Submission to
Senate Select Committee on Health

Social Determinants of Health Advocacy Network

September 2014

About the Social Determinants of Health Advocacy Network

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

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

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

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

Purpose of the Network

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

Vision of the Network

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

Membership

Membership of the Network is open to all Tasmanians who share this vision. Membership is free of charge. The Network currently has more than 200 members across Tasmania from a broad range of sectors.

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

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Contents

Recommendations

SDOHA supports the five recommendations of the Senate Standing Committee on Community Affairs' 20 March 2013 Inquiry report on *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report, Closing the gap within a generation*:

- That the Australian Government –
    - adopt the WHO Report and commit to addressing the social determinants of health relevant to the Australian Context
    - adopt administrative practices that ensure consideration of the social determinants of health in all relevant policy development activities, particularly in relation to education, employment, housing, family and social security policy
    - place responsibility for addressing social determinants of health within one agency, with a mandate to address issues across portfolios.
- That the NHMRC give greater emphasis in its grant allocation priorities to research on public health and social determinates research
- That annual progress reports to parliament be a key requirement of the body tasked with responsibility for addressing the social determinants of health.

In addition:

a. That the Australian Government maintain hospital and health services' funding in the immediate and medium term, with a view to future restructuring of the system to give greater attention to action on the social determinants of health.

b. That the Australian Government does not proceed with the Medicare co-payment or the outsourcing of essential services such as MBS, PBS and primary care.

c. That the Australian Government establishes a high level agency to coordinate action across government of the social determinants of health, health promotion and health equity, and that this body also has a research brief to establish an evidence base on effective measures to reduce health inequities and impact positively on social determinants.

d. That the agency established to implement a social determinants approach look at ways to better integrate the health and social services' systems, with particular attention to aged care.

e. That the Australian Government supports community development and engagement strategies to determine the best ways prevent ill health, reduce health inequities and implement appropriate service

delivery models particularly for vulnerable groups such as Aboriginal people and those living in rural and remote areas.

f. That the Australian Government gives Primary Health Care Networks a strong and unequivocal role in undertaking prevention, promotion and early intervention work that is directly funded by the government and lies outside a fee-for-service structure.

g. That in future budgets, the Australian Government allocates specific funding to:

- State and Territory jurisdictions and Primary Health Networks to train all frontline staff in prevention, promotion and early intervention work
- further develop strong evidence-based research capacity on social determinants of health and effective promotion, prevention and early intervention.

Introduction

The Tasmanian Social Determinants of Health Advocacy Network (SDoHAN) appreciates this opportunity to comment on health policy, administration and expenditure in Australia following the 2014-15 Federal Budget.

We well understand the need for government fiscal restraint at this time. However, for socio-economically vulnerable people living in Tasmania, concurrent health funding cuts both nationally and at the state level have dealt a double whammy that will have serious effects on their lives. It is those who are already experiencing disadvantage who will be most affected by budget cuts and cost-recovery measures.

We believe that the reduction of funding in the areas of prevention, promotion and early intervention that could well have softened the impact of hospital funding cuts, has been short sighted.

We further contend that in bringing down the 2014-15 Federal Budget there was a huge opportunity lost to develop a cohesive approach towards the social determinants of health, thereby greatly reducing the burden of disease that Australia will face further down the track. The Senate Community Affairs Reference Committee tabled its report, Australia's Domestic Response to the World Health Organization's (WHO) Commission on Social Determinants of Health report, 'Closing the Gap in a Generation' in March 2013[1]. This report, and its WHO predecessor, provide ample direction for the Australian Government to begin tackling the social determinants of health, to provide joined up solutions to complex problems, and to provide strong national direction in this regard. The Government's silence to date on the Senate Committee's recommendations is deafening.

Action on the social determinants of health in essentially non-partisan. Such action is necessary if we are to be a strong, vibrant and economically viable country, where fairness and justice prevail. There is a wealth of evidence that reducing health inequities in the population would be good for everyone. A recent report by the National Centre of Social and Economic Modelling on 'The Cost of Inaction on the Social Determinants of Health'[2] provides compelling evidence of the savings to the health system that would ensue from a reduction in health inequities in Australia.

We strongly encourage the Australian Government to show true leadership in the health arena by adopting the recommendations of the Senate's Inquiry into the Social Determinants of Health. These recommendations include ratifying the WHO plan, developing a cross-government process to consider health in all policies, annual reporting to Parliament on social determinants, and prioritising research on

[1] The Senate Community Affairs Reference Committee, *Australia's Domestic Response to the World Health Organization's (WHO) Commission on Social Determinants of Health report, 'Closing the Gap in a Generation'*, March 2013.
[2] Brown, L et al, CHA-NATSEM Second Report on Health Inequalities: *The Cost on Inaction on the Social Determinants of Health.* Catholic Health Australia, 2012.

social determinants within National Health and Medical Research Council grants. As such, these recommendations are neither particularly difficult nor controversial to implement, though their ramifications could be immense.

In addition to our call for a re-focus of the health system on the protection and promotion of health, this submission outlines some key issues that the SDoHAN wishes to raise regarding the 2014-15 health budget and its impact on health equity.

The SDoHAN is particularly concerned about moves to further privatise the health sector by outsourcing the administration of Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS) to the private sector. This could adversely affect access to health care and costs for disadvantaged groups such as those on low incomes and those living in rural and remote areas. Also of grave concern is the potential outsourcing of management of the new Primary Health Care Networks. We believe that if the Government moves further along the road towards privatisation of essential services, it will be abdicating its core function of delivering a fair and equitable health system.

Below we address each of the Terms of Reference for the Senate Select Committee on Health.

a. The impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact of elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting

The SDoHAN contends that reduced Commonwealth funding for health services is having, and will increasingly have a dire impact on state and territory health systems, with the effects being felt disproportionately by those jurisdictions with the most vulnerable populations. These cuts will exacerbate inequities at the state and the individual level.

The effects of these cuts could have been cushioned if a commensurate level of funding had been allocated to health promotion and the prevention of ill health and towards strengthening the resilience of vulnerable Australians by increasing access to social determinants such as an adequate income, good housing, employment and education opportunities. The erosion of the social net, and its consequent effects on the health of individuals will have a multiplier effect on health cuts, particularly in Tasmania which has just brought down a crippling State budget. We will discuss some of these issues later in this submission.

Public hospitals across Australia are struggling to provide adequate care and keep up with demand. We believe that cutting back on Medicare and Pharmaceutical Benefits (and potentially privatising these services), reducing hospital funding, increasing the cost burden on individuals, and reducing effort in health promotion and prevention will only exacerbate this situation.

The inevitable effect of these cuts will be to further disadvantage those with the least capacity to pay, both at the state and the individual levels. Increasing co-payments for primary health services is likely to reduce demand for primary health care, thus resulting in savings at the federal level but increasing costs to the already overburdened state and territory hospital systems further down the track.

The Tasmanian hospital system is generally considered to be in a state of crisis with the federal budget cuts likely to deepen this crisis still further.

Data indicates that:

- Tasmanians tend to be older, sicker and poorer than other Australians and therefore more reliant on public health services
- Tasmania's hospitals are the most costly in Australia
- Tasmania has far fewer hospital beds per capita than any other state or territory
- The cost of running hospitals in Tasmania has risen at a substantially higher rate than the national average. Overall spending on the health system in Tasmania has been increasing by around 10 – 12%

per year. For example, in 2010-11 and 2012-13 the number of hospital surgeons and physicians went down by 21% but the cost per doctor increased by an average of 32%

- Because of its ageing population, Tasmania has a disproportionately high death rate. The high cost of maintaining people in inpatient care places a heavy burden on the health system.[3]

The Tasmanian Health Department Progress Chart for the period ending December 2013[4] showed 7,468 people waiting for elective surgery. A much greater number of people were waiting to see a specialist before being placed on the official waiting list, bringing the total number of people in line for elective surgery to 25,692. As the largest hospital in the state, the Royal Hobart Hospital, the average waiting time for people on the most urgent waiting list was 350 days. All other categories of patients waited more than a year on average with some waiting for up to six years. This includes people with debilitating conditions that seriously affect their quality of life and impair their ability to work. Not surprisingly, these are the people with the least financial capacity and social resilience.

The combined effect of federal and state cuts to health means that in the current financial year public hospitals in Tasmania will lose $84 million with a further $85 million being taken off community based health services and prevention programs. The number of people unable to receive treatment in public hospitals in Tasmania will continue to grow, and probably at a faster rate than in the past.

When hospital funding is in crisis, the likelihood of further reductions in preventative work seems inevitable. However, the economic value of cutbacks in prevention work is highly questionable. Catholic Health Australia's report on *The Cost of Inaction on the Social Determinants of Health*[5] calculated that concerted action on social determinants of health could save $2.3 billion nationally in annual hospital costs and reduce admissions by 60,000 people annually. There would also be considerable savings in Medicare and Pharmaceutical Benefits Scheme (PBS) costs with less people needing to access health services and prescription medications.

It is somewhat ironic that hospitals and health care command such attention in the public arena, often diverting funding away from areas outside the boundaries of the health system where these resources could be used to greatest effect. As Roscoe Taylor, the Director of Public Health in Tasmania expressed it in his State of Public Health 2013 report:

> *A major tension arises from the fact that significant growth in health care system funding will divert resources away from other social goods in order to expand a care system that – for a variety of reasons – has difficulty defining its boundaries. From a public health perspective, this limited view of*

[3] Australian Institute of Health and Welfare, *Australia's Health 2010*.
[4] Department of Health & Human Services Tasmania, *Your Health and Human Services Progress Chart*, December 2013
[5] Brown, L et al, CHA-NATSEM Second Report on Health Inequalities: *The Cost on Inaction on the Social Determinants of Health.* Catholic Health Australia, 2012.

health as "health care" is slowing more effective progress in those things that predominantly determine overall population health and wellbeing outcomes, and that are mostly outside the direct influence of the health care system.[6]

SDoHAN contends that, while we need to maintain health budgets and ensure that services are accessible by those most in need, we also need to look at how we can work differently to address the social determinants of health and maintain good health and wellbeing for all. In the longer term, such restructuring would ensure that the costs of the health system are realistic and contained within governments' capacity to fund.

Recommendation

That the Australian Government maintain hospital and health services' funding in the immediate and medium term, with a view to future restructuring of the system to give greater attention to action on the social determinants of health.

[6] Department of Health and Human Services, *State of Public Health Report*, Tasmania 2013.

b. The impact of additional costs on access to affordable healthcare and the sustainability of Medicare

Australia's universal health scheme - Medicare - aims to ensure that all citizens (and some residents/overseas visitors) have access to a wide range of health services at little or no cost. It is acknowledged that maintaining universal health care is a challenge in all developed countries, including Australia, as demand for care continues to increase, along with costs, expectations and the possibility of cure.[7] However, as outlined by the Director-General of the WHO, Dr Margaret Chan:

> *...universal health coverage is the single most powerful concept that public health has to offer. It is inclusive. It unifies services and delivers them in a comprehensive and integrated way, based on primary health care.*[8]

A key component of universal health coverage, as Dr Chan highlights, is the concept of 'inclusiveness'. Proposals such as the Medicare co-payment are likely to directly corrode the fundamental principles on which universal health coverage is built.

When considering the impact of additional costs on access to affordable healthcare, it necessary to take into account evidence of health inequalities in Australia. This is because those whose health is the poorest are also likely to be those who are in some other way 'disadvantaged'– i.e. those on low income, with poor education attainment, unemployed etc. The Australian Institute of Health and Welfare's (AIHW) report, Mortality inequalities in Australia 2009–2011, found:

> *Despite relatively high standards of health and health care in Australia, not all Australians fare equally well in terms of their health and longevity. Substantial mortality inequalities exist in the Australian population, in terms of overall mortality, and for most leading causes of death, and these inequalities are long-standing.*[9]

The AIHW report highlights particular cohorts to illustrate this point:

- People living in 'Remote' and 'Very Remote Areas' had mortality rates 1.4 times as high as those for people living in 'Major Cities', and higher rates of death due to diabetes and land transport accidents.
- People living in the lowest socioeconomic status (SES) areas had a mortality rate that was 1.3 times as high as the rate among people living in the highest SES areas, and higher rates of death due to diabetes and chronic obstructive pulmonary disease (COPD).

[7] Boxall AM, *The Conversation,* 31 January 2014, http://theconversation.com/explainer-what-is-medicare-and-how-does-it-work-22523.
[8] Chan M, World Health Organisation, Universal Health Coverage: http://www.who.int/universal_health_coverage/en/.
[9] Australian Institute of Health and Welfare (AIHW), August 2014, *Mortality inequalities in Australia 2009-2011,* Bulletin 124.

- The overall mortality rate among Indigenous Australians was nearly twice that of non-Indigenous Australians, and five times as high among Indigenous people aged 35–44.[10]

It is these Australians - those who experience poor health because our social structures and systems disadvantage them - that will feel the impact of additional healthcare costs the most. This isn't fair – it is inequitable.

The AIHW report goes on to state:

> *It is also clear that the greatest inequalities exist for what are considered to be avoidable causes of death.*[11]

The key term in this quote is 'avoidable' – health inequalities are avoidable. If we are serious about addressing rising health care costs, it is imperative that we first address the factors that lead to health inequalities – factors such as poverty, unemployment, poor education, poor transport, discrimination and so forth. The people most affected by these factors are also those with the greatest health care needs yet the least resources to pay for this care.

There is mounting evidence that the Government's proposed Medicare co-payment would have a significant impact on access to affordable healthcare, particularly for those on low incomes. In reporting on out-of-pocket costs in Australian healthcare, the Senate's Standing Committees on Community Affairs identified that imposing additional costs would make it harder for people, particularly in vulnerable groups, to access primary care. This would not only be at a cost to their own health but also to the system as a whole. A $7 GP fee would make the health system less sustainable by preventing patients from seeking early treatment for chronic illnesses, requiring more expensive hospital care in the future.[12] The notion that exempting concession card holders from any co-payment would protect people on low incomes is disputed: *'The concession card is a very blunt instrument to determine the ability for patients to pay for their health care, and without the option of bulk billing, more low-income people will fall through the safety net cracks.'*[13]

Addressing rising health care costs is challenging but there are identified areas of waste. As Rob Moodie, Professor of Global Health at University of Melbourne, points out there are lots of areas where we could be 'much smarter' in terms of health care expenditure. For example, 'Australia is paying more than $1.3 billion a

[10] Ibid.
[11] Ibid.
[12] Hagan K and Knott M, 'GP fee a barrier to necessary treatment, Senate committee warns', *Good fruit and vegetables,* 24 August 2014, http://www.goodfruitandvegetables.com.au/news/metro/national/general/gp-fee-a-barrier-to-necessary-treatment-senate-committee-warns/2709579.aspx.
[13] Hall J and van Gool K, 'AMA co-pay plan: protecting the poor and GPs' bottom line', *The Conversation,* 21 August 2014, http://theconversation.com/ama-co-pay-plan-protecting-the-poor-and-gps-bottom-line-30757.

year too much' for pharmaceuticals and this is money that could be spent on better care, prevention and addressing the underlying causes of health inequality.[14]

SDoHAN is also concerned about the potential privatisation, or semi-privatisation of Medicare and PBS, as implied in the recent call for 'expressions of interest' for administration of these services, and the effect that such a move might have on future cost-escalation, privacy and the commercial impartiality of the health sector.

Recommendation

That the Australian Government does not proceed with the Medicare co-payment or the outsourcing of essential services such as MBS, PBS and primary care.

[14] Moodie R, 'Focus on prevention to control the growing health budget', 2 May 2013, *The Conversation,* http://theconversation.com/focus-on-prevention-to-control-the-growing-health-budget-13665.

c. The impact of reduced Commonwealth funding for health promotion, prevention and early intervention

The WHO defines health as a 'state of complete physical, mental and social wellbeing and not merely the absences of disease or infirmity'.

We again highlight the current crisis in health care allocation. Factors such as the rising incidence of chronic conditions and an ageing population are placing increased demand on health services. At the same time health care costs are growing through the increasing use of expensive technological procedures.[15] If we are unable to financially support the road we are currently on, we believe that it is imperative to look at structural and economic reform and a move toward an equity-oriented health system with a focus on the health promotion and the prevention of ill health.

Australia is a signatory to the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases 2013-2020 *Global Action Plan for the prevention and control of non-communicable diseases* that *'seeks to reduce the preventable and avoidable burden of morbidity, mortality and disability'*[16] These non-communicable diseases (i.e. cardiovascular disease, diabetes, cancer and chronic respiratory disease) pose a global health challenge.

The Global Action Plan seeks to:

- Raise the priority accorded to prevention in national agendas
- Strengthen national capacity to accelerate the response for prevention and control of non-communicable diseases
- Reduce modifiable risk factors and underlying social determinants of health through the creation of health promoting environments
- Strengthen and reorient health systems to address the prevention & control by working to re-dress the underlying social determinants through primary health care and universal health coverage
- Monitor the trends and determinants of non-communicable disease and evaluate progress in their prevention and control.[17]

In 2008 the National Preventative Health Taskforce released a discussion paper 'Australia: The Healthiest Country by 2020' and recommended that, *'we need greatly enhanced monitoring, evaluation and research. Prevention programs need to reach the whole of the population and they must be given time to take effect.'*[18]

[15] Department of Health (SA) 2011, *The South Australian approach to Health in All Policies: background paper and practical guide*, Version 2.
[16] World Health Organisation May 2013, *Global Action Plan for the prevention and control of non-communicable diseases 2013-2020*,
[17] Ibid
[18] National Preventative Health Taskforce 2008; *Australia: The Healthiest Country by 2020*; p. vii

In 2003 the Department of Health and Ageing commissioned a study that revealed strong evidence for investing in health promotion and prevention, showing that long term health gains as well as cost savings were made in the areas of smoking reduction, road safety, HIV/AIDS, and cardiovascular disease.[19]

The Community Affairs Reference Committee looking at the 'Out-of-pocket costs in Australian Healthcare' recommended '*that the Government review existing models for funding and delivery of primary healthcare with a view to identifying opportunities for improved service delivery and health outcomes'.* This recommendation was made based on the evidence submitted to the inquiry that *'underscored the key role for preventative health programs in delivering efficiencies in healthcare'.*[20]

Health Promotion as defined in the Ottawa Charter is the '*process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health'*. This is achieved by:

- Developing personal skills
- Creating supportive environments for health
- Strengthening community action
- Building healthy public policy
- Reorienting health services.[21]

Prior to the 2013 Federal election the Australian Government spent less than 0.5% of the health budget on health promotion and prevention actions. This allocation has been significantly reduced by the current Government.

Appendix 1 of this submission provides a succinct summary produced by the Australian Health Promotion Association (AHPA) on the health and economic costs of investing in health promotion. In brief, for every dollar invested primary prevention, our health system saves over five dollars:

- Every 4% reduction in tobacco smoking saves 3,000 lives in Australia per year
- Obesity costs $120 billion every year in Australia, with much of this cost recoverable through early interventions in schools, workplaces and communities
- Health promotion can help prevent 14,000 hospitalisations due to alcohol misuse each year. (The total cost of alcohol misuse in Australia is estimated at $36 billion per year)
- Health promotion can keep half a million Australians out of hospital per year by preventing chronic diseases, and save $2.3 billion in expenditure

[19] Abelson P and Applied Economics 2003, *Returns on Investment in Public Health*, Canberra: Department of Health and Ageing.
[20] The Senate – Community Affairs References Committee August 2014, *Out-of-pocket costs in Australian healthcare*, p.69
[21] World Health Organisation 1986, *Ottawa Charter for Health Promotion*, Ontario.

- Reducing disadvantage and promoting mental health can create 170,000 jobs and generate $8 billion in earnings. [22]

Investing in health promotion is sound economic policy. We echo the call of the AHPA for greater commitment to, and investment in health promotion.

It appears, though, that rather than increasing investment in health promotion, the Australian Government is doing the opposite. We question how the closure of the Australian National Preventive Health Agency (ANPHA) and transfer of its 'essential functions' to the Department of Health and the termination of National Partnership Agreement on Preventive Health (NPAPH) payments to States and Territories will 'ensure a more efficient approach to prevention, and remove duplication.'[23]

The ANPHA was established on 1 January 2011 to provide national capacity to drive preventive health policy and programs.[24] It provided a clearinghouse for evidence based research on what preventative programs actually work and fostered innovative approaches towards preventing the huge burden of disease caused by potentially modifiable causes in Australia. It signified a comprehensive approach to preventive health that included *'the full range of players that can help make healthy choices easy choices for all Australian's.* We believe that the demise of the ANPHA, which was just beginning to get some traction across Australia has been a very short-sighted move by the Australian Government.

Similarly, the demise of the NPAPH has completely undermined State and Territory efforts to foster healthier populations. In Tasmania, NPAPH funding has supported:

- a range of interventions focusing on the social and environmental conditions that make healthy choices easy choices (e.g. smoking, nutrition, alcohol, physical activity)
- programs and services that have taken place in early childhood facilities, schools and workplaces to promote health and wellbeing; interventions targeting vulnerable or at risk populations (e.g. Aboriginal Australians, children and young people, refugees and asylum seekers)
- interventions focusing on people living with, or at risk of developing a particular chronic condition (e.g. diabetes, heart disease, cancer).

Much of the momentum for change that has occurred through these initiatives and the increased understanding of how we can prevent ill-health will be lost with the de-funding of the NPAPH. The establishment of the Medical Research Future Fund will in no way compensate for the loss of the ANPHA

[22] Australian Health Promotion Association, Policy Action Statement, citing the Australian Institute of Health & Welfare, Australia's Health 2010: http://www.aihw.gov.au/publications/index.cfm/title/11374

[23] Australian Government 2014-15 Health Portfolio Budget Statements. http://www.health.gov.au/internet/budget/publishing.nsf/Content/2014-2015_Health_PBS_sup1/$File/2014-15_Health_PBS_2.01_Outcome_1.pdf

[24] ANPHA website: http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/about-us

and the NPAPH. We believe that the focus of this body is far too narrow and it will, essentially, be looking at 'after-the-fact' solutions to medical conditions rather that effective prevention.

Recommendation

That the Australian Government establishes a high level agency to coordinate action across government of the social determinants of health, health promotion and health equity, and that this body also has a research brief to establish an evidence base on effective measures to reduce health inequities and impact positively on social determinants.

d. The interaction between elements of the health system, including between aged care and health care

We argue that there needs to be greater collaboration between elements of the health system particularly clinical/medical care/treatment services, and prevention/health promotion/population health services. As stated earlier, Australians that fared the worst in terms of mortality rates tended to do so for causes of death that in many cases can be considered either preventable or treatable.[25] It makes sense therefore that more comprehensive, sustained and effective collaborative efforts go into preventative health. Preventative health, with a focus on reducing inequities, should be the priority of the system as a whole.

Greater collaboration is also needed between the health and social services' systems. If we recognise the importance of social services in influencing the determinants of health, then the line in the sand between the two spheres of influence becomes an arbitrary one. Both are part of the crucial social net that can reduce health inequities. Social services provide a range of programs and supports for people during various life stages such as leaving school, having and raising children, finishing formal education or seeking employment, finding appropriate housing, and caring for aged or frail family members. Social services also provide support for people during unexpected life events such as family break-ups and accidents. Such events can cause financial hardship and psychological stress.

The health and social services' systems need to be strongly linked to prevent only 'band aid' or temporary solutions to problems. A good health system without equal access to the social system may not improve health and wellbeing outcomes for individuals who are living in inadequate housing, are long term unemployed, have no access to transport, can't read or write, or are socially excluded. Health services need to consider the underlying causes of poor health and work with the social services' system in order to optimise the conditions for good health and help to ensure a more sustainable approach to prevention.

Indeed if we are serious about addressing the major challenges in health, we must also look beyond the health system to other systems and sectors - as many of the drivers of health operate outside the health care system.

The need for more effective collaboration between aged care and health care will continue into the future as Australia's population continues to age. There has long been concern about the occupation of expensive acute hospital beds by older, non-acute patients due to lack of alternative facilities for such patients. For example, a Tasmanian study by Buist et al 2013 that reviewed 200 sequential admissions to the medical wards in two regional Tasmanian hospitals to determine the incidence of non-acute medical

[25] AIHW, August 2014, *Mortality inequalities in Australia 2009-2011,* Bulletin 124.

patient admission found that 24% of patient admissions had at least one hospital day that could not be justified on medical grounds. Of the 1,438 total bed days, 475 (33%) were for nonmedical reasons, with an estimated cost of $764,800.[26]

The authors comment that those admitted without justified medical grounds were more likely to die in hospital or be discharged to a residential care facility. What we can reasonably draw from this is that there was a cohort of people admitted to hospital who were older, more frail and probably not living is situations where they could be easily looked after if they were sent home instead of being admitted. It is probable that stronger social connections, and greater collaboration between health and community aged care services would help to prevent the need for patients to remain in hospital for non-medical reasons. Other authors such as Cunninghman and Sammut (2012) agree with the ideology that Australia depends too heavily on hospital-based healthcare.[27]

Recommendation

That the agency established to implement a social determinants approach look at ways to better integrate the health and social services' systems, with particular attention to aged care.

[26] Buist MD et al 2013, 'Utilisation of beds on the general medical unit by 'non-acute medical' patients: a retrospective study of incidence and cost in two Tasmanian regional medical hospital units', *Internal Medicine Journal*, Royal Australasian College of Physicians, pp. 171-176.
[27] Cunningham P & Sammut J 2012, 'Inadequate acute hospital beds and the limits of primary care and prevention', *Emergency Medicine Australasia,* 24(5), pp. 566-572.

e. Improvements in the provision of health services, including Indigenous and rural health

SDoHAN welcomes the overall increase in funding levels for Aboriginal health announced in the Federal Budget and some of the extra measures in rural areas such as funding of additional GP consulting rooms and scholarships for nursing and allied health.

However, we question the claim that the 2014-15 Federal Budget will lead to improvements 'in the provision of health services, including indigenous and rural health.' There is considerable evidence to suggest that cuts to health, welfare and pensions will adversely affect the health of vulnerable groups, including Aboriginal and rural Tasmanians and there is nothing in the budget to indicate any likely improvement in health outcomes of these groups.

We also have concerns about the effect of budget cuts on young people and those who are unemployed, on low incomes, are refugees, have mental health issues or a disability, or who are socio-economically vulnerable on some other way.

Indigenous health

In its 2014-15 budget, the Federal Government announced greater flexibility and coordination of Aboriginal health funding through the establishment of the Indigenous Australian Health Programme, consolidating primary health care funding, child and maternal health activities, Stronger Futures in the Northern Territory, and the Aboriginal and Torres Strait Islander Chronic Disease Fund. SDoHAN agrees with the intent of the newly-established Programme to 'to complement and support whole-of-government efforts to improve school attendance, employment and community safety outcomes as the focus of reducing Indigenous disadvantage.'[28] If it can achieve this aim, the Programme will be a great example of action to address the social determinants of health.

There is some fear though that noble intentions will not result in any changes on the ground. Aboriginal community leaders from across Australia have expressed strong concern about the disconnect between government agencies responsible for funding Aboriginal services, referring to an environment of 'confusion, instability and chaos'[29]. They believe that Federal Budget cuts in funding to Children and Family Centres, Family Violence Prevention and Legal Services, and Aboriginal and Torres Strait Islander Legal Services will have a detrimental impact on frontline services. Together with the more direct health

[28] Australian Government 2014-15 Health Portfolio Budget Statements. http://www.health.gov.au/internet/budget/publishing.nsf/Content/2014-2015_Health_PBS_sup1/$File/2014-15_Health_PBS_2.05_Outcome_5.pdf

[29] *Indigenous policy and funding is descending into chaos say leaders,* The Australian, September 2, 2014. http://www.theaustralian.com.au/national-affairs/indigenous-policy-and-funding-is-descending-into-chaos-say-leaders/story-fn59niix-1227045422832?nk=8e8ff20a7636f535fa557ad01d6b2a04

co-payment costs, these cuts are likely to have adverse flow on effects on Indigenous health and wellbeing.

While the Australian Government has announced an overall growth in funding for Indigenous health over the next four years it is, as yet, unclear how this will be rolled out in Tasmania. Too often federal funding is tied to models that do not fit Tasmania's Aboriginal population. These are often designed for remote Aboriginal communities with cohesive groupings rather than Tasmania's highly dispersed Aboriginal population. We would argue that a community development approach, with Aboriginal people largely determining how funding should be allocated to best effect, would be much less wasteful and more effective than have many past government initiatives.

Tasmania's Aboriginal population is subject to similar inequities as the rest of Australia's Indigenous population: an average lifespan more than 10 years less than the non Aboriginal population, lower incomes, more people living in overcrowded housing, more reliance on government pensions and benefits, lower school retention rates, higher rates of incarceration, higher ratios of children in out of home care, and higher prevalence of health risk factors including smoking, obesity, poor nutrition and physical inactivity. Aboriginal people in Tasmania are also affected by discrimination and racism with many experiencing cultural displacement, social exclusion, and political and social oppression. For Tasmanian Aboriginal people culture and land are critical determinants of health and wellbeing. Racism is also a significant determinant. Constitutional reform to recognise Aboriginal and Torres Strait Islanders would be a significant step towards reducing endemic racism in Australia.

Rural health

The National Rural Health Alliance has pointed out that people in rural and remote areas are already those most likely to postpone or miss out on a medical service or medication due to cost.[30] Tasmania, with is proportionately high number of people living in rural and remote areas, is particularly vulnerable in this regard. Proposed GP, pathology and diagnostic imaging co-payments are likely to pose yet another barrier to health service access for rural Tasmanians.

In a 2012 report, the Commonwealth Grants Commission estimated that Tasmania needed to spend 19% more than the national average on community based and other health services because of its demographic disadvantages and low levels of private service provision. The reality was that spending was 40% less than required to provide services at the national standard. This under-spend has impacted particularly on Tasmania's rural areas with their highly dispersed populations. Tasmania's rural areas are hurting very badly from the loss of key industries such as mining and forestry. There are very high rates of unemployment, particularly among young people, with associated mental and physical health effects.

[30] National Rural Health Alliance. *Budget 2014-15: making it work beyond the Big End of Town.* http://ruralhealth.org.au/advocacy/current-focus-areas/budget-2014-15-making-it-work-beyond-big-end-town

Tasmania Medicare Local has identified higher rates of chronic conditions in Tasmania than elsewhere in Australia. Australian Institute of Health and Welfare (AIHW 2013) data indicates that people living in rural and remote areas tend to have higher levels of risk factors and illnesses than people living in cities. Rural Tasmanians therefore suffer from a double whammy. Tasmania Medicare Local has introduced a range of initiatives to better coordinate rural services, to address risk factors such as smoking, obesity and inactivity, to support prevention and self-management initiatives, and to develop better health pathways through the health system. Tasmania Medicare Local is also working with communities to address social determinants and build community capacity and is training health practitioners to help Tasmanians affected by generational poverty and disadvantage. The Rural Primary Health Services Program managed by Tasmania Medicare Local provides coordinated treatment, screening, education and health promotion and prevention programs in rural Tasmania.

While Tasmania Medicare Local is tackling some issues in rural areas in Tasmania, the SDoH Advocacy Network is concerned that primary health care and community health services are being eroded. Crippling federal and state health budgets mean that focus in Tasmania is very much on hospital waiting lists and cost saving strategies. Community development and engagement strategies, which have the potential to turn around communities, are long term processes that receive little attention in the current climate. Groups most affected by health inequities such as those living in poverty, Aboriginal people, families experiencing violence, people with mental health conditions, young people, and refugees, are unlikely to get the support they need to access services.

We also have some concern that much of this promotion and prevention work will be lost in the move to Primary Health Networks which will be 'clinically focussed', with models of funding and delivery 'including partnerships with private insurers'.

Recommendation

That the Australian Government supports community development and engagement strategies to determine the best ways prevent ill health, reduce health inequities and implement appropriate service delivery models particularly for vulnerable groups such as Aboriginal people and those living in rural and remote areas.

f. The better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services

As we have already asserted, the health of Australians is largely affected by factors outside of the health sector (the social determinants), including housing, transport, early years' experience; social isolation, education, employment, and the environment. A 'Health in All Policies' approach with collaboration between all levels of government and across sectors and an investment in the Primary Health Care sector is the most effective strategy to achieving change. Whilst we agree that there is a need for better coordination and integration of services we argue that this needs to extend beyond the medical services cited in this criteria.

There is strong evidence supporting the need to reorient health systems to a primary and community health focus to achieve disease prevention rather than investing in the costly acute care sector. Primary health care is the first level of health that people have contact with, it tends to be the level that people feel most trust in and ideally it should be the most accessible. Primary health care is an integrated model, with the first layer of health working together to support people to stay well or to intervene early in the first stages of ill health within their local communities. Jennifer Doggett states that *"A wealth of international evidence shows that health systems oriented towards primary care achieve better health outcomes for a lower overall cost than systems focused on specialist or tertiary care. The international trend is moving away from hospital care."* [31]

Strong primary health care systems have been shown to have lower costs and to perform better in the health care arena.[32] Baum (2009) states, *'Primary care has been found to be more effective than specialty care in preventing illness and death and it is associated with more equitable distribution of health.'*

SDoHAN is concerned that the Government's intention to 'explore innovative models of primary health care funding and delivery, including partnerships with private insurers'[33] and to establish 'clinically-focussed' Primary Health Networks could greatly reduce the ability of the current primary health care system to work on prevention, promotion and early intervention. If we are to prevent ill-health and establish a sustainable health system, much more attention is needed to this type of work than is currently the case.

[31] Doggett J 2007 for the Centre for Policy Development, A New Approach to Primary Health Care, Occasional Paper No. 1, p. 2
[32] Baum F 2009, Op-Cit, p. 1971.
[33] Australian Government 2014-15 Health Portfolio Budget Statements, http://www.health.gov.au/internet/budget/publishing.nsf/Content/2014-2015_Health_PBS_sup1/$File/2014-15_Health_PBS_2.05_Outcome_5.pdf.

Recommendation

That the Australian Government gives Primary Health Care Networks a strong and unequivocal role in undertaking prevention, promotion and early intervention work that is directly funded by the government and lies outside a fee-for-service structure.

g. Health workforce planning

Our submission recommends that future workforce planning is best oriented towards building a strong primary health care sector. While ongoing investment in the acute care, specialist tertiary sector is necessary, we would argue that providing all health services' staff with a strong understanding of the social determinants of health and how they can work within a health promoting framework would go a long way towards a more cost-effective and sustainable model of health care. Strengthening the primary health workforce, in rural and remote areas, would also help to reduce locational inequities in health outcomes.

We are gravely concerned that reduced Commonwealth funding for health promotion, prevention and early intervention will reduce the considerable expertise that has been established among frontline staff, program developers, administrators and researchers, over recent years and seriously affect Australia's ability to maintain a healthy population and prevent the juggernaut of lifestyle-related chronic conditions that threaten to swamp our health system in future. An exodus of the health promotion workforce from the health system or to other roles will mean that many of the gains that have been made in prevention, early intervention, and the reduction of health inequities will be lost and it will be very difficult to re-establish Australia's position at the forefront of innovative research and practice.

Recommendation

That in future budgets, the Australian Government allocates specific funding to:

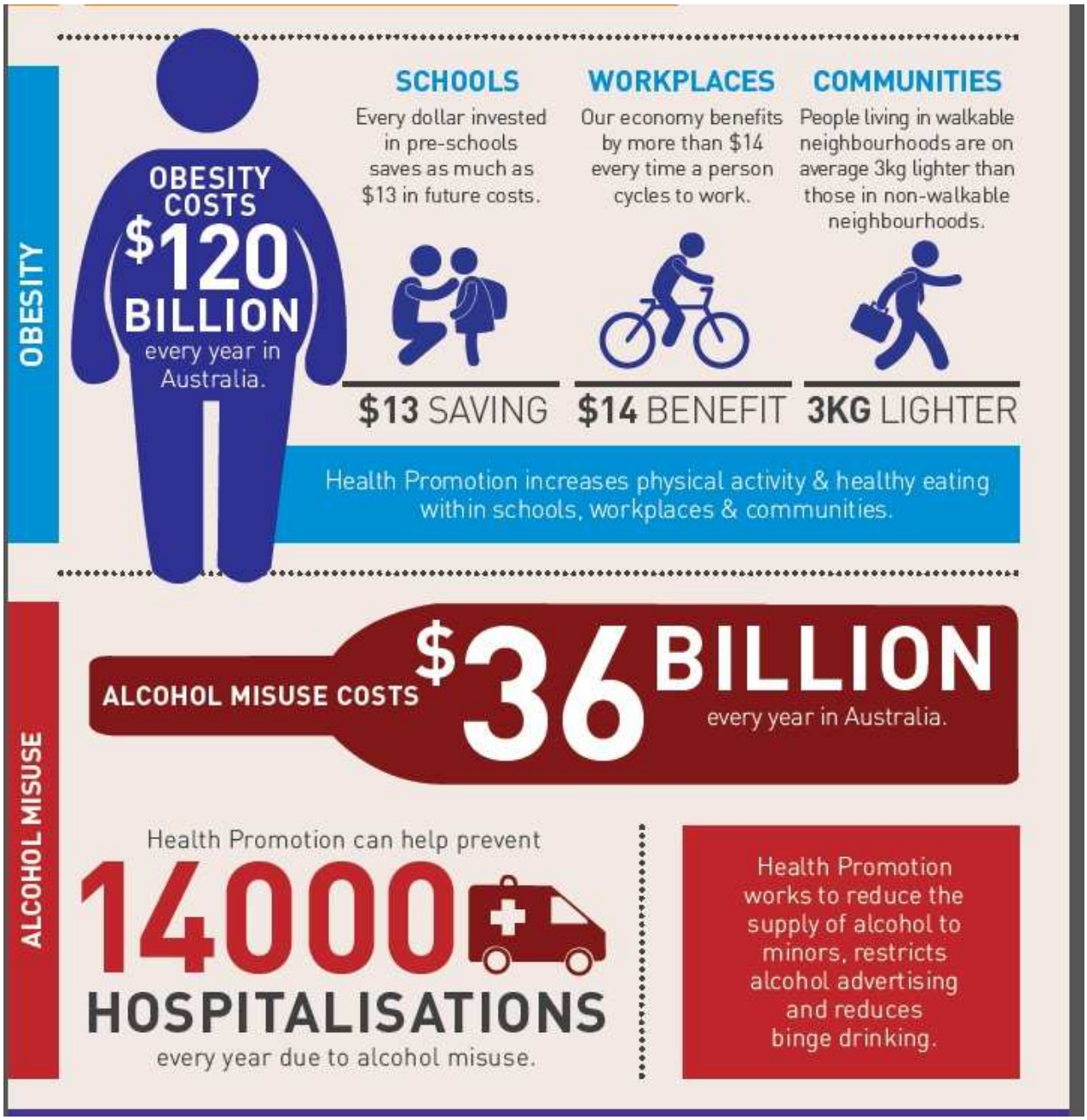
- State and Territory jurisdictions and Primary Health Networks to train all frontline staff in prevention, promotion and early intervention work
- further develop strong evidence-based research capacity on social determinants of health and effective promotion, prevention and early intervention.

h. Any related matters

SDoHAN is also concerned regarding the effects of other cutbacks on the budget that will greatly affect social determinants of health for vulnerable groups. These will causes huge hardship for some people and will have far-reaching effects of physical and mental health:

- Reduced access to Newstart allowance for young people under 30
- Reduced allowances for people on Disability Support Pension under 35 who are moved to Newstart or Youth Allowance
- Reduced funding for employment services
- Removal of some family tax benefits, which will particularly affect sole parents
- Reduction in the relative value of pensions
- Reduced funding for homelessness and housing services
- Deferred funding for the much-needed National Partnership Agreement for adult public dental services.

Attachment 1


OBESITY
OBESITY COSTS $120 BILLION every year in Australia.
SCHOOLS
Every dollar invested in pre-schools saves as much as $13 in future costs.
WORKPLACES
Our economy benefits by more than $14 every time a person cycles to work.
COMMUNITIES
People living in walkable neighbourhoods are on average 3kg lighter than those in non-walkable neighbourhoods.
$13 SAVING
$14 BENEFIT
3KG LIGHTER
Health Promotion increases physical activity & healthy eating within schools, workplaces & communities.
ALCOHOL MISUSE
ALCOHOL MISUSE COSTS $36 BILLION every year in Australia.
Health Promotion can help prevent
14000 HOSPITALISATIONS
every year due to alcohol misuse.
Health Promotion works to reduce the supply of alcohol to minors, restricts alcohol advertising and reduces binge drinking.

Health Promotion benefits those most in need.

HEALTH EQUALITY

Reducing disadvantage & promoting mental health can:

Create
170000 JOBS
and generate
$8 BILLION
in earnings

SAVE
$2.3 BILLION
in hospital expenditure every year.

Health Promotion can keep **HALF A MILLION** Australians out of hospital every year by **PREVENTING CHRONIC DISEASES** like diabetes, cancers, stroke and depression.

Health Promotion is our 'front-line' in health services.

HEALTH PROMOTION

Yet, Health Promotion
RECEIVES
LESS THAN **0.5%**
of the health budget

Every $1 invested in prevention can save over $5 in health spending

We call on political parties to commit to greater investment in best practice health promotion.

You can help by supporting policies that **prioritise health promotion.**

Find out where our parties stand: www.prepoll.com.au