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.

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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]

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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:

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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]

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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

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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:

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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]
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> …
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> 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

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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

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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]

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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]

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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

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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]

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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 Rugkhla, 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.