Supplementary Information to

Senate 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*

Tasmanian Social Determinants of Health Advocacy Network

29 October 2012

Following our submission to the Senate 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* and giving evidence to the Committee on Friday 12 October 2012, we present the following supplementary information for consideration on two matters that were raised during the hearing:

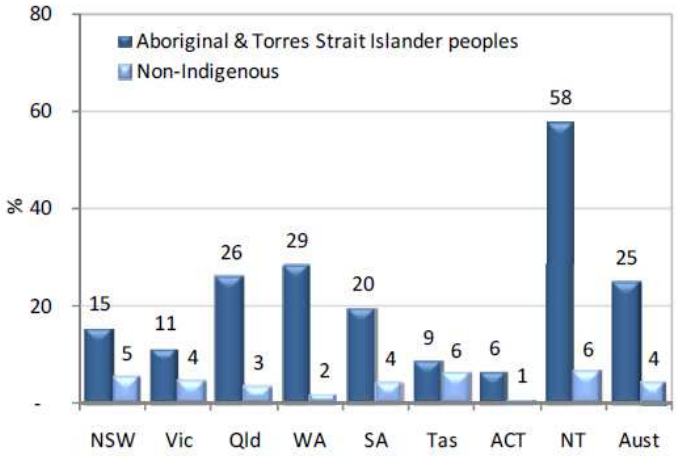
1. Aboriginal health and social determinants in Tasmania (in response to term of reference (c) - the extent to which the Commonwealth is adopting a social determinants of health approach); and
2. Comment on the proposal for an Australian Social Determinants of Health Commission.

1. Aboriginal health and social determinants in Tasmania

According to the latest ABS Census data, there are 19, 626 Aboriginal people living in Tasmania (that's 4% of the population).[1] This equates to the second-highest proportion of Aboriginal people in any Australian State or Territory, after the Northern Territory. At this stage, further 2011 Census data about Tasmania's Aboriginal population and a range of social determinants of health are not available. Below we provide a snapshot of some social determinants of Aboriginal health sourced from earlier data, published in the Australian Health Ministers' Advisory Council's *Aboriginal and Torres Strait Islander Health Performance Framework Report 2010*.[2] Not dissimilar to other jurisdictions, the following examples illustrate the additional burden to achieving optimum health for Aborigines in Tasmania:

- More Aboriginal peoples live in over-crowded households (9%) than non-Aboriginal peoples (6%) in Tasmania:

Figure 72 – Proportion of persons aged 15 years and over living in overcrowded households according to the Canadian National Occupancy Standard, by Indigenous status and state/territory, 2008



Source: ABS and AIHW analysis of 2008 NATSISS, non-Indigenous data from Survey of Income and Housing 2007–08

[1] ABS, 2011, Census, http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/6
[2] Australian Health Ministers' Advisory Council, 2011, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2010*, AHMAC, Canberra

- Aboriginal young people are less likely to continue their secondary education: 39.7% of Aboriginal young people in Tasmania compared to 77.3% non-Aboriginal young people (Australia) continue Year 7 to 12 schooling:

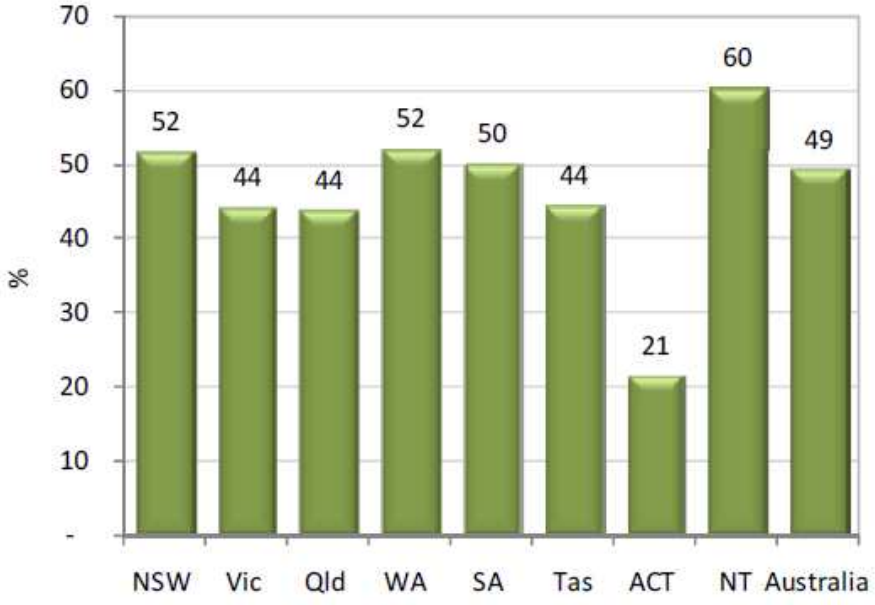
Table 42 – Apparent retention rates , by Indigenous status, jurisdiction and sex, 2009

	Aboriginal and Torres Strait Islander peoples									Non-Indig.
	NSW	Vic.	Qld	WA	SA	Tas.	ACT	NT	Aust.	Aust.
Year 7 to 10 - Apparent retention										
Males	85.2	81.2	96.3	89.0	101.0	105.4	100.0	75.9	89.6	99.2
Females	90.0	79.6	99.4	93.8	94.9	109.2	94.4	74.0	92.3	101.1
Total	87.6	80.4	97.8	91.2	98.0	107.3	97.4	75.0	90.9	100.1
Year 7 to 12 - Apparent retention										
Males	33.3	35.8	53.6	39.3	53.3	27.4	69.0	30.1	41.5	72.1
Females	40.4	50.9	62.5	40.2	58.8	53.5	70.0	39.2	49.5	82.7
Total	36.7	43.4	58.0	39.7	56.0	39.7	69.5	34.5	45.4	77.3
Year 11 to 12 - Apparent retention										
Males	71.2	61.4	73.4	48.1	69.0	73.5	90.6	44.5	64.2	83.7
Females	72.0	65.8	77.2	50.8	78.5	89.1	121.7	56.0	69.6	88.5
Total	71.6	63.9	75.4	49.3	73.6	82.7	103.6	50.2	67.0	86.1

Source: AIHW analysis of ABS National Schools Statistics Collection (NSSC)

- 44% of Aboriginal adults were in the lowest income quintile in Tasmania in 2008:

Figure 91 – Percentage of Aboriginal and Torres Strait Islander persons aged 18 years and over who were in the lowest quintile of equivalised gross weekly household income quintiles, 2008



Source: ABS analysis of NATSISS 2008

- Aboriginal adults are 3.2 times as likely to be in prison than non-Aboriginal adults in Tasmania:

Table 49 – People in Prison Custody by Indigenous status, sex and state/territory 30 June 2009

	Indigenous				Non-Indigenous				Rate ratio
	Number [a]			Age standard-ised rate [b]	Number [a]			Age standard-ised rate [b]	
	Males	Females	Persons		Males	Females	Persons		
NSW	2,138	236	2,374	2,153	7,789	587	8,376	164	13.1
Vic.	221	20	241	968	3,847	262	4,109	101	9.6
Qld	1,460	116	1,576	1,427	3,791	300	4,091	129	11.1
WA	1,633	157	1,790	3,329	2,445	184	2,629	163	20.4
SA	420	29	449	2,072	1,419	92	1,511	133	15.5
Tas.	61	5	66	471	431	38	469	146	3.2
ACT	23	3	26	760	157	20	177	63	12.0
NT	827	37	864	1,700	184	10	192	153	11.1
Aust	**6,783**	**603**	**7,386**	**1,891**	**20,063**	**1,493**	**21,554**	**136**	**13.9**

(a) Number per 100,000 adult population
(b) Number per 100,000 adult population directly age-standardised to 2001 Australian standard population
Source: Source: ABS 2009b

- Aboriginal children are 2.6 times as likely to be in out of home care in Tasmania:

Table 50 – Children (0–17 years) in out-of-home care by Indigenous status and state and territory, at 30 June 2009

	NSW	Vic.	Qld	WA	SA [a]	Tas. [b]	ACT	NT	Aust.
Number of Children:									
Indigenous	4,991	734	2,481	1,197	521	130	100	358	10,512
Non-Indigenous	10,207	4,452	4,547	1,485	1,495	676	391	121	23,374
Total	15,211	5,283	7,093	2,682	2,016	808	494	482	34,069
Rate per 1,000 children									
Indigenous	71.3	48.7	36.0	38.8	41.7	15.8	52.4	13.2	44.8
Non-Indigenous	6.6	3.7	4.6	3.0	4.4	6.1	5.1	3.4	4.9
Total	9.4	4.3	6.7	5.1	5.7	6.8	6.3	7.7	6.7
Rate ratio	10.9	13.2	7.9	13.0	9.5	2.6	10.3	3.9	9.2

(a) South Australia can only provide the number of children in out-of-home care where the Department is making a financial contribution to the care of a child. (b) Tasmania is not able to include children in care where a financial payment has been offered but has been declined by the carer. However, the number of carers declining a financial payment is likely to be very low.
Source: AIHW 2010b

Aboriginal people in Tasmania are also affected by discrimination and racism. While comprehensive data on this are not available, there is evidence that discrimination and racism occur in Tasmania. It is well documented that a person's sense of control over life and health outcomes as well as perceptions of the world as fair and just are significantly influenced by his or her social experiences and environment. Unfortunately, the social environment for many Aboriginal people includes personal and family experiences of racial discrimination that foster perceptions of powerlessness, inequality and injustice. In turn, these perceptions may influence health outcomes and disparities by affecting biological functioning (e.g.

cardiovascular and immune function), mental health and emotional wellbeing, the quality of their relationships with others and promoting psychological distress (self-efficacy, depression, anger) that can be associated with risk-taking and unhealthy behaviours.[3] The question of racism is present not only in society but also institutionally in the health care sector.[4]

In addition, the effects of historical events continue to impact on contemporary Aboriginal cultural identity, connection to land and spirituality. Research has found that the atrocities of the past have had life-long negative consequences. For example, Aboriginal people who were part of the *Stolen Generations* are more likely to suffer from depression, have worse health and a shorter life span than other Indigenous people.[5]

There are many gaps in our understanding of the health status of Aborigines in Tasmania. As stated in our earlier submission, improving health equity needs an evidence-based approach and up to date information. A monitoring system that provides information about the distribution and trends in determinants is an essential part of a social determinants approach to improving health equity.

1.1 *Closing the Gap* in Tasmania

Closing the Gap has enabled Tasmanian organisations and agencies to implement a number of initiatives that could support Aboriginal health improvement, and promote and protect health. Some of these include the Practice Incentive Program (PIP) which aim to improve coordination of health care for Aboriginal people; the National Partnership in Indigenous Early Childhood Development (IECD) project, which is a 4-year initiative which consists of three elements: 1. Integration of early childhood services through the development of Children and Family Centres; 2. Increased access to antenatal care, pre-pregnancy and teenage sexual and reproductive health; and 3. Increased access to and use of maternal and child health services by Indigenous families; cultural competency training delivered by the Tasmanian Department of Health and Human Services; and a range of other projects run from local Aboriginal health services who have strong community knowledge of health issues and are best placed to make a difference in the local community.

While the purported principle of the *Closing the Gap* initiative in Tasmania is welcomed by those who were consulted for this paper, it cannot be said that it has resulted in significant gains for the health and wellbeing

[3] Sanders-Phillips et al, 2009, Social Inequality and Racial Discrimination: Risk Factors for Health Disparities in Children of Color, *Pediatrics,*124:S176–S186
[4] Henry BR, Houston S and Mooney GH, 2004, Institutional racism in Australian healthcare: a plea for decency, *Medical Journal of Australia,* 180,10: 517-520
[5] ReconciliACTION Network, http://reconciliaction.org.au/nsw/about-reconciliaction/

of Aboriginal people in Tasmania to date. Data from the most recent COAG progress report show no outstanding gains for Aborigines in Tasmania specifically. What is more apparent are the failings – such as our progress towards 'halving the gap in literacy and numeracy by 2018' where year 9 Aboriginal students in Tasmania did not meet reading progress points for 2009, 2010 and 2011.[6] However, this conclusion should be treated with caution as part of the problem in Tasmania is the limited data that is available. Tasmanian data are not included in a number of the measures in the COAG progress report.

On the other hand, others have similarly identified the limitations of *Closing the Gap*'s achievements to date:

> *"The report cards to date show that things are on track for the first two targets (access to preschool and infant mortality), some questionable and inequitable progress for child literacy and numeracy, and minimal demonstratable progress for the remainder. None of this is bad news, and all of it is as expected. But there remain many unanswered questions about the strategies being used to reach the targets, the quality of monitoring and above all about the future of Closing the Gap as we approach the deadlines for a number of targets that may not be met."*[7]

This leads us to reiterate our concerns about *Closing the Gap* from our original submission, and more specifically to make the following points:

a) As *Closing the Gap* was a COAG-driven initiative, it did not allow for appropriate consultation with Tasmania's Aboriginal communities during the development and planning stages. As a result a one-size fits all model was developed and implemented. The approach was 'top-down' with considerable control exerted by the Australian Government through standardised implementation and reporting processes, rather than a community development model that would have been much more relevant, particularly to small dispersed Aboriginal populations such as Tasmania. This led to a range of problems during the implementation of *Closing the Gap* in Tasmania.

   Importantly, it should be noted that the rigorous approach of *Closing the Gap* resulted in some inappropriate outputs - such as misdirected funding for housing at the exclusion of areas where it was most needed. It has also not resulted in *cultural security* which is defined as 'a commitment that the construct and provision of services offered by the health system will not compromise the

[6] COAG Reform Council 2012*, Indigenous reform 2010–11: Comparing performance across Australia*, COAG Reform Council, Sydney

[7] Carapetis, J, Aboriginal health in a changing world, *Population Health Congress, Adelaide, 2012*

legitimate cultural rights, views, values and expectations of Aboriginal people' (Houston 2003 p 119).[8]

In future, we believe that it is imperative that the Australian Government develops a more flexible and locally driven approach to improving health outcomes for Aboriginal people driven by local Aboriginal people. The approach must be built on respect. It must be driven by compassion. But it must first and foremost be based on listening and hearing.

We believe that the social determinants of health need to be based on the values of the critically informed communities involved. The work of the WHO Commission is excellent but does not adequately reflect the fact that different communities may have different constructs of the determinants and different priorities. Thus for example land and culture, which we submit are crucial for Aboriginal people's health, are not present. We would argue that they need to be.

Further any policies on the social determinants of health for Aboriginal peoples need to recognise that health is different for Aboriginal people (and this is part of the reason why we have concerns about the philosophy underlying *Closing the Gap* in Aboriginal health). As Houston (2003 p 7) identifies Aboriginal health includes not only physical wellbeing but also culture, being poverty free and a good environment not only as social determinants of health but as components of health.[8]

b) Leading on from this, we are concerned that *Closing the Gap* does not involve a comprehensive evaluation framework that is meaningful for Aboriginal people and Tasmania more broadly. While COAG's targets are undoubtedly important, we suggest that there may be additional targets that are important in Tasmania that have not been considered quite simply because there has not been the opportunity to provide this input.

Tasmanian data are not included in a number of the measures reported in the recent Report to the Council of Australian Governments, *Indigenous reform 2010–11: Comparing performance across Australia*, 30 April 2012. As stated earlier, due to limitations in data we don't know enough about our Aboriginal population in the first instance, making it problematic to see evidence of any gains in the COAG's reporting framework. We do however know enough to know that health outcomes are poorer among Aboriginal people in Tasmania, but not enough to be able to quantify the life expectancy gap in the same way that has been estimated for Australia as a whole. Our

[8] Houston ES, 2003, *The past, the present, the future of Aboriginal health policy,* PhD Thesis. Perth: Curtin University

understanding of how successful *Closing the Gap* has been is therefore very limited. At best we can describe a handful of disparate initiatives, and numerous process issues.

As previously stated we don't believe that *Closing the Gap* is a good working example of a social determinants of health approach. While it is a positive policy initiative it falls short. And importantly, it is not part of a national strategy to reduce inequities in health through action on the social determinants of health that acts across the health gradient, and takes the 'proportionate universalism' approach advocated by Marmot and others.[9]

2. An Australian Social Determinants of Health Commission

Looking at the Southgate Institute for Health Society & Equity submission we believe the establishment of "an independent national Commission to review evidence on social determinants of health and health inequities in Australia and make recommendations for a whole-of-government response from local, state and federal governments" has real merit, especially if it has a broad mandate to span and influence a range of sectors and not just speak to the health sector. We also believe it's important that such a Commission engage with the non-government sector and have a strong focus on citizen engagement and participation.

Australian National Preventive Health Agency would need to be transformed quite a bit to pick this up, if that were the alternative option; possibly including changing its legislative base and certainly requiring a new strategic direction to be endorsed by Health Ministers, since they auspiced the current focus.

The ideal might be a strong Commission plus a reinforced Australian National Preventive Health Agency to manage this work at the national level as suggested by Professor Fran Baum.

A Commission could be the driving force behind our recommendation that the Australian Government develop and implement a National strategy to reduce inequities in health through action on the social determinants of health.

[9] "A social gradient in health exists (ie, health is progressively better the higher the socioeconomic position of people and communities). It is important to design policies that act across the whole gradient, as well as addressing those at the bottom of the social gradient and who are most vulnerable. To achieve both these objectives, we propose policies that are universal but with attention and intensity that is proportionate to need". in Marmot, M et al, WHO European review of social determinants of health and the health divide, *The Lancet,* Vol 380 September 15, 2012

We sincerely thank you for the opportunity to provide this additional information and would be happy to discuss this submission further if required.

This submission was prepared by the following members of the Social Determinants of Health Advocacy Network, Tasmania:

- Mrs Miriam Herzfeld
- Dr Maureen Davey
- Ms Rebecca Essex
- Ms Mary Langdon
- Professor Gavin Mooney

The views expressed in this paper are those of the authors.

29 October 2012