



Tasmania Medicare Local Limited  
ABN 47 082 572 629

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# SUBMISSION

to the Joint Select Committee on  
Preventative Health Care  
by Tasmania Medicare Local  
February 2015

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medicare  
local

TASMANIA

*Connecting health to meet local needs*



Tasmania Medicare Local Limited

**Submission to the Joint Select Committee on Preventative Health  
by Tasmania Medicare Local February 2015**

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## About Tasmania Medicare Local

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Tasmania Medicare Local (TML) is a non-government, not-for-profit primary health organisation working to help coordinate and connect primary health care services for local communities.

TML aims to identify local health care needs, work to address any service gaps and make it easier for Tasmanians to access the health services they need closer to home. Our mandate as a Medicare Local has a strong focus on working with communities and providers to reform, support and deliver primary health care, of which general practice is the cornerstone.

As a statewide organisation, we work to support primary care providers including general practice, nursing and allied health providers, and collaborate with a broad range of committed and experienced health system partners including acute care, aged care, social care and preventative health organisations. We have extensive networks including our 39 member organisations, enjoying a shared focus on working together to meet the primary health care needs of Tasmanians.

The Australian Government also funds TML to manage a range of programs and services in areas including after hours care, mental health, Aboriginal health, refugee health and chronic conditions. Additionally, TML has been funded to deliver a range of initiatives under the Tasmanian Health Assistance Package.

Since its establishment in November 2011, TML has been building on the significant achievements and reputations of its founding members – the three regional Tasmanian divisions of general practice – plus the statewide General Practice Tasmania. We are collaborating with a broad range of committed and experienced health and social care providers in a renewed focus on the primary health care needs of Tasmanians.

### Primary Health Networks

In May 2014, the Australian Government announced the cessation of the national Medicare Local Program (due to cease on 30 June 2015) and the establishment of Primary Health Networks (PHN), to commence 1 July 2015. There will be a single PHN for Tasmania, ensuring the continuation of a primary health organisation with a statewide focus.

The primary objectives of the national PHN program are:

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving coordination of care to ensure patients receive the right care, in the right place, at the right time.

Whilst TML acknowledges our organisation's interest to become Tasmania's PHN, we equally believe in the importance of the content of this submission regardless of the confirmed PHN provider for Tasmania and make this submission on this basis.

## Introduction

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TML welcomes the opportunity to present this submission to the Joint Select Committee on Preventative Health Care and looks forward to the opportunity to supplement this submission with a chance to meet the Select Committee to discuss this document in person.

Primary health care refers to health care services that are provided outside the hospital. Primary health care includes a range of services provided by health professionals such as general practitioners, practice nurses, psychologists, physiotherapists and community health workers. Primary health care helps people better manage their health and plays an important role in preventing disease. A robust primary health care system is strongly and clearly linked with all other parts of the health care system and is crucial to ensuring that people can get the health care they need, when they need it, where they need it. It is about providing more care in the community and will help to keep people well and out of hospital.

TML congratulates the Tasmanian Government's aim for Tasmania to have the healthiest population in Australia by 2025. In order to achieve this, preventive health stakeholders will need to:

- support people to live healthier lives through evidence-based health promotion initiatives that address Tasmania's high rates of smoking, poor diet, poor mental health, insufficient physical activity, harmful alcohol and other drugs use, obesity and high blood pressure, particularly in people who are disadvantaged
- decrease Tasmania's burden of disease through evidence-based primary, secondary and tertiary prevention initiatives that address multi-morbidity and the chronic conditions with the greatest impact
- drive preventive health efforts with a simultaneous focus on reducing and eliminating health disparities through addressing the social determinants of health and improving equitable access to high quality health services according to need, otherwise existing inequalities in health across the Tasmanian population will continue
- ensure decisions regarding preventive health investment and disinvestment are informed by evidence. A key preventive health priority for Government is to collect, monitor and report against indicators of chronic disease and associated risk factors, as well as other measures of population health status. This data is required to inform and evaluate public health status and the associated integrated preventive health strategies and health service provision in Tasmania.

## Tasmanian Health Assistance Package

In 2012 the Australian Government invested \$325 million over four years through the Tasmanian Health Assistance Package (THAP) to ensure the future, long term sustainability of Tasmania's health system across the public, private and non-government organisation sectors. TML was assigned responsibility by the Australian Government to implement action on the social determinants of health and health risk factors as one of 17 elements for implementation via the THAP.

### **Social Determinants of Health and Health Risk Factors**

The aim of this THAP program is to improve the health of Tasmanians through:

1. Targeting known lifestyle-related health risk factors such as excessive alcohol consumption, smoking, physical inactivity and poor diet and nutrition.
2. Addressing the social determinants of health such as social status, health literacy, housing and education.

Through this funding, TML has been charged with the responsibility of identifying the major social determinants of health in Tasmania and to develop and implement activities to address them. In the last 12 months TML has provided funding through a place-based approach (see section 1.2) to eight disadvantaged communities and implemented capacity building training and support (see section 4.1) to workforces and individuals working in the social determinants of health environment.

It is anticipated that the Social Determinants of Health Project (due for completion in June 2016) will empower communities to develop and implement local solutions to their local issues that are realistic and sustainable. Intended outcomes include:

- an awareness of the importance of addressing social determinants of health in Tasmanian communities
- a shift in community attitudes to health and wellbeing and taking affirmative action in relation to the social determinants of health
- development and implementation of health and wellbeing plans to address the social determinants of health
- a well-equipped workforce that can support each other and community members to address their personal health circumstances
- recommendations to advise governments on future health and wellbeing policy and funding decisions
- the strengthening of relationships and partnerships between the community sector, government departments, businesses, service providers and Tasmanians within and between communities to work together to address the social determinants of health
- enabled communities that have developed leaders and champions to tackle the social determinants of health within Tasmania as well as nationally. This will ensure that knowledge and resources are made accessible to other communities.

A separate but complementary project is the Health Risk Factors Project that works in partnership with key health promotion organisations to develop population based programs to improve health outcomes of Tasmanians. The initiatives funded under this project include:

- Excessive Alcohol Consumption and Smoking Prevalence in Young People, through Cornerstone Youth Services
- Poor Diet and Nutrition, Food Security and Obesity, through the Heart Foundation
- Health Literacy Strengthening Self Efficacy and Competency for Practitioners, with the Department of Health and Human Services
- Smoking Population Wide Approach through the Cancer Council.

The future of the Social Determinants of Health and Risk Factors Programs beyond 2014-15 is a decision yet to be taken by government.

The findings of these THAP funded programs will inform future health policy through evaluations of the impact of these interventions on reducing health inequalities, health system pressure and inefficiency.

These types of initiatives present an important opportunity for Tasmania to appropriately plan and establish mechanisms that can lead to long-term reforms and gains in health equity and access.

## Recommendations

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There are a number of matters that we wish to present to the Preventative Health Care Joint Select Committee for consideration. In doing this we will address each of the Terms of Reference, with our first recommendation advocating for a Health In All Policies approach providing an overarching foundation for all information and recommendations contained within this submission.

### **Recommendation 1:**

The Tasmanian Government, in partnership with the non-government sector develops and implements a Health in All Policies (HiAP) approach to policy, program and service development as the overarching framework for all investment in social determinants of health and preventive health.

This recommendation provides the foundation for all proposed actions contained within this document.

### **Recommendation 2:**

The Tasmanian Government, in partnership with the non-government sector, through policy and associated resourcing, formally recognise the importance of the social determinants of health in enhancing health equity and preventing poor health outcomes by:

- reorienting the health care system to take a stronger focus on addressing the social determinants of health
- acknowledging and resourcing the roles of key leaders and influencers such as general practice, other primary health care and social service providers in their role in working with individuals and communities
- implementing a 'proportionate universalism' approach to act across the social gradient of health.
- ensuring health literacy is a foundation priority for work with communities and providers.

### **Recommendation 3:**

The Tasmanian Government:

- work with TML and other key stakeholders to recognise the role of general practice and other primary care providers and focus on building a strong primary health care system in Tasmania that places health equity as a central goal
- utilise the many opportunities existing under the THAP to leverage intensive work occurring in this area and to set the system on a course for recovery
- embed a requirement in all service planning processes to prioritise the development of integrated cross-sectoral models of care weighted ahead of siloed or regionalised service systems
- ensure that service redesign efforts across primary, secondary and tertiary care within the Tasmanian health system need to be based upon a commonly understood and defined set of health pathways incorporating preventative health as a key focus
- undertake workforce redesign based upon agreed and established health pathways occurs as a subsequent process in the system redesign program
- focus on evidence based investment and dis-investment, along with continuous evaluation and monitoring of integrated preventative health strategies to enable long term measurement of health outcomes.

#### **Recommendation 4:**

The Tasmanian Government, in partnership with its community, the non-government and private sectors:

- develop a Health Equity Policy for Tasmania, and a statewide, long-term, whole-of-government plan for reducing health inequities through action on the social determinants of health. Such a plan 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.
- consider place-based approaches as a key mechanism for actioning a HiAP approach.
- in implementing a HiAP consider the Department of Premier and Cabinet as the most appropriate leadership for social determinants of health, with associated mandate, priorities and accountabilities for driving whole of system change.
- identify key strategies such as implementing funding guidelines that include addressing equity as a criteria and indicator for measurable outcomes and outputs to action the HiAP approach.

#### **Recommendation 5:**

The Tasmanian Government:

- utilise the sound body of work that has been carried out to guide action on the social determinants of health, such as reports and recommendations published by the WHO
- implement strategies to raise awareness of the social determinants of health across state government departments, as well as in partnership with the non-government sector and the wider community
- invest in health economics expertise to guide action in Tasmania
- provide training and support to set best practice standards for capacity building, commissioning and governance processes when funding programs to improve equity.

#### **Recommendation 6:**

The Tasmanian Government in partnership with the non-government and private sectors:

- engage with Tasmanian citizens to deepen our collective understanding about new and more efficient models of primary health care and on the factors influencing their health by implementing citizen's juries, consumer panels or other community planning methods to engage citizens in decision making processes related to their health
- resource the provision of training, mentoring and support to community organisations in governance, commissioning and procurement as essential in helping them to achieve expected funding outcomes
- ensure that future investment in and reform of the Tasmanian health system – in particular in respect of integrated primary health systems – be based upon and contribute to the growing local, national and international evidence base.



## 1.0 Term of Reference 1: The current impact of inequalities

### Recommendation 1:

The Tasmanian Government, in partnership with the non-government sector develops and implements a Health in All Policies (HiAP) approach to policy, program and service development as the overarching framework for all investment in social determinants of health and preventive health.

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- acknowledging and resourcing the roles of key leaders and influencers such as general practice, other primary health care and social service providers in their role in working with individuals and communities
- implementing a 'proportionate universalism' approach to act across the social gradient of health
- ensuring health literacy is a foundation priority for work with communities and providers.

## 1.1 The social determinants of health

The social determinants of health are the conditions of everyday living that affect people's health. They are the conditions in which people are born, grow, live, work and age.<sup>1</sup> The social determinants of health are sometimes referred to as '*the causes of the causes*' because they are the underlying reasons why people experience particular health outcomes – positive and negative.

Some of the social determinants that impact on health include:

- how a person develops during the first few years of life (early childhood development)
- how much education a person obtains
- being able to get and keep a job and the type of work
- having food or being able to get food (food security)
- having access to health services and the quality of those services
- housing status
- how much money a person earns
- discrimination and social support.<sup>2</sup>

<sup>1</sup> WHO, Social Determinants of Health website, [http://www.who.int/social\\_determinants/en](http://www.who.int/social_determinants/en), accessed 26 February 2013.

<sup>2</sup> Centre for Disease Control and Management website, <http://www.cdc.gov/socialdeterminants/FAQ.html>, accessed 26 February 2013.

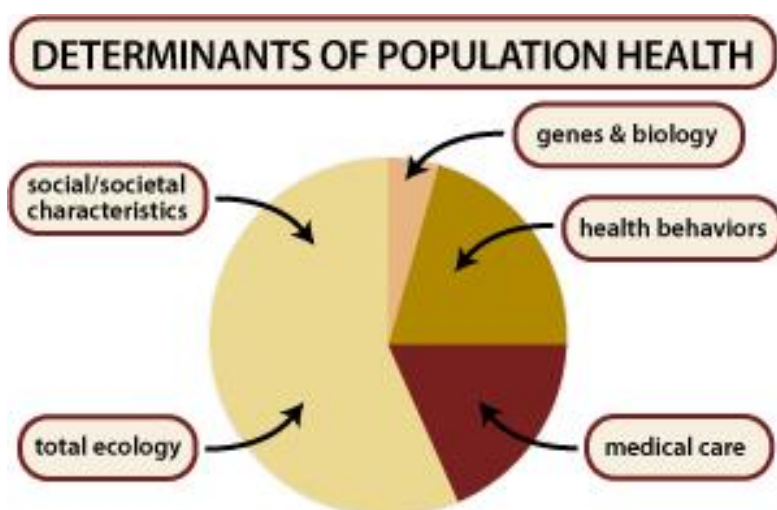
There are numerous resources that can provide background information on the social determinants of health.<sup>3</sup> It is understood that others have made submissions to this process, including the Social Determinants of Health Advocacy Network, of which TML is a member, and have provided some important examples of the current impact of inequalities in the major social determinants of health on health outcomes, and TML encourages the Committee to comprehensively review the range of information provided.

Figure 1 represents broad estimates of how much five determinants contribute to the health of a population. Whilst it is not possible to quantify the precise contributions of each determinant this diagram provides a crude proportional estimation of the impact that social factors have on health outcomes.<sup>4</sup>

The social determinants of health are shaped by the distribution of money, power and resources at global, national and local levels. They are significantly responsible for health inequities. Health equity is *'when everyone has the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance'*.<sup>5</sup>

Addressing the social determinants of health is a primary approach to achieving health equity. Social Determinants of Health such as poverty, unequal access to health care, lack of education, stigma and racism are underlying, contributing factors of health inequities.

**Figure 1: Determinants of Population Health**



It is well known that in Tasmania, our population is at increased risk of poor health as a result of disadvantage with respect to a number of social and economic conditions. For example, the most recently published Australian Bureau of Statistics (ABS) 2011 Census data<sup>6</sup> show that:

- the median weekly personal income for people aged 15 years and over in Tasmania was \$499 compared to \$577 nationally, for the household it was \$948 compared to \$1234 nationally
- the median weekly 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 weekly 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

<sup>3</sup> One example is: WHO 2003, *Social Determinants of Health – The Solid Facts*, 2<sup>nd</sup> edition, edited by Richard Wilkinson and Michael Marmot.

<sup>4</sup> Centre for Disease Control and Management website, Op-Cit.

<sup>5</sup> Ibid.

<sup>6</sup> ABS 2012, *2011 Census Quickstats, Tasmania*.

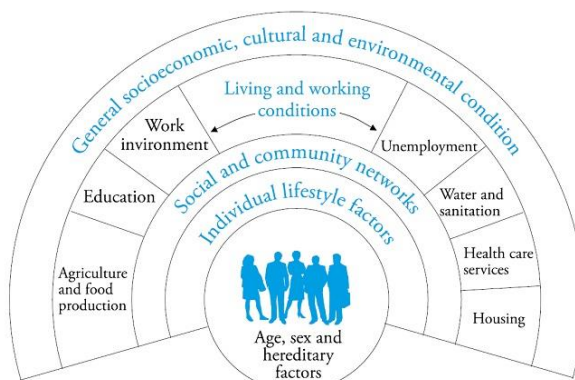
than \$600 and 5.4% (11.2% nationally) of households had a weekly income of more than \$3,000

- 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
- 36.5% of Tasmanians aged 15 years and over (no longer attending school) had completed Year 12 or equivalent, compared to 49.2% nationally
- most people travel to work by car (63.1% as a driver; and 6.8% as a passenger)
- 11.6% (compared to 10.9% nationally) provided unpaid assistance to a person with a disability
- 4% of the Tasmanian population are Aboriginal, compared to 2.5% nationally.<sup>7</sup>

## 1.2 Social gradients in health

If a social determinants of health approach is applied (as reflected in the model of health by Dahlgren and Whitehead, 1992<sup>8</sup> - Figure 2) to the data listed in 1.1 above, we can conclude that these data would place many Tasmanians at increased risk of poor health. In fact, research has confirmed this.

**Figure 2: Dahlgren and Whitehead's model of the Social Determinants of Health**



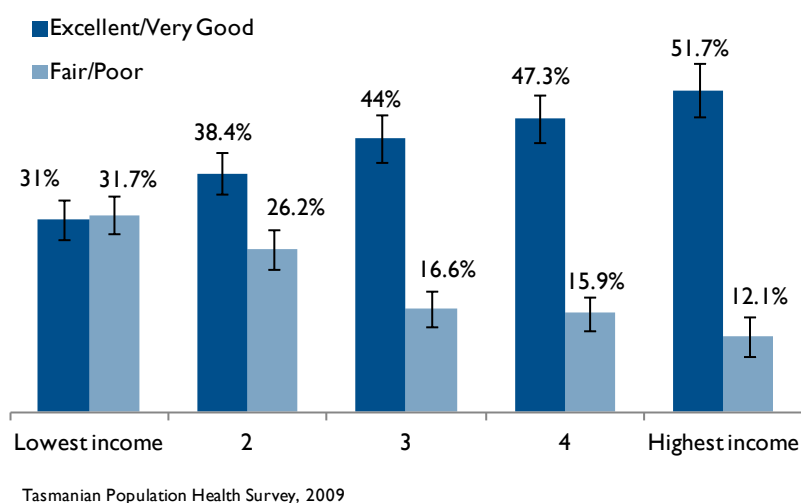
For example, the most recent *State of Public Health Report* (Tasmanian Department of Health and Human Services)<sup>9</sup> illustrates the relationship between household income and self-assessed health (Figure 3).

<sup>7</sup> Ibid.

<sup>8</sup> Dahlgren and Whitehead 1992, *Policies and strategies to promote equity in health*, WHO.

<sup>9</sup> DHHS 2013, *State of Public Health Report*, Tasmanian Government, p.18.

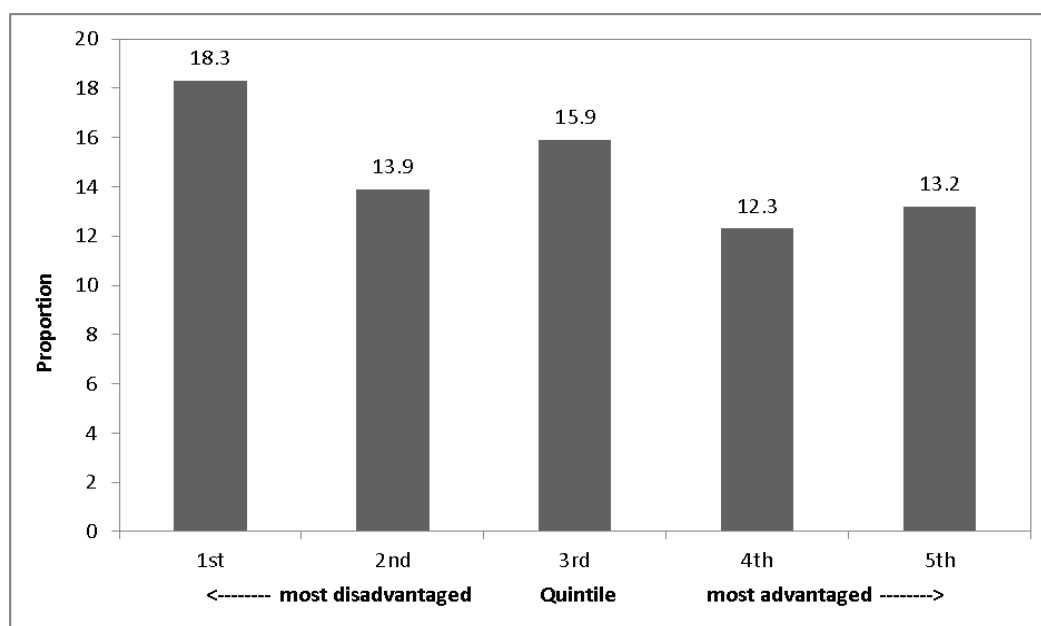
**Figure 3: Self-assessed health by household income quintiles, population 18 years and over, Tasmania 2009**



### 1.2.1 Mental health

The rate of mental health issues is higher among those in the most disadvantaged socio-economic group compared those in the most advantaged group (Figure 4).<sup>10</sup>

**Figure 4: Proportion of persons reporting mental or behavioural problems**



Similar relationships between social and economic factors and health outcomes have been demonstrated elsewhere.<sup>11</sup> What these data are essentially showing is that there is a '*social gradient in health*'. This means that people who are disadvantaged socially and/or economically usually run at least twice the risk of serious illness and premature death as those near the top.<sup>12</sup>

<sup>10</sup> ABS 2012, *Australian Health Survey: First Results 2011-12*, 4364.0.55.001.

<sup>11</sup> Such as the Menzies Research Institute 2009, *Tasmanian Population Health Survey*, University of Tasmania.

<sup>12</sup> WHO 2003, *Social Determinants of Health – The Solid Facts*, 2<sup>nd</sup> edition, edited by Richard Wilkinson and Michael Marmot.

TML has seen evidence of the impact of this in a number of ways. For example, in relation to mental health, there are an increasing number of clients accessing TML provided services for mental health problems and for many their circumstances are compounded by socio-economic disadvantage.

TML manages a number of programs aimed at improving the mental health of Tasmanians. These programs are funded under the Australian Government's Access to Allied Psychological Services (ATAPS) program, which provides access to effective, free or low cost treatment for people with a mental illness who may not otherwise be able to access services. We employ and engage (through commission) mental health clinicians including psychologists, mental health nurses and mental health credentialed social workers. Services are provided for adults and there are specialised services for children, women with perinatal depression and Aboriginal and Torres Strait Islander people.

Short-term psychological treatment (up to 12 sessions) is available for people with mild to moderate mental health issues (such as depression and anxiety) who are likely to respond to short term therapy. This service is available to people who may have difficulty getting to other services because of cost, transport challenges, distance from services or other barriers. Our suicide prevention service is available to people who have a mild to moderate risk of suicide. It is designed to help people who have had a suicide attempt and who are not clients of other mental health services.

TML is aware that our organisation is not the only ones feeling the pressure of increased demand for health care. We are acutely aware that both government and non-government health services as well as social services are under increasing pressure. Many do not have the capacity to address health care needs for patients or clients, let alone focus on prevention and promotion. This situation needs to change.

### 1.2.2 Rurality

Another key social determinant of health that TML is acutely aware of is Tasmania's dispersed settlement patterns. In reporting on the indicators of health status and determinants of health in rural, regional and remote areas, the Australian Institute of Health and Welfare (AIHW, 2008) states:

'Health outcomes, as exemplified by higher rates of death, tend to be poorer outside major cities. The main contributors to higher death rates in regional and remote areas are coronary heart disease, other circulatory diseases, motor vehicle accidents and chronic obstructive pulmonary disease (e.g. emphysema). These higher death rates may relate to differences in access to services, risk factors and the regional/remote environment'.<sup>13</sup>

The AIHW has reported:

- life expectancy decreases with increasing remoteness. Compared with major cities, the life expectancy in regional areas is 1–2 years lower and in remote areas is up to 7 years lower
- people in regional and remote areas were more likely than those in major cities to report an acute or chronic injury, to drink alcohol in quantities risking harm in the short term, or to be overweight or obese
- lower birth weights outside major cities were particularly marked for teenage mothers (those aged younger than 20 years)
- compared with those in major cities, people in regional and remote areas were less likely to report very good or excellent health.<sup>14</sup>

TML currently works to improve access to appropriate health services for people in rural areas, working with and contracting general practice, local government, Aboriginal organisations, aged care and community providers. Programs currently funded through TML in these areas include coordination

<sup>13</sup> AIHW 2008. Rural, regional and remote health: indicators of health status and determinants of health. Cat. no. PHE 97. Canberra: AIHW.

<sup>14</sup> Ibid.

services for people with complex chronic conditions, ATAPS mental health services as noted above, along with the Rural Primary Health Services programs targeted at addressing preventative health and primary health service delivery gaps in these areas.

### 1.3 Proportional universalism

Based on this evidence, we also encourage the Committee to look at action across the social gradient. Poor health is not just about those who are most disadvantaged in other ways - the social gradient in health runs right across society. Marmot (2010) advocates 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.”<sup>15</sup>

Within TML’s approach to addressing the social determinants of health there has been a determined effort to ensure that proportionate universalism is observed. This is implemented through not only funding disadvantaged communities to identify and work in partnership to improve the life choices and circumstances of individuals but also through the provision of training across all workforce sectors in Tasmania. Supporting all Tasmanians to understand and increase their ability to influence the social determinants works towards reducing the steepness of the social gradient in health by making it everyone’s business to observe and effect improvements in equity where they can.

### 1.4 Cost effectiveness of acting on the social determinants of health

Investment in Australia to address the social determinants of health has been modelled by the National Centre for Social and Economic Modelling (NATSEM).<sup>16</sup> The modelling, undertaken for Catholic Health Australia, found that addressing the social determinants of health would have significant economic, budgetary and social positive impacts. Possible impacts include:

- increasing the number of people self-reporting good health by 400,000 because they would be free from chronic illness
- increasing the number of people reporting satisfaction with life by an additional 120,000 Australians
- increasing levels of employment resulting from decreased rates of chronic illness potentially generating as much as \$6 billion in extra earnings by closing the self-assessed gap and increasing the number of people employed by 170,000
- decreasing health system usage and considerable savings to the health system - reducing PBS scripts by 5.3 million annually, reducing Medicare usage by 5.5 million services per year, savings estimated in the order of \$3-4 billion dollars if the prevalence of chronic illness of the most disadvantaged were at the same levels experienced by the most advantaged groups
- reducing the income and welfare support by \$2-3 billion per year.

This approach to assessing the cost of inaction on the social determinants of health is supported by a study<sup>17</sup> undertaken in the European Union by the EU Consortium for Action on the Socioeconomic Determinants of Health project DETERMINE. Reviewing ‘costs’ by including health and welfare costs offers a more complete picture of the costs of ill health.

Other key arguments presented in this research include the cost of healthy life expectancy which is estimated to reduce by five years due to health inequalities – a significant human cost. These inequalities also have significant economic implications when health is valued as a capital good.

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<sup>15</sup> Marmot M 2010, *Fair Society Healthy Lives*.

<sup>16</sup> Catholic Health Australia and NATSEM, 2012, *The cost of inaction on the social determinants of health are essential*.

<sup>17</sup> 23 DETERMINE, 2009, *Economic Arguments for Addressing Social Determinants of Health Inequalities*.



Inequality related losses are estimated at 1.4% of GDP by this research, a significant economic impost.

With regard to action, this research, like others, acknowledges health is largely determined by factors outside of the health system, requiring collaboration inter-sectoral effort. When considering monitoring and evaluation design of the THAP Social Determinants of Health Project this research also identifies several key challenges in assessing the cost effectiveness of future investments and the resultant health inequalities. Identified challenges include:

- attributing outcomes to interventions
- measuring and valuing outcomes
- incorporating equity considerations
- identifying inter-sectoral costs and consequences.

Local Tasmanian research undertaken by an independent academic<sup>18</sup> investigating addressing health inequity and subsequent improvement on the overall health status of Tasmania, highlights that a significant driver for the delivery of increased sustainable health services will reduce expenditure in both health and social expenditure and increased productivity. This research estimates the financial benefit is potentially \$500 million per annum for Tasmania. Consistent with the proposed Social Determinants of Health Project, the review recommends an investment approach that is built on collaboration, engaging communication and a commitment to clear outcomes that have the capacity to achieve sustainable solutions.

Ideally, projects will be developed at a local level by local people collaborating with multiple agencies. Organisations involved need to understand the root causes of disadvantage, have a culture to support successful outcomes and recognise the broader social value of success. While the approach and processes may not be unique, the work undertaken in each community is inherently unique as it reflects that local community and its characteristics. In building solutions the Social Determinants of Health Project is looking at existing models, processes and tools including resilience building frameworks that can be adapted and applied to health inequities

## 1.5 The way forward – Health in All Policies

TML strongly advocates for the adoption of a Health in All Policies (HiAP) approach in Tasmania, as the most strategic and sustainable mechanism for achieving the real and whole of system change required to effect health outcomes. We note the Tasmanian Chronic Disease Prevention Alliance is also supportive of the Tasmanian Liberal Government's Health in All Policies.<sup>19</sup>

This support is based on a plethora of research and recommendations that have been published on the social determinants of health. 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*.<sup>20</sup> In addition, the *Rio Political Declaration on Social Determinants of Health* made the following recommendations:

- Develop and support policies, strategies, programs and action plans that address the social determinants of health, 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 as a policy strategy, which targets the key social determinants of health through integrated policy response across relevant policy areas with the ultimate goal of supporting

<sup>18</sup> O' Loughlin Kevin, 2012, Health Inequity in Tasmania: avoiding the cost of doing nothing.

<sup>19</sup> <http://www.heartfoundation.org.au/driving-change/current-campaigns/local-campaigns/Documents/Final%20Submission%20from%20HiAP%20Collaboration%20to%20the%20SDoH%20Senate%20Inquiry.pdf>

<sup>20</sup> Commission on the Social Determinants of Health 2008, Op-Cit.

health equity.

- Build capacities among policy-makers, managers, and program workers in health and other sectors to facilitate work on the social determinants of health.
- Give due consideration to the social determinants of health 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.<sup>21</sup>

The 8th global WHO conference on health promotion, held in Helsinki in 2013, articulated the HiAP Framework in decisions regarding health promotion nationally and sub-nationally.

HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. As a concept, it reflects the following principles:

- legitimacy grounded in the rights and obligations conferred by national and international law
- accountability of governments towards their people
- transparency of policy-making and access to information
- participation of wider society in the development and implementation of government policies and programmes
- sustainability in order that policies aimed at meeting the needs of present generations do not compromise the needs of future generations
- collaboration across sectors and levels of government in support of policies that promote health, equity, and sustainability.

The Framework identifies a key role for the health sector, particularly to communicate effectively across and within sectors with politicians, civil servants, key civil society organisations and the private sector and sets out six key components that should be addressed in order to put the HiAP approach into action:

- establish the need and priorities for HiAP
- frame planned action
- identify supportive structures and processes
- facilitate assessment and engagement
- ensure monitoring, evaluation, and reporting
- build capacity.

Howard and Gunther (2012)<sup>22</sup> published findings from their examination of key themes for the successful implementation of a HiAP approach. These included:

1. **Leadership** – Explicit political commitment to HiAP at the highest possible level.
2. **Governance and strategy** – It is advantageous to have an overarching high-level strategy that specifically endorses HiAP approach. This can help to overcome divisions when there are apparent conflicting objectives between sectors. It can help to identify common aims across government, and support the use of resources to implement a wider HiAP approach.
3. **Partnership and stakeholder engagement** – Working effectively with a wide range of partners is essential. Including stakeholders by using a community participation approach is a critical factor in a successful HiAP approach.
4. **Capacity and technical skills** – Building skills and capacity both within and external to the health sector is seen by most as essential to the development of HiAP.
5. **Health equity** – A greater understanding is needed of the differences between health equality and health equity, and better data are needed to be able to understand health inequalities at a

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<sup>21</sup> 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.

<sup>22</sup> Howard R & Gunther S 2012, *Health in All Policies: An EU literature review 2006 – 2011 and interview with key stakeholders*, Equity Action.



national and local level.

6. **Tactics** – Identifying win-win approaches, where there are clear and evidence based co-benefits to health and other policy areas, is a fruitful area for implementation of HiAP.<sup>23</sup>

Consistent with WHO policy frameworks, the current Tasmanian Government has indicated that it is committed to establishing Health in All Policies. The Tasmanian Liberal Government plan to build A *Healthy Tasmania* identifies as a priority identifying and bringing together funding streams, resources, skills, experience and programs with a single focus whole of government, whole of community health in all policies approach. This approach has the ultimate aim of improving the health of Tasmanians, and to keep Tasmanians healthier for longer.

Such an approach provides significantly greater opportunities for integrated and comprehensive approaches to addressing health and wellbeing issues. Through recognising the breadth of stakeholders involved in this work, from the communities themselves, large state government departments through to general practice and primary care providers working in communities on a daily basis, and engaging with these resources can achieve joint leadership and action on the social determinants of health. This moves the accountability for action out of a single organisation, to enable coordinated efforts and such as the place-based approaches as described below.

## 1.6 Health Literacy

Health literacy is more than being able to read and understand information about health. It is the knowledge and skills needed to find, understand and use information about physical, mental and social wellbeing.

Around 59 per cent of Australian adults do not have enough knowledge and skills to understand and use general information about health and wellbeing. In Tasmania, this figure rises to around 63 per cent of adults.

People who are not health literate are more likely to experience avoidable illness, injuries, hospital admissions and medication and treatment errors. They also find it harder to access the health and community services they need, and are less likely to use preventive health services including cancer screening and immunisation.

Health literacy has a big impact on whether Tasmanians get the most out of the health services they need, as well as the efficiency and effectiveness of health services. Any strategies identified with a focus on health risk factors and social determinants of health should include health literacy as a priority consideration.

TML is working with the Tasmanian Department of Health and Human Services (DHHS) and the School of Health Sciences within the University of Tasmania's Faculty of Health to undertake a Health Literacy Project. The project will help health and community workers lessen the impact of low health literacy through greater awareness, a deliberate focus on the quality of communication and health information, and by including health literacy considerations in their daily work practices.

TML has committed to developing the capability of its staff to help make a difference to the impact of poor health literacy by improving the way it communicates on health issues via publications, health brochures, information presented on our website and by direct contact with clients via care coordination and clinical services.

TML is a member of the 26TEN which is a network of business, community and Government individuals working together to improve adult literacy.

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<sup>23</sup> Ibid.

## 2.0 Term of Reference 2: A preventative health care model

### Recommendation 3:

The Tasmanian Government:

- work with TML and other key stakeholders to recognise the role of general practice and other primary care providers and focus on building a strong primary health care system in Tasmania that places health equity as a central goal.
- utilise the many opportunities existing under the Tasmanian Health Assistance Package to leverage intensive work occurring in this area and to set the system on a course for recovery.
- embed a requirement in all service planning processes to prioritise the development of integrated cross-sectoral models of care weighted ahead of siloed or regionalised service systems.
- ensure that service redesign efforts across primary, secondary and tertiary care within the Tasmanian health system need to be based upon a commonly understood and defined set of health pathways incorporating preventative health as a key focus.
- undertake workforce redesign based upon agreed and established health pathways occurs as a subsequent process in the system redesign program.
- focus on evidence-based investment and dis-investment, along with continuous evaluation and monitoring of integrated preventative health strategies to enable long term measurement of health outcomes.

TML supports the need for an integrated and collaborative prevention oriented primary health care model that focuses on the prevention, early detection and early intervention for chronic disease.

The past ten years have seen historically high levels of resourcing and investment in prevention by successive Australian and Tasmanian Governments. More recently, governments have experienced increasing fiscal constraint.

In spite of this increased investment, Tasmania has experienced a relative lack of progress in improving lifestyle risk factors and chronic disease compared with other jurisdictions.

Tasmania continues to have high rates of smoking, poor nutrition, excess alcohol intake, physical inactivity and childhood and adult obesity and has made the least progress of all jurisdictions according to successive National Health Surveys (ABS) (see Appendix 1).

Tasmania has higher rates of multi-morbidity (three or more self-reported chronic conditions) than any other jurisdiction and has age standardised mortality rates that are higher than the Australian age standardised mortality rates for a number of conditions. These include cancer, diabetes mellitus, ischaemic heart disease, strokes and intentional self-harm.

TML has concerns that currently within Tasmania's health care system, primary health care is being eroded through misguided reactionary responses to tertiary unsustainability and system overload which result in reallocation of scarce resources to easily measurable and definable outputs such as elective surgery. Preventative efforts are being marginalised and sustainable health promotion initiatives are virtually non-existent. Indeed the withdrawal of Australian Government funding through the National Partnership Agreement on Preventative Health has left a hole of \$8.5 million significantly impacting the capacity of community organisation to support actions. As stated by Baum et al (2009), *'There is growing international evidence of better population health outcomes and cost reductions in*

*instances in which economic incentives are created for community-based preventive health care provision rather than individual curative care provision.*<sup>24</sup>

If the Tasmanian Government was to develop a preventative health care model, TML asserts that it needs to have a strong focus on health equity. Some of the characteristics of a health equity-oriented health care sector include:

- focusing on comprehensive primary health care
- decision making processes that involve local communities
- planning including allocation of resources, based on the needs of populations within a social determinants of health framework
- presence of health sector advocacy programs
- training of the health workforce in the social determinants of health.<sup>25</sup>

TML advocates strongly for a balanced and scientific approach to system redesign and reinvestment that effectively targets activity at efforts resulting in long-term reductions and demands for tertiary intervention. This includes a stronger focus on evaluation of the effectiveness and cost-effectiveness of health promotion initiatives and preventive health services which are funded and / or provided by the Tasmanian Government to monitor performance across relevant quality domains. This will assist in evidence-based decisions regarding investment and disinvestment.

## 2.1 Preventative health care and the social determinants of health

The importance of preventative health efforts being founded on addressing the social determinants of health is also emphasised. Project based methodologies focussing in isolation on 'problem bits' of the system fail to acknowledge the pervasive and lifelong influences associated with the lived and built environment. All too often, we see health promotion and preventative efforts limited to healthy lifestyle interventions and behavioural approaches and while we absolutely believe that this is part of the broader picture, as clearly shown above, we must also prioritise action on *'the causes of the causes'*.

A recent presentation by Duckett (2013)<sup>26</sup> highlights why this is important:

'And if you just use diabetes as an example, people who live in the poorest areas of Australia, the lowest 20 per cent of areas of Australia, have more than two-and-a-half times the risk of getting diabetes relative to people who live in the top 20 per cent of areas.

That difference in risk between a 2 per cent chance of getting diabetes if you live in the best areas versus a 5 per cent chance in the worst areas is a much more significant difference than, say, so-called behavioural factors such as exercise, which is 6 per cent if you are high to moderate exercise person versus 8 per cent if you are sedentary risk of getting diabetes. It's much more important than alcohol, and even more important than obesity.

To understand diabetes, for example, you cannot understand the risk of getting diabetes if you don't start by thinking about the broader social factors. And so it shouldn't be possible to develop, for example, a diabetes strategy in Australia without first starting with a social determinants approach, without starting with those broader factors.

But if you look at the Department of Health and Ageing website today, it refers to lifestyle-related chronic disease as the determining factor or one of the critical factors, and so that suggests to me that we in our health policy are applying the wrong frame as a starting point.

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<sup>24</sup> Ibid, p. 1971.

<sup>25</sup> 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.

<sup>26</sup> Duckett S, (Grattan Institute), Speaking at the launch of the Social Determinants of Health Alliance, Canberra, February 2013.

The old paradigm of this was behavioural risk factors led to disease and the intervention was to change the behaviours. But we've got to recognise those behaviours in many case are shaped by the social determinants – the areas in which you live, the income you have and so on. And so we need, in our policies, to be focussing more upstream in that regard.'

In TMLs experience with the Health Risk Factors Projects there is a growing observation that the poor health of various groups of people living in our communities could be avoided if circumstances were fairer. Early findings from the Health Risk Factors Project is showing supporting evidence that poor health outcomes resulting from inequity are caused by:

- Unhealthy behaviours where the degree of choice to make healthy choices is restricted
- Exposure to unhealthy living and working conditions
- Inadequate access to essential health and other public services
- The tendency for unwell people to move down the social scale.<sup>27</sup>

One of the many challenges for Tasmania is to understand and address health equity in order that Tasmanians are not unfairly disadvantaged in achieving better health outcomes. An approach that considers health equity can ensure services and resources are provided to the right people at the right time in the right way. A health equity lens is key to redesigning services, reallocating resources, improving the social gradient and improving health outcomes.

Health inequity is one of the biggest challenges faced by Tasmania and is highlighted by the differences between Tasmanians and other Australians across a number of indicators and measures. Tasmania often falls behind the nation on many important health and lifestyle measures including the health risk factors identified in this plan (see Appendix 1).

By applying a health equity approach to addressing risk factors, such as obesity, alcohol and tobacco, healthy choices should be physically, financially and socially easier and more desirable choices relative to the less healthy choices.<sup>28</sup> This approach has the potential to re-orientate organisations and services and focus on longer term outcomes.

## 2.2 Investment in preventative health care across the care continuum

Increased focus is needed to embed a preventative health approach across the care continuum.

This requires:

- reorientation of service redesign focus from acute care demand management strategies, to a primary focus on client needs for managing their health and/or chronic condition. This will provide a greater, more balanced focus on evidence-based lifestyle risk factor reduction, a more strategic focus on preventing and reducing the impacts of chronic disease on individuals, communities and the health system. From this basis, it will be possible to identify and re-align the associated type and location of resources to support for priority client focused care needs, which includes access as necessary to acute episodic care
- embedding a preventative health care approach across all parts of the health care continuum, that moves beyond services responding to presenting issues, to a more robust focus on broader coordinated care planning and building a preventative health approach regardless of the type or location of care delivery
- strengthen and appropriately resource the targeted approach to 'upstream' preventative health care. The current health service system remains largely focused on those clients who already have a chronic condition, or who are acutely unwell. Increased focus is required at the very

<sup>27</sup> Department of Health and Human Services, 2011, A Fair and Healthy Tasmania Strategic Review.

<sup>28</sup> 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.

least initially, on targeted care for clients identified as 'at risk' of developing a chronic condition', and ultimately on strengthening the focus on preventative health strategies with the broader population, in order to produce any true longer term change to health outcomes and existing service system pressures.

Critical to this work will be the ability make resource decisions based on evidence of the cost effectiveness of preventative health strategies. For example, the Assessment Cost-Effectiveness in prevention (ACE-Prevention)<sup>29</sup> study, referenced at Appendix 2, provides an overview of the evidence of the cost effectiveness of preventative interventions across a number of lifestyle risk factor, varying from regulatory interventions to program based activities. Such evidence provides a useful foundation for reviewing the success of existing preventative strategies in terms of cost and likely effectiveness.

## 2.3 The role of general practice and primary care providers

Achieving a broadened preventative health approach will required greater interface with, and integrated efforts across health services as evidence-based settings for effective health promotion and anticipatory care. This approach provides significant opportunities to acknowledge and engage with general practice and primary care providers as key drivers and influencers in addressing health risk factors through their essential functions in screening, assessment, early intervention and management of health risk factors and chronic conditions. This will require:

- evidence-based health promotion that targets lifestyle risk factor reduction and the prevention and management of chronic diseases to be more inclusive of general practice and other health services as a key setting for preventive action
- better integration within the general practice environment in the delivery of evidence-based health promotion, early intervention and secondary prevention with a particular focus on lifestyle risk factors and chronic conditions is a sound strategy supported by evidence.
- health promotion providers working with general practice and the broader primary health and social care system to identify the resources and referral pathways required for providers to direct at risk Tasmanians to locally-based lifestyle change programs, services and information.

## 2.4 Cross sector coordination and investment

Improved health and wellbeing requires enhanced collaboration both within the health sector and in partnership across sectors including:

- improved coordination of effort within local areas to maximise funding and workforce resources available across a range of health providers, including government, community based organisations, private providers, community groups and carers
- the health sector working with other sectors to embed a preventative health approach, with examples including: curriculum development in schools, and improved allocation of resources and focus on 'health' as part of Workplace Health and Safety Policy, working with local government to improve physical environments for health and wellbeing activities and services access.

An example of TML's cross sector approach to preventative health is in the area of immunisation. TML works as part of the policy and evidence based approach provided by the Tasmanian Department of Health and Human Services (DHHS) in relation to immunisation and has a specific role to support general practice through education and resources as part a collaborative efforts to maintain Tasmanian's high immunisation rates. Taking access to immunisation a step further in line with the impact of the social determinants of health, for the past two years TML has also worked with these

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<sup>29</sup> NHS Scotland. Best preventive investments for Scotland - what the evidence and experts say. December 2014.

organisations and crisis accommodation providers to offer flu vaccinations for people living at these facilities, who are identified as a group who are at increased vulnerability for influenza.

Our collaborative work with the National Stroke Foundation (Tasmania), Heart Foundation (Tasmania), Diabetes Tasmania and TML to develop integrated pathways for health risk factor awareness raising, identification and management is further evidence of the importance of working collaboratively to improve the efficiency and effectiveness of risk factor approaches. A separate submission has been provided to the Committee providing more details on this integrated approach.

## 2.5 Evidence-based and sustainable resource investment

For many years, the strong evidence of the need for enhanced and long-term focus on preventative health strategies has been acknowledged. However, access to resources for these strategies has struggled to compete for resources within an environment of acute service demand.

Where resources are provided, they are often allocated for specific issues, population groups or activities and with significant time and funding constraints. Targeted resource investment and dis-investment is required that:

- is informed by evidence – a key preventive health priority for Government is to collect, monitor and report against indicators of chronic disease and associated risk factors, as well as other measures of population health status. This data is required to inform and evaluate public health status and the associated integrated preventive health strategies and health service provision in Tasmania
- moves beyond specific conditions or lifestyle behaviours and enables consideration of the broader 'causes of the causes', as discussed in this document
- provides resources for timeframes that enable investment over the longer periods of time required to implement and evaluate preventative health strategies that in many cases, may only be demonstrated over generations
- embeds a requirement in all service planning processes to prioritise the development of integrated cross-sectoral models of care weighted ahead of siloed or regionalised service systems.

## 2.6 Strengthening individual contribution to health and wellbeing

There is a need to invest in people's understanding of their contribution to their own health and wellbeing. This is required as a fundamental strategy to support service redesign, to facilitate a shift in public focus. For example, increasing understanding on the importance of access to improved strength and fitness programs as part of falls prevention, rather than the current well established focus on hospital waiting lists for orthopaedic surgery.

Improving health literacy is central to this change as noted in section 1.6, but also, vitally, is supporting people's capacity act on improving their health, through addressing the social determinants of health, as described within this document.

## 2.7 Workforce Redesign

The changing nature of health care, along with significant workforce shortages requires review of a health workforce that has been largely historically based, particularly for government based services that form a large component of the Tasmanian health workforce. Such a review includes:

- Improved service communication systems to support the role of general practice as core providers for people in health prevention, early intervention and chronic conditions management.

- Improved targeted access to health professionals where there are current service gaps, including, but not limited to, exercise physiologists, diabetes educators and dieticians.
- Establishment of new roles complementing the existing workforce, to better support and target care, such as advanced care practitioners (nursing and allied health), and allied health/primary care assistants.
- Improved understanding and resourcing of care coordination, to support early intervention and management of people with chronic conditions.
- Improved understanding, collaboration and role delineation with broader service providers who often contribute to health care, including human services, transport services and local government.

The Tasmanian Government must take heed of such advice. Building a strong primary health care system in Tasmania is the core business of TML. TML welcomes the opportunity to work closely with the Tasmanian Government to this end.



## 3.0 Term of Reference 3: Structural and economic reform

### Recommendation 4:

The Tasmanian Government, in partnership with its community, the non-government and private sectors:

- develop a Health Equity Policy for Tasmania, and a statewide, long-term, whole-of-government plan for reducing health inequities through action on the social determinants of health. Such a plan should be informed by the recommendations of the World Health Organisation 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.
- consider place-based approaches as a key mechanism for actioning a HiAP approach.
- in implementing a HiAP consider the Department of Premier and Cabinet as the most appropriate leadership for social determinants of health, with associated mandate, priorities and accountabilities for driving whole of system change.
- identify key strategies such as implementing funding guidelines that include addressing equity as a criteria and indicator for measurable outcomes and outputs to action the HiAP approach.

### 3.1 The current situation is unsustainable

In addition to Tasmania's poor performance on many social determinants of health indicators (discussed in more detail in section 2.0), factors such as the rising incidence of chronic conditions and Tasmania's ageing population are placing increased demand on health care services. Financially and ethically this situation is not sustainable.

The problem is not unique to Tasmania and we can take leads in this state from action in other states including in South Australia whose Department of Health recognised this situation some years ago, stating the following:

*'Governments are becoming increasingly concerned that these health care costs are consuming an ever increasing proportion of their country's gross national product, while their revenue base is being eroded through demographic developments such as the ageing of the population. These factors are driving an urgent need to contain the growing cost pressure of ill-health on the limited financial resources of countries.'*

*The SA health budget currently consumes close to 30% of the total state budget. In ten years this will be 50% and without change, health will consume the entire state government budget in less than 25 years (see Figure 1). Much of the increase in health expenditure is related to the rising prevalence of chronic illness conditions. This is clearly unsustainable and a new approach to improving the health and wellbeing of the population is needed.'*<sup>30</sup>

It is clear from any level of scrutiny that our current growth and spending trajectories in Tasmania will render the State with a completely unaffordable and unsustainable system within the next few years.

<sup>30</sup> Department of Health (SA) 2011, *The South Australian approach to Health in All Policies: background paper and practical guide*, Version 2, p. 9.



Tasmania literally cannot continue to ignore the social determinants of health when considering the health and wellbeing of the community, the crisis in health care expenditure, and assuring the health and wellbeing of future generations. There is a sound evidence base that enables us to argue that the way forward must involve a stronger focus on health equity, addressing the social determinants of health, and building a stronger primary health care system so as to keep people out of hospitals.

Other desired goals in our society gain more attention, such as the need to build a healthy economy is important for Tasmania (in fact, this will also contribute to better health outcomes), but this should not come at the expense of recognising that the health and wellbeing of people more broadly is the most important outcome of all. Health clearly must be Tasmania's central goal. As Duckett (2013) states,

*'I'm talking about policies which are not "instead of"...., but "as well as" policies. So focussing on growing the economy is not instead of developing the issues of the social determinants report of the WHO.*

*'And so my argument here is this: When we think about the social determinants, we don't think about just this terrible burden on society that is going to cause a whole lot of problems and cost the government a whole lot of money we can't afford.*

*What we should be talking about is this – we can do both. We can in an economically rational way improve the economy, and in so doing, we can improve the life situation of people who are affected by this and in so doing we can start to address the social determinants. I'm not saying this is instead of the other issues – the health in all policies approach and so on. This is as well as, it is an economically sensible way. Don't say we can't afford to do it, because we can.'<sup>31</sup>*

### 3.2 Addressing the social determinants of health within the health system

TML is concerned that for too long, the responsibility for the social determinants of health has been confined to the health system. As evidenced by the HiAP, this approach is unlikely to achieve the desired outcomes. The reduced likelihood of success is further challenged by the fact that the decisions and initiatives that have shaped the health system and are driving change have been confined to the acute care sector. The reality is that the acute system is only one part of the broader health care system.

To provide true leadership and action on the determinants of health within the health context, we urge the Tasmanian Government to engage meaningfully with a broad cross-section of primary and tertiary health care providers. This will enable service planners and managers to build a system that enacts the mantra of right care, right place, right person and right time. Furthermore, a collaborative approach will help maximise use of available health infrastructure to its fullest extent.

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

*'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<sup>32</sup> (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*

<sup>31</sup> Duckett S 2013, *Time to ditch the old paradigm of risk factors and behaviours (take note diabetes strategy)*, presentation at launch of Social Determinants of Health Alliance, Professor Stephen Duckett, Grattan Institute, February 2013.

<sup>32</sup> 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.

*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.'*

Clearly structural and economic reform is required to address this situation within the health system, in order that health can continue to be a driver for change as part of the broader group of leaders engaged as part of a HiAP approach.

### 3.3 Addressing the social determinants of health beyond the health system

Stakeholders both within and outside the health sector have worked hard to address social determinants of health. This has been a necessary and welcome focus of the state's preventive health efforts over the past ten years. However, there are continuing and important opportunities to strengthen stakeholder leadership of the social determinants agenda, both within and beyond the health system. The HiAP approach referenced earlier at section 1.5 that supports whole of government, whole of community social determinants action is a preferred approach.

To take effective action, Tasmania's response to addressing the social determinants of health should therefore be led both within and beyond the health portfolio. A broadened scope of social determinants activity that is more reflective of all of the WHO's intervention areas and inclusive of a whole of government Health in All Policies approach should be pursued.

The maturation of the health sector's social determinants program of work over time provides the opportunity for this body of work to be transitioned to a leadership body, such as the Department of Premier and Cabinet, who has overarching responsibility for whole of government action in the many policy areas that affect social determinants of health. This transition should occur with clear mandate, priorities and accountabilities for leading this important work that flow to the multiple agencies involved in this whole of government approach.

This transition provides the opportunity and requirement for the health system to continue to demonstrate leadership in this area, but as a key system partner, not in isolation. Additionally, it provides opportunities to drive partnership with broader private, non-government and community partners in addressing the social determinants of health.

With appropriate policy infrastructure for addressing health inequalities in place, the Tasmanian Government, in partnership with its communities, the non-government and private sectors, will be able to implement mechanisms that will lead to long-term, sustained improvements in health and wellbeing outcomes for Tasmanians.

### 3.4 Place-Based Approaches to Addressing the Social Determinants of Health

Critical to the success of policy initiatives is the implementation approach. The HiAP, not only provides an opportunity for shared leadership and accountability for improvement, a whole of system approach also lends itself to change being implemented using place-based approaches.

The rationale for using place-based approaches advocates that places shape people's health and wellbeing. Feeling connected and having social networks contributes to wellbeing and locational disadvantage can lead to a 'disabling social environment' and the collapse of the economic environment in some locations.<sup>33</sup>

Similarly in light of the WHO recommendations for addressing the social determinants of health, recent work undertaken by the Tasmania Department of Health and Human Services<sup>34</sup> also advocated for place-based approaches.

Place-based approaches:

- are designed in response to the unique needs of locations
- engage local stakeholders across all sectors in collaborative decision making and governance
- seize opportunities particularly local skills and resources
- evolve and adapt to new learning and stakeholder interests
- are transparent and accountable to local communities
- encourage collaborative action by crossing organisational borders and interests
- pull together assets and knowledge through shared ownership
- attempt to change behaviour and/or social norms in a location
- should be supported by social policy and legislative interventions that help build supportive environments.

The combination of poor health outcomes in particular locations across Tasmania and the social determinants of health associated with these areas suggest that addressing locational disadvantage is a necessary and valid response. Similarly where multiple complex issues occur, multiple agencies and community members should combine in a collaborative process to work towards making a difference.

The success of place-based approaches is dependent on:

- sufficient resourcing
- strong relationships between stakeholders
- community participation, ownership and leadership
- skill and capacity building
- adequate time for outcomes and impacts to occur
- support by government
- respond to local needs and must be measured and evaluated.

TML has focused efforts on supporting place-based approaches to preventative health through a number of initiatives. These include Social Determinants of Health Project, as described in the introduction, along with initiatives such as the Smoking Cessation Program grants pilot program funded through neighbourhood houses, Child and Family Centre and Local Government in 2013-14, working with local service providers to develop skills in smoking cessation brief interventions, offering community programs and access to cessation aids for participants.

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<sup>33</sup> Moore, T.G. and Fry, R. (2011). *Place-based approaches to child and family services: A literature review*. Parkville, Victoria: Murdoch Children's Research Institute and The Royal Children's Hospital Centre for Community Child Health.

<sup>34</sup> Department of Health and Human Services Tasmania, 2012, *Place-Based Approaches to Health and Wellbeing Issues Paper*.

### 3.4.1 General practice

As detailed in Terms of Reference 2, the role of general practice as a key setting for driving change in preventative health and the social determinants of health cannot be underestimated. In developing and implementing policy, this place based resource should be considered and appropriately resourced as a critical contributor and driver at individual and local community level.

TML's provider support program actively supports general practice in its role in preventative health through the development of education and resources such as Absolute Risk Guidelines to support their role of screening, early intervention and management of health risk factors and chronic conditions.

### 3.4.2 Local government

Local government could be a critical stakeholder in addressing the social determinants of health. The key legislation that establishes the powers and function of local government in Tasmania is the *Local Government Act 1993*.<sup>35</sup> It currently states that council's role is to provide for the health, safety and welfare of the community, represent the interests of the community and provide peace, order and good government of the municipal area.

In recent years there has been an increasing interest in local governments in Tasmania and the role the sector can play in expanding their mandatory health protection role to encompass a broader health promotion approach. Currently health promotion is not a statutory requirement for Tasmania's local government and hence there is no reporting attached to health prevention activity. Consequently resourcing of health and wellbeing initiatives is inconsistent and largely reliant on external funding.

The Healthy Communities Initiatives, for example, were funded by the Department of Health and delivered by the Cradle Coast Authority, Southern and Central Midlands Councils and Glenorchy Council. These initiatives worked towards addressing personal behaviours that increase physical activities and improve healthy eating. However, in other unfunded locations there is little or no activities as councils are not sufficiently resourced to act.

Research conducted in Tasmania and nationally,<sup>36</sup> including local governments throughout Tasmania, has found a high level of willingness to adopt practices and policies that support improving health and wellbeing. This research and others<sup>37</sup> have identified several barriers and facilitating factors<sup>38</sup> that will support local governments to act in the future.

The findings signal a level of interest in delivering place-based projects within local government in Tasmania when adequate resourcing is provided and the model allows communities to have a high level of influence over prioritising and developing plans to drive change. Local government should be encouraged to form partnerships with other key community organisations for the projects. Local government is a critical stakeholder for the success of the projects and may take a lead role in community projects. Additionally, other lead agencies may include Rural Primary Health Services, Community or Neighbourhood Houses, community sector and ultimately service delivery.

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<sup>35</sup> Heart Foundation Tasmania, 2011, Review of Local Government Health Promotion Initiatives in Tasmania <http://www.heartfoundation.org.au/SiteCollectionDocuments/Review%20of%20Local%20Government%20Health%20Promotion%20final%20summary%20report%20August%202011.pdf>

<sup>36</sup> Allender S et al., 2009, Moving beyond rates, roads and rubbish: How do local governments make choices about healthy public policy to prevent obesity? Australia and New Zealand Health Policy. 6:20.

<sup>37</sup> Capon AG, Blakely EJ, 2007, Checklist for healthy and sustainable communities. New South Wales Public Health Bulletin 18 (4): 51-54.

<sup>38</sup> Ashe et al., 2007, Local venues for change: Legal strategies for healthy environments. Journal of Law, Medicine and Ethics. Spring:138-147.

## 4.0 Term of Reference 4: Experience and expertise

### Recommendation 5:

The Tasmanian Government:

- utilise the sound body of work that has been carried out to guide action on the social determinants of health, such as reports and recommendations published by the World Health Organisation
- implement strategies to raise awareness of the social determinants of health across state government departments, as well as in partnership with the non-government sector and the wider community
- invest in health economics expertise to guide action in Tasmania
- provide training and support to set best practice standards for capacity building, commissioning and governance processes when funding programs to improve equity.

It is difficult for TML to comment on the extent to which experience and expertise in the social determinants of health is appropriately represented on whole of government committees or advisory groups, however overall we believe that collectively we need to develop a deeper understanding of the social determinants of health in Tasmania and the best ways forward. There is a significant body of literature that can assist the Tasmanian Government to move forward on this agenda, such as that undertaken by the WHO, as mentioned earlier.

Importantly, the collective relevance of such recommendations within the Tasmanian context must be recognised. TML refers the Committee to Tasmania's experiences with Tasmania Together as a model for comprehensive engagement with our citizens on a broad range of issues.

Whilst the Tasmania Together experience may be judged as unsuccessful by some this is more likely attributable to the fact that some priorities and targets were not adequately addressed, prioritised or resourced.

TML recognises the broad spectrum of stakeholders that should be involved in making decisions about health and wellbeing outcomes for Tasmanians, including its citizens. TML believes that it is important to develop the knowledge of our citizens and refer to the value of citizen's juries (elaborated in section 5), which aim to develop a critical awareness among participants, while at the same time engaging them in making decisions about their health needs.

### 4.1 Capacity Building as a lever for change

Embedding community capacity building in the planning and implementation of place based approaches to address the social determinants of health is essential for creating responsive, functional and effective community systems. This will enable community organisations and actors to successfully fulfil their role of contributing to health outcomes.

Core components should include:

- **Enabling environments and advocacy** - including community engagement and advocacy for improving the policy, legal and governance environments, and affecting the social determinants of health.
- **Community networks, linkages, partnerships and coordination** – enabling effective activities, service delivery and advocacy, maximising resources and impacts, and coordinated, collaborative working.

- **Resources and capacity building** – including human resources with appropriate personal, technical and organisational capacities, financing (including operational and core funding) and material resources such as infrastructure, information and essential medical and other commodities and technologies.
- **Community activities and service delivery** – accessible to all who need them, informed by evidence and based on community assessment of resources and needs.
- **Organisational and leadership strengthening** – including management, accountability and leadership for organisations and community systems.
- **Monitoring and evaluation planning** – including monitoring and evaluation systems, situation assessment, evidence building, and research, learning, planning and knowledge management.<sup>39</sup>

The role of governance in addressing the social determinants of health with a place-based approach has been highlighted as essential. Recent research undertaken by the Rowntree Foundation<sup>40</sup> in the UK identified some key recommendations for local governance groups managing place-based work to adopt when addressing poverty. The Foundation believes that current practice using a place-based approach can be strengthened when the poverty lens is more rigorously applied to local planning and solution building. These recommendations are worthy of consideration in the design and implementation of the proposed projects or alternatively act as a 'check list' against which to measure performance where resolving the drivers of poverty is an objective. Recommendations include:

- **Service design and commissioning** – identify partners to establish community budgets, design services around outcomes, identify service opportunity for co-delivery, identify the wider benefits and gather business intelligence.
- **Governance and strategy** – undertake poverty assessments and adopt addressing poverty as a corporate objective, train staff in embedding poverty considerations and undertake a collaborative review of each partner's role in addressing poverty.
- **Procurement** – adopt targeted recruitment and training practices, simplify the procurement process and share corporate priorities with potential supply chains and embed poverty considerations into tender criteria.
- **Delivery** – continually monitor the contribution towards poverty outcomes; influence the behaviour of the existing supply chain, and join up governance arrangements and partners.

TML's work with Tasmania's neighbourhood houses through this Connecting Ideas and Processes project is an example of working with local community resources to strengthen their capacity to plan and deliver programs in local communities. The project supported access to training focused on community development planning and evaluation, identifying priority health needs and community consultation and included a small grants program for houses to then apply their new skills. Working in this way not only provides an injection of resources for the local community, it provides an opportunity for continued relationship and network development and access to shared information that continues to build the health profile of local communities to inform future planning and responses.

<sup>39</sup> World Health Organisation, 2010, Community Systems Strengthening Framework (Global Fund to Fight Aids, Tuberculosis and Malaria Collaboration).

<sup>40</sup> Joseph Rowntree Foundation, 2013, Addressing Poverty through Local Governance.



## 4.2 Opportunity to strengthen commissioning in Tasmania

There is an excellent opportunity for the Tasmanian Government to partner with the new Primary Health Network (PHN) once it is established in Tasmania from 1 July 2015 by the Australian Government, regardless of the provider. The core functions of the PHN will be to reduce preventable health services presentations and to support people with chronic conditions to manage their conditions better, underpinned by a focus on population health planning.

The PHN will be a commissioning entity. Commissioning for prevention is well established in the UK, where the National Health Service (NHS) has incorporated a population health planning approach into the distinct steps for governance planning, policy and framework development and skills and capacity planning for commissioning in health. Co-commissioning provides the opportunity to target people with the most disadvantage rather than further worsening inequalities.

In order to reduce duplication of preventive health effort and enable the efficient use of preventive health resources, there would be benefit in the Tasmanian Government developing a commissioning partnership with the PHN (once established). Co-commissioners should commission the delivery of preventive health services and programs using the results of population health status assessment and program evaluation to determine priorities for commissioning evidence-based, effective preventive activities and disinvestment in preventive activities not shown to be effective.

An important distinction between commissioning and procurement is the focus of commissioning on health outcomes and health system change. For example, were co-commissioners to commission a 10% reduction in smoking rates in pregnant women in the local community, providers could themselves determine the most suitable strategies to implement to achieve the commissioned outcome. That is, the commissioner tells the provider what to achieve, not how to achieve it.

As noted above, local government, general practice and other community organisations are logical provider groups from whom preventive health programs and services could be commissioned.

## 4.3 Health Economics

Lastly TML recognises that given the implications of this matter – in terms of the health and wellbeing of Tasmanians, social justice, as well as the economic sustainability of our state – that it is imperative that the Tasmanian Government engage health economics expertise to provide some guidance on ways forward.

*'Health economics brings the economist's way of thinking to how health is "produced" in populations and how it can be produced better and distributed more fairly. It involves the study of healthcare systems, payment mechanisms for clinicians, and factors outside the health system that affect health as well (such as employment, taxation and education).*

*If you have ever heard that hospital A or country Y gets better recovery rates from coronary bypass surgery at less cost than hospital B or country Z, then you are learning from health economists. If you read that building more footpaths increases quality of life and reduces healthcare costs then that is health economic research also.'*<sup>41</sup>

Tasmanian has health economics expertise right on its door step. TML recently partnered with the Menzies Health Economics team to develop a new Tasmanian incentive funding model for the provision of after hour medical care by general practice. The team undertook a review of after hours provider data and extensive consultation to develop the new model which was implemented 1 January 2015. Importantly, there is ongoing evaluation by the Menzies team to determine the impact on access to timely and appropriate after hours medical care.

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<sup>41</sup> Shiel A, 2013, 'The founding father of health economics', *The Age*, 7 January 2013.

## 5.0 Term of Reference 5: Research

### Recommendation 6:

The Tasmanian Government in partnership with the non-government and private sectors:

- engage with Tasmanian citizens to deepen our collective understanding about new and more efficient models of primary health care and on the factors influencing their health by implementing citizen's juries, consumer panels or other community planning methods to engage citizens in decision making processes related to their health
- resource the provision of training, mentoring and support to community organisations in governance, commissioning and procurement as essential in helping them to achieve expected funding outcomes
- ensure that future investment in and reform of the Tasmanian health system – in particular in respect of integrated primary health systems – be based upon and contribute to the growing local, national and international evidence base.

An area of investment typically lacking and often cut in times of crisis is that of health research. Working closely with academic institutions both within and external to Tasmania and investing in research and evaluation will build a more robust and responsive system, a system focussed and based on evidence and outcome, and one less susceptible to the vagaries of political influence or inheritance.

Sound research and deepening of our understanding of integrated primary health care models and the social determinants of health and health inequities is always welcomed, however it must not take place of *action*, but inform and evaluate the action taken.

Overall, Tasmania does not have a strong track record when it comes to gathering data on the social determinants of health. This has contributed to ill-informed decision making and a lack of long-term vision for health and wellbeing in Tasmania.

One area of 'research' that TML is passionate about is growing and listening to the voice of our citizens. Aligned with the need to increase citizen understanding and participation in their own health care (as noted in section 2.6) it is incumbent upon policy makers and providers to actively engage with their communities to provide information about health issues and options and to seek input into service prioritisation, planning, delivery and evaluation. One example of this engagement is citizen's juries.

A citizen's jury takes a random selection of citizens, provides them with information about a topic and gives them the opportunity to have their say about the issue. TML became the first Medicare Local to consult its community through a citizens' jury when it convened its after hours jury in April 2012.

The after hours citizens' jury was held over two days and was facilitated by the late Professor Gavin Mooney, a health economist of 35 years' standing and pioneer of citizens' juries in health in Australia. The jury consisted of 14 randomly selected people from around Tasmania. The jury members were provided with information on TML and on after hours care, deliberated on what they had heard, then made recommendations on the principles on which they, as Tasmanian citizens, wanted after hours care to be based and what aspects of after-hours care they saw as priorities.

The key priorities identified included equity, information about availability and appropriate use of after hours services, and making best use of resources. Jury participants saw improving community awareness of after hours services as a key priority, with more resources dedicated to vulnerable population groups. The citizens' jury recommendations – along with advice from health professional stakeholders – are guiding TML's plan to improve access to after hours care.<sup>42</sup>

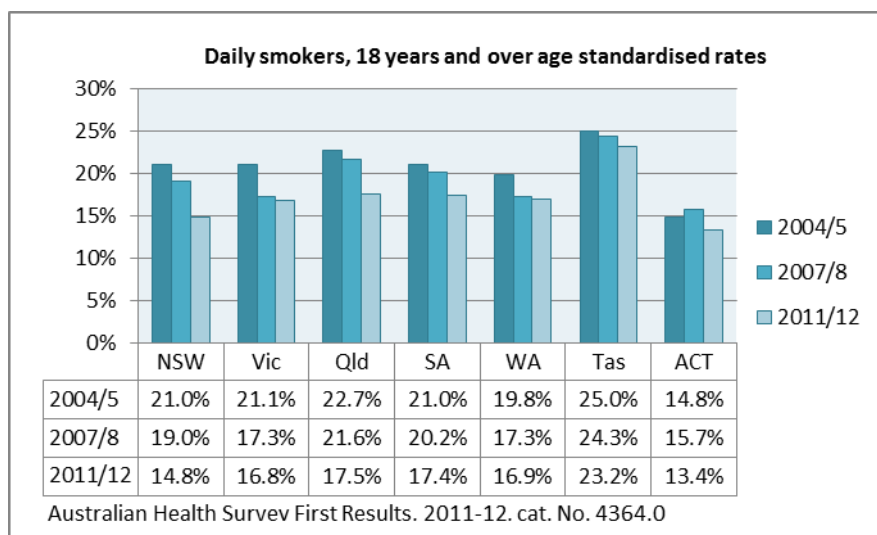
<sup>42</sup> Tasmanian Medicare Local (by Professor Gavin Mooney), April 2012, Report on Citizen's Jury: After Hours Medical Care.



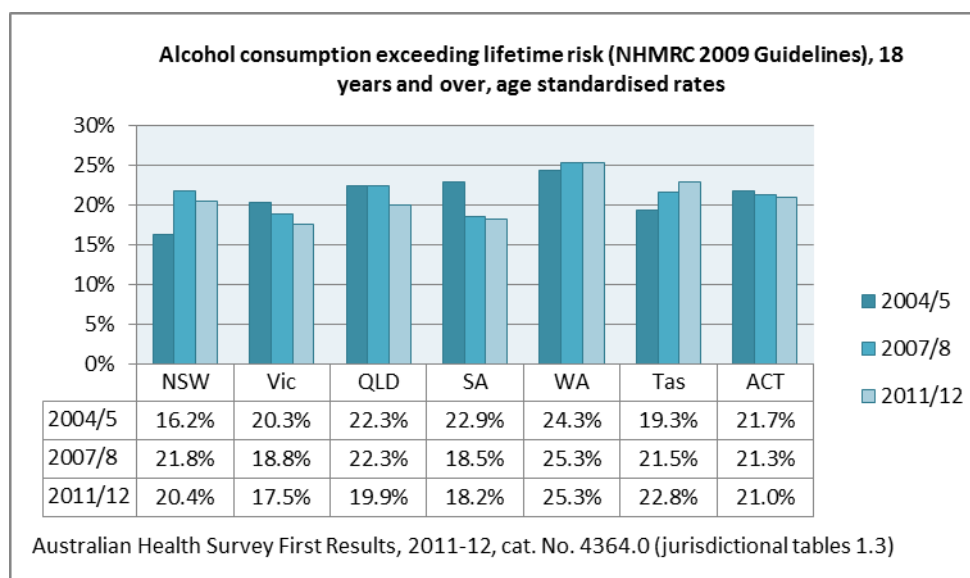
## Appendix 1: National Health Survey - lifestyle risk factor progress

Tasmania has fared less favourably than other jurisdictions in improving the key preventive health outcomes associated with lifestyle risk factors. This is demonstrated in a comparison of key preventive health outcomes across jurisdictions between 2004/05 and 2011/12 as measured in successive Australian Bureau of Statistics surveys.

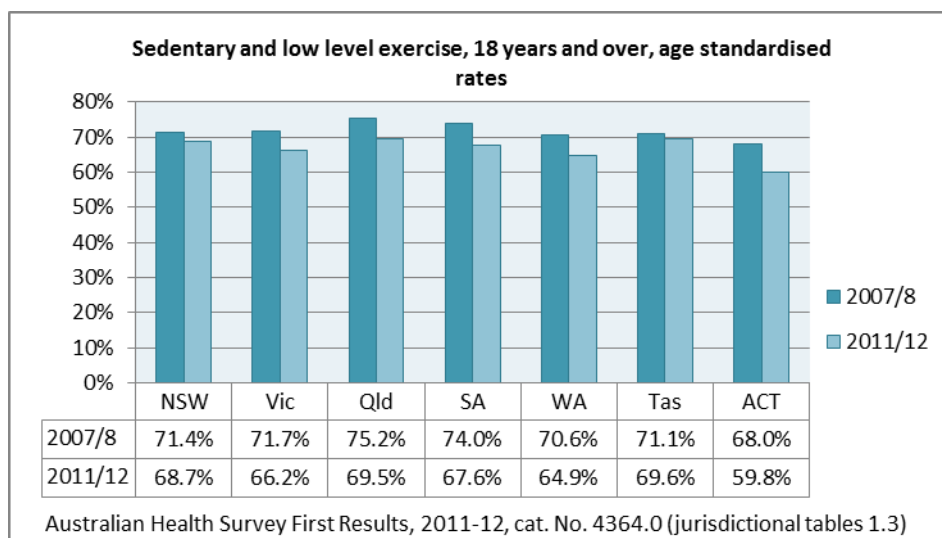
Tasmania has experienced a smaller decrease in smoking rates relative to other jurisdictions.



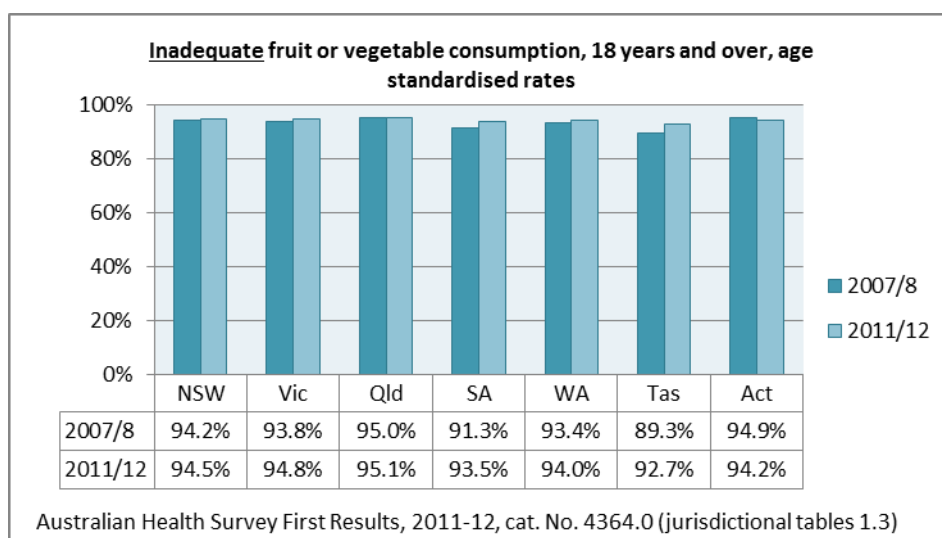
Alcohol consumption has increased between 2004/05 and 2011/12 in Tasmania. In the majority of jurisdictions alcohol consumption has decreased.



Between 2007/08 and 2011/12 other jurisdictions achieved a greater reduction in the percentage of people with sedentary and low level exercise than Tasmania.



Between 2007/08 and 2011/12 Tasmania observed a greater increase in the proportion of people with inadequate fruit and vegetable intake compared with other jurisdictions.



## Appendix 2: ACE Prevention cost-effectiveness estimates for alcohol, tobacco, physical activity and obesity

Taken from the National Health Service Scotland. Best preventive investments for Scotland - what the evidence and experts say (December 2014)

Topic area	Cost-effectiveness	Intervention	Cost per disability adjusted life year (DALY) averted	Strength of evidence
Alcohol	Dominant	Taxation	Dominant	Likely
		Advertising bans	Dominant	Limited
		Increase minimum legal drinking age to 21	Dominant	Limited
	Very cost-effective	Licensing controls	3,200	Likely
		GP Brief intervention	3,800	Sufficient
		GP Brief intervention with telemarketing support	7,500	Sufficient
	Cost-effective	Drink drive mass media	14,000	Limited
		Random breath testing	23,000	Likely
Tobacco	Dominant	Taxation	Dominant	Likely
	Very cost-effective	Cessation aid: varenicline	5800	Sufficient
		Cessation aid: bupropion	7700	Sufficient
		Cessation aid: NRT	8900	Sufficient
Physical activity	Dominant	Pedometers	Dominant	Sufficient
		Mass media	Dominant	Inconclusive
	Very cost-effective	Internet info and advice	2,400	Sufficient
		GP Prescription	9,500	Limited
	Cost-effective	GP referral to exercise physiologist	21,000	Limited
		Travelsmart	21,000	May be effective
	Not cost-effective	School walking bus <sup>22</sup>	760,000	Weak
Body mass	Dominant	Front of pack traffic light nutrition labelling	Dominant	No evidence
		Unhealthy food tax 10%	Dominant	May be effective
		Banning advertisement of energy-dense food <sup>22</sup>	Dominant	Limited
		School-based education programme to reduce television viewing <sup>22</sup>	Dominant	Inconclusive

		Multi-faceted school-based programme including nutrition and physical activity <sup>22</sup>	Dominant	Limited
	Dominant	School-based education programme to reduce sugar sweetened drink consumption <sup>23</sup>	Dominant	Limited
		Family-based targeted programme for obese children <sup>23</sup>	Dominant	Sufficient
		Multi-faceted school-based targeted child healthy weight programmes <sup>23</sup>	Dominant	Limited
	Very cost-effective	Gastric banding – adolescents <sup>23</sup>	4,400	Sufficient
		Family-based GP-mediated programme <sup>23</sup>	4,700	Limited
		Laparoscopic adjustable gastric banding BMI>35	5,800	Sufficient
	Cost-effective	Orlistat for adolescents <sup>24</sup>	11,000	Limited
		Multi-faceted targeted school-based programme without an active physical activity component <sup>23</sup>	21,300	Limited
		Diet and exercise for BMI>25	28,000	Sufficient
		Low-fat diet for BMI>25	37,000	Limited
	Not cost-effective	Active After Schools Communities Programme <sup>23</sup>	82,000	None
		Weight watchers	84,000	Sufficient
		'Lighten up' combined weight loss, diet and physical activity for adults	94,000	May be effective
		Sibutramine for BMI>30	230,000	Sufficient
		Orlistat for BMI>30	700,000	Sufficient



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