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Mr Tom Wise
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Dear Mr Wise

In response to a letter from Ruth Forrest MLC, dated 5 December 2012, the Premier's Physical Activity Council (PPAC) would like to take the opportunity to provide a submission to the Joint Select Committee Inquiry on Preventative Health Care.

As part of this submission, specific responses to terms one and three of the committee's Terms of Reference have been provided. These highlight the impact of inequalities on the social determinants of health in Tasmania and present PPAC as an example of an effective model for an integrated and collaborative approach to preventative health care.

I would be pleased to appear before the committee to provide verbal evidence on behalf of PPAC. For further information regarding PPAC, please contact PPAC Manager, Michelle Morgan by email Michelle.Morgan@development.tas.gov.au or telephone 6233 5625.

Yours sincerely



Graeme Lynch
Premier's Physical Activity Council Chair

1 March 2013

Submission to the Joint Select Committee Inquiry: Preventative Health Care from the Premier's Physical Activity Council

PPAC Position Statement to the Committee

PPAC supports the establishment of an overarching governance structure in Tasmania that provides a framework in which not only strategies to reduce health risk factors such as physical inactivity would sit, but which more broadly encompasses the social determinants of health.

The established structure of PPAC would easily sit within such a whole of government framework, providing advice and input on the linkages between the health risk factors of physical inactivity and how they be integrated within broader intersectoral actions to address the social determinants of health.

Introduction

It is submitted that the Premier's Physical Activity Council (PPAC) provides a working model of how an intersectoral Health in All Policies approach can address the issues of health inequity and impact on physical activity levels of Tasmanians where they live, work and play.

The PPAC approach is based on strong governance with two main elements:

Firstly, PPAC developed a 20 year strategy, *Tasmania's Plan for Physical Activity 2011-2021* to provide a focus for activities to encourage more Tasmanians to be physically active

Secondly, PPAC has in its current work plan identified gaps where it can directly focus its resources, mapped against *Tasmania's Plan for Physical Activity* and work on projects that require an intersectoral and collaborative approach. These projects are designed to have outputs that can be measured and delivered in the short, medium and long term that address those gaps.

There are many things that may have an impact on the levels of physical activity undertaken by Tasmanians. These include: planning law (where people live, housing density, open spaces, transport routes, cycle and pathways); public transport policy; private transport providers; climate change and the direct impact of fuels on health and also on sustainable communities; road user safety; safe neighbourhoods; green environments with shade, trees and features to encourage active living; creation of local destinations, and supporting of community spirit, and school policies.

All of these impacts are determined by decisions in the most part made outside the province of the Department of Health and Ageing (Commonwealth) and the Department of Health and Human Services (State) - agencies charged with the delivery of acute and primary health care service to Tasmanians.

The impacts on the social determinants that affect physical activity in our community are more commonly governed by the private sector and government agencies and departments. Those within the government sector that are key stakeholders in addressing access and removing barriers for the disadvantage in our society are the Department of Infrastructure Energy and Resources (transport, roads), Department of Education (school policies), Department of Premier and Cabinet (social inclusion, young people, local government), Department of Justice (planning and Emergency Services), Department of Economic Development Tourism and the Arts (sport and recreation, tourism infrastructure, economic development) and many Government Business Enterprises and statutory authorities.

Representatives from many of these varied stakeholder groups sit on PPAC or on its working groups.

Addressing selected Terms of Reference for the committee

PPAC will address specific responses to terms one and three of the committee's Terms of Reference. These highlight the impact of inequalities on the social determinants of health in Tasmania and present PPAC as an example of an effective model for an integrated and collaborative approach to preventative health care.

Term 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.

Causes of poor health and health inequity

The socio-economic, cultural and environmental conditions have the most significant impact on the health of individuals and populations and these are known as the social determinants of health (CDCP, 2011). These conditions are shaped by the distribution of wealth, power and resources at global, national and local levels, which are themselves influenced by policy decisions (WHO, 2012b).

Wilkinson & Marmot (2003) identify 10 factors affected by the social determinants of health that have the greatest influence on health outcomes. These are the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport. These determinants are largely outside of the health sector.

The social determinants of health are largely responsible for health inequity. Health inequity is described as the measurable differences in health status that are outside the control of the individuals concerned, result from avoidable factors that can be changed and are also considered to be unfair, unacceptable or unjust (WHO, 2012a). This differs from the concept 'health inequalities', which in addition to health inequities, also includes natural, unavoidable factors that cannot be changed, such as gender, genetics, age and disability (WHO, 2012a). There is however emerging scientific evidence that suggests a person's genetic make-up is influenced by

changeable factors such as socio-economic status and environmental conditions (DHHS, 2011).

The Tasmanian context

Tasmania's population is significantly older than the Australian population and is aging at a rate faster than any other Australian jurisdiction. In 2009, Tasmania had the oldest population of all the states and territories with a median age of 39.6 years (ABS, 2009c). Over the next 10 years, it is estimated that the number of Tasmanians aged 65 to 84 years will increase from 14 to 19 per cent (Demographic Change Advisory Council, 2008), which presents a number of social, health and economic challenges for the state.

Tasmania is also characterised by population groups who are vulnerable to poor health. For example, almost 40 per cent of the population have a disability or long term health condition, 11 per cent of Tasmanians over 15 years have mental and behavioural issues (ABS, 2011b) and 4 per cent are people of Indigenous origin (ABS, 2009b). While Tasmania does not have a large culturally and linguistically diverse community, it does have the highest proportion of refugee arrivals per capita when compared to other Australian jurisdictions, and these arrivals are expected to increase (ABS, 2012; Salmon, 2008).

Compared with most other Australian jurisdictions, Tasmania has the poorest health outcomes. Life expectancy has continued to improve significantly over time, however when compared to other Australian jurisdictions, Tasmanians have the second lowest life expectancy after the Northern Territory (ABS, 2009a).

Most causes of death and burden of disease in Tasmania are non-communicable diseases, of which a large proportion is preventable (DHHS, 2008). Health risk factors that relate to physical activity levels, diet, alcohol consumption, smoking status and body mass index make up 35 per cent of the total burden of disease (ABS, 2009c), indicating there are more complex factors influencing health outcomes than lifestyle choices.

Tasmania's health outcomes correlate with the socioeconomic status of its population, demonstrating a clear gradient with disadvantaged populations experiencing poorer health outcomes more so than those who experience socio-economic advantage (ABS, 1999; DHHS, 2008).

According to the Socio-Economic Indexes for Areas (SEIFA), which uses a selection of weighted variables for a geographic area including low income, educational qualifications, unemployment, overcrowded housing, disability, household resources and Indigenous population, 21.2 per cent of the Tasmanian population is classified as being in the most disadvantaged decile, compared to any of Australian jurisdiction (ABS, 2006). This compares with 19.5% in the Northern Territory and 14.3% in South Australia the second and third most disadvantaged jurisdictions in Australia.

The capacity for health and community services to meet the needs of populations is adversely affected by the social determinants of health

There is a growing body of evidence supporting action on the social determinants of health (Putland, Baum, & Ziersch, 2011) and while many community-based interventions aim to address health inequities, there is not a widespread understanding of health inequities and how addressing them translates into action.

The World Health Organisation's Commission on Social Determinants of Health identified a "need to provide training on the social determinants of health to policy actors, stakeholders, and practitioners and investment in raising public awareness" (cited in Putland et al. 2011, p. 10). To address inequities, Putland et al. (2011) recommends that in addition to expert knowledge on the causes of health inequalities, that increasing an understanding of the collective actions to address the structural causes will be required to generate the public and political support for their implementation.

Term 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.

Tasmania is characterised by numerous complex factors that influence its poor population health outcomes and health inequity. The factors that influence health outcomes are largely outside of the health sector, which calls for the need for an integrated, cross-sector approach to address the causes of poor health.

Physical inactivity is just one aspect of many multi-factorial issues affecting poor health outcomes in Tasmania and ultimately, the very high and growing use of our acute and primary health care sectors. Following is an example of how the issue of physical inactivity is effectively and efficiently being addressed using an integrated, cross-sector and collaborative approach in Tasmania. This same approach can be applied across all preventative health and social determinants of health measures, which will result in the delivery of significant outcomes at minimal cost and avoid duplication of costs and efforts.

Physical inactivity is a key preventative health risk factor. However in Tasmania, 70 per cent of adults do not meet the National Physical Activity Guidelines for health benefits (ABS, 2013). Attachment A provides evidence that highlights the importance of physical activity in preventative health care.

Many of the most important influences on physical activity levels do not fall within the direct control of any one sector or organisation. Environment, planning, infrastructure, sport and recreation, transport, education and health sectors all have a role in influencing physical activity levels. While the outcomes of interest often differ, physical activity is usually the common interest. For example:

- The goal for transport is efficient traffic flow
- The goal for environment is reduced pollution and cleaner air
- The goal for health is reduced premature morbidity and mortality in the population

But, the common vehicle is physical activity.

There is a strong body of scientific evidence that indicates the most effective interventions to increase physical activity levels are those that combine multiple strategies at multiple levels across all sectors (Salmon, 2008). They involve a range of stakeholders and the community, and include leadership, capacity building, building partnerships and facilitating cooperation. It is vital to ensure that health and wellbeing are fundamental considerations in public policy development across all sectors. One of the key challenges this presents is overcoming the silos.

To respond to physical inactivity in Tasmania, in 2001 the then Premier, the Hon Jim Bacon, established PPAC to provide a coordinated, cross-sector and collaborative response to increasing and improving opportunities for physical activity in Tasmania, including responsibility for the development and oversight of a long-term strategy for physical activity for the state.

PPAC is an independent advisory council and its members, who are appointed by the Premier, represent many sectors and organisations that have a role in influencing physical activity participation. They come from state and local government, community organisations, business, research, planning and industry.

The functions of PPAC are to:

- Provide strategic leadership, direction, advice, coordination and advocacy, across government and the community, for physical activity in Tasmania;
- Support and foster stakeholders to undertake initiatives that contribute to achieving the vision and goals of Tasmania's plan for physical activity;
- Raise awareness of the value and importance of physical activity across all sectors of the community and the public; and
- Undertake initiatives in response to specific gaps and demands, in accord with Tasmania's plan for physical activity.

In 2011, the Premier, the Hon Lara Giddings MP launched the second strategic plan for physical activity in Tasmania, *Tasmania's plan for physical activity 2011-2021* (www.getmoving.tas.gov.au/tpa/), which PPAC developed in consultation with the Tasmanian community. This long-term plan is the main vehicle of work for PPAC. It articulates the vision, goals and key performance indicators PPAC aspire to achieve.

PPAC is governed by a Terms of Reference and is supported by project specific working groups to undertake specific tasks (see Attachment B for PPAC's current operating structure and key priority areas for 2013). PPAC reports to the Premier on priority areas for action and seeks advice and support from the Premier to progress priority areas as required.

PPAC's governance model and structure is a low-cost and efficient approach to providing a coordinated, cross-sector and collaborative response to addressing physical inactivity as a key health risk factor.

Since its establishment, PPAC has made many positive contributions to the health and wellbeing of the Tasmanian community, such as providing the strategic direction of physical activity across the state for the many stakeholders through two state-

wide physical activity plans, raising awareness of the importance and value of physical activity through activities such as Find thirty, Get Moving Tasmania, community forums and the active Tasmania awards, and being the leader in workplace health and wellbeing, which is now a key activity under the national preventive health agenda.

In the most recent Australian Health Survey, compared to all other health risk factors and jurisdictions, Tasmania is leading the way in terms of improving physical activity levels. From 2007-08 to 2011-12, there was a three percentage point increase in Tasmanian's over the age of 18 who met the Australian Physical Activity Guidelines. While this change is not statistically significant, it is still a positive result in that it hasn't worsened. While we are making some progress at improving physical activity levels in Tasmania, it is a long-term task that requires long-term commitment and leadership, and there is still much more work to be done.

Through PPAC's experience, the benefits of integration and collaboration have proven to be essential for the delivery of positive outcomes and overcoming the silos. Key elements that have contributed to this include having a clearly defined vision and mission, an overarching framework for all stakeholders that have a role in addressing physical inactivity (*Tasmania's plan for physical activity 2011-2021*) and an implementation plan that is actively managed by PPAC which provides the opportunity to identify the activity being undertaken across major stakeholders, as well as opportunities for collaboration and responding to the gaps where PPAC can have the greatest impact. The leadership from the Premier, as well as the support and commitment from stakeholders across sectors has also been essential for achieving success.

From its success of an intersectoral and collaborative approach to addressing physical activity as a key health risk factor to improve population health outcomes, PPAC supports the establishment of a structure that promotes the integration of a preventative approach to health and wellbeing in Tasmania.

Attachment A - The importance of physical activity in preventive health care

Regular physical activity is a major factor in preventing a number of chronic diseases and can provide a wide range of economic, environmental, physical, social and mental health benefits. Despite this, seven out of 10 Tasmanians 18 years and over do not meet the national physical activity guidelines of 30 minutes of moderate-intensity physical activity on at least five days of the week (ABS, 2013).

Insufficient physical activity for adults is second only to tobacco as the modifiable behavioural risk factor most associated with the burden of disease in Australia (AIHW, 2010). Physical inactivity is a risk factor for eight of the nine National Health Priority Areas, which are cardiovascular health, injury prevention and control, mental health, diabetes mellitus, some types of cancer, arthritis and musculoskeletal conditions, obesity and dementia (AIHW, 2012). Physical inactivity contributes to over 16 000 deaths per year in Australia, equating to 43 deaths per day or 1.8 deaths per hour (Medibank, 2008).

The cost of physical inactivity to the Australian economy, in terms of healthcare, productivity and mortality costs is estimated to be \$13.8 billion per annum (Medibank, 2008). This considers the costs to employers, individuals, and the economy more broadly from reduced productivity and premature mortality, as well as direct healthcare costs.

Car dependence has been identified as a major contributor to sedentary lifestyles (AIHW, 2010) and the largest contributor to road transport greenhouse gas emissions in Tasmania (Department of Climate Change, 2006). Up to half of all car trips can be easily replaced by walking, cycling or public transport. Walking and cycling can provide efficient transport to destinations within about four kilometres and cycling is a viable commuter alternative for trips up to 20 kilometres. Car trips that are less than two kilometres are the most fuel inefficient and create more pollution per kilometre. For every litre of petrol saved, greenhouse gas emissions are reduced by 2.8 kilograms, which reduces the cost of petrol plus vehicle wear-and-tear (PPAC, 2010).

The need to respond to physical inactivity is reflected in numerous government, community and advocacy documents, at a state, national and international level, such as Tasmania Together, Tasmania's plan for physical activity 2011-2021, the National Partnership Agreement for Preventive Health and the Toronto Charter for Physical Activity.

Attachment B – PPAC’s operating structure and key priority areas for 2013

At the end of 2011, PPAC undertook a strategic review which involved developing a new operating structure to ensure the most efficient and effective use of resources to achieve agreed goals. This new structure is outlined in diagram 1.

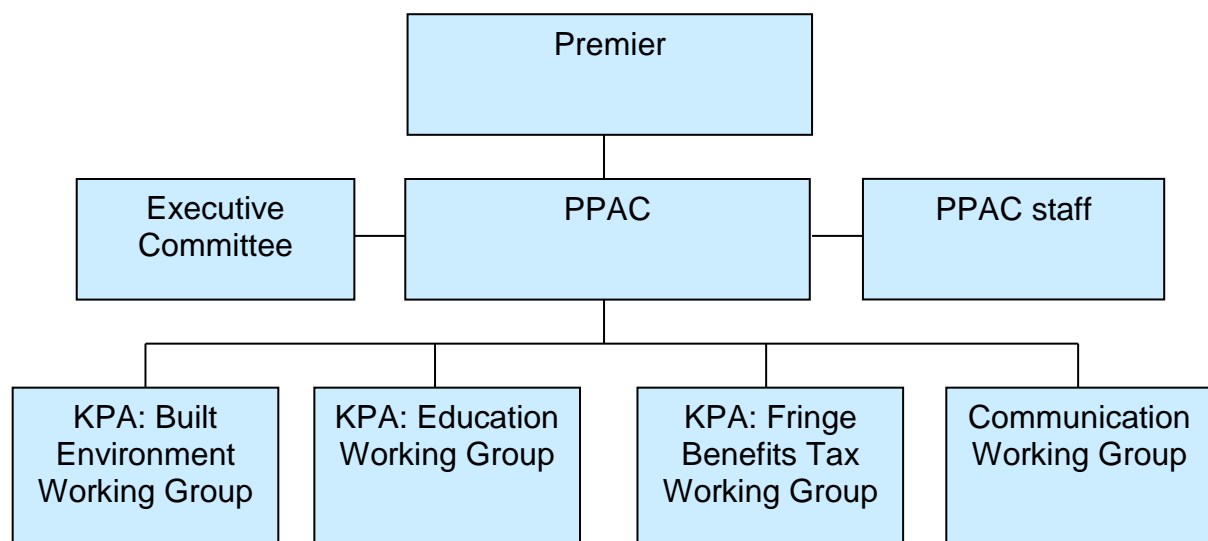
PPAC staff is provided by Sport and Recreation Tasmania in the Department of Economic Development, Tourism and the Arts. The team of 3.2 full-time employees is led by Michelle Morgan, Manager PPAC, who is responsible for managing the administration of PPAC as well as key projects.

The Executive Committee meet on an as needs basis and are responsible for addressing operational tasks that do not need to be presented to the full council, such as budgeting and PPAC membership.

The Built Environment, Education and Fringe Benefits Tax (FBT) working groups are project specific and have been formed to progress PPAC’s key priority areas (KPAs) for 2012-13. Each of these groups has Terms of Reference and defined project outputs which are endorsed by PPAC. They involve PPAC members and staff, as well as external members and meet as required. The secretariat support for the Built Environment and FBT working groups is provided by the Department of Premier and Cabinet and Department of Health and Human Services, due to the limited capacity of PPAC staff.

In December 2012, PPAC agreed to form a communications working group to lead an integrated and strategic process for all PPAC communication activities. This group is yet to be established however should be formed in 2013.

Diagram 1: PPAC’s operating structure



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