Australian Government
Australian National Preventive Health Agency

promoting a healthy australia

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Dear Senators

re: 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"

Thank you for the opportunity to submit comments to the 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".

The Australian National Preventive Health Agency is pleased to provide the attached submission to the Inquiry.

I wish you well with your deliberations on this important Inquiry.

Yours sincerely

Louise Sylvan
Chief Executive Officer

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INTRODUCTION

The Australian National Preventive Health Agency (the Agency) appreciates the opportunity to provide a submission to the 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" (WHO Commission). The Agency acknowledges the WHO Commission's fundamental premise that inequities in health arise from the circumstances in which people grow, live, work and age, and the corollary that many actions the address social determinants of health must come from beyond the health sector.

The Agency also notes the many previous submissions that have detailed data and evidence in relation to social determinants of health. This submission does not attempt to repeat these data and, in the interest of brevity, focuses on the Agency's current functions in disease prevention and health promotion and the relevance of these activities to the social determinants of health.

THE AGENCY'S ROLE

The Council of Australian Governments (COAG) first agreed in November 2008 to establish Australia's first national preventive health agency as part of the *National Partnership Agreement on Preventive Health*.[1] Creating a national prevention agency was also recommended by the National Health and Hospitals Reform Commission[2] and the National Preventative Health Taskforce.[3]

The Agency was established on 1 January 2011, following enactment of the *Australian National Preventive Health Agency Act 2010,* with a mandate to strengthen Australia's investment in preventive health. The legislated functions are to:

(a) effectively monitor, evaluate and build evidence in relation to preventive health strategies;
(b) facilitate a national health prevention research infrastructure;
(c) generate new partnerships for workplace, community and school interventions;
(d) assist in the development of the health prevention workforce; and
(e) coordinate and implement a national approach to social marketing for preventive health programs.

The Agency supports the development and implementation of evidence-based approaches to preventive health initiatives. The Agency has been resourced to focus initial efforts on the risks and burdens of preventable disease associated with obesity, tobacco and harmful alcohol use. Accordingly, the Agency's key objective as defined in the *Portfolio Budget Statements*[4] is:

> *A reduction in the prevalence of preventable disease, including through research and evaluation to build the evidence base for future action, and by managing lifestyle education campaigns and developing partnerships with non-government sectors.*

To achieve this vision and functions, the Agency collaborates with governments, researchers, industry, media, non-government and community partners. The Agency provides leadership to enhance the exchange of knowledge, advice and support for disease prevention and health promotion efforts across Australia.

The Agency's *Strategic Plan 2011-2015*[5] clearly acknowledges that many of the underlying causes of poor health originate from the environmental and social contexts in which people grow, live, work and age. This reflects the evidence that good and poor health are unevenly distributed, and that those Australians with less income, education or secure working conditions are more likely to experience premature morbidity and mortality. These disparities are especially acute for Aboriginal and Torres Strait Islander peoples, people with a disability, and those with poor literacy, limited access to health services and to affordable healthy lifestyle choices.

It should be noted that the Agency and the Department of Health and Ageing share responsibility for aspects of preventive health activity, and neither agency has sole accountability for addressing all aspects of obesity, tobacco or harmful alcohol use. This submission should be considered in the broader context of the Department's preventive and health system activities, and within the diversity of Australian and state/territory government policies and programs that influence social determinants (such as in education, workforce participation, housing, social services, etc.).

HEALTH AND SOCIAL DISADVANTAGE IN AUSTRALIA

According to most measures, Australia is a very healthy country. Life expectancy has increased by 25 years over the last century and Australians enjoy one of the highest levels of life expectancy in the world.[6] These improvements are due to a variety of factors, including better infectious disease control, hygiene and sanitation, childhood immunisation, medical care advancements, overall living standards and working conditions, nutrition, health literacy and education, and reduced smoking levels.

But there is no room for complacency, as positive health and wellbeing are not fairly distributed across the social spectrum. Evidence clearly illustrates the complex interplay between social gradients and health status in Australia. Many measures of health status and risk factor prevalence are impacted by variables as diverse as poor access to healthcare, low levels of health literacy, poor housing conditions and even chronic stress. Conversely, chronic poor health can also directly impair an individual's socioeconomic status.[7]

Nowhere is the life expectancy gap greater than between Indigenous and non-Indigenous Australians.[8] Life expectancy gaps also exist between the most and least disadvantaged areas in Australia.[9] Differentials across social gradients are demonstrated in the prevalence of most chronic diseases and self-assessed health status.[10] Severe disability is more common in regional and remote areas than in major cities,[11] while there is a strong correlation between low socioeconomic areas and the prevalence of severe disability even within major cities.[12]

In terms of the Agency's initial priority areas, a distinct relationship exists between disadvantage and tobacco smoking and obesity, both of which involve multiple factors that often originate in youth and continue throughout the life cycle. The relationship between socioeconomic status and alcohol consumption is much more complex. Establishing a causal relationship between many social determinants and health outcomes is problematic, due to data gaps.[13] Evidence is generally stronger in relation to easily measurable factors (income, education, ethnicity) than measures such as norms and values, life course transitions, and physical and social environments.

***Obesity*:** Latest data indicate that 63.4% of all adult Australians are either overweight or obese, at 35.0% and 28.3%,[14] respectively. An understanding of the complex interplay between social determinants, overweight and obesity and associated risk factors is critical if the increasing prevalence is to be reversed. For instance, social gradients are evident for:

- obesity prevalence in adult Australians – demonstrated by 33% prevalence amongst the most disadvantaged quintile compared to 19% in the least disadvantaged quintile,[15] higher prevalence with Indigeneity[16] and increasing rurality and remoteness,[17] and positive correlations between obesity and inequality in educational attainment[18] and income;[19] and
- associated risk factors of physical activity and nutrition – with fruit and vegetable intake decreasing with increasing rurality and remoteness,[20] the likelihood of not exercising increasing with disadvantage,[21] and more likely to be impacted adversely by changing life cycle circumstances such as leaving school, leaving the family home, starting full-time employment and having children,[22] divorce, violence at home and workplace harassment.[23]

Socioeconomic status influences weight. Poorer neighbourhoods tend to be less conducive to physical activity,[24] with fewer fitness facilities and public green spaces.[25] Accessibility and affordability of fruit and vegetables is an important determinant of consumption patterns, especially for Indigenous Australians living in remote areas, while low socioeconomic areas are more likely to have a greater concentration of fast-food outlets and fewer full-sized supermarkets.[26] Income also influences food choices, and it is reported that welfare-dependent families need to allocate at least one-third of their weekly income to food in order to eat according to public health recommendations.[27]

Tobacco: Australia's comprehensive tobacco control efforts over the past 30 years have dramatically reduced smoking rates throughout the population. However, a clear social gradient is evident across smoking rates. Almost 25% of people in the lowest socioeconomic quintile smoke every day, which is twice the rate of those in the highest quintile.[28] Some of the most discriminating socioeconomic factors in smoking include education, occupational class, housing tenure and income, with smoking most common among younger women living in public rental accommodation[29] and Indigenous Australians,[30] for whom tobacco-attributable mortality accounts for one in every five (20%) deaths.[31]

Some 17% of the health gap between Indigenous and non-Indigenous people is due to smoking.[32,33] Smoking has declined by more than 20% in New Zealand's Maori men and women in just four years of targeted activity, whereas Australian Indigenous smoking rates have barely changed in the last 15 years.[34] Targeting smoking rates amongst Indigenous communities is the single most critical intervention in closing the Indigenous health inequity gap,[35] and the 2009 National Preventive Health Taskforce report highlights the evidence and clear recommendations regarding how to do so.[36]

Harmful consumption of alcohol: Alcohol is entwined in Australia's social, cultural and economic fabric. Australia's per capita consumption of alcohol, at 9.99 litres of pure alcohol (2010-11),[37] is considered high by world standards. Harmful alcohol consumption impacts on both the drinker and wider society in terms of public safety, family violence, workplace productivity, vandalism and road accidents.[38,39] People aged 18 to 29 years are more likely than the rest of the population to drink at levels that put them at risk of these types of harm, with males more likely than females to do so.[40]

There is some indication of a reverse social gradient in risky alcohol consumption, with 45% of people living in highest income households drinking at risky levels, compared to 19% amongst lowest income households.[41] Other apparent social differentials include:

- higher prevalence of harmful alcohol consumption amongst people in the paid workforce,[42] Aboriginal and Torres Strait Islanders,[43] and residents of remote or very remote areas;[44]
- higher alcohol-related disease and mortality burden amongst Aboriginal and Torres Strait Islanders; [45] and
- an almost five-fold increase in risky alcohol consumption amongst English-speaking households compared to non-English-speaking households.[46]

The complex social differentials across many measures of harmful alcohol use reinforce the importance of having good quality evidence to drive appropriately targeted alcohol-related policy and program interventions. This is an area in which "one size fits all" approaches are clearly not suitable.

THE AGENCY'S APPROACH TO PREVENTION

As indicated previously, the Agency was charged by COAG with focusing its initial efforts on the risks and burdens of preventable disease associated with obesity, tobacco and harmful alcohol use. While these priorities have been criticised by some quarters, the reality is that almost one-third of Australians are currently affected by these three risk factors, and they are responsible for a considerable proportion of preventable disease burden in Australia. Further, the Agency's work to address these issues forms part of a broad approach to prevention which, by necessity, encompasses:

- diverse methodologies such as regulation, health promotion, research, and targeted programs;
- evidence generation and dissemination;
- reinforcing prevention through structural change and health reform;
- working in partnership to support those who can make a difference; and
- social marketing to understand people's issues, deliver initiatives to address identified needs, and ultimately seek to influence community norms and generate changing attitudes.

In all of these approaches to program design and implementation, consideration of equity, disadvantage and removing barriers to access is paramount.

The Agency's *Strategic Plan 2011-2015*[47] provides a high level framework to guide its work program and reflects the well-documented evidence that effective disease prevention and health promotion requires approaches that:

- reach whole populations;
- include targeted strategies to meet the particular needs of diverse groups;
- include multiple strategies and comprehensive approaches, delivered at scale and over time;
- have a strong commitment to measuring and reporting; and
- are implemented in a variety of settings where people grow, live, go to school, work and spend time in recreational activities.

The following discussion highlights examples of the Agency's work in prevention to illustrate the ways in which these approaches are being adopted to address health inequities.

Data

Information and reporting on health outcomes, risk factors, determinants of health and health inequities are essential for informing effective preventive health policy and program development, as reflected in the WHO Commission's third overarching recommendation (that is, to measure and understand the problem and assess the impact of action).[48] Health information can be a very powerful resource with which to drive priorities to address inequities in health and access to health care, as well as in planning, implementing and evaluating health policy and programs. The health sector has a pivotal role in data collection and dissemination, which ultimately helps drive activity in other sectors like education, urban planning and income support, and measures their impact on determinants of health.

One of the Agency's key functions is to synthesise and disseminate information about prevention and health promotion in Australia, and provide authoritative reporting on these. This will primarily be done through the biennial *State of Preventive Health Reports* to be first published in 2013.

The Agency also supports the ongoing development and improvement of national surveillance systems in all areas related to prevention and health promotion related policies and programs.[49]

Nationally defined indicators are being used to report on the Agency's three focus areas (obesity, smoking and harmful alcohol consumption), which are monitored and reported at a high level as part of the National Healthcare Agreement.[50] The COAG Reform Council is due to report in 2013 on the prevalence of these three risk factors by remoteness, Indigenous status and socioeconomic status.

Research

The Agency's research program aims to support national prevention policies and programs with the best possible evidence. To this end, the Agency is currently developing a *National Preventive Health Research Strategy* to foster research and evaluation in Australian preventive health. Some submissions received in recent consultations to inform the final strategy note the importance of considering social determinants of health when setting preventive health research priorities.

The Agency's 2011-12 *Preventive Health Research Grants Program* funded a diverse range of projects, including: evaluating the impact of potential obesity prevention policies on the social distribution of overweight and obesity, identifying strategies likely to decrease the difference in obesity prevalence between social strata, and analysing the social, demographic and policy issues surrounding alcohol consumption and related harm.

Tobacco

As part of Australia's comprehensive tobacco control efforts, the Agency undertakes a range of activities aimed at reducing smoking among low socioeconomic and disadvantaged population groups. The Agency recently established a *National Network on Smoking and Disadvantage* with Cancer Council Australia. The aim of the Network is to contribute to the reduction in smoking among groups with high smoking prevalence through:

- sharing information relating to action on smoking and disadvantage across states and territories, Australian government agencies and peak organisations;
- identifying and disseminating effective policy and practice occurring throughout Australia;
- promoting effective policy from the local to the national level; and
- influencing smoking cessation efforts in a range of sectors where the core business is to assist people experiencing hardship.

The Agency is also developing a priority-driven research agenda for tobacco control, under which two key themes are low socioeconomic groups and Aboriginal and Torres Strait Islander peoples.

Social marketing

The Agency's social marketing programs are premised on an understanding of people and the social and environmental conditions they experience that can lead to adverse health outcomes. Social marketing campaigns come under close scrutiny, both internally and externally, and therefore need to be based upon both academic evidence (e.g. to ensure the accuracy of content) and marketing evidence (e.g. consumer testing) to follow trends in the market.

The Agency's social marketing aims to stimulate ongoing social and structural change, with a focus on improving health outcomes for individuals, communities and populations. In addition to influencing individual risk factor prevalence, these initiatives also provide a critical platform and change agenda under which other policies and programs can be introduced. For instance, the *National Tobacco Campaign* has operated since 1997 to influence community perceptions and ultimately create a supportive environment in which to introduce healthy settings and regulatory changes such as plain packaging and smoke-free public places – changes which would not have been considered acceptable a generation ago.

The *National Tobacco Campaign* also seeks to reduce the prevalence of daily smoking by addressing health literacy and greater awareness of the health impacts of smoking, as well as promoting and supporting quit attempts amongst smokers. This is based on evidence that high exposure to media campaigns that educate about the harms of smoking continue to be effective in changing smoking attitudes and beliefs and in reducing uptake by young people.[51] They are also essential for encouraging quit attempts and reducing adult smoking prevalence among lower socioeconomic status smokers.[52] The *More Targeted Approach* campaign (managed by the Department of Health and Ageing) complements the *National Tobacco Campaign* by targeting hard to reach groups, including smokers from 28 culturally and linguistically diverse backgrounds, who amongst socially disadvantaged groups, are pregnant (or are partners of pregnant women), who have a mental illness, or are in prisons.

The Agency is also working towards a nationally coordinated and collaborative approach, involving national, jurisdictional and community levels. As an initial step, the Agency recently consulted with Medicare Locals on their needs and how best to support them to implement initiatives to address local needs and complement the national *Swap It, Don't Stop It* campaign activities.

Medicare Locals

Medicare Locals are expected to improve health outcomes and address local community needs, including ensuring a greater focus on prevention to address health inequities and improve health outcomes. The WHO Commission noted that action to address social determinants of health was not the sole domain of Government, and that partnerships of citizens and local communities of interest were also critical.[53] The Agency supports this view, and to this end recognises the pivotal role that Medicare Locals have in developing community-wide approaches to improve health outcomes and health services in local communities.

The Agency believes that Medicare Locals should be supported to take a community partnership approach to address population health and social determinants in their communities, through their critical levers, including:

- governance – through their board composition, membership and ensuring relevant aims and principles are enshrined in their constitutions;
- community engagement – that is, how and with whom Medicare Locals work;
- integrated planning – shared visions, goals, priorities and policies with their community partners;
- undertaking community needs assessments – including ensuring the needs of the most disadvantaged and marginalised groups are considered;
- funding priorities to improve health outcomes and access – including prevention, equity, and identified high needs groups; Medicare Locals must be supported to target resources to best effect, while also being mindful of their broad remit across the health care continuum;
- Medicare Local internal operations – the organisational structures, recruitment practices, position descriptions and explicit performance expectations of management and staff are powerful mechanisms through which principles of community engagement and addressing social determinants can be embedded into the fabric of Medicare Locals;
- collaborative partnerships – across the full range of Medicare Local activities; and
- ensuring transparent accountability for priorities and decisions within their local communities.

The Agency is developing its organisational capacity to support Medicare Locals to embed an evidence-based focus on prevention and health promotion in the formative stage of their establishment.

In June 2012, the Agency released a joint statement with the Australian Medicare Local Alliance on disease prevention and health promotion in Medicare Locals,[54] supported by an evidence review monograph.[55] These resources outline the Agency's vision for prevention in Medicare Locals, and assist Medicare Locals to develop evidence-based preventive health activities to improve the health of their communities. Both documents point to the importance of Medicare Locals in reducing health risks and inequalities, addressing determinants of health in their local communities, and collaborative local level partnerships and true community engagement in the identification of local health needs and in the design and delivery of preventive programs.

These resources also laid the foundation for the Agency's new *Disease Prevention and Health Promotion in Medicare Locals* program. This evidence-based program provides funding for Medicare Locals to collaborate with Local Hospital Networks and other key partners (e.g. local councils, industry, and non-government organisations such as the National Heart Foundation and Diabetes Australia) to promote health and reduce preventable chronic disease and risk factors in their local communities. Importantly, the program is premised on local needs and reducing differentials by targeting social disadvantage. Where evidence is currently lacking, the program seeks to generate evidence through robust data collection and evaluation, and to actively promote the uptake of effective preventive activities within Medicare Locals. To this end, the Agency also notes the recommendation from the National Preventive Health Surveillance Forum hosted in April 2012 to identify data that can be used to report on preventive work undertaken by Medicare Locals.[56]

Medicare Locals have advised the Agency of their need for quality information about the effectiveness (including cost effectiveness) of preventive interventions that they can use in their local communities. Preventive health on such a population-wide scale is a relatively new responsibility for the fledgling Medicare Locals. The importance of supporting an evidence-based approach and providing guidance and tools to Medicare Locals as they build preventive health capacity and address local inequity issues cannot be underestimated.

DISCUSSION

Australia has a long and deservedly proud history of actively addressing social disadvantage through public policies and programs that promote universal access to quality education, health care, child and family support, and initiatives as diverse as employment and training, housing and transport, while also providing financial safety nets for the most disadvantaged groups in Australian society.

Closing the Gap

One of the most notable Australian examples of concerted action across multiple sectors is the *Closing the Gap* Strategy, to which all Australian governments have committed to help improve the lives of Indigenous Australians. The health and living conditions of Indigenous Australians is the most profound Australian example of why coordinated cross-portfolio activity, political commitment, and concerted investment are essential to address the complex, longitudinal and intergenerational interactions between social risk and ill-health. *Closing the Gap* aims to address the disadvantage faced by Indigenous Australians in life expectancy, child mortality, education and employment. It is a long-term ambitious framework that acknowledges that improving opportunities for Indigenous Australians requires intensive and sustained effort from all levels of government, as well as from the private and not-for-profit sectors, communities and individuals.

Closing the Gap is not just about improving health, but also opportunities through education and childhood development and better economic and health outcomes. The Australian Government's Health and Ageing portfolio is one part of a coordinated effort across a spectrum of social and economic policies and programs across housing, education, infrastructure, welfare and community services. Appropriately, overall policy responsibility for driving *Closing the Gap* sits outside the health sector, in the Department of Families, Housing, Community Services and Indigenous Affairs, while another non-health agency, the Productivity Commission, has responsibility for regularly reporting on progress towards meeting the *Closing the Gap* targets through its *Overcoming Indigenous Disadvantage: Key Indicators* series.[57]

Improved health outcomes are critical to the success of *Closing the Gap*, and while there is much to be done to address Indigenous disadvantage within the health sector, coordinated whole of government approaches appear to be essential for targeting inequality. The Agency notes that, if evaluations ultimately demonstrate that the whole of government strategy of *Closing the Gap* delivers the anticipated long term benefits, similar whole of government approaches could be considered for addressing other policy areas or the needs of other disadvantaged communities.

No one way to address social determinants

Evidence clearly indicates that most of the significant factors that affect health lay outside the influence of the health sector.[58,59] The Public Health Agency of Canada, in their useful overview of the key determinants and underlying premises, evidence and inter-relationships,[60] lists income and social status as the two most important determinants of health. Other key factors include: an individual's social support networks, education and literacy, employment and working conditions, social environments and networks within communities, physical environments (including water and food quality as well as the built environment and quality housing), personal health practices and coping skills, healthy child development, biology and genetic endowment, access to health services, gender, and culture.[61]

The Economist's recently published comprehensive report on the world economy, *For richer, for poorer*,[62] notes that issues of inequality and fairness have moved up towards the forefront of political agendas, courtesy of 'Occupy Wall Street' and similar campaigns. The report canvasses a range of issues and broad reforms for governments to address inequality, some of which may be relevant to the Inquiry's deliberations on social determinants of health.

The past three decades have witnessed intensive work globally to address the social determinants of health and abundant evidence of effective approaches to improving health outcomes for disadvantaged groups (including around obesity, smoking and alcohol).[63] However, evidence is lacking on the pragmatic next steps for taking a broad approach to addressing social determinants of health (that is, rather than within the confines of addressing a given risk factor or chronic disease). While there is widespread acknowledgement of the importance of addressing the broader determinants, robust analysis and evaluation of the various approaches remains critical. The central questions appear to be:

- *What are the practical actions needed to effectively influence social determinants in ways which result in demonstrably improved health outcomes?*
- *Which actions on which determinants will drive the greatest impacts on health outcomes?*
- *What are the most appropriate responsibilities for each of the players at each level of government and community influence?*

Is the most appropriate way forward one of overall coordination of activities, policies and programs to address social determinants? Or is it one of regular reviewing of the effectiveness of these activities, and reporting on progress within a social equity lens?

In recent years, different Australian state and territory governments have chosen alternate paths to address the complex questions around social determinants of health. While they are appropriate responses to the WHO Commission recommendations, we are awaiting evaluations regarding their overall effectiveness. For instance, many submissions to this Inquiry have called on the Australian Government to implement a *Health in All Policies* approach, as adopted in South Australia.[64] However, the Agency notes that Tasmania and the Australian Capital Territory have adopted alternate methods. The Agency believes that critical evaluations are needed of the given approaches in Australia to date, to inform governments of the most effective ways of organising activity to address social determinants.

The Agency recognises that many of the WHO Commission's recommendations are outside the Agency's scope and function. As the preceding discussion highlights, many recommendations are outside the scope of the health sector.

The Agency notes the WHO Commission's assertion that the health sector's role in relation to social determinants should be providing leadership, advocacy and policy.[65] It should also be noted that many of those in the Australian health sector (including government agencies at all levels, community and non-government organisations, and individual health care providers) are acutely aware of their obligations to consider social disadvantage in health policies, programs and services.

While all that is done within health programs and services may not always be recognised as being within the paradigm and language of "social determinants of health", the health sector has long recognised the inter-relationships between health and the age-old issues of poverty and marginalisation. The array of behavioural, biological, social, environmental and structural determinants of health has increasingly driven the design and delivery of health programs and services over recent decades, and is further demonstrated in the targeting of some programs and services to maximise outcomes for those with the greatest need.

It is also important to acknowledge that health programs that are universal in design also benefit the whole community, including the most disadvantaged. The principle of universal coverage in health program financing is recognised by the World Health Assembly as guaranteeing access for all to necessary health services while providing protection against financial risk,[66] and is entirely consistent with WHO's concepts of 'health for all' and 'primary health care'. These principles drive initiatives such as *Medicare*, the *Pharmaceutical Benefits Scheme* and the *National Immunisation Program* – universal health access programs which clearly also benefit the most disadvantaged groups in Australian society.

Finally, 'traditional' public health approaches – including sanitation, vector-borne and communicable disease control, and food safety – continue to be amongst the most critical public health contributions in support of the determinants of health, and particularly to ensuring health-conducive environments.

CONCLUSION

The recent health reforms have led to the establishment of numerous cross-government partnerships, including the *National Partnership Agreement on Preventive Health,* under which this Agency was established. Importantly, this Partnership includes a commitment to social inclusion and responding to Indigenous disadvantage.

The Australian National Preventive Health Agency will continue to build on its foundation work to date in providing national leadership in disease prevention and health promotion in Australia, including continuing to embed an understanding of the social determinants of health across the Agency's diverse activities. The Agency remains committed to supporting Australian efforts to address the broader social, economic and environmental factors that contribute to poor health outcomes.

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