Submission from

The Australian Association of Social Workers

Senate Standing Committees on Community Affairs

Australia's domestic response to the World Health Organisation's (WHO) Commission on Social Determinants of Health report

"Closing the gap within a generation: Health equity through action on the Social Determinants of Health" (CSDH, 2008)

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Introduction

The Australian Association of Social Workers (AASW) welcomes the opportunity to make a submission to the Senate Community Affairs Reference Committee Inquiry into Australia's domestic response to the World Health Organization's Commission on Social Determinants of Health report "*Closing the gap within a generation: Health equity through action on the Social Determinants of Health*" (CSDH, 2008).

The social work profession is committed to maximising the well being of individuals, families and society in socially inclusive communities, which emphasise principles of social justice and respect for human dignity. In carrying out their professional tasks and duties, social workers strive to act in ways that give equal priority to respect for human dignity and worth, and the pursuit of social justice. This commitment is demonstrated through service to people with integrity and competence which characterise professional social work practice.

The AASW is the only national organisation for social workers in Australia and has a membership of over 6,500. Social workers are involved in the delivery of a range of community services including health, family, child welfare, income support, in the public, private and not for profit sectors. Social workers are represented at every level of organisations and government, from direct practice to policy, management and providing senior advice to government.

Response to Report

The Australian social work profession operates at the interface between people and their social and cultural environments. As such the profession is committed to maximising the wellbeing of individuals and groups whose quality of life, human rights and experience of social justice across the lifespan, has been or is at risk of impairment as a result of variable health experiences arising from past and current structural inequities in Australian society. In this respect, the AASW Code of Ethics (AASW, 2010) recognises the centrality of the principles of human rights and social justice as being fundamental to the practice of social work nationally and internationally.

The World Health Organization (WHO) report "*turns the spotlight on the link between social inequality and individual health* (Graham, cited in Bywaters 2009)". In addition to the rights issue, as referenced by the Universal Declaration of Human Rights (UN, 1948), the AASW agrees with the WHO report (CSDH, 2008) that the causes of health inequalities refer to the broad set of factors in society that contribute to the social patterning of health, disease and illness. In this respect, addressing health inequalities in Australia is held to be a significant focus for social work intervention at primary, secondary and tertiary prevention levels. Health equity is defined as "*the absence of systematic disparities in health between and within social groups that have different levels of underlying social disadvantages or disadvantages- that is different positions in a social hierarchy* (Braveman & Gruskin, 2003, p. 254)". Social determinants of health include but are not limited to poverty, unequal access to health care as a result of race, culture and/or gender, education experience and opportunity or otherwise for work. Each of these variables has a differential impact on the conditions of daily life: the circumstances in which people are born, grow, live, work and age

(Marmot & Wilkinson, 2003). Social workers understand that the institutional or structural drivers of these conditions concern inequity associated with issues of power, money and resources, at local, national and global levels.

The AASW acknowledges that since the second world war to the present time, there have been ongoing attempts in Australia to address the social determinants of health through government policies and action implemented from both sides of the political spectrum. Gardiner-Garden & Simon-Davies (2012) state that: "*Identifiable Commonwealth expenditure in the area of Indigenous affairs began with the establishment of the Office of Aboriginal Affairs soon after the landmark referendum in 1967. The expenditure was relatively low in the first few years but increased significantly with the creation of the Department of Aboriginal Affairs soon after the Whitlam Government came to office in December 1972, and continued to grow through the 1980s* [p. 2]". Specific policy achievements from this period also include the introduction of a universal health system through MediBank and the Community Health service in the early 1970's (Baum & Simpson, 2006). The latter program anticipated many of the key messages of the Alma Ata Declaration (WHO, 1978) that proposed "*an acceptable level of health for all the people of the world by the year 2000*". Australian Government health policy development also reflects key objectives embodied in the Ottawa Charter for Health Promotion (WHO, 1986) that identifies the fundamental conditions and resources for health and promotes: development of healthy public policy, creation of supportive environments, strengthening community action, development of personal skills and reorientation of health services. The AASW agrees with the Ottawa Charter in so far as it is accepted that changes in the social determinants of health and improvement in health outcomes require a secure foundation in a range of basic prerequisites that include: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.

In a different area, government policy at state and federal levels in the 1980's identified family violence as a key social determinant of health. This resulted in changes to laws in relation to violence in the home, as well as the provision of a range of supports and services designed to mediate the impact of family violence upon the health and well being of women, children and young people (Baum & Simpson, 2006). Despite such achievements, the AASW notes with concern the existence of policy trends that risk accentuating difference and disadvantage. One example is the current Government decision to reduce lone parent payments (when the youngest child turns eight years of age) to the level of the Newstart payment resulting in the loss of approximately $100 to the weekly family budget. The stated purpose of this change is not to reduce the impact of disadvantage on many of the poorest Australian families but rather to achieve budgetary savings of $200 million. The AASW believes that the social ramifications of such policy decisions are self evident and operate directly contrary to the health, welfare and social justice needs of a specific sector of our community.

In more recent times, the COAG Close the Gap in Indigenous Disadvantage framework, that arose from the 2008 National Apology, identified six targets and seven building blocks with a view to addressing Indigenous disadvantage by targeting key social determinants including:

early childhood; schooling; health; economic participation; healthy homes; safe communities; and governance and leadership for government action (NIRA Review Working Group, 2011). Given known disparities in Indigenous life expectancy where the Australian Institute of Health & Welfare (AIHW) reports that "*Indigenous Australians born in the period 1996-2001 are estimated to have a life expectancy at birth of 59.4 years for males, and 64.8 years for females [which] is approximately 16-17 years less than the overall Australian population born over the same period (*ABS 2007 cat. no. 3302.0 cited in AIHW, 2012a), the targets are ambitious and require intensive and sustained effort from all levels of government, as well as the private and not-for-profit sectors, communities and individuals.

The AASW recognises that evidence of progress towards the Close the Gap outcomes does exist. In relation to the provision of primary health care services, the AIHW's Aboriginal and Torres Strait Islander Health Services report found that in 2010-2011 "*primary health-care services, funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH), provided 2.5 million episodes of health care to about 428,000 clients. Compared with 2009–10, there was a 4% increase in episodes of care* (AIHW, 2012b)". Despite such outcomes, the AASW is aware that there have been complexities in implementing elements of this program for a range of reasons but recognises that the focus on the social determinants of Indigenous health has the potential to make a substantive contribution to health and well-being of Indigenous people across the lifespan. However, on reviewing the data, the AASW notes with concern a development indicating that while Indigenous expenditure as a percentage of gross domestic product for the period 1968-2012 has trended upwards, recent expenditure has plateaued between the years 2000 to 2007 and has since fallen (Gardiner-Garden & Simon-Davies, 2012). This suggests either an element of inconsistency in terms of addressing the social determinants of health and/or complexity in managing priorities across the broader government policy agenda. In this respect, the AASW recognises that the current government proposals for a National Disability Insurance Scheme and a National Dental Scheme represent substantive national contributions to the work needed to reduce the impact of structural inequities for other disadvantaged sectors of Australian society. In addition, the AASW would also be supportive of improving access to primary care: specifically mental health services.

The AASW emphasises that the policy domains cited in this submission are selected from a broader pool of disadvantage that includes the aged, the long term unemployed, residents of rural and remote areas, people experiencing gender and sexual discrimination, chronic diseases, mental health issues, homeless people and refugees: each of whom experience diminished quality of life as a result of differential experience of the social determinants of health. To the extent that this is the case, Australian society as a whole is diminished by the loss of what an able bodied, empowered individual might contribute to family, work, their local community and the wider social fabric.

Recent research: *ACOSS Poverty Report* (ACOSS, 2011), *Australia's Health 2012* (AIHW, 2012c) and *The Cost of Inaction on the Social Determinants of Health* (Brown, Thurecht & Nepal, 2012) identifies a clear association between socio-economic status (SES) and health outcomes. The research demonstrates that lower SES in conjunction with employment and

education levels correlates with poorer health outcomes and represents a significant burden to Australian society as a whole. The WHO references this phenomenon in terms of the '*social gradient of health*' and confirms that health and illness can be mapped to levels of income in all countries (CSDH, 2008). While it is evident that the lower the socio-economic status, the worse the health burden, poor health is not solely confined to those worst off. In this respect, (Brown et.al., 2012) note that if the WHO's recommendations regarding the social determinants of health through a '*health in all policies*' approach were to be adopted in Australia then social and economic benefits could be significant. The data predicts that upwards of "*500,000 Australians could avoid suffering a chronic illness; 170,000 extra Australians could enter the workforce, generating $8 billion in extra earning; annual savings of $4 billion in welfare support payments could be made; 60,000 fewer people would be needed to be admitted to hospital annually, resulting in saving of $2.3 billion in hospital expenditure and 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of $273 million* [p.vii]*"*.

In light of such potential outcomes, the AASW is mindful of research by ACOSS (2011) that the number of Australians living in poverty has increased. ACOSS data shows that "*approximately 2.2 million people, or 11% of Australians lived in poverty in 2006, the latest date for which statistics were available- compared with 10% in 2004 and 8% in 1994 (based on the OECD's measure of 50 median income poverty line)* [p.2]". This suggests the existence of a dynamic within Australian society fluctuating between well-being and increased social disadvantage.

In this context, it is clear that health and well-being need to be conceptualised has having their origins in more than individual pathology: a conclusion that is consistent with the Alma Ata Declaration (WHO, 1978) where health is defined as consisting not only of the absence of disease but also a state of complete physical, mental and social well being.

The AASW would like it to be noted by the Senate Committee that the Association is supportive of current or future action by the Australian government that continues to address the social determinants of health despite the complexity of the task at hand while being mindful of the range of competing policy priorities currently being addressed by government.

The health sector is the largest employer of social workers in Australia (AASW, 2011) and the AASW contends that social workers are uniquely placed to address inequities arising as a result of the social determinants of health and so contribute to improving health and well being in Australia. Recent literature reviews provide evidence for "*the relevance of social work and social care interventions for promoting physical and mental health, preventing illness and helping people to build and maintain independence and life skills that improve outcomes related to the social determinants of health* (Coren, Iredale, Rutter & Bywaters, 2011, p. 602)". Social work practice is directed towards improving the health and wellbeing outcomes for individuals, their families and the community across a broad spectrum of disadvantage. Service settings, where social workers address inequity arising from the social determinants of health, cover the continuum of health care from community health, acute

inpatient, rehabilitation, health promotion, mental health, end of life (palliative care) services, veterans' affairs, aged care, child welfare, disability and Indigenous health. To achieve client needs, social work practice includes but is not limited to: interpersonal practice including case work, counselling, clinical intervention, work with individuals, families, partnerships, communities and groups; advocacy; community work and social action addressing both personal difficulties and systemic issues in addition to undertaking of research, social policy development, education, training, supervision and evaluation (AASW Code of Ethics, 2010).

Finally, in the absence of opportunities for growth and wellbeing at individual or community levels, facilitated by the social work practice repertoire, any increase in the burden of health inequity for disadvantaged people in Australian society risks the loss of social capital at a time when social cohesion in our increasingly diverse multicultural society is even more essential than in times past. As stated by VCOSS in a previous submission to the Senate Community Affairs References Committee:

"*Health is an essential component of active citizenship as without health a person cannot access other rights and cannot enjoy quality of life. Equitable access to health prevention services and care is therefore vital* (VCOSS, 2004, p.213)".

The AASW agrees with the findings of the WHO report (CSDH, 2008) that the true upstream drivers of health inequities reside in national social, economic and political environments. Crucially, these environments are shaped by policies, which in turn makes these environments amenable to change (Blas & Kurup, 2010), if a commitment to principles of social justice and equity and the political will to continue driving change can be combined.

Conclusion

In conclusion, the AASW hopes that the Australian Government's response to the World Health Organization's (WHO) Commission on Social Determinants of Health will be to make a clear and unequivocal statement of support for the findings and recommended policy directions as outlined in the WHO report (CSDH, 2008) and that it will also make a commitment to Australians that addressing the social determinants of health will remain at the forefront of the Government's policy agenda.

Thank you for the opportunity to submit this response to the Committee and we look forward to the opportunity to address the Committee in person.

Submitted for and on behalf of
the Australian Association of Social Workers Ltd

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