SENATE COMMUNITY AFFAIRS COMMITTEE

INQUIRY INTO

AUSTRALIA'S DOMESTIC RESPONSE TO THE WORLD HEALTH ORGANIZATION'S (WHO) COMMISSION ON SOCIAL DETERMINANTS OF HEALTH REPORT "CLOSING THE GAP WITHIN A GENERATION"

SUPPLEMENTARY SUBMISSION FROM

THE AUSTRALIAN GOVERNMENT

DEPARTMENT OF HEALTH AND AGEING

DECEMBER 2012

Contents

Executive Summary

This supplementary submission provides an overview of some of the recent international activity and research focused on the social determinants of health and health inequity.

The World Health Organization (WHO) defines social determinants of health as the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. [1]

The Australian Government has long recognised the importance of the underlying and complex social factors affecting health and has adopted an integrated and cross-sectoral approach to the development of health policies and programs. This is evidenced in numerous Australian Government initiatives that were discussed in more detail in the original submission from the Department of Health and Ageing. In this regard, Australia is well positioned and is already working across the spectrum of determinants to provide a mix of universal and targeted programs that contribute to improved health and wellbeing outcomes.

Despite the accumulation of knowledge about the relationship between health and other social factors there is limited evidence that confirms direct causal factors to address health inequities. Knowledge and experiential gaps may also mean that interventions contribute to long term, unintended or unforeseen consequences. It is noted that there are inherent difficulties in identifying causal pathways in any social research and this is further complicated by the complexities and connections evident in the social determinants of health.

The Strategic Review of Health Inequalities in England post 2010 (the English review) has made similar recommendations and highlighted the need for further research to guide the ongoing development of good practice in this area. The Commission inquiry overseen by the WHO recognised this gap in knowledge and made strong recommendations to facilitate ongoing accumulation of evidence and knowledge, including routine monitoring, data collection, evaluation and training.

In this context it is clear that there is much that Australia can both contribute to and gain from this growing evidence base. Emerging evidence suggests that locally driven, place-based approaches offer significant potential to address the social factors that affect health. Through the regular monitoring and evaluation embedded within the governance of place-based initiatives such as Medicare Locals, Local Hospital Networks and the Healthy Communities component of the National Partnership Agreement on Preventive Health, the Australian experience can contribute to this broader international dialogue.

[1] World Health Organization website: http://www.who.int/social_determinants/en/

International Context

In recent years three major reviews have investigated global evidence on the social determinants of health and their impact on health inequity. These include the WHO Commission on the Social Determinants of Health, the Strategic Review of Health Inequalities in England post 2010 (the English review) and the Report on Social Determinants of Health and the Health Divide in the WHO European Region (the European review) which is currently underway and expected to release its final report later this year.

The Australian Government has noted these reviews with interest and, in the case of the review conducted by the WHO, Australia has been an active participant.

A table outlining the timeframe for these reviews and associated activities is at **Attachment 1**.

World Health Organization (WHO)

WHO Commission on Social Determinants of Health (2005-2008)
In 2005 the World Health Organization established the Commission on Social Determinants of Health to provide advice on how to reduce the widening inequities in the social determinants of health. The Commission was chaired by Professor Sir Michael Marmot.

The Commission's final report - *Closing the gap in a generation: Health equity through action on the social determinants of health* was published in August 2008 and made three overarching 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 and understand the problem and assess the impact of action – evaluate and 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. [2]

World Conference on Social Determinants in Rio de Janeiro (2011)
WHO organised this conference as a global platform for dialogue on how the recommendations of the final report *Closing the gap in a generation: Health equity through action on the social determinants of health* could be taken forward. During the conference, the Rio Political Declaration on Social Determinants of Health was adopted. A copy of the Rio Political Declaration is at **Attachment 2.**

[2] Commission on Social Determinants of Health (2008) CSDH Final report: *Closing the gap in a generation: Health equity through action on the social determinants of health.* Geneva: World Health Organization

The Rio Political Declaration of 2011 confirmed the commitment of Member States to take action to address the social determinants of health in five areas:

- Adopt improved governance for health and development
- Promote participation in policy-making and implementation
- Further reorient the health sector towards promoting health and reducing health inequities
- Strengthen global governance and collaboration
- Monitor progress and increase accountability.

Australia is committed to progressing the Rio Political Declaration on Social Determinants of Health.

8th Global Conference on Health Promotion (2013)
The 8th Global Conference on Health Promotion will be held in Helsinki, Finland, from 10-14 June 2013. The conference is being co-organised by the WHO and the Ministry of Social Affairs and Health of Finland. Participation at the Conference will be by invitation only.

The Conference will examine the historical and scientific context of health promotion since the Alma Ata Declaration of 1978 and the Ottawa Conference on Health Promotion in 1986. It is anticipated participants will review and discuss:

- how the public agenda for health is set
- how public policy is formulated
- which activities have been found effective in promoting health and health equity
- how the health impact of policy is assessed
- how intersectoral action is set up and governed at international, regional, national and local levels.

Conference participants will share experiences in engaging in the "Health in All Policies" approach and seek to establish some guidance for concrete action in countries at all levels of development.

Strategic Review of Health Inequalities in England post 2010 (2008-2010)
In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010.

The Review had four tasks:

1. Identify, for the health inequalities challenge facing England, the evidence most relevant to underpinning future policy and action
2. Show how this evidence could be translated into practice
3. Advise on possible objectives and measures, building on the experience of the current Public Service Agreement targets on infant mortality and life expectancy
4. Publish a report of the review's work that will contribute to the development of a post-2010 health inequalities strategy.

The final report, *Fair Society Healthy Lives*: *A Strategic Review of Health Inequalities in England Post-2010*, was published in February 2010. Based on the evidence

assembled, the review made six overarching policy recommendations to reduce health inequities:

A. Give every child the best start in life
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives
C. Create fair employment and good work for all
D. Ensure healthy standard of living for all
E. Create and develop healthy and sustainable places and communities
F. Strengthen the role and impact of ill health prevention. [3]

In response to this review, a series of reforms for the public health system in England were outlined in a White Paper published by the Coalition Government in November 2010. These include the establishment of a new public health service called Public Health England. This will become operational in April 2013 and will be set up as part of the Department of Health. [4]

Report on Social determinants of health and the Health divide in the WHO European Region (2010 – 2012)

The WHO Regional Office for Europe commissioned a regional review of the health divide and inequalities in health from July 2010 to 2012. The review is being conducted by a consortium of experts and institutions, and is chaired by Professor Sir Michael Marmot.

The executive summary is currently available and the full, final report is expected to be available later this year.

The stated purpose of the review is to consider the relevance of the findings of the WHO Commission on the Social Determinants of Health, the Strategic Review of Health Inequalities in England post 2010 and other new evidence to the European context. These will be translated into policy proposals. The European Review will also feed into the development of a renewed European health policy: *Health 2020* referred to later in the submission.

The European Review draws on best practices, examples and experience of addressing social determinants of health and health inequities in the region. One of the key goals of the review is to identify what can be implemented with sufficient scale and intensity to make a difference across the diverse contexts of the European region. [5]

A first interim report was published in September 2010, and describes the subsequent stages and content of the rest of the review. A second interim report was published in August 2011, and outlines some of the key areas emerging. These include a focus on health assets, addressing processes that increase people's vulnerability and a whole-of-government approach.

---

[3] The Marmot Review (2010) *Fair Society, Healthy Lives – Strategic Review of Health Inequalities in England Post 2010.*

[4] Healthy Lives, Healthy People: Our Strategy for public health in England (2010). HM Government, Department of Health UK

[5] UCL Institute of Health Equity website: http://www.instituteofhealthequity.org/projects/who-european-review

The European review is being informed by 13 task groups that are undertaking work to build on existing knowledge and propose effective strategies for action in key areas relating to health. Eight topic groups are each covering one or more of the key social determinants of health in the European region and/or key stages of the life cycle:

1. early years, education and the family
2. employment and working conditions, including occupation, unemployment and migrant workers
3. disadvantage, social exclusion and vulnerability
4. GDP, taxes, income and welfare
5. sustainability and community
6. preventing and treating ill health
7. gender
8. older people.

A further five cross-cutting groups are each focusing on issues that span across two or more of the topic groups:

1. economics
2. governance and delivery systems
3. global factors
4. equity, equality and human rights
5. measurements and targets. [6]

The review indicates that countries should have two clear aims:

- improving average health; and
- reducing health inequities by striving to bring the health of less advantaged people up to the level of the most advantaged.

The Executive Summary goes on to say that improving the levels and equitable distribution of the social determinants should achieve both aims. Similarly, reducing health gaps between countries requires striving to bring the level of the least healthy countries up to that of the best. To achieve this, two types of strategy are needed:

- within each country, action on the social determinants of health to improve average health and reduce health inequities; and
- action at the transnational level to address the causes of inequities between countries.

Based on the evidence assembled, the review has grouped its recommendations into four themes and states that action is required in all four themes:

1. life-course stages
2. wider society
3. the macro-level context
4. systems. [7]

---

[6] European Portal for Action on Health Inequalities website: http://www.health-inequalities.eu/HEALTHEQUITY/EN/about_hi/marmot_reviews/

[7] Report on social determinants of health and the health divide in the European region, Executive Summary (2012). Geneva: World Health Organization - Regional Office for Europe

Health 2020

Health 2020 is the new European health policy framework. Its stated aims are to support action across government and society to: "significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality". [8]

Health 2020 is the product of two-year consultation process across the European region and was adopted by the 53 Member States of the region during the sixty-second session of the WHO Regional Committee for Europe in September 2012.

[8] WHO Organization – Regional Office for Europe: http://www.euro.who.int/en/what-we-do/health-topics/health-policy/health-2020

Related World Health Organization Activities

Australia is one of the 194 Member States of the World Health Assembly, the governing body of the World Health Organisation (WHO). The Assembly is the supreme decision-making body for the WHO. The Department of Health and Ageing has lead responsibility, on behalf of the Australian Government, in interactions with the WHO.

Australia also currently holds a membership (2012–2015) of the WHO Executive Board. The Executive Board gives effect to the decisions and policies of the World Health Assembly and generally facilitates its work.[9] The Secretary of the Department of Health and Ageing represents Australia at both the WHO Executive Board and the World Health Assembly.

The WHO progresses a work plan covering a wide range of areas relevant to the social determinants of health including the following.

Prevention and Control of Non Communicable Diseases
On 19 and 20 September 2011, the United Nations General Assembly High Level Meeting on the Prevention and Control of Non-Communicable Diseases was held in New York. At this meeting, Member states agreed that the WHO should work to:

a. progress global monitoring on non-communicable diseases (NCDs);
b. develop policy options to strengthen multi-sectoral action on NCDs; and
c. update the 2008-13 Action Plan for the Global Strategy for the Prevention and Control of NCDs for 2013-20.

(a) Global Monitoring Framework
The WHO secretariat has released three discussion papers on the Global Monitoring Framework in December 2011, March 2012 and July 2012. WHO have also hosted formal consultations with Member States to discuss the Framework.

During October and November 2012 the third discussion paper has been used as the basis for further consultation with Member States to develop a draft framework.

The draft framework incorporates three areas: Mortality and morbidity, Risk factors and National system response. Member States have recommended 25 indicators to monitor trends and to assess progress and a set of 9 voluntary global targets for the prevention and control of NCDs within the Framework. The WHO intends to report on progress in 2015, 2020 and 2025

The WHO secretariat will seek endorsement of the outcomes of the draft framework at the WHO Executive Board meeting in January 2013 and the World Health Assembly in May 2013.

(b) Strengthening and Facilitating Multisectoral Action
International activity in relation to multi-sectoral action has been directly driven by the WHO Director-General (DG) with limited involvement of WHO Member States. A report prepared by the DG presenting options for strengthening and facilitating multisectoral

[9] http://www.who.int/en/

action for the prevention and control of NCDs through effective partnership, was discussed by the UN General Assembly in late November 2012.

(c) Global Action Plan for the Prevention and control of non-communicable diseases 2013-2020

The WHO Secretariat prepared a discussion paper on the development of the WHO Global Action Plan which was discussed during the first informal consultation with Member States and UN Agencies on 16-17 August 2012. The outcomes from these consultations were incorporated into the 'zero draft' of the 2013-2020 Action Plan, which was discussed at a second informal consultation for Member States and UN Agencies on 1 November 2012. The outcome from these second informal consultations will serve as an input for the WHO Secretariat to prepare a draft 2013-2020 Action Plan for submission to the Sixty-sixth World Health Assembly in May 2013, through the Executive Board in January 2013.

Framework Convention for Tobacco Control

The WHO FCTC is the first treaty negotiated under the auspices of the WHO and has since become one of the most rapidly and widely embraced treaties in United Nations history. Australia was one of the first countries to ratify the FCTC after it was adopted by the World Health Assembly on 21 May 2003, and became a full Party to the Convention when it entered into force on 27 February 2005. The WHO FCTC is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. It was developed in response to the globalization of the tobacco epidemic.

On 12 November 2012 the delegates of more than 140 Parties to the WHO FCTC, including Australia, adopted the Protocol to Eliminate Illicit Trade in Tobacco Products, the first Protocol made pursuant to the FCTC. The Protocol is now a treaty-level text, binding on those FCTC Parties that sign and ratify it. The Protocol includes a range of controls on the supply chain for tobacco, as well as arrangements for international cooperation, so as to combat the illicit trade in tobacco. A key measure in the Protocol is the establishment of a global tracking and tracing system.

The Protocol will now be open for signature by FCTC Parties for one year, starting 10 January 2013. Signatories will then need to decide, in accordance with their national law, whether to ratify the Protocol. The Protocol will enter into force 90 days after 40 ratifications are achieved.

Global Mental Health Action Plan

The Sixty-fifth World Health Assembly adopted a resolution (WHA65.4) on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. It requested the WHO Secretariat to develop a comprehensive mental health action plan, to be submitted to the Sixty-sixth World Health Assembly through the Executive Board.

WHO has developed a 'zero draft' 2013-2020 Global Mental Health Action Plan. The draft is based on current scientific knowledge, available evidence and a review of international experience. It contains a proposed vision, objectives and target areas for action by Member States. Comments on the zero draft were sought from

27 August 2012 to 19 October 2012 and are currently being incorporated into the next version.

In response to paragraph 2.1 of World Health Assembly resolution WHA65.4, requesting the WHO Director-General to develop a comprehensive mental health action plan with measurable outcomes, the WHO Secretariat has prepared a 'zero draft' 2013-2020 Global Mental Health Action Plan, which was published on 27 August 2012. The 'zero draft' 2013-2020 Global Mental Health Action Plan was used as a basis for further consultations with Member States and UN agencies at an informal consultation on 2 November 2012 at WHO.

The WHO Secretariat convened an informal consultation with Member States and UN agencies on 2 November 2012 on the 'zero draft' 2013-2020 Global Mental Health Action Plan. During the informal consultation, a summary of comments was received from Member States and UN agencies, as well as the views from relevant global NGOs and selected private sector entities.

To conclude the work, the WHO Secretariat will submit a final draft of the 2013-2020 Global Mental Action Plan to the Sixty-sixth World Health Assembly (May 2013) through the Executive Board (January 2013) for consideration by Member States.

Emerging Approaches

The WHO has demonstrated its commitment to sharing evidence and successful approaches to addressing the social determinants of health through the establishment of an Electronic Discussion Platform - *Action:SDH*. The platform can be accessed at http://www.actionsdh.org/Contents/Action/Governance/Building_governance/Health_in_All_Policies_approach3.aspx

Although the evidence base for working with a social determinants approach is still being developed, a few strategies are emerging for tackling the issue of health inequity through social determinants. These include a focus on governance, place-based approaches and monitoring and evaluation.

Governance

An increasing number of conceptual models for addressing the social determinants of health have emerged since the finalisation of the WHO's *Closing the Gap in a Generation* report.

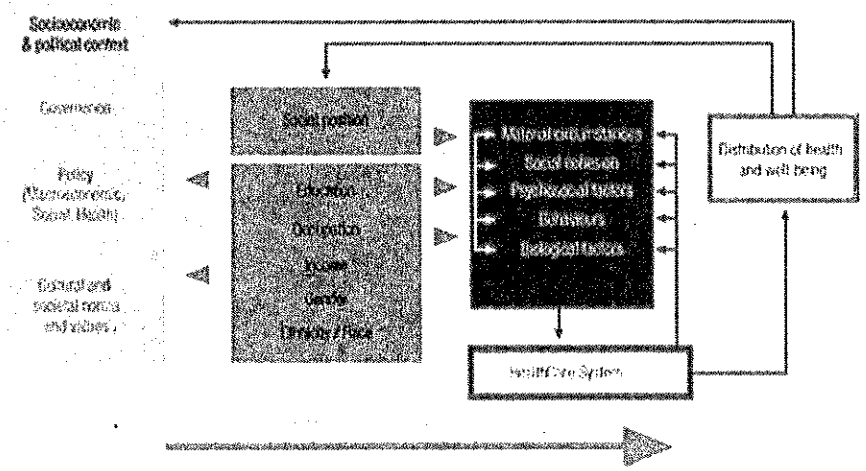


Figure 1: Conceptual Framework from Closing the Gap in a Generation (amended from Solar & Irwin2007

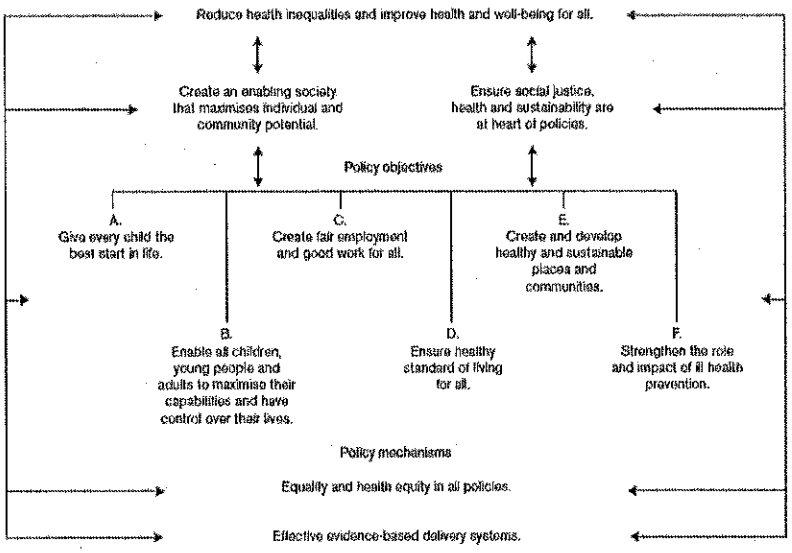
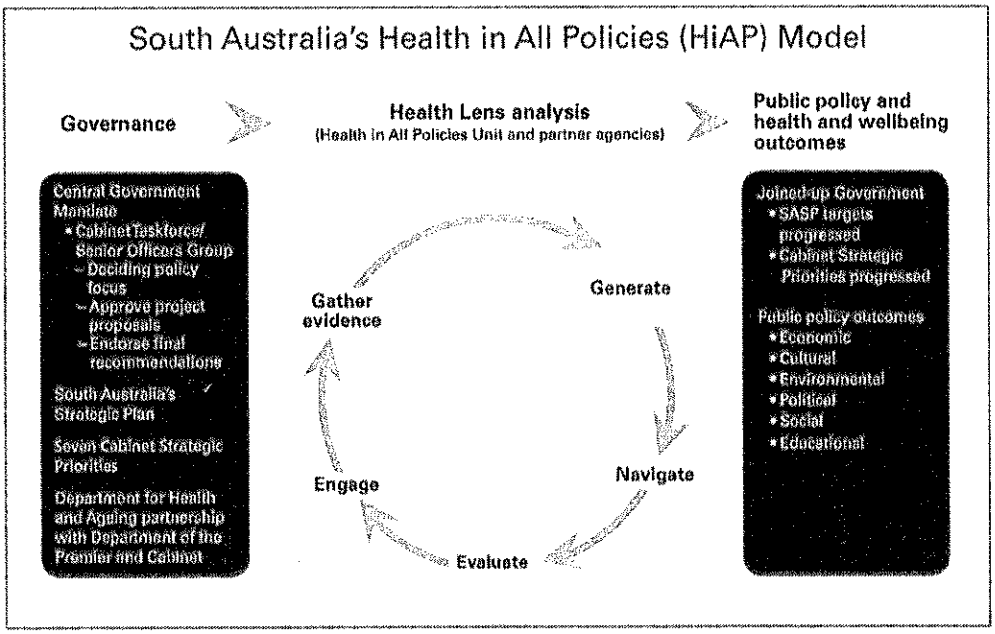


Figure 2: Conceptual Framework from Fair Society, Healthy Lives (The Marmot Review)

These models present contextual information that can guide the development and delivery of policies and programs addressing the social determinants of health. They are characterised by the combination of social and environmental factors influencing human health within the policy making context. It is noted that whilst many features of these conceptual models are similar they are all made relevant by the addition of specific features particular to the context in which they operate.

Within Australia, a number of governance models are emerging to facilitate and coordinate state based activity addressing the social determinants of health. The models developed by the South Australian Government (Submission No. 51) and the Tasmanian Health in All Policies Alliance (Submission No.39) are combining traditional policy development models with locally relevant policy drivers and objectives.



In the case of both the South Australia 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.

Place-based approaches

Collaborative, place-based approaches have emerged as one potential strategy for addressing public health policy issues that have multiple causes and solutions (sometimes referred to as "wicked" public policy in the literature or "middle ground" issues). Examples that demonstrate complexity include obesity, child abuse, poverty and homelessness.

Complex public health issues often traverse the boundaries of any one organisation or government department. Consequently there may be differences of opinion about their causes and the best way to redress them. Collaborative, place-based approaches are one strategy that may be useful for addressing such issues as they seek to bring together a range of players in a geographical area to work together to address a complex issue.

Place-based approaches can have a broader impact on the problems that affect a given community/population. For example, interventions that target housing or early childhood or social inclusion are likely to also have an impact on the health outcomes of the target group.

The Murdoch Children's Research Institute notes a number of factors that form the rationale for adopting a place-based approach:

- Place (both social and physical environments) influences health and wellbeing
- Feeling connected and having social networks matters for people's wellbeing
- Some communities are trapped by locational disadvantage
- Local services are not able to respond effectively to the complex needs of families and communities. [10]

Establishing the effectiveness of place-based initiatives, policy and planning is challenging. Due to the unique nature of place-based strategies new research or evaluation approaches may be required to effectively measure their impacts. [11] [12] Challenges for effectively evaluating place-based approaches primarily include:

- Capturing long-term outcomes, accessing data and attributing causation - the diverse nature of using multiple policy levers diffuses the measurability of their impacts.
- Measurement is a challenge for place-based approaches.
- Having multiple partners/funding bodies
- Many place-based approaches are driven by small organisations that do not have the resources to carry out effective, robust evaluation. [13]

Characteristics of successful place-based interventions include[14] [15]:

- Meeting the unique needs of a community/location - communities participate, lead and own the intervention
- Investment in capacity building – time, funding and resources
- Adequate time
- Strong leadership and support from governments
- Effective collaboration and partnerships across organisations/stakeholders.
- Governance structures need to deliver effective engagement of all stakeholders
- Rigorous measurement to evaluate outcomes from project conception.

Research suggests that to be effective, a place-based approach should only be one mechanism in the public policy toolbox. It should not be viewed as a 'sure fix' but be carefully chosen based on issue, context and cost effectiveness and will likely be a

[10] Murdoch Children's Research Institute. Place-based approaches to supporting children and families. Policy Brief 23, 2011. Available at: www.rch.org.au/ccch/policybriefs.cfm
[11] Tasmanian Government, Department of Health and Human Services, Place-based Approaches to health and Wellbeing, Issues Paper. September 2012
[12] Government of Canada, Policy horizons Canada, The Evaluation of Place-Based Approaches. June 2011
[13] Government of Canada, Policy horizons Canada, The Evaluation of Place-Based Approaches. June 2011
[14] Murdoch Children's Research Institute. Place-based approaches to supporting children and families. Policy Brief 23, 2011. Available at: www.rch.org.au/ccch/policybriefs.cfm
[15] Tasmanian Government, Department of Health and Human Services, Place-based Approaches to health and Wellbeing, Issues Paper. September 2012

part of a more comprehensive framework i.e. they may be run in tandem with other, complementary services, regulation and taxation strategies. [16]

In recent years Australia has developed and implemented a number of place-based initiatives across a variety of social policy areas. Examples include: Healthy Communities, Healthy Workers and Healthy Children components of the National Partnership Agreement on Preventive Health and the Communities for Children program (Australian Government Department of Families, Housing, Community Services and Indigenous Affairs).

The NPAPH Healthy Communities component supports a targeted, progressive roll out of community-based healthy lifestyle programs which facilitate increased access to physical activity, healthy eating and healthy weight activities for disadvantaged groups and those not in the workforce.

Reviews of Australian work in place-based interventions suggest that it is still too early to tell what difference these will make over the long term. There is a need for well-designed outcome evaluations of place-based initiatives to support which clear conclusions about effectiveness. The NPAPH has given a focus to developing a detailed evaluation framework for this reason.

An example of a well established place-based initiative outside Australia is Sure Start in the United Kingdom. The Sure Start initiative was first announced in 1998 with the aim of "giving children the best possible start in life". The National Evaluation of Sure Start 2010 study investigated child and family functioning and reported key findings. The research conducted demonstrated significant effects of the programs on eight out of the 21 outcomes: two positive outcomes for children (lower BMIs and better physical health), four positive outcomes for mothers and families (more stimulating and less chaotic home environments, less harsh discipline, and greater life satisfaction), and two negative outcomes (more depressive symptoms reported by mothers, and parents less likely to visit schools for planned meetings).

Monitoring and Evaluation

While there is considerable explanatory analysis demonstrating the links between health and social factors, more research is needed to fully understand the causal pathways and the magnitude of their impact on health. This research can then be used to inform strategy development and policy implementation. Research is also needed to provide evidence to guide interventions such as policy or legislative changes that are likely to be effective in addressing the social determinants of health.

Global

The importance of routine monitoring for health equity and the social determinants of health, locally, nationally and internationally was acknowledged in the final recommendations made by the WHO Commission in their final report *Closing the gap in a generation: Health equity through action on the social determinants of health*. The Commission also made specific recommendations in regard to the importance of generating and sharing new evidence on the ways in which social determinants influence population health and health equity and on the effectiveness

[16] Government of Canada, Policy horizons Canada, The Evaluation of Place-Based Approaches. June 2011

of measures to reduce health equity and the effectiveness of measures to reduce health inequities through action on social determinants. [17]

England
Fair Society, Healthy Lives included proposed indicators to support monitoring of the overall strategic direction in reducing health inequalities. The London Health Observatory and the UCL Institute of Health Equity (previously known as the Marmot Review Team) have produced baseline figures for some key indicators of the social determinants of health, health outcomes and social inequality that correspond, as closely as is currently possible, to the indicators proposed in *Fair Society, Healthy Lives.*

The indicators are life expectancy and measures of inequality around life expectancy, children achieving a good level of development at age 5, young people who are not in education, employment or training, people in households in receipt of means-tested benefits and measures of inequality for people in these households.

The indicators were first published in February 2011 and were updated in 2012. [18]

Europe
The European review proposes to examine the most effective mechanisms for improving reporting and monitoring across the Region. The Second Interim report has noted that strengthening monitoring within and across countries will require increased coordination, harmonisation and accessibility of data from population and institution-based sources that complement rather than replace existing mechanisms at the national level.

The review will develop is a monitoring framework that could be measured in all countries in the European Region. The Second Interim Report has acknowledged that this may need to be progressively adopted over time. [19]

It should be noted that the World Health Organization and many countries, including Australia use similar indicators and frameworks to collect and analyse data for a variety of policy purposes.

---

[17] Commission on Social Determinants of Health (2008) CSDH Final report: *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: World Health Organization.
[18] London Health Observatory website:
http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx
[19] Regional Office for Europe (2011) Interim second report on social determinants of health and the health divide in the WHO European Region. Geneva: World Health Organization

Discussion

Research into the social determinants of health has been ongoing for a long period. The original Whitehall Study investigating the social determinants of health was conducted over a period of ten years, beginning in 1967. It showed that a variety of factors influenced health. Work has been done in Australia and internationally to increase our understanding of how these factors affect health and what can be done to change outcomes. Despite this, it is difficult to identify and attribute direct causal pathways between the multiple policy levers at work and health outcomes. Work is being progressed across a wide spectrum of areas that affect health outcomes – from social inclusion through to education and housing.

Countries and international organisations are working towards building an evidence base – by gathering data, evaluating outcomes and developing new evaluation tools. This information is helpful in guiding policy actions. Across a range of social policy areas place-based approaches are being used in recognition that universal approaches, on their own, may not reach all of the population. Targeted population health approaches are also used nationally and internationally where countries have remote or Indigenous communities who face different circumstances to many others in the same country.

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 a dilution of health effort, or adversely impacts on access to health services, health outcomes may suffer.

The Australian experience has demonstrated that neither the social determinants themselves nor our efforts to understand, measure or address them are new. Their causality is extremely complex and interconnected. Efforts to respond can be intergenerational and require multi-sectoral, collaborative approaches.

For example, it is widely recognised that Aboriginal and Torres Strait Islander Australians experience multiple disadvantage across their life course culminating in poorer health outcomes and a reduced life expectancy. The Australian Government is working with state and territory governments, industry, communities and other stakeholders to roll out a number of initiatives including the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes to address these problems.

Notwithstanding these efforts, the Central Australian Aboriginal Congress has noted in their submission to this Inquiry (No. 56) it is important that "access to quality health care is included as one of the key social determinants of health as far too often this has been excluded when it comes to discussion about the social determinants of health."

Governments within Australia have been actively seeking to respond to the social determinants of health in a wide variety of ways and over sustained periods of time. Alongside these efforts has been and continues to be a commitment to monitor progress, assess impacts and grow the evidence base. As described earlier in this submission this is a key factor for success.

In terms of data gathering, monitoring and reporting, Australia currently engages in a broad range of initiatives and strategies. These were discussed in more detail on pages 29-31 of the original submission from the Department of Health and Ageing. In particular, it is worth noting the overarching focus on monitoring and accountability agreed to by the Council of Australian Governments (COAG), under the Federal Financial Framework. As part of this agreement the COAG Reform Council publishes regular reports against specified indicators, targets and benchmarks that are analysed by a range of socioeconomic factors.

Australia is addressing issues affecting the social determinants of health through a variety of policies and programs and is continuing to monitor and adjust policies in response to evaluation results. Australia is also actively involved in international efforts to learn more about the social determinants of health and contribute to progressing actions to address issues so improve health inequities.

Attachment 1

Timeline – International activities in relation to Social Determinants of Health & Health inequality

Date	Meeting/Activity	Brief summary
Global Review		
2005 - 2008	In 2008 the Commission published its final report called *Closing the gap in a generation: Health equity through action on the social determinants of health.*	The World Health Organization (WHO) established the Commission on Social Determinants of Health to support countries and global health partners to address the social factors leading to ill health and inequities. [1] The Commission was Chaired by Professor Sir Michael Marmot.
May 2009	62nd World Health Assembly.	Australia supported the resolution for the WHO Commission's final report - *Closing the gap in a generation: Health equity through action on the social determinants of health.*
October 2011	World Conference on Social Determinants in Rio de Janeiro.	WHO convened a World Conference on Social Determinants, which was organised by the WHO as a global platform for dialogue on how the recommendations of the final report *Closing the gap in a generation: Health equity through action on the social determinants of health*, could be taken forward. During the conference, the Rio Political Declaration on Social Determinants of Health was adopted. Australia was represented by an officer from the Department of Health and Ageing at this meeting.
May 2012	65th World Health Assembly.	Australia supported the adoption of a resolution endorsing the Rio Political declaration on Social Determinants of Health.

[1] World Health Organization website: http://www.who.int/social_determinants/en/

Date	Meeting/Activity	Brief summary
English review		
2008 - 2010	Professor Sir Michael Marmot was asked by the Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010.	Marmot Review of health inequalities in England post 2010. Commissioned by the government, this review recommended policies and strategies to tackle social inequalities so as to reduce health inequalities, based on the so-called 'social determinants' approach to preventing ill health. Under the Coalition Government's proposals, public health responsibilities will be transferred from the National Health Service to local authorities. In February 2010 the report *Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010* was published.
September 2012	The Lancet – WHO European review of social determinants of health and the health divide.	Written by Professor Sir Michael Marmot, Jessica Allen, Ruth Bell, Ellen Bloomer, Peter Goldblatt, on behalf of the Consortium for the European Review of Social Determinants of Health and the Health Divide. It is based on the Executive summary of the forthcoming full report, expected to be published later in 2012.
Europe Review		
2010 to 2012	The WHO Regional Office for Europe commissioned a regional review of the health divide and inequalities in health.	The stated purpose of the review is to consider the relevance of the findings of the WHO Commission on the Social Determinants of Health, the Strategic Review of Health Inequalities in England post 2010, and other new evidence to the European context and translate these into policy proposals. [2] This review was conducted by a Consortium of experts and institutions, and chaired by Professor Sir Michael Marmot.

[2] European Portal for Action on Health Inequalities website: http://www.health-inequalities.eu/HEALTHEQUITY/EN/about_hi/marmot_reviews/

Date	Meeting/Activity	Brief summary
September 2010	60th session of the WHO Regional Committee for Europe.	Member States and partners agreed to the development of a new European health policy, *Health 2020.*
September 2010	First interim report on social determinants of health and health divide in the WHO European Region.	This first phase of the review has assessed levels of inequalities in health across the European Region and identified the barriers to and opportunities for reducing these.
August 2011	Second interim report on social determinants of health and health divide in the WHO European Region.	Outlines some of the key areas emerging. These include a focus on health assets, addressing processes that increase people's vulnerability and the whole of-government approach.
September 2012	62nd session of the WHO Regional Committee for Europe.	The new European policy for health – Health 2020, as adopted by the 53 Member States during the sixty-second session of the WHO Regional Committee for Europe in September 2012.
Expected Later in 2012	Final report on social determinants of health and health divide in the WHO European Region.	

World Conference on
Social Determinants of Health

RIO DE JANEIRO | BRAZIL | 19–21 OCTOBER 2011

All for Equity

World Health Organization

Rio Political Declaration on Social Determinants of Health

Rio de Janeiro, Brazil, 21 October 2011

1. Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.

2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an "all for equity" and "health for all" global action.

3. We underscore the principles and provisions set out in the World Health Organization Constitution and in the 1978 Declaration of Alma-Ata as well as in the 1986 Ottawa Charter and in the series of international health promotion conferences, which reaffirmed the essential value of equity in health and recognized that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". We recognize that governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures and that national efforts need to be supported by an enabling international environment.

4. We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security.

5. We reiterate our determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 ("Reducing health inequities through action on the social determinants of health"), which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action.

6. Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels.

7. Good health requires a universal, comprehensive, equitable, effective, responsive and accessible quality health system. But it is also dependent on the involvement of and dialogue with other sectors and actors, as their performance has significant health impacts. Collaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective goals, good health and well-being for all should be given high priority at local, national, regional and international levels.

8. We recognize that we need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels. Based on the experiences shared at this Conference, we express our political will to make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to safe drinking water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth, through resolute action on social determinants of health across all sectors and at all levels. We also acknowledge that by addressing social determinants we can contribute to the achievement of the Millennium Development Goals.

9. The current global economic and financial crisis urgently requires the adoption of actions to reduce increasing health inequities and prevent worsening of living conditions and the deterioration of universal health care and social protection systems.

10. We acknowledge that action on social determinants of health is called for both within countries and at the global level. We underscore that increasing the ability of global actors, through better global governance, promotion of international cooperation and development, participation in policy-making and monitoring progress, is essential to contribute to national and local efforts on social determinants of health. Action on social determinants of health should be adapted to the national and sub-national contexts of individual countries and regions to take into account different social, cultural and economic systems. Evidence from research and experiences in implementing policies on social determinants of health, however, shows common features of successful action. There are five key action areas critical to addressing health inequities: (i) to adopt better governance for health and development; (ii) promote participation in policy-making and implementation; (iii) to further reorient the health sector towards reducing health inequities; (iv) to strengthen global governance and collaboration; and (v) to monitor progress and increase accountability. Action on social determinants of health therefore means that we, the representatives of Governments, will strive individually and collectively to develop and support policies, strategies, programmes and action plans, which address social determinants of health, with the support of the international community, that include:

11. To adopt better governance for health and development

11.1 Acknowledging that governance to address social determinants involves transparent and inclusive decision-making processes that give voice to all groups and sectors involved, and develop policies that perform effectively and reach clear and measurable outcomes, build accountability, and, most crucially, are fair in both policy development processes and results;

11.2 We pledge to:

(i) Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard;

(ii) Develop policies that are inclusive and take account of the needs of the entire population with specific attention to vulnerable groups and high-risk areas;

(iii) Support comprehensive programmes of research and surveys to inform policy and action;

(iv) Promote awareness, consideration and increased accountability of policy-makers for impacts of all policies on health;

(v) Develop approaches, including effective partnerships, to engage other sectors in order to identify individual and joint roles for improvements in health and reduction of health inequities;

(vi) Support all sectors in the development of tools and capacities to address social determinants of health at national and international levels;

(vii) Foster collaboration with the private sector, safeguarding against conflict of interests, to contribute to achieving health through policies and actions on social determinants of health;

(viii) Implement resolution WHA62.14, which takes note of the recommendations of the final report of the Commission on Social Determinants of Health;

(ix) Strengthen occupational health safety and health protection and their oversight and encourage the public and private sectors to offer healthy working conditions so as to contribute to promoting health for all;

(x) Promote and strengthen universal access to social services and social protection floors;

(xi) Give special attention to gender-related aspects as well as early child development in public policies and social and health services;

(xii) Promote access to affordable, safe, efficacious and quality medicines, including through the full implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;

(xiii) Strengthen international cooperation with a view to promoting health equity in all countries through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchange of good practices for managing intersectoral policy development.

12. ***To promote participation in policy-making and implementation***

12.1 Acknowledging the importance of participatory processes in policy-making and implementation for effective governance to act on social determinants of health;

12.2 We pledge to:

(i) Promote and enhance inclusive and transparent decision-making, implementation and accountability for health and health governance at all levels, including through enhancing access to information, access to justice and public participation;

(ii) Empower the role of communities and strengthen civil society contribution to policy-making and implementation by adopting measures to enable their effective participation for the public interest in decision-making;

(iii) Promote inclusive and transparent governance approaches, which engage early with affected sectors at all levels of governments, as well as support social participation and involve civil society and the private sector, safeguarding against conflict of interests;

(iv) Consider the particular social determinants resulting in persistent health inequities for indigenous people, in the spirit of the United Nations Declaration on the Rights of Indigenous Peoples, and their specific needs and promote meaningful collaboration with them in the development and delivery of related policies and programmes;

(v) Consider the contributions and capacities of civil society to take action in advocacy, social mobilization and implementation on social determinants of health;

(vi) Promote health equity in all countries particularly through the exchange of good practices regarding increased participation in policy development and implementation;

(vii) Promote the full and effective participation of developed and developing countries in the formulation and implementation of policies and measures to address social determinants of health at the international level.

13. ***To further reorient the health sector towards reducing health inequities***

13.1 Acknowledging that accessibility, availability, acceptability, affordability and quality of health care and public health services are essential to the enjoyment of the highest attainable standard of health, one of the fundamental rights of every human being, and that the health sector should firmly act to reduce health inequities;

13.2 We pledge to:

(i) Maintain and develop effective public health policies which address the social, economic, environmental and behavioural determinants of health with a particular focus on reducing health inequities;

(ii) Strengthen health systems towards the provision of equitable universal coverage and promote access to high quality, promotive, preventive, curative and rehabilitative health services throughout the life-cycle, with a particular focus on comprehensive and integrated primary health care;

(iii) Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health;

(iv) Build, strengthen and maintain health financing and risk pooling systems that prevent people from becoming impoverished when they seek medical treatment;

(v) Promote mechanisms for supporting and strengthening community initiatives for health financing and risk pooling systems;

(vi) Promote changes within the health sector, as appropriate, to provide the capacities and tools to act to reduce health inequities including through collaborative action;

(vii) Integrate equity, as a priority within health systems, as well as in the design and delivery of health services and public health programmes;

(viii) Reach out and work across and within all levels and sectors of government by promoting mechanisms for dialogue, problem-solving and health impact assessment with an equity focus to identify and promote policies, programmes, practices and legislative measures that may be instrumental for the goal pursued by this Political Declaration and to adapt or reform those harmful to health and health equity;

(ix) Exchange good practices and successful experiences with regard to policies, strategies and measures to further reorient the health sector towards reducing health inequities.

14. ***To strengthen global governance and collaboration***

14.1 Acknowledging the importance of international cooperation and solidarity for the equitable benefit of all people and the important role the multilateral organizations have in articulating norms and guidelines and identifying good practices for supporting actions on social determinants, and in facilitating access to financial resources and technical cooperation, as well as in reviewing and, where appropriate, strategically modifying policies and practices that have a negative impact on people's health and well-being;

14.2 We pledge to:

(i) Adopt coherent policy approaches that are based on the right to the enjoyment of the highest attainable standard of health, taking into account the right to development as referred to, inter alia, by the 1993 Vienna Declaration and Programme of Action, that will strengthen the focus on social determinants of health, towards achieving the Millennium Development Goals;

(ii) Support social protection floors as defined by countries to address their specific needs and the ongoing work on social protection within the United Nations system, including the work of the International Labour Organization;

(iii) Support national governments, international organizations, nongovernmental entities and others to tackle social determinants of health as well as to strive to ensure that efforts to advance international development goals and objectives to improve health equity are mutually supportive;

(iv) Accelerate the implementation by the State Parties of the WHO Framework Convention on Tobacco Control (FCTC), recognizing the full range of measures including measures to reduce consumption and availability, and encourage countries that have not yet done so to consider acceding to the FCTC as we recognize that substantially reducing tobacco consumption is an important contribution to addressing social determinants of health and vice versa;

(v) Take forward the actions set out in the political declaration of the United Nations General Assembly High-Level Meeting on the Prevention and Control Noncommunicable Diseases at local, national and international levels – ensuring a focus on reducing health inequities;

(vi) Support the leading role of the World Health Organization in global health governance, and in promoting alignment in policies, plans and activities on social determinants of health with its partner United Nations agencies, development banks and other key international organizations, including in joint advocacy, and in facilitating access to the provision of financial and technical assistance to countries and regions;

(vii) Support the efforts of governments to promote capacity and establish incentives to create a sustainable workforce in health and in other fields, especially in areas of greatest need;

(viii) Build capacity of national governments to address social determinants of health by facilitating expertise and access to resources through appropriate United Nations agencies' support, particularly the World Health Organization;

(ix) Foster North-South and South-South cooperation in showcasing initiatives, building capacity and facilitating the transfer of technology on mutually agreed terms for integrated action on health inequities, in line with national priorities and needs, including on health services and pharmaceutical production, as appropriate.

15. ***To monitor progress and increase accountability***

15.1 Acknowledging that monitoring of trends in health inequities and of impacts of actions to tackle them is critical to achieving meaningful progress, that information systems should facilitate the establishment of relationships between health outcomes and social stratification variables and that accountability mechanisms to guide policy-making in all sectors are essential, taking into account different national contexts;

15.2 We pledge to:

(i) Establish, strengthen and maintain monitoring systems that provide disaggregated data to assess inequities in health outcomes as well as in allocations and use of resources;

(ii) Develop and implement robust, evidence-based, reliable measures of societal well-being, building where possible on existing indicators, standards and programmes and across the social gradient, that go beyond economic growth;

(iii) To promote research on the relationships between social determinants and health equity outcomes with a particular focus on evaluation of effectiveness of interventions;

(iv) Systematically share relevant evidence and trends among different sectors to inform policy and action;

(v) Improve access to the results of monitoring and research for all sectors in society;

(vi) Assess the impacts of policies on health and other societal goals, and take these into account in policy-making;

(vii) Use intersectoral mechanisms such as a Health in All Policies approach for addressing inequities and social determinants of health; enhance access to justice and ensure accountability, which can be followed up;

(viii) Support the leading role of the World Health Organization in its collaboration with other United Nations agencies in strengthening the monitoring of progress in the field of social determinants of health and in providing guidance and support to Member States in implementing a Health in All Policies approach to tackling inequities in health;

(ix) Support the World Health Organization on the follow-up to the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

(x) Promote appropriate monitoring systems that take into consideration the role of all relevant stakeholders including civil society, nongovernmental organizations as well as the private sector, with appropriate safeguard against conflict of interests, in the monitoring and evaluation process;

(xi) Promote health equity in and among countries, monitoring progress at the international level and increasing collective accountability in the field of social determinants of health, particularly through the exchange of good practices in this field;

(xii) Improve universal access to and use of inclusive information technologies and innovation in key social determinants of health.

16. Call for global action

16.1 We, Heads of Government, Ministers and government representatives, solemnly reaffirm our resolve to take action on social determinants of health to create vibrant, inclusive, equitable, economically productive and healthy societies, and to overcome national, regional and global challenges to sustainable development. We offer our solid support for these common objectives and our determination to achieve them.

16.2 We call upon the World Health Organization, United Nations agencies and other international organizations to advocate for, coordinate and collaborate with us in the implementation of these actions. We recognize that global action on social determinants will need increased capacity and knowledge within the World Health Organization and other multilateral organizations for the development and sharing of norms, standards and good practices. Our common values and responsibilities towards humanity move us to fulfil our pledge to act on social determinants of health. We firmly believe that doing so is not only a moral and a human rights imperative but also indispensable to promote human well-being, peace, prosperity and sustainable development. We call upon the international community to support developing countries in the implementation of these actions through the exchange of best practices, the provision of technical assistance and in facilitating access to financial resources, while reaffirming the provisions of the United Nations Millennium Declaration as well as the Monterrey Consensus of the International Conference on Financing for Development.

16.3 We urge those developed countries which have pledged to achieve the target of 0.7 percent of GNP for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard. We also urge developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets.

16.4 World leaders will soon gather again here in Rio de Janeiro to consider how to meet the challenge of sustainable development laid down twenty years ago. This Political Declaration recognizes the important policies needed to achieve both sustainable development and health equity through acting on social determinants.

16.5 We recommend that the social determinants approach is duly considered in the ongoing reform process of the World Health Organization. We also recommend that the 65th World Health Assembly adopts a resolution endorsing this Political Declaration.