Submission to the Parliament of Tasmania's Joint Select Committee Inquiry into Preventive Health Care, March 2013

Authors and Scope of Submission

We welcome this timely Inquiry into the development, implementation and evaluation of integrated preventive health care programs in Tasmania. We have prepared this brief submission in our capacity as researchers from the fields of health policy and sociology with an active interest in studying the social, economic and environmental causes of health inequality (with an emphasis on so-called place based explanations) in the Tasmanian context. We have a particular interest in the development and evaluation of policy interventions designed to address such inequality in a cost effective and sustainable way.

This submission does not reflect the views of The University of Tasmanian or any of the agencies and organisations with which we collaborate.

We append a research report reviewing the literature on place based approaches to addressing health inequality prepared for the Department of Health and Human Services (2012). Naturally we are prepared to appear before the Committee to discuss further the contents of this submission.

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March 1 2013

Response to the Inquiry's Terms of Reference

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;

Population health outcomes have improved dramatically since the mid-20th Century as evidenced by improvements in life expectancy and mortality rates from disease. Large scale public health initiatives such as vaccination and population-based health screening have played their part as have improved health services from primary care through to tertiary treatments. Despite advances, these improved health outcomes are not equitably dispersed throughout the population. Health status and health outcomes are characterised by a social gradient whereby the most advantaged members of the population enjoy the best health outcomes whilst the most disadvantaged have the worst (Macintyre 2007). In spite of improvements in health outcomes these overall gains have concealed a widening gap between the most advantaged and the least advantaged, due to the relatively slower improvement in health among lower socioeconomic groups relative the their more affluent peers (Klein 2004; Baum 2007; Dahlgren & Whitehead 2006; Macintyre 2007). Improving our understanding of and devising effective interventions to reduce community level health inequity has become a major focus of population health policy.

The challenge of addressing health inequality is particularly acute in Tasmania as the State's population experiences greater levels of disease and disability overall compared to other Australians and particular groups within the population are more vulnerable to poor health outcomes. Tasmania has the highest percentage of households in the nation who are dependent on government pensions and allowances. Over 64,000 Tasmanians or 13 per cent of the population live on or below the poverty line; the resultant social and economic disadvantage puts them at a significant risk of poor health.

The pattern of disadvantage in Tasmania means that certain communities are more at risk of poor health than others. In 2006, 38,600 people or 8% of the population were living in communities ranked among the most disadvantaged in Australia. This disadvantage is concentrated spatially, with 43% of the State's disadvantaged found in just four of the 29 Local Government Areas in 2007 (DHHS 2011). With such a high level of risk, there is a clear need to develop and implement community specific interventions designed to address inequity and improve health and wellbeing. However, vulnerable communities often fail to respond to conventional preventive health and health promotion strategies and therefore fall further behind in terms of health and wellbeing outcomes.

Place based strategies, which are the focus of our research, are designed to address health inequality by identifying and responding to the social barriers to wellbeing experienced in particular communities. Evidence suggests that the most effective of these strategies focus specifically on child development and parenting because barriers to health and wellbeing across the life course begin before birth with childhood health, social and economic wellbeing having a lasting impact upon children as they grow into adulthood (Case *et al.* 2002). We believe that place based strategies have the potential to address health inequality in the Tasmanian context.

Tasmanian Child and Family Centres as an example of place based health and wellbeing promotion

The Tasmanian Child and Family Centres (CFCs) are perhaps the most promising example of a place based preventive health strategy and represent a major plank of the Tasmanian Government's response to the *National Early Childhood Development Strategy*. Tasmania's 12 CFCs are places for families with children from birth to five years to access a range of services. They have a child focused approach combined with support and opportunities for parents, caregivers and families. They aim to improve the health and well-being, education and care of Tasmania's very young children by supporting parents and enhancing accessibility of services in the local community.

The CFCs are more than an integrated service delivery site. They are designed to provide a forum where communities can come together to identify *their* priorities to support children and families in *their* community, which includes access to a range of health, education and support services. The community is a partner in creating the conditions that enhance very young children's outcomes and shapes their life chances.

As researchers the CFC initiative provides an important opportunity to study a place based health and wellbeing strategy. As a research team we are working with State agencies to secure National Health and Medical Research Council (NHMRC) funding for a 5 year project to better understand the contributions CFCs are making to their communities, their governance and how the health and wellbeing profiles of the communities they serve change over time.

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

There is a consensus in the existing literature that effective preventive healthcare programs require an integrated and collaborative approach. When considering health disadvantage (as opposed to specific illness) at a population or community level, academic research suggests that social, economic and environmental factors combine contribute to poor health outcomes and health inequality. The relevance of these findings to the Tasmanian context has been affirmed in important research conducted by the DHHS Division of Population Health and reported in recent *State of Public Health* reports, and more recent the Healthy Tasmania

strategy. The inference from this preliminary research is that investing in community development, improved general (as well as specific health) education and social infrastructure will deliver health dividends. However the research on 'place based' health promotion in which we specialise highlights the complex and contingent nature of these relationships. Our current research (described above) aims to improve our understanding of these relationships in the Tasmanian context and to use this data for improving strategies for addressing place based barriers to health promotion at a community level.

One specific priority that the Committee (and subsequently government agencies) need to explore is improving the integration and availability (to researchers, community organisations and perhaps the general public) of population health, education and other socio-economic data required to generate comprehensive community profiles capturing the full range of the social determinants of health. At present relevant agencies (DHHS, DoE) collect relevant data for internal and national reporting purposes. While significant progress has been made in integrating specific population health data (through the DHHS/Menzies Tasmanian Data Linkage Unit for example) and separately various education and learning data (DoE Early Years Data Linkage Project), at present there is no integrated source of health, educational and other relevant social data. We believe that there is a clear case for integrating these existing data sets and supplementing them with other relevant qualitative evidence concerning health and wellbeing at a community level. Without such a resource it is difficult for researchers or policy makers to understand the relationship health outcomes and their social determinants at a community level. More importantly in the absence of such data it is difficult to assess the contributions policy initiatives such as CFC have made to improving child health and development. This deficiency could be addressed through the creation of combined socio-health research centre/clearing house which would collate, integrate (and perhaps supplement) relevant data and make it available to agencies and relevant stakeholders. One model might be an extension of the existing Menzies/Tasmanian Data Linkage Unit.

(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;

As mentioned above, there is a clear relationship between social and economic disadvantage and poor health outcomes both in Australia and internationally. At a population level, social and economic policies which can significantly improve levels of educational attainment, job security and financial wellbeing will, *ceteris paribus*, deliver improved health outcomes and reduce the social gradient of health. For example, it is unsurprising that wealthy egalitarian countries, such as the Scandinavian states, have high levels of health equality. However, in the Australian context, State and (and indeed federal) Governments lack the capacity, financial resources and policy instruments to achieve such large scale socioeconomic change. Given this context policy interventions must target the most needy communities and identify and address the specific barriers to improved health outcomes which they face.

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

As academics with an arms length relationship with agencies involved in this policy arena we are unable to give a definitive response to this question. However we would observe that any initiative designed to address the social determinants of health requires a multi-agency approach spanning (but not necessarily limited to) DHHS, DoE and DPAC. It is commendable that interagency committees and governance structures do exist (Tasmanian Early Years Foundation; Joint Steering Committee for the Child and Family Centre initiative etc) but, based on our limited experience, there is scope for more systematic inter-agency cooperation. For example, one of the goals of our proposed analysis of the Child and Family Centres is to extend and integrate health (DHHS) and learning (DoE) data to generate comprehensive community health and wellbeing profiles.

(5) The level of government and other funding for research addressing social determinants of health;

The State Government both directly through agencies and, in the case of child health promotion in particular, through the Tasmanian Early Years Foundation, has provided funding for small research projects designed to investigate and address health inequality.

We believe that through greater coordination and improved cooperation we can increase this research effort signficantly. If State agencies and community organisations can partner with academic teams then there are good prospects of attracting additional federal research funding (from the National Health and Medical Research Council (NHMRC) and to a lesser extent the Australian Research Council (ARC)). For example, The NHMRC funds Partnership Projects to support partnerships to create new opportunities for researchers and policy makers to work together to define research questions, undertake research and also to interpret and implement the findings. Partnership Projects aim to answer specific research questions which influence health and well-being through changes in the delivery, organisation, funding and access to health services.

Under the partner projects initiative, the NHMRC will match the funding committed by the policy/practice partners. Partner funding can be provided as cash and/or in-kind and as such provides a significant opportunity to secure additional funding for preventive health research. In order to capitalise on such opportunities relevant State agencies should be encouraged to engage in such partnerships and provide appropriate financial and in kind support.

Our proposed study of the Child and Family Centre initiative is an example of this type of research collaboration.

References

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