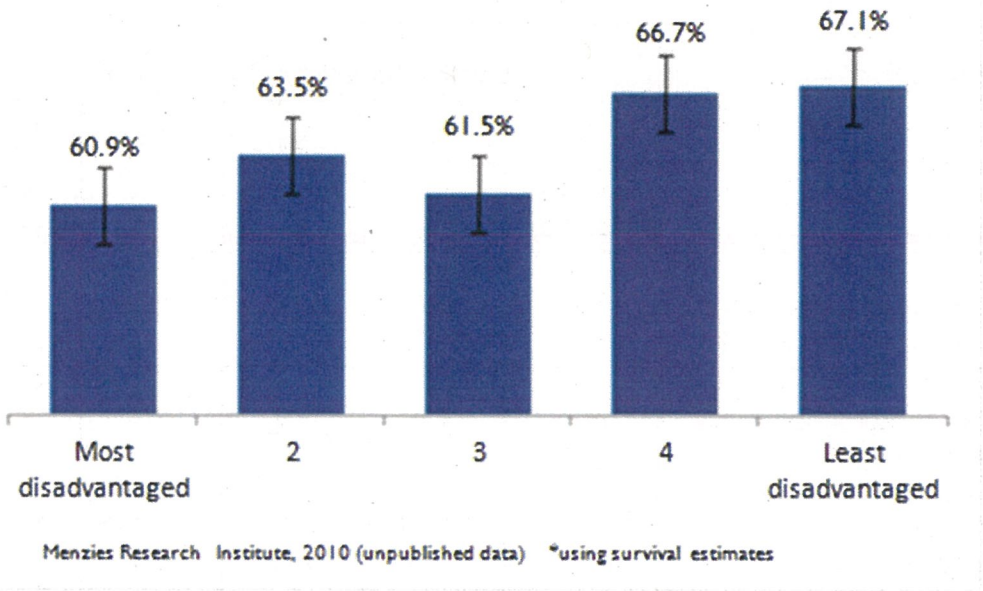
Over the past three decades there have been significant improvements in survival times for people diagnosed with cancer. The estimated five-year survival rate for Tasmanians diagnosed with cancer in 2003-07 was 64% overall, with a slightly higher survival for males and Tasmanians aged less than 65 years at the time of diagnosis. Tasmanians living in areas of least socio-economic disadvantage at the time of their cancer diagnosis have significantly higher cancer survival rates than those living in areas experiencing the most disadvantage (Figure 11).

Poor survival outcomes in areas of greater socio-economic disadvantage may be due, in part, to a higher proportion of cases being diagnosed at a more advanced stage of cancer, and for some conditions such as breast cancer there is evidence that good psychosocial support improves survival.

Nationally, in the 5 years from 2006 to 2010, the five-year relative survival from all cancers combined was significantly higher for people living in the highest (71%) compared with the lowest (63%) socioeconomic status areas; and higher in major cities (67%) and lowest in remote and very remote areas (63%).[15] Due to timing differences these figures are not directly comparable to those shown below for Tasmania in Figure 11.

[15] Australian Institute of Health and Welfare & Australasian Association of Cancer Registries 2012. Cancer in Australia: an overview, 2012. Cancer series no. 74. Cat. no. CAN 70. Canberra: AIHW.

Figure 11: Five-year cancer survival rates* by socio-economic status (SEIFA), Tasmania 2003-2007



Behavioural risk factors

A snapshot of progress towards healthier lifestyles in Tasmania remains mixed. Tasmanians display higher levels of some of the behavioural risk factors which continue to contribute to the burden of disease. For example, Table 1 shows that compared to the national average, Tasmanians are more likely to be overweight or to smoke.

Table 1. Selected chronic disease risk factor prevalence (% adults aged 18+)[16]

Risk Factor	Indicator	Tasmania %	National Average %
Smoking	Current daily smokers	21.8	16.3
Alcohol misuse	At risk of long-term alcohol-related harm	22.7	19.5
Physical inactivity	Classified as sedentary or low level activity	69.4	67.5
Overweight	Overweight/Obesity BMI	65.6	63.4

As shown in Table 2, the distribution of certain risk factors for chronic conditions follows the social gradient in Tasmania, with those in lower income brackets more likely to be physically inactive or smoke. Smoking and obesity are strongly related to socio-economic status, with

[16] *Australian Health Survey Data 2011/2012*

smoking and obesity around twice as common for Tasmanians residing in the most disadvantaged areas.

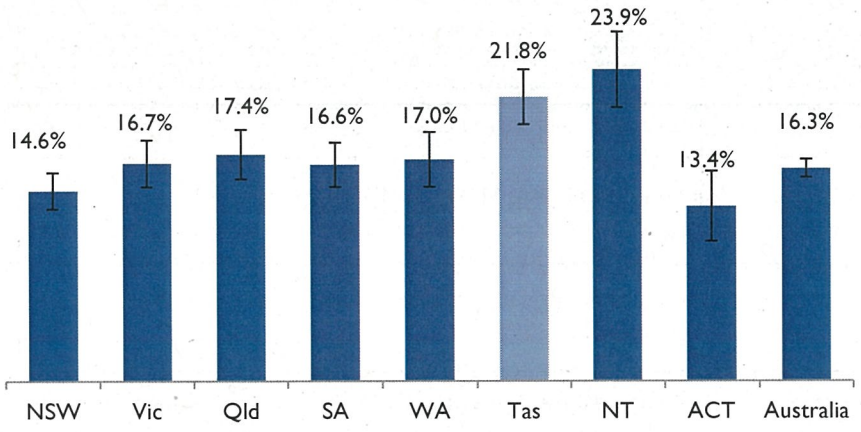
Table 2. Selected Chronic Disease Risk Factor Prevalence by Household Income[17]

Risk Factor	% within household income quintile				
	1st (Lowest Income)	2nd	3rd	4th	5th (highest income)
Daily/occasional smoking (persons aged 18+ years)	32.1	29.4	24.9	23.9	15.6
Alcohol consumption levels at risky/high risk for long term harm	9.4	9.6	9.9	15.6	17.0
Sedentary activity levels (persons aged 12+ years)	41.9	41.9	33.8	27.4	17.8

Smoking rates

With 21.8% of adults smoking daily, Tasmania continues to have higher rates of smoking than all other states and territories except the Northern Territory (Figure 12).

Figure 12: Daily smokers 18 years and over by Jurisdiction, 2011-12



Australian Health Survey First Results, 2011-12, cat. No. 4364.0

In 2011-12, over 30% of young Tasmanians aged 18-24 years were current (daily or occasional) tobacco smokers, compared with about 7% of older Tasmanians aged 65 years and over.

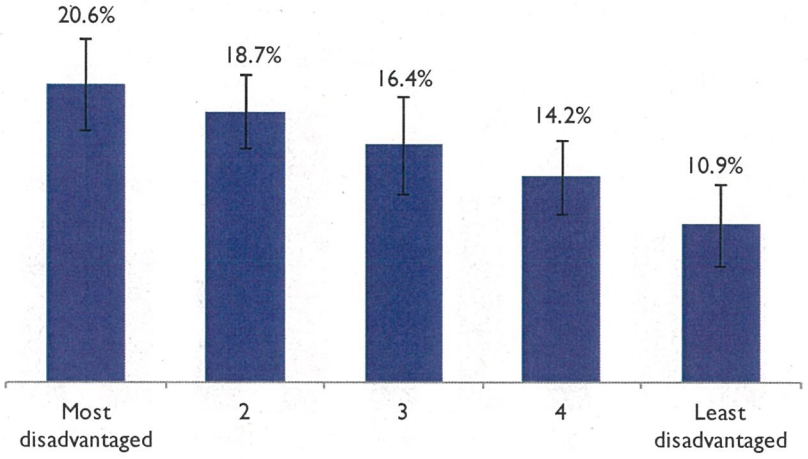
[17] National Health Survey Data 2004/2005

In 2010 the rate of Tasmanian women who continued to smoke during pregnancy was 23%, with 46.8% comprising teenage mothers[18]

Smoking rates for secondary students have declined significantly since 1984, from 22% down to 6% for 12-15 year olds in 2011, and from 31% down to 16% among students aged 16-17 years.

Figure 13 shows that smoking is about twice as prevalent within the most disadvantaged communities (20.6%) compared to the least disadvantaged areas (10.9%).

Figure 13: Daily smoking prevalence by socio-economic status (SEIFA), population 18 years and over, Tasmania 2009



Tasmanian Population Health Survey, 2009

Alcohol-related harms

Alcohol consumption exceeding single occasion risk (more than 4 standard drinks on a single occasion) was higher in Tasmania (54.6%) than at the national level (44.7%), and higher for younger age groups and males. Alcohol consumption at levels averaging more than 2 standard drinks per day is associated with increased risk of long-term harms (NHMRC 2009 Guideline). In Tasmania the proportion of the adult population exceeding this guideline is 22.7% - comprising 35.9% among males (compared to 29.1% of males at the national level) and 10.2% in females (compared to 10.1% nationally).

Alcohol consumption during pregnancy has halved, from 18.3% in 2005 to 9.2% in 2010, with the majority of these women reporting less than one drink per day on average.

Physical inactivity

Being sedentary, or insufficiently physically active, is a powerful risk factor associated with cardiovascular disease, type 2 diabetes, some types of cancer and mental health problems.

Physical activity levels remain low with 69.4% of Tasmanian adults reporting inadequate levels of activity, comparable to the Australian figure of 67.5%. The National Physical Activity Guidelines recommend at least 30 minutes of moderate physical activity for adults on at least five days of the week for a total of 150 minutes per week.

Similarly, Tasmanian secondary school students are insufficiently active, with less than 20% of students reporting adequate levels of physical activity. Australia's physical activity

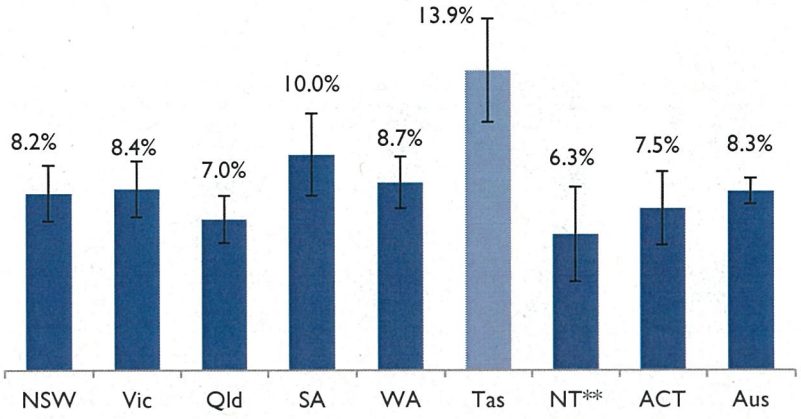
[18] Tasmanian Council of Obstetric & Paediatric Mortality & Morbidity. Annual Report 2010. DHHS, August 2012.

recommendation for children and adolescents up to the age of 18 years is to engage for at least 60 minutes in moderate to vigorous activity seven days a week. In Tasmania in 2011 only 18% of students aged 12-15 years and 17% of students aged 16-17 years met this recommendation.

Nutrition

Only one in seven Tasmanians (13.9%) meet the national nutrition guidelines recommending at least 5 serves of vegetables per day – significantly higher than the national average but clearly also there is large scope for improvement (Figure 14).

Figure 14: Adequate vegetable consumption (>5 serves daily), 18 years and over by jurisdiction, 2011-12



Australian Health Survey First Results, 2011-12, cat. No. 4364.0

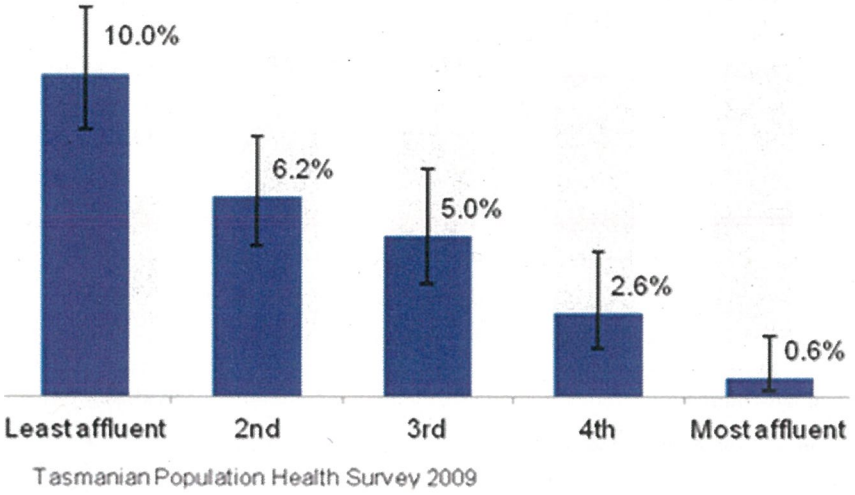
The proportion of Tasmanian adults eating at least two pieces of fruit a day has fallen from 53.7% in 2004 to 43.1% in 2011.

Breastfeeding initiation rates have been reasonably stable over time, with almost 80% of Tasmanian mothers reporting their intention to breast feed at the time of maternal discharge – but 'fully breastfed' rates drop to around half that by the age of 4 months.

Food security - the ability to purchase adequate food – is closely associated with income, but can also be influenced by factors such as local availability and transport. The 2009 Tasmanian Population Health Survey showed a substantial gap in food security between 'rich' and 'poor' households. Overall, 5% of Tasmanian adults reported to have run out of food in the last 12 months and were unable to purchase more – with this figure being 10% in the least affluent households compared with less than 1% of adults in the most affluent households (Figure 15).

A factor reported by a number of low income households in not being able to purchase nutritionally adequate food, was lack of access to transport.

Figure 15: Proportion of adults who experienced food insecurity by household income quintiles, Tasmania, 2009

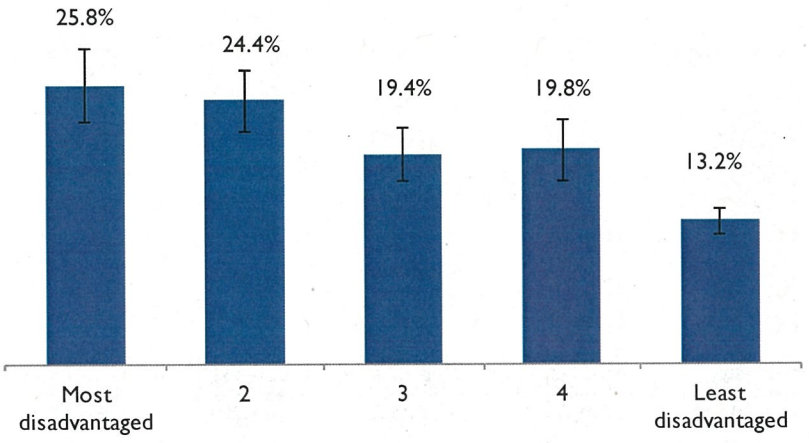


Overweight/obesity

The rate of overweight/obesity in Tasmanian adults in 2011-12 was 65.6%, which is higher than the Australian rate of 63.4% but the difference was not statistically significant, including after adjusting for age. Since 2007-08, the prevalence of measured overweight/obesity has increased by about 2% for both Tasmania and Australia as a whole. The crude Tasmanian rate for overweight (BMI 25 – 25.9) in 2011-12 was 37.2% and for obesity (BMI 30 or higher) it was 28.5%.

The 2011-12 Australian Health Risk Survey found that 50.8% of Tasmanian women in the 18 – 34 year age group were found to be either overweight or obese. Around one in four pregnant women are obese at the time of conception. Figure 16 shows that the proportion of Tasmanian adults living in areas with the greatest disadvantage who were obese (25.8%) was almost twice that of adults living in areas with the least disadvantage and reporting to be obese (13.2%). It should be noted that self-reported data on height and weight are less reliable than measured data, so the rates shown below may understate the true prevalence.

Figure 16: Obese BMI by socio-economic disadvantage (SEIFA), population 18 years and over, Tasmania 2009



Tasmanian Population Health Survey, 2009

Mental Health

'Mental illness' is a term that describes a diverse range of behavioural and psychological conditions. These conditions can affect an individual's mental health, functioning and quality of life. It is widely recognised that mental illness is a substantial burden for individuals and communities in Australia. In brief:

- At any one point in time, 2-3% of the Australian adult population will be affected by severe mental illness, 4-5% by moderate mental illness, and 9-10% by mild mental illness[19].
- Mental illness ranks fourth as the major cause of life-years lost (after heart attacks, stroke and cancer).
- Mental illness typically affects people at important developmental stages such as late adolescence and early adulthood.
- Up to 14% of children and adolescents experience mental health problems each year, with the potential for long term disability.
- One in five adults, or approximately 60 000 Tasmanians per year experience mental ill-health including depression or anxiety, sometimes with contributing issues such as alcohol or substance use.
- Between 2006 and 2010 Tasmania had the second highest suicide rate of all jurisdictions (14.4 deaths per 100 000 compared to the national rate of 10.4)[20].
- The Tasmanian age-standardised mortality rate for deaths due to suicide in 2010 was 13.1 deaths per 100,000 persons, higher than the Australian rate of 10.5 deaths per

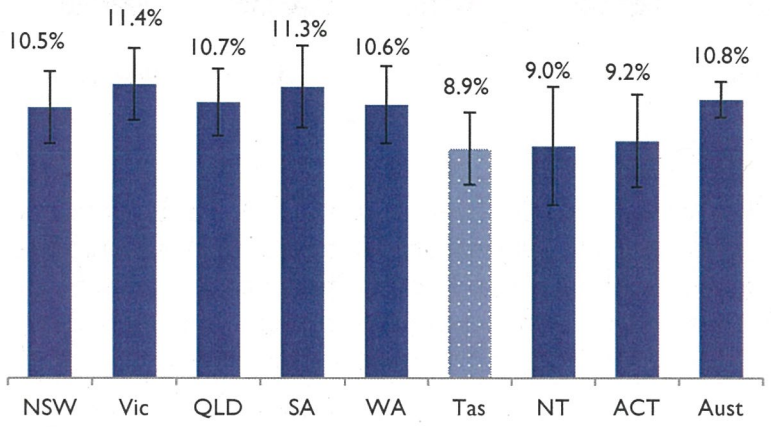
[19] Mental Health Standing Committee (2008). *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07*. Canberra: Australian Health Ministers Advisory Council.
[20] Report on Government Services 2013, access via: http://www.pc.gov.au/gsp/rogs/2013

100,000 persons. Between 1978 and 2010, the age-standardised mortality rates for suicide appeared relatively stable in both sexes. It is important to note that suicide is not always associated with pre-existing diagnosed mental illness.

In 2011-12, 15% of the Tasmanian population reported having been diagnosed with a mental health or behavioural problem at some time in their life (compared with 13.6% for Australia).

Despite this, the proportion of Tasmanian adults who reported to have experienced high to very high levels of psychological distress in the four weeks prior to interview (8.9%) was lower than for the other jurisdictions and Australia as a whole (10.8%) (Figure 17).

Figure 17: Prevalence of high/very high psychological distress by jurisdiction, 18 years and over, Tasmania 2011/12

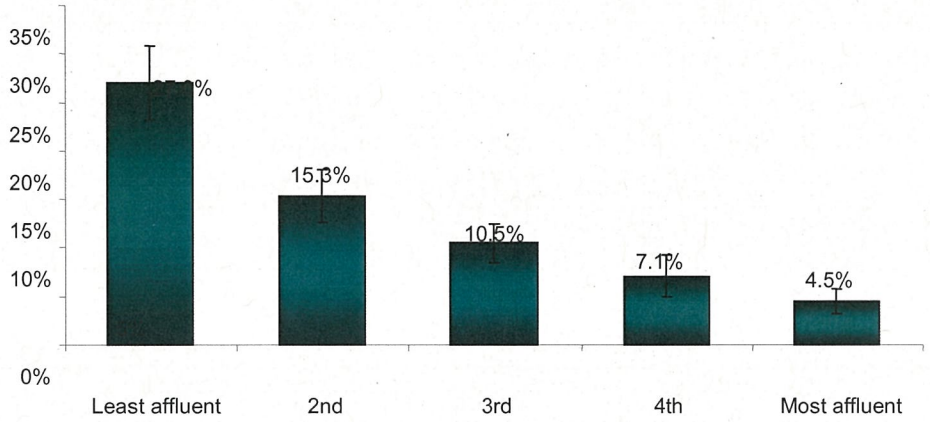


Australian Health Survey First Results, 2011-12, cat. No. 4364.0

The 2009 Tasmanian Population Health Survey found that psychological distress scores were much higher in those who experience food insecurity in the form of running out of food and not being able to afford to purchase food for the family - 39.9% of Tasmanian adults in this situation experienced high to very high levels of psychological distress, significantly above the State average of 10.9%.

There is an association between household income and levels of psychological distress, with the lowest income quintiles experiencing the highest levels of distress (Figure 18). Household income is strongly influenced by social determinants including employment and education.

Figure 18: Prevalence of psychological distress by household income quintiles, Tasmania 2009



The Health of Tasmanian Aboriginals

Reliable health data for the reporting of Aboriginal and Torres Strait Islanders' health status are generally limited in Tasmania to information collected through national Aboriginal and Torres Strait Islander Surveys, as Aboriginal and Torres Strait Islander status is significantly under-reported in Tasmanian administrative datasets, and deaths and hospital data remain of insufficient quality to monitor and report on Aboriginal health issues.

Nationally, there are significant health inequities between the Indigenous and non-Indigenous populations. Aboriginal and Torres Strait Islander people have higher prevalence rates of many health conditions, particularly circulatory diseases (including heart disease), diabetes, respiratory diseases, and kidney disease. They also have a lower life expectancy and more disability. Some of these inequities may find their origin in greater socio-economic disadvantage such as lower incomes, education, and higher unemployment or/and be related to higher rates of lifestyle risk factors which mirror socio-economic disadvantage.

Reliable estimates of Aboriginal and Torres Strait Islander life expectancy are confounded by identification issues, such as uncertainty regarding Indigenous identification in deaths data and self-identification issues in Census data collections, but some broad national estimates are available.

Table 3 below shows that for the period 2005-07, Indigenous life expectancy nationally was 11.5 years lower for males and 9.7 years lower for females than that of the non-Indigenous population. Although life expectancy data is not available for Tasmanian Indigenous people, Tasmania is likely to fit this national pattern based on self-assessed Aboriginality rates.

Table 3: Life expectancy at birth by Indigenous status, Australia 2005-07[21]

	Indigenous	Non-Indigenous
Males	67.2	78.7
Females	72.9	82.6

Tasmanian Aboriginal and Torres Strait Islander people were nearly twice as likely as non-Indigenous Tasmanians to rate their health as fair or poor. This poorer perceived health status may be associated with lower income and education, higher unemployment, and a higher prevalence of chronic conditions.

There are differences in the prevalence of disabilities among Indigenous and non-Indigenous people. As shown in Table 4 the proportion of Indigenous Tasmanians who reported a profound or severe core activity limitation in 2008 was 2.5 times that reported by non-Indigenous Tasmanians, which is a statistically significant difference.

Table 4: Profound/severe core activity limitation by Indigenous status, 18 years and over, 2008[22]

	Indigenous	Non-Indigenous
Tasmania	12.0%*	4.7%*
Australia	10.3%	4.7%

*statistically significant difference at the 95%CI

Similarly, Census data show that 6.6% of all Aboriginal and Torres Strait Islander people in Tasmania required assistance with core activities due to disabilities, compared to 5.8% of non-Indigenous Tasmanians as shown in Table 5.

Table 5: Need for assistance with core activities* by Indigenous status, Australia 2011[23]

	Indigenous	Non-Indigenous
Tasmania	6.6%	5.8%
Australia	7.7%	4.3%

*refers to self-care, mobility and communications and age standardised to the Australian population 2001

[21] Australian Health Ministers Advisory Council, Aboriginal and Torres Strait Islander Health Performance Framework Report 2010, 2011, p.51

[22] AIHW, Aboriginal and Torres Strait Islander Health Performance Framework Report, Tasmania, 2010

[23] ABS, Census 2011

2.1.2 The Impact of Tasmania's Dispersed Population

The ABS classification divides Australia into major cities, inner regional, outer regional, remote and very remote categories (with none of Tasmania fitting into the major cities category). As shown in Table 6, 98% of Tasmania's population falls within the 'inner regional' or 'outer regional' categories, 1.5% are 'remote' and 0.5% 'very remote' – a very different pattern from all other states and territories except the Northern Territory.

Table 6: Population distribution by remoteness category, 2011

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Major cities	73.1%	75.3%	59.8%	71.2%	72.8%	0.0%	99.8%	0.0%	68.8%
Inner regional	20.2%	20.0%	22.0%	13.6%	12.3%	64.8%	0.2%	0.0%	19.7%
Outer regional	6.2%	4.6%	15.2%	8.9%	11.2%	33.1%	0.0%	56.1%	9.3%
Remote/very remote	0.5%	0.1%	3.0%	6.3%	3.7%	2.0%	0.0%	43.9%	2.2%

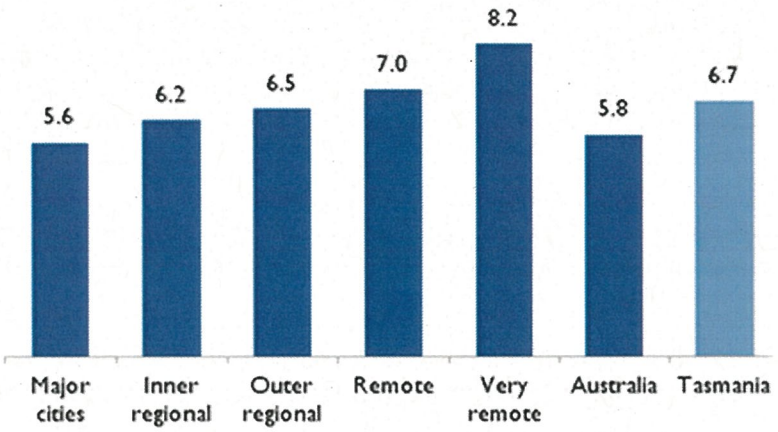
ABS, Regional Population Growth Australia, March 2012

Unsurprisingly, given Tasmania's dispersed population, the State's pattern of social and health indicators in general is more comparable with regional Australia than other states, where overall health outcomes are strongly influenced by the better health status of populations living in major metropolitan areas.

In terms of interpreting Tasmania's health outcomes, such as death rates, it can be helpful to benchmark against inner and outer regional data for Australia.

Tasmania's three year averaged age-standardised mortality rate of 6.7 per 1,000 population is slightly higher than the national inner and outer regional rates, which would indicate a poorer health status than expected on the basis of Tasmania's predominantly inner regional status (Figure 19).

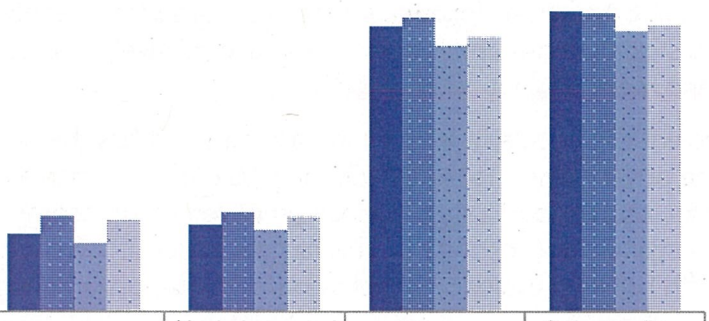
Figure 191: Standardised mortality rates* (all-cause) per 1,000 population by remoteness classification, 2011



ABS, Deaths Australia 2011 Table 7.1; *3-year averaged standardised rate per 1,000 population for all areas

On average, people who live in regional and remote areas are more likely to engage in behaviours that are associated with poorer health outcomes, such as smoking and physical inactivity. Tasmania's rates are comparable with and sometimes better than the inner and outer regional area rates shown below in Figure 20.

Figure 202: Risk factor behaviours by remoteness classification, 2011



	Daily smoker	Alcohol - exceed lifetime risk	Overweight/obese	Sedentary/low level exercise
Inner regional	18.5%	20.7%	68.0%	71.6%
Outer regional/remote*	22.8%	23.7%	70.1%	71.2%
Australia	16.3%	19.5%	63.4%	66.9%
Tasmania	21.8%	22.7%	65.6%	68.2%

Australian Health Survey: First Results 2011-12, Table 5.3; *outer regional and remote areas combined, excludes very remote areas

2.1.3 The Social Gradient in Health[24]

There is a social gradient that runs across all people and communities and this concept is used to describe the way health outcomes differ across the population in relation to socioeconomic status. Life expectancy is shorter and most diseases are more common further down the social ladder in every society.

International research[25] has found that people from low-income households are more likely to:

- report their health as fair or poor;
- have depression;
- have days off work due to ill health;
- report greater levels of disability;
- have difficulty accessing and affording healthcare; or
- be treated differently by the health system than their more wealthy counterparts.

The behavioural factors associated with poor health are strongly linked to social and economic conditions. For example, researchers have found that people who are more educated are

[24] See glossary at attachment 3.1 for definition of the social gradient adapted from the WHO.
[25] Wilkinson R, and Pickett K *The Spirit Level: Why Equality is Better for Everyone.* Penguin, London 2009

more likely to have access to and eat healthy foods, which has a positive impact upon health[26]. Similarly, low income households are more likely to report their health as poor, experience depression, have time off from work due to illness and report physical impairment[27].

There is evidence of a social gradient in almost all aspects of health and wellbeing outcomes. For example, disadvantaged groups in the population are known to experience the impacts of oral disease more frequently[28] and research shows that oral disease is strongly associated with socioeconomic status[29].

Mental health is also known to follow a strong social gradient. People with low education levels, low-status occupations and low incomes have relatively poorer mental health than their higher status and more affluent counterparts.

The social gradient is particularly relevant in Tasmania as it has the highest proportion of people living below the poverty line[30] (over 64 000 or 13% of the Tasmanian population) as a result of very low median incomes and a high reliance on government income support payments (over one third of Tasmanian households)[31]. This has the effect of lowering the health status of Tasmanians, with higher prevalence of behavioural risk factors and hospitalisations.

The effect of the gradient upon health means that potentially the health of everyone can be lifted – even the 'well off' – to match the people at the very top of the social gradient. Inequities can be experienced across the social gradient and people who are 'worst off' in life are not the only ones who could have better health.

Comments

Research has also indicated an association between the social environment and health outcomes throughout life, independent of individual risk factors[32,33]. A number of factors that have been identified as increasing the sensitivity of health to the social environment include: the social gradient, stress, early life, social exclusion and social support, addiction, work and unemployment. For each of these factors behavioural issues such as parenting, nutrition, exercise and substance abuse may play a role; as well as structural issues including employment factors and poverty (among many others) [34,35].

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[26] Melchers, N.V., Gomez, M., & Colagiuri, R. 'Do socio-economic factors influence supermarket content and shoppers' purchases,' in Health Promotion Journal of Australia, 2009, 20(3), 241-246

[27] VicHealth. *Research Summary: Burden of disease due to health inequities.* Melbourne, Government of Victoria: 2008.

[28] Sanders, A.E. and Spender, A.J. Oral Health Inequalities and Psychosocial Factors. Presented at 33rd Public Health Association of Australia Annual Conference, 2001

[29] Sheiham, A. & Watt, R.G. 'The Common Risk Factor Approach: a rational basis for promoting oral health.' Community Dent. Oral Epidemiology, 28, 399-406, 2000

[30] NATSEM describes the poverty line as the disposable income of households (the amount of income available for spending) and defines a household as being below the poverty line if it has no more than half of the median (midpoint average) disposable income of all households.

[31] See the Social Inclusion Strategy for Tasmania - access via http://www.dpac.tas.gov.au/__data/assets/pdf_file/0015/65013/Social_Inclusion_Strategy.pdf

[32] Henderson, G., Robson, C., Cox, L., Dukes, C., Tsey, K. & Haswell, M. (2007). Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander People within the Broader Context of the Social Determinants of Health. In I. Anderson, F. Baum and M. Bentley (Eds.). *Beyond Bandaids: Exploring the underlying social determinants of Aboriginal health.* Northern Territory: Cooperative Research Centre for Aboriginal Health.

[33] South Australian Council of Social Service (SACOSS) (2008). *The Social Determinants of Health: SACOSS Information Paper.* Adelaide.

[34] World Health Organisation (WHO) (2004). Promoting Mental Health: Concepts, emerging evidence, practice: Summary report. Geneva: WHO.

[35] Wilkinson, R. & Marmot, M. (Eds.) (2003). *Social Determinants of Health: The Solid Facts (2nd edition).* Geneva: World Health Organization.

For Aboriginal and Torres Strait Islander populations, issues such as cultural connectedness, colonisation, and racism have also been identified as having a unique influence on mental health and social and emotional wellbeing. Similarly for people from culturally and linguistically diverse backgrounds the process of immigration, connection with culture and discrimination play a significant role on health and mental health outcomes.

The Commission on the Social Determinants of Health established by the WHO reflects the international scale of interest in addressing the social factors that lead to ill-health and health inequalities. The relevance of a comprehensive understanding of the impact of social determinants is essential for effective health and wellbeing (including mental health) promotion which seeks to foster positive individual, social and environmental qualities. Lower levels of education (leaving school before the age of 16) is associated with higher prevalence of common mental disorders[36] [37].

Health inequities are therefore evident in a number of health outcomes, with inequalities in behavioural risk factors continuing to contribute to inequities in health outcomes in Tasmania. Given the known links between these risk factors and health outcomes, the health and wellbeing implications of these statistics are important. Some Tasmanians are living at risk of poor health outcomes as a result of socioeconomic disadvantage.

With many of these health outcomes and health risk factors there is a clear evidence demonstrating 'social gradient' based on income or other measures of socioeconomic status. The key indicators are the evidence of risk and protective factors, the incidence and prevalence of many diseases and conditions and the outcomes of health care, including avoidable deaths.

The evidence of a social gradient in the health of Tasmanians is well documented, both in terms of health outcomes and health risk factors. Consecutive State of Public Health Reports (in 2003 and 2008) have discussed the importance of the social determinants of health for the Tasmanian population, with the 2008 Report illustrating the social gradient in health and highlighting the role that governments must play in reducing health inequities.

The social gradient for health explains how inequities exist right across the social scale. This has profound implications for population health and the burden of disease. Focusing only on the health of the most disadvantaged addresses only a part of the problem. There also needs to be a focus on population health improvement.

Moving towards a levelling up of the social gradient approach means that policies and programs will have greater potential reach to a wider population, thereby improving the health of more people across the social and economic spectrum.

2.1.4 The Impact of Social Determinants in Tasmania

Housing

The WHO recognises adequate housing as a 'fundamental condition and resource' for health. Epidemiological studies show poorer health outcomes amongst people who are poorly housed, including: mental illness; infectious diseases; injury; substance-abuse; and exposure to violence.[38] Certain population groups also experience a greater burden of housing insecurity and related

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[36] Barry, M. & Jenkins, R. (2007). *Implementing Mental Health Promotion*. Elsevier.

[37] Victorian Health Promotion Foundation (VicHealth) (2005). *A Plan for Action 2005-2007: Promoting mental health and wellbeing*. Carlton South: VicHealth.

[38] Wellesley Institute. *Housing and Health: Examining the Links*. Wellesley Institute, Canada 2012

poorer health such as those living with a chronic condition and those in long-term unemployed. This demonstrates a significant health inequity.

Demographic analysis based on income alone shows that 76 283 Tasmanian households (39.6%) would be eligible for public housing and a further 51 002 (26.4%) would be eligible for the National Rental Assistance Scheme.[39] This amounts to a total of around 66% of Tasmanian households.

The Housing Tasmania wait list at 31 January 2013 was 2174. This includes 159 applicants either in Category One or exceptional need. This represents a decrease from January 2012 of 627 applicants or 22%.

The 2011 Census shows that 9.5% of Tasmanians, or 22 075 households, rent in the private property market and pay over 30 of income as rent. This has increased by 2.1% from the 2006 census and is slightly lower than the 2011 Australian rate of 10.4%.

The 2011 Report on Government Services shows that 22.7% of low income households (those in the bottom two income quintiles) in Tasmania are in rental stress, compared to the Australian rate of 37.2%.

Education and Health Literacy

Education is also an important social determinant that contributes to the social gradient and is often used as an indicator of socioeconomic status. Education is recognised as having a significant impact on our productive ability and therefore our health and wellbeing.

Educational attainment for both women and men directly contributes to better health and the ability to participate fully in a productive society, and creates engaged citizens.[40] The Tasmanian Adult Literacy Action Plan 2010-2015 provides the direction for improving adult literacy. The Department of Education (DoE) have established Learning Information Network Centres (LINC) centres around the State as a key strategy to improve literacy.

Evidence also suggests that poor health of children or family members impedes educational attainment, reducing educational potential and abilities to solve life challenges and pursue opportunities in life.[41] The DoE *Launching into Learning* program aims to improve educational potential by working with families and communities to improve children's early learning prior to kindergarten.

Education also plays a critical role in preventive health through the development of literacy, numeracy and health literacy skills, which enable employment and active participation in the community. In the 2006 Adult Literacy and Lifeskills Survey (ALLS) the ABS found that only around half of Tasmanian adults had adequate literacy (51% prose and 49.3% document literacy) and numeracy (43.8%) skills.

Literacy and numeracy skills are the primary factors that determine health literacy. Health literacy includes the knowledge and skills required for people to manage their own health and navigate the health system to find the care they need.[42] The 2006 ALLS found that over 60% of Tasmanian adults lacked the health literacy skills to cope with daily life. Government

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[39] Data provided by Housing Tasmania, Department of Health and Human Services.
[40] WHO. *Adelaide Statement on Health in All Policies.* Adelaide, Government of South Australia: 2010.

[41] WHO. *Adelaide Statement on Health in All Policies.* Adelaide, Government of South Australia: 2010.
[42] See glossary at attachment 3.1 for definition from the Department of Health and Human Services Communication and Health Literacy Action Plan.

frontline services in health, education, and Service Tasmania can assist people in health literacy by better communication and respectful engagement. This has the potential to improve health outcomes and efficiency of services consequently reducing the cost burden on Tasmania's public services, including healthcare.

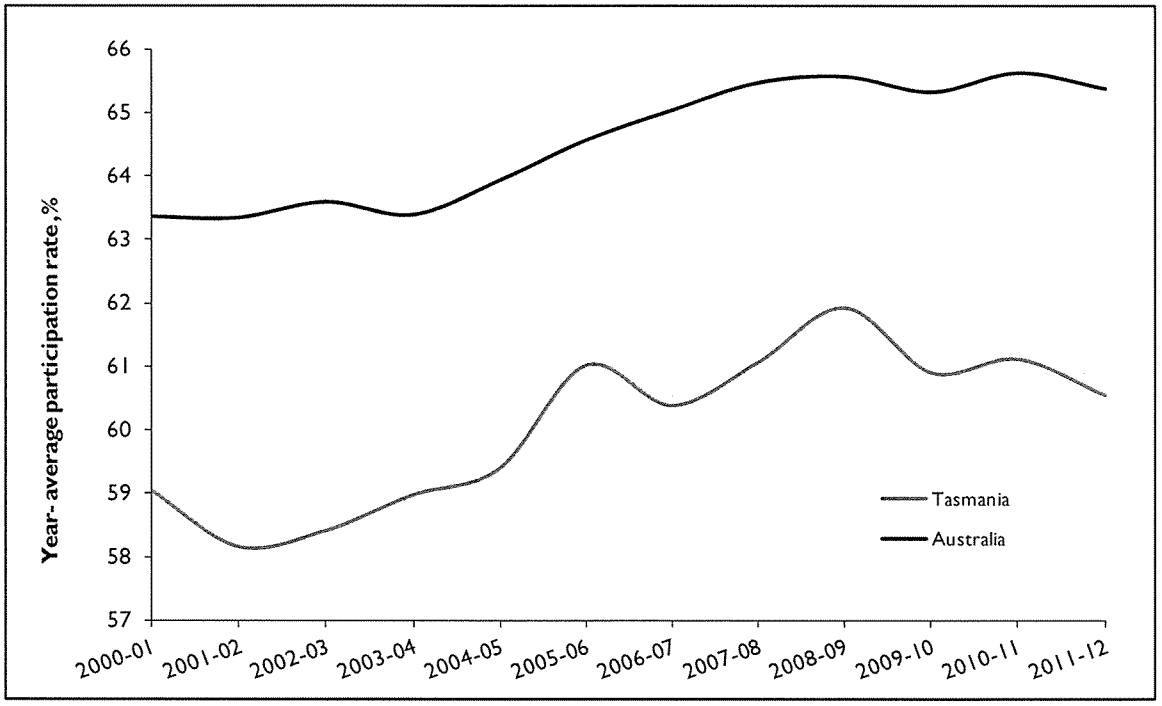
Employment and Income

For physical and mental health, generally employment is good and unemployment is bad. Long-term unemployment in particular may not only cause poverty, but may also lead to related social consequences which include health problems, a loss of self-confidence, together with stress on families, children and relationships.

The size of the labour force is determined by the total number of people 15 years and over who are willing and able to work. It includes everyone who is working or actively looking for work. In January 2013, Tasmania had 250,200 persons in the labour force.

The proportion of the working age population who are actually in the labour force is known as the participation rate. In January 2013, Tasmania had a working age population of around 415,930 persons, with a workforce participation rate of 60.2%, below that of other jurisdictions and below the national rate of 65.0%[43]. While there has been a trend increase in the Tasmanian participation rate over the last decade, it has continued to be significantly below the national level. Analysis undertaken by the Department of Treasury and Finance in 2012 suggested that Tasmania's older population structure accounts for around 58 per cent of the difference between the Tasmanian and national participation rates.

Figure 21: Tasmanian and Australian participation rates, 2000-01 to 2011-12[44]



[43] ABS, Labour Force Australia, January 2013
[44] ABS, The Labour Force, Australia, Cat No 6202.0

In January 2013, Tasmania had the highest rate of unemployment of all jurisdictions, 7.4% compared with 5.4% nationally, in trend terms.

However, the unemployment rate is significantly lower than a decade ago, despite a larger share of the working age population in the labour force. This is because employment in Tasmania's economy has grown substantially over this period, principally from 2002-03 until it faced the impact of the global economic downturn in 2008.

Figure 22: Tasmanian and Australian unemployment rates, 2000-01 to 2011-12

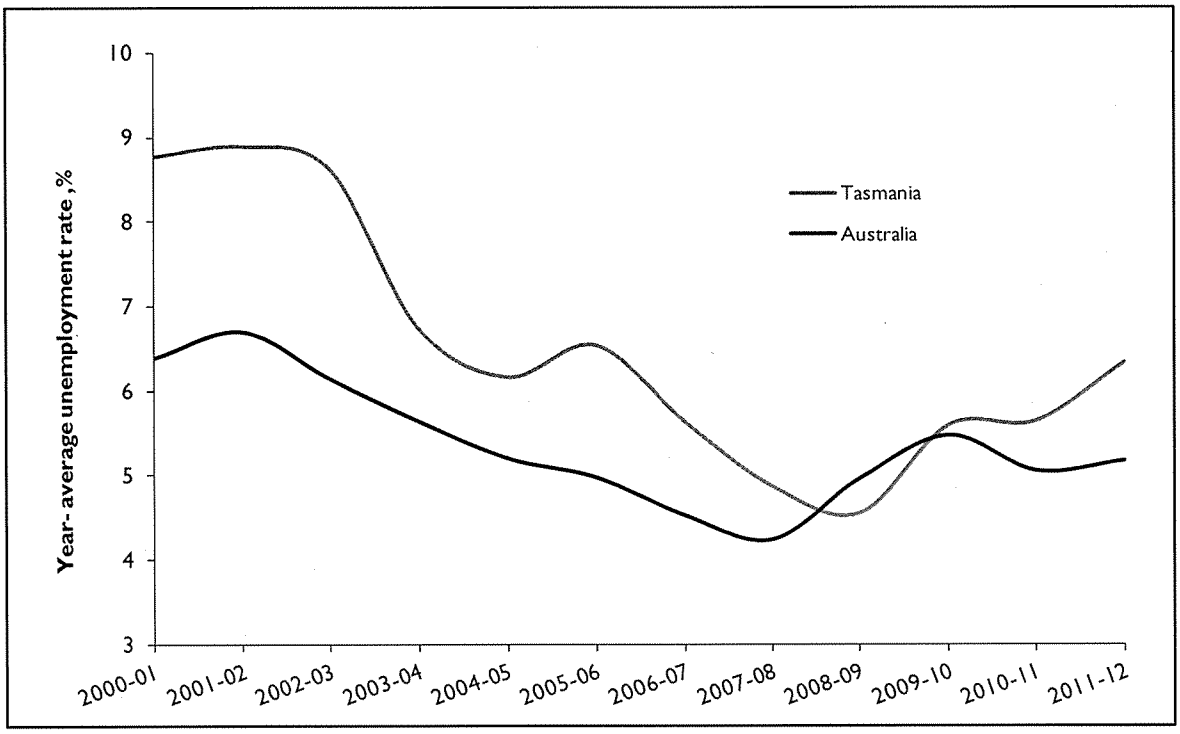
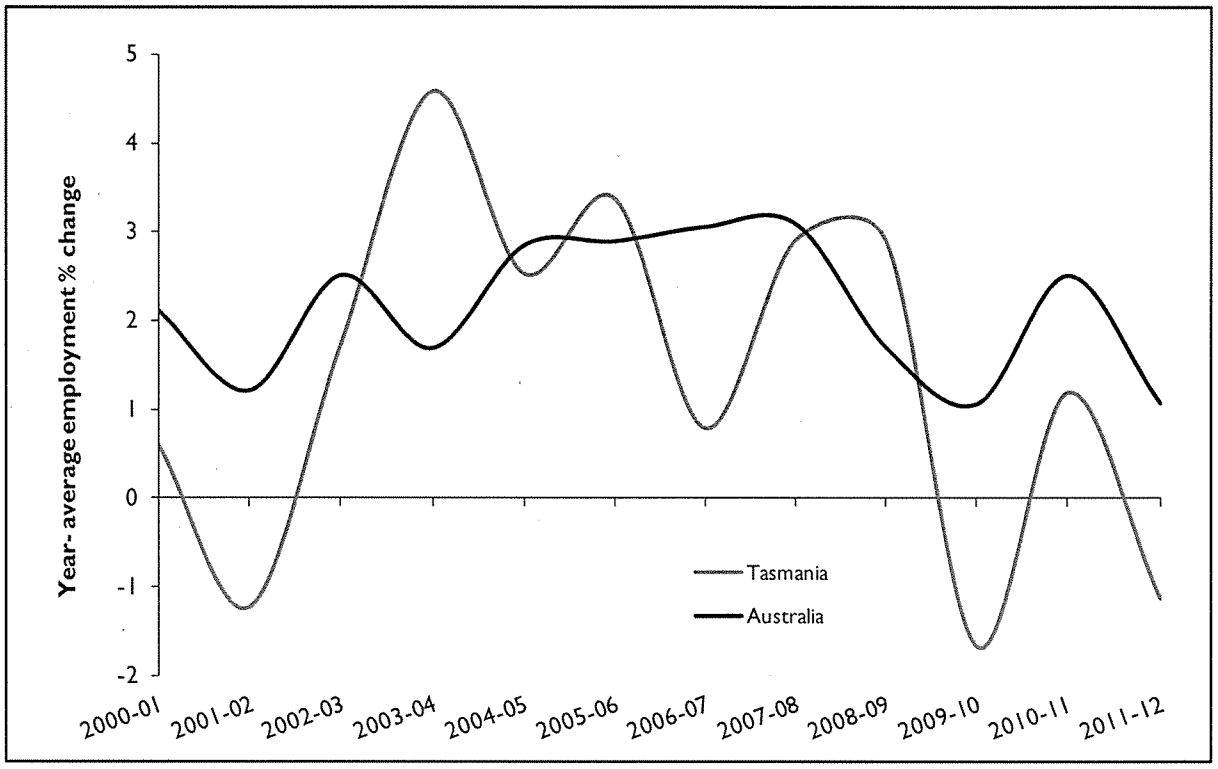


Figure 23: Tasmanian and Australian year-average employment growth, 2000-01 to 2011-12[45]



The 2011 Census collected household income. People were asked to report the total of their wages or salaries, government benefits and any other income they usually receive. Tasmanians reported the lowest household median income of all jurisdictions at $948 per week and significantly below the national level. However, household income in Tasmania has been increasing by more than inflation in recent years.

The total proportion of Tasmanian households relying on income support payments as the principal income source was 31% in 2011, the highest proportion of any jurisdiction. Of these households, 23% were recipients of either an age pension or a disability pension.

Intergenerational Crime

Levels of disadvantage are frequently evident in individuals and groups that become involved in criminal activity. A recent Tasmanian study into intergenerational crime acknowledged the prevalence of disadvantage amongst these families, including high levels of unemployment, low levels of education, and indications of impact on health and general wellbeing[46]. The study also supported that being born into a family with criminal tendencies predisposes an individual to adopting these. This study supports preceding work in this area. Importantly, the study notes the value of programs to improve parenting across health and social spectrums, in 'addressing child and family environmental risk factors' and influencing outcomes.

The Pathways to Prevention project was a significant piece of work that comprehensively examined mechanisms to support individuals and families to make better choices, and prevent progression to offending behaviours[47]. The project highlighted that providing interventions and

[45] Ibid
[46] Goodwin V & Davis B Trends & Issues in Crime and Criminal Justice no. 414, Australian Institute of Criminology, May 2011.
[47] Gilmore, Linda (1999) Pathways to prevention: Developmental and early intervention approaches to crime in Australia. National Crime Prevention, Attorney-General's Department: Canberra.

support to disadvantaged groups in an integrated, comprehensive and holistic way, supported better social outcomes.

2.1.5 Health and Community Service Capacity

Internationally there is a growing awareness of the underlying causes of health and the influence of all parts of society upon it. A number of major publications have examined the social determinants of health, highlighted the health gap and recognised the need to address it through inter-sectoral action[48]. These reports have also found that health departments working in isolation have little influence over the underlying determinants of health.

These sentiments have been echoed in Australia and many state and territory governments are now moving towards inter-sectoral action on health inequity by 'joining up' activities across portfolios.

While Tasmania's health care services have a relatively minor influence on the social determinants of health, they are responding to the needs of individuals who are adversely affected by socioeconomic or locational disadvantage. Further information on this is provided under ToR 2.

The Commission on Delivery of Health Services in Tasmania (the Tasmanian Health Commission) has been established to oversight implementation of the Tasmanian Health Assistance Package. The role of the Commission is to identify inefficiencies that can be remediated in the provision of health care and structural and system improvements in Tasmania's health system to optimise the system's performance and sustain outcomes into the future. The Commission recently released its *Preliminary Report to the Australian Government and Tasmanian Government Health Ministers* (Preliminary Report)[49]. The Preliminary Report includes an assessment of relative spending on hospitals and community care:

> *"The apparent imbalance in spending and efficiency between the hospitals and community health care is of particular importance to us. The methodology used by the Commonwealth Grants Commission (CGC) to estimate what states need to spend to provide services at a national average standard has guided our thinking in this area.*
>
> *In its 2012 update report, the CGC concluded that Tasmania needed to spend 11.6% more than the national average on admitted patient services in 2010-11, in order to provide those services at the national standard. This is largely because the Tasmanian population is older and poorer than the national average, offset somewhat by the fact that distances between Tasmanian population centres are not as great as in other states. The CGC's analysis indicated that Tasmania was in fact spending 34% more than was required to provide hospital services at the national standard, pointing to potential opportunities to improve the efficiency of service provision.*

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[48] See for example:
Commission on Social Determinants of Health. *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* final Report. Geneva, WHO, 2008.
Crossing Sectors – Experiences in Intersectoral Action, Public Policy and Health. Public Health Agency of Canada, Geneva WHO Knowledge Network 2007.
Marmot M et al. *Fair Society, Healthy Lives: the Marmot Review.* London Government of England, 2010
Kickbush, I *Healthy Societies: Addressing 21st Century Health Challenges.* Adelaide, Government of south Australia: 2008

[49] The Preliminary Report dated 21 December 2012 was publicly released on 25 February 2013. Access via http://www.tasmaniahealthcommission.gov.au/internet/tascomm/publishing.nsf/Content/prelimreport

The situation with community-based and other health services is quite different[50]*. Here, the CGC's analysis indicated that Tasmania needed to spend 19% more than the national average (with demographic disadvantages compounded by low levels of private service provision), but was spending 40% less than was required to offer services at the national standard. This figure is consistent with the view of participants in consultation forums and focus groups, that the community health sector in Tasmania is underdeveloped.*

From this analysis, it appears that Tasmania is spending about 5% more on the health sector as a whole than the CGC estimates is needed to provide services at the national standard. The additional cost of admitted patient services is being offset by under-spending in community health and other health services.

We believe this requires further examination, both from an efficiency perspective and to ensure resources are being directed in the most appropriate way.[51]"

This is a complex area of analysis and the CGC assessment is designed to achieve horizontal fiscal equalisation between the states and territories, not prescribe a state's level of service delivery. It should be noted that:

- the CGC assesses non-policy related expenditure adjustments to a notional national standard of service as a result of a state's particular demography, geography and other non-policy influenced characteristics;
- a notional national standard of service should not be assumed to reflect either an actual observable level of service or act as a policy prescription on states and territories; and,
- ordering expenditure into 'Admitted Patients' and 'Community and Other Health Care' categories is subject to variance in classifying health services between the states and territories.

The Tasmanian Health Commission has appropriately identified this matter as an area for further investigation in its final report in seeking to understand what may explain its observation in relation to apparent inefficiencies and/or over servicing in Admitted Patients and under servicing in Community and Other Health Services.

2.2 Terms of Reference 2

(2) The need for an integrated and collaborative preventative health care model which focuses on the prevention, early detection and early intervention for chronic disease.

This ToR focuses on seeking information on a preventive health care model for chronic disease. This level of specificity is contrary to the discussion under the first ToR concerning the social determinants of health.

While this section of the submission discusses the role of preventive health care as distinct from actions to address the social determinants of health, the importance of inter-sectoral action on the social determinants of health is also examined and discussed.

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[50] The "Community and Other Health Services" category used by the CGC comprises all health expenses except those relating to admitted patients and patient transport. It includes expenses on the administration, inspection, support and operation of non-admitted patient services such as hospital emergency departments and outpatient clinics, community health and public health services.

[51] Ibid, page 12

A health care model (or 'model of care') describes the way health services are best delivered and what is required for best practice patient care. They are usually defined separately for different clinical streams of patients, including for different diseases, conditions or population groups[52].

The objective of a model of care is to ensure people get the right care, at the right time, by the right health providers and in the right place.

Many disease-specific models of care include prevention, early detection and early intervention for chronic disease. For example, a model of care for diabetes includes providing lifestyle advice to people with obesity (prevention), testing people with obesity or a positive family history for diabetes (early detection) and regular eye checks to find and manage retinopathy before this affects the person's vision (early intervention)[53].

In practice, the way this model of care is delivered is highly dependent on the social determinants of health. Consider the following two people with type 2 diabetes.

Box 1

Bob is a 60 year old disability pensioner with type 2 diabetes. He lives in a caravan park in a low socio-economic suburb and has no transport. He has not worked since his mid 30s due to a back injury when employed as a builder's labourer. Bob has obesity (body mass index 40), and does not exercise. He is a non-smoker and drinks alcohol occasionally.

Anthony is a 60 year old engineer with type 2 diabetes. He lives in a mid-high socio-economic suburb in his own home. He runs his own business in Hobart as a structural engineer and drives a car. Anthony has obesity (BMI 40) and does not exercise. He is a non-smoker and drinks alcohol occasionally.

Both men have the same model of care for their type 2 diabetes. They both need lifestyle advice, to see an ophthalmologist or optometrist at least every two years, to see a diabetes educator or dietician about their excess body weight, to consider seeing a podiatrist for reviewing their foot care, to visit a dentist regularly because they are at high risk of gingival and tooth disease and to be reviewed at least every three months by their general practitioner or practice nurse.

Both men need care that focuses on prevention (of cardiovascular disease, by regularly checking their blood pressure, cholesterol and making sure they continue to not smoke), early detection (of damage to the eyes, kidneys, nervous system and blood vessels which are the complications of diabetes) and early intervention (treating complications when they develop). According to national clinical practice guidelines, this is the appropriate standard of care for both Bob and Anthony[54]. Both also need preventive care for other diseases, including regular screening for bowel cancer and routine vaccination[55].

However, in reality, Anthony and not Bob will receive 'integrated and collaborative preventive health care' for their diabetes and most probably Bob will not receive care that focuses on prevention, early detection and early intervention, as outlined in national guidelines. Why?

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[52] Waikato District Health Board, 2004
[53] Diabetes Australia. Diabetes Management in General Practice. 2012/13.
[54] Diabetes Australia. Diabetes Management in General Practice. 2012/13.
[55] RACGP. Guidelines for preventative activities in general practice. 8th edition.

Because Bob has a low income, inadequate housing, limited transport, is unemployed and is more likely to suffer the consequences of low health literacy.

The research unequivocally shows that Bob is at higher risk of death and of complications from his diabetes because of the social determinants of health[56]. Even if he sees the doctor and the 'small army' of allied health professionals that guidelines recommend for him, he still will not have the same ability to control his blood sugar as Anthony does[57]. His lower level of education decreases his ability to adopt and adhere to complex new diabetes treatments. His low income makes many of these treatments unaffordable. His lack of transport makes attending multiple clinical appointments more difficult for him[58].

According to Smith et al. (2013)

> *Those in lower education groups face a triple threat with diabetes. First, at least in more recent years, they are of slightly higher risk in contracting the disease. Second, they remain at considerably greater risk of having their diabetes undiagnosed and presumably untreated. Third, even after diagnosis, they have considerably more difficulty in successful self-management of the disease using the complex but effective treatments necessary to diminish the negative health consequences associated with diabetes*[59].

This illustrates that there is a place for preventive interventions in a health care setting in addressing chronic diseases, but it will be the action taken in the broader social determinants of health that acknowledges the relevance and importance of the socioeconomic factors that influence health outcomes, builds and strengthens capacity, and promotes wellbeing.

For example, addressing inequities in early childhood development, in education and skills, in sustainable and healthy communities, in health and community services, and in employment and working conditions will have multiple benefits to the Tasmanian community that extend well beyond the health sector.

2.2.1 Prevention and Preventive Health Care

It is widely accepted that prevention saves lives. It reduces illness and disability, improves productivity and can free up resources to be used elsewhere. The social and economic benefits of prevention are profound.

In the first study of its kind in Australia, the National Centre for Social and Economic Modelling (NATSEM) report *The Cost of Inaction on the Social Determinants of Health*[60] modelled the economic consequences for Australia in not adopting the recommendations made by the WHO[61] for action on the social determinants of health. NATSEM found that if the WHO's recommendations were adopted in Australia:

- 500 000 Australians could avoid suffering a chronic illness;

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[56] Saydah S et al. Socioeconomic status and mortality: contribution of health care access and psychological distress among US adults with diagnosed diabetes. Diabetes Care 2013; 36: 49-55.
[57] Lievre M et al. Cross-sectional study of care, socio-economic status and complications in young French patients. Diabetes and Metabolism 2005; 31: 41-6.
[58] The National Bureau of Economic Research. Diabetes and Socioeconomic Status.
[59] Ibid
[60] Catholic Health Australia *The Cost of Inaction on the Social Determinants of Health* Canberra, NATSEM, 2012
[61] Commission on Social Determinants of Health (2008) *Closing the gap in a generation: health equity through action on the social determinants of health,* Final Report of the Commission on Social Determinants of Health, World Health Organization, Geneva.

- 170 000 extra Australians could enter the workforce, generating $8 billion in extra earnings;
- Annual savings of $4 billion in welfare support payments could be made;
- 60 000 fewer people would need to be admitted to hospital annually, resulting in savings of $2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of $273 million; and
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of $184.5 million each year.

In the Tasmanian Government's submission to the Senate Inquiry on the Domestic Response to the WHO report[62], it was noted that the HIAP Collaboration, a coalition of non-government organisations advocating for action on social determinants and health equity in Tasmania, had used the NATSEM analysis to estimate savings for Tasmania[63]. The Collaboration found that if the WHO recommendations were implemented:

- 15 000 Tasmanians could avoid suffering a chronic illness;
- 5 100 extra Tasmanians could enter the workforce, generating $240 million in extra savings;
- annual savings of $120 million in welfare support payments could be made;
- 1 800 fewer people admitted to hospital annually, resulting in savings of $69 million in hospital expenditure;
- 165 000 fewer Medicare services would be needed each year, resulting in annual savings of $8.2 million; and
- 159 000 fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of $5.5 million each year.

Prevention refers to action to reduce, delay, or eliminate the onset, causes, complications or recurrence of disease. There are three levels of prevention, each with its own place in the health care continuum:

- Primary prevention – preventing ill health before it occurs through reducing exposures to risk factors and risk conditions, and promoting factors that are protective of health.
- Secondary prevention – reducing the progression of disease through early detection, usually by screening before the emergence of symptoms, and early intervention.
- Tertiary prevention – effective management or rehabilitation of people with chronic conditions to reduce complications and maintain an optimum level of functioning.

Population Health in the Tasmanian Department of Health and Human Services (DHHS) works within the Comprehensive Model of Prevention and Management of Chronic Conditions

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[62] Department of Health and Human Services Tasmania Submission to Senate Committee on Australia's domestic response to theWHO Commission on the Social Determinants of Health report "Closing the gap within a generation".

[63] Note: Tasmanian estimates were calculated as 3% of the national figure. The figure of 3% was chosen given that Tasmania makes up approximately 2.3% of the national population, with the additional 0.7% applied due to a higher proportion of our population being in the lowest Socio-Economic Index of Financial Advantage (SEIFA) decile.

(Attachment 3.3). This model was developed by all states and territories through the National Public Health Partnership Agreement in 2001 and acknowledges the role of the three levels of prevention across the health care system.

The prevention 'system' includes:

- Policy – National, state departments and service providers;
- Legislation and regulation – protection and promotion of health;
- Programs – to prevent illness and injury, to promote and protect health and wellbeing; and
- Practice – providing primary and secondary prevention within care systems

Queensland Health summarised this diagrammatically (Attachment 3.4) as a Framework for Identifying and Addressing the Determinants of Health and Wellbeing that includes the role of the individual and their family and community context.

2.2.2 Responsibility for Preventive Health Care

Concurrent responsibilities between the two levels of government (Commonwealth and State) have steadily increased in the Australian Federal System. This has led to overlap in many areas of policy including preventive health. The allocation of responsibilities in preventive health policy could be further clarified. While the Commonwealth Government is responsible for primary health care (including General Practices and the Tasmania Medicare Local), it has also claimed responsibility for health promotion. Notwithstanding, state and territory governments, with responsibility for secondary and tertiary health care, also have a responsibility for undertaking health promotion activities to assist in prevention activities across the health care continuum. Councils and community organisations also play an active role.

Prevention operates in a system that includes many drivers and influences for health and wellbeing that lie outside of the span of control of the Tasmanian Government. Many of the key drivers and potential policy levers arise at the national level. For example the Commonwealth Government has responsibility for taxation (tobacco and food), manufacturing controls (food standards), and packaging and labelling.

There is significant importance in the system of prevention for Tasmanian Government departments, particularly:

- The Department of Education;
- The Department of Infrastructure, Energy and Resources (including transport);
- The Department of Economic Development (including sport and recreation);
- The Department of Justice (including the Tasmanian Planning Commission); and
- The Department of Primary Industries, Water and Environment (including Parks and Wildlife).

In addition to the key role of Population Health in DHHS, the following units have a role:

- Housing Tasmania;
- Child and Youth Services including Child Health and Parenting Services;

- Tasmanian Health Organisations including primary and community services; and
- Statewide and Mental Health Services, including Alcohol and Drug Services.

Other key entities outside of the Tasmanian Government include:

- primary care and General Practice;
- the Tasmania Medicare Local;
- community sector organisations and peak bodies;
- aged care bodies; and
- councils.

While Population Health in DHHS plays a vital role in preventing illness and injury, prevention requires a whole of government and cross-sector approach. The Population Health business unit works with other governments (the Commonwealth and Local Government) as well as with other State Government departments, and also across sectors (private, community). The remit is generally one of influence rather than regulatory or legislative control although the latter are vigorously pursued when they are an option under State legislation.

The Tasmanian Government has an important role in diverting people from hospital and health care through preventive health strategies. This remains an area of focus in the national health reform agenda. The Tasmanian Health Commission will also consider this matter in reporting to the Tasmanian and Commonwealth Ministers for Health on the Tasmanian Health Assistance Package[64].

The National Partnership Agreement for Preventive Health[65] (NPAPH) is the major funding agreement between the Commonwealth Government and state and territory governments that supports investment in preventive health in Australia. The NPAPH includes three components where states are responsible for implementing actions: Healthy Workers, Healthy Children and Healthy Communities. The focus is on lifestyle behaviour programs for chronic disease prevention, which is only part of the solution. The Commonwealth is responsible for implementing actions in the remaining three component areas: Social Marketing, Industry Partnerships and Enabling Infrastructure. The Healthy Communities program is most strongly aligned with targeted initiatives that improve the health and wellbeing of vulnerable population groups.

Funding under the NPAPH is time limited and the Agreement expires in 2018.

The National Health Reform Agreement requires that a state-specific bilateral GP and Primary Health Care Plan be completed and approved by the end of June 2013. Work is well underway in Tasmania with a Steering Committee comprising membership drawn from across DHHS, the Tasmania Medicare Local, and the State Manager for the Commonwealth Government Department of Health and Ageing. There is a strong focus on the social determinants and how these should inform the providers of care services.

The Commonwealth released the *National Preventative Health Strategy* in 2009[66] and established the National Preventative Health Agency in 2011.[67] Like the NPAPH, the Strategy

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[64] Access information here: http://www.health.gov.au/internet/main/publishing.nsf/Content/tas-health-assist

[65] Commonwealth Government, *National Partnership Agreement for Preventative Health*, 2010

[66] Access via http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/national-preventative-health-strategy-1lp

and the Agency focus on tackling the burden of chronic disease, although the latter focus on chronic disease caused by obesity, tobacco, and excessive consumption of alcohol.

2.2.3 Tasmanian Government Priorities – Preventive Health Care

In 2010 Population Health in DHHS led the *Fair and Healthy Tasmania Strategic Review* at the request of the Minister for Health[68] to explore the issues surrounding the health and wellbeing of Tasmanians and to make recommendations for action. The Review examined the best available evidence from around the world for direction, and built on the evidence from the State of Public Health Report to make recommendations on how to improve the outcomes for Tasmanians.

The Strategic Review recommended whole-of-community action through collaborative partnerships with communities, government, non-government and private sectors, to improve the conditions in which Tasmanians are born, grow, live, work and age.

The Review's main findings are that 'leadership across sectors' and 'place-based approaches' are the best ways of improving health and reducing health inequity in Tasmania. The key messages were:

- there is a growing awareness of the underlying causes of health and the influence of all parts of society upon it;
- many factors build the health and wellbeing of people and communities. These factors can be personal, social, economic and environmental, they are often complex and interact;
- no matter how effective healthcare becomes, there will always be some differences in the health and wellbeing of people and communities because of factors outside of healthcare;
- there are vulnerable population groups who are at greater risk of poor health and have fewer resources to cope when illness strikes;
- every day health and social inequity costs the Tasmanian community dearly in both human and financial terms;
- 'leadership across sectors' and 'place-based approaches' are the best ways of improving health and reducing health inequity in Tasmania; and
- population and social health information and research are the 'health intelligence' that will build a better understanding of health and wellbeing in Tasmania."

It concluded that a coordinated, statewide approach was needed to bring together all the sectors that shape the conditions that determine health and wellbeing in Tasmania.

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[67] Access information here: http://www.anpha.gov.au/internet/anpha/publishing.nsf

[68] See a *Fair and Healthy Tasmania Strategic Review, final Report 2010* at: http://www.dhhs.tas.gov.au/about_the_department/our_plans_and_strategies/a_healthy_tasmania

A Healthy Tasmania

A Healthy Tasmania: Setting New Directions for Health and Wellbeing[69] (A Healthy Tasmania) is the Tasmanian Government's response to the Review. It is a long-term approach for building good health and wellbeing in collaboration with communities. A Healthy Tasmania identifies the Tasmanian Government's priorities for preventive health care (Attachment 3.5 provides further detail on the directions and actions associated with these priorities):

- Bring together and strengthen our health intelligence;
- Support the health and wellbeing of Tasmanians who are vulnerable;
- Build supportive environments and policies;
- Address locational disadvantage;
- Spread the message of a healthy Tasmania; and
- Build leadership.

The social determinants of health are recognised and prioritised in A Healthy Tasmania. At the heart of this is the notion that getting people to maintain their wellbeing is part – not all – of the solution.

Health and Wellbeing Advisory Council

The Tasmanian Government recognises that there needs to be a clear way forward for improving preventive health care in Tasmania. The Health and Wellbeing Advisory Council is a group of independent leaders appointed by the Minister for Health to champion new partnerships for health and wellbeing. The primary task of the Council is to identify how best the Tasmanian Government can help parents, families, individuals and communities to maintain and improve their own health and wellbeing.

The Council provided the Government with its first Annual Report in 2012[70], which reiterates priorities for preventive health care in Tasmania that are consistent with those of the Government. The Council made the following interim recommendations in its Annual Report:

- Communicate and empower – An effective health system is based on an understanding of the community context and underlying social determinants. Improving communication between government and communities will help empower Tasmanians to maintain and improve their own health and wellbeing.
- Secure children's wellbeing for life – Assisting parents to give children the best start in life will increase their chances of achieving good health and wellbeing in the first place. A comprehensive approach must be taken that targets children and families and helps to build supportive environments.
- Build connections across sectors – Addressing the underlying social determinants of health requires strong governance and intersectoral collaboration. Supportive

[69] Department of Health and Human Services. *A Healthy Tasmania: Setting the Direction for Health and Wellbeing* Hobart, Government of Tasmania 2011 access via http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0007/82465/Healthy_TAS_Aug11_Web.pdf

[70] Access via http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0006/124368/Health_and_Wellbeing_Advisory_Council_Annual_Report_2012.pdf

infrastructure can help to build connections across sectors. Government must collaborate to identify and change policies and practices that influence health outcomes.

- Invest in systems – Creating the capacity within Tasmania to act effectively on health and wellbeing will require investment. Ensuring we have the right systems in place to monitor and evaluate the problem is one part of the solution. So is long-term commitment to public health approaches.

The Council also completed a *Health and Wellbeing Mapping Report*[71] (Mapping Report) that identified a number of policies, programs, projects and activities in Tasmania under the banner of 'health and wellbeing.' The Mapping Report covered both government and non-government activity. It showed that while a great deal of activity is underway, there could be better connectivity or linkage across portfolios, particularly in terms of funding. Further, this activity was more likely to target individual behaviour change than the underlying social determinants of health.

In 2013 the Council will continue to consider the most pressing health and wellbeing issues facing Tasmania with a view to identifying the best strategies to promote health and reduce health inequity. The Council will then deliver a set of final recommendations to the Tasmanian Government.

2.2.4 Intersectoral Approaches

There is a growing awareness that the key to closing the health gap is for the different parts of society that influence health and wellbeing to work together. This is called 'intersectoral action.' Intersectoral action acknowledges that the major causes of health and wellbeing are not controlled by hospitals and health services.

Intersectoral Action on the Social Determinants of Health

If the major determinants of health are socioeconomic, then so to must be the solution. Wider social policy and intersectoral action will be crucial to the reduction of health inequities. Sectors like housing, education, agriculture and transport need to champion collaborative action for better health.

By working together, there is greater capacity, knowledge and expertise to address problems more effectively, to improve cohesion and to reduce duplication of effort.

Sectors that are considered to fall within the scope of intersectoral action for health equity include the broad public sector (or government): health, environment, education, finance/treasury, defence and natural resources; as well as the private sector (civil society): business, professional, media and community actors.

By addressing the social determinants of health through multiple impacts across multiple sectors significant economic and social benefits are to be gained.

Community-Driven Approaches

As well as influencing political, economic and social factors, action to address health and inequity at the community and neighbourhood level is important to provide people with greater opportunities in their lives, reduce some of the barriers to good health and protect people from the consequences of disease and injury.

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[71] Department of Health and Human Services. *The Health and Wellbeing Mapping Report.* Hobart, Government of Tasmania 2012.

'Community-driven' or 'place-based' approaches were also identified as priorities by both A Healthy Tasmania and the Health and Wellbeing Advisory Council. Community-driven approaches are a priority shared by a number of areas across the Tasmanian Government.

Community-driven approaches take place at a community or neighbourhood level and can focus on the determinants of health in a location rather than a single risk factor or issue. Such approaches:

- are designed to meet the unique needs of locations;
- engage stakeholders across all sectors in collaborate decision-making;
- seize opportunities, particularly local skills and resources;
- evolve and adapt to new learning and stakeholder interests;
- encourage collaborative action by crossing organisational borders and interests;
- pull together assets and knowledge through shared ownership; and
- encourage new behaviours and 'norms' in a location.

Community-driven action can help create more socially supportive environments for development of the personal skills that will improve resilience and health. Intersectoral and community driven action applies to many issues, including those that surround smoking, nutrition, alcohol and physical activity.

The Tasmanian Government recognises the opportunities to improve the health and wellbeing of Tasmanians through a more proactive, joined-up approach to working together locally, particularly through local government, community and neighbourhood houses, child and family centres and community health centres.

The Health and Wellbeing Advisory Council strongly supports community-driven approaches to health inequity, through a focus on community engagement, community-development, self-determination and the release of local capacity.

Intersectoral Action in Tasmania

It is clear that all sectors of the Tasmanian community have a potential role in the preventive health care agenda because social and economic factors strongly drive health and wellbeing. There are many successful examples of intersectoral action already underway in Tasmania. The previously referred to Mapping Report prepared by the Health and Wellbeing Advisory Council provides a comprehensive list of relevant programs and activities by both government and non-government organisations.

The Tasmanian Government also provided financial and in-kind support to the Health Promotion Association Tasmania Branch and TasCOSS to develop a suite of fact sheets on the Social Determinants of Health that were publically launched in April 2012[72].

An example of successful intersectoral action to improve the health and wellbeing of Tasmanian communities has been the development of Child and Family Centres (CFCs). In March 2009, the Tasmanian Government announced the establishment of CFCs and by the end of 2012, nine State funded and two Commonwealth funded CFCs have been built. The

[72] Links to the fact sheets on the TasCOSS website are included in the Healthy Tasmania Website via http://www.dhhs.tas.gov.au/about_the_department/our_plans_and_strategies/a_healthy_tasmania/social_determinants_of_health

CFCs are located at Queenstown, Burnie, East Devonport, Beaconsfield, Ravenswood, St Helens, Bridgewater, Chigwell, Clarence Plains, New Norfolk and Geeveston. Plans for a CFC at George Town have been developed .

CFCs are designed to:

- provide cohesive community support for children and families to build supportive social networks and welcoming community environments for very young children from birth to age 5 and their families;
- improve the accessibility of services in communities so that we can respond more promptly to the emerging needs of young children and their families; and
- contribute to a strong service system that will provide high quality, inclusive and well integrated child and family services.

The CFC framework is based on the assumption that all people involved agree to work together in a new way contributing from their own area of responsibility for a shared purpose. In all centres there are strong examples of collaborative models with practitioners from education, health and non-government agencies working in this way. The broad outcomes that the Tasmanian Government and local communities would like to achieve are:

- Children are born and remain healthy and are confident and curious learners;
- Families nurture healthy development and wellbeing of their children;
- Communities support, value, honour and respect children and childhood; and
- Support and services respond early to the identified needs of young children and their families in culturally appropriate ways.

CFCs provide access to multiple services to children and families in a cohesive and holistic way. They recognise the impact of family and community contexts on children's development and learning and focus on improving outcomes for children, families and communities. Through respectful, collaborative relationships, they actively seek to maximise the impact of different disciplinary expertise in a shared intent to respond to family and community contexts

CFCs also demonstrate the Government's commitment to evidence based decision making, as their locations have been determined based on statistical evidence of need. The establishment and operation of CFCs also embody a collaborative approach requiring government agencies (and non-government organisations) to work together.

Other examples of intersectoral action on preventive health in Tasmania include:

- The Food for all Tasmanians Strategy – which focuses on local solutions to increase access to affordable and nutritious feed for all Tasmanians, but in particular those Tasmanian's most at risk.
- The Health in All Policies Collaboration - is a network of organisations in the community led by the Tasmanian Chronic Disease Prevention Alliance that is proposing intersectoral action for heath equity;
- The Tasmanian Suicide Prevention Strategy – with implementation supported by intersectoral groups including the Tasmanian Suicide Prevention Community Network to facilitate community engagement in suicide prevention;

- The Social Determinants of Health Advocacy Network - established in 2012 it provides information and links to research and resources to its members on the social determinants of health; and
- The Premier's Physical Activity Council (PPAC) – it provides a coordinated approach to the promotion and provision of opportunities for physical activity in Tasmania. PPAC membership represents a broad range of community and government interests.

The Tasmanian and Commonwealth Governments together with the broader community can continue to build on these approaches and learn from the many challenges and achievements.

The Case Study on Social Determinants of Health

Tasmania has been represented on an inter-jurisdictional Working Group led by South Australia that was established in December 2011 to develop a shared understanding of current thinking and action on the social determinants of health from across Australia and consider opportunities for increased dialogue, coordination and action nationally and in state and territory boundaries. The first area of action for the Working Group has been to support the Commonwealth Government in its role on the organising committee to the 8th Global Conference on Health Promotion in Helsinki 2013, on Health in All Policies.

The Working Group is compiling an Australian Social Determinants of Health Case Study Book that will be taken to the Helsinki Conference by the Commonwealth Government. The Editor of the book is Professor Vivian Lin, Public Health Latrobe University, with support from jurisdictions and the Commonwealth Government. It is expected to be published in April 2013.

Comment

Unfortunately, while a substantial body of literature exists on the need for intersectoral action on the social determinants of health and health inequity, on the ground evidence of the most successful strategies is less readily available.

The Health and Wellbeing Advisory Council has spent its formative year considering the available evidence and strongly believes that combination of intersectoral action and community-driven approaches is the best way forward for Tasmania.

While the health and community sectors provide vital care to our communities, working across sectors can help to influence the underlying conditions that determine a person's chances of achieving good health in the first place.

Community engagement, particularly from the social services sector has been strong, with a particular focus on inequities experienced by Tasmanians.

2.3 Terms of Reference 3

(3) The need for structural and economic reform that promotes the integration of a preventative approach to health and wellbeing, including the consideration of funding models.

The WHO outlines the key structural components that all countries need to integrate in implementing a social determinants approach. In particular, the Policy into Practice paper identifies the role of the health sector in regards to social determinants and health equity.[73]

[73] WHO, *Closing the Gap: Policy into Practice on Social Determinants of Health,* World Conference on Social Determinants of Health, 2011 WHO. Access at www.who.int/sdhconference/Discussion-Paper-EN.pdf

The paper argues that there are four broad, interrelated functions through which the health sector can make a useful contribution to governance for action on social determinants:

> *"First, the health sector has a key role in advocating for a social determinants approach and explaining how this approach is beneficial both across society and for different sectors. In particular, the health sector needs to articulate why health inequities are a high-priority indicator of a society's lack of well-being that justifies an integrated response.*
>
> *Second, the health sector has particular expertise in and responsibility for monitoring health inequities and the impact of policies on social determinants.*
>
> *Third, through marshalling of evidence and successful advocacy, the health sector can play an important role in bringing sectors together to plan and implement work on social determinants — for example, identifying issues that require collaborative work, building relationships, and identifying strategic allies in other sectors as potential partners.*
>
> *Fourth, the health sector has an important role in the development of capacities for work on social determinants. An important caveat is that the health sector should avoid claiming any of these roles as its exclusive function."*

Importantly, it is this last sentence – 'the health sector should avoid claiming any of these roles as its exclusive function' – that is the tipping point for change and progress. Implicit in this sentence is that other sectors recognise that lasting structural change comes with their accepting contributory responsibility for the social determinants of health.

The paper also identifies a range of specific responsibilities and tasks which will assist the health sector to take on these functions:

- understand the political agendas and administrative imperatives of other sectors;
- building the knowledge and evidence base of policy options and strategies;
- assessing comparative health consequences of options within the policy development process;
- creating regular platforms for dialogue and problem solving with other sectors;
- evaluating the effectiveness of intersectoral work and integrated policy-making in partnership with other stakeholders;
- building capacity through better mechanisms, resources, agency support and skilled and dedicated staff; and
- working with other spheres of government to achieve their goals and, in doing so, advance health and wellbeing.

This is a critical consideration for the role of the Tasmanian Government in meeting the aims of improving the health outcomes of all Tasmanians.

The health inequities that cause disability and premature death for some Tasmanians[74] requires that new policy instruments and new governance arrangements be considered to ensure better

[74] AIHW, Burden of Disease and Injury in Australia 2003

protection and promotion of health and wellbeing and complementarity across government policy and practice.

Tasmania is examining opportunities to target the resources that are available, and work smarter and positively to assist places and people to secure a fair and healthy future.

In considering strategies to support preventive health approaches, the following principles might be considered:

- the costs of measures should be considered in terms of resources invested in prevention, savings to the health system and the benefits to the broader community;
- decisions should be based on evidence and incorporate cost-benefit analysis; and
- the efficacy of interventions should be evaluated and this information used to inform future decisions.

2.3.1 Structural Reform

As discussed under ToR 1 and 2, it is important for a preventive health approach to include both activities from a health system perspective, as well as those that more broadly address the social determinants of health.

From a health system perspective, to improve and progress the ability to address the social determinants of health, inequitable health outcomes and disadvantage generally, there is a need to refocus the system to one where health, wellbeing and prevention are central. This is an inherent tension facing all governments. Primary and community health care needs to be recognised as central to the public health system if there is to be a commitment to preventive approaches. That means that hospitals are not seen as the first health access point, but the last.

A number of significant health initiatives are in the early stages of implementation in Tasmania. These initiatives, which have the potential opportunity to advance the preventive health care agenda in Tasmania, include the:

- Tasmanian Health Commission – As noted earlier, the Tasmanian Health Commission has been established to oversight implementation of the Tasmanian Health Assistance Package which provides $325 million from the Commonwealth Government designed to benefit all Tasmanians. The Commonwealth Government funding will be provided for a range of initiatives across the Tasmanian health system, with the aim of enhancing timely access to primary health care, acute care, palliative care and mental health services. The Preliminary Report of the Commission notes that 'Tasmania's health system has potential for system reconfiguration and clinical redesign to enable sustainable models of care…'. This Preliminary Report will be followed later in 2013 by a more detailed report including comprehensive analysis of the implementation of the Assistance Package;
- Tasmania Medicare Local – The Tasmania Medicare Local has been funded $13.3 million over four years through the Tasmanian Health Assistance Package to implement a Program for Risk Factors and the Social Determinants of Health. DHHS is providing Steering Committee assistance for the Program. The aim of this Program is to improve the health of Tasmanians through addressing the social determinants of health such as social status, health literacy, housing and education, and targeting known lifestyle-related health risk factors such excessive alcohol consumption, smoking, physical inactivity and

poor diet and nutrition. The specific program objectives are to contribute to: reducing inequalities in health and improving health outcomes across Tasmania; improving Tasmanian health system efficiency; and reducing Tasmanian health system pressure; and

- The Tasmanian Health Plan (2007) – The Tasmanian Health Plan is being reviewed in 2013 and include the bilateral GP and Primary Health Care Plan. Partners to develop the primary health plan include the Commonwealth Government, the Tasmanian Medicare Local and service and policy areas in DHHS. This represents the opportunity to establish a preventive healthcare model that strengthens the role of the health sector in prevention, early detection and management of chronic conditions, while acknowledging the underlying determinants of health.

The Tasmanian Government has overseen significant reforms in the areas of disability, housing and homelessness, and community support in recent years that align with a preventive and early intervention approach. The majority of these services have undergone, or are currently undergoing, significant reform to service models and delivery. These reform activities include moving services closer to the client by outsourcing to community service organisations.

The majority of the reforms within the Human Services program areas have been focused around moving to a more place-based service model, where services are better integrated into the communities they are supporting. These changes are guided by the following principles:

- improving accessibility and use of services;
- responsiveness to the broad range of people's needs;
- alignment of support and assistance to people's needs;
- increased efficiency in their operations;
- earlier intervention and prevention strategies;
- creating capacity within the service system to respond to those children, young people and families where vulnerability and/or risk factors are present;
- the use of coordinated planning processes to support integrated interventions and responses;
- strengthening capability and capacity to develop resilient people and communities;
- improving community connections and access to community resources;
- improving the health of low-income households; and
- enhancing community wellbeing and connectedness through the application of liveability principles in residential development.

Within DHHS, Children and Youth Services has also adopted a service system structure that will support and provide services to families before they reach crisis points and require statutory care. Fundamental to this is the implementation of early and universal interventions. Critically, children's' service system reform has been elevated across Government through the establishment of the Committee of Cabinet on Children, Young People and Their Families. The membership of the Cabinet Committee is the Premier (Chair), the Attorney-General and the Ministers for Children, Health, Human Services, Police and Emergency Management, and Education and Skills.

A supporting Interdepartmental Committee (IDC) was also established with a membership of Heads of Agency for Health and Human Services, Education, Police and Emergency Management, Justice and Premier and Cabinet. The role and function of the IDC is to operationalise the strategic direction provided to it by the Cabinet Committee.

There are many other examples of Tasmanian Government activity that aim to address the social determinants of health and improve the health and wellbeing of Tasmanian communities. Attachment 3.6 provides a snapshot of Government activity aligned with the top ten social determinants of health as set out by the WHO[75]. The snapshot provides an indication of Tasmanian Government activity and is evidence of the broad interventions required to make progress on the social determinants of health.

Many of the barriers people face can only be tackled with the combined efforts of government, community and business. Core to the Tasmanian *Social Inclusion Strategy* is the shift from a deficit to an assets model for people and places; promoting enterprise solutions to build capacity and sustainability to individuals. The Strategy advocates for local support and relationships built on trust and community networks[76]. The Strategy notes that community networks can be more resilient and able to face challenges. Community bonds of support and belonging can give people the confidence to reach their potential. Evidence presented by the Strategy was the need for communities to be self-managing and for the role of government in helping develop their own 'voice'. The Strategy adopts a localised approach, suggesting that by involving people, government and communities established networks and relationships can best implement local projects. In accepting the evidence of this report, the Government has started to progress a number of structural approaches to addressing exclusion, and the consideration of alternative funding models.

The Government is progressing consultative frameworks for people to participate in decision making processes. Opportunities for participation are available through a range of consultative committees, networks, advisory councils and processes for local collaboration for particular groups or issues. In its response to the Strategy the Government has also acknowledged the need to ensure that people from groups and communities at risk of exclusion are included in these arrangements. [77]

Reforms are being progressed to ensure sustainable and progressive partnerships with the non-government sector, industry and the community, to improve health and social outcomes for Tasmanians. For example, the Tasmanian Leadership Program, and the Collaboration Framework between the key government agencies and the community sector.

Other Opportunities

Healthy Public Policy, or Health in All Policies, simply means that policies and actions, across key government agencies are consciously developed in such a way that they do no harm and improve health and equity where possible.

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[75] WHO *The Solid Facts: Second Edition.* Edited by Richard Wilkinson and Michael Marmot. Geneva, 2003.
[76] D. Adams, *A Social Inclusion Strategy for Tasmania*
[77] Department of Premier and Cabinet, *A Social Inclusion Strategy for Tasmania: Preliminary Response*

There are various tools, mechanisms and strategies that can support a Health in All Policies approach that have been implemented in Australia and internationally and were summarised in the *Fair and Healthy Review*[78] as follows:

Table 7: Supports for Intersectoral Action

Supports for Intersectoral Action	
Information Tools	Information, ranging from anecdotal evidence to formal research has been used to highlight the social determinants of health and influence sectors to act. Within this context, Impact Assessments have been used to raise awareness and influence decision-making.
Institutional Arrangements	The establishment of new organisational entities or institutional arrangements to support intersectoral action has been applied at many decision-making levels.
Financial Mechanisms	A lack of financial mechanisms is generally noted, however examples have included: exclusive financial allocations, conditional funding, cost-sharing or resource pooling and contribution of in-kind resources.
Legislation and Regulations	Legislation and regulations can be combined with other tools and mechanisms for intersectoral action. For example legislation used to formalise the establishment of institutional arrangements or Impact Assessments.
Policy and Planning	A number of supports for intersectoral action for health equity can be encompassed under the broad heading of policy and planning. For example: • *Broad Policy Frameworks* – are commonly used at the global, national and jurisdictional level to bring together multiple sectors to address the social determinants of health. • *Accountability Frameworks* – hold the various public, private and community sector organisations to account for the achievement of outputs and outcomes. • *Planning and Priority Setting* – ongoing process within Governments provide the opportunity for intersectoral action to be institutionalised and allocated funding.

While the Tasmanian Government has implemented various forms of the above tools (such as the Collaborative Approach and Stats Matter), there may be opportunity to explore other actions.

For example, the Health Equity Impact Assessment is a type of information tool that can be used to support intersectoral action for health equity. It is used to raise awareness of the influence that the activities of all sectors have over the conditions of daily living that affect health.

Health Equity Impact Assessment is a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.

It is a valuable tool because it brings sectors together and builds understanding that can lead to positive changes in the way the sectors operate. This can help all sectors to achieve their goals.

[78] Access at: http://www.dhhs.tas.gov.au/about_the_department/our_plans_and_strategies/a_healthy_tasmania

By predicting health equity impacts it is possible to amend a policy or proposal to reduce potentially negative impacts upon health and equity and enhance potentially positive impacts.

There is a mechanism for Health Impact Assessment already in use in Tasmania, but its application only relates to the public health aspects of potential environmental exposures associated with development proposals being assessed under the *Environmental Pollution Control Act 1994*. Section 74(5) of the Act provides that, if required by the Director of Public Health, an Environmental Impact Assessment must include an assessment of the impact of the proposed activity on public health.

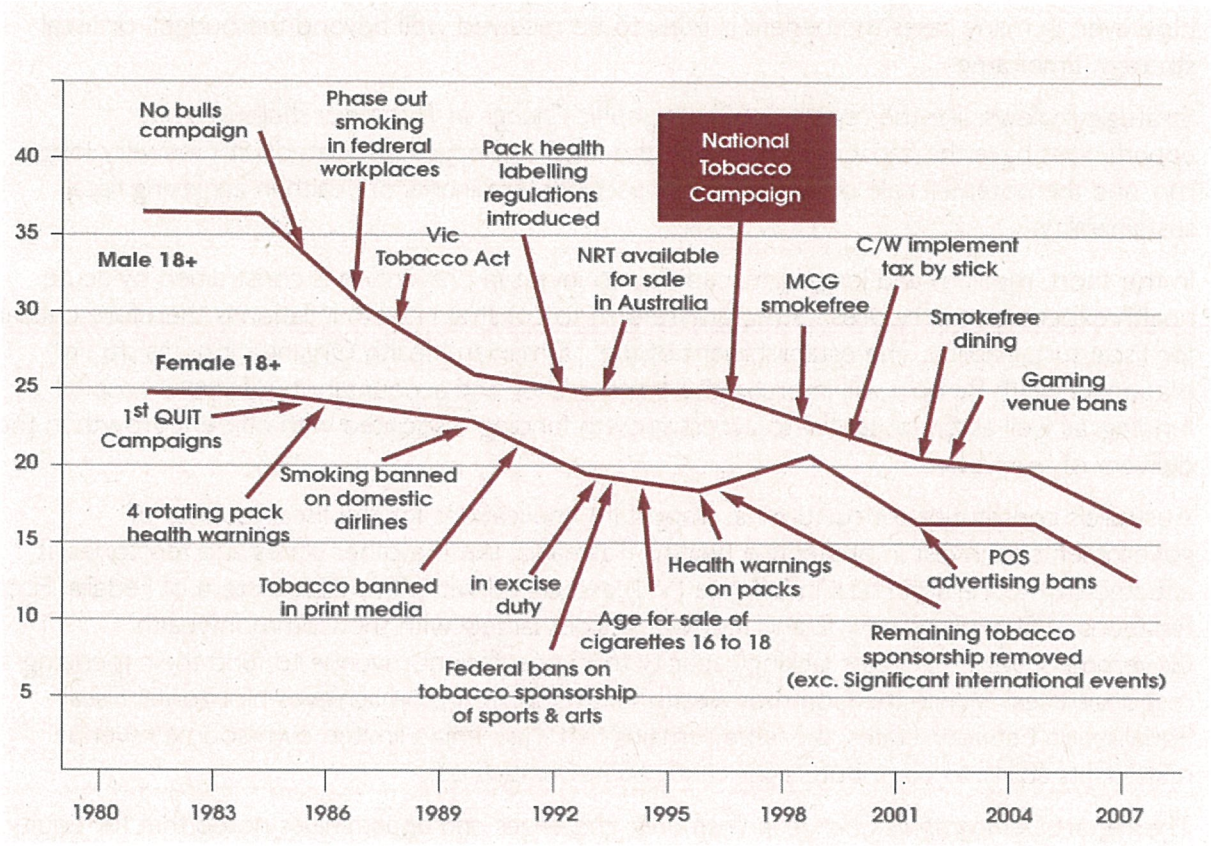
While it is important to continue the work set out under the *Environmental Pollution Control Act 1994*, in order to truly adopt a Health in All Policies approach, a much more universal approach is required that will have an influence across all the policy decisions that impact on health, not just environmental aspects of new developments.

The Health in All Policies approach has been generally promoted as a further extension of the Healthy Public Policies approach of the WHO, which refers to the use of a broad suite of actions and strategies for taking action on the social determinants of health. In Tasmania, the HIAP Collaboration has adopted the term. However, the HIAP Collaboration is advocating for the use of a legislative framework to underpin a stronger focus on prevention that would require structural and governance changes. It is important to note the use of multiple policy levers concurrently is a more accurate reflection of the Health in All Policies approach that is promoted by the WHO.

Take for example, the advances made in the reduction of smoking since 1980 in Australia (See section 2.1.1 for the data and explanation). As Figure 11 demonstrates, the reduction in smoking has been substantively achieved through the use of multiple policy levers, including legislation. Changes have been incremental and over a 30 year period, using multiple and equitable policy approaches such as labelling, smokefree places, increased taxes and restrictions in sale.

Smoking has more or less halved during the period from 1980, but there are still a significant percentage of smokers in Tasmania. The factors that influence smoking in Tasmania now are still responsive to further equitable policy levers, but also require targeted social marketing and approaches that focus on the inequities experienced by the people and communities that are representative of more smokers.

Figure 24: Multiple strategies to reduce tobacco use 1980-2007[79]



South Australia's Health in All Policies approach is perhaps the most significant and high profile attempt by any government in Australian to act on the social determinants of health. Health Equity Impact Assessment and high level leadership underpin the approach. The South Australian approach uses 'Health Lens Analysis' a modified version of Health Equity Impact Assessment, to influence the development of selected government priorities. The Health Lens Analysis is backed by a high level mandate across whole-of-government to support this work and a small, but dedicated Health in All Policies Unit in the Department of Health.

2.3.2 Economic Reform and Funding Models

Tasmania is currently facing the challenge of managing the rising costs of providing health services at a time of tight fiscal circumstances. Getting the right balance between investment in preventive health care, other care services in the community and acute health care is therefore particularly difficult.

The slowdown in GST and state revenue growth following the Global Financial Crisis has placed further constraints on government capacity to fund health and other government services. The fiscal challenges Tasmania currently faces are part of a broader fiscal challenge in the context of demographic change with an aging population and rising health costs. Effective investments in preventive health, both in social determinants, behavioural change and hospital avoidance can be part of a balanced pathway to long-term fiscal sustainability. However this requires a long-term focus extending over several decades.

[79] Prepared by Population Health Epidemiology Unit, DHHS in 2012

Tasmania's fiscal strategy contains short, medium and long-term targets. Investments in preventive health can be measured in terms of quality adjusted life years or years of life saved. However, in many cases the benefit is likely to be received well beyond the budget, or fiscal strategy, timeframe.

Strategic reviews, like the report on *Demographic Change in Tasmania: challenges and opportunities* have the capacity to examine the fiscal challenges associated with the very long-run, and the potential role of investment in social determinants of health in achieving fiscal sustainability.

In the short, medium and long-term, capacity to invest in prevention is constrained by acute health expenditure pressures. Structural reform to constrain health inflation is therefore critical for fiscal sustainability. The establishment of the Tasmanian Health Organisations, as part of National Health Reform will improve the transparency and accountability of public hospital funding, as well as the potential to access growth funding associated with efficient growth in the delivery of services.

Australia's constitutional structure has important implications for the fiscal capacity of governments to invest in preventive health. Tasmania, like the other states and territories, is affected by the Vertical Fiscal Imbalance (VFI) associated with Australia's system of Federal Fiscal Relations. VFI explains how financial power resides largely with the Commonwealth Government with the states lacking capacity to raise sufficient revenue to fund their spending responsibilities. While the Commonwealth Grants Commission achieves Horizontal Fiscal Equalisation between states, the issue remains that Tasmania's limited own-source revenue restricts its ability to contribute significantly to new initiatives.

The report *Demographic Change in Tasmania: challenges and opportunities* noted that for equity reasons there has been reluctance to provide individuals with the full set of 'price signals' (incentives) to reflect the health costs they impose on taxpayers and to encourage lifestyle choices. Constitutionally, excises that could be used to provide price signals, can only be levied by the Commonwealth and not by State Governments. The demand for public hospital services is similarly excluded from price signals.

As the majority funder of the hospital system, State Governments are exposed to the impact of shortfalls in investment in preventive care through increased demand for acute hospital services and the associated cost. However, they do not have the fiscal capacity to 'double-down' by simultaneously funding current acute health services and optimising the level of investment in preventive health, particularly social determinants, that would minimise future hospital costs.

Given the high level of VFI in the Australian Federation and the blurred policy responsibilities in the area of preventive health, further consideration by the Select Committee of Inquiry into the Commonwealth's level and model of financial investment would be beneficial.

Noting the financial constraints, Tasmania is examining opportunities to target the resources that are available, and work smarter and positively to assist places and people to secure a fair and healthy future.

In considering strategies to support preventive health approaches, the following principles might be considered:

- the costs of measures should be considered in terms of resources invested in prevention, savings to the health system and the benefits to the broader community;
- decisions should be based on evidence and incorporate cost-benefit analysis;

- moving away from interventions targeting specific groups to a social gradient approach to prevention focussed on improving the health of all; and
- the efficacy of interventions should be evaluated and this information used to inform future decisions.

Adoption of such approaches will maximise the return on investment in preventive health. This can be supported by evaluations that identify the most effective interventions for preventive health that then support informed budget decisions.

The lack of financial mechanisms to support intersectoral action on the social determinants of health and health inequity is commonly identified as a barrier.[80] Financial incentives and disincentives are considered to have a strong influence on the behaviours of organisations and individuals involved in intersectoral action. Types of financial mechanisms for intersectoral action for health equity include:

- *Financial allocations exclusively for intersectoral action* - with clear criteria on what does or does not constitute intersectoral action, financial allocations can be combined with regulations that provide legal instruments to enforce intersectoral action in certain situations;
- *Intersectoral action as a condition of funding* - is used by international financing institutions to require sectors to work collaboratively in addressing difficult solutions. This incentives-based approach provides parameters that support cross-boundary work;
- *Cost sharing or resource pooling* - involves financial contributions by a range of government and non-government organisations for a specific population or issue that aligns with the organisations' mandates; and
- *In-kind resources* - have been used by sectors that are constrained by the limitations of funding agreements to contribute non-financial resources (e.g. people, information, expertise, physical space and technology) to support shared objectives. The accountability requirements associated with in-kind resources are often less stringent than those for investments of financial resources and offer greater flexibility to adapt to changing needs.

Alternative funding models are currently being progressed by the Tasmanian Government. This is evident through the Tasmanian Food Security Council's adoption of coalition funding models as a way of helping build sustainable community networks to address food security in Tasmania. The funding models were shown to be successful upon evaluation[81].

Coalition funding models are also evident in the Food for All Tasmanians (FFAT) Grants Program. It builds on existing community food solutions and funds innovative ways of addressing food access and affordability for Tasmanians in need. The Grants Program demonstrated that communities have innovative ideas and are willing to collaborate to find solutions to social problems[82].

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[80] Public Health Agency of Canada. *Crossing Sectors – Experiences in Intersectoral Action, Public Policy and Health.* Geneva, WHO Health System Knowledge Network: 2007

[81] Tasmanian Food Security Council, *Food for All Tasmanians. A Food Security Strategy,* 27; DHHS, *Evaluation of the Tasmanian Food Security Fund* (June 2012)

[82] Ibid. See also Department of Premier and Cabinet, "Food For All Tasmanians Grants Program"

Coalition food security models are also evidenced through the Emergency Relief Funding provided under FFAT through the funding provided to Foodbank, SecondBite and Produce to the People[83].

Social Procurement may also provide a mechanism for working towards the achievement of multiple social objectives under a budget constraint. Social Procurement uses procurement processes and purchasing power to generate positive community outcomes in addition to the delivery of efficient goods, services, and works. It can contribute to an organisation's objectives, using procurement to contribute to building stronger communities. Social procurement processes include:

- employing local workers and/or providers;
- encouraging participation in procurement by diverse providers, including social benefit suppliers[84];
- incorporating social benefit objectives, outcomes and requirements into procurement documentation;
- purchasing fair trade products; and
- supporting ethical supply chains.

Other models that could be further examined include incentive based approaches or a nominated benchmark for spending on preventive health.

More work is required to analyse the impact of the NPAPH funding model. Through the Agreement the Commonwealth provides time-limited facilitation funding with reward payments tied to benchmarks that focus on behavioural change of individual Tasmanians.

It is suggested by some stakeholders that 'benchmarking' or 'quarantining funding' is a mechanism available to governments to prioritise and lock in guaranteed funding to preventive health and avoid preventive health funding being subject to the competitive pressures of other priorities. This will enable programs to be delivered over a longer term timeframe within a known funding envelope. An example may include nominating that a specified percentage of the health budget be allocated to preventive health.

All Governments, and especially Governments operating in constrained budget environments, face difficult choices from competing priorities when framing their annual budgets and the forward estimates. For this reason, Governments require the maximum policy and financial flexibility and cannot erode this flexibility by quarantining funding from competitive whole-of-Government policy review. The effectiveness of programs and their outcomes demands that there is an ongoing questioning and evaluation of expenditure and this is intrinsic to the annual budget development process.

There are drawbacks to quarantining or tying funding to a fixed percentage of a wider health or state budget. In the broad context of the social determinants of health, the definition of preventive health investment is very broad and any allocation could be considered arbitrary and represent a cap or constraint on spending.

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[83] Ibid

[84] Social benefit suppliers are those who, through their organisational purpose or by the nature of their structure, have a specialised focus on delivering social impacts. Many private businesses and government organisations are beginning to operate within a corporate social responsibility framework.
This includes, but is not limited to social enterprises, which are set up to meet a community need through the trading of goods and services.

It may be appropriate that benchmarking could be undertaken to determine 'best practice' (however defined) in investment in preventive health. However, given the Tasmanian fiscal constraints and budget principles, this should only be a guide.

2.4 Terms of Reference 4

4) The extent to which experience and expertise in the social determinants of health is appropriately represented on whole of government committees or advisory groups.

Various Tasmanian Government plans, strategies, frameworks and their respective implementation bodies aim to influence health and wellbeing. Some examples include the Food and Nutrition Whole of Government Policy (2004), the Food Security Strategy (2011), the Economic Development Plan (2011), Tasmania's Plan for Physical Activity and the Adult Literacy Plan.

The Arts Tasmania Advisory Board has met with officers for the Health and Wellbeing Advisory Council and agreed to formalise the partnerships for Arts and Health that is also part of the discussion between cultural Ministers and Health ministers nationally.

Tasmanian Government agencies often seek to work together with non-government organisations and community representatives in a collaborative way to meet shared goals and objectives. Given the very broad framework of the social determinants of health, all eight Government agencies are engaged at some level on relevant inter-governmental committees and working groups.

An Interagency Working Group on Place (IAWG) was established in 2012 to implement the Government's commitment to A Healthy Tasmania. Members are drawn from Deputy Secretary level or delegate. The IAWG is responsible for driving action in priorities for health and wellbeing and is to:

- provide advice and recommend the best approaches to place-based health and wellbeing;
- collaborate across sectors, including examining options to pool resources and meet shared responsibilities;
- explore and recommend new solutions and approaches, drawing on the available resources and opportunities, to reduce avoidable health inequities and improve wellbeing for all Tasmanians;
- gain an understanding of patterns of inequity and how to address them; and
- develop new information and research on population health approaches relevant to the focus of equity and place-based approaches.

The expertise in government agencies on the social determinants of health is expanding as new knowledge is brought to the attention of working groups and senior government officers. The IAWG has an important role in assisting the development of institutional expertise and growing the understanding within agencies for what they can do, and what they may do, that can reduce health inequities.

While the social determinants of health is a framework that is being increasingly used by governments to address health inequity, the focus of experience and expertise at this stage

largely resides within DHHS. However this does not negate the experience and expertise brought by the representatives of other agencies whose core business has a relationship with the social determinants of health. For example, while representatives from the Department of Infrastructure, Energy and Resources may not have explicit experience with the social determinants of health, the work of the agency in improving access to public transport for disadvantaged communities would be highly relevant (see details in Attachment 3.6).

2.5 Terms of Reference 5

(5) The level of government funding for research addressing social determinants of health.

Population and social health information and research refers to the health intelligence and research knowledge that is necessary to identify health inequity issues, support effective action and evaluate changes in health and social outcomes overtime. Information is one of the most powerful catalysts for bringing sectors together to work on reducing health inequity and improving health and wellbeing. One of the issues in addressing social determinants of health is embodied in the maxim "no data = no problem = no action."

Limited information is available about how the social determinants of health play out at a local level or how they affect different population groups in Tasmania. Currently the health indicators Tasmania report is produced as a companion document to the State of Public Health Report every five years, although this is limited in terms of publication timeliness. Tasmanian health care professionals, policymakers, State and Local governments, non-government organisations and members of the community currently have limited access to data about the health and wellbeing of Tasmania's population. Community based organisations such as CFCs and community health centres could benefit from access to information about local health and wellbeing to assist their local decision making and priority setting. Available information sources could be better linked, easier to locate and kept more up-to-date and ideally on-line wherever possible.

It is important to note that research and data gathering is not only relevant to academics and the State Government, but is also critical for communities and local decision makers. Better information would assist with integrated needs based planning and the evaluation of health services and health promotion activities in Tasmanian communities. It would assist Local Government, non-government organisations and Tasmanian Government departments to plan strategies and responses based on knowledge about the problems affecting the communities they serve. Such information would also enable community members working with researchers and professionals, to identify strengths and resources, to monitor and understand barriers and evaluate the effects of different interventions.

The social determinants of health encompass a broad spectrum of social, economic and environmental factors, which would suggest a potentially wider range of funding sources would be available for research, particular at a national level through competitive grants processes. In reality, the amount of research funding that is allocated directly towards research on the social determinants of health is very limited.

The major funders of health-based research in Australia are the National Health and Medical Research Council and Australian Research Council. Both are potential sources of grants funding, but focus more often on the high profile area of medical research. Although the National Health and Medical Research Council does fund projects which are designed to promote 'Partnerships for Better Health' between governments and research institutions. This

program represents the best source of supplementary funding for a preventive health research agenda. Attracting this type of Commonwealth Government funding is highly dependent on government agencies providing financial and in-kind support.

Research into preventive health care in Tasmania is largely conducted through collaborative partnerships between the University of Tasmania and Tasmanian Government agencies. These partnerships often involve the provision of in-kind support by allocating staff time within existing resources rather than explicit funding agreements.

The newly established, Tasmanian Data Linkage Unit (TDLU) at the Menzies Research Institute of Tasmania is an important asset to Tasmania. Establishment of TDLU has been possible through short-term national grants funding with some support from DHHS. TDLU will provide capacity to bring together a range of administrative and other datasets and generate high-resolution information about the ways in which social determinants are influencing outcomes for the Tasmanian community, as well as monitoring for trends over time. Securing long-term funding to ensure the ongoing availability of this service is essential to preventive health care in Tasmania.

The *Partnering Healthy@Work* research partnership between the Menzies Research Institute and DHHS is an example of a successful NHMRC Partnership Project Grant supporting local research into the social determinants of health. This partnership builds upon existing Tasmanian Government effort laying the foundations for workplace health and safety through the cross agency programs and policy established through *Healthy@Work*.

A significant opportunity also exists to improve the breadth and quality of the information available about the health and social outcomes of Tasmanian communities. A number of projects are already improving the quality of demographic information available to assist service planning and development, including:

- Stats Matters – a long-term, whole-of-government strategy to improve the Tasmanian Government's statistical capability;
- Data Linkage – the TDLU provides the potential to bring together and cross reference a range of health and social data from disparate sources;
- Sense-T – is a partnership between CSIRO and the Department of Economic Development, Tourism and the Arts which facilitates the analysis of geospatial data in real time to aid in decision making.; and
- Web-Epi – the web-based epidemiological reporting system that provides a user-friendly way to analyse the latest data about hospitalisations, cancer incidence, infectious diseases and mortality to identify health trends and outcomes in Tasmania. This could become a more publicly accessible health data system – a resource accessed via the internet, and there is also potential to expand this to incorporate other sources of data down to small area levels.

To address access to information barriers Population Health in DHHS is developing a website that could provide a 'one stop shop' for access to Tasmanian health and wellbeing data. The web portal will include local level data on:

- Prevention: Tasmanians are born and remain healthy;
- Primary and Community Health: Tasmanians receive appropriate high quality and affordable primary and community health services;

- Hospital and Related Care: Tasmanians receive appropriate high quality and affordable hospital and hospital-related care;
- Aged Care: Older Tasmanians receive appropriate high quality and affordable health and aged care services;
- Patient Experience: Tasmanians have positive health and aged care experiences which take account of individual circumstances and care needs;
- Social Inclusion and Indigenous Health: Tasmania's health system promotes social inclusion and reduces disadvantage, especially for Indigenous Tasmanians; and
- Sustainability: Tasmanians have a sustainable health system.

Tasmania does not fund a regular state-based health survey data collection system. There would be value in the establishment and maintenance of systems that allow for the regular collection, integration, sharing and analysis of data that researchers and providers in government and other sectors could access. There is potential to focus such a system in Tasmania on data most relevant to the social determinants of health and data that provides more detailed information at a local level. Such a system would offer local decision makers more timely data on preventive health issues and opportunities to develop appropriate responses in their local area.

The only recent reliable survey to include local level health information in Tasmania was a one-off Tasmanian Population Health Survey in 2009, which consisted of a computer-assisted telephone interview of persons from 6319 households.

In 1998 a Healthy Communities Survey was funded and undertaken by the Tasmanian Government and published in 2001 that surveyed twenty five thousand households (by postal survey) in the State and provided a significant depth of local social and community level data.

Establishing population and social health information and research is fundamental to understanding how the social determinants influence the health and wellbeing outcomes of Tasmanians. Furthermore, the development of information sharing systems plays a key role in making this information broadly available to inform policy responses and service planning that meets the needs of local communities.

The Tasmanian Government will consider this matter in the context of the findings of the Health and Wellbeing Advisory Council, the Tasmanian Health Commission, and the Tasmanian State of Public Health Report 2013.

3 Attachments

3.1 Glossary

3.2 The Government Policy Framework 2013-14

3.3 Comprehensive Model of Prevention and Management of Chronic Conditions

3.4 Framework for Identifying and Addressing the Determinants of Health

3.5 Directions for A Healthy Tasmania – Priorities in Preventive Health

3.6 The Social Determinants of Health and a Snapshot of Government Activity

Glossary

Chronic condition – A chronic condition is a sickness or disability that affects a person's quality of life over a long period of time.

Community – A community is a group of people who are linked by work or social ties, share the same interests or point of view, and often live in the same location.

Health Equity Impact Assessment – Health Equity Impact Assessment is a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on equity in a population.

Health – The WHO originally defined health in its broader sense as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' The WHO Ottawa Charter later expanded upon this to add 'To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities.'.

Health in all policies – Health in all policies is a strategy that introduces improved health outcomes and closing the health gap as shared goals across all parts of government. By incorporating a concern with health impacts into the policy development processes of all sectors and agencies, it allows government to address the determinants of health in a more systemic manner.

Health Inequity – Health inequities are health inequalities that are unjust and avoidable. Systematic differences in health between social groups that are avoidable by reasonable means, are unfair.

Health Inequality- The term health inequalities is used when there are differences, variations and disparities between the health outcomes or health status of different groups and individuals. Many such inequalities are unavoidable but there are also many that could be prevented.

Health literacy – Health literacy refers to the knowledge and skills needed to access, understand, and use information related to physical, mental and social wellbeing. (DHHS Communications and Health Literacy Action Plan, 2011).

Health promotion – Health promotion is any activity that enables people to increase control over and improve their own health.

Intersectoral action – Intersectoral action brings together different parts of government and other organisations to improve health and reduce health inequity through action on the social determinants of health.

Preventative health – More accurately termed 'Preventive' health, it refers to any action to stop or lessen the onset, progression and return of sickness or disability and its causes. There is a role for prevention both within and without the care system, with primary prevention predominantly occurring outside of the health care system (see Attachment 3.3 for the National Public Health Partnership Comprehensive Model of Prevention and Management of Chronic Conditions).

Policy – Policy is a process of making and carrying out decisions. Policy is used to guide the actions taken by government, business and other organisations. It is often in the form of a plan, procedure, strategy or set of principles.

Sector – The word sector is used to tell apart different parts of society, such as the education, health, business, public, private and community sectors.

Social determinants of health – These are the conditions that a person lives in everyday that determine their chances of achieving good health. They have been described as the conditions in which people are born, grow, live, work and age. See section 1.1 for further information.

Social gradient in health (adapted from the WHO) – The social gradient in health is a concept that describes the way health outcomes differ across the population in relation to socioeconomic status. Evidence shows that in general the lower an individual's socioeconomic position the worse their health. The social gradient in health describes the slope of decreasing health status not just the difference between health outcomes at the top and the bottom of the socioeconomic spectrum. The social gradient in health means that health inequities affect everyone.

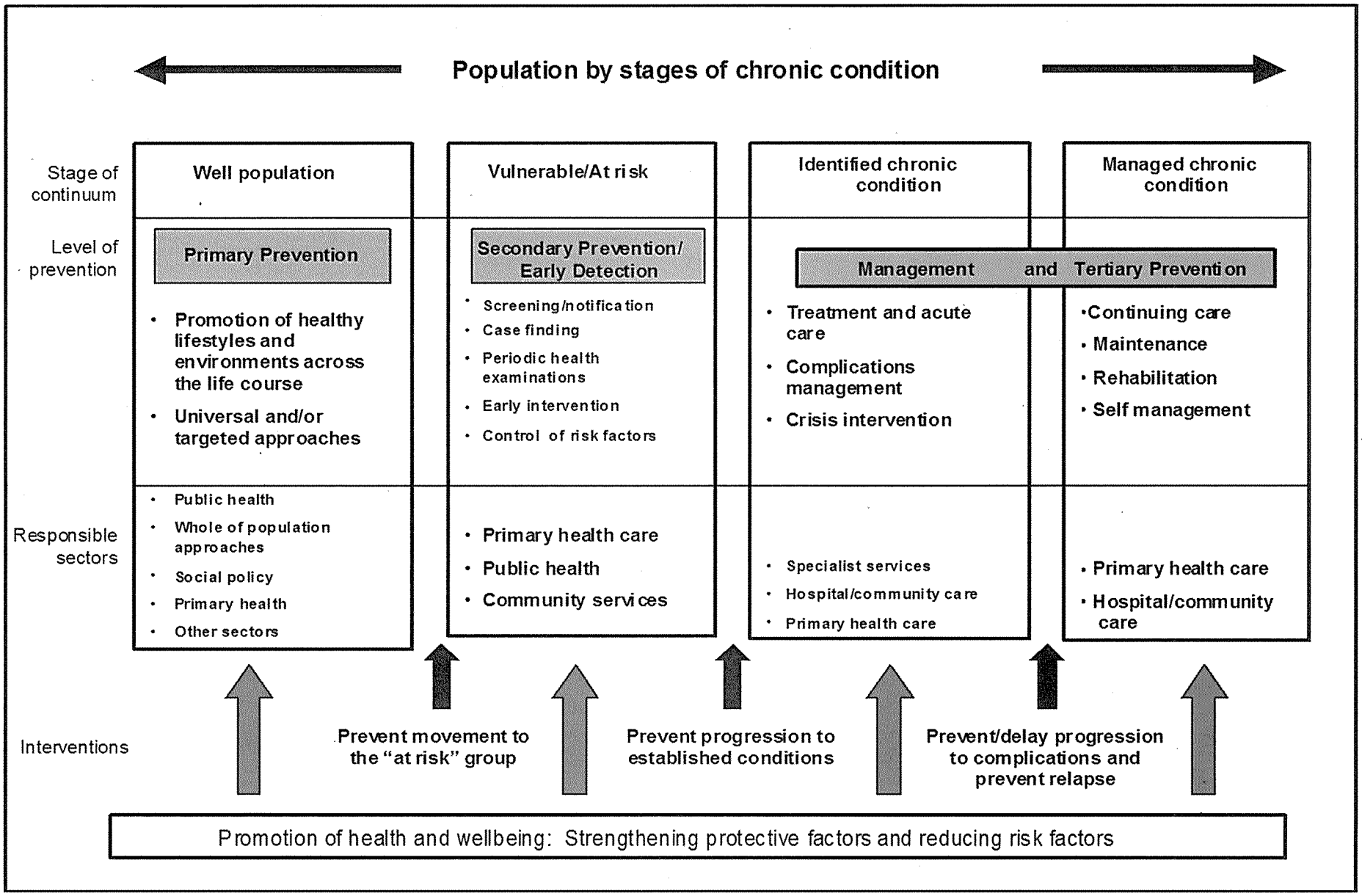
Wellbeing – Wellbeing is a state of being happy, healthy and prosperous.

The Giddings Government Policy Framework 2013–14

jobs	*people*	*opportunities*
MODERNISING THE ECONOMY	**REDUCING INEQUALITY**	**INVESTING IN THE NEXT GENERATION**
'It's all about jobs.'	*'Caring for people.'*	*'Generating new opportunities for our kids.'*
> Clear the way for major job-creating projects	> Support healthy living by investing in preventative health	> Create the linked State by leveraging the National Broadband Network
> Build business and consumer confidence	> Remove barriers to participation	> Integrate Government services for kids aged zero to 12
> Grow Tasmania's natural advantages	> Improve access to safe, good quality housing	> Develop skills for our new and emerging industries

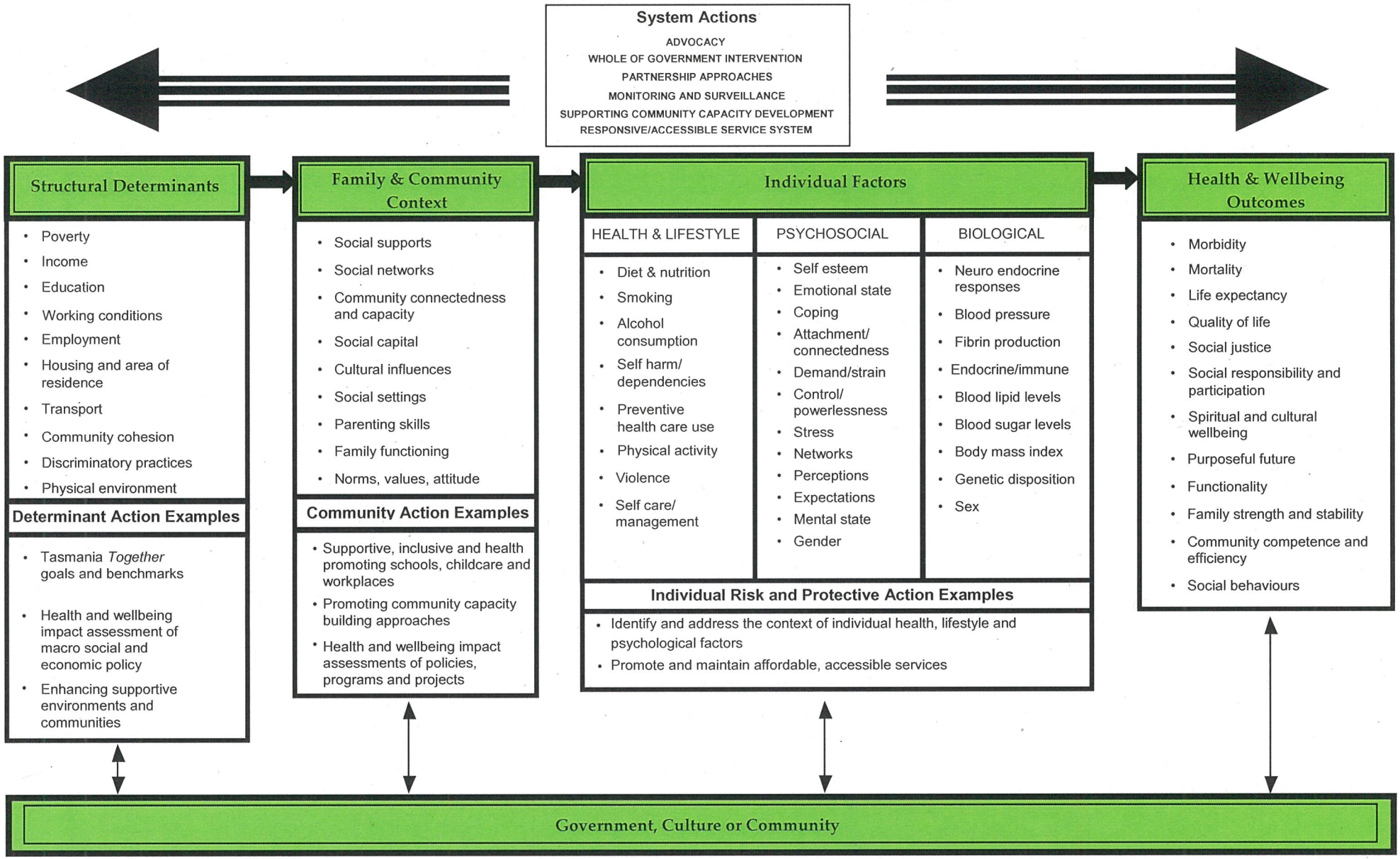
> Sound financial management..... Sustainability..... Engaging in the Asian century <

Comprehensive Model of Prevention and Management of Chronic Conditions - National Public Health Partnership 2001



(Figure 2) A FRAMEWORK FOR IDENTIFYING AND ADDRESSING THE DETERMINANTS OF HEALTH AND WELLBEING*

Health and wellbeing goes beyond the provision of health and community services as people's health and wellbeing cannot be separated from the social, cultural and economic environments in which they live, work and play.



*(Adapted from Social Determinants of Health-The Role of Public Health Services. 2001 Queensland Health)

Directions for a Healthy Tasmania

Bring together and strengthen our health intelligence:

- Fostering social action research by developing partnerships between citizens, researchers and health practitioners to find out what keeps Tasmanian healthy and well.
- Establishing health and wellbeing indicators to improve the data and analysis needed to profile the health of our communities and meet national reporting requirements.
- Investigating health outcomes commissioning with the aim of funding services more effectively to meet the needs of local populations.

Support the health and wellbeing of Tasmanians who are vulnerable:

- Adopting a life-course approach to coordinate programs across key life-transitions, from pregnancy and the early years, to young adulthood, ageing and dying well.
- Targeting social determinants of health across sectors to influence the underlying causes of health and health inequity.

Build supportive environments and policies:

- Promote and protect to make healthy lives and healthier choices easier through legislation, regulation and settings-based strategies (e.g. food labelling, school canteens).
- Build healthy people and places by promoting facilities and spaces that are healthy by design, providing more access to alternative transport options and more opportunities for physical activity.
- Explore Health Equity Impact Assessment that will deliver evidence of the impact of all sectors on wellbeing.

Address locational disadvantage:

- Encouraging place-based approaches to mobilise the strengths of communities to help overcome the barriers Tasmanians face to living well.
- Using people-centred planning to develop health and wellbeing programs with consumers and communities in accordance with their needs.

Spread the message of *A Healthy Tasmania:*

- Empower people and communities to have more control over their lives and the conditions that affect them.

- Connect people to support by linking marketing to services and programs that support people to change (e.g. smoking cessation services and walking groups).

- Enable access to all services in the health and community services system by, for example, adopting 'no wrong door' and client first approaches.

Build leadership:

- Working together to drive collaboration across government and community sectors for the attainment of shared goals and responsibilities.

- Taking intersectoral action for health and wellbeing to address how root causes of health are profoundly influenced by issues and actions across sectors – like housing, education, agriculture and transport.

- Addressing inequity and health so that we have increased understanding of patterns of inequity; how they affect health to create unfair, unjust and avoidable differences; and how we can address this.

The Social Determinants of Health and a snapshot of Tasmanian Government Action

Social Determinants of Health[1]	Example of Tasmanian Government Activity	Key features
the social gradient	Economic Development Plan	Provides a basis for the next ten years to deliver increased economic growth, jobs, and a better, more equitable and sustainable future for Tasmanians. Centres on making the most of Tasmania's assets to secure prosperity and jobs.
stress	Mental Health Promotion, Prevention and Early Intervention Framework	Focused on enhancing positive mental health for Tasmanians, as well as reducing the prevalence of mental disorders. Reflects the involvement of government and community sectors as well as clinical and nonclinical services. Founded on the understanding that 'mental health is everybody's business' and that the impact of a broad range of policies and practices on mental health must be identified and considered across whole of government and whole of community.
early life	Tasmanian Early Years Foundation	A non-profit organisation to support and promote the wellbeing, development and learning of Tasmanian children up to the age of 6 years. The Foundation is to play a central role in bringing sectors together to help foster a society in which all Tasmanian children are valued and given the best possible start to life.
	Our Children, Our Young People, Our Future Agenda	The Agenda for Children and Young People aims to improve policies and service delivery arrangements for children, young people and their families. The Agenda sets out key directions for the next 10 years and assists in determining the sort of environment we wish our children to grow up in.
social exclusion	The Social Inclusion Strategy	Recognises that social exclusion contributes to disadvantage. Set out the following principles: • Everyone's responsibility • Enterprise not welfare

[1] ten key socioeconomic factors understood to have the greatest influence upon health - World Health Organization (WHO). *The Solid Facts: Second Edition.* Edited by Richard Wilkinson and Michael Marmot. Geneva, WHO: 2003.

Social Determinants of Health[1]	Example of Tasmanian Government Activity	Key features
		• Family centred communities • Addressing the basics as well as tackling structural causes • Prevention and early intervention
	Social Enterprise Loan Fund	The Social Enterprise Loan Fund is designed to assist social enterprises to establish, expand or diversify commercially viable ventures, with the principal objective of addressing barriers to social inclusion in Tasmania. Ventures supported through the Fund will: • deliver clearly defined measurable social outcomes linked to specific groups in the community and the barriers they face • be commercially viable and able to generate sufficient cash flow to cover ongoing expenses and loan repayments • have demonstrated community support
work	26TEN Grants program	Aims to increase the core skills levels of people in the workplace and communities, to build a culture of life-long learning and to make it easier for employees and community groups to access literacy support
	Tasmanian Skills Strategy 2008-2015	Seeks to guide investment to match Tasmania's skill needs. This investment is for the 400,000 Tasmanians over the age of 15 years that make up the state's working age population. The strategy has four themes: • increasing opportunity; • a better system for clients; • workforce development; and • skills for the future.
unemployment	Tasmanian Jobs Package	'All Tasmanians deserve the opportunity to get a job and build a better life'. Elements include: • Businesses will receive full payroll tax rebate for all new jobs created in Tasmania; • Small businesses can access grants of up to $250 000 to help them expand

Social Determinants of Health[1]	Example of Tasmanian Government Activity	Key features
		and create jobs in Tasmania
social support	Integrated Family Support Services	Services are targeted to at-risk populations with a focus on: • Early intervention and prevention strategies • Creating capacity within the service system • The use of coordinated planning processes • Strengthening parent capability to provide basic care, ensure safety and promote their child's development • Improving the family's community connections and access to community resources
	Housing Connect	A one stop shop connecting Tasmanians on low incomes and in crisis, with long-term stable housing and support where it is needed. Housing Connect will provide immediate assistance, assessment and intake service from next year for people who need help with housing or who are homeless. Clients will now get one housing and support assessment instead of going to three or four different services to get the help needed.
addiction	Tasmanian Alcohol and Other Drugs Promotion, Prevention and Early Intervention Strategic Framework: *Everybody's Business*	Seeks to address the complex underlying causes of substance use by looking beyond traditional health and law enforcement/justice responses and education initiatives. Advocates a holistic developmental health approach looking at the interplay between the cognitive, physical and social development throughout an individual's life course and how this affects their life outcomes.
food	Food for All Tasmanians Strategy	Progresses priority actions to develop local solutions to food insecurity. Includes Government investment in a number of food security models connecting local governments, schools, children, families and older Tasmanians to local, low cost and nutritious food.
transport	The Tasmanian Walking and Cycling	Vision of creating a safe, accessible and well-connected transport system that

Social Determinants of Health[1]	Example of Tasmanian Government Activity	Key features
	for Active Transport Strategy 2010	encourages more people to walk and cycle as part of their everyday journeys. Incorporates a focus on collaborative synergies across government and stakeholders including the Premier's Physical Activity Council.

Other Social Determinants of Health that the Tasmanian Government is actively pursuing action on not covered in the WHO's top ten include physical activity, the built environment and housing. Examples of this activity is included below

Social Determinants of Health	Example of Tasmanian Government Activity	Key features
physical activity	Healthy Parks, Healthy People initiative	An integrated, multi-disciplinary, collaborative approach led by Tasmania Parks and Wildlife Service in partnership with various other entities. The initiative aims to lift the quality of visits to national parks and reserves by encouraging people to experience their natural surroundings and enjoy the physical, social, mental and spiritual health benefits of visiting national parks.
built environment	Tasmanian Planning System	The Tasmanian Planning Commission has specific statutory responsibility in a number of key areas and uses a Planning System based upon furthering the 'sustainable development' objectives set out in the *Land Use Planning and Approvals Act 1993*. The Planning System: • aims to "secure a pleasant, efficient and safe working, living and recreational environment for all Tasmanians and visitors to Tasmania; and • facilitates an integrated and collaborative approach between local, regional and state policies covering economic, environmental and social issues. Further specific aspects of the relationship between health and wellbeing and

Social Determinants of Health	Example of Tasmanian Government Activity	Key features
		planning are being explored through for example the planning of 'liveable communities' which seek to address wellbeing in the broadest sense.
housing	Tasmanian Residential Development Strategy	The Residential Development Strategy supports state and regional settlement strategies and develops a broad vision for housing in Tasmania. The Strategy applies liveability principles and best-practice in urban design to enhance community cohesiveness, provide green public spaces, improve safety and to build resilience and energy efficiency into housing design. It adopts a long-term integrated approach to the planning and development of Tasmanian communities, with a focus on quality urban designs as a catalyst for achievement of improved social outcomes. Having a safe, secure place to call home is a basic human need and is critical to the development of inclusive, socially integrated communities. The Strategy recognises that healthy communities lead to better individual and social outcomes.