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Dr Ian Holland
Committee Secretary
Senate Standing Committee on Community Affairs
Parliament House

1st October 2012

Dear Dr Holland,
Thank you for the invitation to input into the Senate Inquiry on Australia's response to the World Health Organization's Commission on Social Determinants of Health report "Closing the gap in a generation". I applaud Minister Plibersek and Minister Butler for their concern about these issues and their leadership in taking action on the societal level factors that affect the health of all Australians.

The WHO Commission on Social Determinants of Health
The World Health Organisation Commission on Social Determinants of Health (CSDH) shone a global spotlight on the marked health inequities that exist between and within countries at the start of the 21st century.[1]

Our analysis concentrated on the empowerment of individuals, communities and nations to have the freedom to live healthy and flourishing lives. We identified that three dimensions of empowerment, material, psychosocial and political are interconnected - people need the basic material requisites for a decent life, they also need to have control over their lives, and they need voice and participation in decision-making processes. Behind empowerment and its social distribution lie the social determinants - the economic and social policies that generate and distribute power, income, goods and services, at global, national and local levels, which in turn shape people's daily living conditions. The nature of these daily living conditions influence how different social groups live, work, play and age, with consequences for health and health equity.

A social determinants approach therefore suggests that health and health inequities are fundamentally produced not by individual behaviour but rather by policies, programmes and actions within sectors such as planning, transport, trade, agriculture, education, labour, as well as health.

Our analysis of the global evidence base led to three necessarily broad recommendations:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

The CSDH final 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. Many countries across the world have responded using a range of policy frames and approaches such as Comprehensive Primary Healthcare, Universal Health Coverage, Health in All Policies, Multisectoral action plans for non-communicable diseases and Healthy Islands.

Steps towards a Fair, Healthy and Sustainable Australia

There have been incredible improvements in health outcomes in Australia over the past few, many of them attributable to a strong sustained investment in public health. However, avoidable differences in health risks and outcomes continue to exist along a number of social dimensions. For example, heart disease, diabetes, asthma, mental health conditions and obesity are each more prevalent in the lowest socio-economic quintile compared to the highest quintile.[2] There is an incredible gap of 12 years life expectancy at birth between Indigenous males compared to the average Australian male. There are gaps but there are also social gradients. As one moves down the socio-economic ladder the risk of shorter lives and higher levels of disease risk factors increases.[2, 3]

Historically, public policy in Australia did much to address the social determinants of health and health inequity, and today in some States and Territories there are some progressive actions,[4] although recent cuts to public (health) spending in some jurisdictions such as Queensland will very likely undermine the progress that has been made. What about the Federal policy space?

The health care system

Systems of disease control and health care can be both a determinant of health inequities and a powerful mechanism to reduce inequities. There have been a number of recent major national initiatives within the health sector which are helpful for health equity in Australia:

1. The National Health and Hospitals Reform Commission (NHHRC) highlighted inequities in healthcare in Australia including gaps in dental, public hospital and mental health services, and noted access and quality of services is poorer for remote and rural Australians and Aboriginal and Torres Strait Islanders.[5] The NHHRC articulated two ways to build healthier communities – by tackling health inequities, including access to health care, and through health promotion and disease prevention. Some of the proposals suggested by the NHHRC are to specifically address these health gaps and include Denticare scheme; increased funding to reduce waiting times in public hospitals; top-up payments for remote/rural doctors; extra payments for rural patient's travel costs and accommodation. Other recommended measures that are good for equity include

investment in prevention, complex care co-ordination and comprehensive primary health care centres. However, the NHHRC did not directly acknowledge the marked socioeconomic gaps in health and access to services. *Private health insurance (and subsidy of) is a great source of inequity and was not addressed at all.* The cost of most doctor visits is subsidised in Australia through Medicare and there are provisions to limit out-of- pocket costs. The *Medicare Select* proposal has the potential to increase inequity - more choice usually means more choice for the better off. 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.[6] This is of particular concern when trying to prevent and treat chronic disease – the main health burden in Australia today – where optimal care requires use of multidisciplinary services.

2. 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 health equity. *It will be important to monitor the effectiveness of Medicare Locals in terms of impact on disease risk, health outcomes and their social distribution.*

3. In 2009 the National Preventative Health Taskforce (NPHT) made recommendations for how to make Australia the healthiest country by 2020.[7]
    a. The primary focus of the recommendations was on tobacco use, alcohol consumption, poor nutrition and inadequate physical activity, which are indeed among the top ten risk factors for Australia's non-communicable disease burden.
    b. While these behaviour-related risk factors were the primary focus, the NPHT did move the dialogue beyond individual responsibility and spoke of matters to do with building healthy environments and settings and measures of market regulation and taxation. The cigarette plain packaging is a fantastic example of societal level intervention to protect public health.
    c. However, 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. Of particular relevance is the inequity in the physical and social experiences in early life; access to and quality of education, particularly that of females; how cities are planned and designed plus the livability of rural locations; and the financial, psychosocial and physical conditions of working life. Promoting health equity through healthy weight, limited alcohol and tobacco use also means tackling some of the structural issues that affect people's living conditions, daily practices and behaviour-related risks. That means dealing with matters of trade; market regulation; the nature of foreign direct investment, taxation policy and labour conditions.[8]
    d. Encouragingly the NPHT made recommendations to close the health gap between Indigenous and non-Indigenous Australians and reduce health inequities by targeting disadvantaged groups. Instead of just targeting disadvantaged groups, better health for all could be achieved using *Proportionate Universalism* - as the evidence shows, a universal approach to population health is the most sustainable and equitable but

obviously some people need more support that others – a proportionate universalism policy framework does both.

Non-health sectors

As outlined previously, much of what affects health equity happens beyond the health sector. There are a number of promising examples of healthy public policy in Australia.

- The introduction of the new workplace relations system, through the introduction of Australian Fair Work Bill 2008 is one example.[9] The new system aspires to ensure a fair and comprehensive safety net of minimum employment conditions; a system that has at its heart bargaining at the collective/enterprise level; protections from unfair dismissal for all employees; protection for the low-paid; a balance between work and family life; the right to be represented in the workplace. This has the potential, if done well, to reduce health inequities but we need to explicitly monitor its impact.
- Around the time of the global financial collapse, the then Prime Minister, Kevin Rudd, asserted the role of central government in protecting society and being the provider of public goods, including health. While the specifics could be much better from a health equity perspective, as a rapid social protection response to an acute situation the Australian stimulus package was to be commended. The government pledged 1% of gross domestic product to be spent on pension reforms, support payments for low and middle-income families, help for first-time home buyers, and the creation of new training places. By seeking to provide strong social protection measures and build strong resilient systems and societies, former Prime Minister Rudd suggested political values and a policy framework which could measure its success by improvements in the distribution of health in Australia.[10]
- At the 24th meeting of the Council of Australian Governments in November 2008, significant amounts of money were allocated to infrastructure necessary to sustain social development.[11] 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. Many of the National Partnerships announced relate to the social determinants of health (although not explicitly referred to as this), focusing on issues of social inclusion, education improvement and poverty alleviation. An explicit COAG commitment to Indigenous reform and "closing the gap" was made with $4.6 billion to be allocated across early childhood development, health, housing, economic participation and remote service delivery and the establishment of the National Indigenous Health Equality Council. Each of these SPP and NPs has the potential to really improve the lives of people and consequently their health and wellbeing – but an explicit analysis of these impacts is needed.
- Of particular significance to the social determinants of obesity, alcohol and tobacco was the Preventative Health NP, with dedicated preventative health research funding and commitment to establishing a National Preventative Health Agency and related surveillance program. The Australian National Preventative Health Agency has the potential to address the societal level factors that affect peoples' health-related behaviours. However, the current requirements for ANPHA to focus to a large extent on social marketing diverts its relatively small personnel and financial resources away from tackling some of the more upstream drivers of health behaviours.

Data

We had a saying in the CSDH - 'no data, no problem, no action'. Australia has very good data collection systems – the recent health report from AIHW gives us some of the socially stratified information that we need to monitor changes in health outcomes across a range of social groups but we need to do that type of analysis systematically across all datasets. We need national level measurable indicators for the social determinants – employment, health care use, education etc – and be able to connect them to socially stratified health outcome data. The excellent work undertaken for the social atlas of Australia could be extended to give fine grain local level health inequities. Finally we need a mechanism where a health, and health equity lens is systematically applied to key non-health policies and programs and the impact of these policies on health and health equity routinely assessed. An equity-focused health impact assessment enables the systematic consideration of health inequities early on within the development of policies and programmes prior to their implementation. For example, an urban planning policy - the "Sydney Metro Strategy" proposed that large undeveloped areas of land on suburban fringe of Sydney be opened up for development. Having identified food production as a determinant of health, a HIA uncovered that these areas in fact housed market gardens supplying large quantities of fruit and vegetables to the Sydney area. The HIA determined that the proposed strategy would likely lead to loss of livelihoods for market gardens, and raise fresh food prices across Sydney, disproportionately impacting on low income households, thus exacerbating inequalities. Without these types of analyses it will be impossible to assess the positive effects being made on health and wellbeing through intersectoral action.

These are just a few examples of some evidence and policy areas where things have developed in a way that holds promise for health equity. But there is much more that can and must be done if Australia is to become the healthiest country by 2020 in a way that is fair and sustainable. Climate change, not discussed in this paper, will increasingly exacerbate Australia's health inequities through its impact on people's social conditions. This must be in the mix of policy considerations for health equity.

Since early September 2010 Australia has had a minority labour government with the support of three Independents and the Australian Greens. Since then the real meaning of power sharing has been actualised in 'negotiated' reform, legislation development and policy pledges. In some of those instances, such as tobacco plain packaging, the Health Minister has been at the Cabinet table, powerfully making the case for action on the determinants of health equity. Much more of this is needed - the intersectoral nature of the determinants of health equity demands an intersectoral response and hopefully the Prime Minister and Ministers Pliberseck and Butler will ensure Ministers for finance, trade, agriculture, commerce, education, employment and the environment each consider the impact of their decisions on the health and wellbeing of all Australians.

Underpinning action on the determinants of health equity requires political will at the highest level, supported by an empowered public sector based on principles of justice, participation, and intersectoral collaboration. This means strong core functions of government and public institutions in relation to policy coherence, participatory governance, planning, regulation development and enforcement, and standard setting. Prime Minister Gillard and Ministers Pliberseck and Butler are to be congratulated on supporting such an approach in Australia. It

would be extremely helpful if we also had an explicit policy framework around the societal level factors that affect health and health equity. Similarly, in the WHO CSDH work, success occurred most often when there was explicit comittment and a mechansim at the central policy level – a committee or review body sitting in the Prime Ministers office. Perhaps through the Senate Inquiry we can establish such a mechanism and undertake an Australian equivalent of the global CSDH.

I would be very happy to provide more information at any point. I look forward to the deliberations of the Senate Inquiry and would be very pleased to input in to it in person.

Yours sincerely,

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