CATHOLIC HEALTH
Australia

Catholic Health Australia

Submission to the Tasmanian Joint Select Committee on Preventative Health Care

1st March 2013

To the members of the Joint Select Committee on Preventative Health Care

Catholic Health Australia (CHA) welcomes the opportunity to provide a submission to the Tasmanian Joint Select Committee on Preventative Health Care.

Catholic Health Australia (CHA) has had an interest in advocating the need for action on the social determinants of health since 2009. CHA's policy and advocacy principles are based on a range of foundational principles, one being a preference for the poor and under-served.

CHA and the National Centre for Social and Economic Modelling (NATSEM) released a report in 2010 entitled *Health Lies in Wealth*, where the important issue of the social determinants of health and their impact on health outcomes was highlighted and showed that 65% of those in the lowest income group report a long term health problem compared with just 15% of the most wealthy.

CHA also edited a book titled *Determining the Future: A Fair Go & Health for All* that brought together a unique collection of essays on the social determinants of health from some of Australia's leading health and social policy experts – medical professionals, academics, opinion leaders, thinkers and writers.

Last year CHA and NATSEM released another report entitled *The Cost of Inaction on the Social Determinants of Health* where again the important issue of the social determinants of health and the impact on health outcomes, including the economic impact, were discussed. Key findings suggested that if the WHO recommendations were adopted in Australia then:

- 500,000 Australians could avoid suffering a chronic illness;
- 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;
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of $184.5 million each year.

This year CHA have been instrumental in the formation of the Social Determinants of Health Alliance, an alliance of like-minded organisations from the areas of health, social services and public policy established to work with governments to reduce health inequities in Australia (see www.socialdeterminants.org.au). In addition CHA have worked closely with the Heart Foundation in Tasmania, as well as the Health in All Policies Collaboration, and supported the Health in All Policies forum gathering held in Hobart April 2012.

In addressing your committees the terms of reference:

> To inquire into and report upon —
>
> (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;
>
> (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;
>
> (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;

(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;

(5)The level of government and other funding for research addressing social determinants of health;
Any other matter incidental thereto.

CHA offer for consideration by the Committee, the CHA submission to the current Senate inquiry into the Commonwealth's response to the 2008 World Health Organisation's (WHO) Commission on Social Determinants of Health report *Closing the Gap within a Generation*. This submission addresses a number of these terms of reference, particularly the need for structural and economic reform that promotes the integration of a preventative health approach.

CHA advocate for a model for action on the social determinants of health. Specifically CHA have called for:
- Development of principles to guide action on the social determinants of health
- Indicator development by COAG
- Coordination of data collection through the Productivity Commission
- Australian National Audit Office to undertake an audit of government programs in order to report on government programs in relation to efficiency of government funding directed to social determinants of health programs
- Development of a national strategy to address health inequity
- Identification of governance mechanisms to keep the issue on the national agenda
- The Prime Minister, through the Productivity Commission and the COAG Reform Council, to report annually on action on the social determinants of health

CHA also call for a number of specific recommendations, some of which may be transferrable to the Tasmanian context. These specific recommendations include:
1. That Australian National Preventative Health Agency (ANPHA) use a social determinants framework or lens in all research conducted by the agency in order to begin to identify and address the factors that influence health in Australia.

2. That additional support be provided for the collection of socio-economic coded health service use and cost data.

3. That the evaluative component of any research undertaken by ANPHA is grounded with a view to ensuring evidence-informed policy and practice.

4. That locally based entities (such as local area health authorities, Medicare Locals, Local Health Networks or local governments or shires) develop and support policies, strategies, programs and action plans that address social determinants of health within their own catchment areas - with clearly defined goals, activities and accountability mechanisms and identify resources for their implementation.

5. That locally based entities build public understanding of health inequities and social determinants within their catchment areas.

6. That firm political commitment to addressing the social determinants of health is undertaken.

7. That a Commonwealth coordination role be established to ensure a shared understanding of goals, approaches, roles and accountabilities for outcomes.

8. Australian Medicare Local Alliance to take a lead role in coordination of planning with other local entities, to address the social determinants of health, and the National Health Performance Authority to report on social determinants data produced by Medicare Locals.

9.   That the Social Inclusion Unit continues to identify areas that require action for the most disadvantaged in the community.

10. That the Social Inclusion Unit develop principles for action on the social determinants of health.

11. All government social policy plans should follow the lead of the *Discussion Paper for the Development of a National Aboriginal Health Plan* and have determinants of health as a key consideration and opportunity to improve health and well-being.

12. Resources for Closing the Gap initiatives to remain separate in any process that audits government programs with the aim of reducing duplication.

13. That the renewal of existing National Partnership Agreements consider using this opportunity to help guide government policy-making and program design for improving the health and social determinants of all Australians.

14. Work to commence on the identification of data sources, selection of indicators, data collection and setting of targets.

15. Identify a process that allows the sharing of data across sectors and ministries so that it can be used to conduct health and equity assessments of all policies before implementation.

16. Public Health Information Development Unit and Australian Institute of Health and Welfare to partner in the collation of information and data on the social gradient of health in Australia.

17. The Prime Minister to report to Parliament annually on the progress of action on the social determinants of health. The annual report to be coordinated by Social Inclusion Unit and conducted by Productivity Commission.

If you wish to discuss further any of the issues raised in this submission I would be happy to travel to Tasmania and appear before the Committee.

Yours Sincerely

Martin Laverty
Chief Executive Officer
CATHOLIC HEALTH AUSTRALIA

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Appendix (separate attachments)

a) CHA Policy Paper 2009 *The central place of Health in Australia's Social Inclusion Agenda: Addressing the Social Determinants of Health to achieve social inclusion*

b) CHA / NATSEM *Health Lies in Wealth* Report

c) CHA / NATSEM *The Cost of Inaction on the Social Determinants of Health*

d) Laverty M, Callaghan L (eds) : 2011: *Determining the Future: A Fair Go and Health for All*

About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care facilities are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

Executive Summary

Catholic Health Australia calls on the government to implement a model for action on the social determinants of health.

The model would include the development of principles by the Social Inclusion Unit within Prime Minister and Cabinet to guide action on the social determinants; the development of indicators and priorities through the COAG process; coordination of data collection by the Productivity Commission; undertaking of an audit of government programs by the Australian National Audit Office in order to monitor the efficiency of government funding directed to initiatives that address the social determinants of health; the development of a national strategy to address health inequality; identification of appropriate governance mechanisms; and presentation by the Prime Minister in Parliament of an annual report prepared jointly by the COAG Reform Council and the Productivity Commission on the indicators for action on the social determinants of health.

Australia is already taking action on the social determinants of health, but it is fragmented and uncoordinated. The non-government sector is playing a role in this area as well and are often more innovative and responsive than government programs can be.

The World Health Organisation (WHO), in contrast, has undertaken a comprehensive program of action on the social determinants commencing in 1998 through to 2012. Many countries have responded to the call from the WHO to act and *develop and support policies, strategies, programs and action plans that address social determinants of health, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation.* Australia has not been one of these countries.

Catholic Health Australia (CHA) has had an interest in advocating the need for action on the social determinants of health since 2009. CHA's policy and advocacy principles are based on a range of foundational principles, one being a preference for the poor and under-served.

CHA and NATSEM released a report in 2010 entitled *Health Lies in Wealth*, where the important issue of the social determinants of health and their impact on health outcomes was highlighted and showed that 65% of those in the lowest income group report a long term health problem compared with just 15% of the most wealthy.

CHA also edited a book titled *Determining the Future: A Fair Go & Health for All* that brought together a unique collection of essays on the social determinants of health from some of Australia's leading health and social policy experts – medical professionals, academics, opinion leaders, thinkers and writers.

This year CHA and NATSEM released another report entitled *The Cost of Inaction on the Social Determinants of Health* where again the important issue of the social determinants of health and the impact on health outcomes, including the economic impact, were discussed. Key findings suggested that if the WHO recommendations were adopted in Australia then:
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It has proved difficult to identify any specific Commonwealth government response to relevant WHO reports and resolutions, however the language of social determinants is starting to be used. But it is

evident that there is not a policy understanding of the approach to health equity through the social determinants of health. Two key factors are missing from the Australian landscape: **coordination** and **accountability**.

There are already a number of data gathering processes in place in Australia and these can all be used to undertake measurement and analysis to inform policies and build accountability on social determinants.

Social determinants of health are so complex that often the cause and effect relationships are not readily apparent; correlation is common; but not causation.

Routine data poorly collected or not at all can often mean policy implementation fails because of lack of data. Also the multitude of stakeholders in the policy development leads to difficulty in implementation.[1]

There are a number of options open to government that would allow them to act on the social determinants. All that is required is the political leadership to do so.

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[1] Exworthy M: *Policy to tackle the social determinants of health: using conceptual models to understand the policy process*; Health Policy and Planning 2008;23:318–327, pp 319-321

Recommendations

General Recommendation

Implement a model for action on the social determinants of health

- Develop principles to guide action on the social determinants of health
- Indicator development by COAG
- Coordinate data collection through the Productivity Commission
- Australian National Audit Office to undertake an audit of government programs in order to report on government programs in relation to efficiency of government funding directed to social determinants of health programs
- Develop a national strategy to address health inequity
- Identify governance mechanisms to keep the issue on the national agenda
- The Prime Minister through the Productivity Commission and the COAG Reform Council to report annually on action on the social determinants of health

Specific Recommendations

18. That ANPHA use a social determinants framework or lens in all research conducted by the agency in order to begin to identify and address the factors that influence health in Australia.

19. That additional support be provided for the collection of socio-economic coded health service use and cost data.

20. That the evaluative component of any research undertaken by ANPHA is grounded with a view to ensuring evidence-informed policy and practice.

21. That locally based entities (such as local area health authorities, Medicare Locals, Local Health Networks or local governments or shires) develop and support policies, strategies, programs and action plans that address social determinants of health within their own catchment areas - with clearly defined goals, activities and accountability mechanisms and identify resources for their implementation.

22. That locally based entities build public understanding of health inequities and social determinants within their catchment areas.

23. That firm political commitment to addressing the social determinants of health is undertaken.

24. That a Commonwealth coordination role be established to ensure a shared understanding of goals, approaches, roles and accountabilities for outcomes.

25. Australian Medicare Local Alliance to take a lead role in coordination of planning with other local entities, to address the social determinants of health, and the National Health Performance Authority to report on social determinants data produced by Medicare Locals.

26. That the Social Inclusion Unit continues to identify areas that require action for the most disadvantaged in the community.

27. That the Social Inclusion Unit develop principles for action on the social determinants of health.

28. All government social policy plans should follow the lead of the *Discussion Paper for the Development of a National Aboriginal Health Plan* and have determinants of health as a key consideration and opportunity to improve health and well-being.

29. Resources for Closing the Gap initiatives to remain separate in any process that audits government programs with the aim of reducing duplication.

30. That the renewal of existing National Partnership Agreements consider using this opportunity to help guide government policy-making and program design for improving the health and social determinants of all Australians.

31. Work to commence on the identification of data sources, selection of indicators, data collection and setting of targets.

32. Identify a process that allows the sharing of data across sectors and ministries so that it can be used to conduct health and equity assessments of all policies before implementation.

33. Public Health Information Development Unit and Australian Institute of Health and Welfare to partner in the collation of information and data on the social gradient of health in Australia.

34. The Prime Minister to report to Parliament annually on the progress of action on the social determinants of health. The annual report to be coordinated by Social Inclusion Unit and conducted by Productivity Commission.

Introduction

Life expectancy at birth continues to increase in OECD countries, reflecting sharp reductions in mortality rates at all ages. Some of these gains in longevity can be attributed to rising living standards, improved lifestyle and better education, and greater access to quality health services[2]. Of all OECD countries Australia has the fifth highest life expectancy at birth and overall has gained 10.7 years since 1960. This is a significant improvement, but Australia could do better. For example Italy, Japan and Spain all spend considerably less on health per capita yet have higher life expectancy rates, and Israel spends almost 30 per cent less on health per capita and yet has the same life expectancy as Australia[3]. Catholic Health Australia believes that part of the solution to this issue lies in a close examination of what action on the social determinants of health can do for life expectancy and spending on health care.

This document presents Catholic Health Australia's initial submission on the Commonwealth's response to the 2008 World Health Organisation's (WHO) Commission on Social Determinants of Health report *Closing the Gap within a Generation*.

Catholic Health Australia (CHA) members are major not-for-profit providers of health, community and aged care services in Australia. These services are provided in fulfilment of the Catholic Church's mission to provide care and healing for those who seek it.

A snapshot of the Catholic Health Australia sector reveals that there are:
- 19,000 residential aged care beds;
- 6,253 retirement and independent living units and serviced apartments;
- 8,000 Community Aged Care packages (CACP);
- 6,000 Home and Community Care programs (HACC) and Extended Aged Care at Home packages (EACH);
- rural and regional aged care facilities and services;
- 9,500 beds in 75 health care facilities - publicly (21) and privately (54) funded hospitals and 7 teaching hospitals;
- Eight dedicated hospices and palliative care services;
- expanding day centres and respite centres; and
- approximately 35,000 people working in the sector.

There is growing concern amongst Catholic Health Australia members about fulfilling their mission of care to the poor and marginalised those experiencing the effects of social determinants in the community in the years ahead.

The membership has welcomed and applauded the initiation of this senate inquiry, and all members congratulate the Senators for having the courage and vision to undertake this inquiry.

When looking at health care across the continuum the Australian Government has addressed adequately through public policy the first three components of the health continuum. It is the fourth component, social determinants, which requires attention.

← LIFE / HEALTH CONTINUUM →			
Social Determinants	**Preventative**	**Health / Acute**	**End of life care**

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2 Health at a Glance- OECD Indicators 2011-2012 http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2011/life-expectancy-at-birth_health_glance-2011-4-en, accessed 2 October 2012

3 Health at a Glance- OECD Indicators 2011-2012 http://www.oecd-ilibrary.org/sites/health_glance-2011-en/01/01/g1-01-01.html?contentType=/ns/Book,/ns/StatisticalPublication&itemId=/content/book/health_glance-2011-en&containerItemId=/content/serial/19991312&accessItemIds=&mimeType=text/html, accessed 2 October 2012

The Catholic Church across education, health, community and social services – is involved in all four areas of the health continuum and will continue to be so for many years to come.

Table 1 Catholic sector involvement across the continuum

← LIFE / HEALTH CONTINUUM →			
Social Determinants	**Preventative**	**Health / Acute**	**End of life care**
Early Childhood	Early Childhood	Pre-natal/post-natal	Palliative care
Indigenous services	Indigenous services	Indigenous services	Indigenous services
Education	Education	Chronic Disease	Chronic Disease
Housing	Medical Research	Trauma	
Income support	Health Promotion	Acute Services	
Mental Health	Mental Health	Mental Health	Mental Health
		Aged Care	Aged Care

CHA does not argue from a health systems perspective for a reduction in funding of preventative, acute/health or end of life care, but rather that by addressing the social determinants of health adequately there may in fact be less demand on preventative, acute, health and end of life services into the future.

The declaration of Alma Ata adopted in 1978 by the International Conference on Primary Health Care and the 1986 Ottawa Charter for health promotion urged the need for joined up action to promote health and well-being. It has now been well established that the heaviest burden of disease and major causes of health inequities occur because of conditions in which people are born, grow, live, work and age.[4]

So why should governments - of all persuasions - act on this information?

It can be argued that governments have a responsibility for the health of the people that can only be fulfilled by the provision of adequate health and social measures. With a healthy investment in preventative health, Australian governments have successfully oriented policy toward the paradigm that says individuals are largely responsible for the health choices they make and as a consequence are responsible for the burden of disease they incur. What has not been acknowledged sufficiently in Australian health policy is the fact that behavioural choices are heavily structured by one's material conditions of life and that behavioural risk factors account for a relatively small proportion of the incidence and death from various diseases. There are many examples of this to be found in the literature. For example in the United States:

> "Reports in 2005 revealed the mortality rate was 206.3 per 100,000 for adults aged 25 to 64 years with little education beyond high school, but was twice as great (477.6 per 100,000) for those with only a high school education and 3 times as great (650.4 per 100,000) for those less educated. Based on the data collected, the social conditions such as education, income,

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[4] Commission on Social Determinants of Health Final Report "Closing the Gap" 2008

and race were very much dependent on one another, but these social conditions also apply independent health influences."[5]

And reported this month is evidence that in the US white women without a high school diploma, have lost five years of life expectancy between 1990 and 2008.[6]

The Liberal Party believe in a just and humane society and believe in equal opportunity for all Australians. They want all to enjoy the highest possible standards of living, health, education and social justice, whilst strongly believing in individual freedom and free enterprise.

For the Australian Labor Party fairness is a guiding principle for Labor in government, as is respect for basic human rights such as access to adequate health care. Labor believes in social justice and social inclusion. The Labor Party values state: "As a nation, our true greatness lies in our treatment of those among us who are most marginalised"[7].

The Australian Greens believe that individual health outcomes are influenced by the inter-relationship of biological, social, economic and environmental factors and that preventative approaches, measures to alleviate social disadvantage, and universal access to an effective health care system are necessary to address inequities in health outcomes. The Australian Greens have demonstrated a commitment to addressing the social determinants of health, as evidenced, for example, by Senator Di Natale's maiden speech to parliament where he stated:

> "Our efforts as health professionals are futile unless we also improve people's access to housing, education, clean air and water, secure employment, and participation in community life. The reality is that inequalities in health arise because of inequalities in society. Reducing health inequalities is a marker of our progress towards a fairer society. At its core, health is a social justice issue."[8]

It is clear that all political parties agree with each other, and it is CHA's view that this inquiry can deliver on this shared political agreement.

A social determinants approach would be attractive to government because it could relieve most of the burden of disease and major causes of health inequities, as well as:

- Help to streamline government funding through the use of audit;
- Reduce duplication of funding across portfolios for the same types of initiatives; and
- Increase the number of years of health, therefore increasing productivity

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[5] Woolf, S. H. "Social Policy as Health Policy." JAMA: The Journal of the American Medical Association 301.11 (2009): 1166-169. Print. Accessed 27th September 2012 from http://en.wikipedia.org/wiki/Social_determinants_of_health

[6] http://www.nytimes.com/2012/09/21/us/life-expectancy-for-less-educated-whites-in-us-is-shrinking.html?_r=1emc=tha2_20120921&, accessed 24th September, 2012

[7] www.alp.org.au/australian-labor/our-values/compassion/ accessed 21st September 2012

[8] http://richard-di-natale.greensmps.org.au/content/speeches/richards-first-speech-parliament, accessed 2 October 2012

1. Background to the Social Determinants of Health

Before addressing the inquiry's terms of reference, CHA offer's a comprehensive background to the issue and current debates surrounding the social determinants of health.

History

The Social Determinants of Health - The Solid Facts[9] was first published by the World Health Organisation (WHO) in 1998. The goal was to promote awareness, informed debate and action on the social determinants. The debate about social determinants had largely been within academic circles where much activity collating evidence to support the theory of social determinants was being conducted. At about the same time the third phase of the Healthy Cities Program was being rolled out by the WHO. The WHO European Healthy Cities Network that is still operating today, which runs in five-year phases, aims to put health high on the social, economic and political agenda of city governments. The Healthy Cities Program includes health considerations in economic, regeneration and urban development efforts. The Healthy Cities program has successfully helped to shape the social determinants debate internationally.

Australia

Meanwhile in Australia, in 1999, the Department of Health and Ageing commissioned a study on the social determinants of health titled *Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda* (principal author Gavin Turrell, Queensland University of Technology in association with the Health Inequalities Research Collaboration[10]). The report aimed to:

- review Australian research pertaining to socioeconomic health inequalities;
- provide a descriptive profile of Australia's research capacity vis-à-vis socioeconomic health inequalities;
- critically examine the policies and interventions that have been suggested to reduce socioeconomic health inequalities; and
- make a number of preliminary recommendations about the development of a national health inequalities research program and a policy and intervention agenda.

Across Australia different state and territory governments were picking up the language of social determinants. Queensland Health led with the development of the social determinants of health support packages, a series of fact sheets produced for policy makers outlining key messages and policy implications across the determinants.

Public Health Information Development Unit

The Public Health Information Development Unit (PHIDU), located at The University of Adelaide, was also established in 1999 and funded by the Department of Health and Ageing to assist in the development of public health data, data systems and indicator monitoring. A major emphasis of their work has been the development and publication of small area statistics for monitoring inequality in health and well-being. Their website [11] contains 120 indicators describing inequality in a range of indicators of socioeconomic status and health status. A quick examination of their indicators reveals that a social gradient exists in Australia, as it does elsewhere. Australia is not immune to this phenomenon.

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[9] Social Determinants of Health - The Solid Facts: 2003:World Health Organisation
http://whqlibdoc.who.int/euro/1998-99/EUR_ICP_CHVD_03_09_01.pdf

[10] Turrell, Gavin, Oldenburg, Brian F., Mcguffog, Ingrid, & Dent, Rebekah (1999) Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda. Queensland University of Technology, Brisbane, QLD. http://eprints.qut.edu.au/585/, accessed 11 September 2012

[11] http://www.publichealth.gov.au/inequality-graphs/monitoring-inequality.html

Health in All Policies - South Australia

The leading state in Australia in terms of action on the social determinants of health is South Australia. In 2007 South Australia adopted a 'Health in All Policies' (HiAP) approach, placing it strategically as a central process of government to improve health and reduce inequities, rather than an approach run by, and for, the health sector and imposed on other sectors. This approach has been framed as essential to achieve not only health priorities, but also a range of goals in the state's main planning document, South Australia's Strategic Plan. For South Australia, HiAP starts from the recognition that the determinants of health lie largely in the policy domains of other sectors of government. It is therefore crucial for the health sector to positively engage with these other sectors to ensure sustained action on the social determinants of health. The HiAP program in South Australia provides a mechanism for agencies to jointly reflect on a particular policy issue, and work in a collaborative and deliberative way to determine issues and take timely policy decisions. The HiAP process builds on traditional health impact assessment methodology by incorporating a suite of additional methods (eg economic modelling) to allow the process to deliver rigour and flexibility. It seeks to facilitate joint exploration of policy problems and issues. As a consequence, the specific methodology employed is modified for each project. Evaluation is also built into each individual project. In 2011 the South Australian Government moved to strengthen the mandate and sustainability of Health in All Policies approaches through specific provisions in new public health legislation[12].

In 2010 the WHO and the government of South Australia jointly issued the *Adelaide Statement on HiAP*, providing succinct advice on how to develop and strengthen the approach on the basis of equity.[13] After the *2010 Adelaide Statement on HiAP* health ministers from south-east Europe pledged to focus on health equity in all policies; health ministers of the Pacific Islands countries committed themselves to adopting multifactorial action to improve health; and more than 300 government leaders and city mayors at the Global Forum on Urbanisation and Health (held in Japan in November 2010) committed to the "Kobe call to action for redressing urban health inequities". The HiAP approach resulted from consultations with member states and experts, reflecting current thinking on policy formulation and ways to engage leaders and policy makers in improving health equity. Action on HiAP is one of the key recommendations from the meeting this year in Geneva of the World Health Assembly.

Tasmania - 2012

Tasmania, building on the experience of South Australia, is also moving toward adopting a HiAP approach. But before this happens Tasmania may undergo an inquiry, to be led by a Joint Select Committee, to inquire into issues pertaining to the social determinants of health in Tasmania. The Committee terms of reference have been amended but prior to this amendment (which is waiting to pass the Lower House) the terms of reference were to investigate:

- 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;
- The need for an integrated and collaborative preventative health care model which focuses on the prevention, early detection and early intervention for chronic disease;
- The need for structural and economic reform that promotes the integration of a preventative approach to health and well-being, including the consideration of funding models;
- The extent to which experience and expertise in the social determinants of health is appropriately represented on whole of government committees or advisory groups;
- Government and other funding for research addressing social determinants of health.[14]

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[12] www. sahealth.sa.gov.au/publichealthact

[13] WHO, Government of South Australia "Adelaide statement on HIA P: moving towards a shared governance for health and well-being", 2010

[14] http://www.parliament.tas.gov.au/ha/hanote.pdf

Early Childhood Plan – Northern Territory (NT)

The Department of Education and Training, in collaboration with the Departments of Health; Children and Families; Police, Fire and Emergency Services; Housing, Local Government and Regional Services and the Department of the Chief Minister, are developing an early childhood plan for the Northern Territory[15].

The plan will ensure the current national and NT strategies and reforms, for pre-birth to 8 year olds, are aligned and relevant to the NT context. The plan will set out the direction for building better services and programs that have measurable improvements in outcomes for the NT's youngest children and their families. It will also address challenges across portfolios including health, education, childcare and child safety and will be a mechanism for working in partnership across government and industry.

The Menzies School of Health Research has written an Early Childhood Series of papers to inform the consultation process and development of the early childhood plan. *A population approach to early childhood services* is the third paper in the series produced on behalf of the Department of Education and Training in the Northern Territory by the Menzies School of Health Research.[16.] The paper suggests that a population approach to improve developmental health and well-being in the NT would include:

1. A central focus on population-level outcomes and determinants as the basis for decisions: use of best evidence to inform policy; use of a variety of data and methods to identify effective interventions; disseminating findings and facilitating policy uptake.
2. Increased upstream investment in prevention, balancing long- and short-term investments.
3. Application of multiple intervention strategies: taking action on early life determinants and their interactions; implementing strategies to reduce inequalities; applying a comprehensive mix of interventions and strategies; integrating actions in multiple settings; aiming to improve health over the lifespan.
4. Collaboration across sectors and levels: engaging partners to align values and purpose and establishing concrete objectives and visible results; identifying champions and investing in alliances; securing political support; sharing leadership, accountability and rewards among partners.
5. Employing mechanisms for public involvement and demonstrating accountability for developmental outcomes: implementing results-based accountability; instituting effective evaluation systems; promoting impact assessment measures and publicly reporting results.

With a change of government in the NT it is unclear whether this comprehensive program will continue to be supported. The evidence, however, between the links of early childhood investment in education and health outcomes is clear.

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[15] http://www.det.nt.gov.au/parents-community/early-childhood-services/ntecplan, accessed 2 October 2012

[16] Robinson G, Silburn SR, Arney F, 2011. *A population approach to early childhood services: Implementation for outcomes.* Topical paper commissioned for the public consultations on the Northern Territory Early Childhood Plan. Darwin: Northern Territory Government.
http://www.det.nt.gov.au/__data/assets/pdf_file/0010/19486/PopulationApproachToEarlyChildhoodServices.pdf, accessed 29th September 2012

Education as a determinant of health

Research in the United States has found that policy initiatives that link quality early childhood care, child development programs, and parental training in a seamless continuum with strengthened kindergarten through to year 12 education can have a positive impact on the social determinants of health - "…a policy based on evidence from research on the social determinants of health and that integrates early child care and education would not just strengthen educational attainment and the stock of human capital, but it would also improve overall health status, reduce income inequality, and promote economic growth." [17]

The American College of Physicians has listed those social determinants of health that it considers as more important to health outcomes than levels of access to primary health care, with the main indicator being job classification. This was found to be a better predictor of cardiovascular death than cholesterol level, blood pressure, and smoking combined. The College also found that non-completion of high school is a greater risk factor than biological factors for development of many diseases, an association that is explained only in part by age, ethnicity, sex, or smoking status. Finally the most compelling finding was that the level of formal education predicted cardiovascular mortality better than random assignment to active drug or placebo over 3 years in a clinical trial that provides optimal access to care. [18]

Non-Government Organisations' contributions

The non-government sector in Australia is vibrant and innovative and already plays a key role in addressing the social determinants of health. The literature tells us, however, that in order to sufficiently address the social determinants of health, support provided to non-government and services outside of health services is needed in order to identify their public health role[19].

Detailed below are a number of non-government organisations, (NGOs) programs that work to address aspects of the social determinants of health. The list is not exhaustive, but suffices to say that all major NGO service providers potentially contribute in some way to addressing the social determinants of health. The effort, as in government, is not coordinated, nor is there any level of accountability for addressing the social determinants of health.

Learning for Life

The Smith Family's *Learning for Life* program is an example in Australia of putting into action the findings of the American College of Physicians, cited above. The *Learning for Life* program supports disadvantaged children and young people all the way through their education, from pre-school and primary school, to senior school and on to tertiary studies if they choose.

Learning for Life support is provided to disadvantaged children and young people in three main ways:
- through Learning for Life Workers, who connect them to learning opportunities in their local community and also encourage them to fully participate in their education;
- by enabling access to Smith Family literacy programs and mentoring support;
- and through financial assistance to help families afford the cost of their children's essential education items.

This holistic, long-term support gives young Australians the assistance they need to develop vital life skills, stay engaged in their education and have the best chance to realise their potential. [20]

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[17] M. David Low, Barbara J. Low and Elizabeth R. Baumler Phuong T. Huynh: Can Education Policy Be Health Policy? Implications of Research on the Social Determinants of Health: Journal of Health Politics, Policy and Law: **2005** Volume 30, Number 6: 1131-1162 **;** http://jhppl.dukejournals.org/content/30/6/1131.abstract, accessed 2 October 2012

[18] Laverty M, 2009: The central place of Health in Australia's Social Inclusion Agenda: Addressing the Social Determinants of Health to achieve social inclusion: http://cha.org.au/images/policy/Social%20Determinants%20of%20Health%20-%20Jan%202009%20Final.pdf, p.7

[19] Lundgren B.: Experiences from the Swedish determinants-based public health policy. Int J Health Serv. 2009;39(3):491-507 http://www.ncbi.nlm.nih.gov/pubmed/19771952, accessed 1 October 2012

[20] http://www.thesmithfamily.com.au/site/page.cfm?u=9

St Vincent's Health Australia Social Justice through Health Strategy

St Vincent's Health Australia (SVHA) is one of CHA's largest members and is Australia's largest Catholic provider of diversified health and aged care. They have 27 facilities including two public A1 Tertiary teaching hospitals in Melbourne and Sydney, and across the Eastern Seaboard they also operate private hospitals, acute and sub-acute facilities, and aged and palliative care. SVHA is also comprised of several high-profile research institutes such as Victor Change Institute and the Garvin Institute.

SVHA has developed a unique approach to working with population groups who experience health and social vulnerabilities that is informed by the Social Determinants of Health approach. At this stage their work in this area is focused on Aboriginal and Torres Strait Islanders peoples, people who experience chronic homelessness, and community residing asylum seekers. The SVHA approach to health services for these population groups is called '*Social Justice through Health*' - it is an innovative program that links three 'delivery pathways' for bringing about better health outcomes for these population groups: clinical care, research, and advocacy.

In each of the three delivery pathways, there is a focus on providing excellent clinical care for the person while being cognisant of the deeper causes and patterns of poverty that lead to and exacerbate ill-health. In this way, they are taking a social determinant of health approach, seeking to work with social service agencies who share their philosophy of empowerment, and they are also establishing a very solid evidence base for their work with these population groups that will inform their advocacy role.

Jesuit Social Services

Provides a range of programs that work to build a just society where all people can live to their full potential - by partnering with community to support those most in need and working to change policies, practices, ideas and values that perpetuate inequality, prejudice and exclusion.

For example Jesuit Social Services have developed education, training and employment programs in recognition of the strong and continuing links between low levels of education, low job skills, crime, disadvantage and poverty. An example of a program is the Collingwood Community Information Centre where services are grouped according to the following:

- Self-directed access – drop-in services (photocopier, fax, computers, refreshments); tax help.
- Information provision – community information.
- Advocacy – complex cases; networking; partnerships.
- Capacity building via training and mentoring – CCIC volunteer program; informal outreach; English help program; student placements.
- Enhancing connection and engagement – drop-in services; welcome lunches, meeting rooms, office infrastructure for local groups; activity information[21].

The service is staffed by public housing residents and a team of trained volunteers from the neighbourhood. Volunteers who demonstrate commitment to the service are offered enrolment in the Unit of Competency CHCCS416A Assess and Provide Services for Clients with Complex Needs. The service has become a popular meeting point and not only provides information but is perceived as a safe and welcoming place to find support and meet other community members, thus providing a focus for community connectedness for local residents.

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[21] http://www.jss.org.au/programs/all-programs/collingwood-community-information-centre

2. World Health Organisation activity

The following summarises the World Health Organisation's (WHO) activity in relation to the social determinants of health.

Table 2: WHO activity on the social determinants of health

1998	**Social Determinants of Health - The Solid Facts**	**First edition published**
2003	Social Determinants of Health - The Solid Facts	Second edition published
2005	CSDH	Commission on Social Determinants of Health (CSDH) was set up by the WHO.
2008	"Closing the Gap within a Generation" report	The WHO commission on social determinants of health compiled recommendations to create an extensive prescription of what is required to "close the gap" through action on the social determinants of health, across all sectors of society.
2009	World Health Assembly passes resolution	Resolution 62.14 "reducing health inequities through action on the social determinants of health" passed, which aimed to put the recommendations in the 2008 report into practice.
2009	World Health Assembly (WHA) resolution	62.14 also requested the director-general to provide support to member states in measures that included convening a global event, before the 65th WHA in order to discuss renewed plans to address the social determinants of health.
2010	2010 Adelaide Statement	WHO International Meeting on Health in All Policies held in Adelaide. Discussed how the health sector can support broader policy goals related to societal well-being and evolved into the Adelaide Statement on Health in All Policies[22].
November 2010	"Kobe call to action"	300 government leaders and city mayors at the Global Forum on Urbanisation and health called for action on redressing urban health inequities.
October 2011	Publication of social determinants of health case studies	Online 28 case studies presenting successful examples of policy action aiming to reduce health inequities. The case studies cover a wide range of issues, including conditional cash transfers, gender-based violence, tuberculosis programs and maternal and child health.
October 2011	Online platform launched *Action:SDH[23]*	At the World Conference on Social Determinants of Health the WHO launched an innovative web-based platform – Action SDH – to facilitate discussion on how health equity could be improved through action on social determinants of health.
October 2011	Member states adopt Rio Political Declaration at World Conference on Social Determinants of Health	125 participating Member States at the World Conference on Social Determinants of Health adopted the Rio Political Declaration on Social Determinants of Health, pledging to work towards reducing health inequities by taking action across five core areas.

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[22] http://www.who.int/bulletin/volumes/88/10/10-082461.pdf, accessed 11 September 2012

[23] See http://www.actionsdh.org/

May 2012	World Health Assembly adopts the Rio Political Declaration on Social Determinants of Health	A resolution endorsing the Rio Political Declaration on Social Determinants of Health was adopted by WHO Member States at the 65th World Health Assembly (WHA) in Geneva, Switzerland.
July 2012	Final Report of the World Conference on Social Determinants of Health now available	

As detailed, the WHO Commission on Social Determinants of Health compiled recommendations to create an extensive prescription of what is required to "close the gap" through action on the social determinants of health, across all sectors of society. In 2009 the World Health Assembly's member states (of which Australia is one) passed a resolution to put the recommendations in the 2008 report into practice by adopting Resolution 62.14 "reducing health inequities through action on the social determinants of health".

The resolution requested the director-general to provide support to member states in measures that included convening a global event. This was to occur before the 65th World Health Assembly where renewed plans to address the social determinants of health were to be discussed. These renewed plans were necessary because of the "alarming trends of health inequities".[24]

Rio Political Declaration

A world conference on social determinants of health was held in Rio de Janeiro on 19–21 October 2011. Organised by the WHO its focus was on turning policy into practice with regard to the social determinants of health.

Prior to the conference a discussion paper was released that was to inform proceedings and contribute to fulfilling the purpose of the world conference, i.e. "closing the gap: policy into practice on social determinants of health".

The conference shared experiences about how to address the challenges posed by health inequities. The discussion paper released prior to the conference identified five key themes that countries need to address in order to put policy into practice on the social determinants of health:

1. *Governance to tackle the root causes of health inequities*: implementing action on the social determinants of health.
2. *Promoting participation*: community leadership for action on social determinants.
3. *The role of the health sector*, including public health programs, in reducing health inequities.
4. *Global action on social determinants*: aligning priorities and stakeholders.
5. *Monitoring progress*: measurement and analysis to inform policies and build accountability on social determinants.

It was the premise of the paper that these five components represented the constituent parts of the social determinant approach that should be adopted by governments worldwide. The components are detailed below.

Governance

Countries should aim to build good governance for action on social determinants of health and establish governance that clarifies the individual's and joint responsibilities of different actors and sectors in the pursuit of health and well-being as a collective goal linked to other priorities. There should be a link between collaborative action and sectors; this would require the creation of conducive policy frameworks and approaches to health with an emphasis on shared objectives and values. Good governance should build on the positive factors in the policy environment, engage key

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24 65th WHA A65/16 provisional agenda item 13.6 point 2, 22 March 2012

partners at the outset, share leadership, provide accountability rewards and facilitate public participation.

Promoting participation

The Rio discussion paper recommended the creation of conditions for participation by creating formal, transparent and public mechanisms through which civil society organisations (such as NGOs, public health services, schools etc.) can contribute to policy development. Participation should be brokered by Government and be representative – with the aim to facilitate empowerment and equitable public representation through targeted mechanisms to reach under represented groups. An additional way to facilitate participation by civil society could be, for example, encouraging 'shadow reports'.

Role of the health sector

The health sector should be used to advocate for action, monitor health inequities and impact of policies, and bring sectors together to plan and develop capacity for work on social determinants of health. The health sector should aim to reorient health services and public health programs to decrease inequities and institutionalise equity into health systems governance. This may be done through a primary health care approach with equity as a priority.

Global action on Social Determinants

The discussion paper talked about aligning global stakeholders and priorities.

Monitoring progress: measurement and analysis

The discussion paper called for the need to identify sources, select indicators, collect data and set targets –including disaggregating data to better understand baseline levels and potential impacts of policy. It called on countries to move forward even if systematic data were not available and to prioritise the strengthening of systems to capture the most vital required data. The aim should be to disseminate data on health inequities and social determinants and integrate these data into policy processes. Data must be linked to the policy-making processes. Integrated analysis of data into the policy-making processes is seen as beneficial because it can be used to develop evidence-informed policies. Effort should be made to share information across sectors, and to conduct health and equity assessment of all policies before implementing by using tools such as health impact assessment.

The World Conference on Social Determinants of Health in Rio brought together member states and stakeholders to share experiences and build support for ways to implement policies and strategies to decrease health inequities. At the end of the meeting the Rio Political Declaration on Social Determinants of Health was adopted. The full communiqué can be found at http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf.

The declaration endorsed the five key themes, outlined above and called for global action on the social determinants of health.

Following the Rio conference, the WHO secretariat launched *Action: SDH* on the internet to provide advice and create a community of practice aimed at improving health equity through dealing with the social determinants of health (www.actionsdh.org).

In May this year, the 65th World Health Assembly (WHA) met in Geneva. "WHA 65.8" endorsed the Rio Political Declaration on Social Determinants of Health adopted by the World Conference on Social Determinants of Health.

The endorsement urges member states to:
- implement pledges made in the Rio Declaration with regard to the five areas, outlined above;
- to develop and support policies, strategies, programs and action plans that address social

determinants of health, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation;

- support further development of HiAP approaches as a way to promote health equity;
- build capacities among policy-makers, managers and program workers in health and other sectors to facilitate work on social determinants of health; and
- call on the international community to also support the Rio Declaration.

During the past 14 years, many countries have responded to the call from the WHO to act, including the United Kingdom, Canada, many European countries, Africa, New Zealand and countries in the Americas. The United States of America has even begun to consider how public policy could be shaped to address the social determinants.[25]Australia appears to be one of the countries that have not yet commenced action to:

> *"develop and support policies, strategies, programs and action plans that address social determinants of health, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation"*

as prescribed in the World Health Assembly Resolution 65.8 that endorses the Rio Political Declaration on the Social Determinants of Health[26].

With the work of the Commission and the Rio Declaration there has been improved understanding of the contribution that health can play towards achieving other goals such as social cohesion and economic development.

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[25] The Robert Wood Johnson Foundation Commission to Build a Healthier America was recently charged to identify strategies beyond medical care to address health disparities in the U.S. related to social and economic disadvantage. http://www.ncbi.nlm.nih.gov/pubmed/21146780, accessed September 11 2012

[26] 65th World Health Assembly: Outcome of the World Conference on Social Determinants of Health, Agenda Item 13.6, 26 May 2012:http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_R8-en.pdf, accessed 11th September 2012

3. The policy experience

There are many examples internationally where an approach to acting on the social determinants of health has been explored. The table below details some examples.

Table 3: Social determinants in practice

Country	Area	Summary
Austria[27]	Homelessness	Demand-oriented health care services for the homeless. Aims to safeguard and improve homeless people's access to standard/primary level health services
Ireland[28]	National - communities	Building Healthy Communities Programme. Aims were to promote the principles and practice of community development in improving health and well-being outcomes for disadvantaged communities; to build the capacity in community health; to guide and support policy initiatives addressing the link between poverty and health; and to explore mechanisms for effective, meaningful and sustainable community participation in making decisions about health.
Spain[29]	Promotion of health, access	People from within the Roma community are trained as mediators and then act as peer educators and as a liaison between the community and the central health, social and education services. The mediator plays a key role in documenting the health history of families in the health implementation zone and drawing up a health plan in cooperation with the appropriate service providers.
Germany	Health promotion	With Migrants for Migrants - Intercultural Health in Germany. Aims to level unequal long-term health opportunities by making the health system more accessible to immigrants, increasing their health literacy and empowering them through a participatory process, thus promoting their individual responsibility for health and awareness of health issues.
UK- Scotland[30]	Health promotion/ coordination	Inequalities Sensitive Practice Initiative (NHS Greater Glasgow and Clyde). 14 pilot projects exploring different approaches to improving service provision for individuals with multiple and complex needs.
Sweden[31]	Legislation	A comprehensive Swedish public health policy was adopted by the Swedish Parliament in April 2003. (detailed below)

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27 http://data.euro.who.int/Equity/hidb/Resources/Details.aspx?id=1

28 http://data.euro.who.int/Equity/hidb/Resources/Details.aspx?id=3

29 http://data.euro.who.int/Equity/hidb/Resources/Details.aspx?id=10

30 http://data.euro.who.int/Equity/hidb/Resources/Details.aspx?id=16

31 http://www.ncbi.nlm.nih.gov/pubmed/19771952

Policy experience - Norway

Norway introduced a national strategy (2007) to reduce social inequalities in health. At the same time they introduced two other initiatives: one that addresses employment welfare and inclusion, and one that is an early intervention for lifelong learning strategy.

Norway developed a comprehensive and integrated approach to addressing social inequalities in health because of mounting evidence of:

1. Systematic inequalities in health, for example increasing differences in mortality among adults
2. Main causes of death (e.g. cancers) being unevenly distributed in society
3. Significant social inequalities in mental health
4. Inequalities being evident at every stage of life - where income, living conditions, work and working environment relate to the distribution of health in the population

The Norway strategy was based on the assumption that:
- social inequalities in health are mainly due to differences in material, psychological and behaviour related risk factors, and
- the work to reduce these inequalities is long term and will be targeted.

For Norway the primary objective has been to reduce social inequalities in health by 'leveling up'- that is, by increasing the health outcomes for all people, not just the bottom quintile. Norway's goals have been to:

1. Reduce social inequalities that contribute to inequalities in health through
   - reducing economic inequalities
   - implementing safe childhood conditions and equal development opportunities
   - creating inclusive working life and healthy working environments
2. Reduce health inequalities in health behaviour and use of health services through
   - reduction of social inequalities in health behaviour
   - provision of equitable healthcare services
3. Introduce targeted initiatives to promote social inclusion through
   - creating better living conditions for the most disadvantaged people
4. Develop knowledge and cross sectoral tools through
   - creation of systematic overview of developments
   - promotion that all sectors of society assume responsibility
   - increasing knowledge about causes and effective measures

The gradient approach that Norway has taken means that they give priority to universally oriented population strategies (health for all) with appropriate specific and targeted measures for disadvantaged groups - a combination of priority universal and, where appropriate, targeted strategies. The stated intention is to improve the social gradient in health across the population.

Norway also undertook early engagement and advocacy of NGOs, which have provided strong support for such a broad determinants approach. Norway has discovered solutions within and across organisational boundaries and sectors.

The Norway approach also addresses health systems functions. In 2007 the Norway government set up an expert group within health who recommended an equity audit of health programs as the beginning step, and in 2009 developed a report on accessibility and the use of health services. In response to identifying objectives for reducing health inequalities Norway has developed a reporting system that aims to monitor the distribution of inequalities in order to feedback into policy development.

Policy experience - Sweden

Like Norway, Sweden - through legislation, and the orientation of the role of the Swedish National Institute of Public Health (SNIPH) has made equity in health a high priority. The SNIPH has monitored the development of 42 determinants and used reports from 22 central agencies and eight county administrative boards together with interviews with all Sweden's county councils and all municipalities. The issues of structural factors in society affecting people's health and living conditions are well understood within Sweden.[32]

The Government of Sweden defined the social determinants of health in 2003 by legislating 11 objectives for the public health system to achieve in order to reduce the adverse impacts of the social determinants of health. The 11 objectives are: participation and influence in society; economic and social security; secure conditions during childhood and adolescence; healthier working life; healthy and safe environments and products; health and medical care that more actively promotes good health; protection against communicable diseases; safe sexuality; increased physical activity; good eating habits and safe food; and reduction in tobacco, alcohol, drug use and excessive gambling[33].

The Swedish legislation represented a departure from Sweden's earlier approach of building policy in response to specific diseases. It also meant that the majority of public health work would need to take place outside traditional medical care service environments in recognition that most of the factors that impact health are found outside the spheres of medical practice.[34]

What has worked for Sweden in terms of the implementation of this legislation is the use of indicators to follow up exposures to determinants; the support to actors outside the health service in order to identify their public health role; a continuous steering from the government and other political bodies; and coordination of public health promotion at a regional level.[35]

Policy experience – United Kingdom

In 2008 Sir Michael Marmot was asked to chair a "Review of Health Inequalities in England" to inform policy making when addressing health inequalities. The study commenced in 2010. The Review was announced at the launch of the Commission on Social Determinants of Health report *Closing the Gap in a Generation.*

Following the review of health inequities (*Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010*), national targets in three areas were proposed.
1. Health outcomes across the social gradient (life health expectancy and well-being)
2. Child development across the social gradient (school readiness employment training)
3. Income sufficient for healthy living

The final report included some suggested indicators to support monitoring of the overall strategic direction in reducing health inequalities. The London Health Observatory has been monitoring annually a suite of indicators which include the following:
- Male and female life expectancy
- Slope indices of inequality (SII) for male and female life expectancy
- Slope indices of inequality (SII) for male and female disability-free life expectancy
- Children achieving a good level of development at age 5
- Young people who are not in education, employment or training (NEET)

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[32] Lundgren B.: Experiences from the Swedish determinants-based public health policy. Int J Health Serv. 2009;39(3):491-507 http://www.ncbi.nlm.nih.gov/pubmed/19771952, accessed 1 October 2012

[33] Agren, G (2003), *Sweden's new public health policy: National public health objectives for Sweden,* National Institute of Public Health, Stockholm, Sweden.

[34] Laverty M, 2009: The central place of Health in Australia's Social Inclusion Agenda: Addressing the Social Determinants of Health to achieve social inclusion: http://cha.org.au/images/policy/Social%20Determinants%20of%20Health%20-%20Jan%202009%20Final.pdf, p.7

[35] Lundgren B, *op cit*

- People in households in receipt of means-tested benefits
- Slope index of inequality for people in households in receipt of means-tested benefits

Two years after the release of the report, indicator findings have shown that while life expectancy improved for most of the 150 local authority areas in England - which will take over responsibility for public health in April 2013 - inequalities within these areas also increased. The amount by which the gap in life expectancy varies between the wealthiest neighbourhoods and the most deprived has risen in the majority of these 150 local authorities.[36] Ongoing monitoring is occurring and is a useful tool for the local authority areas in planning and targeting service delivery in their areas.

Policy experience – Europe

Following the review of health inequalities in England, the WHO Regional Director for Europe commissioned a similar review of social determinants of health and the health divide in the European Region, and engaged Sir Michael Marmot to undertake this work. The purpose of the review has been to identify the relevance of the findings of the WHO Commission on the Social Determinants of Health (CSDH), the *Strategic Review of Health Inequalities in England post 2010* (Marmot Review), and other new evidence to the European context and translate these into policy proposals.[37]

Marmot, in an article in *The Lancet* where the European Review is discussed, states:

> "The cost of health inequities to health services, lost productivity, and lost government revenue is such that no society can afford inaction. Tackling inequities in the social determinants of health also brings other improvements in societal well-being, such as greater social cohesion, greater efforts for climate-change mitigation, and better education."[38]

The review has been completed and the recommendations were published in September this year and have developed detailed recommendations across four themed areas: life course; wider society; macro-level broader context; and systems of governance.

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36 http://www.lho.org.uk/viewResource.aspx?id=17757, accessed 27th September 2012

37 http://www.instituteofhealthequity.org/projects/who-european-review, accessed 27th September, 2012

38 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61228-8/fulltext, accessed 27th September, 2012

4. Alternate views on social determinants of health

There are of course critics of the social determinants view of health. Some argue that a human rights approach is absent,[39] others, that there is an exclusion of the sociopolitical and class contexts that shape interest group power and citizen health[40].

Labor MP Andrew Leigh also holds a dissenting view on the social determinants, where he asserts:
> "One set of arguments suggests that we should care about inequality for what are called 'instrumental reasons'. Inequality, some contend, is associated with worse outcomes in areas that society cares about, such as health, crime, savings and growth. This argument is put most strongly in The Spirit Level, by Richard Wilkinson and Kate Pickett. It is an argument that I used to believe. Indeed, I deeply want to be true, but my own research persuades me otherwise. The closer you get to these asserted effects, the more fragile are the findings. If there are negative effects of inequality on those social outcomes, they must be extremely small."[41]

Economists' concerns with the social determinants lie in the fact that measurement of inequality and the underpinning reasons behind it do not provide a clear-cut picture. For this reason when it comes to social determinants, standards of evidence used to guide social policy need to be rigorous, and also more comprehensive than traditionally used to inform clinical interventions. Costa-Font and Hernandez-Quevedot argue it is unclear what "evidence" actually suggests about the reasons for inequalities. It is also unclear what the best possible instruments to measure both inequality and socioeconomic health gradients ought to be.[42]

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[39] http://www.hhrjournal.org/index.php/hhr/article/viewArticle/368/565

[40] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447750/

[41] http://www.andrewleigh.com/blog/?p=2521#_edn26. And also Dan Andrews, Christopher Jencks and Andrew Leigh, 2011, 'Do Rising Top Incomes Lift All Boats?' *B.E. Journal of Economic Analysis & Policy* (Contributions), 11(1): Article 6; Andrew Leigh, Christopher Jencks and Tim Smeeding, 2009, 'Health and Inequality' in W. Salverda, B. Nolan, and T. Smeeding (eds) *The Oxford Handbook of Economic Inequality*, Oxford, Oxford University Press, 384-405; Andrew Leigh and Alberto Posso, 2009, 'Top Incomes and National Savings' *Review of Income and Wealth*, 55(1): 57-74; Christopher Jencks and Andrew Leigh, 2007, 'Inequality and Mortality: Long-Run Evidence from a Panel of Countries', *Journal of Health Economics*, 26(1): 1-24.

[42] Costa-Font J, Hernández-Quevedo C. Health Policy. Measuring inequalities in health: what do we know? What do we need to know? 2012 Jul;106(2):195-206. Epub 2012 May 18, http://www.ncbi.nlm.nih.gov/pubmed/22607941, accessed 10th September 2012

5.   Catholic Health Australia contribution to the social determinants of health policy debate

Catholic Health Australia has had an interest in advocating the need for action on the social determinants of health since 2009. CHA's policy and advocacy principles are based on a range of foundational principles, one being a preference for the poor and under-served. Catholic social teaching has embraced a preferential option for the poor where concern is expressed for the provision of adequate, timely health care for all, especially those who have little choice, opportunity or capacity to pay.

CHA, along with the National Centre for Social and Economic Modelling (NATSEM) released a report in 2010 entitled *Health Lies in Wealth*, where the important issue of the social determinants of health and their impact on health outcomes was highlighted. In relation to this report the then Health Minister Nicola Roxon was quoted as saying:

> "There is opportunity for the Preventive Health Agency to strategically assess the social determinants of health as shown earlier this week by the report commissioned by Catholic Health Australia, *Health Lies in Wealth*. The report shows 65% of those in the lowest income group report a long term health problem compared with just 15% of the most wealthy."

CHA also edited a book titled *Determining the Future: A Fair Go & Health for All* that brought together a unique collection of essays on the social determinants of health from some of Australia's leading health and social policy experts – medical professionals, academics, opinion leaders, thinkers and writers. The book provides some tangible solutions to the social determinants of health which, according to the World Health Organisation (WHO), are mostly responsible for the unfair and avoidable differences in health status seen within and between countries.

CHA and NATSEM released in August 2012 another report entitled *The Cost of Inaction on the Social Determinants of Health* where again the important issue of the social determinants of health and the impact on health outcomes, including the economic impact, were discussed. The findings of *The Cost of Inaction on the Social Determinants of Health* suggest that if the World Health Organisation's recommendations were adopted within Australia:

- 500,000 Australians could avoid suffering a chronic illness;
- 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;
- million fewer Medicare services would be needed each year, resulting in annual savings of $273 million;
- million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of $184.5 million each year.

Catholic Health Australia is committed to ensuring that there is government action on the social determinants of health.

6.   Addressing the Senate Committee Terms of Reference
Australia's domestic response to the World Health Organisation's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"
   a)   **Government's response to other relevant WHO reports and declarations;**
   b)   **Impacts of the Government's response;**

It has proved difficult to identify any specific Commonwealth government response to relevant WHO reports and resolutions.

Five national specific purpose payments (SPP) were created in 2008 with funding of $60.5 billion in a National Healthcare SPP; $18 billion in a National Schools SPP; $6.7 billion in a National Skills and Workforce Development SPP; $5.3 billion in a National Disability Services SPP; and $6.2 billion in a National Affordable Housing SPP. Specific projects began in 2009. An explicit COAG commitment to Indigenous reform and "closing the gap" was made with $4.6 billion to be allocated across early childhood development, health, housing, economic participation and remote service delivery and the establishment of the National Indigenous Health Equality Council. Whilst not framed under a heading of "social determinants of health", this type of program and others like it, led by this current government and several governments before it, do in fact go some way to try and address the social determinants issues. Two key factors missing however are **coordination** and **accountability**.

Detailed below are a number of examples where the language of social determinants is starting to be used, but it is evident that there is not a policy understanding of the approach to health equity through the social determinants of health.

Preventative Health

The Commonwealth Government has stated it is committed to refocussing the health system towards prevention[43] and has taken action on 28 of the 35 key action areas identified by the Preventative Health Taskforce. The Australian National Preventive Health Agency (ANPHA), funded at $133.2 million over four years, is the first national agency dedicated to preventative health.

Taking Preventative Action - A response to Australia: the Healthiest country by 2020 The Report of the National Preventative Health Taskforce[44] was the Government's response to the *Report of the National Preventative Taskforce*. It mentions social determinants of health on four separate occasions only. The report states that the National Women's Health Policy will seek to reduce risk factors by addressing the social determinants of health (p.5); that the Government is committed through the social inclusion agenda to targeting services to address the causes of disadvantage, including the social determinants of health (p.54); that there is ongoing research on effective strategies to address social determinants of obesity in Indigenous communities (p.60); and that the Aboriginal and Torres Strait Islander Health Performance Framework Report (HPF) monitors Indigenous health outcomes and determinants of health including risk factors and health system performance on a biennial basis. Analysis is also prepared on the relationship between social determinants of health, risk factors and health outcomes (p.100).

The Preventative Health Taskforce's technical papers, on the other hand, called for action on health equity and addressing economic inequality: "policy coherence and inter-sectoral action for health – 'health in all policies' – are essential, and renewed government leadership is urgently needed to balance public and private sector interests."[45]

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[43] http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/take-prev-action-toc~take-prev-action-prev-health-act-over-ch2~take-prev-action-prev-health-act-over-ch2.1#.UE7RX2DWF8c, accessed 11th September 2012

[44] Taking Preventative Action - A response to   Australia: the Healthiest country by 2020 The Report of the National Preventative Health Taskforce http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/report-preventativehealthcare/$File/6588%20DoHA%20Health%20Strategy_120510.pdf, accessed 12th September 2012

[45] Technical Paper 1: Obesity in Australia: A need for urgent action, http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/tech-obesity-toc~tech-obesity-3~tech-obesity-3.2~tech-obesity-3.2.7, accessed 12th September 2012

When asked to submit a policy paper to the National Preventative Taskforce, Professor Sharon Friel, who led the secretariat team for the WHO Commission on Social Determinants of Health, asked the taskforce to consider:

> "A range of needed actions … in areas of education, employment, urban development, trade, economic policy, social inclusion, each of which, if pursued, will contribute significantly to preventing obesity, alcohol and tobacco related ill-health. The Taskforce must recommend action in these areas and work with the health sector, particularly DoHA, to develop its stewardship role in brokering policy coherence and intersectoral collaboration for health".[46]

As previously noted at the time of the introduction of the legislation to establish the ANPHA, Minister Roxon, the then Health Minister, said:

> "There is opportunity for the Preventive Health Agency to strategically assess the social determinants of health as shown earlier this week by the report commissioned by Catholic Health Australia, *Health Lies in Wealth*. The report shows 65% of those in the lowest income group report a long term health problem compared with just 15% of the most wealthy."

But the current ANPHA noncommunicable research strategies appear to focus on behavioural change strategies only. Popay, Whitehead and Hunter talk about "lifestyle drift" which is "the tendency for policy to start off recognising the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors". Popay et al go on to say "with lifestyles in the ascendancy, action to address the upstream determinants of inequalities in health is at best neglected, at worse undermined". The authors urge public health to resist lifestyle drift, silo-based working and the drive in policy and delivery for "quick fixes" and low-lying fruit.[47] Without considerable thought being put into translational components of the current ANPHA lifestyle priorities, a reduction in health inequalities will not happen.

Recently the ANPHA called for responses to its research agenda. In its response CHA called for: the use of a social determinants framework or analysis in all research conducted by ANPHA in order to begin to identify and address the factors that influence health in Australia; additional support for the collection of socio-economic coded health service use and cost data; and that the evaluative component of any research undertaken by ANPHA is grounded with a view to ensuring evidence-informed policy and practice.

Research around the social determinants of health offer new avenues of research in the area of prevention, and these opportunities are not currently being fully picked up by ANPHA.

RECOMMENDATION

1. That ANPHA use a social determinants framework or lens in all research conducted by the agency in order to begin to identify and address the factors that influence health in Australia.

2. That additional support be provided for the collection of socio-economic coded health service use and cost data.

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[46] Health equity in Australia: A policy framework based on action on the social determinants of obesity, alcohol and tobacco, Dr Sharon Friel National Centre for Epidemiology and Population Health, The Australian National University & The Department of Epidemiology and Public Health, University College London for the Australian National Preventative Health Taskforce 27 May 2009 , p.ii http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/0FBE203C1C547A82CA257529000231 BF/$File/commpaper-hlth-equity-friel.pdf, accessed 10th September 2012

[47] J Popay, M Whitehead and D Hunter: 2010: Journal of Public Health Volume 32, Issue 2Pp. 148-149: Injustice is killing people on a large scale—but what is to be done about it? http://jpubhealth.oxfordjournals.org/content/32/2/148.full 2010, accessed 21st September, 2012

3. That the evaluative component of any research undertaken by ANPHA is grounded with a view to ensuring evidence-informed policy and practice.

Primary Health

In relation to the development of Australia's first primary health care strategy the Commonwealth states that a number of submissions proposed that the *National Primary Health Care Strategy* needed to encompass a broad definition of comprehensive primary health care including consideration of the social determinants of health. The Commonwealth response to this call was the following:

> "Whilst recognising the importance of the social determinants of health, the Draft Strategy does not attempt to actively address the range of non-health issues which impact on health outcomes and inequalities. At the same time, the Social Inclusion Principles identified as part of the Social Inclusion Agenda adopted by the Australian Government are an important aspect in guiding this reform. The Australian Government's Women's and Men's Health policies are also considering these broader issues".[48]

This provides an example of how a silo-based approach to considering the impact of the social determinants of health means accountability for it can get "lost", and in the end there are no accountability mechanisms for action. The literature clearly identifies the area of health as playing a key role in coordination, development of policy and support to non-health areas. The *National Primary Health Care Strategy* provided an opportunity to be that point to "develop and support policies, strategies, programs and action plans that address social determinants of health, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation".[49] This was a lost opportunity to respond to the WHO calls for action.

RECOMMENDATION

4. That locally based entities (such as local area health authorities, Medicare Locals, Local Health Networks or local governments or shires) develop and support policies, strategies, programs and action plans that address social determinants of health within their own catchment areas - with clearly defined goals, activities and accountability mechanisms - and identify resources for their implementation.

5. That locally based entities build public understanding of health inequities and social determinants within their catchment areas.

National Health and Hospital Reform Commission

The *Healthier Future for All Australians - Final Report June 2009* identified a number of design and governance principles[50] for the health system, one being "equity". This principle, as articulated in Appendix F, says:

> Addressing inequity in health and aged care access and outcomes also requires action beyond universal programs, including through engagement with other policy sectors (such as the education system, and employment) and a focus on the social determinants of health.

There appears to be little evidence of the application of this principle within the governance and

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[48] http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc~nphc-draftreportsupp-ch3~nphc-draftreportsupp-ch3-scope#.UE7UkGDWF8c accessed 11th September 2012

[49] 65th World Health Assembly: Outcome of the World Conference on Social Determinants of Health, Agenda Item 13.6, 26 May 2012:http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_R8-en.pdf, accessed 11th September 2012

[50] Appendix F: Design and Governance Principles http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nhhrc-report-toc~nhhrc-report-appf#.UE7XfmDWF8c, accessed September 11th, 2012

design of health systems thus far. One exception is the Medicare Locals.

RECOMMENDATION

6. *That firm political commitment to addressing the social determinants of health is undertaken.*

7. *That a Commonwealth coordination role be established to ensure a shared understanding of goals, approaches, roles and accountabilities for outcomes.*

Medicare Locals

A key component of the Australian Government's National Health Reforms is the establishment of the new nationwide network of Medicare Locals. Medicare Locals are primary health care organisations established to coordinate primary health care delivery and tackle local health care needs and service gaps. They will drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities.

The Operational Guidelines for Medicare Locals note the following:
"Key Reporting Area 4: Increased delivery of health promotion and/or preventative health initiatives to address locally relevant risk factors". Under this reporting area "Medicare Locals are encouraged to take a social determinants of health perspective in developing and implementing health promotion and preventative health initiatives in their local communities."[51]

How this will take shape is not really yet known or clear, but what is clear is the very strong commitment shown by the Australian Medicare Local Alliance to support and advance the development of sustainable policies and initiatives that address the social determinants of health.

RECOMMENDATION

8. *Australian Medicare Local Alliance to take a lead role in coordination of planning with other local entities, to address the social determinants of health, and the National Health Performance Authority to report on social determinant data produced by Medicare Locals.*

Social Inclusion

The Social Inclusion Committee of Cabinet, a Social Inclusion Unit in the Department of the Prime Minister and Cabinet and the advisory group – the Australian Social Inclusion Board are all working toward initiatives around social inclusion and target particular disadvantaged groups in society.

The Social Inclusion Board, established in 2008, is the main advisory body to Government on ways to achieve better outcomes for the most disadvantaged in the community.

Priorities for the Australian Social Inclusion Board include:

- Service delivery reform and how services can better meet the needs of people facing barriers to inclusion;
- Measurement and reporting of social inclusion indicators;
- Place-based interventions to assist disadvantaged people (through the National Place-Based Advisory Group).
- Providing advice to Government on approaches that may improve employment outcomes for

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[51] Operational Guidelines Medicare Locals, September 2012
http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/38692354D690BAC4CA257A770020FD69/$File/Medicare%20Locals%20Operational%20Guidelines%20-%20revised%2020120903.pdf, p.41, accessed 21st September, 2012

- very disadvantaged job seekers;
- Consolidating the body of knowledge around improving the financial capability of disadvantaged Australians; and
- Providing advice to Government on how it can best respond to the emerging issue of older women and homelessness.

The Social Inclusion Board's work is targeted by nature. It has supported a number of publications, including how best to measure disadvantage and social exclusion in Australia and how to effectively address locational disadvantage.

The Australian Government has adopted principles to guide social inclusion and theoretically these can be applied at many levels, from local to national. They include aspirations and recommended approaches. What is lacking is the cross-portfolio response that recognizes and understands the issues associated with social inequality. There is a role for appropriate specific and targeted measures for disadvantaged groups as well as universally oriented population strategies.

RECOMMENDATION

9. That the Social Inclusion Unit continues to identify areas that require action for the most disadvantaged in the community.

10. That the Social Inclusion Unit develops principles for action on the social determinants of health.

The extent to which the Commonwealth is adopting a social determinants of health approach through: (i) relevant Commonwealth programs and services

As detailed above, ANPHA, Medicare Locals, Social Inclusion Unit, National Health and Hospital Reform Commission and the Primary Care Strategy have all begun to play a small role in the addressing the social determinants of health. Other Commonwealth programs and services include:

The National Women's Health Policy

This policy is based on a gendered approach that is inclusive of a social view of health and accounts for the diversity in women's experiences. The social model of health acknowledges the complex ways that the context of a woman's life, including how her gender, age, socioeconomic status, ethnicity, sexuality, disability and geography might shape her health outcomes; access to health care; experiences of health, wellbeing and illness; and even her death.[52]

Within the policy there is outlined government actions to address the social determinants of health. The Government actions appear to be the funding of $3.6 million over three years for six National Women's Alliances (2010-2013). The Alliances are made up of more than 100 women's organisations as well as individual members, and aim to engage with Government on policy issues as part of a more informed and representative dialogue between women and government.

Government actions described in the National Women's Health Policy that seek to address social determinants have considered issues of access to resources, diversity and national health reform. The 2009 discussion paper for the National Women's Health Policy detailed at length issues relating to the social determinants of health.

The Men's Health Policy

The Men's Health Policy Information Paper (2009) articulated well the cultural, political, economic,

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[52] National Women's Health Policy http://www.health.gov.au/internet/publications/publishing.nsf/Content/womens-health-policy-toc~womens-health-policy-social~womens-health-policy-social-det, accessed 12th September 2012

psychological and spiritual contexts of men's lives. It also asks that the social determinants of health be considered in the development of men's health policy.

With both these gendered policies there is little to be found in terms of development of measures, strategies or programs that address and monitor the impact of the social determinants of health on these groups.

Closing the Gap - Child Health Check Initiative and the Expanding Health Service Delivery Initiative

The Child Health Check Initiative and the Expanding Health Service Delivery Initiative mentions a social determinant of health assessment tool that measures the following:
- Water supply
- Sewerage system
- Solid waste disposal
- Electricity supply
- Healthy housing

This is an example of broadening out the understanding of social determinants of health to include environmental and housing issues.

National Aboriginal Health Plan

The discussion paper for the development of a National Aboriginal Health Plan, released in September 2012, identifies the plan as helping to guide governments in policy making and program design for improving the health and social determinants of health of Aboriginal and Torres Strait Islander (ATSI) peoples.

In the discussion paper it is suggested that between one-third and one-half of the health gap may be explained by differences in the social determinants of health.[53]

The Closing the Gap initiative has a very mature understanding of the social determinants of health and their impact on ATSI health outcomes. It is this understanding that has brought together indigenous health leaders and Congress. For this reason, any attempts to reduce Closing the Gap work because of possible growth in mainstream social determinant of health initiatives are to be avoided.

RECOMMENDATION

11. All government social policy plans should follow the lead of the *Discussion Paper for the Development of a National Aboriginal Health Plan* and have determinants of health as a key consideration and opportunity to improve health and well-being.

12. Resources for Closing the Gap initiatives to remain separate in any process that audits government programs with the aim of reducing duplication.

Outside of health there are a number of different policies, programs and services that address some of the upstream social determinants of health. Initiatives such as early childhood learning, parenting support, homelessness strategy, and head space could all be counted as intersectoral support for social determinants of health. Again the key features missing are **coordination** and **accountability** for these programs in terms of trying to achieve reductions in social and health inequalities.

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[53] The Development of National Aboriginal & Torres Strait Islander Discussion Paper, September 2012, Page 8

Extent to which the Commonwealth is adopting a social determinants of health approach through: (ii) the structures and activities of national health agencies

The Australian National Preventive Health Agency and Medicare Locals provide the infrastructure required to address preventative health efforts now and into the future.

The National Partnership Agreement (NPA) on Preventive Health, to which it allocated $872.1 million in November 2008, is due to expire in June 2013. The partnership has funded a comprehensive range of initiatives, including interventions supporting people to adopt healthier lifestyles and public awareness campaigns of the risks of chronic disease. But as CHA has argued some of this activity is at the expense of action on upstream social determinants of health inequality, leading to "lifestyle drift"[54]. The renewal of the Preventive Health NPA and all other NPAs provides an opportunity to take upstream action in the areas of education, employment, social inclusion, health promotion and economic policy.

RECOMMENDATION

13. That the renewal of existing National Partnership Agreements consider using this opportunity to help guide government policy-making and program design for improving the health and social determinants of all Australians.

Extent to which the Commonwealth is adopting a social determinants of health approach through: (iii) appropriate Commonwealth data gathering and analysis

There are a number of data gathering processes in place in Australia. Highlighted below are the main health-related data sources. The data sources would be clearly broader than what is presented here.

Australian Bureau of Statistics

The Australian Bureau of Statistics (ABS) provides key data items that can be used to analyse the social determinants of health. Data derived from the Census such as SEIFA and other data sets such as Household, Income and Labour Dynamics in Australia Survey (HILDA) and the Measures of Australia's Progress – across society, economy and environment - all provide useful baseline and longitudinal data sets with which to analyse.

The Australian Institute of Health and Welfare (AIHW)

As Australia's national agency for health and welfare statistics and information, AIHW is well placed to produce data and analysis in relation to the social determinants of health – and in fact already do so and have indicated an increased interest in examining in more detail the social determinants of health.

There are a number of areas that are examined by AIHW that are relevant to the social determinants of health. For example, AIHW produces a number of child health and well-being reports. These reports provide comprehensive information on children's health, development and well-being, which are essential for monitoring the progress of Australia's children, and are critical for the development of evidence-based policy.

Another example is the annual publication *Australia's Health.* This year's publication noted that the joint contribution of those determinants to the total burden on health was 32%. That is, of all the ill health, disability and premature death that occurred in Australia in 2003, almost one-third was attributed to the presence of the health risk factors studied. A limitation of this study is the 10-year-old data. It is quite feasible that the total burden on health from the social determinants will have increased markedly.

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54 Op Cit; Popay et al

Australia's Health 2012 for the first time provided an in-depth introduction to the social determinants of health and developed a determinants of health framework through which to view health. AIHW is well placed to coordinate the collection of indicators to monitor the impact of policy on the social determinants of health.

Public Health Information Development Unit

Established in 1999, and funded by Department of Health and Ageing to assist in the development of public health data, data systems and indicators, the Public Health Information Development Unit (PHIDU) provides information on a broad range of health determinants across the life course.

There have been two editions of the *Social Health Atlas* published and the work of the PHIDU includes the monitoring of inequality, providing approximately 120 indicators describing inequality in a range of indicators of socioeconomic status and health status [55]. Along with AIHW, the PHIDU would provide a very comprehensive snapshot of inequality in Australia.

COAG Reform Council

The COAG Reform Council, which among other tasks assesses progress under COAG's National Healthcare Agreement, is another source of data analysis. For example, *Healthcare 2010–11: Comparing performance across Australia*[56] found that health outcomes are still not equal for all Australians. For example, more people delayed seeing a GP due to cost, and a quarter of people report financial barriers to seeing a dentist.

The COAG Reform Council is independent of individual governments and reports directly to COAG on reforms of national significance that require cooperative action by Australian governments. There is potential for the COAG Reform Council to play a significant role in the action on social determinants of health not only through data analysis but also through providing independent, evidence-based assessments of the performance of governments. If, for example, social determinants of health legislation was enacted, and a national agreement was struck, then the Reform Council could report on the performance of that agreement through comparative analysis of the performance of governments and provide an independent assessment of whether predetermined performance benchmarks have been achieved.

Social Inclusion Unit

As mentioned previously, the Social Inclusion Unit has developed reports on how best to measure disadvantage and social exclusion in Australia and how to effectively address locational disadvantage.

Universities and research centres have utilised aspects of all these data sets to assess the impact of the social determinants of health on Australians. There are, however, a number of coordinating issues that should be addressed in order to achieve action on the social determinants of health.

RECOMMENDATION

14. Work to commence on the identification of data sources, selection of indicators, data collection and setting of targets.

15. Identify a process that allows the sharing of data across sectors and ministries so that it can be used to conduct health and equity assessments of all policies before implementation.

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[55] http://www.publichealth.gov.au/inequality-graphs/monitoring-inequality.html

[56] *Healthcare 2010–11: Comparing performance across Australia*
http://www.coagreformcouncil.gov.au/reports/healthcare.cfm

16. Public Health Information Development Unit and Australian Institute of Health and Welfare to partner in the collation of information and data on the social gradient of health in Australia.

17. The Prime Minister to report to Parliament annually on the progress of action on the social determinants of health. The annual report to be coordinated by Social Inclusion Unit and conducted by Productivity Commission.

In addressing the following Terms of Reference: **Scope for improving awareness of social determinants of health: (i) in the community, (ii) within government programs, and (iii) amongst health and community service providers** CHA has put forward a plan for action on the social determinants of health that will address these terms of reference. The 'policy' problem in Australia is firstly articulated, then a plan proposed to address improving awareness of social determinants of health.

The policy problem in Australia

From a policy perspective it will be difficult to achieve change in Australia because of the complexity of social determinants of health. Social determinants of health are multi-faceted phenomena with many causal reasons for existence. Some of these reasons are detailed below.

Because social determinants occur over the life span, it is often difficult to be certain that interventions enacted in early childhood will reap the reward in later life – the problem of long-term initiatives with short-term views.

The need to work across portfolios and whole of government can also be a difficult thing to navigate because of the silo-based nature of government departments where forced collaboration without true buy-in means reduced compliance to accountability measures.

Also social determinants are just one of many competing government priorities and often get lost in the health budget headlines, as we saw with the NSW Health budget cuts announced in September 2012[57].

Social determinants of health are so complex that often the cause and effect relationships are not readily apparent; correlation is common; but not causation.

Routine data poorly collected or not at all can often mean policy implementation fails because of lack of data. The multitude of stakeholders in the policy development also leads to difficulty in implementation.[58]

Despite these difficulties the need for 'something' to be done to address the growing inequities in health is clear. Take for example the former Health Minister Nicola Roxon's "Light on the Hill" speech in 2008 where she said:

> We now stand at a crossroads. Both the PBS and Medicare are being challenged by demographic and economic trends...Without change, Australian Government spending on health is projected to almost double as a proportion of GDP over the next forty years, with spending on medicines projected to grow the fastest of all health factors. At the same time, the invasion of our lives by chronic diseases like diabetes and heart disease – and the early death that they bring – threatens the sustainability of Medicare, and poses new challenges

57 For example from ABC website, 14th September 2012, headline- "NSW Health told to find $3bn in savings-The New South Wales Health Minister has directed the state's health department to make more than $3 billion in savings http://www.abc.net.au/news/2012-09-14/243-billion-squeezed-from-nsw-health-budget/4260814, accessed 14th September, 2012

58 Exworthy M: *Policy to tackle the social determinants of health: using conceptual models to understand the policy process*; Health Policy and Planning 2008;23:318–327, pp 319-321

for the way we think about delivering health care. We know that health is a major indicator of inequity. If you want to judge how affluent a suburb is, you could check its tax returns – or you could look at its medical records. Rates of diabetes, of heart disease, early deaths, infant mortality, how many teeth a person has left – all are clear markers of socio-economic status…..a confused combination of government regulation and badly designed markets can hamper our ability to deliver the health care that people deserve. Which means health inequalities are becoming entrenched in our community.[59]

Governments are all equally troubled by health inequalities, not only because of beliefs in a just and humane society, fairness and in equal opportunity for all, but also because of the impact that health inequalities have on the productivity of the nation. This issue was demonstrated in the CHA and NATSEM publication *The Cost of Inaction on the Social Determinants of Health,* where again the important issue of the social determinants of health and the impact on health outcomes, including the economic impact, were discussed. The findings (as stated previously in this submission) of *The Cost of Inaction on the Social Determinants of Health* appear to suggest that if the World Health Organisation's recommendations were adopted within Australia:

- 500,000 Australians could avoid suffering a chronic illness;
- 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;
- million fewer Medicare services would be needed each year, resulting in annual savings of $273 million;
- million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of $184.5 million each year.

The international experience

Dahlgren and Whitehead have noted in relation to the increasing numbers of countries and international organisations who now recognise the importance of developing more comprehensive strategies for tackling the health divide that:

> "Many declarations to tackle inequities, however, appear to be merely rhetorical, as they have not been followed by any comprehensive policies and actions to address the problem"[60.]

Dahlgren and Whitehead do not share this pessimistic view on their own. Sir Derek Wanless, an eminent banker from the United Kingdom, was the author of the seminal 2002 report on National Health Service funding which advocated the need for substantial investment. He was also the author of the report *Securing Good Health for the Whole Population*. In this report he noted the following:

> "What is striking is that there has been so much written often covering similar ground and apparently sound, setting out the well-known major determinants of health, but rigorous implementation of identified solutions has often been sadly lacking"[61.]

Wanless's 2004 report was about improving public health and reducing health inequalities and urged the government to develop a more coherent strategy to reduce preventable illness caused by

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[59] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/sp-yr08-nr-nrsp200908.htm?OpenDocument&yr=2008&mth=09

[60] Dahlgren G, Whitehead M. 2006. Levelling up (part 2): a discussion paper on European strategies for tackling social inequities in health. Copenhagen: WHO Europe., p16, http://www.who.int/social_determinants/resources/leveling_up_part2.pdf, accessed 14th September, 2012

[61] Wanless D. 2004. Securing good health for the whole population: population health trends. London: HM Treasury, p.3, http://www.phac-aspc.gc.ca/php-psp/pdf/securing%20_good_health_for_the_whole_population.pdf, accessed 11th September 2012

unhealthy behaviour such as smoking and physical inactivity.

Wanless outlined 21 points to improve health for the whole population and these are detailed below.

Table 4 Improvement for the whole population - Wanless [62]

The Treasury should draw up a framework to guide ministers on what economic policies might promote better public health, such as tax credits or a tax on junk food.
The government should draw up consistent national objectives to improve the nation's health, including specific targets for children's health. Targets should be set with a three- or seven-year deadline.
Primary care trusts (PCTs), local authorities and other relevant agencies should devise local targets based on the government's national objectives, but taking account of local needs.
The cost-effectiveness of public health strategies and treatments should be evaluated.
The health secretary should be responsible for ensuring that the cabinet assesses the impact on the future health of the population of any major government policy.
National service frameworks, drawn up to raise standards of healthcare, should include details about the cost-effectiveness of different treatments, particularly efforts to improve patients' lifestyles.
Measures of how productive the NHS is should be based on the benefit of treatments, rather than the amount of operations carried out, and compare the benefits of preventing and curing ill health.
The Department of Health's review of health quangos and regulatory bodies should ensure that there is no overlap, nor any gaps, in the responsibilities of different public health bodies. This includes responsibility for public education and the regulation of smoking.
The DoH review should also assess how public health bodies, such as the Health Development Agency, should work locally with PCTs.
There should be regular monitoring of the effectiveness of a national strategy to improve public health.
PCTs should establish pilot schemes to assess the benefits of using electronic patient records to detail and monitor the risks to individual patient's health.
Academics and other experts should work together to improve public health research.
The government's forthcoming public health white paper should tackle the barriers to obtaining public health data posed by patient confidentiality.
Methods to improve public understanding of health messages, particularly by those with poor literacy, should be devised.
The consultation on the public health white paper should address the balance between an individual's right to choose an unhealthy lifestyle, such as smoking, and the impact that behaviour has on wider society.
A website and a national telephone helpline should be set up to offer advice on healthy living, perhaps as part of the existing nurse-led advice service NHS Direct.
There should be an annual report on the state of the nation's health.
Public awareness of public health advice should be assessed, as well as support for controversial policies to tackle unhealthy lifestyles, such as higher taxes.
The Commission for Healthcare Audit and Inspection should draw up performance indicators to assess the public health work of PCTs and strategic health authorities.
A national strategy to develop the public health workforce should be drawn up, assessing the role of specialist practitioners and the wider health workforce.
The NHS should do more to improve the mental and physical wellbeing of its workforce.

Wanless's report and recommendations are instructional for Australia. Wanless also urges consideration of the importance of both the internal and external costs on society of not acting on

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[62] http://www.guardian.co.uk/society/2004/feb/25/publichealth

the social determinants of health:

- the resources required to cure or prevent poor health;
- lost production whilst the individual is incapacitated, or after he or she has died;
- the discomfort from pain and poor quality of life; and
- anti-social costs e.g. cost of related crime.[63]

Wanless's report clearly says that from a public policy perspective social determinants are complex, but it is not impossible to forge a path forward.

Awareness of social determinants

In order to address the level of awareness of social determinants of health in the community, awareness by governments and amongst service providers, analysis or mapping of the current situation is necessary.

Analysis of the 'problem', 'policy' and 'political' streams is instructional in understanding the current environment and identifying where action should take place.

The policy stream model, as it applies to social determinants within the Australian context, is detailed below. The policy stream model demonstrates that the policy window is now open, and action is required before it closes again.

In order to couple these policy streams together CHA has acted as one several policy entrepreneurs – willing to invest resources in return for future policies that are favoured.[64]

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[63] Annex E The Economic of Externalities; in Wanless D. 2004. Securing good health for the whole population: population health trends. London: HM Treasury
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4076148.pdf, accessed 14th September 2012

[64] Kingdon J. 1995. Agendas, alternatives and public policy. Boston: Little Brown

Table 5: The Policy Streams Model in Australia for Social Determinants of Health [65]

Problem	Policy	Politics
Publication of evidence International • As described by WHO Domestic • Health Promotion Associations • Research Projects of Baum, Friel, Sainsbury, et al • Social Health Atlas • AIHW • NATSEM • Social Inclusion • NGOs -all demonstrate trends Events • Tasmania – House of Assembly Inquiry • Medicare Locals-Grand Challenge • Focus of several conferences • Integrated planning events in Victoria • NGO sector have developed strategies to address SDoH Community • Limited knowledge in the community about the term 'social determinants' • High awareness in the community about impacts of social determinants. • Eg. Four Corners episode, "Growing up Poor"[66]	A gradient approach Failure of the policy stream • Not technically feasible • Not the dominant policy value • No leadership • Unintended consequences of addressing symptoms of SDoH (eg obesity, alcohol and drug misuse) rather than causes	Coalition building • NGO, academia, peak bodies, government • Formalised *Determinants of Health Alliance* Labor Party Policy Fairness is guiding principle as well as respect for basic human rights such as access to adequate health care. Labour believes in social justice and social inclusion. "As a nation, our true greatness lies in our treatment of those among us who are most marginalised". Liberal Party Policy Believe in a just and humane society and believe in equal opportunity for all Australians, want all to enjoy the highest possible standards of living, health, education and social justice, whilst strongly believing in individual freedom and free enterprise. Labor Health Policy Targeted Lifestyle drift Does not take into account gradient issues and need for universal proportionalism Liberal Health Policy Untested Greater role for NGOs in delivery of services

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65 Adapted from Kingdon J. 1995. Agendas, alternatives and public policy. Boston: Little Brown

66 Four Corners http://www.abc.net.au/4corners/stories/2012/09/20/3594298.htm

7. Directions for Social Determinants of Health in Australia

What is needed is a synthesis of plausible evidence, political vision and practical strategies[67].

In considering the main levers for Government action - taxes, subsidies, service provision, regulation and information - there are a number of options open to Government to act on the social determinants should it wish to do so. The following details the approach Catholic Health Australia would like to see governments adopt in Australia in order to take action on the social determinants of health.

a) Develop principles to guide action on the social determinants of health.

The development of principles will serve to inform government about what is important act upon and help to focus support for action on the social determinants. Norway's principles of public health[68] could be adapted to the Australian context.

- **Health equity:** Health inequities arise from the societal conditions in which people are born, grow, live, work and age; the social determinants of health. Social inequities in health form a pattern of a gradient throughout society. Levelling up the gradient by action on the social determinants of health is a core public health objective. A fair distribution of societal resources is good public health policy.

- **Health in all policies:** Equitable health systems are important to public health, but health inequities arise from societal factors beyond health care. Impact on health must be considered when policies and action are developed and implemented in all sectors. Joined up governance and intersectoral action is key to reduce health inequities.

- **Sustainable development**: Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs. Public health work needs to be based on a long-term perspective.

- **Precautionary principle**: If an action or policy has a suspected risk of causing harm to the public or to the environment, the absence of scientific consensus that the action or policy is harmful cannot justify postponed action to prevent such harm.

- **Participation:** Public health work is about transparent, inclusive processes with participation by multiple stakeholders. Promotion of participation of civil society is key to good public health policy development.

In addition, the following principles could add value to those outlined above:

- **Transparency**: Development of clear objectives, mechanisms that achieve those objectives and the resources to facilitate the process.

- **Levelling up**: Interventions should address the health gradient by providing health for all and, where appropriate, targeted initiatives.

- **Efficiency:** Effort should be expended to ensure that government funding is streamlined and that there is no duplication of funding for specific initiatives and outcomes across departments. And where possible use existing structures and processes to achieve goals and reorient existing mechanisms and systems to achieve policy objectives.

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[67] Nutbeam D. 2004. Getting evidence into policy and practice to address health inequalities. Health Promotion International 19: 137–40.

[68] http://www.actionsdh.org/Contents/Action/Governance/Public_health_legislation/Norway.aspx, accessed 14th September, 2012

- **Productivity:** Policies need to incorporate increases to productivity by setting targets for increasing the number of disability-free life years.

b) Indicator development by COAG

COAG to be asked to undertake a process that identifies indicators for monitoring action that is undertaken on the social determinants, as well as identifying priorities.

c) Coordinate data collection through the Productivity Commission

Productivity Commission (PC) to coordinate the collection of social determinants data. In this role the PC could also undertake gap, trend and interdependency analysis. Data that exists to monitor social determinants is not located in one place nor is it integrated. A PC coordination function could be commenced through the formation of a Productivity Taskforce that could be structured in such a way that it has an ongoing reporting function. An example of this the 'Red Tape Taskforce' established in 2006 where there is an annual report published by the PC each year called 'Reducing the Regulatory Burden on Business', even though the work of the Taskforce has finished.

d) Australian National Audit Office to undertake an audit of government programs in order to report on government programs in relation to efficiency of government funding directed to social determinants of health programs.

The Australian National Audit Office (ANAO) supports the Auditor-General of Australia and as such audits financial statements of Commonwealth agencies, authorities, companies and their subsidiaries in accordance with the *Financial Management and Accountability Act 1997*. The ANAO also conducts performance audits which are tabled in Parliament.
The results of this audit would help to shape a policy proposal to address the social gradient in health and call for cross-ministerial action through the formation of a national strategy.

e) Develop a national strategy to address health inequity

A national strategy, developed by the COAG Reform Council and the Social Inclusion Unit, should set out objectives to reduce social inequalities in income distribution, educational achievements, labour market, working environments, health behaviours and health services. In addition to the development of indicators, the strategy should describe relevant policies and measures to be undertaken within the objective areas.

The strategy should also identify a reporting system that aims to monitor the distribution of such inequalities. Reporting against the indicators should occur annually.

States and territories now have far greater flexibility in regard to how they spend Commonwealth grant money in each social policy area. The COAG Reform Council now assesses and publicly reports on how well governments are progressing toward meeting outcomes contained in the National Agreements, therefore through the COAG process first ministers could identify what aspects of the social determinants of health are viewed as important and what they wish to achieve. The COAG Reform Council, along with the Productivity Commission, could then report against these indicators, providing the **coordination** and **accountability** mechanisms required to put the social determinants of health on the political agenda.

f) Identify governance mechanisms to keep the issue on the national agenda

Development of a governance model that takes into consideration the need to:
- Establish standardised national statistics on prevalence and causes of health inequity as well as interventions.
- Ensure relevant experts are available to advise on translation of research into meaningful

strategies.

- Have consistency in framing the issue, across jurisdictions.
- Align policy with other governance structures and priorities.

The governance model should also be cognisant of the challenges it would face in implementation: cooperation across sectors (horizontal), implementation across levels (vertical); the time it takes to confirm successful interventions and measurable health effects; where to successfully set targets (upstream or downstream); lack of knowledge across departments in this field; and data availability, including monitoring issues.[69]

g)   The Prime Minister, through the Productivity Commission and the COAG Reform Council to report annually on action on the social determinants of health

The Productivity Commission (PC) to work with the COAG Reform Council to measure and publish annually data on the equity, efficiency and cost effectiveness of action on the social determinants of health, in the same way that both the COAG Reform Council and the PC report annually on government services, national agreements and national partnerships.

The PC would coordinate data collection and undertake gap analysis, trend analysis and interdependency analysis of data. The COAG Reform Council will report on the performance of governments across the boundaries that separate each part of COAG's reform agenda.

Figure 1: A simple implementation model

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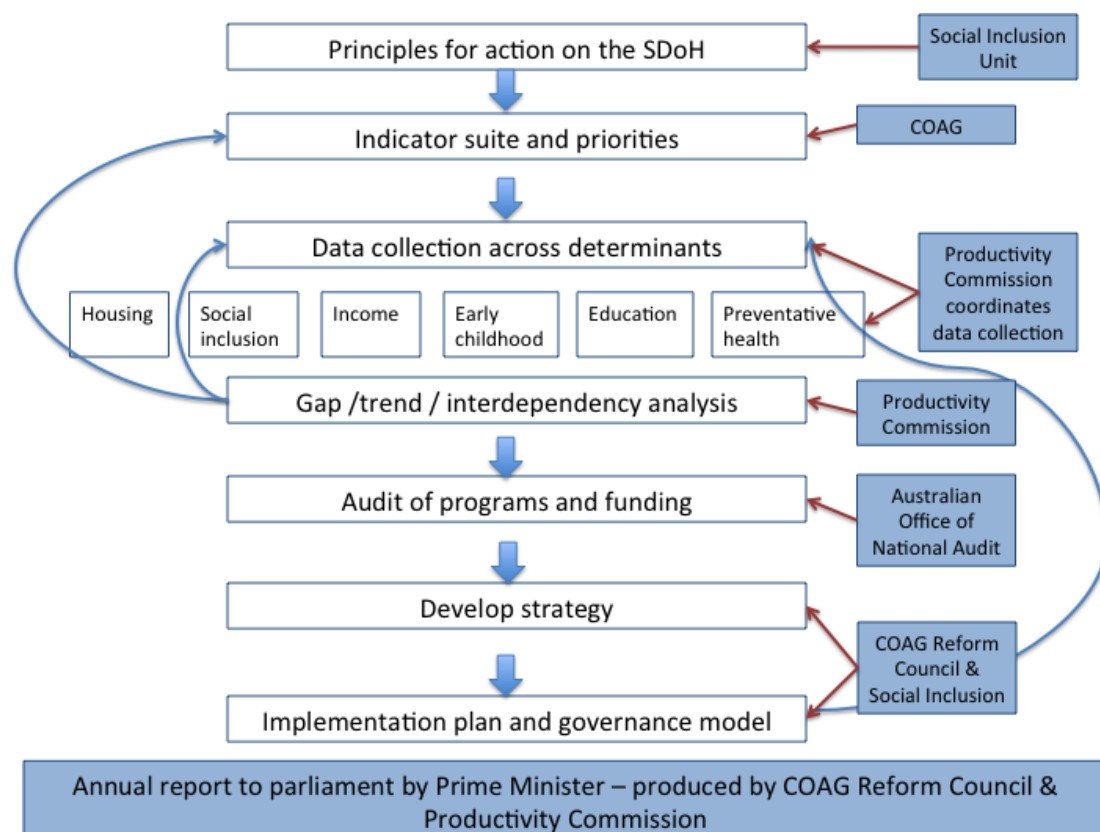
69 http://ec.europa.eu/health/archive/ph_determinants/socio_economics/documents/ev_090629_co05_en.pdf, accessed 14th September, 2012