

The Senate

Community Affairs
References Committee

Australia's domestic response to the World
Health Organization's (WHO) Commission
on Social Determinants of Health report
"Closing the gap within a generation"

March 2013

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43rd Parliament

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LIST OF RECOMMENDATIONS

Recommendation 1

4.45 The committee recommends that the Government adopt the WHO Report and commit to addressing the social determinants of health relevant to the Australian context.

Recommendation 2

4.63 The committee recommends that the government 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.

Recommendation 3

4.71 The committee recommends that the government place responsibility for addressing social determinants of health within one agency, with a mandate to address issues across portfolios.

Recommendation 4

5.36 The committee recommends that the NHMRC give greater emphasis in its grant allocation priorities to research on public health and social determinants research.

Recommendation 5

5.38 The committee recommends that annual progress reports to parliament be a key requirement of the body tasked with responsibility for addressing the social determinants of health.

Chapter 1

Australia's domestic response to the World Health Organisation's Commission on Social Determinants of Health report 'Closing the gap within a generation'

Terms of Reference

1.1 On 22 August 2012 the Senate referred the following matter to the Senate Community Affairs Committee for inquiry and report:

Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation", including the:

- (a) Government's response to other relevant WHO reports and declarations;
- (b) impacts of the Government's response;
- (c) extent to which the Commonwealth is adopting a social determinants of health approach through:
 - (i) relevant Commonwealth programs and services,
 - (ii) the structures and activities of national health agencies, and
 - (iii) appropriate Commonwealth data gathering and analysis; and
- (d) scope for improving awareness of social determinants of health:
 - (i) in the community,
 - (ii) within government programs, and
 - (iii) amongst health and community service providers.

1.2 The reporting date for the inquiry was set by the Senate for 27 March 2013.

Conduct of the inquiry

1.3 The committee invited submissions from the Commonwealth Government and interested organisations. The committee received public submissions from 68 organisations and individuals (listed at Appendix 1).

1.4 The committee held four public hearings over the course of the inquiry. The hearings were held in:

- Canberra – 12 October 2012 and 23 November 2012; and
- Melbourne – 4 and 11 December 2012.

1.5 A list of witnesses who appeared before the committee is set out in Appendix 2.

1.6 Submissions, additional information, the Hansard transcript of evidence and responses to questions on notice can be accessed through the committee's website at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/index.htm

1.7 References in this report are to individual submissions as received by the committee, not to a bound volume.

1.8 The committee sincerely thanks all submitters and witnesses for their contribution and participation in the inquiry process. The committee recognises that this inquiry would not have been possible were it not for a number of key organisations whose ongoing advocacy and work continue to progress the social determinants agenda.

Structure of the report

1.9 This report is comprised of 5 Chapters:

- Chapter 2 provides a broad overview of the theory and evidence indicating that social determinants play an important role in individual health outcomes in Australia;
- Chapter 3 summarised the World Health Organisation published report *Closing the Gap in a Generation* and its key recommendations;
- Chapter 4 discusses government responses to the social determinants of health in Australia. Current state and Commonwealth government initiatives are reviewed; and
- Chapter 5 summarises the current data gather mechanisms for the social determinants of health, as well as arguments regarding the efficacy and appropriateness of current efforts.

Chapter 2

Evidence for the Social Determinants of Health in Australia

2.1 Even in the world's wealthiest countries there are significant discrepancies in life expectancies and health outcomes between groups in society. Research into the correlation between health outcomes and factors such as education and income has led to a growing understanding of the sensitivity of human health to the social environment. Such factors, which include education, gender, power and the conditions of employment, have become known as the social determinants of health.¹ It is argued in the World Health Organisation's Commission on Social Determinants of Health's (CSDH) report *Closing the Gap in a Generation* (WHO Report), that:

The structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequalities between and within countries.²

...

Reducing health inequities is, for the Commission on Social Determinants of Health, an ethical imperative...there is no necessary biological reason why there should be a difference in [life expectancy at birth] of 20 years or more between social groups in any given country. Change the social determinants of health and there will be dramatic improvements in health equity.³

2.2 By addressing the social determinants of health that are the genesis of many health problems, the costs to government of providing healthcare can be reduced, and individuals can enjoy better health outcomes. One recent Australian study found that by addressing the social determinants of health in line with the recommendations of the WHO Report (discussed in Chapter 3), then:

- 500 000 Australians could avoid suffering a chronic illness;
- 170 000 extra Australians could enter the workforce, generating \$8 billion in extra earnings;
- Annual savings of \$4 billion in welfare support payments could be made;

1 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 7.

2 Commission of the Social Determinants of Health, *Closing the Gap in a Generation: Health equity through action on the social determinants of health*, World Health Organisation, Geneva, 2008, p. 1.

3 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 26.

- 60 000 fewer people would need to be admitted to hospital annually, resulting in savings of \$2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of \$273 million; and
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts would need to be filled each year, resulting in annual savings of \$184.5 million each year.⁴

2.3 Social determinants do not attempt to address the choices of specific individuals, but the context in which personal choices are made. The committee heard that:

Often when people talk about social determinants they are talking about preventative health – stopping people from smoking and having poor diets or getting diabetes or HIV or whatever it happens to be. That is not actually dealing with the social determinants of health. That is an element of an approach and it is a very important element of an approach to dealing with health outcomes and population health, but it is not the whole story.

I think that sometimes we fall into that trap of thinking that, if you deal with prevention and get health promotion right, you solve health outcomes. You do not. But all you are doing is stopping someone from smoking or reducing obesity rates. You are not dealing with income, you are not dealing with educational outcomes, you are not dealing with people's housing situations, which as we know are the key things to sort out. Most of these other health issues are not such an issue in the end anyway. As we all know, there is higher prevalence of these types of diseases, illnesses and conditions in people who have poor housing, low income, poor access to education who are born in particular parts of the country.⁵

2.4 Professor Moore from the Public Health Association of Australia articulated the meaning of 'social determinants':

Australians ought to get it, because it is just about a fair go; it is just about common sense. Take as an example two people growing up in different communities. One is from the North Shore of Sydney, who has educational opportunities, is encouraged by their parents, has adequate food and has parents who are not alcoholics. Compare that person to the extreme case of somebody growing up in the community of Yuendumu, just out of Alice Springs, where there are not the educational opportunities and encouragement. I have to say they do have a lot of other things like family support and so forth; I am not saying it is all negative. But their health outcomes would be very different.⁶

4 Catholic Health Australia, *Submission 19*, p. 3.

5 Mr Symondson, Research and Policy Manager, Victorian Healthcare Association, *Committee Hansard*, 4 December 2012, p. 56.

6 Professor Moore, Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, 12 October 2012, pp. 1–2.

2.5 This chapter provides an overview of the theory and evidence underpinning the argument that social determinants of health are a major health problem that needs to be addressed, with a particular focus on Australia. The following chapter will examine the WHO Report.

The key social determinants of health

2.6 The social determinants of health are interrelated. Although they are considered here in isolation, in any one person's life several may be relevant. For example, a single parent may have limited access to the labour market which may compel the family to live in a poorer neighbourhood, enjoy fewer amenities and medical services, and buy less-nutritious food. It also means that the children may be more likely to do worse at school and later may themselves have more trouble accessing the labour market, in turn resulting in a negative impact on their health.⁷

2.7 The following sections highlight a number of key areas of life and society in which the social determinants of health play out. In particular, early childhood education, employment and income, and access to healthcare are discussed. These three issues were highlighted to the committee as being among the most important in improving the social determinants of health.⁸

Early life and children

2.8 The foundations of adult health have been shown to be laid before birth and in early childhood. Underlining the inequalities in society that can begin to impact on health from birth, the WHO Report argues:

Children from disadvantaged backgrounds are more likely to do poorly in school and subsequently, as adults, are more likely to have lower incomes and higher fertility rates and be less empowered to provide good health care, nutrition, and stimulation to their own children, thus contributing to the intergenerational transmission of disadvantage.⁹

2.9 The WHO Report is unequivocal on the importance of Early Childhood Development (ECD):

The science of ECD shows that brain development is highly sensitive to external influences in early childhood, starting in utero, with lifelong effects. The conditions to which children are exposed, including the quality of relationships and language environment, literally 'sculpt' the developing brain. Raising healthy children means stimulating their physical, language/cognitive, and social/emotional development. Healthy development during the early years provides the essential building blocks

7 HealthWest Partnership, *Submission 16*, pp. 2–3.

8 Mr Laverty, Catholic Health Australia, *Proof Committee Hansard*, 4 December 2013, p. 9; Mr Symondson, Victorian Healthcare Association, *Proof Committee Hansard*, 4 December 2013, p. 59; Professor Baum, Professor of Public Health, *Committee Hansard*, 12 October 2012, pp. 17–18.

9 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 50.

that enable people to lead a flourishing life in many domains, including social, emotional, cognitive, and physical well-being.¹⁰

2.10 Deficiencies in foetal development are a risk for health in later life. For example, infants with a birth weight less than 2.5 kilograms have almost seven times the chance of developing diabetes in later life than infants born weighing in excess of 4.3 kilograms.¹¹ Insecure emotional attachment and poor stimulation as an infant can lead to reduced readiness for school, low educational attainment, problem behaviour, and the risk of social marginalisation in adulthood. Furthermore, the development of good health-related habits such as eating sensibly, exercising and not smoking, is associated with parental and peer group examples, as well as with education.¹²

2.11 Investment in ECD has great potential to reduce health inequalities; furthermore, it is an investment likely to pay for itself many times over according to the WHO Report.¹³ There are strong intergenerational effects evident in the health and education outcomes of children. The level of education of the mother has been recognised for the last two decades as a critical determinant of child health and educational attainment.¹⁴

2.12 Speaking in relation to the social determinants of health in Australia, Catholic Health Australia CEO Martin Laverty cited early childhood experience as one of the 'best building blocks of income and social status', and argued that 'early childhood development is one of the most crucial determinants that governments and civic society organisations can invest in'.¹⁵ Similarly, Professor Fran Baum highlighted for the committee that:

I think we are still clear that the best investment we can make in terms of social determinants is giving every child a good start to life. Of course, that starts in pregnancy, and there is more and more information that there are a whole lot of things that happen when you are a foetus that affect your chances in life subsequently.¹⁶

10 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 50.

11 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, pp. 14–15.

12 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 14.

13 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 51.

14 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 50.

15 Mr Laverty, Chief Executive Officer, Catholic Health Australia, Committee Hansard, 4 December 2012, p. 9.

16 Professor Baum, Professor of Public Health, *Committee Hansard*, 12 October 2012, pp. 17–18.

2.13 In Australia, research has indicated that although all children benefit from early childhood education, the benefits are most pronounced among vulnerable children:

There is consistent evidence showing the positive impact of high-quality early education and care programs on young children's cognitive and social outcomes and adjustment to school. Importantly, while vulnerable children at risk of school failure seem to benefit most from high-quality early childhood programs, there is also evidence of far-reaching academic and social benefits for all children. Unfortunately...many of the most vulnerable children do not participate in early childhood programs or they attend the lowest quality programs. Similarly, children of working poor families are most often exposed to poor-quality care.¹⁷

Employment, income and work

2.14 Employment and working conditions have a powerful effect on health equity. Work is cited by the WHO as the key arena 'where many of the key influences on health are played out.'¹⁸ The WHO report argues that 'people's economic opportunity and financial security is primarily determined, or at least mediated, by the labour market.'¹⁹ It goes on to note that when working conditions and access to the labour market are good: '[T]hey can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial hazards.'²⁰ There are two key ways in which employment and health intersect: access to the labour market, and the nature of the work undertaken.

2.15 There are clear negative health consequences for people unable to access the labour market, or who are precariously engaged in paid employment. Unemployment negatively impacts on the health of both the unemployed person and their family.²¹ The health effects of unemployment have been linked to both its psychological consequences and the financial problems it brings, especially debt. The health effects of unemployment begin before a person actually loses their job; the insecurity people first feel when their job is threatened is also detrimental to health. Job insecurity has been linked to mental health (particularly anxiety and depression), self-reported ill-health and heart disease.²²

2.16 The committee heard that income inequalities not only impact individual health through reducing access such things as services and education, but also provide

17 Alison Elliott, *Early Childhood Education: pathways to quality and equity for all children*, Australian Council for Educational Research, 2006, p. 23.

18 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 5.

19 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 73.

20 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 5.

21 Council of Social Services NSW, *Submission 44*, p. 12.

22 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 20.

a metric for social inequality more broadly. The Tasmanian Social Determinants of Health Advocacy Network argued that:

The greater the income inequality in a country, the greater the health and social problems such as life expectancy, obesity, poor education outcomes and so forth.²³

2.17 The nature and organisation of the available work and workplaces can also impact on the health of an individual. Having little control over one's work is particularly strongly related to negative health outcomes. Similarly, receiving inadequate rewards for the effort expended at work in the form of money, status and self-esteem is associated with increased cardiovascular risk.²⁴ Physical and psychological health at work are important factors contributing to an individuals' overall health outcomes. It is increasingly recognised that maintaining a healthy work-life balance is important for health and overall wellbeing.²⁵

2.18 The clearest outcome of exclusion from the labour market is a lack of money. The committee heard that 'income is probably in everybody's top three' social determinants of health.²⁶ The impacts of low income on health can be seen through statistics provided by the Australian Social Inclusion Board that indicate that 33 per cent of people in the lowest income quintile reported fair or poor health compared with just 6.5 per cent of those in the highest income quintile.²⁷ Research by the Australian Council of Social Services provides an insight into the number of low income families in Australia, finding that:

In 2010, after taking account of household costs, an estimated 2 265 000 people or 12.8% of all people, including 575 000 children (17.3% of all children), lived in households below the most austere poverty line used in international research. This is set at 50% of the median (middle) disposable income for all Australian households...A less austere but still low poverty line, that is used to define poverty in Britain, Ireland and the European Union, is 60% of the median income....When this higher poverty line is used, 3 705 000 people including 869 000 children, were found to be living in poverty. This represented 20.9% of all people and 26.1% of children.²⁸

2.19 Poverty, relative deprivation and social exclusion have a major impact on health and premature death. Absolute poverty – a lack of basic material necessities of

23 Mrs Herzfeld, Facilitator, Tasmanian Social Determinants of Health Advocacy Network, *Committee Hansard*, 12 October 2012, p. 25.

24 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 18.

25 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 80.

26 Mr Symondson, 4 December 2012, *Committee Hansard*, p. 59.

27 Australian Social Inclusion Board, *Submission 65*, p. 4.

28 Australian Council of Social Services, *Poverty in Australia: ACOSS Paper 194*, 2012, p. 7.

life – continues to exist even in wealthy countries. Relative poverty means being much poorer than most people in society and is often defined as living on less than 60% of the national median income.²⁹ Relative poverty can deny people access to decent housing, education, transport and other factors vital to full participation in life. The stresses of living in poverty are particularly harmful during pregnancy, to babies, children and to old people.³⁰

2.20 Receiving a living wage throughout a person's life course was also highlighted by the WHO Report as essential for positive health outcomes. A living wage takes into account the current cost of living, and is regularly updated based on health needs such as adequate nutritious food, shelter and social participation.³¹ The WHO Report highlights the benefits of a strong system of social protections:

Countries with more generous social protection systems tend to have better population health outcomes, at least across high-income countries for which evidence is available...countries with higher coverage and greater generosity of pensions and sickness, unemployment and work accident insurance (taken together) have a higher [life expectancy at birth].³²

2.21 The committee received evidence that addressing income and employment disadvantage results in better health outcomes in the Australian context. A recent study conducted in the Northern Territory found that lifting socio-economic index scores for family income and education/occupation by two quintile categories for low socio-economic indigenous groups was sufficient to overcome the excess hospital utilisation among the Aboriginal population compared with the non-Aboriginal population in the Northern Territory.³³

Access to healthcare

2.22 The healthcare system itself is an important social determinant of health that is influenced by and has influence over other social determinants. Australia currently has a universal healthcare system. However, it is well documented that some areas of Australia, and some social groups, are better serviced by health infrastructure than other areas. The NSW Council of Social Services reported that:

Structural barriers in Australia's health system inhibit equitable access to health care and cause or compound health inequalities. These include health care costs and user fees, unavailability of timely, quality services, and low health literacy. For instance, more than a quarter of people (26.4%) report

29 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 16.

30 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 16.

31 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 78.

32 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 85.

33 Northern Territory Government Department of Health, *Submission 64*, p. 2.

financial barriers to seeing a dentist, and nearly one in ten people (8.7%) delayed or did not see a GP due to cost. Australians in the most disadvantaged areas have lower rates of dental services, optometry services, and ambulatory mental health services.³⁴

2.23 According to the WHO Report, universal coverage means that everyone within a country can access the same range of goods and services according to needs regardless of their level of income or social status.³⁵ The National Health and Hospitals Reform Commission has highlighted inequalities in healthcare in Australia including gaps in dental, public hospital and mental health services.³⁶ People living in rural locations with minimal access to healthcare report poorer health outcomes and lower life expectancies than people living in major metropolitan areas.³⁷ The Australian Institute of Health and Welfare's *Health Workforce 2025* reported that:

...people living in regional, rural and remote areas exhibit:

- 20 percent higher self-reported rates of fair or poor health;
- 10 percent higher levels of mortality;
- 20 percent higher rates of injury and disability;
- 10-70 percent higher rates of perinatal death.³⁸

2.24 Although access to most healthcare is subsidised through Medicare to ensure access for all people to medical treatment, access to certain areas of healthcare appears to remain constrained by income with Professor Friel noting:

We see this already in Australia – for a given level of need, socio-economically advantaged women are more likely to use specialist medical, allied health, alternative health and dental services than less advantaged women.³⁹

2.25 As can be seen from the above examples, the provision of healthcare services, and access to them, are social determinants of health.

The social gradient

2.26 There is a relationship between people's social circumstances and economic wellbeing, and their health, referred to as the social gradient. As explained by Professor Friel, one of the of the WHO Report's authors: 'As one moves down the socio-economic ladder the risk of shorter lives and higher levels of disease risk factors increases.'⁴⁰ Researchers have labelled this the social gradient of health.⁴¹ The social

34 Council of Social Services NSW, *Submission 44*, p. 15.

35 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 8.

36 Professor Friel, Professor of Health Equity, *Submission 2*, p. 2.

37 Professor Friel, Professor of Health Equity, *Submission 2*, p. 2.

38 Australian Institute of Health and Welfare, *Health Workforce 2025*, volume 1, Canberra, 2012, pp 157–158.

39 Professor Friel, Professor of Health Equity, *Submission 2*, p. 3.

40 Professor Friel, Professor of Health Equity, *Submission 2*, p. 2.

gradient is not confined to relatively poor countries. Recent research undertaken in Australia has borne out this trend:

The NATSEM report that Catholic Health Australia commissioned indicated that a person in the lowest socioeconomic group in Australia can expect to die on average some three years earlier than someone in the highest socioeconomic group. That report also indicated that a person in the lowest socioeconomic group can expect to have twice the prevalence of chronic illness during their life than someone in the highest socioeconomic group.⁴²

2.27 Evidence for a social gradient of health was not confined to one problem or group, with one study finding that:

Socioeconomic differences were found in all the health indicators studied, and were evidence for both men and women and for both age groups. Health of Australians of working age was found to be associated with socio-economic disadvantage, irrespective of how socio-economic status or health was measured...Household income, level of education, household employment, housing tenure and social connectedness all matter when it comes to health.⁴³

2.28 Health outcomes are heavily impacted by the context in which people work, live, and play:

One of the quite critical issues that comes up around social determinants is the balance between people's personal responsibilities in relation to health and what is socially determined and drives their health. If it were simply up to individuals then you would have no social gradient, basically; you would not be able to see that in your data. It would not matter if somebody were in the top quintile rather than the bottom quintile.⁴⁴

2.29 In other words, without a social gradient of health, a wealthy person would be equally as likely as a poor person to be obese or to experience a range of other health problems. The available evidence indicates however that this is not the case, and it is deduced from this that something other than each individual's decisions must be influencing health outcomes.⁴⁵

41 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 31.

42 Mr Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 1.

43 National Centre for Social and Economic Modelling, *Health Lies in Wealth: health inequalities in Australians of working age*, September 2010, p. 35.

44 Ms Sylvan, Chief Executive Officer, Australian National Preventive Health Agency, *Committee Hansard*, 11 December 2012, p. 1.

45 NATSEM, *Health Lies in Wealth: health inequalities in Australians of working age*, September 2010, pp. 23–29.

2.30 Areas of health showing a strong social gradient are broad including heart disease, diabetes, asthma, mental health conditions and obesity.⁴⁶ The underlying objective in social determinants of health theory is to level the social gradient so that health outcomes are not determined by one's place in the economic hierarchy of society, and to improve health by targeting structural factors that can lead to harm.

Education

2.31 A crucial social determinant of health, according to the WHO Report, is ensuring that people have access to quality education throughout their lives.⁴⁷

2.32 For children, the environment into which they are born can play a decisive role in their later scholastic achievements. The socio-economic position of a child's parents has been shown to play a significant role in educational outcomes. This holds true in developed countries with universal education such as Australia. As explained by macroeconomist Joann Wilkie:

High-income earning parents may be able to purchase or produce better 'inputs' for their children's development. Low-income earning parents cannot offer their children the same quantity or quality of inputs. Studies have shown that children from low-income backgrounds are more likely to have lower educational attainment and earnings in adulthood than those from high-income households.⁴⁸

2.33 Evidence from the United States of America demonstrates the impact of education on the social gradient of health:

Reports in 2005 revealed the mortality rate was 206.3 per 100,000 for adults aged 25 to 64 years with little education beyond high school, but was twice as great (477.6 per 100,000) for those with only a high school education and 3 times as great (650.4 per 100,000) for those less educated.⁴⁹

2.34 Evidence from the Australian Bureau of Statistics highlighted the positive impact education can have on Indigenous health, finding that:

In 2008, 59 per cent of Aboriginal and Torres Strait Islander people aged 15–34 years who had completed Year 12 reported excellent/very good health compared with 49 per cent of those who had left school early (Year 9 or below).⁵⁰

46 Professor Friel, Professor of Health Equity, *Submission 2*, p. 2.

47 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 79.

48 Joann Wilkie, 'The role of education in enhancing intergenerational income mobility', *Economic Round-Up*, Canberra, Spring 2007, p. 84.

49 Catholic Health Australia, *Submission 19*, p. 8.

50 Australian Bureau of Statistics, *4704.0 – The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, October 2010, available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/lookup/4704.0Chapter365Oct+2010>, accessed: 18 December 2012.

2.35 For Australia more broadly, data presented by the Department of Health and Ageing (Department) showed clearly that long-term health risk factors such as obesity, diabetes, hypertension and arthritis are higher for early school leavers than those that go on to complete Year 12.⁵¹ Similarly, the *Health Lies in Wealth* report found that: 'Early high school leavers...are 10 to 20 per cent less likely to report being in good health than those with a tertiary education.'⁵²

2.36 The importance of education continues throughout a person's life. Access to education enables people to changing jobs or retrain when they are not in work. Education is a major contributor to intergenerational social mobility as individuals who are more highly educated typically receive higher remuneration and the health benefits that brings.⁵³

Social security

2.37 The WHO Report emphasized that all people need social protection throughout their lives from infancy and childhood, throughout their working years and in old age, providing surety in times of disability, injury or loss of work.⁵⁴ The Report noted that: 'Generous universal protection systems are associated with better population health, including lower excess mortality among the old and lower mortality levels among socially disadvantaged groups.'⁵⁵

2.38 A major obstacle in improving society-wide health outcomes is intergenerational poverty.⁵⁶ Children born to parents from lower socioeconomic backgrounds are more likely to do poorly at school,⁵⁷ more likely to be unemployed, and more likely to have poor health. Adequate social protection systems can prevent intergenerational poverty and prevent temporary unemployment from becoming entrenched unemployment.

2.39 This chapter has already canvassed the negative health impacts that can be caused by poverty. Recent research indicates that those most likely to be impoverished are reliant on social security payments: unemployed households, single adults over 65 years of age, and households whose main income is social security.⁵⁸ The committee heard that unemployment allowances in Australia had not been increased in real terms

51 Department of Health and Ageing, *Submission 60*, p. 12.

52 National Centre for Social and Economic Modelling, *Health Lies in Wealth: health inequalities in Australians of working age*, September 2010, p. 36.

53 Joann Wilkie, 'The role of education in enhancing intergenerational income mobility', *Economic Round-Up*, Canberra, Spring 2007, pp. 84, 91–92.

54 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 84.

55 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 7.

56 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 7.

57 Janet Taylor and Nina Gee, *Turning 18: Pathways and Plans – Life chances study stage 9*, Brotherhood of St Laurence, 2010, p. 9.

58 Australian Council of Social Services, *Poverty in Australia: ACOSS Paper 194*, 2012, p. 8.

for over two decades, and that now 'over 50 per cent of people living on [Newstart] are living below the poverty line.'⁵⁹ The New South Wales Council of Social Services expressed concern that the current levels of income support are insufficient to keep people out of poverty, and therefore out of poor health:

The [Councils of Social Services] have serious concerns about the inadequacy and inequality of unemployment and income support payments. We believe that it is everyone's right to have access to paid work, and when looking for paid work, to have income support to live with dignity. Yet our social security system is failing to provide people with this basic guarantee, plunging people into poverty.⁶⁰

2.40 While it is important to have sufficient social supports in place to protect people throughout the life cycle, it is also necessary to ensure that there are steps in place to move people from the welfare system to employment. It was pointed out to the committee that in the case of Tasmania, the number of people in receipt of government aid has not changed in a long time, and it is necessary to establish pathways to assist people into employment:

We do have to find better ways of getting the third of the population who are on income support payments back into the workforce, back into participating in life. For those who have disabilities, et cetera, that does not mean that they are not able to be engaged in work or in social activities. It is important for us to start to look at that more closely and how we can shift that. That 30 per cent figure has not changed in a long, long time and I think it is something we definitely have to look at as well.⁶¹

Lifestyle factors: food, addiction, stress

2.41 Lifestyle factors that can cause poor health such as diet, alcohol and tobacco use are often deemed to be, and responded to, as individual factors that should be addressed through individual behavioural change. Professor Friel highlighted for the committee the correlation of environmental factors – in this case social status – on individual health outcomes, explaining:

The systematic evolution and continuation of the uneven distribution of obesity, tobacco and alcohol use suggests that there is something about the broader society that is affecting people's ability to pursue healthy behaviour, increasingly so with decreasing social status.⁶²

2.42 The social determinants approach shifts the focus – and thereby the necessary solution – from the individual to the context.

59 Dr Goldie, Chief Executive Officer, Australian Council of Social Services, *Committee Hansard*, 23 November 2012, p.26.

60 Council of Social Services NSW, *Submission 44*, p. 12.

61 Mrs Herzfeld, Facilitator, Tasmanian Social Determinants of Health Advocacy Network, *Committee Hansard*, 12 October 2012, p. 28.

62 Professor Friel, Professor of Health Equity, *Submission 2*, p. 3.

2.43 It was noted by the Northern Territory Department of Health that many of the 'lifestyle' risk factors are exacerbated by other social determinants of health:

Many of the modifiable risk factors that influence the development of chronic conditions such as smoking, consumption of excess alcohol, poor diet and limited physical activity are linked to the [social determinants of health], and are exacerbated by other [social determinants of health] such as level of income, limited education and unemployment which are risk factors for chronic conditions in their own right.⁶³

2.44 A good diet is central to health and well-being. Social and economic conditions result in a social gradient in diet quality that contributes to health inequalities. Food insecurity is not typically considered a problem for countries such as Australia, however levels of food insecurity have been found to impact between 5–10 per cent of the population.⁶⁴ Excess intake (also a form of malnutrition) contributes to cardiovascular disease, diabetes, cancer, degenerative eye diseases, obesity and dental caries. The main difference between social classes is the source of the nutrients, with poor demographics tending to substitute cheaper processed food for fresh food. People on low incomes, such as young families, the elderly and unemployed are least able to eat well and are therefore most at risk.⁶⁵ One explanation for this trend is provided by the WHO Report:

Trade liberalisation – opening many more countries to the international market – combined with continuing food subsidies has increased the availability, affordability, and attractiveness of less healthy foodstuffs, and transnational food companies have flooded the global market with cheap-to-produce, energy-dense, nutrient-empty foods.⁶⁶

2.45 Social and psychological circumstances can cause long-term stress which is harmful to human health. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over home and work life have powerful effects on health. Such psychological risks accumulate over life and increase the chances of a person suffering from poor health.⁶⁷

2.46 Alcohol dependence, illicit drug use and cigarette smoking are all closely associated markers of social and economic disadvantage. All three are a significant drain on the financial resources of poorer people and a large cause of health problems and premature death.⁶⁸ In Australia, for example, areas of relative disadvantage such

63 Northern Territory Government Department of Health, *Submission 64*, p. 1.

64 Macarthur Future Food Forum, *Submission 15*, p. [3].

65 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 26.

66 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, pp 134–135.

67 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 12.

68 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 24.

as regional areas show significantly higher rates of alcohol and tobacco use than wealthier metropolitan areas.⁶⁹

Urban design

2.47 The planning and design of urban environments has a major impact on health equity through its influence on behaviour and safety.⁷⁰ The WHO Report notes that:

Where people live affects their health and chances of leading flourishing lives. Communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being, and that are protective of the natural environment are essential for health equity.⁷¹

2.48 For the first time in human history more people live in urban than rural areas.⁷² The impact of the growing urbanisation on human health will be determined, in many ways, by the decisions regarding how urban areas are developed and maintained. Improvements over the last 50 years in mortality and morbidity in highly urbanised countries such as Japan, the Netherlands, Singapore and Sweden highlight that modern cities can be healthy environments. The above examples also point towards the importance of supportive political structures, appropriately applied financial resources, and social policies that underpin the equitable provision of conditions and services.⁷³

2.49 The kind of neighbourhood an individual lives in also impacts on their exposure to crime – which tends to concentrate in specific areas, and availability of and access to appropriate housing and transport.⁷⁴ Evidence provided from the Australian Council of Social Services highlighted the impact of income on access to services, noting: 'that there was virtually nowhere in the capital cities that people living on social payments could afford to rent in the private rental market.'⁷⁵

2.50 While there is evidence that urban environments can be places of health, there are also threats to human health. One of the greatest emerging health issues among

69 Tobacco use is reported to be 24 percent higher, while rates of risky alcohol consumption increases by 32 percent. Australian Institute of Health and Welfare, *Health Workforce 2025*, volume 1, Canberra, 2012, pp 157–158.

70 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 4.

71 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 60.

72 Central Intelligence Agency, *World Fact Book*, available from: <https://www.cia.gov/library/publications/the-world-factbook/geos/xx.html>, accessed: 19 September 2012.

73 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 63.

74 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, pp 62–66.

75 Dr Goldie, Chief Executive Officer, Australian Council of Social Services, *Committee Hansard*, 23 November 2012, p.26.

wealthy countries is obesity, a problem particularly prevalent among socially disadvantaged groups in many cities throughout the world.⁷⁶ The WHO Report argues:

Physical activity is strongly influenced by the design of cities through the density of residences, the mix of land uses, the degree to which streets are connected and the ability to walk from place to place, and the provision of and access to local public facilities and spaces for recreation and play. Each of these plus the increasingly reliance on cars is an important influence on shifts towards physical inactivity in high- and middle-income countries.⁷⁷

2.51 Transport policy can play a key role in combating sedentary lifestyles by reducing reliance on cars and increasing the number of people who walk, cycle and use public transport. Not only does walking and cycling improve an individual's health, it reduces the cost to society of road deaths and injuries, has a lower environmental impact, and increases social interactions. Urban areas that depend on car use isolate the young and the old.⁷⁸ The WHO Report highlights the 'vicious cycle' of growing car dependence, land-use change to facilitate car use, and increased inconvenience of non-motorised transport modes leading to even more car use.⁷⁹ The report goes on to call for the prioritisation of walking and cycling over car use in order to address some of the health impacts of existing urban environments.⁸⁰

Social Exclusion

2.52 A person's inclusion in society and control over their destiny are each important for social development and health. Having the freedom to participate in economic, social, political, and cultural relationships has been shown to have intrinsic value.⁸¹ Social exclusion may result from unemployment, discrimination, stigmatisation and other reasons. Poverty and social exclusion also increase the risks of divorce and separation, disability, illness, and addiction. People who live in, or have recently left institutions such as prisons, psychiatric homes and orphanages are particularly vulnerable. The greater the length of time that people live in

76 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 62.

77 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 62.

78 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 28.

79 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 66.

80 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 67.

81 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 157.

disadvantaged circumstances, the more likely they are to suffer from a range of health problems.⁸²

2.53 Being included in the society in which one lives is vital to the material, psychological, and political aspects of inclusion that underpin social well-being and equitable health. As noted by the WHO Report:

Health equity depends vitally on the empowerment of individuals and groups to represent their needs and interests strongly and effectively and, in doing so, to challenge and change the unfair and steeply graded distribution of social resources to which all men and women, as citizens, have equal claims and rights.⁸³

2.54 Social support and good social relations make an important contribution to health. Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. Supportive relationships may also encourage healthier behavioural patterns. High levels of social cohesion, defined as the quality of social relationships and the existence of trust, mutual obligation and respect in communities, also help protect a person's health.⁸⁴

Conclusion

2.55 Good health involves improving access to education, reducing insecurity and unemployment, improving housing standards, and increasing the opportunities for social engagement available for all citizens. Addressing the discrepancies of health outcomes resulting from the prevailing social determinants means addressing the causes of those social determinants. The following chapters discuss areas of possible government action to address the social determinants of health in Australia.

82 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 16.

83 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 155.

84 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 22.

Chapter 3

Social Determinants of Health: the World Health Organisation's policy agenda

3.1 Over the last several decades, there has been increasing recognition that social determinants of health have an impact on human health, and that they must be addressed if the overarching goals of health equality among all people are to be achieved. At the 1978 International Conference on Primary health Care in Alma Ata, governments from around the globe affirmed a holistic view of health as more than the absence of illness, and that maintaining high standards of health required action in the social and economic spheres, declaring:

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.¹

3.2 Almost a decade later in 1986, the first International Conference on Health Promotion held in Ottawa, Canada, culminated in the 'Ottawa Charter for Health Promotion' (Ottawa Charter). The Ottawa Charter highlighted a number of prerequisites for health including peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.²

3.3 More recently, the 1997 WHO Global Conference on Intersectoral Action for Health, the 2005 Bangkok Health Promotion conference and the 2006 EU's Finnish presidency's theme of Health in All Policies each recognised that political, economic, social, cultural, environmental, behavioural, and biological factors can all favour health or be harmful to it, and the need for all sectors of society to be involved in health policy.³ These milestones demonstrate an appreciation in the international community that the most effective means of tackling the social determinants of health is through intersectoral action. As most of the determinants of health lie outside of the health sector, the solutions will have to involve areas outside the health sector.

1 International Conference on Primary Health Care, 'Declaration of Alma Ata', Alma Ata, 12 September 1978, available from: http://www.who.int/publications/almaata_declaration_en.pdf, accessed: 4 October 2012.

2 First International Conference on Health Promotion, 'The Ottawa Charter for Health Promotion', Ottawa, 21 November 1986, available from: <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>, accessed: 4 October 2012.

3 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 110.

3.4 In 2008 the World Health Organisation's (WHO) Commission on Social Determinants of Health published a report titled 'Closing the gap in a generation: health equity through action on the social determinants of health' (WHO Report).⁴ This report refocused attention on the necessity of addressing the social determinants of health. In the words of one of the report's authors, the WHO Report:

...shone a global spotlight on the marked health inequalities that exist between and within countries at the start of the 21st century...the [WHO Report] in 2008 was a call to action to governments and non-governmental agencies around the world to adapt the necessarily general global recommendations into national and local socioeconomic and sociocultural contexts.⁵

3.5 The Australian perspective was actively represented on the Commission with one of the 19 commissioners being Australian. During the preparation of the WHO Report there was also a seminar in Adelaide which considered the social determinants of indigenous health.⁶

3.6 In May 2009, following the publication of the WHO Report, WHO Resolution 62.14 urged member states:

To tackle the health inequities within and across countries through political commitment on the main principles of 'closing the gap in a generation' as a national concern, as is appropriate, and to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, where appropriate, by using health and health equity impact assessment tools; [and]

...

To take into account health equity in all national policies that address social determinants of health, and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being.⁷

3.7 In the wake of the report a number of countries around the world and governments in Australia began exploring options to address the social determinants of health within their own populations.

4 Commission on the Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*, Geneva, World Health Organisation, 2008.

5 Professor Sharon Friel, *Submission 2*, pp. [1–2].

6 Professor Baum, Southgate Institute for Health, Society and Equity, *Committee Hansard*, 12 October 2012, p. 19.

7 World Health Organisation Resolution 62.14, 21 May 2009, available from: http://apps.who.int/gb/ebwha/pdf_files/WHA62-REC1/WHA62_REC1-en-P2.pdf, accessed: 9 October 2012, p, 23.

3.8 The key social determinants of health vary between countries: developed and developing countries necessarily face different challenges and will need to adopt different solutions. In developed countries – such as Australia, a low socioeconomic position means fewer education and employment opportunities, job insecurity, poorer working conditions, a lack of amenities, and unsafe neighbourhoods, with their consequent impact on family life.⁸

Recommendations from the Commission on Social Determinants of Health

3.9 The WHO Report highlighted three broad key areas for action:

- Improve daily living conditions including education, nutrition, working conditions, and social protections;
- Address the inequitable distribution of power, money and resources; and
- Maintain accurate measurements of social determinants of health and assess new policies' potential impact on health outcomes.⁹

3.10 The WHO Report notes that although there are broad principles that can be used to guide action in addressing the social determinants of health, precise policy measures need to be devised by each individual nation depending on their individual circumstances.¹⁰ This chapter highlights the key policy areas nominated by the WHO Report for action. The following chapters will discuss policy options for the Australian context.

Strengthening public sector leadership

3.11 The Report notes the importance of public sector leadership in effective national and international regulation of products, activities, and conditions that damage health or lead to health inequalities.¹¹ As the report explains:

Underpinning action on the social determinants of health and health equity is an empowered public sector, based on principles of justice, participation, and intersectoral collaboration. This will require strengthening of the core functions of government and public institutions, nationally and sub-nationally, particularly in relation to policy coherence, participatory governance, planning, regulation development and enforcement, and standard setting.¹²

8 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 31.

9 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 2.

10 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 46.

11 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 14.

12 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 45.

3.12 A key proposal put forward in the WHO Report to improve the social determinants of health is the inclusion of a health equity impact statement as a component of public policy creation and administration to ensure that all policies are assessed against their potential health impacts.¹³ Policy coherence is highlighted as a key area of concern; ensuring that all government policies complement each other in relation to promoting health equity is an important step in addressing the social determinants of health.¹⁴ This extends beyond the traditional domains of health: all policies should be assessed for their health impact.¹⁵ In the words of the WHO: 'The argument for a coherent approach to health equity through action on the social determinants in all socioeconomic and sociocultural contexts is unequivocal.'¹⁶ The WHO Report argues that: 'Health equity impact assessment of policies and programmes must happen as a matter of course – that is, it should be a routine procedure in policy development.'¹⁷

3.13 One recommendation in the WHO Report is that governments formally commit to improving health equity through action on the social determinants of health as a measure of government performance.¹⁸ One mechanism to achieve this is through reporting mechanisms. This option is discussed in more detail in Chapter 5 of this report.

Ensure universal social protection

3.14 The WHO report argues that universal social protections are important for population health in general, and especially for disadvantaged groups, and recommends that social protection systems are universal in scope and extend across the life course. Universality in this context means that all citizens have access to social protection as a social right. It is argued that:

Universal approaches are important for the dignity and self-respect of those who need social protection the most. And because everybody benefits, rather than just one group that is singled out, universal social protection systems can enhance social cohesion and social inclusion, and can be politically more acceptable. Including the middle classes by means of universal programmes can enhance willingness of large parts of the

13 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, pp. 114, 190.

14 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 110.

15 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 136.

16 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 111.

17 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 190.

18 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 111.

population to pay the taxes needed to sustain universal and generous policies.¹⁹

3.15 The report goes on to note that universal benefits can improve the social status and inclusion of older people who can no longer earn a living in the market, and also decrease gender inequalities as women tend to live longer and earn less than men making contributory pension schemes disadvantageous.²⁰

3.16 The WHO Report emphasizes the importance of ensuring universal access to healthcare based on the principle of access rather than ability to pay. Out of pocket expenses are argued to generate 'utilisation inequalities' and potentially exclude vulnerable groups such as the aged and single parents.²¹

3.17 The WHO Report highlights the importance of adequate funding to address the social determinants of health. As the report explains:

Health equity relies on an adequate supply of and access to material resources and services; safe, health-promoting living and working conditions; and learning, working, and recreational opportunities. Supply of and access to these, in turn, requires public investment and adequate levels of public financing, and/or regulation of markets where private provision can be an effective and efficient means of equitable access...Traditionally, governments are expected to play an active role in providing public goods. Left solely to the market, such goods are undersupplied.²²

Promoting gender equality

3.18 The WHO has pointed out that, globally, women control less capital, receive lower wages, and carry more of the domestic burdens than their male counterparts. This trend is as true in developed as developing countries. In order to address the social determinants of health, there is a need to improve the status and position of women in society; ensuring that they receive the same remuneration as men for the same work, that their domestic contributions are not overlooked, and that they are compensated for reduced earnings caused by familial responsibilities such as child-birth and -rearing.²³

19 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, pp. 87–88.

20 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, pp. 88, 91.

21 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, pp. 99–103.

22 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 120.

23 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, pp. 145–154.

3.19 It was suggested that the provision of quality childcare facilities, flexible working hours, and parental leave for men and for women would assist in improving gender equality.²⁴

3.20 One of the serious consequences of women receiving lower wages than men and spending more time out of the labour market as a consequence of acting as primary caregivers is that they have lower accumulated retirement incomes. Poverty and low pension benefits are strongly associated with worse health outcomes.²⁵

Lesbian, Gay, Bisexual, Transgender and Intersex people

3.21 During the inquiry the committee heard some criticism of the lack of consideration of Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people in the WHO Report.²⁶ Although the WHO report discusses the impacts of gender on the health of women and girls, there is no mention of sexuality, nor its impacts on health.

3.22 The committee received evidence from a number of submissions that LGBTI social determinants of health should also be considered in any government response.²⁷ Evidence provided to the committee highlighted that in Australia sexuality acts a social determinant of health and needs to be recognised as such.²⁸ Fields such as education and access to healthcare were cited as key areas in which the social determinants of health are acting on LGBTI people.²⁹

Improve understanding of the social determinants of health

3.23 One of the key recommendations of the WHO Report – to improve the measurement and understanding of the social determinants of health – is born out of the acknowledgement that in many areas there is limited data available on the impacts and causes of the social determinants of health. The standard tools found in the researchers toolbox such as controlled trials and benchmarking are difficult (and often unethical) to apply to a community.³⁰ Establishing chains of cause and effect for social determinants of health is conceptually and empirically difficult as many

24 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 153.

25 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 152.

26 Victorian Gay and Lesbian Rights Lobby Policy Working Group, *Submission 50*.

27 Victorian Gay and Lesbian Rights Lobby Policy Working Group, *Submission 50*, National LGBTI Health Alliance, *Submission 42*.

28 Ms Brown, Victorian Gay and Lesbian Rights Lobby, *Committee Hansard*, 4 December 2012, p. 31.

29 Ms Brown, Victorian Gay and Lesbian Rights Lobby, *Committee Hansard*, 4 December 2012, p. 31.

30 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 42.

determinants are distant – spatially and temporally – from the individuals they impact.³¹

3.24 Although the WHO Report recognises the limitations in the available data, especially in relation to the most effective interventions to address the social determinants of health, the available evidence appears to strongly correlate with the theory of social determinants of health as discussed in the previous chapter. Chapter five of this report provides a more fulsome discussion of the importance of research and data to addressing the social determinants of health.

3.25 Successfully tackling the social determinants of health will require evidence-based policies. As the name implies, this will require good data on the extent of the problem, and up-to-date evidence on determinants and on what works to reduce health inequalities. It also requires that policy-makers and other professions understand both the social determinants of health and the evidence available in relation to them.³²

3.26 In order to successfully research the social determinants of health, adequate research funding needs to be made available. The WHO Report argues that although the largest health improvements come from addressing the social determinants of health, the available research funding remains 'overwhelmingly' biomedically focused.³³

3.27 In light of the large amount of work that needs to be done to adequately understand the social determinants of health, the WHO Report highlights three key areas of action:

First, research on determinants of health inequalities, rather than determinants of average population health, need further study. Second, more research is needed on what works to reduce health inequalities in what circumstances, and how best to implement interventions such that they contribute to a reduction of these inequalities...The third area for investment is the development of methods for measuring and monitoring health inequities and for evaluating the impact of population-level interventions.³⁴

3.28 The WHO Report advocates that governments collect data on the most important social determinants of health ranging from daily living conditions to more structural drivers of health inequality. The system, it is argued, should be designed in

31 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 42.

32 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 178.

33 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, pp. 179, 186.

34 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 186.

such a way that it is possible to follow differences in gender and social-strata outcomes over extended periods of time.³⁵

Conclusion

3.29 The theory and evidence for the social determinants of health having a direct impact on the lives of individuals has been well documented by the WHO and researchers from around the world. The WHO Report touches on almost all areas of society and government responsibility. In response to the rising awareness of the expansive nature of the social determinants of health, a number of countries have begun taking a social determinant of health approach to public policy making. There are also several initiatives in Australia which are beginning to address the social determinants of health. The following chapter discusses various social determinants of health and potential means to addressing them in the Australian context.

35 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 181.

Chapter 4

Government responses to the Social Determinants of Health

4.1 This chapter discusses current government action to address the social determinants of health in Australia and also alternative models put forward as possible means to improve Commonwealth government endeavours to address the social determinants of health of Australians.

Efforts to address the social determinants of health by State governments

4.2 The committee received evidence that governments around Australia are individually, and together, taking action to address the social determinants of health. An example of intergovernmental action is the *Closing the Gap* initiative, through which the Commonwealth, in partnership with other governments, is making efforts to address social determinants of health amongst Indigenous Australians. The Northern Territory's Department of Health reported that:

At a national level through the Council of Australian Governments and at a Territory level, actions have been taken to raise awareness of the Social Determinants of Health. In the Northern Territory responses include funding agreements with the Commonwealth Government through Closing the Gap and Stronger Future agreements.¹

4.3 Different State and Territory governments are adopting a variety of approaches to address the social determinants of health in their individual jurisdictions. The Northern Territory, for example, reported that it is addressing the social determinants of health through the *Northern Territory Chronic Conditions Prevention and Management Strategy 2010–2020* by improving living conditions, food security, education, employment and health literacy.²

4.4 In response to calls for greater action on social determinants of health the Tasmanian Government initiated the *Fair and Healthy Tasmania Strategic Review* in 2010 to consider the most appropriate approaches to improve health and reduce health inequality in Tasmania.³ In response to the *Fair and Healthy Tasmania Strategic Review* the Tasmania Government launched *A Healthy Tasmania* which outlines six streams of activity to address the social determinants of health.⁴ One notable feature of Tasmania's efforts in improving health equality is specific reference to the social determinants of health as an important area of action for government.

1 Northern Territory Government Department of Health, *Submission 64*, p. 1.

2 Northern Territory Government Department of Health, *Submission 64*, p. 2.

3 Department of Health and Human Services Tasmania, *Submission 22*, p. 11.

4 Department of Health and Human Services Tasmania, *Submission 22*, p. 12.

4.5 The South Australian government's actions in addressing the social determinants of health were regularly cited in submissions to this inquiry as representing the best practise approach to addressing the social determinants of health. The South Australian government has adopted a collaborative interdepartmental response to the social determinants of health. Demonstrative of the South Australian government's commitment to addressing the social determinants of health, the Minister for Health and Ageing specifically referred to the WHO Report in his second reading speech for the *Public Health Act 2011 (SA)* noting that the legislation 'in part provides for South Australia's response to this challenge.'⁵ It was explained to the committee that 'in particular, [the legislation] includes principles of sustainability, partnerships, equity and prevention, providing a mandate for working together and recognising that the social determinants of health are fundamental to improving population health outcomes.'⁶

4.6 Other components of the South Australian government's approach include the introduction of the Health in all Policies initiatives – discussed in further detail below – and the identification of strategic priority areas in domains such as housing, employment and education.⁷

4.7 The Australian government has not implemented any formal response to the WHO recommendations. The approaches taken by the South Australian and Tasmanian Government were assessed by the Department as 'combining traditional policy development models with locally relevant policy drivers and objectives.'⁸

4.8 In preparation for the Helsinki 2013 8th Global Health Conference on Health Promotion, a number of Australian jurisdictions, led by SA Health, have formed a working group to develop a publication of Australian case studies of action on social determinants and health equity.⁹ As explained by the Tasmanian Department of Health and Ageing:

The Australian social determinants case studies book will be used to promote and document examples of Australia's work on the social determinants at the Global Conference, as well as providing a useful resource for jurisdictions. Its purpose is to support the current momentum for action on social determinants and health equity in Australia and overseas.¹⁰

5 The Hon. J.D. Hill, Minister for Health, *South Australian House of Assembly Hansard*, 29 September 2010, p. 1389.

6 Dr Buckett, Director of Public Health, SA Health, *Committee Hansard*, 4 December 2012, p. 19.

7 South Australian Government, *Submission 51*, p. 3.

8 Department of Health and Ageing, *Supplementary Submission*, p. 13.

9 Department of Health and Human Services Tasmania, *Submission 22*, p. 8; South Australian Government, *Submission 51*, p. 3.

10 Department of Health and Human Services Tasmania, *Submission 22*, p. 8.

4.9 The committee heard that at the domestic intergovernmental level COAG has developed a range of responses to indirectly address the social determinants of health by the implementation of a range of programs, strategies and frameworks, including those funded under the National Partnership Agreement Preventative Health and the National Partnership Agreement Indigenous Early Childhood Development.¹¹

The Commonwealth Government

4.10 One of the terms of reference of this inquiry is the role of the Commonwealth in addressing the social determinants of health, and the extent to which the Commonwealth is adopting a social determinants of health approach to programs and services, administrative arrangements, and data gathering and analysis.

4.11 The Department, appearing at a public hearing in Canberra, informed the committee that the Commonwealth is already undertaking a social determinants of health approach:

An approach is taken, certainly by our department, that recognises the interconnectedness and complexity of the social determinants of health through integrated approaches to the development and implementation of social policy and programs, both at the Commonwealth level but also across all levels of government...Using evidence and innovation the government is working in a coordinated way with other governments across the spectrum of determinants—education, housing, income support and social inclusion—to provide a mix of universal and targeted programs that contribute to improved health and wellbeing outcomes.¹²

4.12 There are instances within the Department's submission that appear to use the common language of the social determinants approach. For example, when discussing the development of a National Aboriginal and Torres Strait Islander Health Plan to tackle disadvantage, the submission states:

The Australian Government recognises that avoidable health inequalities arise because of the circumstances in which people grow, live, work and age, and that factors such as education, income, housing and community functions affects the health of people and influences how a person interacts with health and other services.¹³

4.13 However, in spite of the evidence presented to the committee arguing that the Commonwealth is taking numerous measures to address the social determinants of health, evidence for these claims appears to be minimal. Word searches of recent annual reports and appearances by the Department at Senate Estimates hearings reveal that:

11 Northern Territory Government Department of Health, *Submission 64*, p. 5.

12 Ms Flanagan, Deputy Secretary, Department of Health and Ageing, Committee Hansard, 23 November 2012, p. 34.

13 Department of Health and Ageing, *Submission 60*, p. 20.

- The 564–page 2011–12 Annual Report makes one mention of social determinants of health;¹⁴
- The 634–page 2010–11 Annual Report makes one mention of the social determinants of health;¹⁵ and
- There have been no mentions of the social determinants of health during appearances at Senate Estimates in either 2011–12 or 2012–13.

4.14 Evidence provided in the Department's supplementary submission also appears to emphasize that they currently maintain a traditional focus on addressing health concerns using the health system as the primary vehicle for attaining improved health outcomes, stating:

While many factors affect health, recognition must be given to the importance of health programs and policies on health. There is a risk that focusing on delivering programs more broadly, outside the health sector, may result in inadequate resourcing of health programs. If such diversity leads to dilution of health effort, or adversely impacts on access to health services, health outcomes may suffer.¹⁶

4.15 The committee was not alone in querying whether the Department was taking the kind of social determinants approach as indicated in their submission. HealthWest Partnership, at the request of the committee, reviewed the submission of the Department and concluded:

On review of the DOHA submission, it was not clear that social determinants were being considered as complex, interlinked and requiring comprehensive response, as would be expected if a Health in All Policies approach was adopted.¹⁷

4.16 These facts appear to support the observation made to the committee by Catholic Health Australia that noted that Australia has so far addressed the social determinants of health 'in an ad hoc and not necessarily coordinated way.'¹⁸ Catholic Health Australia did highlight however that on many fronts the Commonwealth, and Australia as a whole, already has important investments and mechanisms in place:

The submission of the Department of Health and Ageing indicates the significant investment the Australian government makes and we, too, from Catholic Health Australia's perspective, acknowledge that the quality of early childhood development, of our schools and of workforce participation

14 Department of Health and Ageing, *Annual Report 2011–12*, p. 84.

15 Department of Health and Ageing, *Annual Report 2010–11*, p. 85.

16 Department of Health and Ageing, *Supplementary Submission*, p. 17.

17 HealthWest Partnership, answers to questions on notice, 4 December 2012 (received 20 December 2012).

18 Mr Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 3.

programs in Australia and, indeed, the social safety net which exists in our welfare system, that all of these important parts of social infrastructure go a long way to addressing social determinants of health. But what we see, despite this very good social safety net and very good social infrastructure of schooling and early childhood support, is that some Australians still slip through the cracks.¹⁹

4.17 Catholic Health Australia put forward a three-point plan to improve the Commonwealth's ability to address the social determinants of health in Australia:

- The Australian Parliament should formally adopt the WHO Report;
- The Prime Minister should table an annual report indicating progress against the social determinants of health; and
- All Cabinet submissions be required to consider the social determinants of health.²⁰

Current Commonwealth action addressing the social determinants of health

4.18 A number of examples were put to the committee as evidence that the Commonwealth is cognisant of, and addressing, the social determinants of health. Although each of the following examples are worthy measures to improve the health of Australians, it is not always clear whether they take a social determinants approach by accident, design, or at all.

Closing the Gap

4.19 In 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of governments to work with indigenous communities to achieve the target of *Closing the Gap* in indigenous disadvantage. *Closing the Gap* is cited by a number of submissions as the principal example of a social determinants of health approach being undertaken by the Commonwealth.²¹ As explained by Flinders' University's Professor Baum:

The Council of Australian Governments *National Indigenous Reform Agreement on 'Closing the Gap'* in health and other social outcomes between indigenous and non-indigenous Australians incorporates goals in areas of early childhood education, literacy and education improvements, employment outcomes, healthy homes and safe communities, and governance; as well as improved access to healthcare. As such it is a good example of policy recognising and taking action on SDH within a particular segment of the Australian population.²²

19 Mr Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 2.

20 Mr Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 4 December 2012, pp 2–3.

21 Foundation for Alcohol Research and Education, *Submission 55*, p. 12.

22 Southgate Institute – Flinders University, *Submission 7*, p. 5.

4.20 Following the commitment by Australian governments to close the gap between indigenous and non-indigenous groups, the *Indigenous Health Equality Summit Statement of Intent* (Statement of Intent) was signed between representatives of the Commonwealth and key non-government organisations.²³ The *Statement of Intent* commits governments to 'adopting a rights based approach to health'.²⁴

4.21 Closing the Gap and the associated Statement of Intent are based on the principles highlighted in the WHO Report. For example, the Statement of Intent articulates the right for Indigenous peoples to:

Participate in decision-making through a commitment to a partnership between Aboriginal and Torres Strait Islander peoples, their representatives and Australian governments that will underpin the national effort to address health inequality.²⁵

4.22 The Central Australian Aboriginal Congress Inc. reported to the committee that the advances in Aboriginal health improvement in the Northern Territory – a 26 percent improvement in the age standardised death rate since 1998 – can be attributable to improved access to healthcare.²⁶ It was highlighted to the committee that the positive results being achieved under the auspices of *Closing the Gap* are archetypal of the actions and results that can be expected when a social determinants of health approach is adopted.²⁷

Medicare Locals

4.23 Medicare Locals are another program that was highlighted by the Commonwealth as a way in which it is currently addressing the social determinants of health. The work of Medicare Locals was also supported by a number of stakeholders, with St Vincents Health, for example, noting:

Medicare Locals are critical to what it is that we are talking about, because they really do have a remit within their terms of reference to take more of a population-based health approach to the health outcomes of the community that they are responsible for.²⁸

4.24 The Public Health Association of Australia were positive about Medicare Locals, stating that it appears that Medicare Locals are taking social determinants

23 The governments of Queensland, Victoria, the Australian Capital Territory, Western Australia, South Australia and New South Wales have also signed the *Statement of Intent*.

24 Close the Gap Campaign for Indigenous Health Equality, *Submission 53*, p. [4].

25 Close the Gap Campaign for Indigenous Health Equality, *Submission 53*, p. [7].

26 Central Australian Aboriginal Congress Inc., *Submission 56*, pp 1-2.

27 Mr Laverty, Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 4.

28 Dr Batten, Group Chief Executive Officer, St Vincent's Health Australia, *Committee Hansard*, 23 November 2012, p. 4.

seriously.²⁹ The Department cited Medicare Locals as an important tool to enable health solutions being tailored to local needs.³⁰ As explained by Mr Smyth:

I think that Medicare Locals is a key area now where at the local level we are going to be doing some service mapping, but also getting a better understanding of the health profile and the social profile of those groups to ensure that interventions are appropriately constructed to ensure that you are going to get a better outcome.³¹

4.25 Professor Friel highlighted the Medicare Locals program as a way in which the Commonwealth is addressing the health needs of Australians:

The national rollout of Medicare locals with a prevention mandate is encouraging and they have proactively sought input [from me and others] on how best to take a social determinant of health approach to population health and equity.³²

4.26 However, Professor Friel cautions that: 'It will be important to monitor the effectiveness of Medicare Locals in terms of impact on disease risk, health outcomes and their social distribution.'³³

4.27 The committee received evidence from other stakeholders querying the efficacy of Medicare Locals as a mechanism to address social determinants:

Whilst you might have stated commitments to addressing determinants or, more likely, discussions around primary health and primary care, what we are seeing on the ground is that the mechanics of funding and supporting organisations to work in this space do not actually realise those aspirations at all effectively...I think it is highly likely that significant amounts of those funds will in fact go more to early intervention or, at best, tertiary prevention, largely because they is not sufficient specificity in the policy framework.³⁴

4.28 There was also some concern expressed regarding the structure of the Medicare Local scheme. Although primary care service provision that takes into account local needs appears to have positive outcomes, it is unclear if the fragmented structure is appropriate for addressing social determinants. As explained by HealthWest Partnership:

29 Professor Moore, Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, 12 October 2012, p. 3.

30 Ms Flanagan, Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 23 November 2012, p. 34.

31 Mr Smyth, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 23 November 2012, p. 37.

32 Professor Friel, Professor of Health Equity, *Submission 2*, p. 3.

33 Professor Friel, Professor of Health Equity, *Submission 2*, p. 3.

34 Ms Morgain, Chair – Primary Care Partnership, HealthWest Partnership, *Committee Hansard*, 4 December 2012, p. 46.

The language says that 'these are going to be locally focused'—well, of course we believe in that; we are passionately committed to things that are locally focused. But we are a little bit worried that the Pty Ltd structure creates a level of variability in how each of the Medicare Locals interprets matters like population health data, burden of disease, health inequalities, and necessary community strategies. Those are things for which you need a coherent approach. I talked in the beginning about vertical integration. You really need to drive that quite comprehensively through your various policy schemas, through your various levels of government, and our concern is that, whilst Medicare Locals might be locally focused, they are very dispersed and different and have greater or lesser capacity in the population health, planning, prevention space, and that worries us enormously.³⁵

Administrative bodies

4.29 The establishment of the Australian National Preventive Health Agency (ANPHA) and the Australian Social Inclusion Board (ASIB) in recent years has created infrastructure that has the capacity to address the social determinants of health.

4.30 Established on 1 January 2011, ANPHA is tasked with overseeing improvements in how Australians can deal with lifestyle risk factors such as obesity, tobacco use, and excessive consumption of alcohol. The committee was informed that:

[ANPHA] will support all Australian Health Ministers in managing the complex challenges of preventable chronic disease, focusing on issues such as poor nutrition, physical inactivity, smoking, obesity and excessive alcohol consumption through research and social marketing programs. It will collect, analyse and disseminate information and is required to publish a report on the state of preventive health in Australia every two years.³⁶

4.31 The Australian Social Inclusion Board was established in May 2008 as the main advisory body to the Commonwealth on ways to achieve better outcomes for the most disadvantaged individuals in society.³⁷ The 'Social Inclusion Approach' was presented to the committee thus:

The Australian Government's vision of a socially inclusive society is one in which all Australians have the opportunity and support they need to participate fully in the nation's economic and community life, develop their own potential and be treated with dignity and respect.³⁸

...

The Australian Social Inclusion Board's role is to provide advice to Government on the social inclusion agenda, and ways the Government can

35 Ms Morgain, Chair – Primary Care Partnership, HealthWest Partnership, Committee Hansard, 4 December 2012, p. 50.

36 Department of Health and Ageing, *Submission 60*, p. 28.

37 Department of Health and Ageing, *Submission 60*, p. 15.

38 Australian Social Inclusion Board, *Submission 65*, p. 3.

achieve better outcomes for the 5 [per cent] most disadvantaged in our community.³⁹

4.32 The committee heard that:

The Australian Government's *Social Inclusion* agenda recognises the complex nature of entrenched social disadvantage, and the importance of ensuring that people have access to employment opportunities, social services, secure housing and community connections.⁴⁰

4.33 The National Health and Medical Research Council (NHMRC) is mandated under its 1992 Act to raise the standard of individual and public health throughout Australia. It was reported to the committee that the NHMRC is currently providing funding for 89 grants looking at the social determinants of health with a combined value of \$15 million.⁴¹

4.34 The committee heard some concerns regarding the narrow focus of these agencies. Women's Health Victoria noted for example that ANPHA currently has an issues-based focus rather than a social determinants approach and that social inclusion is only one of the social determinants of health.⁴² The committee also heard that the current focus on individual lifestyle factors did not represent a social determinants approach that call for complex intersectoral strategies that achieve long-term improvements:

We see responding to the social determinants of health to prevent the unfair difference in health outcomes between population groups and responding to disease epidemics as similarly needing a complex set of strategies. The current focus of programs on changing individual's behaviours is equivalent to teaching people to swim to prevent Titanic-like disasters. It is a limited and inadequate response.⁴³

4.35 This view was echoed by Professor Baum who observed that:

...while the preventative health agenda does attempt to focus on the causes of disease it is limited by the absence of a national agenda devising strategies to address social determinants of health in a systemic way. The predominant focus on individual 'lifestyle choices' and behaviour change as the target of interventions does not adequately address the social context in which behaviours occur, or give sufficient emphasis to the role of health

39 Australian Social Inclusion Board, Answers to question on notice, 19 December 2012 (received 18 January 2013), pp 1–2.

40 Southgate Institute – Flinders University, *Submission 7*, p. 5.

41 Department of Health and Ageing, *Submission 60*, p. 32.

42 Ms Durey, Policy and Health Promotion Manager, Women's Health Victoria, Committee Hansard, 4 December 2012, p. 40.

43 HealthWest Partnership, answers to questions on notice, 4 December 2012 (received 20 December 2012).

promotion strategies focused on creating healthy settings and development of healthy communities.⁴⁴

4.36 The narrow focus of ANPHA in particular, but also ASIB to a lesser extent, limits their ability to take a social determinants approach.

National Partnership Agreements

4.37 In November 2008 COAG allocated significant amounts of money to infrastructure necessary to sustain social development. Five new national specific purpose payments (SPP) were created with funding of \$60.5 billion in a National Healthcare SPP; \$18 billion in a National Schools SPP; \$6.7 billion in a National Skills and Workforce Development SPP; \$5.3 billion in a National Disability Services SPP and \$6.2 billion in a National Affordable Housing SPP. The committee heard that 'each of these SPP and National Partnerships has the potential to really improve the lives of people and consequently their health and wellbeing.'⁴⁵

4.38 The National Healthcare Reform Alliance criticised the national partnership agreements for not taking a social determinants approach and perpetuating the policy siloes:

If you look at all of the COAG agreements they are all very separate—education is education, transport is transport, health is health—they don't really link together. Even the actual actions in the health agreement do not really link together other than through your being able to do a hypothetical link between safety and quality and between performance and health workforce. But how those people actually talk to each other and how it actually happens in reality is very different. I think that happens across all of the current agreements; I don't think there is this overarching: 'Well, what are we doing this all for,' perspective.⁴⁶

Suggested Commonwealth response to WHO Report and the social determinants of health

4.39 The four key areas of action suggested throughout this inquiry to be implemented at the Commonwealth level were to endorse the findings of the WHO Report and its associated recommendations; to include a 'Health in All Policies' approach to public policy making; to centralise administrative responsibility for addressing the social determinants of health; and to establish reporting mechanisms to track progress in addressing the social determinants of health.

Adopting the WHO Report and its recommendations

4.40 Among submissions received by the committee, there is widespread support for addressing the social determinants of health in Australia in line with the

44 Southgate Institute – Flinders University, *Submission 7*, p. 7.

45 Professor Friel, Professor of Health Equity, *Submission 2*, p. 4.

46 Mrs Walker, Executive Committee Members, Australian Healthcare Reform Alliance, *Committee Hansard*, 12 October 2012, p. 34.

recommendations put forward in the WHO Report.⁴⁷ Articulating the sentiment of many submissions, Catholic Health Australia called for the formal adoption of the WHO Report arguing that:

The Australian Government, supported by all political parties, hopefully in the Australian Parliament, should enforce and formally adopt the World Health Organisation's 2008 *Closing the gap in a generation* report.⁴⁸

4.41 Similarly, the Australian Psychological Society noted that:

Poverty harms the poor most – but it is everyone's problem...and requires that all of us attend to its solutions...The adoption of the recommendations contained in the WHO report, and each of the priority areas is important if Australia is to address the health inequalities and improve health outcomes for all people.⁴⁹

4.42 The WHO Report was written for a global audience and as such some of the recommendations would have little application in Australia – such as access to drinking water. There are however areas only tangentially touched by the WHO Report that are of critical concern to Australia such as the health consequences of living in rural and remote locations,⁵⁰ and gender-related health concerns.⁵¹

4.43 The Department reported to the committee that 'Australia is committed to progressing the Rio Political Declaration on Social Determinants of Health' which confirms the commitment of United Nations Member States to take action to address the social determinants of health.⁵² Given this commitment to action, a response to the WHO Report appears a logical step.

Committee view

4.44 The committee considers the WHO Report as an important document in the evolving thinking around the social determinants of health. The Commonwealth, like many other governments internationally have done, should adopt the WHO Report. As is noted in the WHO Report, 'although there are general principles, the precise nature of policy solutions needs to be worked out in national and local context.'⁵³ The means and manner in which the Commonwealth address the social determinants of health will necessarily depend on the needs of the Australian people, but the general

47 Consumer Health Forum, *Submission 12*, p. 2.

48 Mr Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 2.

49 Australian Psychological Society, *Submission 49*, p. 8.

50 Mr Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 2.

51 Ms Clarke, Convenor – Policy Working Group, Victorian Gay and Lesbian Rights Lobby, *Committee Hansard*, 4 December 2012, p. 31.

52 Department of Health and Ageing, *Submission 60 – Supplementary*, p. 5.

53 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 46.

principles of health equality expressed through the social determinants framework should be recognised as an important policy goal by the adoption of the report.

Recommendation 1

4.45 The committee recommends that the Government adopt the WHO Report and commit to addressing the social determinants of health relevant to the Australian context.

Adopting a Health in All Policies approach

4.46 The pre-eminent idea put to the committee to address the social determinants of health in Australia was for the Commonwealth government to adopt a similar mechanism as the South Australian 'Health in All Policies' (HiAP) approach to government action. HiAP is a horizontal health policy strategy that incorporates health as a shared goal across all parts of Government and addresses complex health challenges through an integrated policy response across portfolio boundaries.⁵⁴ As explained by representatives from the South Australian Government:

Health in All Policies is essentially an approach to working collaboratively on policy issues across government to enable joined up policy responses to complex, so-called wicked, policy goblins. The problems faced by the health department results from these wicked problems, such as obesity, chronic disease and health inequities. All of these have serious impact on health services and health financing and budgets, but health departments do not actually have the policy levers to address them. Other sectors and departments do have the policy levers—such as transport, agriculture, employment and education—however many of these agencies that are able to take action on these determinants of health and wellbeing do not see health as their business...Our version of Health in All Policies looks at how we can assist other agencies in meeting their goals, in a way that supports health and wellbeing...In South Australia the Health in All Policies approach is applied in the internal government policy process, focusing strongly on Health being a partner rather than a director in the public policy process.⁵⁵

4.47 Under the South Australian model, in order to ensure that policies have considered potential health impacts, *health impact assessments* are used. Health impact assessments consider the potential health consequences of a policy.

4.48 A large number of stakeholders called for the Commonwealth to adopt HiAP approach similar to the one used by the South Australian government.⁵⁶

54 Northern Territory Government Department of Health, *Submission 64*, p. 4.

55 Dr Buckett, Director of Public Health, SA Health, *Committee Hansard*, 4 December 2012, p. 20.

56 Foundation for Alcohol Research and Education, *Submission 55*, p. 7; Dr Goldie, Chief Executive Officer, Australian Council of Social Services, *Committee Hansard*, 23 November 2012, p.26; Consumer Health Forum, *Submission 12*, p. 1.

4.49 It was argued by some that a HiAP approach would improve the efficacy and value for money of programs designed to improve health outcomes. For example, the Central Australian Aboriginal Congress Inc. argued:

There has been a lot of new funding coming into the NT in these areas in recent years from COAG, FaHCSIA, DoHA and other sources but it is not been allocated into these core services and programs in a planned manner. The investment is now largely being wasted...because competitive tendering of new funds on non-evidence based services and programs will not lead to further improvements.⁵⁷

4.50 In a similar vein it was noted by the Northern Territory Department of Health that the best health outcomes would be achieved through inter jurisdictional cooperation:

For Australia to fully benefit from the utilisation of HiAP to achieve action on the [social determinants of health], COAG would have to adopt it as a generic approach and fund the implementation in States and Territories.⁵⁸

4.51 One of the key benefits of a HiAP approach is that it provides a focus for policy makers. The importance of centralisation was highlighted by St Vincents Health Australia which noted:

Unless you have one body with the responsibility for collecting the information, collecting the data, having the data reported to it and reporting on the KPIs to see if we are making a difference within the Australian healthcare system then we are going to continue the fragmentation.⁵⁹

4.52 The role of the Commonwealth government was cited as the key driving force behind tackling inequality on a national scale. The Australian Medical Students' Association for example argued:

Action to address health inequalities in Australia as a result of inequalities in social determinants of health should be tackled through a multi-sectoral approach spearheaded by the Commonwealth government.⁶⁰

4.53 Professor Baum argued that the HiAP approach relies on leadership from the top levels of government to motivate agencies traditionally removed from the health portfolio to 'buy-in', positing:

If the agencies are not on the side of government and you are not getting buy-in from those central agencies who are seeing that this is part of their core business, you have got to find a way of making that work. I am sure there are several ways you could do that, but I think the outcome you would

57 Central Australian Aboriginal Congress Inc., *Submission 56*, p. 4.

58 Northern Territory Government Department of Health, *Submission 64*, p. 4.

59 Dr Batten, Group Chief Executive Officer, St Vincent's Health Australia, *Committee Hansard*, 23 November 2012, p. 2.

60 Australian Medical Students' Association, *Submission 54*, p.1.

want is that whatever strategy you had was really led from Prime Minister and Cabinet and had that kind of status behind it.⁶¹

4.54 One argument put forward for the adoption of a health impact or equity assessment framework was that it would 'create a little bit more awareness and consciousness around how decisions we make in every government department impact on people's health and equity issues.'⁶² The actions already taken by a number of state governments point towards some jurisdictions being well ahead of the Commonwealth when it comes to ensuring that there is a sufficient understanding of the social determinants of health within government programs. Improving the awareness of health in areas outside the traditional health field is to be encouraged.

4.55 Although the Department conceded that health impact assessments might be useful, it was argued that this needs to be considered alongside their time- and cost-heavy nature:

Health impact assessments have been promoted as a means of assessing the health impacts of policies, plans and projects using quantitative, quantitative and participatory techniques. While we think that they may be a useful tool, we believe that they have the potential to be expensive and time-consuming, and we believe that this needs to be taken into account in any further consideration of these.⁶³

4.56 This point was expounded upon in the Department's supplementary submission:

In the case of both the South Australian Government and Tasmanian Health in All Policies Collaboration, key drivers have been established through legislation; in particular Public Health Acts, as well as state based strategic plans and/or targets. Duplication of such approaches at a national level could add further complexity to an already complicated environment without a clear mandate for action.⁶⁴

4.57 The Australian Social Inclusion Board made a similar case against the use of a South Australian style approach:

The development of a more formally structured framework, such as the South Australian approach, could introduce ambiguity into existing Commonwealth mechanisms and therefore detract from the social inclusion narrative. It could also result in current measurement and reporting framework and social inclusion principles holding less currency.⁶⁵

61 Professor Baum, Professor of Public Health, Committee Hansard, 12 October 2012, p. 20.

62 Ms Butera, Executive Director, Women's Health Victoria, *Committee Hansard*, 4 December 2012, p. 41.

63 Ms Flanagan, Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 23 November 2012, p. 34.

64 Department of Health and Ageing, *Supplementary Submission*, p. 13.

65 Australian Social Inclusion Board, *Answers to question on notice*, 19 December 2012 (received 18 January 2013), p. 2.

4.58 However, representatives from the Department argued that there was already adequate consideration given to health in public policy making:

An approach is taken, certainly by our department, that recognises the interconnectedness and complexity of the social determinants of health through integrated approaches to the development and implementation of social policy and programs, both at the Commonwealth level but also across all levels of government. Key aspects of the approach include a number of things: firstly, strong governance arrangements. Some examples of those are the Australian Social Inclusion Board, the Social Policy and Social Inclusion Committee of Cabinet and also COAG's standing committees that look into these issues...[W]e believe that other approaches can and are also being used to achieve coordination across sectors and levels of government.⁶⁶

4.59 The committee did not receive any evidence in the form of improved health outcomes that the South Australian model is more effective than comparative systems. The diversity of international and domestic responses to rising awareness of the social determinants of health points to a field of practice undergoing rapid evolution of thought. As noted by the Chief Executive Officer of ANPHA:

We are not sure which approaches will work best. We have almost got a set of natural experiments going on in Australia, which we think ought to be evaluated before we come to a conclusion on that. The South Australian method is one way of doing it...We are not quite sure what will do the trick here. It is one of the reasons we looked at Canada so closely. They do a bundle of different things, and other countries have done different things as well.⁶⁷

Committee view

4.60 The committee notes that the Department believes that it effectively takes a social determinants approach within its own policy making. However, the key point is that such an approach needs to be taken across government, and in particular in social, economic and employment policy decisions that affect social determinants (such as employment status, levels of welfare benefit, and access to education). The need for a social determinants approach lies not only within, but beyond, the health portfolio.

4.61 There are already mechanisms in place to ensure that important issues are considered across government when necessary, such as the requirements for inter-departmental consultation in the preparation of cabinet submissions, the requirement for Regulatory Impact Statements in conjunction with the introduction of legislation, and statements of compatibility with human rights.

4.62 Introducing a health in all policies approach of some sort would not therefore represent a completely new dimension to policy development. While the committee

66 Ms Flanagan, Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 23 November 2012, p. 34.

67 Ms Sylvan, Chief Executive Officer, Australian National Preventive Health Agency, *Committee Hansard*, 11 December 2012, p. 12.

does not have a fixed view about how it should be done, the government's adoption of a social determinants approach should influence the policy development process, particularly in relevant areas such as education, employment, housing, family and social security.

Recommendation 2

4.63 The committee recommends that the government 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.

Centralising responsibility for addressing the social determinants of health

4.64 The committee heard from several stakeholders that there was a need for additional leadership at the Commonwealth level to address the social determinants of health.⁶⁸ The Australian Healthcare Reform Alliance noted that there is not necessarily a need to establish any new agencies, but that 'what you do need is...the leadership and the point of reference to be able to channel all the resources into.'⁶⁹

4.65 The importance of centralised coordination to address social determinants was articulated by both community and the government stakeholders. Women's Health Victoria, for example, argued that:

It is really important to have something that is centralised. Whilst there is a lot of work that has been going on in different departments to varying degrees, it is really important to have a coordinating approach and having someone take a leadership role and being in an advisory position...We think it is vital to have something that is quite concrete and central.⁷⁰

4.66 Similarly, ANPHA informed the committee that:

The whole point of social determinants is that the health outcomes are determined by things other than the health system. You need the overarching entity not sitting within one of the portfolios, such as education or health or something...there needs to be a central agency.⁷¹

68 Mrs Herzfeld, Facilitator, Tasmanian Social Determinants of Health Advocacy Network, *Committee Hansard*, 12 October 2012, p. 24; Mrs Walker, Executive Committee Member, Australian Healthcare Reform Alliance, *Committee Hansard*, 12 October 2012, p. 31; National Rural Health Alliance, *Submission 59*, p. 7; Council of Social Services NSW, *Submission 44*, p. 20; Centre for Women's Health, Gender and Society, *Submission 48*, p. 2.

69 Mrs Walker, Executive Committee Members, Australian Healthcare Reform Alliance, *Committee Hansard*, 12 October 2012, p. 33.

70 Ms Rughla, Health Promotion Officer, Women's Health Victoria, *Committee Hansard*, 4 December 2012, p. 40.

71 Ms Sylvan, Chief Executive Officer, Australian National Preventive Health Agency, *Committee Hansard*, 11 December 2012, p. 6.

4.67 Suggestions put to the committee included ANPHA adopting a more proactive approach to advocating for action on the social determinants of health.⁷² It was argued by Women's Health Victoria and the Australian Healthcare Reform Alliance for instance, that ANPHA would be a natural fit if its remit was broadened from an issues based focus to a broader social determinants focus.⁷³ Professor Baum argued a similar point, positing:

[T]heir terms of reference have pushed them in the direction of doing a lot of direct lifestyle and behavioural change. If they could have an extension of their role to really considering social determinants then it could be that they could fulfil the role that we imagine for a commission. I think the important thing in this areas is not to come in and pretend that there is nothing there already...because of their somewhat narrow terms of reference they are constrained when it comes to looking at social determinants. There is no reason why that could not change, but currently there is that constraint on the way that they operate.⁷⁴

4.68 ANPHA was the agency most frequently mentioned, but is not the only Commonwealth body that could act as a central point for driving a social determinants policy agenda. It is something that could appropriately be located within the Prime Minister's Department. The Department, Australia's Social Inclusion Board, the ANPHA, and the Australian Institute of Health and Welfare all provided some form of evidence to the committee on the subject, and could play a role in taking responsibility for the issue.

4.69 Catholic Health Australia nominated ASIB as a potential lead agency in addressing the social determinants of health at the national level.⁷⁵ ANPHA commented that the Social Inclusion Board is not 'an absolutely perfect [fit], but it is pretty close.'⁷⁶ The ASIB were equivocal in their response to the proposal:

The Board's role in relation to the social determinants of health, and similar matters, is to highlight the importance of such issues within the broader framework of the social inclusion agenda...

Where the Board's role in advising the Government on these priorities areas is relevant to the promotion of the social determinants of health, the Board would

72 Ms Williams, Manager – Health in all policies unit, SA Health, *Committee Hansard*, 4 December 2012, p. 22; Southgate Institute – Flinders University, *Submission 7*, p. 7; Consumer Health Forum, *Submission 12*, p. 6.

73 Ms Durey, Policy and Health Promotion Manager, Women's Health Victoria, *Committee Hansard*, 4 December 2012, p. 40; Mr McGowan and Mrs Walker, Executive Committee Members, Australian Healthcare Reform Alliance, *Committee Hansard*, 12 October 2012, p 35.

74 Professor Baum, Professor of Public Health, *Committee Hansard*, 12 October 2012, pp. 18–19.

75 Mr Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 6.

76 Ms Sylvan, Chief Executive Officer, Australian National Preventive Health Agency, *Committee Hansard*, 11 December 2012, p. 6.

bring this to the attention of the Minister for Social Inclusion, who in turn could bring this to the Ministers of Health.⁷⁷

Committee view

4.70 In line with many of the submissions provided to this inquiry, the committee is of the view that it is necessary for one body to take responsibility for coordinating responses to social determinants at the Commonwealth level. The committee would like to see the government engage with key stakeholders to assess whether this is done through extending the remit of an existing agency, the creation of a new agency, or within an existing department such as Prime Minister and Cabinet.

Recommendation 3

4.71 The committee recommends that the government place responsibility for addressing social determinants of health within one agency, with a mandate to address issues across portfolios.

77 Australian Social Inclusion Board, answer to question on notice, 18 January 2012, p. 2.

Chapter 5

Research and Reporting

5.1 One of the three overarching recommendations of the WHO Report was to 'Measure and Understand the Problem and Assess the Impact of Action'. This included specific recommendations on ways to improve the generation of new evidence concerning the social determinants of health. Health problems caused by social determinants are only recognised through the collection and analysis of data. The report emphasises the value of good data in tackling these problems:

Good evidence on levels of health and its distribution, and on the social determinants of health, is essential for understanding the scale of the problem, assessing the effects of actions, and monitoring progress.¹

5.2 The Department reported to the committee that problems do not lie with the quantity of data that is collected, but rather with the capacity to analyse the data:

There is, and I think our submission reflects this, a lot of data collected in Australia and there is a lot of different kinds of data collected. There is administrative data, there are surveys, there are longitudinal surveys and there is work that has been going on with quite a bit of intensity in recent years about linking administrative records to get longer term pictures...I wonder sometimes, when people raise this question, whether they are actually asking for more analysis rather than more data...It is like everything: there has got to be some trade-off about how much data you collect.²

Current data gathering capacity

5.3 Much of the health data captured for the government is done through the AIHW. According to their submission the AIHW has recently been involved in a number of projects that aim to improve the knowledge base in this area. They provided examples of reports produced on:

[T]he social distribution of health risk and health outcomes; the health of males in five key population groups; and lung cancer by socioeconomic status (including risk factors, incidence and mortality rates). In addition to this work, AIHW has created an on-line Indigenous Observatory, reports against 68 indicators as part of monitoring the Aboriginal and Torres Strait Islander health performance framework, has been involved in establishing

1 CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva, World Health Organization. Executive Summary, Part 3, p. 20.

2 Ms Goodspeed, Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 23 November 2012, p. 36.

the Closing the Gap Clearinghouse and has been accredited as an integration authority for undertaking data linkage.³

5.4 In the most recent publication of the bi-annual report, *Australia's Health* there is a section included on the social determinants of health. The report recognises the difficulties in measuring the effects of the various determinants and the section briefly looks at individual as distinct from community risk factors. It also differentiates between 'upstream' and 'downstream' determinants. Upstream determinants are described as education, employment, income and family structures, and suggests that these are 'more directly influenced by the broad features of society; that is, our culture, resources and policies.'⁴ According to Community Indicators Victoria, 'downstream determinants are where we already know we have the problem', and 'tend to be more illness or medically focused.'⁵ AIHW use the examples of smoking prevention or efforts to tackle teenage drinking as measures to address downstream determinants.⁶

5.5 While the *Australia's Health* report does not provide explicit data on the impact on health of social determinants it does refer to studies on how health risk factors, including social determinants contribute to the burden of disease and ill health:

The effect of risk factors on health depends not only on their prevalence in the population but also on the relative amount they contribute to the level of ill health. Studies that quantify this burden use a measure of disability-adjusted life years (DALYs) to describe the relative contribution of specific illnesses and risk factors to the overall burden of ill health.

Australia's most recent national study of the burden of illness and injury used data from 2003 and summarised the contribution of 14 selected risk factors to the national burden for that year. The joint contribution of those determinants to the total burden was 32%. That is, of all the ill health, disability and premature death that occurred in Australia in 2003, almost one-third was attributed to the presence of the health risk factors studied.⁷

5.6 The Department outlined in their submission the current data gathering activities undertaken across government that support the development of evidence base of factors that impact on health outcomes. These include:

- 2011-13 Australian Health Survey (ABS);
- Past National Health Surveys, conducted 3 yearly since 2001 (ABS);

3 Australian Institute of Health and Welfare, *Submission 36*, p. 3.

4 Australian Institute of Health and Welfare 2012. *Australia's health 2012*. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW. p. 11.

5 Dr Davern, Research Fellow, Community Indicators Victoria, *Committee Hansard*, 4 December 2012, pp 14–15

6 Australian Institute of Health and Welfare 2012. *Australia's health 2012*. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW. p. 11.

7 Australian Institute of Health and Welfare 2012. *Australia's health 2012*. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW. p. 15.

- Survey of Disability, Ageing and Carers (ABS);
- Periodic Mental Health Surveys (ABS);
- Periodic General Social Surveys (ABS)
- Census of Population and Housing (ABS);
- Longitudinal Study of Women's Health (DoHA);
- Longitudinal Study of Men's Health – Ten to Men (DoHA);
- Household Income and Labour Dynamics in Australia Survey (FaHCSIA);
- Longitudinal Study of Australian Children (FaHCSIA);
- Longitudinal Study of Indigenous Children (FaHCSIA);
- Longitudinal Study of Australia's Youth (DEEWR); and
- Australian Early Development Index (DEEWR).⁸

5.7 This data is then utilised in the formation of a number of regular reports:

- Measure of Australia's Progress (ABS – last published Oct 2012);
- How Australia's Faring (Social Inclusion Board – last published Sep 2012);
- Australia's Health (AIHW last published in June 2012);
- Social Health Atlases (Public Health Development Unit – available online);
- Australian Early Development Index (DEEWR – last published 2011); and
- State of Preventive Health report (ANPHA – from 2013).⁹

5.8 In all of the recent reforms that were provided by the Department as examples of measures that focus on the social determinants of health, the federal government, in conjunction with the States and Territories through COAG, has identified improved data collection and analysis as key to advancement on tackling adverse health outcomes. Recent reforms in this area include:

- Closing the Gap in Indigenous Health Outcomes;
- Early Childhood Development;
- National Partnership Agreement on Preventive Health;
- Housing and Homelessness;
- National Mental Health Reform;
- Urban Planning; and
- Gender Equity.¹⁰

5.9 The COAG National Early Childhood Development Strategy - Investing in the Early Years (endorsed in 2009) for example has 'building a better information and a solid evidence base' as one of its six priority areas.¹¹

8 Department of Health and Ageing, *Submission 60*, p. 29.

9 Department of Health and Ageing, *Submission 60*, p. 30.

10 Department of Health and Ageing, *Submission 60*, p. 18.

11 Department of Health and Ageing, *Submission 60*, pp. 20-21.

5.10 Medicare Locals are also highlighted as a key service delivery mechanism for implementing action on the social determinants of health. The department submitted information on how data gathering and analysis conducted by the National Health Performance Authority will affect the operation of Medicare Locals:

The National Health Performance Authority has been tasked with regular reporting on the performance of every Medicare Local areas against a range of agreed indicators. This will provide a means to examine where Medicare Locals are seeing improvements in health outcomes, and give exposure to approaches that are effective using performance indicators defined in the Performance and Accountability Framework (PAF). Medicare Locals are then able to review their results and adjust services in response to changes in needs for their own community.¹²

Gaps in data

5.11 Despite strengths in some areas, the committee received evidence that data blind spots remain that will need to be filled in order to measure and analyse the social determinants of health. FARE noted that there is no national repository of alcohol data, and that the information that is available is often difficult to locate, access and utilise. Furthermore, there is no nationally agreed measure for collecting such data making comparisons difficult.¹³

5.12 The Department also noted that research around the social determinants of health is extremely complex, especially in relation to causal relationships:

It is so complex that it is very hard to get a comprehensive understanding, through survey data, through the combination of all data, because you will miss certain elements of it. That is the difficulty that we are playing with here: it is an incredibly complex situation.¹⁴

5.13 The Public Health Association of Australia submitted that there was a need for public health research in general, but as a priority the NHMRC should be directed to fund with specific research into the following areas:

- Understanding social determinants of physical and mental health in Australia;
- Evaluation of public health interventions;
- Aboriginal and Torres Strait Islander health research;
- Health and social policy research, to understand what kinds of policy are best placed to support gains in population health and well-being, and improve health equity;
- Health services research, including in primary health care;
- Research on translation of public health evidence into effective public policy;

12 Department of Health and Ageing, *Submission 60*, p. 27.

13 Foundation for Alcohol Research and Education, *Submission 55*, p. 14.

14 Mr Smyth, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 23 November 2012, pp. 37–8.

- Understanding, managing and preventing the adverse health effects of climate change; and
- Examining the impact of trade and macroeconomic policy on health and health inequities.

5.14 The Australian Healthcare Reform Alliance was of the view that while there was data available it was not being effectively utilised. They suggested that a national set of indicators on social determinants be created:

AHCRA supports the development of an agreed set of national indicators on social determinants (such as employment, access to health care and education etc.) and that these are used systematically to assess our progress in these areas. These indicators could then be used to broaden the scope of national agencies, programs and services to ensure they included action on social determinants.¹⁵

5.15 In their submission Catholic Health Australia proposed that the Productivity Commission should have the primary coordination role in gathering data required to build the evidence base to support policy to address the social determinants of health. This would be achieved through formation of a taskforce modelled on the 'Red Tape Taskforce' that was established in 2006 and provided the foundation for the annual report, *Reducing the Regulatory Burden on Business*.¹⁶

5.16 The committee was made aware of ongoing discussions concerning the research needs around the social determinants of health. The committee heard from the ANPHA that the Academy of Social Sciences of Australia and the Public Health Association of Australia held a workshop at NHMRC's Canberra Offices on 25 September to discuss important questions around social determinants of health and health equity and to identify priority areas for research.¹⁷

5.17 The draft recommendations that came out of the roundtable discussion at the workshop were that the NHMRC develop a social determinants of health research funding stream that is open to applications concerning the following:

- Impact of macro-economic environments on health;
- Barriers and opportunities for policy recognition and action on SDH in non-health government agencies;
- The relationship between economic growth and population health outcomes;
- The social determinants of mental health, and of substance abuse;
- The social determinants of Aboriginal health including racism, the impact of colonisation;
- The social determinants of health outcomes at different points in the life course including childhood, working life, parenting and ageing;

15 Australian Healthcare Reform Alliance, *Submission 30*, p. 7.

16 Catholic Health Australia, *Submission 19*, p. 39.

17 National Health and Medical Research Council, Research Tracker, 5 October 2012, available at: <http://www.nhmrc.gov.au/media/newsletters/research-tracker/2012/research-tracker-5-october-2012>, accessed on 17 January 2013.

- Development and application of health equity impact assessments methodologies;
- Assessment of interventions which address the social determinants of health and health equity;
- More social scientists and social determinants researchers should be included as experts on NHMRC panels/review committees and an expert SDH panel should be appointed;
- NHMRC should encourage greater methodological diversity in grant applications and avoid privileging one research approach over another, instead ensuring panels consider the what methodologies are both feasible and relevant in different settings; and
- NHMRC should conduct a detailed analysis of what counts as 'public health research' including the extent of research that could be described as SDH research. This analysis could be used as a baseline to measure NHMRC's success in increasing the amount of SDH research.¹⁸

Preventative health research

5.18 It was put to the committee that the current focus and funding of healthcare in Australia is weighted severely in favour of treating illnesses after they appear, rather than taking preventative measures. It was observed by St Vincent's Health Australia that:

In fact, we only get funded when people come through our front door, when we are treating people. We have got the incentives wrong within our system. What we should be doing is working out how we can prevent people coming into that emergency department in the first place.¹⁹

5.19 This perception of treatment rather than prevention being given priority is also prevalent at the research level. It was noted by representatives from the South Australian Government that this 'there is very little money spent on public health research and preventative health research compared to biomedical research.'²⁰ Professor Baum, Professor of Public Health at Flinders University, also stated that 'overwhelmingly, NHMRC's budget goes on issues which are about treating people once they get sick. Hardly any of their budget is spent on how we create healthy societies.'²¹

5.20 The Public Health Association of Australia concurred in their evidence to the committee. Professor Moore also highlighted the relative funding for public health research in comparison to medical research:

18 Academy of Social Sciences in Australia, *Report on Social Determinants of Health Research Roundtable – Sept 2012*, available at: <http://www.assa.edu.au/>, accessed 17 January 2013.

19 Dr Batten, Group Chief Executive Officer, St Vincent's Health Australia, *Committee Hansard*, 23 November 2012, p. 2.

20 Dr Buckett, Director of Public Health, SA Health, *Committee Hansard*, 4 December 2012, p. 22.

21 Professor Baum, Professor of Public Health, *Committee Hansard*, 12 October 2012, p. 18.

Research and data are important. Although public health has been generally looked at, it is quite clear ... that the poor cousin in research has been areas of public health, such as funding of research by governments.²²

5.21 Professor Moore expanded on what research should be done, and how it should be utilised most effectively:

The research should not only look at possible public health interventions but also evaluate what we do. I think that quite often our public health interventions appear to work. We need to look at campaigns—take the Measure Up campaign at the moment—and the sorts of research that needs to go into them. We need to ask whether the outcomes are due to the campaign on its own or whether they are due to the campaign combined with a run of other things that improve public health. Certainly that is the general understanding. We need health policy research to understand what are the best policies and the best practice, how to put policy into practice and how to translate public health evidence into effective policy. These are all areas of research that we believe need to be done. We probably also need to put into practice a whole-of-government response in terms of research.²³

Longitudinal studies

5.22 The committee heard that one of the areas of research need was longitudinal studies that were able to provide evidence of causal links, if any, between environmental factors and individual health outcomes. SA Health's Dr Buckett explained the difficulty in researching the social determinants of health:

It is a very long time frame that we are dealing with in public health so interventions are often quite difficult. Success is much easier with a double-blind clinical trial at the medical end of health, to actually do an intervention, manipulate one particular variable and see an outcome very quickly. So that sort of research gets very much supported, and so it should, but some of the longer term issues and the more difficult and complex issues tend to be seen as too difficult and therefore are not supported for research.²⁴

Reporting

5.23 One of the key purposes of conducting ongoing research is to track changes in the health outcomes of the population. St. Vincent's Health recommended to the committee that:

[T]he No 1 thing we would suggest is allocating responsibility for the health of the community to a part of the healthcare system. To do that we

22 Professor Michael Moore, Public Health Association of Australia, *Committee Hansard*, 12 October 2012, p. 1.

23 Professor Michael Moore, Public Health Association of Australia, *Committee Hansard*, 12 October 2012, p. 1.

24 Dr Buckett, Director of Public Health, SA Health, *Committee Hansard*, 4 December 2012, p. 22.

need to set up some KPIs [Key Performance Indicators] so that we are measuring the health of the community and reporting on it publicly.²⁵

5.24 ANPHA also emphasised the importance of having a reporting framework established to both track and monitor progress on the social determinants agenda:

[I]t is absolutely critical to have the reporting, whether we call it that or whether we call it something else—that report across inequitable health outcomes, looking at the real determinants, such as the question of whether people get access to good advice in pregnancy or whether people did not have early childhood education. It is quite critical to bring that together in a single entity as a report—which they do.²⁶

5.25 Both ANPHA and Catholic Health Australia²⁷ discussed the correlation between improvements in indigenous health and regular reporting:

In the same way you use Closing the Gap here in relation to Indigenous disadvantage, when you have that report, produced in this case by the Productivity Commission through its COAG indicators, repeatedly coming up in front of you then first of all you make sure the invisibility does not occur. When you report in a consistent way with an institution of that econometric and statistical capacity, and you report repeatedly on both the states and territories of the Commonwealth on outcomes which matter and not just reporting, that focuses the minds of governments.²⁸

5.26 Ms Sylvan from ANPHA added that while she believed the necessary data on social determinants exists, it is not being brought together in one report to identify linkages, and variation in the language used can make progress difficult to track. Which body is the most appropriate to carry out this task was also discussed:

...almost all that stuff is sitting there, it seems to me; it is just not gathered in that way. I know that in their submission the AIHW said quite clearly that they were looking forward to contributing to the social determinants questions. Whether it sits there or whether it sits within a COAG or CRC reporting structure, which the Productivity Commission largely does, it needs an entity that can pull the state, territory and Commonwealth information together to report. We have another report that is very important and that is not entirely dissimilar, which is *Measures of Australia's progress*, by the ABS, which is also critical in this space—

25 Dr Batten, Group Chief Executive Officer, St Vincent's Health Australia, *Committee Hansard*, 23 November 2012, p. 2.

26 Ms Louise Sylvan, Chief Executive Officer, Australian National Health Prevention Agency, *Committee Hansard*, 11 December 2012, p. 5.

27 Mr Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 4.

28 Ms Sylvan, Chief Executive Officer, Australian National Preventive Health Agency, *Committee Hansard*, 11 December 2012, p. 3.

although, again, they do not use the language of social determinants; they use the language of people's progress.²⁹

5.27 Dr Batten from St Vincent's Health observed that there needed to be clear responsibility for reporting on social determinants:

Unless you have one body with the responsibility for collecting the information, collecting the data, having that data reported to it and reporting on the KPIs to see if we are making a difference within the Australian healthcare system then we are going to continue the fragmentation. Does it need to be an entirely separate body? Could it be a body that is subsumed within many of the other systems already created, whether the Australian Institute of Health and Welfare or the Prime Minister and Cabinet's office? I am not saying where it needs to sit, but unless you have a body with that focus to collect that data and to report on the progress being made then we will continue the fragmented approach we have had.³⁰

5.28 Catholic Health Australia had a clear idea on how the data should be brought together and how that could be reported on a regular basis:

Our second recommendation is that on an annual basis the Prime Minister would make a report to the Australian parliament indicating progress against the World Health Organization framework. We have the advantage that the Australian Institute of Health and Welfare has already looked at the World Health Organization framework and has done some of the localisation work that we think is necessary. The Institute of Health and Welfare, the Australian Bureau of Statistics, the Productivity Commission and the Department of the Prime Minister and Cabinet themselves already collect almost all of the data that would be required to report progress on an annual basis against the WHO targets. There is not necessarily a need for new data capture to be facilitated. Rather, there is a benefit of harnessing that data which is already captured, reporting it in one place against a social determinants framework and giving it the profile of a Prime Minister on an annual basis making a report to parliament on progress.³¹

5.29 The Department of Health and Ageing provided the committee with examples of reports currently produced that 'analyse and report...', often against agreed frameworks and indicators, and with consideration of how Australia's social circumstances are changing over time' including:

- Measure of Australia's Progress (Australian Bureau of Statistics);
- How Australia's Faring (Social Inclusion Board);
- Australia's Health (Australian Institute of Health and Welfare);

29 Ms Louise Sylvan, Chief Executive Officer, Australian National Health Prevention Agency, *Committee Hansard*, 11 December 2012, pp. 5-6.

30 Dr Batten, Group Chief Executive Officer, St Vincent's Health Australia, *Committee Hansard*, 23 November 2012, p. 7.

31 Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 2.

- Social Health Atlas (Public Health Development Unit);
- Australian Early Development Index (Department of Education, Employment and Workplace Relations); and
- State of Preventive Health (Australian National Preventive Health Agency).³²

Committee View

5.30 The committee received positive evidence from Professor Baum, amongst others, on current Australian activity around the social determinants of Health agenda:

Australia already does a lot of things that are very good in terms of social determinants, so that is why we think it is really important that it needs to document what is already being done that is really good and that we would want to maintain and enhance...³³

5.31 However the committee has not been convinced that this current activity is providing a coherent strategic analysis of the social determinants of health that could inform potential actions to address negative health outcomes. The Marmot review in the UK provided the vehicle and the focus for examining the social determinants of health in that country. The extensive review utilised a vast amount of data to produce a compelling case for reducing health inequalities, and a framework for doing so. The committee does not think that the Australian government has such a focus currently.

5.32 The AIHW discussed ongoing activities undertaken as a result of the government's focus on tackling indigenous disadvantage as part of the closing the gap agenda. Significant efforts have been made to address data gaps that inhibit effective monitoring and reporting, through the establishment of bodies such as the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data. In the committee's view the coordination between agencies such as the ABS and the AIHW, facilitated by a strong political will and concomitant funding, is what is required to achieve a similarly comprehensive and coherent policy outcome for social determinants of health.

5.33 The committee heard that there were significant gaps in the data that needed to be addressed through targeted research. There was a perception that the NHMRC funding in particular was geared towards medical research rather than public health research.

5.34 The committee was surprised to hear that a research event had taken place in September 2012 to discuss the research requirements around the social determinants agenda, yet neither the Department, nor NHMRC themselves had thought it appropriate to inform the committee of this discussion, in spite of it occurring during the committee's inquiry.

32 Department of Health and Ageing, *Submission 60*, p. 30.

33 Professor Baum, Professor of Public Health, *Committee Hansard*, 12 October 2012, p. 18.

5.35 The committee supports an analysis of the priorities of the NHMRC to establish whether there should be a realignment of research priorities to ensure a greater emphasis on public health research, including research into social determinants.

Recommendation 4

5.36 The committee recommends that the NHMRC give greater emphasis in its grant allocation priorities to research on public health and social determinants research.

5.37 The committee is strongly supportive of a regular reporting framework being established specifically on the social determinants of health. The regular reporting on the *Closing the Gap* agenda to tackle Indigenous disadvantage ensures that a focus on Indigenous disadvantage is maintained, and progress against milestones is assessed at the highest levels within government and in the media.

Recommendation 5

5.38 The committee recommends that annual progress reports to parliament be a key requirement of the body tasked with responsibility for addressing the social determinants of health.

**Senator Rachel Siewert
Chair**

APPENDIX 1

Submissions and Additional Information received by the Committee

Submissions

- 1** Beyond Blue Ltd
- 2** Prof Sharon Friel
- 3** Gippsland Women's Health Service
- 4** Hume Whittlesea Primary Care Partnership
- 5** Doctors Reform Society
- 6** Women's Health Victoria
- 7** Southgate Institute, Flinders University
- 8** Victorian Healthcare Association
- 9** Centre for Health Equity Training Research and Evaluation
- 10** Victorian Dental and Oral Health Therapist Association Inc
- 11** Women's Health West
- 12** Consumers Health Forum of Australia
- 13** Public Health Information Development Unit
- 14** Public Health Association of Australia
- 15** Macarthur Future Food Forum
- 16** HealthWest Partnership
- 17** Dr Matthew Fisher
- 18** Australian College of Nursing
- 19** Catholic Health Australia
- 20** Doctors for the Environment Australia Inc

- 21 Family Planning NSW
- 22 Tasmanian Department of Health and Human Services
- 23 Merri Community Health Services Limited
- 24 Prof Hal Kendig
- 25 Community Indicators Victoria
- 26 Tasmanian Social Determinants of Health Advocacy Network
- 27 Australian Federation of AIDS Organisations
- 28 Australian Health Promotion Association
- 29 Australian Healthcare and Hospitals Association
- 30 Australian Health Care Reform Alliance
- 31 St Vincent's Health Australia
- 32 Australian Nursing Federation
- 33 Sydney Local Health District
- 34 Australian Bureau of Statistics
- 35 The Pharmacy Guild of Australia
- 36 Australian Institute of Health and Welfare
- 37 Municipal Association of Victoria
- 38 Western Region Health Centre Ltd
- 39 Health in All Policies Collaboration
- 40 Gay and Lesbian Rights Lobby
- 41 Australian Women's Health Network
- 42 National LGBTI Health Alliance
- 43 South Western Sydney Local Health District
- 44 Councils of Social Service
- 45 The Royal Australasian College of Physicians

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- 46** General Electric (Australia and New Zealand)
- 47** Cancer Council Australia and the National Heart Foundation of Australia
- 48** Centre for Women's Health, Gender and Society
- 49** The Australian Psychological Society Limited
- 50** Victorian Gay and Lesbian Rights Lobby Policy Working Group
- 51** South Australian Government
- 52** Australian Association of Social Workers
- 53** Close the Gap Campaign for Indigenous Health Equality
- 54** Australian Medical Students' Association
- 55** Foundation for Alcohol Research and Education
- 56** Central Australian Aboriginal Congress
- 57** Aboriginal Medical Services Alliance of the Northern Territory
- 58** Australian National Preventive Health Agency
- 59** National Rural Health Alliance
- 60** Department of Health and Ageing
- 61** Ms Liz Furler
- 62** Men's Health Information and Resource Centre, UWS
- 63** Australian Medicare Local Alliance
- 64** Northern Territory Department of Health and Families
- 65** Australian Social Inclusion Board
- 66** National Aboriginal Community Controlled Health Organisation (NACCHO)
- 67** Social Determinants of Health Alliance
- 68** Local Government Association of NSW and Shires Association of NSW (LGSA)

Additional Information

- 1 Population Health Congress 2012 Communique from the Public Health Association of Australia, received 12 October 2012
- 2 Constitution and Rules from the Public Health Association of Australia, received 12 October 2012
- 3 Report of the National Preventive Health Surveillance Forum from the Australian National Preventive Health Agency, received 10 January 2013
- 4 Preliminary advice to the NHMRC (Nov 2012) in relation to social determinants of health and research priorities from the Australian National Preventive Health Agency, received 10 January 2013
- 5 Tabled documents from Australian National Preventive Health Agency, at Melbourne public hearing 11 December 2012

Answers to Questions on Notice

- 1 Answers to Questions on Notice received from Victorian Healthcare Association, 13 December 2012
- 2 Answers to Questions on Notice received from HealthWest Partnership, 20 December 2012
- 3 Answers to Questions on Notice received from Catholic Health Australia, 3 January 2013
- 4 Norwegian Public Health Policy Report 2009 (provided by Catholic Health Australia)
- 5 Answers to Questions on Notice received from Victorian Gay and Lesbian Rights Lobby, 11 January 2013
- 6 Answers to Questions on Notice received from Australian Social Inclusion Board, 18 January 2013
- 7 Answers to Questions on Notice received from Department of Health and Ageing, 15 March 2013

Correspondence

- 1 Correspondence from South Australian Government, received November 2012

APPENDIX 2

Public Hearings

Friday, 12 October 2012

Parliament House, Canberra

Witnesses

Southgate Institute for Health, Society and Equity

BAUM, Professor Fran, Professor of Public Health

NATSEM, University of Canberra

BROWN, Professor Laurie Jennifer, Research Director

Tasmanian Social Determinants of Health Advocacy Network

HERZFELD, Mrs Miriam, Facilitator

Australian Health Care Reform Alliance

MCGOWAN, Mr Russell, Executive Committee Member

WALKER, Mrs Joanne, Executive Committee Member

Public Health Association of Australia

MOORE, Professor Michael, Chief Executive Officer

WALKER, Ms Melanie, Deputy Chief Executive Officer

Friday, 23 November 2012

Parliament House, Canberra

Witnesses

Australian Institute of Health and Welfare

AL-YAMAN, Dr Fadwa, Senior Executive, Social and Indigenous Group

St Vincent's Health Australia

BATTEN, Dr Tracey, Group Chief Executive Officer

MUIR, Ms Janet, Group General Manager, Strategy

WITTMACK, Sister Leone, Group Mission Leader

Department of Health and Ageing

FLANAGAN, Ms Kerry, Deputy Secretary
SMYTH, Mr Nathan, First Assistant Secretary, Population Health Division
GOODSPEED, Ms Sally, Assistant Secretary, Health in Social Policy Branch,
Population Health Division

Council of Social Service of New South Wales

FROST, Ms Solange, Senior Policy Officer

Foundation for Alcohol Research and Education

THORN, Mr Michael, Chief Executive Officer
GIORGI, Ms Caterina, Manager, Policy and Research

Australian Council of Social Service

GOLDIE, Dr Cassandra, Chief Executive Officer

Tuesday, 4 December 2012

Parliament of Victoria, Melbourne

Witnesses**Municipal Association of Victoria**

HARGREAVES, Ms Clare, Manager, Social Policy
BLACK, Ms Jan Christina, Policy Adviser

Victorian Gay and Lesbian Rights Lobby

BROWN, Ms Anna, Co-Convenor
CLARKE, Ms Barbary, Convenor, Policy Working Group

SA Health

BUCKETT, Dr Kevin, Director, Public Health
WILLIAMS, Ms Carmel, Manager, Health in all policies unit

Women's Health Victoria

BUTERA, Ms Rita, Executive Director
DUREY, Ms Rose, Policy and Health Promotion Manager
RUGKHLA, Ms Ornwipa (Pam), Health Promotion Officer

Catholic Health Australia

LAVERTY, Mr Martin, Chief Executive Officer

Gay and Lesbian Health Victoria

LEONARD, Mr William, Director

HealthWest Partnership

MORGAIN, Ms Lyn June, Chair, Primary Care Partnership

REIMERS, Ms Jenny, Prevention and Advocacy Coordinator

Department of Education and Child Development

STRACHAN, Ms Patricia, Interim Head, Child Development

Victorian Healthcare Association

SYMONDSOON, Mr Thomas, Research and Policy Manager

TEMPLIN, Mr Christopher, Research and Policy Officer

**Community Indicators Victoria, School of Population Health, University
Melbourne**

DAVERN, Dr Melanie, Research Fellow

Tuesday, 11 December 2012

Parliament of Victoria, Melbourne

Witnesses**Australian National Preventive Health Agency**

SYLVAN, Ms Louise, Chief Executive Officer

ROE, Ms Jenny, Manager, Medicare Locals Taskforce