



Submission to

Joint Select Committee

Preventative Health Care Inquiry

Social Determinants of Health Advocacy Network

March 2013



About the Social Determinants of Health Advocacy Network

In response to the World Health Organisation's (WHO) Commission on Social Determinants of Health report, *Closing the gap in a generation: health equity through action on the Social Determinants of Health*, and other activities that led to a greater focus on the Social Determinants of Health (SDoH) at the international and national level, the Australian Health Promotion Association (AHPA Tas) and Tasmanian Council of Social Service (TasCOSS) undertook to raise awareness of the SDoH in the Tasmanian context.

As a result of this partnership a series of 10 action sheets (plus one introductory sheet) were developed covering the following determinants:

- Aboriginality
- Education & literacy
- Food
- Health & social services' system
- Housing
- Poverty
- Sex, sexuality & gender identity
- Social exclusion
- Transport
- Work.

In considering ways to continue the momentum generated by this piece of work, a number of non-government organisations, researchers and peers, determined that it would be appropriate to establish a network with a focus on the SDoH (19 May 2012). This was considered an appropriate next step because at the time there was no clear leadership on the SDoH in Tasmania that also provided an opportunity for interested parties from across the community to be part of the conversation and subsequent action. The Network was officially launched in August 2012.

Purpose of the Network

The purpose of the Network is to work together to leverage action on the Social Determinants of Health so as to improve health and wellbeing outcomes for all Tasmanians.

Vision of the Network

All Tasmanians have the opportunity to live a long, healthy life regardless of their income, education, employment, gender, sexuality, capabilities, cultural background, who they are or where they live.

Membership

Membership of the Network is open to all Tasmanians who share this vision. Membership is free of charge. Membership to the Network can be obtained by providing a name, organisation (where there is one but individuals can join as individuals), address, telephone and email address to the Facilitator. The Network currently has more than 160 members across Tasmania from a broad range of sectors.



The Social Determinants of Health Advocacy Network wishes to acknowledge and pay our deep respect to our dear friends and colleagues, the late Professor Gavin Mooney and Dr Del Weston.

Both were members of this Network. Gavin was instrumental in the Network's establishment.

We take this opportunity to honour their memory in calling for:

- a truly universal health care system
- more comprehensive support for people with mental illness
- greater recognition and support for Carers of people with mental illness.

We are blessed to have known you. Thank you for sharing your time with us.

Nothing beautiful in this world is ever really lost - All things beloved live on in our hearts forever.



This submission was prepared by members of the Social Determinants of Health Advocacy Network, Tasmania by:

- Miriam Herzfeld
- Morven Andrews
- Rebecca Essex
- Leah Galvin
- Suzanne Fieke
- Ella Haddad
- Sophia Avery

The views expressed in this paper are those of the authors.

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For further information please contact:

Miriam Herzfeld

Facilitator, Social Determinants of Health Advocacy Network (Tasmania)

☎ 0400 480 908

✉ miriam_herzfeld@internode.on.net

📍 5 Sherbourne Avenue, West Hobart, Tasmania 7000



Contents

| | |
|--|----|
| About the Social Determinants of Health Advocacy Network | 2 |
| Introduction..... | 6 |
| Summary of Recommendations | 8 |
| 1.0 The Current Impact of Inequalities..... | 9 |
| 1.1 Social gradients..... | 17 |
| 1.2 There is enough evidence and guidance to act now | 23 |
| 2.0 Preventative Health Care | 28 |
| 2.1 A health-equity oriented health care system..... | 28 |
| 2.2 Health Equity in All Policies | 31 |
| 2.3 Comprehensive primary health care | 31 |
| 3.0 Structural and Economic Reform | 34 |
| 3.1 Crisis in health expenditure – we need a new way forward | 34 |
| 3.2 Power to the people | 36 |
| 3.4 The social inclusion <i>tragedy</i> | 39 |
| 4.0 Expertise | 40 |
| 5.0 Research | 42 |
| 6.0 Conclusion | 42 |



Introduction

We sincerely welcome the opportunity to present our views on ways to improve the health and wellbeing of Tasmanians to the Parliamentary Committee on Preventative Health Care.

Good health – it is the one resource that is absolutely essential for the survival of human beings. We use the terms ‘resource’ because this is how we view health and it is how the World Health Organisation (WHO) defines health: *“Health is a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities”*.¹ We also believe that the highest attainable standard of health is a human right.

The essential nature of good health may appear obvious to most people, yet health is also a resource that many people struggle to attain. While we pour millions of dollars into trying to achieve good health, at the level of society, we continue to fail. Why? There is a growing body of evidence that this is because we do not put enough effort into addressing health equity through action on the Social Determinants of Health.

What does this mean? Put simply it means this: We need to create a society where we provide equal access for equal need.² Health equity seeks to eliminate differences in health outcomes between groups of people who are economically or socially worse-off and their better-off counterparts.³ Health equity is about giving everyone the opportunity to achieve good health regardless of who they are or where they come from. Health equity is about justice and achieving this should be a key goal for Tasmania - not only because it is the right thing to do but also because it is a goal that we cannot afford not to have.

We have failed to fully acknowledge the *Social Determinants of Health (SDoH)*. Health starts long before illness - it starts in our everyday lives. Many studies have shown that the houses we live in, the transport we are able to access, the level of stress in our lives, the job we have or do not have, the social support we have around us and how much money we’ve got, have as much impact on our health and wellbeing as our genes and behaviours. These factors in our lives are known as the *Social Determinants of Health*. The SDoH are the conditions in which people are born, grow, live, work, play and age. They are sometimes referred to as *‘the causes of the causes’* because they are the underlying reasons why people experience poor health.

¹ WHO 1986, *Ottawa Charter for Health Promotion*.

² Mooney G, 2012, *The Health of Nations*, pp. 190.

³ Braveman P, 2013, *What is Health Equity: And How Does a Life-Course Approach Take us Further Toward it?* Journal of Maternal and Child Health, Published online 10 February 2013.



Speed is essential.⁴ We must act now to improve health equity for Tasmanians. If we do not act now we will not be able to afford the rising cost of health care and we will not be able to guarantee future generations a healthy life.

For too long we have been focusing most of our efforts on treating poor health rather than acting on the causes of poor health. Preventative health efforts (as the terminology goes) have been marginalised and pushed aside.

At this point it is worth raising some quick points about terminology and the issues that we are really talking about here.

The Parliamentary Inquiry is called *Preventative Health Care*. This title implies measures taken within the health care system to prevent illness or disease and thus does not explicitly encompass a social view of health in which many of the underlying causes of ill health occur outside of the formal care system. As outlined above (when considering the WHO definition of health), the SDoH Advocacy Network takes a much broader view of health. We are concerned not just with the prevention of poor health but also the protection and promotion of health, and the building of capacity and resilience to withstand threats or risks to health, so Tasmanians can live healthy, happy and good quality lives.

We see health as a social goal - one that is about people, for people and driven by people. Social, environmental, economic and biological factors all influence health outcomes and quality of life. We recognise the health of people within the context of our broader environment. The world we live in – the environment – is inextricably linked to health and wellbeing. We cannot look at health in isolation.

It has been five (approaching six) years since the WHO Commission on the Social Determinants of Health handed down its report, *Closing the Gap within a Generation*⁵. It is heartening to see that nationally the Australian Government is investigating Australia's domestic response to the WHO Commission on Social Determinants of Health report while in Tasmania this Parliamentary Committee has been established to look at this important aspect of wellbeing. It is imperative that we see action and outcomes as a result of these investigations. As stated in the WHO Report: *“There is enough evidence on the Social Determinants of Health to act now.”*⁶

We look forward to one of the outcomes of this Inquiry being the identification of healthy equity as a central goal for Tasmania, with planning put in place and resources dedicated towards concerted long term action to address the SDoH.

⁴ Kickbusch I 2008, *Healthy Societies: Addressing 21st Century Health Challenges*, Government of South Australia.

⁵ Commission on the Social Determinants of Health 2008, *Closing the gap in a generation – health equity through action on the social determinants of health*, Final Report, Executive Summary, WHO.

⁶ Ibid, p. 30.



Summary of Recommendations

That the Government of Tasmania:

1. Demonstrate leadership by developing a state-wide, long term, whole-of-government plan for reducing health inequities in Tasmania. Such a plan must reflect the voices of our citizens (refer to Recommendation 9) and should be informed by the recommendations of the WHO Commission on the Social Determinants of Health and related documents of significance. It should have clearly defined goals, activities and accountability mechanisms, with adequate resources for their implementation.
2. Develop policies that address the Social Determinants of Health and reduce health inequities, taking guidance from the recommendations of the WHO Commission on the Social Determinants of Health.
3. Adopt a 'proportionate universalism' approach in current Government service and program delivery that acts on the Social Determinants of Health.
4. Encourage greater sharing of responsibility for health outcomes through inter-sectoral initiatives that foster participation, ownership and commitment.
5. Reorient the health care system to improve its equity performance, for example by building a strong primary health care approach, involving communities in decision making, enhancing access to health care and building stewardship.
6. Employ high level leadership to implement mechanisms to routinely assess the impacts of decisions, policies and programs on health and equity across all sectors of government.
7. Build a strong primary health care system in Tasmania.
8. Rethink the way we fund health and health care. We must maximize the benefits and do the best with what limited resources we have available, while keeping our eye on the ultimate goal of health equity. We must enhance transparency and look at ways of resourcing and financing joint government initiatives.
9. Work through the Health Minister's Health and Wellbeing Council to establish how best to enable the opinions, values and perspectives of Tasmanian citizens to contribute to the decisions that affect their health and wellbeing, and promote more equitable health outcomes.
10. Revisit the Social Inclusion Strategy for Tasmania.
11. Engage the citizens of Tasmania in building their understanding of the Social Determinants of Health and health equity.
12. Advocate for, and fund research on the Social Determinants of Health and health equity.



1.0 The Current Impact of Inequalities

There are numerous SDoH impacting on the lives of Tasmanians. A thorough investigation of the most important of these and how they link to health in Tasmania has yet to be undertaken. However, we can draw on our knowledge of specific determinants and a strong international evidence-base to get an indication of some of the key factors contributing to health inequities in Tasmania.

This is what led the Australian Health Promotion Association (Tasmanian Branch) and Tasmanian Council of Social Service (TasCOSS) to publish a series of action sheets on some of the key SDoH in Tasmania:

- Aboriginality
- Education & literacy
- Food
- Health & social services' system
- Housing
- Poverty
- Sex, sexuality & gender identity
- Social exclusion
- Transport
- Work.

Currently four more action sheets are under development covering the following topics:

- Climate change
- Culturally & linguistically diverse communities
- Disability
- Equality.

The impact that these determinants have on health is well documented. Table 1 provides a summary of some of the evidence that has been published. It is important to note that the below list of SDoH relevant for Tasmanians is not exhaustive, but shows some of the key issues that have been identified and analysed to date.



Table 1: Some Key Social Determinants of Health

| Social Determinant | Examples of the impact of inequalities on health outcomes |
|----------------------|--|
| Aboriginality | <ul style="list-style-type: none"> For the period 2005–2007, the life expectancy at birth was estimated to be 67 years for Aboriginal and Torres Strait Islander males (compared to 79 for non-Aboriginal males) and 73 years for females (83 for non-Aboriginal females).⁷ More Aboriginal people lived in over-crowded households (9%) than non-Aboriginal people (6%) in Tasmania.⁸ Aboriginal young people were less likely to continue their secondary education: 39.7% of Aboriginal young people in Tasmania compared to 77.3% of non-Aboriginal young people (Australia) continue Year 7 to 12 schooling.⁹ 44% of Aboriginal adults were in the lowest income quintile in Tasmania in 2008.¹⁰ Aboriginal adults were 3.2 times as likely to be in prison than non-Aboriginal adults in Tasmania.¹¹ Aboriginal children were 2.6 times as likely to be in out of home care in Tasmania.¹² The health of Aboriginal and Torres Strait Islander people is closely linked with the history of colonisation. As a result of systemic displacement, many Aboriginal and Torres Strait Islander people experience cultural disruption, social exclusion, increased feelings of stress, a decreased sense of identity, political and social oppression, and a feeling of loss of control over their lives and livelihoods. Aboriginal people in Tasmania are also affected by discrimination and racism.¹³ In turn, these perceptions may influence health outcomes and disparities by affecting biological functioning (e.g. cardiovascular and immune function), mental health and emotional wellbeing and the quality of their relationships with others; and by promoting psychological distress (self-efficacy, depression, anger) that can be associated with risk-taking and unhealthy behaviours.¹⁴ The question of racism is present not only in society but also institutionally in the health care sector.¹⁵ Aboriginal people who were part of the <i>Stolen Generations</i> are more likely to suffer from depression, have worse health and a shorter life span than other Indigenous people.¹⁶ |

⁷ ABS 2012, *Gender Indicators, Australia*, 4125.0.

⁸ Australian Health Ministers' Advisory Council, 2011, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2010*, AHMAC, Canberra.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

¹³ Herzfeld M, Davey M, Essex R, Langdon M & Mooney G 2012, *Supplementary Information to Senate Inquiry into Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report - Closing the gap within a generation*, Tasmanian Social Determinants of Health Advocacy Network, 29 October 2012.

¹⁴ Sanders-Phillips et al, 2009, Social Inequality and Racial Discrimination: Risk Factors for Health Disparities in Children of Color, *Pediatrics*, 124:S176–S186.

¹⁵ Henry BR, Houston S and Mooney GH 2004, Institutional racism in Australian healthcare: a plea for decency, *Medical Journal of Australia*, 180,10: 517–520.

¹⁶ ReconciliACTION Network, <http://reconciliaction.org.au/nsw/about-reconciliaction>.



Addiction

- Addiction is a social determinant of health in the sense that people often turn to alcohol, tobacco or other drugs as a way to escape adversity and other stressors in life.¹⁷
- There is a strong relationship between addiction, and social and economic disadvantage. Addictions involve a two-way relationship, where people may turn to addiction in the first instance to numb the effect of disadvantage and addiction also prevents people from being able to move out of disadvantage.
- When someone has a substance misuse issue and is in need of community service assistance, most of the time it is the addiction treatment which is most vital, in that other areas of their life are difficult to improve or work on without first addressing the addiction issue.
- Data shows that 23% of Tasmanians smoke tobacco and 36% of Tasmanians drink alcohol in excess of NHMRC guidelines;¹⁸ 14.7% Australians had recently used illicit drugs;¹⁹ recent illicit drug use was highest in the 20–29 year age group for both males and females (30.5% and 24.3%, respectively).²⁰
- The use of illicit drugs is more common in unequal countries.²¹
- Other types of addiction such as gambling are also of concern in Tasmania.

Culturally & Linguistically Diverse (CALD) Communities

- Poor health in CALD communities is primarily a result of systematic barriers. These barriers unconsciously discriminate and cause inequality for people from CALD backgrounds. However, the biggest barriers of all are racism and stigma.
- Discrimination, racism and stigma can manifest as stress and mental health problems, as well as illnesses associated with the endocrine and cardiovascular systems, other chronic conditions, as well as premature death.²²
- Barriers to optimum health for people from CALD communities include communication, literacy (including health literacy), employment, social economic status, mental health issues and housing. Some of these barriers can be attributed to the complexity and the makeup of family structures, spiritual beliefs and specific health issues related to CALD communities.
- There is an over-representation of mental health issues among refugees. This may be due to experiences of trauma and torture from war or resettlement experienced by refugees and asylum seekers. There is also been a growing concern about the risk of suicide within CALD communities.²³

Disability

- People with a disability face a range of interrelated challenges resulting in poorer health and wellbeing outcomes including, they:
 - are more likely to smoke and less likely to get enough exercise
 - have poorer self-reported health, disproportionately high levels of secondary medical conditions (such as obesity, diabetes and dental problems) that aren't directly related to their disability

¹⁷ Wilkinson R & Marmot M (eds) 2003, *Social Determinants of Health, The Solid Facts*, 2nd Edition, World Health Organization, p.24.

¹⁸ Ibid.

¹⁹ Australian Institute of Health and Welfare 2011, *2010 National Drug Strategy Household Survey report*, AIHW, Canberra, Cat. no. PHE 145.

²⁰ Ibid.

²¹ Wilkins R & Picket K, 2009, *The Spirit Level – Why Equality is Better for Everyone*.

²² Wilkinson R & Marmot M (eds) 2003, *Op-Cit*, p.12.

²³ Ibid.



| | |
|-------------------------------|---|
| Disability | <ul style="list-style-type: none"> • have poorer mental health • more frequently suffer discrimination, abuse and neglect • are less likely to seek health assistance, often facing barriers when they do, and more likely to find the help they receive doesn't meet their needs.²⁴ • The primary reason that people with disabilities are disadvantaged when it comes to many SDoH is due to discrimination, exclusion and barriers to equal opportunity.²⁵ • Research indicates Carers have poorer physical and mental health (particularly depression), reduced labour market participation and lower incomes than non-carers.²⁶ |
| Education and Literacy | <ul style="list-style-type: none"> • Overall, people who are better educated are healthier than those with lower education levels.²⁷ Lack of education in itself does not lead to ill health. However, in combination with other social determinants, it contributes to poorer health and wellbeing. • Tasmania has low levels of education attainment. In 2011, 36.5% of Tasmanians aged 15 years and over (no longer attending school) had completed Year 12 or equivalent, compared to 49.2% nationally.²⁸ • The 2006 Australian Adult Literacy and Life Skills Survey found that overall, Tasmania had the lowest level of adult literacy in the nation and there was no improvement in adult literacy levels since they had previously been measured in 1996.²⁹ • Around half of the Tasmanian sample in the survey lacked the literacy skills necessary to cope with the demands of everyday life and work. For example, 49% of adult Tasmanians, or approximately 174 000 people, did not have the basic skills needed to understand and use information from newspapers, magazines, books and brochures.³⁰ • Tasmanians in regional municipalities tended to have lower literacy levels compared with those living in major metropolitan areas.³¹ • The 2006 Survey found that only one third of Tasmanians had sufficient <i>health literacy</i> skills to understand and use information relating to health issues such as drugs and alcohol use, disease prevention and treatment, safety and accident prevention, first aid, emergency responses, and staying healthy, compared with 40.5% for Australia.³² |
| Food | <ul style="list-style-type: none"> • Food is important for the healthy growth and development of babies, children and young people, and for adults to maintain health and vitality, and prevent diseases. • People who are food insecure may: |

²⁴ Kavanagh A, Krnjacki L & Kelly M 2012, *Disability and health inequalities in Australia: Research summary*, VicHealth, Victoria.

²⁵ Email correspondence, Herzfeld – Banks, Anti-Discrimination Commissioner, 6 December 2012.

²⁶ Edwards B et al, 2008, *The nature and impact of caring for family members with a disability in Australia*, Australian Institute of Family Studies, Melbourne.

²⁷ Ronson B & Rootman I 2009, 'Literacy and Health Literacy: New Understandings about their Impact on Health', In Raphael D (Ed), *Social Determinants of Health: Canadian Perspectives*, 2nd edition, Toronto: Canadian Scholars Press, pp. 170-186, in Mikkonen J & Raphael D, *The Social Determinants of Health Canadian Facts*, York University School of Health Policy and Management, Toronto, p. 15.

²⁸ ABS 2012, *2011 Census Quickstats: Tasmania*.

²⁹ ABS 2008, *Adult Literacy and Life Skills Survey, Summary Results 2006*, 4228.0.

³⁰ Ibid.

³¹ Ibid.

³² Ibid.



Food

- not get the nutrients they need (malnutrition). This can affect the body in many different ways. Malnutrition during childhood has long-term effects on a child's physiological and psychological development. Malnutrition among older adults may lead to physical decline and frailty, poor mental health and wellbeing, an increase in health problems and the use of multiple medications
- suffer distress as a result of anxiety and guilt associated with not being able to obtain food
- experience a range of behavioural, emotional and academic problems (particularly school children)
- be at greater risk of being overweight or obese. Foods with high fat, salt and sugar content can appear cheaper and easier to access, and these foods are often felt to be more palatable and acceptable
- be at greater risk of chronic diseases such as heart disease, diabetes, cancer, eye disease and dental problems.³³
- It is estimated that 5% of Tasmanians sometimes run out of food or can't afford to buy food.³⁴ However, we don't know exactly how many people are affected by food insecurity in Tasmania and more research is needed. Data shows that the number of people seeking emergency relief assistance in Tasmania has increased in recent years.³⁵
- Tasmanian research suggests that people in rural and isolated areas find it particularly hard to buy affordable fresh food.³⁶
- Eating large quantities of food that is cheap but not nutritious, can contribute to people becoming overweight and obese. The 2011-12 National Health Survey reports that, 65.6% of Tasmanian adults are overweight or obese.³⁷

Housing

- People who have adequate housing are more likely to be physically, socially and mentally healthy and have a stronger sense of identity.³⁸
- Those who do not have adequate housing may:
 - be at risk from dangers associated with electricity, gas, fire, sewage and structural safety issues
 - be more likely to suffer from respiratory conditions resulting from dampness, dust and poor ventilation
 - be more likely to suffer from bacterial and viral infections caused by inadequate sanitation facilities
 - suffer from mental ill health as a result of trauma associated with isolation, stigma, overcrowding, unsafe conditions, insecurity or social exclusion
 - seek unhealthy means of coping such as substance abuse.³⁹
- In 2006 it was estimated that there were around 2,500 homeless people in Tasmania. Of these, 385 people were *sleeping rough*.⁴⁰

³³ Wilkinson R & Marmot M 2003, Op-Cit, p. 26.

³⁴ Tasmanian Government 2004, *Tasmanian Food and Nutrition Policy*.

³⁵ Herzfeld M 2010, *The Intersection of Emergency Food Relief and Food Security*, TasCOSS, Tasmania.

³⁶ Tasmanian Council of Social Service 2009, *Just Scraping By? Conversations with Tasmanians living on low incomes*, TasCOSS, Tasmania.

³⁷ ABS, 2012, *Australian Health Survey: First Results 2011-12*, Op-Cit.

³⁸ Ronson B & Rootman I 2009, Op-Cit, p. 29.

³⁹ Ibid.



Housing

- In September 2012, there were 2,675 people were on the waiting list for public housing in Tasmania.⁴¹
- Fuel poverty is defined as the inability to afford sufficient warmth in a home for comfort, health and quality of life. Fuel poverty, which can lead to mould growth in homes and cause respiratory problems, is common in Tasmania.⁴²
- Space heating accounts for about 50% of energy used in Tasmanian homes, not only costing consumers financially but also contributing to climate change.⁴³

Poverty

- More equal income distribution has proven to be one of the best predictors of better overall health of a society.⁴⁴
- People living on low incomes:
 - die earlier than those who are wealthier - they run at least twice the risk of serious illness and premature death as those with more income and resources
 - have poorer access to health services
 - have less capacity to develop healthy behaviours like eating well, exercising regularly or stopping smoking
 - are more likely to experience social exclusion, stress and anxiety
 - are more likely to suffer from chronic health conditions such as mental illness, heart disease, cancer, diabetes, injury and respiratory diseases such as asthma.⁴⁵
- Children are at greater risk of abuse and neglect in low income households. Other risk factors for abuse comprise younger age (ie. infants and toddlers are at highest risk), female gender, disability, indigenous ethnicity, having parents with mental illness or who misuse substances, or living in a family where there is domestic (intimate partner) violence.⁴⁶
- About one third of households in Tasmania receive Government income support payments as their principal source of income, which is more than the national average.⁴⁷
- On average, Tasmanians earn less per week than the average Australian weekly income. The median weekly personal income for people aged 15 years and over in Tasmania in 2011 was \$499 compared to \$577 nationally, for the household it was \$948 compared to \$1234 nationally. The median family income for families without children (two incomes) was \$1,771 in Tasmania and \$2,081 nationally. For families with children (two incomes) the median family income was \$1,999 compared to \$2,310 nationally. In Tasmania, 30.7% (23.7% nationally) of households had a weekly household income of less than \$600 and 5.4% (11.2% nationally) of households had a weekly income of more than \$3,000.⁴⁸

⁴⁰ Housing Tasmania, Department of Health & Human Services, 2010, *Tasmanian Homelessness Plan 2010-2013*, Tasmanian Government.

⁴¹ Department of Health & Human Services Progress Chart, September 2012.

⁴² Mallet P 2009, *What would it take to eradicate fuel poverty? Insights from UK Study Tour 15 May - 12 June 2009*, Anglicare.

⁴³ Sustainable Living Tasmania, 2007, *Energy Use in the Typical Tasmanian Family Home*.

⁴⁴ Wilkinson R & Marmot M 2003, *Op-Cit*, p. 10-13.

⁴⁵ Ibid.

⁴⁶ Taylor P, Moore P, Pezzullo L, Tucci J, Goddard C and De Bortoli L 2008, *The Cost of Child Abuse in Australia*, Australian Childhood Foundation and Child Abuse Prevention Research Australia: Melbourne.

⁴⁷ ABS 2011, *Household Economic Resources*, *Op-Cit*.

⁴⁸ ABS 2012, *2011 Census QuickStats*, *Op-Cit*.



Poverty

- More Tasmanians were unemployed than the Australian average, fewer were employed in full time work, and more work away from home and work in part time positions than other Australians. There were 232,126 people who reported being in the labour force in the week before Census night in Tasmania. Of these 54.5% were employed full time (compared to 59.7 nationally), 32.9% were employed part-time (compared to 28.7 nationally) and 6.4% were unemployed (compared to 5.6 nationally). The proportion of families where both parents or partners aged 15 years and over were unemployed was 23.1%, compared to 19.2% nationally.⁴⁹
- The 2012 National Health Survey found that 10.4% of Tasmanians experience stress associated with not being able to get a job or involuntary loss of job.⁵⁰

Sexuality, Sex & Gender Identity

Gender is not the same as *sex* or *sexuality*. *Sex* refers to the way our society currently categorises people according to biology. Common terms include female, male, intersex and transgender. *Gender* relates to roles, expectations and behaviours that our society identifies as being masculine or feminine. Gender identity is the way in which people personally express their gender and can be predominantly masculine, feminine or anywhere between or outside of these two positions (i.e. 'gender queer'). Gender identity need not necessarily 'match' one's biological 'category' (male/female).

Gender, gender identity, sex and sexuality interact strongly and are linked with health outcomes. For example:

- Men fare worse than women in education, health and crime.⁵¹
- Women generally live longer than men but are more likely to suffer from long-term disability and chronic diseases. The life expectancy of Tasmanian males is 77.9 and for females is 82.2 years.⁵²
- Men are more likely to commit suicide than women. Tasmania has a high suicide rate with three out of four suicides being undertaken by males.⁵³
- Suicide rates among Lesbian, Gay, Bisexual Transgender & Intersex (LGBTI) communities are much higher than in the general population.⁵⁴
- Women are far more likely than men to be victims of domestic violence and sexual assault. One in three Australian women experiences physical violence in their lifetime and nearly one in five Australian women experiences sexual assault.⁵⁵

Transport

- People who have accessible transport are more likely to:
 - have a stronger sense of wellbeing
 - be at lower risk of depression
 - be able to access services that help keep them healthy such as dental check ups, cancer screening services, and mental health support groups

⁴⁹ Ibid.

⁵⁰ ABS 2012, *Australian Health Survey: First Results 2011-12*, Op-Cit.

⁵¹ ABS 2012, *Men fare worse than women in education, health and crime*, Media Release:

[http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4125.0~Jul%202012~Media%20Release~Men%20fare%20worse%20than%20women%20in%20education,%20health%20and%20crime%20\(Media%20Release\)~6152](http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4125.0~Jul%202012~Media%20Release~Men%20fare%20worse%20than%20women%20in%20education,%20health%20and%20crime%20(Media%20Release)~6152).

⁵² ABS 2011, *Tasmanian Indicators*, 1304.6.

⁵³ Australian Institute of Health and Welfare, *Australia's Health 2010*.

⁵⁴ Suicide Prevention Australia 2009, *Position Statement, Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities*.

⁵⁵ Australian Human Rights Commission website, *Sex Discrimination*, various publications, www.hreoc.gov.au/sex_discrimination/index.html.



Transport

- participate in social activities that keep them active and engaged in their communities.⁵⁶
- Walking, cycling and use of public transport offer tremendous benefits for individuals, communities and the environment, including:
 - physical activity, which can protect against heart disease, mental illness and diabetes
 - increased social contact, which can enhance mental health and wellbeing
 - reduced air pollution
 - enhanced neighbourhood safety
 - reduced fatal motor vehicle-related accidents.⁵⁷
- Hundreds of road accidents as well as an unacceptable number of fatalities occur each year in Tasmania. In 2012, 32 people lost their lives (up 33.3% from 2011) and 245 people had serious injuries as a result of motor vehicle accidents.⁵⁸
- Accessible public transport (defined as being those services on which a commercial fare is levied) is limited, particularly in rural and urban fringe areas and has been raised as an issue by numerous organisations.⁵⁹
- Community transport is funded and delivered by a number of different organisations and is not always well coordinated to meet the needs of clients.⁶⁰
- A survey in 2010 found that fewer than 1% of residents in Hobart cycle and only 20% walk as part of their daily travels.⁶¹ The latest Census data revealed that people in Tasmania still prefer to travel to work by car than any other means, with 69.9% of the population reporting this as their primary method of travel to work (either as the driver or passenger). There has also been a small decline in the proportion of people who choose to walk to work, with only 5% of people in 2011 compared to 5.7% in 2006, reflecting a slower rate of growth compared to other methods of travel.⁶²
- Road transport contributes 92% of transport greenhouse gas emissions in Tasmania, with cars being the largest contributor.⁶³

Work

- People who have a job generally experience better health than those who do not. However, the relationship between having a job and health is not straightforward. The structure and organisation of workplaces, the way power is managed and decision making is undertaken, as well as the social organisation and relationships that exist in a workplace, all impact on health and wellbeing.⁶⁴
- Some examples of how work and health are linked include:
 - People who experience stress in the workplace are more likely to take sick leave, experience poor health overall and die prematurely
 - Studies show that not having the opportunity to contribute to work in a

⁵⁶ Wilkinson R & Marmot M 2003, Op-Cit, p. 28.

⁵⁷ Ibid.

⁵⁸ Department of Infrastructure, Energy and Resources, *Tasmanian Crash Statistics 2012*.

⁵⁹ Including TasCOSS, COTA TAS, Carers Tasmania and others.

⁶⁰ Herzfeld M 2011, *Access to transport for older People in Tasmania*, COTA Tasmania.

⁶¹ Department of Infrastructure, Energy and Resources, 2010, *Greater Hobart Household Travel Survey, Summary of analysis and key findings*, Tasmanian Government.

⁶² ABS 2012, *2011 Census of Population and Housing, New 2011 Census data reveals more about Tasmania*, Media Release, 30 October 2012.

⁶³ Department of Infrastructure, Energy and Resources 2010, *Tasmanian Urban Passenger Transport Network*, Tasmanian Government.

⁶⁴ Wilkinson R & Marmot M 2003, Op-Cit, p. 18.



Work

meaningful way, not having control over one's work, and receiving inadequate rewards for effort, are strongly related to an increased risk of lower back pain, sickness absence and cardio-vascular disease

- High stress jobs predispose individuals to high blood pressure, cardio-vascular diseases and physical and psychological problems such as depression and anxiety.⁶⁵
- Around 60% of Tasmanians participate in the workforce including around 65.9% of men and 54.7% of women.⁶⁶ For January 2013, the Labour Economics Office in Tasmania reported that employment in Tasmania fell to 231,700, the unemployment rate increased to 7.4 per cent and the participation rate fell slightly to 60.2 per cent.⁶⁷
- In Tasmania in 2009, almost 400 injuries were related to mental stress, including depression, anxiety, or drug and alcohol-related problems.⁶⁸ The long term physical responses to stress (including workplace stress) include heart disease, cardio-vascular disease and Type 2 Diabetes. Such conditions are largely preventable.⁶⁹
- In Tasmania in 2009, over 9,000 people were injured and 15 people were killed at work.⁷⁰
- Certain groups of workers such as family Carers are extremely disadvantaged when it comes to job opportunities and having a voice in the workplace. Barriers to paid employment for Carers include difficulty arranging working hours around their caring responsibilities and the lack of alternative care. Even after their caring role has finished, they may experience barriers to employment such as lack of recent job experience, out of date qualifications and lack of confidence.⁷¹
- People with disabilities and people from CaLD Communities may also experience specific employment challenges.

1.1 Social gradients

Evidence illustrating social gradients and how these link with health outcomes is also well documented internationally. The literature on social gradients points to the fact that life expectancy is shorter and most illnesses are more prevalent among those with greater social and economic barriers in their lives. Patterns of ill health therefore follow a gradient, with people further down the social ladder at greater risk of ill health and premature death. People who are disadvantaged in this way usually run at least twice the risk of serious

⁶⁵ Ibid.

⁶⁶ Labour Economics Office, Tasmania, January 2013, *Trends – The Tasmanian Labour Market Review – Commonwealth Department of Education, Employment and Workplace Relations*.

⁶⁷ Ibid.

⁶⁸ Workplace Relations Minister Media Release, 2010, www.sites.thomsonreuters.com.au/workplace/2010/11/05/no-let-up-in-workplace-mental-stress and www.abc.net.au/news/2010-10-24/stress-blamed-for-workplace-injuries/2309234.

⁶⁹ Wilkinson R & Marmot M 2003, *Op-Cit*, p. 18.

⁷⁰ Ibid.

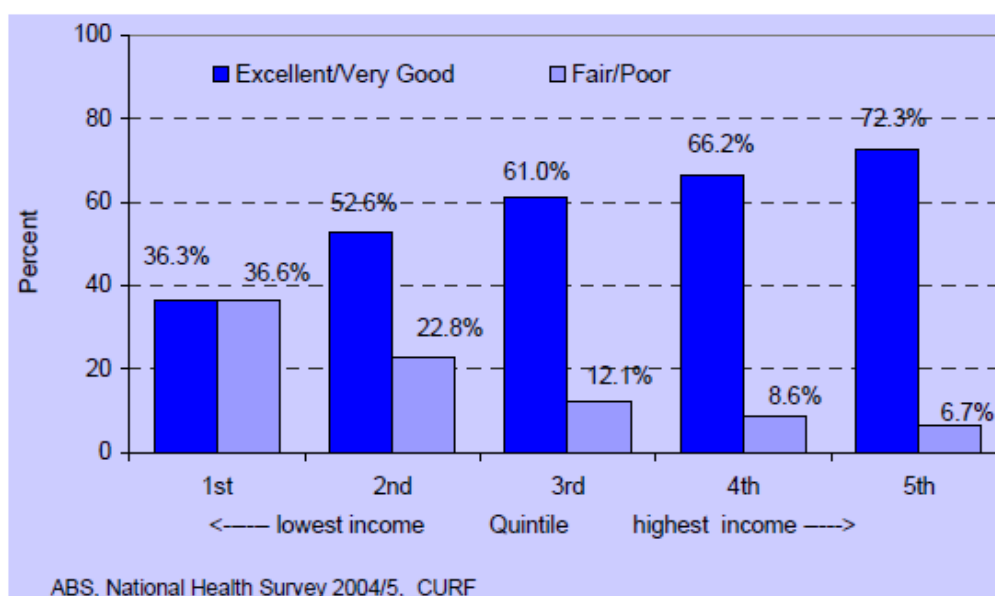
⁷¹ Carers Tasmania, various publications.



illness and premature death as those near the top.⁷² Some examples of the social gradient are illustrated in data from the most recent State of Public Health Report (Tasmanian Department of Health and Human Services, 2008)⁷³, the 2009 Tasmanian Population Health Survey (Menzies Research Institute, 2009)⁷⁴ and the Australian Health Survey (Australian Bureau of Statistics 2012)⁷⁵.

Figure 1 illustrates the relationship between household income and self-assessed health.⁷⁶ Persons in the lowest household income quintile report much higher levels of poor or only fair health compared with those in the highest household income quintile.

Figure 1: Self-Assessed Health by Household Income Quintile, Tasmania 2004/05



Similarly, when measuring the prevalence of self-reported psychological distress (an indicator of mental health), the 2004/05 National Health Survey found a four-fold gradient in psychological distress across income groups in Tasmania (refer to Figure 2).⁷⁷ The 2009 Tasmanian Population Health Survey also showed that those respondents reporting very high levels of distress were more likely to have come from low income households and less likely to be employed.⁷⁸

⁷² WHO 2003, Op-Cit, p. 10.

⁷³ DHHS 2008, *State of Public Health Report*, Tasmanian Government.

⁷⁴ Menzies Research Institute 2009, *Tasmanian Population Health Survey*, University of Tasmania.

⁷⁵ ABS 2012, *Australian Health Survey: First Results 2011-12*, Op-Cit.

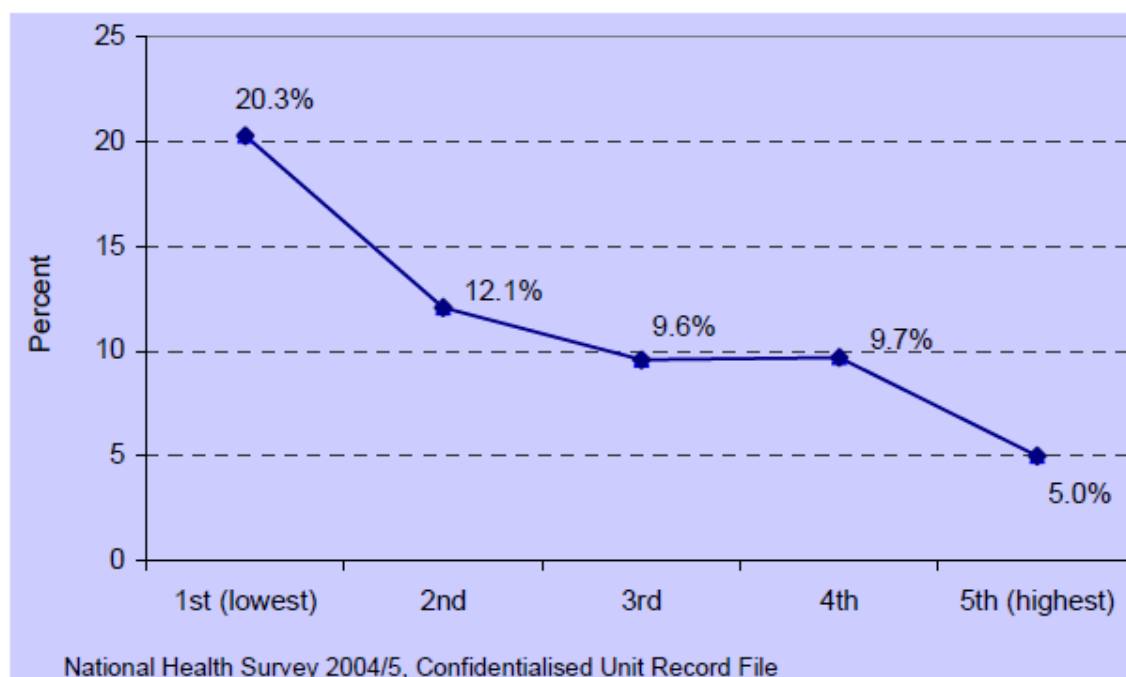
⁷⁶ DHHS 2008, Op-Cit, p. 18.

⁷⁷ DHHS 2008, Op-Cit, p. 19.

⁷⁸ Menzies Research Institute 2009, Op-Cit, p. 59.



Figure 2: High/Very High Level of Psychological Distress by Household Income Quintile, Tasmania 2004/05



Marmot (2008)⁷⁹ commented on the evidence base for a number of SDoH and depression during a presentation at the EC Conference on Mental Health, concluding the following:

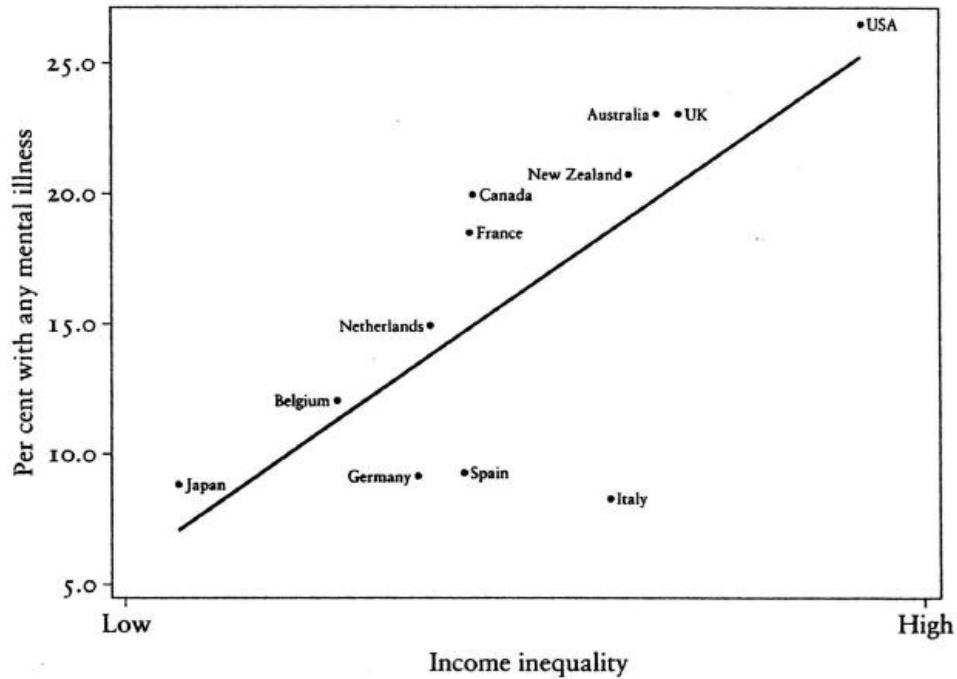
| Social Determinant | Overall level of evidence |
|--|---------------------------|
| Low socioeconomic profile | Very convincing |
| Low education | Very convincing |
| Unemployment and under employment | Very convincing |
| Food insecurity and early nutrition deficiency | Strong |
| Gender inequity | Strong |
| Low income | Strong |

Figure 3 from *The Spirit Level* illustrates that mental illness is more common in more unequal countries.

⁷⁹ Marmot M, 2008, *Social Determinants of Mental Health and Wellbeing*, EC Conference on Mental Health, June 13 2008.

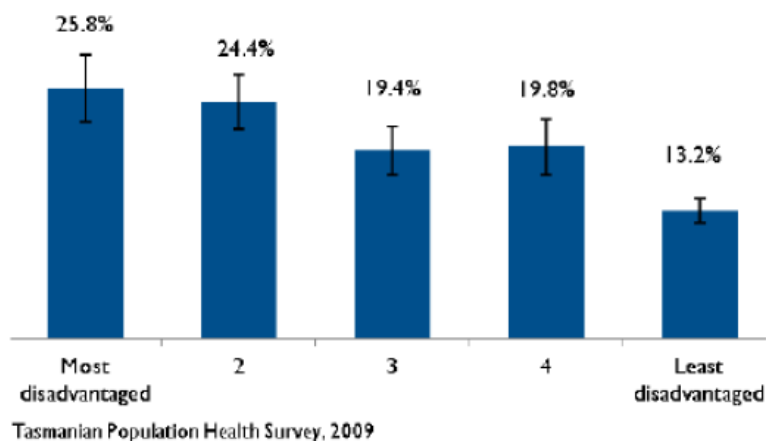


Figure 3: More people suffer from mental illness in more unequal countries⁸⁰



Another example, below, highlights the relationship between obese body mass index (BMI) and socio-economic disadvantage (Figure 4)⁸¹:

Figure 4: Obese BMI by Socio-Economic Disadvantage (SEIFA), Population 18 years+, Tasmania 2009



⁸⁰ Wilkins R & Pickett K 2009, Op-Cit.

⁸¹ Taylor R 2012, presentation at launch of Social Determinants of Health Advocacy Network, 24 August 2012.



But poor health is not just about those who are most disadvantaged in other ways - the social gradient in health runs right across society. This is why highly-regarded researchers such as Sir Michael Marmot (who chaired the WHO Commission on the Social Determinants of Health and has published extensively on this topic) advocate for an approach known as *“proportionate universalism”*, which is described as follows: *“Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism.”*⁸²

This is a really critical point that is often missing from our understanding of how best to address health inequities. So often we see only targeted interventions at the expense of population-wide approaches. Only recently we have seen this occur in relation to the Department of Health and Human Services’ newly established parent groups, which fail to adopt a proportionate universalist approach.

At the heart of the issue of social gradients is inequality. In countries such as Australia, where there is a large gap between those who are rich and those who are poor, this strong social gradient contributes to many health and social problems. Figure 5 from the much-lauded text, *The Spirit Level* (Wilkinson & Pickett 2009) (which we encourage you to read if you have not done so to date) illustrates that many health and social problems are worse in more unequal countries, irrespective of their overall wealth. This is why action on the social determinants is so imperative.



Universal support needed for all new parents

“I’m a new first time Mum living in the Hobart area. I feel very isolated. I wasn’t offered any connections to mums’ groups. I had heard that you used to get linked into the mums’ groups at the North Hobart Health Centre but I wasn’t offered anything.”

⁸² Marmot M 2010, *Fair Society Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England post-2010*.



All the health education programs in the world are not going to be effective if we do not act on the underlying causes of poor health – inequality. Of course, healthy behaviours are part of the picture but unless we act on the *causes of the causes* we are not going to improve the health of Tasmanians.

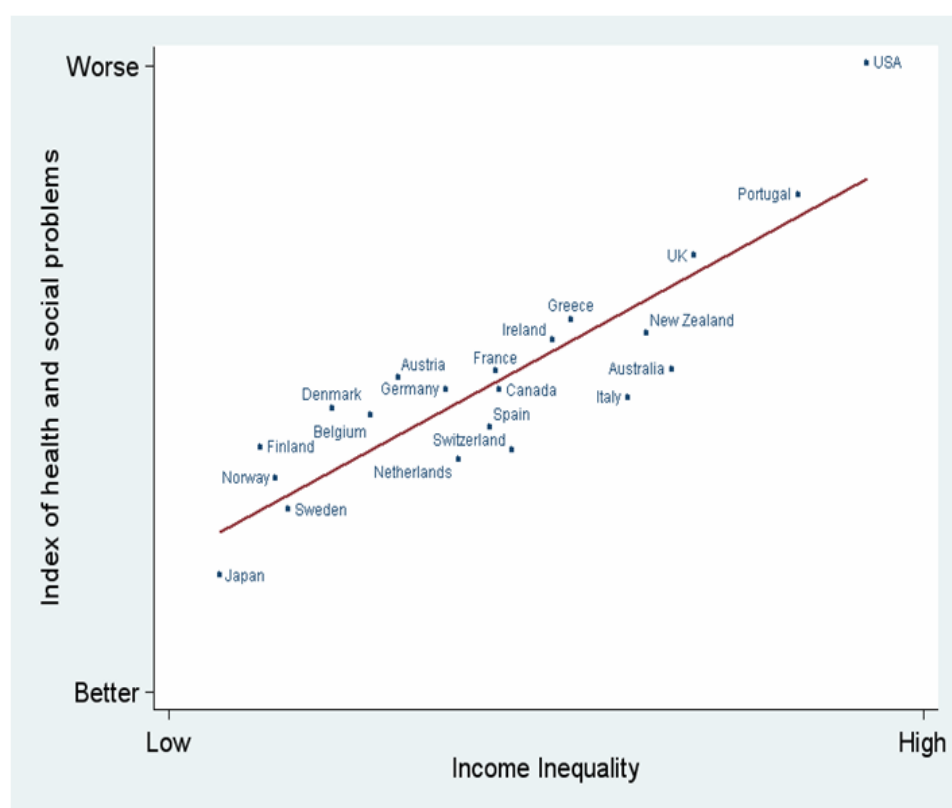
This will require fundamental shifts in the way we organise society. We need to be brave and tackle not only the primary determinants – such as housing, transport, poverty and so forth – but in doing so we must also act on the structural drivers of these issues – power, money and resources. Solutions to some of these issues may appear to lie beyond our own backyards but it is indeed possible to commence action in Tasmania, while at the same time advocating on the national and international stages for appropriate responses. Some of the examples we provide under Term of Reference 3 below illustrate how this might occur.

Figure 5: Data from *The Spirit Level*, 2009⁸³

Health and Social Problems are Worse in More Unequal Countries

Index of:

- Life expectancy
- Math & Literacy
- Infant mortality
- Homicides
- Imprisonment
- Teenage births
- Trust
- Obesity
- Mental illness – incl. drug & alcohol addiction
- Social mobility



Source: Wilkinson & Pickett, *The Spirit Level* (2009)

www.equalitytrust.org.uk

The Equality Trust

⁸³ Wilkinson R and Pickett K 2009, *The Spirit Level – Why Equality is Better for Everyone*, from the Equality Trust.



1.2 There is enough evidence and guidance to act now

We wish to bring the Committee’s attention to the plethora of research and information that has been published on the SDoH. Most notable at the international level is the WHO Commission on Social Determinants of Health report, *Closing the gap in a generation: health equity through action on the Social Determinants of Health*⁸⁴. The Commission made three overarching recommendations to guide efforts to eliminate health inequities for local communities and nations and throughout the world:

1. Improve daily living conditions — the circumstances in which people are born, grow, live, work, and age
2. Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally
3. Measure and understand the problem and assess the impact of action – measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the SDoH, and raise public awareness about the SDoH

In addition, the WHO advocates the following five key building blocks and a range of priority strategies as part of a SDoH approach⁸⁵:

1. Adopt better governance for health and development to tackle the root causes of, and reduce health inequities by building good governance for action on social determinants, and implementing collaborative action between sectors (“intersectoral action”)
2. Promote participation in policy-making and implementation for action on SDoH, engaging actors and influencers outside of government, including civil society by creating the conditions of participation; brokering participation and ensuing representativeness; and facilitating participation by civil society
3. Further reorient the health sector towards reducing health inequities, including moving towards universal health coverage that is accessible, affordable, and good quality for all by executing the health sector’s role in governance for social determinants; reorienting health care services and public health programs to reduce inequities; and institutionalising equity into health systems governance
4. Strengthen global governance and collaboration, including coordinated global action on SDoH aligned with national government policies and global priorities

⁸⁴ Commission on the Social Determinants of Health 2008, Op-Cit

⁸⁵ WHO 2011, *Closing the Gap: Policy into Practice on Social Determinants of Health, Discussion Paper*, World Conference on Social Determinants of Health, Rio de Janeiro, Brazil 19-21 October, 2011, pp. 3-4.



5. Monitor progress and increase accountability to inform policies on SDoH including identify sources, select indicators, collect data, and set targets; move forward despite unavailability of systematic data, disseminate data on health inequities and social determinants, and integrate these data into policy processes.

In addition, the WHO states that:

- Action on social determinants to reduce health inequities requires long-term, sustained implementation. Benefits can become apparent in the short term, however, and the sooner countries start to implement a social determinants approach, the better
- The initial step is to build public understanding of health inequities and SDoH
- Equitable health and wellbeing need to be placed as a priority goal for government and broader society
- Ensuring coordination and coherence of action on social determinants is essential
- A social determinants approach cannot be a “program” that is rolled out, but rather requires a holistic approach incorporating all of the five building blocks (outlined above) applied across society.⁸⁶

The World Health Assembly, in addition to advocating for members to enact the pledges made in the *Rio Political Declaration on Social Determinants of Health*, urged member states to:

- Develop and support policies, strategies, programs and action plans that address the SDoH, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation
- Support the further development of the “health-in-all-policies” approach 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 the SDoH
- Give due consideration to the SDoH as part of the deliberations on sustainable development, in particular in the Rio+20 United Nations Conference on Sustainable Development and deliberations in other United Nations forums with relevance to health.⁸⁷

All of this work that has been carried out at the international level has relevance for us here in Tasmania. We urge the Committee to take heed of this valuable guidance and make recommendations for action based on these bodies of work.

⁸⁶ Ibid, p 2.

⁸⁷ Sixty-fifth World Health Assembly WHA 65.8, Agenda item 13.6, 26 May 2012, Outcome of the World Conference on Social Determinants of Health.



Recommendations:

1. ***Demonstrate leadership by developing a state-wide, long term, whole-of-government plan for reducing health inequities in Tasmania. Such a plan must reflect the voices of our citizens (refer to Recommendation 9) and should be informed by the recommendations of the WHO and related documents of significance. It should have clearly defined goals, activities and accountability mechanisms and with resources for their implementation.***
2. ***Develop policies that address the Social Determinants of Health and reduce health inequities, taking guidance from the recommendations of the WHO Commission on the Social Determinants of Health.***
3. ***Adopt a 'proportionate universalism' approach in current Government service and program delivery that acts on the Social Determinants of Health.***





1.3 Health is everybody's business

When we first established the SDoH Advocacy Network, one of the key aims of our dear colleague and friend, Professor Gavin Mooney, was to achieve greater sharing of responsibility for health. The need to extend the boundaries of health beyond the immediate funded health sector is well documented. Back in 1978, the Declaration of Alma Ata, in reference to primary health care, stated that it, *'involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors and demands the coordinated efforts of all those sectors.'*⁸⁸ Again 1986 in the highly regarded Ottawa Charter for Health Promotion⁸⁹, the WHO stated clearly that health is not just the responsibility of the health sector.

In an article published by Herzfeld and Mooney in September 2012, they make the following points:

'The real push of the SDHAN [Social Determinants of Health Action Network] is to get recognition that this really needs a whole of community effort. Thus if someone is an architect or a plumber in the building industry; a lawyer or a policewoman or a court attendant in the justice system; or a teacher or a school janitor or university cleaner in the education system; or a merchant banker or a bank clerk in the financial sector; or a retired or unemployed person with time on their hands, then each of these in their different ways can contribute to the health not only of themselves but also the health of the broader community. The SDHAN emphasises the need for action at a state level but also in local communities, indeed especially the latter. The seeming cliché that health is everyone's business is in principle and practice the driving force behind the Network.'

'Through the Network what we are trying to do is get all of these different people to realise that working at a community level we can all make a contribution.'

- *The building industry: we know that people who live in inadequate housing are more likely to suffer from respiratory conditions. The Network seeks greater recognition among those in the building industry that good housing is good for health.*
- *The justice system: we know that mental health issues can contribute to crime and violence. Acknowledging that can bring greater understanding to the way in which the justice system operates and treats offenders.*
- *The education system: the more educated live longer and healthier lives. Is it not the role of those in the education sector to use this as a stimulus to try that bit harder to guide and support students to*

⁸⁸ International Conference on Primary Health Care 1978, *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

⁸⁹ WHO 1986, *Ottawa Charter for Health Promotion*, First International Conference on Health Promotion, Ottawa, 21 November 1986.



do the best they can? But the Network also wants to see more recognition of the importance of literacy and numeracy in day to day life. Lack of literacy can be a serious barrier to health.

- The financial sector: many bankers (and others in society) are wealthy and as a result healthy. The Network seeks to persuade the better off that they have a role to support those who are less fortunate.

‘For those familiar with the literature on the SDoH, there is nothing really new here. But in Tasmania our Network wants action and we want that action to be genuinely social. The SDoH can work. The evidence is there. Our Network wants to make a practical difference, hence the ‘advocacy’ in our title.

‘Tasmania is a relatively poor state. Poverty breeds ill-health. But it is also a small state where we tend to think that we know everyone and everyone knows us! Not true of course but more true than most other parts of Australia. And that is an advantage in trying to build on the SDoH. As a coherent and cohesive state on most fronts, we can all start doing more to share in the responsibility for maintaining the health and wellbeing of our communities. Our health services, excellent though they are, struggle to cope with the demands made on them. The message for our Network is: ‘Let’s not leave it all to the formal health service. What can the Tasmanian community do to make health our core business?’⁹⁰

Recommendations:

4. **Encourage greater sharing of responsibility for health outcomes through inter-sectoral initiatives that foster participation, ownership and commitment.**



⁹⁰ Herzfeld M & Mooney G 2012, *Making health Tasmania’s core business*, Croakey 4 September 2012.



2.0 Preventative Health Care

2.1 A health-equity oriented health care system

We acknowledge the importance of an integrated and collaborative preventative health care model that focuses on the prevention, early detection and early intervention for chronic disease; however our priority lies with health equity. Again, we wish to bring to the Committee's attention the need to focus on the underlying causes of chronic disease. As the old cliché goes: *'Health starts long before illness - it starts in our everyday lives'*.

Health promotion initiatives aimed at preventing chronic conditions, where incorporated into a health care system at all (in many cases they are either not funded at all or are woefully under-resourced), are generally aimed at changing the behaviour of individuals rather than creating wider physical, social and economic environments supportive of healthy behaviour. Moreover, prevention as well as early detection and early intervention initiatives may actually exacerbate health inequities as those that do not take account of inequities are generally much more available to advantaged groups before, if ever, trickling down the social gradient.⁹¹

Unfortunately the way that the health care system is currently structured and much of what goes on within the sector contributes to generating health inequity.⁹² It is well documented that those with the worst health status often receive less health care. This is a pattern that is evident both within countries and between countries.⁹³

A preventative health care model focussed on equity considerations would tackle some of the underlying *'causes of the causes'* of chronic disease – for example, poverty, low levels of educational attainment, discrimination and social exclusion. The high teenage pregnancy rate in Tasmania (the 2nd highest in Australia next to the Northern Territory) is a strong indicator of some of these underlying issues. As discussed in an unpublished paper prepared by the 'Kids Come First' Unit, Children and Youth Services, Department of Health & Human Services in Tasmania:

*'Although many teenage births result in positive outcomes for both the mother and her child, teenage mothers are more likely to have poorer health, education and economic outcomes than older mothers.'*⁹⁴ Risks include an increased likelihood of miscarriage, preterm delivery, low birth

⁹¹ Baum F, Begin M, Houweling, AJ and Taylor S 2009, 'Changes Not for the Fainthearted: Reorienting Health Care Systems Toward Health Equity Through Action on the Social Determinants of Health', *American Journal of Public Health*, vol 99, no. 11, pp. 1967-1974.

⁹² Ibid.

⁹³ Ibid.

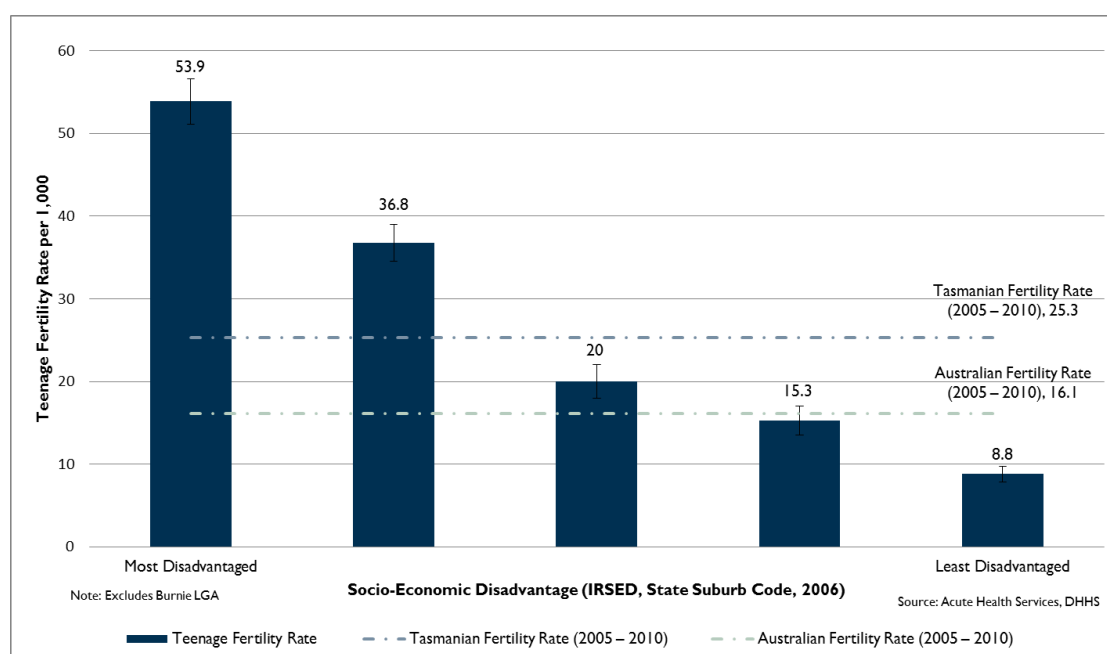
⁹⁴ AIHW, 2009, *A picture of Australia's children 2009*. Cat. no. PHE 112, AIHW, Canberra, p. 69.



weight and other complications.⁹⁵ Teenage mothers are more likely to have interrupted schooling, be lone parents, rely on government assistance, be unemployed and live in poverty.⁹⁶ When the children of teenage mothers are older, they are more likely to develop behavioural problems and live in social and economic disadvantage.⁹⁷

Teenage fertility rates in Tasmania (i.e. births per 1,000 women aged 15-19) have been consistently 20 percent to over 80 percent higher than the average rates for Australia as a whole over the past decade, with a massive difference in rates between the lowest quintile of the population in terms of socio-economic disadvantage, and the highest quintile – the most disadvantaged group having an average annual teenage fertility rate of 53.9 in the period 2005-2010, while the least disadvantaged group having a rate of only 8.8 (refer to Figure 6). Tasmania's high teenage fertility rate also correlates with our high degree of rurality in comparison to other Australian states and territories.

Figure 6: Tasmanian teenage fertility rate x disadvantage (2005–2010)⁹⁸



An equity-focussed response to high teenage pregnancy rates would look at responses such as comprehensive sexual and reproductive health education; strategies to open up alternative pathways for young people, particularly those living in disadvantaged circumstances; and improved supports for those

⁹⁵ AIHW 2011, *Headline indicators for children's health, development and wellbeing 2011*, Cat. no. PHE 144, AIHW, Canberra, p. 82.

⁹⁶ AIHW 2009, *A picture of Australia's children 2009*, Cat. no. PHE 112, AIHW, Canberra, p. 64.

⁹⁷ AIHW 2011, *Headline indicators for children's health, development and wellbeing 2011*, Cat. no. PHE 144, AIHW, Canberra, p. 82.

⁹⁸ ABS 2010, *Births Australia, 2010. Cat 3301.0*, and LGA data source: Unpublished data, Health Statistics Unit, DHHS.



who do become young parents. The Social Inclusion Strategy for Tasmania, discussed in Section 3.5 of this submission, offered many other strategies to tackle disadvantage and discrimination.

We encourage the Committee to recognise the work done by highly regarded researchers such as Professor Fran Baum and others who have published on the opportunities for the health sector to reverse the sector’s propensity to generate health inequity. Figure 7 below provides some key points for consideration.

Recommendations:

5. ***Reorient the health care system to improve its equity performance, for example by building a strong primary health care approach, involving communities in decision making, enhancing access to health care and building stewardship.***

Figure 7: Characteristics of a Health Equity-Oriented Health Care Sector⁹⁹

Characteristics of a Health Equity-Oriented Health Care Sector

Leadership: Improving the equity performance of the health care system

- Focus on comprehensive primary health care
- Decision making processes that involve local communities
- Universally accessible care that is publicly funded, preferably through general taxation; good-quality health services free at point of use
- Planning, including allocation of resources, based on the needs of populations within a social determinants of health framework
- Policy statements and strategies that are explicit about closing the health equity gap and the need for action on the social determinants of health to achieve this goal in all programs, including those that are disease focused
- Evidence that the health care system has a systematic approach to increasing its spending on community-base services until a significant proportion of funding is devoted to community-based care and that it has reformed its financing system so that it rewards keeping people healthy through preventive action rather than throughput of clinical cases

Stewardship: Working with other sectors to improve health and health equity

- Presence of health sector advocacy program with other sectors regarding need for action on the social determinants of health and the importance of intersectoral action
- Development of expertise to establish a health equity surveillance system and to conduct cross-government health equity impact assessments on a regular basis along with private-sector activities
- Reform of medical and health professional education so that the importance of social determinants is reinforced in theory teaching, clinical training, understanding of population health perspectives, and skill development for inter-professional collaboration.
- Training and education of professionals (including urban and transport planners, teachers and architects on importance of social determinants of health
- Specified, funded program of research on the impact of social determinants of health and evaluation interventions deigned to address them, with a significant proportion of health research funding devoted to studies on social determinants.

⁹⁹Baum F, Begin M, Houweling, AJ and Taylor S 2009, Op-Cit, p. 1970.



2.2 Health Equity in All Policies

Similarly we urge the Committee to look at what is needed at the level of policy making to affect health outcomes. The WHO's Commission on the Social Determinants of Health recommends that responsibility for action on health and health equity must be placed at the highest level of government, and ensure its coherent consideration across all policies.¹⁰⁰ *“Every aspect of government and the economy has the potential to affect health and health equity – financial, education, housing, employment, transport and health, just to name six. Coherent action across government, at all levels, is essential for improvement of health equity.”*¹⁰¹

The Commission recommends:

- Make health and health equity corporate issues for the whole of government, supported by the head of state, by establishing health equity as a marker of government performance
- Assess the impact of all policies and programmes on health and health equity, building towards coherence in all government action.¹⁰²

Recommendations:

- 6. Employ high level leadership to implement mechanisms to routinely assess the impacts of decisions, policies and programs on health and equity across all sectors of government.**

2.3 Comprehensive primary health care

Strong primary health care systems have been shown to have lower costs and to perform better in the health care arena.¹⁰³ Baum (2009) states, *‘Primary care has been found to be more effective than specialty care in preventing illness and death and it is associated with more equitable distribution of health.’*

A stronger commitment and investment in primary health care is needed in Tasmania. This commitment should allow for community health centres and primary health care services to engage in community development practice with other local organisations (not limited to traditional health-focused organisation) and the community to build resilience against ill-health, including addressing the SDoH.

The Commission on Delivery of Health Services in Tasmania Preliminary Report to the Australian Government and Tasmanian Government Health Ministers stated the following:

¹⁰⁰ Commission on the Social Determinants of Health 2008, Op-Cit, p. 16.

¹⁰¹ Ibid

¹⁰² Ibid

¹⁰³ Baum F 2009, Op-Cit, p. 1971.



‘The apparent imbalance in spending and efficiency between the hospitals and community health care is of particular importance to us. The methodology used by the Commonwealth Grants Commission (CGC) to estimate what states need to spend to provide services at a national average standard has guided our thinking in this area.

In its 2012 update report, the CGC concluded that Tasmania needed to spend 11.6% more than the national average on admitted patient services in 2010-11, in order to provide those services at the national standard. This is largely because the Tasmanian population is older and poorer than the national average, offset somewhat by the fact that distances between Tasmanian population centres are not as great as in other states. The CGC’s analysis indicated that Tasmania was in fact spending 34% more than was required to provide hospital services at the national standard, pointing to potential opportunities to improve the efficiency of service provision.

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

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

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

Note:

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

A comprehensive primary health care system should involve:

- District-based programs
- Community participation and social empowerment
- Multidisciplinary teams
- Appropriate technology



- A solid grounding in a social understanding of health
- A focus on health promotion
- Intersectoral action
- Strong links with tertiary care service.¹⁰⁴

It is critical that the establishment of the Tasmanian Health Organisations does not result in the Tasmanian Government buck-passing its responsibility to provide comprehensive primary health by confining it to health promotion action in a limited number of communities. Tasmanian Health Organisations must have key performance indicators built into their funding agreements that require them to focus on the delivery of comprehensive primary health care; at present outputs are acute care focused only.

Primary Health Care in Southern Tasmania

Community Health Centres and Primary Health Care Services are well positioned to respond to local community needs and to engage with disadvantaged community members. Currently the Southern Tasmanian Health Organisation has Community Health Centres located in high need areas such as Rokeby, New Norfolk, Glenorchy, Bridgewater, Geeveston and Ouse. These communities experience many barriers to optimum health such as high unemployment, poverty, social isolation, mental health issues, family stress in the early years, insecure housing, and lack of transport. Community Health Centres are involved in working with other agencies on addressing the SDoH within their communities.

The SDoH Advocacy Network is concerned that Primary Health Care and Community Health Services are being eroded and are not adequately supported by the decision makers of the Department of Health and Human Services and the newly formed Tasmanian Health Organisations who are focussed on acute care and cost savings strategies.

Stretched resources and more demands on services to respond to the rising rate of chronic conditions and the needs of an ageing population mean that attention is taken away from community development and community engagement. Groups within the community that need greater support to access services are individuals and families living in poverty, Aboriginal people, families experiencing violence, people with mental health conditions, young people, men, and people from refugee backgrounds.

¹⁰⁴ Ibid, p. 1971.



Recommendations:

7. Build a strong primary health care system in Tasmania.

3.0 Structural and Economic Reform

With respect to this third Term of Reference under the Preventative Health Care Inquiry, we wish to discuss a number of sub-points:

3.1 Crisis in health expenditure – we need a new way forward

The first point we wish to highlight is the crisis in health care expenditure. Factors such as the rising incidence of chronic conditions and Tasmania's ageing population are placing increased demand on health services. At the same time health care costs are growing through the increasing use of expensive technological procedures.¹⁰⁵ Our own Premier, the Honourable Lara Giddings MP, is quoted as saying:

*'In the last financial year we were able to increase Tasmanian health recurrent funding by 7.9% in real terms, that is above the CPI increase and it does not include the Federal Government's contribution to help rebuild the Royal Hobart Hospital. The simple fact is some of the medical procedures increased in price during the same period by up to 25%. In ten years' time at the present rate of cost increase, the entire Tasmanian budget will be absorbed by Health alone.'*¹⁰⁶

The notion that expenditure on the health system in its current form is unsustainable has been reiterated by others.¹⁰⁷ If we are unable to financially support the road we are currently on, it is imperative to look at structural and economic reform and a move toward an equity-oriented health system with a focus on the prevention of ill health. The graph below (Figure 8) clearly shows the crisis we are in:

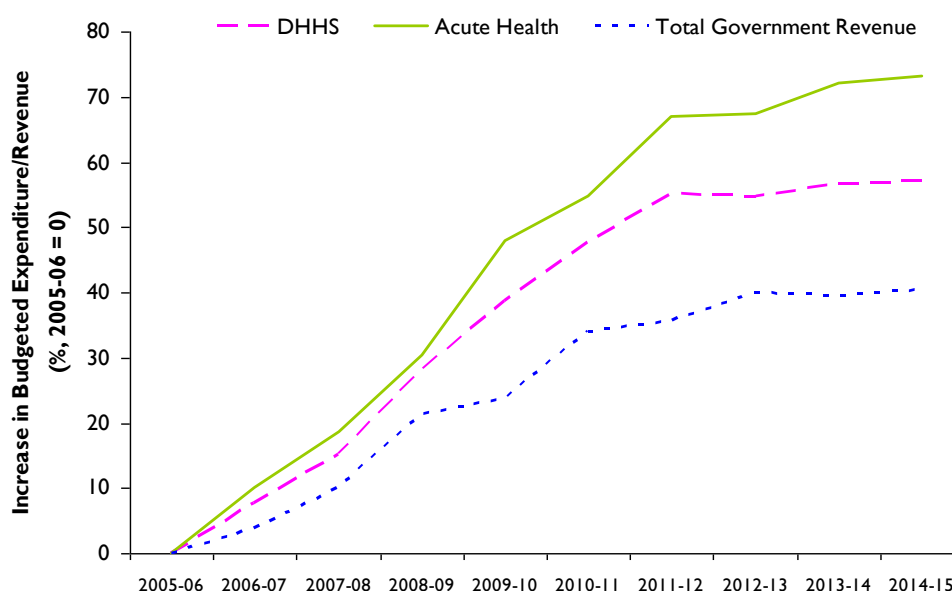
¹⁰⁵ Department of Health (SA) 2011, *The South Australian approach to Health in All Policies: background paper and practical guide*, Version 2.

¹⁰⁶ Tasmanian Style Magazine 2012, <http://www.tasmanianstyle.com.au/tsm/?c=8&langID=1>.

¹⁰⁷ Nicholson, D (Director Policy and Intergovernmental Relations, DHHS) 2012, *Challenges in Funding and Administration*, presented at the Alcohol Tobacco and other Drugs Council Conference, Hobart, 15 May 2012.



Figure 8: Predicted patterns in health care expenditure to 2015, Tasmania



As stated by Mooney (2012) in discussing priority setting in health: *“If we can shift resources and do better, then let’s shift resources!”*¹⁰⁸ It would appear that now is a good time to heed this advice. Mooney also stated that:

- It is crucial that priorities are set on an informed rational basis
- To do so all we need technically are opportunity costs and the margin
- Politically there needs to be the political will.
- And then ideally critically informed citizens – after all, it is *our* health service and our health!

To ensure that the SDoH are effectively addressed by all of government and by all sectors a new funding approach is needed. The SDoH Advocacy Network advocates for all funding decisions to be made with a ‘health equity lens’. Equity-impact assessment processes aim to determine the potential differential and distributional impacts of a policy, program or project on the health of the population as well as specific groups within that population; and secondly, to assess whether the differential impacts are remediable and unfair.

We also encourage the Committee to consider recommendations that will make the decision making process with regard to government funding more transparent. While many very worthwhile innovations come out of the budget process, some may not be further supported or endorsed by designated departments and

¹⁰⁸ Mooney G, 2012, *Priority Setting in Health*, presentation to the Tasmanian Health Conference, 21 July 2012.



therefore they do not receive the ongoing investment they deserve. The funding model needs to be much more transparent to all stakeholders – particularly Tasmanian citizens.

The SDoH Advocacy Network also encourages the Committee to consider recommending that greater focus is given to funding outcomes rather than simply departments. As Kickbusch (2008) – Thinker in Residence to the South Australian Government - recommended: *‘The stakeholders within government need to respond to challenges in health and wellbeing by jointly creating new forms of across-portfolio budgeting and accountability.’*¹⁰⁹

When it comes to funding health and health care, the SDoH Advocacy Network advocates for a progressive taxation system. Quite simply, those can afford to pay should pay. As Professor Mooney stated, *‘Taxes are good for all of us. They not only allow us to be socially compassionate, they encourage us to be involved as citizens, to think through how we want our tax money used and to take part in the public debate about what sort of society we want to be.’*¹¹⁰

Recommendations:

- 8. It is time to rethink the way we fund health and health care. We must maximize the benefits and do the best with what limited resources we have available, while keeping our eye on the ultimate goal of health equity. We must enhance transparency and look at ways of resourcing and financing joint government initiatives.**

3.2 Power to the people

There are some shining examples internationally of what can be achieved by moving the goal posts and creating a health system by the people and for the people. Our colleague, Professor Mooney, wrote about this in his most recent book, *The Health of Nations*.¹¹¹ Mooney writes about Venezuela – a country which has shifted power to focus very much on the community rather than individuals as decision making entities. *‘The Venezuelan model emphasises primary care, is based on community participation in decision making and funded by the public sector. This integrated model of care emphasises a holistic approach to health and illness through the coordination of (the primary health care organisation with others) addressing education, food security, public sanitation and employment, among other key Social Determinants of Health.’*¹¹²

¹⁰⁹ Kickbusch I 2008, Op-Cit, p. 10.

¹¹⁰ Mooney G 2012, ‘Bring on warm and fuzzy taxes’, *The West Australian*, 25 November 2012.

¹¹¹ Mooney G 2012, *The Health of Nations*, Zed Books, UK.

¹¹² Ibid, p. 173.



We draw the Committee’s attention to the SDoH Advocacy Network’s submission to the Tasmanian Government 2013-2014 Budget Community Consultation, *Ask me * Listen to me * Share with me - A call for greater citizen engagement in our health & social systems*. In this submission we recommended that the Government work through the Health Minister’s Health and Wellbeing Council to establish how best to enable the opinions, values and perspectives of Tasmanian citizens to contribute to the decisions that affect their health and wellbeing, and to promote more equitable health outcomes.

Our arguments in this Submission were as follows¹¹⁶:

- At present ‘ordinary’ Tasmanian citizens are not given the opportunity to have a say - a meaningful and valued say - about the issues that are important for their health and wellbeing, particularly those issues that are the underlying causes of many poor health outcomes – the SDoH.
- Health is unequally distributed among Tasmanians. In a nutshell those who are more privileged, have better education, jobs, housing, access to transport, supportive social networks and so forth, have better health than those who do not. These inequalities in health are unfair. Importantly, they are modifiable. This means that, if we can get these things right, we have a huge chance of not only improving the health and wellbeing of individuals and communities but also reducing health care costs.
- This is important particularly because of spiralling health care costs. A recent report, *The Cost of Inaction on the Social Determinants of Health*, reveals that nationally \$2.3 billion in annual hospital costs could be saved through concerted action on the SDoH.¹¹⁷ In Tasmania, the findings of this study have been calculated to equate to:
 - 15,000 Tasmanians avoiding chronic disease
 - 5,100 extra Tasmanians entering the workforce, generating \$240 million in extra savings
 - \$120 million in welfare support payments saved each year
 - 1,800 fewer people admitted to hospital annually, resulting in savings of \$69 million in hospital expenditure
 - 165,000 fewer Medicare services utilised each year, resulting in annual savings of \$8.2 million
 - 159,000 fewer Pharmaceutical Benefit Scheme scripts being filled each year, resulting in annual savings of \$5.5 million.¹¹⁸
- We must focus on keeping people out of the health care system. The only way to do this is to act on the underlying causes of poor health – the SDoH. But where should we start? Let’s ask our citizens! The SDoH are - as the name suggests - first and foremost **social**. They are best identified and prioritised by society i.e. by ‘ordinary’ (but yes, critically informed) Tasmanian citizens. It is also the case that there is evidence in the literature that being engaged in the community, participating in the community, is good for people’s health.

¹¹⁶ Social Determinants of Health Advocacy Network 2012, *Submission to Tasmanian Government 2013-2014 State Budget, Community Consultation*.

¹¹⁷ CHA-NATSEM 2012, *The Cost of Inaction on the Social Determinants of Health*.

¹¹⁸ Health in All Policies Collaboration, 2012, *Background Paper, Intersectoral Action on the Social Determinants of Health*.



- While we are aware that the Government consults with the community on various issues, the consultation processes are usually one-off and control is very much retained by the agency driving the issue. We argue that engagement with the community should be an ongoing, collaborative process, with greater power-sharing arrangements.
- We are also aware that the Government is currently developing a community engagement strategy and while we welcome this as an internal working document, we argue that what is needed is for the Government to allow the community to have greater control of the mechanisms that could be used to engage with them. Consulting the community should start with consulting the community on how they want to be consulted!
- This is a whole of Tasmania responsibility not just a health sector issue. As stated by Marmot et al (2012): *“At every level of governance arrangements are needed that are capable of building and ensuring joint action and accountability of health and non-health sectors, public and private organisations, and of ordinary people, with a common interest in improving health and equal terms.”*¹¹⁹

Recommendations:

9. ***Work through the Health Minister’s Health and Wellbeing Council to establish how best to enable the opinions, values and perspectives of Tasmanian citizens to contribute to the decisions that affect their health and wellbeing, and promote more equitable health outcomes.***

3.4 The social inclusion tragedy

The SDoH Advocacy Network urges the Committee to recognise the need for commitment and investment to the SDoH over the long term action.

In 2008 the Tasmanian Government appointed a Social Inclusion Commissioner tasked with developing a strategy¹²⁰ to improve social inclusion outcomes. The subsequent strategy identified a selection of indicators with which to measure the progress of the strategy against its actions and desired outcomes. The vast majority of these indicators were measures of various social determinants, such as food security, housing, employment, education and household income.

Consequently we would refer the Committee back to this nationally recognised and often cited strategy to consider again a way forward in delivering improved outcomes around the SDoH. The strategies and actions identified in the Social Inclusion Strategy aimed to improve access to services, the basics in life and

¹¹⁹ Marmot M et al, WHO European review of social determinants of health and the health divide, *The Lancet*, Vol 380 September 15, 2012.

¹²⁰ Adams D 2009, *A Social Inclusion Strategy for Tasmania*.



information through ICT, education and skill building, strengthening community connections, exploring novel approaches to job creation, building community resilience and improved planning and liveability. Importantly, it sought to improve civil engagement in decision making through strengthened governance. All of these actions would improve the SDoH.

Ironically, within the Strategy the author suggested that previous attempts to address recalcitrant health and wellbeing outcomes had failed to give sufficient time to become bedded down and acted on in a cross sectoral and whole of government and community manner. The Strategy sought to apply scale, scope and connectivity with a sustainability lens continuously applied, offering *all Tasmanians access to personal, social, economic and civic resources and relationships that make life healthy, productive and happy*.

Recommendations:

10. Revisit the Social Inclusion Strategy for Tasmania.

4.0 Expertise

It is difficult for us to comment on the extent to which experience and expertise in the SDoH is appropriately represented on whole of government committees or advisory groups, as the Network is not directly involved with any such groups.

Overall we feel that there is a general lack of understanding of:

- a. what the language of SDoH and related terms such as health equity means
- b. how SDoH relate to Tasmania
- c. what can be done to translate knowledge of SDoH into appropriate action.

Others have written about this topic in other jurisdictions. For example Raphael (2012) in writing about the experiences in Canada – which is frequently regarded as a world-leader in developing health promotion and population health concepts – urges the public health community to educate the public about the SDoH as effectively as it took on the task of educating the public of the importance of not smoking, of exercising and adopting a healthy diet.¹²¹ We regard ‘the public’ in this publication to include people who sit on whole of government committees and advisory groups.

¹²¹ Raphael D 2013, ‘Educating the Canadian public about the social determinants of health: the time for local public health action is now!’, *Global Health Promotion*, vol. 9, no. 3, pp 54-59.



As highlighted earlier, we believe that the health arena is one that needs to be shared with multiple players and therefore finding language that is engaging and meaningful for all participants is important. Further, we feel it is important to emphasise that we must not stop merely at enhancing knowledge; rather, we must implement action to foster positive change.

Recommendations:

- 11. *Engage the citizens of Tasmania in building their understanding of the Social Determinants of Health and health equity.***





5.0 Research

With regard to this Term of Reference, we draw the Committee’s attention to the recommendations of the WHO Commission on the Social Determinant of Health:

‘The world is changing fast and often it is unclear the impact that social, economic, and political change will have on health in general and on health inequities within countries or across the globe in particular. Action on the SDoH will be more effective if basic data systems, including vital registration and routine monitoring of health inequity and the SDoH, are in place and there are mechanisms to ensure that the data can be understood and applied to develop more effective policies, systems, and programmes. Education and training in SDoH are vital.’¹²²

‘There is enough evidence on the SDoH to act now. Governments, supported by international organizations, can make action on the SDoH even more effective by improving local, national, and international monitoring, research, and training infrastructures.’¹²³

The SDoH Advocacy Network would like to see greater research funding for SDoH across the board, however this must not come at the expense of action.

Recommendations:

12. Advocate for, and fund research on the Social Determinants of Health and health equity.

6.0 Conclusion

The SDoH Advocacy Network congratulates the Government on establishing this Inquiry.

We look forward to the Committee’s careful consideration of these matters and recognition that the way forward is not difficult but it is a long road and one that requires political will.

We look forward to meeting with the Committee to further discuss this submission.

¹²² Commission on the Social Determinants of Health 2008, Op-Cit, p. 28.

¹²³ Ibid, p. 30.

