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This book was initiated by Catholic Health Australia, the body of Catholic hospitals and aged care services operating right across nation. The mission of the Catholic Church in healthcare is to heal the sick, with a special priority for the poor. In contemporary Australia, this healing mission is fulfilled through the operation of near to 10 per cent of the nation's public and private hospital beds. It is also achieved by a focus on the social determinants of health through provision of schools and university education and social services and outreach to people in socio-economic disadvantage.

The book has been authored by a number of expert contributors, each with their own views and different perspectives, most from outside the community of the Catholic Church. The views expressed in this book are those of the authors, and are not necessarily endorsed by Catholic Health Australia. No contributor has been paid for their work, and they will receive no royalties from book sales. Any profits from publication will be directed to a social determinant charity. Each author takes sole responsibility for what is said in these pages, and they have contributed out of a shared sense that Australia should take action in response to what is known about the social determinants of health.

CATHOLIC HEALTH
Australia

Contents

Foreword

Frank Brennan,
Advocate in Residence for Catholic Health Australia, Catholic Social Services Australia and the St Vincent de Paul Society

In June 2010, Martin Laverty the CEO of Catholic Health Australia was appearing before a Senate Committee to give evidence about the COAG health reforms. In his opening statement he drew attention to a lacuna in the public discussion and policy planning. There was next to no reference to the social determinants of health. He said:

> I would be misleading this inquiry if I suggested we were entirely happy with the announcements that COAG made. We are critical of what was not actually agreed to. For example, income levels, as a measure of socioeconomic status, are a better predictor of cardiovascular death than cholesterol levels, blood pressure and smoking combined. Let us think about that for a moment. A person's access to income is more important to the chances that they face of dying of a heart attack than whether or not they have high cholesterol, high blood pressure or whether they smoke. The point I am making is that the social determinants of health, those factors that include housing, income, educational level, family support, supports at times of personal crisis in a person's life, can have more bearing on a person's health outcomes than access to health systems.

No senator had any interest in taking up this challenge. There were more immediate issues to tackle—like hospital funding and the mooted structure of Medicare Locals. Hopefully this publication will contribute to public discussion about the need for a new paradigm with a focus on the social determinants of health. The contributors to this book all see a strong connection between their areas of concern and expertise and the prospect of better health outcomes for all Australians. The idea of the book is not to provide the authors with an opportunity to push their own barrow with just an added health label, but rather to give the reader the opportunity to get a good overview of the inter-relatedness of the social determinants of health.

There are five key influences on our health: genetics, social circumstances, lifestyle, accidents, and access to health care. There is not much we can do to alter our genetics. With better occupational health and safety at work, good design standards, and improved public infrastructure, we can reduce the risk of accident. Writers from the University of Sydney Centre for Health Equity remind us that 'The local built environment also influences whether people are able to live physically, psychologically and socially healthy lives'.

The World Health Organisation (WHO) and Sir Michael Marmot in the UK have done a power of work finding that social determinants have a big impact on health outcomes. Fran Baum from Flinders University has worked closely with Marmot and brought home to Australia many of his key findings. If you are from a poor, dysfunctional family with little education and low job prospects, your health outcomes most probably will be much worse than those of the person from a well off functional family with good education and fine job prospects. Following the Blair initiative from the UK, Kevin Rudd as Prime Minister announced a social inclusion agenda aimed at ensuring that all persons can secure a job, access services, connect with family, friends, work personal interests and local community, deal with personal crisis and have their voice heard.

The Rudd Government started concerted work on addressing the social determinants of health for Indigenous Australians with the annual 'Closing the Gap' report. The Gillard government has continued to present parliament with an annual update on closing the gap. It is time for a similar approach to address the health needs of marginalised groups in the community generally.

The Gillard Government maintains a commitment to social inclusion. Sir Michael Marmot found in the UK that health inequalities result from social inequalities. He has put forward the idea of proportionate universalism. He says, ‘Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.’

In their essay in this collection, *Action on the social determinants of health: what does Australia need to do?,* Fran Baum and Matt Fisher observe: ‘However, one can see that while the Closing the Gap and the social inclusion initiatives tackle social determinants, they do this from the point of view of the most disadvantaged and don’t tackle the issue of the health gradient’. Meanwhile Tom Calma and Mick Gooda speaking for their Indigenous brothers and sisters remind us, ‘Aboriginal and Torres Strait Islander peoples have long asserted that their health is linked to their collective ability to control their lives and cultures and the recognition of their rights’. As Indigenous leaders of the Close the Gap campaign they are convinced that ‘a holistic and empowering approach that reduces the impact of negative cultural determinants (such as racism) and strengthens the support provided by culture, language and land is vital in any overall national effort to achieve health equality’.

David Cooper from the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) is very critical of government’s ‘pathologising of traditional culture’. He concedes that Closing the Gap is ‘the most expensive, extensive and far-reaching policy intervention in Indigenous affairs in recent times’, but claims that ‘it comes at the cost of Aboriginal community control being weakened or dismantled to facilitate government control’. For him, ‘The pattern that has emerged in Closing the Gap policies is one of asserted Aboriginal failure or deficit being used to justify transferring Aboriginal control to government.' Recent research shows better health outcomes in some remote Aboriginal communities like Utopia in the Northern Territory even though there is less access to routine services than in major centres like Alice Springs.

The Commonwealth has undertaken fresh initiatives to improve the lifestyle of Australians most likely to have poor health outcomes—especially smokers, heavy drinkers, the unexercised and the obese. But there is only so much government can achieve in attempting to modify people's behaviour without also improving their prospects in education, housing, work, income, and social connectedness. Policies that target behavioural change in a vacuum just do not work. There is little point in telling the unemployed, homeless person with minimal education and few social contacts: 'Don't smoke and don't eat fast food. It's not good for you'. Steve Hambleton, President of the AMA points out, 'Generally, people on low incomes—including young families, elderly people and those who are unemployed—are often most at risk from poor nutritional choices.' The AMA has called on government to 'improve the quantity and quality of services to those in the poorest and most disadvantaged communities and make such services accessible to the resident populations'.

Most of the airplay on health reform is dedicated to better access to health care services. The research commissioned for the 2009 National Human Rights Consultation which I was privileged to chair found that such access is the issue of most importance to the majority of Australian—coming in ahead of pensions and superannuation issues, human rights, global warming and the quality of roads. This becomes an issue of good money after bad unless there is also action on social determinants and lifestyle questions. Though the majority of Australians think our human rights are adequately protected, over 70 per cent of those surveyed thought that persons suffering a mental illness, the aged, and persons with a disability needed better protection of their human rights. More than 50 per cent thought regional communities also needed better protection. We need better outcomes for the same outlays.

NATSEM (the National Centre for Social and Economic Modelling at the University of Canberra) has now completed a report *Health Lies in Wealth* applying some of the WHO and Marmot methodology to Australia, studying health inequalities in Australians of Working Age. Up to 65 per cent of those living in public rental accommodation have long term health problems compared with only 15 per cent of home-owners. More than 60 per cent of men in jobless households report having a long term health condition or disability, and more than 40 per cent of women. The most discriminating socio-economic factors for smoking are education, housing tenure and income. Fewer than 15 per cent of individuals with a tertiary education smoke. Education and housing tenure are consistently related to rates of obesity. Around 40 per cent of Australian men of working age are high risk alcohol drinkers. The likelihood of being a high risk drinker for younger adults who left high school early is up to twice as high as for those with a tertiary qualification.

We are not only seeking better health outcomes for all persons. It is not a matter of providing more resources which improve the lot of all persons much like the rising tide raises all boats. At the same time as we lift the bar, we want to decrease the steep gradient between those with the best and those with the worst outcomes, whether the indicators are income, education, housing, employment or social connectedness.

The Commonwealth Government is committed to establishing Medicare Locals and Local Hospital Networks as part of the COAG health reform process. It will be a lost opportunity for comprehensive health reform if these institutions are permitted to focus only on improved access to health care facilities. We need to break down the silo mentality and have health professionals educated to a greater awareness of the inequalities confronting their patients and committed to greater equity in their local regions so that the scarce health dollar might deliver better real health outcomes for all, especially those whose health is most at risk. This way, the government's social inclusion agenda could impact usefully on the allocation of scarce health resources.

John Falzon, the CEO of St Vincent de Paul, insists that 'the personal is political'. He says, 'Health is not a commodity to be bought and sold. It is a complex of social relations. Like all social relations it is in a state of permanent flux. Everything is related to everything else and everything is constantly changing. Good health is a social good. Good health is hard to achieve in a context of disempowerment and a lack of self-determination.' His members are 'daily witnesses to the experience of people who are crushed and colonised by the undiluted messages that they are to blame for having been left out or pushed out of prosperity afforded by a strong economy and the freedoms afforded by a strong democracy.'

Rhonda Galbally, Acting CEO of the National Preventive Agency, sees a National Disability Insurance Scheme as the 'best buy for health improvement because it will improve 'the capacity of many people with disability to exercise their rights to be treated as equal citizens'. It would allow them 'to participate in their communities, exercise their rights, undertake education and training, and find employment. It would change their lives'. 2010 Australian of the Year, psychiatrist Patrick McGorry calls for a 21st century approach to mental health which 'provides stigma-free comprehensive community based mental heatlh care closely linked to the primary health care system'. Jenny May, Chair of the National Rural Health Alliance Council, points out that people in the bush don't only have lower socio-economic status than their city cousins. They also encounter greater health risk factors including poorer roads and lesser access to preventive and acute health services. Journalist Melissa Sweet says, 'The social determinants of health receive plenty of rhetorical attention, but there is far less investment in action to tackle them.'

Hopefully this collection will motivate decision makers to redirect investment and human resources, breaking down the silo mentality and forging partnerships which can provide a pathway to improved health and wellbeing for all persons, and not just for those at either end of the gradient. In this land of the fair go, we need to flatten the gradient of adverse health outcomes, not just attend to those at the top or the bottom. Next time, let's hope our politicians will be ready to discuss these matters and not just the contested allocation of the siloed health care dollar.

Introduction

Social building blocks of good health—opportunity for action

Martin Laverty,
Catholic Health Australia

At different stages of a person's life, the presence or absence of certain social building blocks will determine how long a person lives, and how healthy they will be during their lifetime. Experts know these building blocks as the social determinants of health.

Health policies, and recent efforts for health reform in Australia, have mostly focused on how hospitals and health professionals enable access to treatment. Policy and reform efforts have incorporated a good and necessary understanding of the need for physical activity, dietary management, tobacco, and alcohol control.

Hospitals, health professionals, physical activity, and awareness of what we eat, drink, and smoke, are indeed important building blocks of good health. Yet there are other key social building blocks that are not routinely considered by health policy makers, despite a genuine and real interest of health policy experts to improve the health of all Australians.

There is growing evidence that the influences of some social determinants on a person's health are in fact greater than biomedical and behavioural risk factors.[1] This evidence has only begun to be understood in any meaningful way in the last decade, but health policy in Australia has been slow to respond. Australian health policy has remained focused on biomedical and behavioural risk factors, and has largely ignored the two landmark reports of the World Health Organisation delivered first in 2003[2] and then in 2008,[3] that invited Australia to expand health policy thinking by considering social determinants alongside medical and behavioural health priorities.

It is partly because of Australia's continued inaction on the recommendations of the 2008 World Health Organisation report, known commonly as the Marmot Review, that this book has been written. Because most state, territory, and Commonwealth governments of all political persuasions over the last decade have not taken the opportunity for action in response to the Marmot Review, this book has emerged to offer different, diverse, and confronting policy and practical proposals that invite all Australian governments to broaden their health policy parameters to include a new focus on the social determinants of health.

The need for action arises out of recent evidence that establishes some Australians die earlier and have less healthy lives than they otherwise would if more emphasis was placed on the social building blocks for good health. Average life expectancy for Australians in the lowest socio-economic group is three years less than those in the highest socio-economic group, and long term health conditions are near to three times more prevalent in the lowest socio-economic

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[1] Raphael, D, *Social Justice is Good for Our hearts: Why Societal Factors—Not Lifestyles—are Major Causes of Heart Disease in Canada and Elsewhere*, Centre for Social Justice Foundation and Research and Education, Toronto, Canada, 2002.

[2] Marmot, M, and Wilkinson, R, *Social Determinants of Health: The Solid Facts,* World Health Organisation, Holland, 2003.

[3] Commission on Social Determinants of Health, *Closing the Gap in a Generation,* World Health Organisation, Switzerland, 2008.

group than that of the highest.[4]

The building blocks of good health are best understood by considering the various stages and potential crisis points of a person's life span. Good health starts in the womb, and needs a safe and secure pregnancy. It needs positive early childhood experiences. School participation, transition to reliable work, safe and secure housing, access to safe food and sustenance, and sufficient access to income and resources are all necessary building blocks to good health. So too is social interaction, and the development of skills to engage with a person's community. With the exception of pregnancy management and food regulation, each of these policy areas is overseen by agencies located outside the normal boundaries of a health portfolio.

Applying the lens of the life span and knowledge that good health starts from the time of conception, the National Health and Medical Research Council (NH&MRC) advises that maternal alcohol consumption can harm a developing fetus or breastfeeding baby.[5] For women who are pregnant or planning a pregnancy, not drinking is advised by the NH&MRC as the safest option. Not drinking as the safest option for pregnant women may be the very first better health building block of their unborn child's life.

A study of the American Psychiatric Association looked at the adult mental health of 25 people living with either fetal alcohol syndrome or fetal alcohol effects, triggered by alcohol exposure in the womb prior to birth. Eighteen of the people studied, or 72 per cent, each suffered a debilitating mental illness of some sort, leading the study authors to conclude that children born with fetal alcohol syndrome will likely go on to suffer substantial mental illness in later life.[6]

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[4] Brown, L, Nepal, B, *Health lies in wealth: Health inequalities in Australians of working age,* NATSEM-Catholic Health Australia, September 2010.

[5] National Health and Medical Research Council, *Australian Guidelines to Reduce Health Risks from Drinking Alcohol,* Commonwealth of Australia, 2009.

[6] Famy, C, Streissguth, A, and Unis, A, *Mental Illness in Adults With Fetal Alcohol Syndrome or Fetal Alcohol Effects,* American Journal of Psychiatry 155:552-554, April 1998.

A similar study looked at 415 adults living with fetal alcohol effects. The study revealed 61 per cent had disrupted school experiences, 60 per cent had trouble with the law, and 35 per cent suffered drug and alcohol problems.[7] With this confronting finding, the study authors also pointed to the opportunity for action. They found the odds of escaping these adverse life outcomes are increased two to four fold by receiving a diagnosis of either fetal alcohol syndrome or fetal alcohol effects at an earlier age, and by being reared in good stable environments.

The opportunity for action—or rather confusion about how to best grasp the opportunity for action—is a key reason why health policy today does not easily embrace the theory of the social determinants of health. Asking a health practitioner or health policy expert to consider early childhood policy, social housing policy, or income policy risks overloading the capacity of otherwise competent people to do good. Governments are not structured to easily work across portfolios, and whole of government responses to social challenges are both rare and hard to achieve.

Australia does have milestones to be proud of in grasping the opportunity for action on social determinant theory. By way of illustration, poor water quality accounts for some 1.5 million deaths a year world-wide, with nine out of 10 such deaths being children.[8] In contrast, water quality related disease in Australia is almost non-existent, with a major study in Melbourne finding no evidence of waterborne disease at all.[9] The study attributes the absence of waterborne disease in Melbourne to sound water management,

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[7] Streissguth, A, Bookstein, F, Barr, H, Sampson, P, O'Malley, K, Young, J, *Risk Factors for Adverse Life Outcomes in Fetal Alcohol Syndrome and Fetal Alcohol Effects,* Journal of Developmental & Behavioral Pediatrics, Volume 25 - Issue 4 - pp 228-238, August 2004.

[8] Ashbolt, N, Microbial contamination of drinking water and disease outcomes in developing regions, *Toxicology*, Volume 198, Issues 1-3, 20 May 2004, Pages 229-238.

[9] Hellard, M, Sinclair, M, Forbes, A, and Fairley, C, A Randomized, Blinded, Controlled Trial Investigating the Gastrointestinal Health Effects of Drinking Water Quality, Environmental Health Perspectives, Volume 109, Number 8, August 2001, Australia.

which is practiced in most western societies. Access to clean and safe water saves lives and enables better health. Decades of public policy investment delivered today's system of safe drinking water, but it needn't take decades to apply the new knowledge we have of how to address social determinants of health to help improve the lives of all Australians.

As governments of the past achieved success in making safe our water, so to today should governments take the opportunity for action in helping people live longer and suffer less chronic illness. The same brave action taken to improve the quality of water in the past, which even today is still opposed by some who object to treatment and fluoridisation of water, is required in response to what the Marmot Review confirms about social determinants of health. Taking such action would in time save costs in the health system and increase the economic productivity of the nation's workforce, which is a key priority for a rapidly ageing community.

The task will be by no means easy, mainly because governments will be unsure as to where they should start. Adopting Marmot is the first logical step, and this book recommends a Senate inquiry should be established to develop an Australian implementation plan for the recommendations of Marmot.

Yet this book, written by way of contribution from health and social policy experts and practitioners from outside of government, also invites committed people working in health, in social services, education, and housing to explore the interconnected reality of the development of social capital and health outcomes. The book hopes to offer to motivated people outside of government a mix of research translated into both policy and practical programs, just in case governments continue their well established reluctance for social determinants action.

To identify how policy can best translate into the opportunity for action, an illustration is found in the study findings[10] of the 415 adults living with fetal alcohol effects. The researchers found that an early diagnosis and being reared in good stable environments improves by two to four fold the chance of avoiding adverse health outcomes. This points to the opportunity to assess the adequacy of social supports for mothers and children at risk of fetal alcohol effects.

Another illustration is found in evidence that low literacy is associated with several adverse health outcomes.[11] A study of 2500 patients in public hospitals that controlled for age, gender, and race, found patients with lower literacy levels reported two times the prevalence of chronic illness compared to patients with higher literacy.[12] This finding points to the important role of literacy and education in health outcomes, and how improving the reading ability of the population is in fact a building block of good health.

The role of educational attainment in health outcomes was underscored by the American College of Physicians, who found noncompletion of high school is a greater risk factor than biological factors for development or many diseases, and that the level of a person's formal education predicted cardiovascular mortality better than random assignment to a three year clinical trial providing optimal access to care.[13] This research points to the tangible role that educational attainment plays as a building block of health, and asks Australians to consider if greater encouragement for higher educational attainment might enable better health.

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[10] Streissguth, A, et al, op cit.

[11] DeWalt, D, Berkman, N, Sheridan, S, Lohr, K, and Pignone, M, Literacy and Health Outcomes, Journal of General Internal Medicine, Volume 19, Issue 12, Pages 1228-1239, December 2004.

[12] Baker, D, Parker, M, Williams, M, Clark, W, Nurss, J. The relationship of patient reading ability to self reported health and use of health services. American Journal of Public Health, Pages 1027-30, 1997.

[13] Pincus, T, Esther, R, DeWalt, D, and Callahan L, *Social Conditions and Self-Management are more powerful determinants of health than access to care,* Annals of Internal Medicine, American College of Physicians, USA, 1998.

Income plays just as important a role as a building block to good health. A study of 126 countries published in the *British Medical Journal* assessed income inequality data held by the United Nations Development Program and mortality data held by the World Health Organisation. The study found income inequality is associated with high mortality, and that mortality falls as personal income rises.[14] A rationale put forward for the link between low income and poor health is that the psychosocial stress of being in a relatively low position within a social and economic hierarchy leads to actual physiological harm.[15] These findings suggest Australians could consider both the role of financial support for low income Australians as a contributor to good health, but also the opportunity to address the causes of psychosocial stress of those in socioeconomic disadvantage.

These few opportunities for action to better focus on strengthening the social building blocks of good health form part of a larger set of possibilities outlined in this book. The views expressed here are those of individuals. They are offered to prompt government to action, and trigger thinking of others outside of government about what the next phase of health reform should be.

While ever health policy remains focused on biomedical and behavioural factors, it will not achieve best health outcomes, and will burden future taxpayers with ever escalating health costs. There will always be a need for investment in hospital care, for expansion in health workforce, and preventive health initiatives. This investment will become urgent as the Australian population soon reaches peak ageing. Yet in addition to traditional health system investment, new investment is needed in social determinants, and Australia can start by working out how best to implement the World Health Organisation's 2008 social determinants action

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[14] Dorling, D, Mitchell, R, Pearce, J, *The Global impact of income inequality on health by age: an observational study,* British Medical Journal, 2007.

[15] Marmot, M, *The Status syndrome: how social standing affects our health and longevity.* London, Bloomsbury, 2004.

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Action on the social determinants of health—what does Australia need to do?[16]

Fran Baum, Matt Fisher,
Flinders University

Introduction

The Commission on the Social Determinants of Health (CSDH) reported in 2008[17] following three years of work. These three years included extensive deliberation by the commissioners at a series of meeting around the world, the research of nine knowledge networks, intensive work in a range of countries, and the systematic contribution of civil society to the process.

The final report made a series of recommendations that went to the heart of the ways in which the world internationally and within countries could organise social, economic and everyday life in order to maximise population health and health equity. The CSDH report was aimed at a global audience and so inevitably the recommendations are broad in scope and have to be re-interpreted within each country context.

To date there has been no systematic response to the CSDH report from Australia which has been disappointing. In this context of lack of response the initiative of Catholic Health Australia in

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[16] This chapter draws on material from Baum, F. 2009.

[17] Commission on the Social Determinants of Health. 2008.

commissioning from The National Centre for Social and Economic Modelling (NATSEM) the 'Health lies in wealth: Health inequalities in Australians of working age' report[18] is a very welcome addition to the debate about social determinants in health. This paper examines the implication of the CSDH and the NATSEM report for Australian public policy over the coming years.

NATSEM report

The report documents the ways in which health status is affected by social factors in Australia. In summary it shows significant social gradients, and marked differences in health outcomes for Australians of working age between the most and least disadvantaged groups—according to most of the health outcome measures used, and with most of the indicators employed to measure socio-economic status (SES).

Remoteness was an exception with no significant differences found between regional/remote and city dwellers in self-assessed health status, or long-term health conditions. Significant SES gradients were also found in relation to the selected health behaviours, with the exception of risky alcohol consumption, where results were more mixed. The picture drawn of health inequities and their links with social factors reflect patterns repeated around the world.

Australian policies relevant to health equity

We have conducted a brief survey of the Australian landscape in terms of policy initiatives relevant to the social determinants.[19] The main policy initiative that does recognise the social determinants

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[18] Brown, L et al. 2010.

[19] Newman, L et al. 2006.

of health is the COAG *Closing the Gap* initiative.[20] It includes among its objectives the need for access to early childhood education, increasing reading, writing and numeracy achievements for Indigenous children, and improved year 12 completions, and sets out to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade. Thus two of the most powerful determinants of health—education and employment—are central to the policy. The national social inclusion agenda[21,22] also addresses social determinants from the perspective of improving the lives of the 5 per cent of Australians who are most disadvantaged, and considers geographical areas of extreme disadvantage and the need to involve disadvantaged people in education and employment. However, one can see that while the *Closing the Gap* and the social inclusion initiatives tackle social determinants, they do this from the point of view of the most disadvantaged and don't tackle the issue of the health gradient. The CSDH report was clear that addressing health equity required consideration of the evidence showing that health status most often operates as a gradient across society.

For the broad Australian population the main policy response has been the national preventive health strategy[23] which is primarily a disease prevention agenda. There is, of course, much to applaud about this: it often takes a public health perspective; it does seek to prevent disease; and it does keep a focus on the need to shift the focus of the health system to what causes illness. Yet it is also frustrating, because it could be so much more exciting and cutting edge if our national agenda had also devised strategies to address the social determinants of health in a more systematic way. Australia

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[20] Council of Australian Governments. 2007.

[21] Australian Government. 2010.

[22] Commonwealth of Australia. 2010.

[23] National Preventative Health Taskforce. 2009.

is not alone in this—Raphael[24] has pointed out that Canada's effort are similarly focused on a limited disease prevention agenda which does little to consider the basic structures of society and how they might detract or contribute to health. He notes that health promotion has become de-politicised and focuses on 'population health' with an application of epidemiology to social issues and a strong discourse of lifestyle choices. This also resonates with the 'preventive health' agenda in Australia.

Our current prevention agenda has a built-in tendency to see those individuals or groups who do not achieve low risk and disease rates as deviant in some way—characterised as 'high risk groups' or 'non-compliers'. They, rather than the social and economic structures that constrain their lives, are viewed as the problem.

Perspectives from the Commission on the Social Determinants of Health

The CSDH's report was structured around three main concerns—improving the conditions of daily living, the need for redistribution of power and resources, and better means of measuring, understanding and educating about the social determinants of health equity. What is striking about the commission's report is that, while it recognises the public health importance of the continuing burden of infectious disease (especially of course in poor countries) and of chronic disease it also accepts the evidence that shifts in the pattern of disease largely reflect factors to do with the organisation of societies and the distribution of power. The CSDH report for instance says little about directly changing individual behaviours because it accepted the evidence showing such strategies are largely ineffective without significant structural change to support them.[25] By contrast current Australian debates

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[24] Raphael, D. 2008.

[25] See, for example: Syme, SL. 2004.

concerning 'preventive health' are largely silent on the need for a redistribution of resources and changes to unhealthy structures.

A social determinants agenda for Australia

The current preventive health agenda appears to be motivated by a fear of a threatening tidal wave of health care expenditure in the wake of a growing epidemic of chronic disease.[26] This explains the focus on risk factors (something very tangible that can be tackled and so is immediately politically attractive) and also explains the relative silence on social determinants of health, especially those that address the more fundamental causes of inequity and ill health. Addressing health inequities will require a concerted whole of government approach and actions in all sectors. In Table 1 (see end of chapter) we list the major areas of recommendation from the CSDH and suggest some possible Australian policy responses. We recognise that the private sector has a significant and growing role in health (especially the food industry). However, the CSDH report expressed scepticism about corporate responsibility which essentially leaves health promotion up to the self-regulation of industry. It suggests instead that corporate accountability is likely to be a stronger framework whereby industries such as the food industry are required by legislation to modify their unhealthy practices such as marketing food high in fat and sugar content to children.

In the context of this article there is insufficient space to expand fully on the responses we suggest in Table 1. The changes required are elaborated on in more depth in Baum's *The New Public Health*[27] (Part 6: Healthy Societies and Environments) which makes it clear that the approach must incorporate an ecological perspective and assess the extent to which the basic structures of

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[26] The Treasury. 2010.

[27] Baum, F. 2008.

society (the economy, the structures of our cities and the fabric of our community and social lives) contribute or detract from health. Crucially, there are no simple answers and responses must be framed within an understanding of complexity[28], and the need to develop salutogenic environments which promote positive health.[29]

Baum[30] has suggested the establishment of an *Australia 2040 Commission* with the following brief:

- Develop a broad strategic vision and plan for Australia's future.
- Be mandated to encourage cross-government action towards implementing this plan. Encourage and facilitate a widespread citizens' debate about the future, posing the question of, What society do we want for us and our future generations to live in by 2040?
- Determine mechanisms to implement this vision and plan across government through processes such as the Health in All Policies approach.
- Determine measures of our progress as a society that go beyond a focus on economic development and encompass a consideration of human health and well-being.

A 2040 Commission would be able to provide vision and integration across government, and stimulate a broad citizen dialogue about our future in order to produce a strategic planning framework for ensuring a healthy Australia. It would enable us to explore the great issues we face: how to develop economic activity in a way that doesn't threaten our very survival? How do we best protect the environment for future generations? How do we create a society that encourages mentally and physically healthy citizens? How do we distribute the benefits of society more equitably? How

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[28] Jayasinghe, S. 2011.

[29] Antonovsky, A. 1996.

[30] Baum, F. 2009.

do we ensure social and economic inclusion? What responsibilities does Australia have for creating a more equitable global community and how can we ensure that this community happens?

There are many building blocks that the 2040 Commission could use to develop consensual visions and plans for the future. The Australia 2020 Summit[31] produced ideas and suggestions for our future that could provide a starting point for the 2040 Commission. The Australian Social Inclusion Board will have much to offer—it is an across government venture and the South Australian Social Inclusion Initiative has shown that such an approach can be effective in breaking down bureaucratic barriers.[32] Within the health sector, the National Preventative Health Taskforce, the National Indigenous Health Equality Council and the National Hospitals and Health Service Reform Commission show signs of producing ideas that are relevant to a broader understanding of health, such as using policy to create environments that make healthy choices easier to make.

Other sectors crucial to the determinants of health, including housing, employment, education and environment, will all have existing processes that could feed into the Australia 2040 exercise. There are also many citizen groups and non-government organisations who would bring an essential voice to the table. Much could also be learnt from the growing literature on happiness and how different social organisations and personal habits can shape the extent of happiness.[33,34] This literature notes that, like health, after a certain level of economic development there is no linear relationship between the average happiness levels and economic development measured in Gross National Product (GNP). This signals the need for a citizen debate about what the sources of

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[31] Australia 2020 Summit.

[32] Newman, L et al**.** **2**007.

[33] Layard, R. 2005.

[34] Eckersley, R. 2005.

satisfaction are and what type of society is likely to bring happiness and health.

Finally, we need to develop a few agreed measures or an index to determine how well we are doing as a society. Economic growth remains a central measure of how we measure our success and progress but increasingly the wisdom of this is questioned. Calls are mounting for measures of progress that count factors that matter to people's everyday lives. An example is the Happy Planet Index[35], developed by the New Economics Foundation, which is based on the criteria of average life expectancy, life satisfaction and ecological footprint. When applied, this index demonstrates that there is no necessary relationship between long and happy lives and high levels of resource consumption. Adding an equity measure to this index would be useful. The idea of the index would be to shift Australian decision making to a broader base than purely economic criteria.

Conclusion

We commend Catholic Health Australia's initiative in striving to put and keep social determinants of health on the Australian policy agenda. We have made a series of recommendations of how Australia might respond to the CSDH report and proposed an Australian 2040 Commission to develop a vision supported by a strategic framework for shaping our collective futures in a way that is inclusive, equitable and supportive of health and well-being.

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[35] Marks, N et al. 2006.

Table 1: Selected key recommendations from the Commission on the Social Determinants of Health highlighting messages for Australia

Key recommendation	Example of application to Australia
Establish Australian 2040 Commission to provide across government response to social determinants of health	
Improve daily living conditions	
Equity from the start—including physical, social/emotional and language and cognitive domains—to ensure all children reach their potential	• Ensuring coherent policies between sectors for early childhood and through the school years. • Generous parenting leave. • Policies to support parents to encourage healthy lifestyles. • Environments that encourage health—play parks, wide spread availability of healthy food in child care and schools. • Public health perspectives on child support and protection.
Healthy places healthy people	• Major initiative to shift urban planning to encourage physical exercise and use planning regulations to control fast food and alcohol outlets. • Put health equity at heart of urban governance and planning. • Develop range of healthy setting initiatives including healthy and sustainable communities based on local government, state government and NGO co-operation.
Fair employment and decent work	• Policies to reduce the adverse health impacts of employment. • Provision of healthy work-choices in work related food outlets. • Encourage and support active transport options for travel to work. • Increased concern with occupational health including exposure to material hazards & psychosocial impact. • Encourage healthy work-life balance.

Social protection across the lifecourse	• Aim for universality rather than targeting and conditionalities in social protection payments. • Increase generosity of family policy. • Maintain and extend Medicare (including to dental services). • Create citizen debate about how health service spending can be curtailed. • Achieve a demonstrated shift of health dollars to primary health care and health promotion. • Provide support for particularly disadvantaged groups to be included in society's activities especially employment and education.
Tackle the inequitable distribution of power, money and resources	
Health equity in all policies, systems and programs	• Adoption of an across government *health equity in all policies* initiative lead by state premier's departments and the Prime Minister's Department. • Health departments adopt a social determinants function across policies and programs, and take a stewardship role to support a social determinants approach across government.
Fair financing	• Implement progressive taxation and advocate for global financial mechanisms to ensure global funding for action on global social determinants in health. • Increase expenditure on overseas aid to 0.7% of GDP.
Market responsibility	• Ensure that basic services essential to health (water, sanitation, power supply, health services) are publicly run and accountable. • Encourage citizen debate about public ownership of assets and need for regulation to control private sector activity so that it does not undermine population health.
Gender equity—tackling gender bias in institutions	• Increase female representation in parliaments, governments and boards of management. • Assess broader family and work policies to ensure they encourage gender equity. • Continue work to reduce gender-based violence.

Political empowerment—inclusion and voice	• Work to improve the operation of parliamentary democracy. • Encourage genuine rather than token participation in government decision making. • Fund independent bodies to support citizen participation. • Support recipients of government funding to participate in critiques of government policy.
Good global governance	• Australia should support the development of a global architecture of market regulation. • Australia, as a member state, should strongly encourage WHO to adopt a social determinants in health approach in all its policies and programs.
Knowledge, monitoring and skills	
Knowledge base	• Require NH&MRC and the Australian Research Council to fund a program of research on the social determinants of health and evaluating action on the social determinants of health. • Continue and extend the work of the Australian Institute of Health & Welfare on monitoring the impact of social determinants on health
Education and training	• Include study on the impact of social determinants and actions to address them in all health professional initial and in-service training and in the training of professionals in the determinants sectors (especially urban planning, education and housing)
Building a global movement	
Advocacy	A wide range of NGOs can play a role in building a national and global movement for action on the social determinants of health and health equity

References

Antonovsky A. (1996) 'The salutogenic model as a theory to guide health promotion.' *Health Promotion International,*11: 11-18.

Australia 2020 Summit. Available at: www.australia2020.gov.au/

Australian Government (2010) *A Stronger, fairer Australia: National statement on Social Inclusion*. Canberra: Department of Prime Minister and Cabinet, Australian Government.

Baum F. (2008) *The new public health*. 3rd edition. Melbourne: Oxford University Press, 2008.

Baum, F. (2009) 'Prevention: The Commission on the Social Determinants of Health and recasting the debate to focus on health and well-being.' *Public Health Bulletin of South Australia* 6**:** 16-20.

Brown, L. & Nepal, B. (2010) *Health lies in wealth: Health inequalities in Australians of working age*. Canberra: National Centre for Social and Economic Modelling, Catholic Health Australia.

Commission on the Social Determinants of Health (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: World Health Organization. Available at: www.who.int/social_determinants/en/

Commonwealth of Australia (2010) *Taking preventative action—A response to Australia: The Healthiest Country by 2020—The Report of the National Preventative Health Taskforce*. Canberra: Commonwealth of Australia, Department of Health and Ageing.

Council of Australian Governments (2007) *National Indigenous reform agreement (closing the gap)*. Canberra: Council of Australian Governments.

Eckersley R. (2005) *Well & Good: Morality, Meaning and Happiness*. 2nd edition. Melbourne: Text Publishing.

Jayasinghe, S. (2011) 'Conceptualising population health: From mechanistic thinking to complexity science'. *Emerging Themes in Epidemiology,* 8: 1-7.

Layard R. (2005) *Happiness: Lessons from a new science*. London: Penguin Books.

Marks, N., Abdallah, S., Simms, A. & Thompson, S. (2006) *The happy planet index: An index of human well-being and environmental impact*. London: New Economics Foundation.

National Preventative Health Taskforce (2009) *Australia: The healthiest country by 2020—National Preventative Health Strategy—the roadmap for action*. Canberra: Commonwealth of Australia.

Newman, L., Baum, F. & Harris, E. (2006) 'Federal, state and territory government responses to health inequities and the social determinants of health in Australia'. *Australian Journal of Health Promotion,* 17**:** 217-25.

Newman, L., Biedrzycki, K., Patterson, J., Baum, F. (2007) *A Rapid Appraisal Case Study of South Australia's Social Inclusion Initiative. Report prepared for the Social Exclusion Knowledge Network of the WHO Commission on Social Determinants of Health*. Adelaide:

Australian Health Inequities Program, Flinders University, Social Inclusion Unit, Dept of Premier and Cabinet-SA Government.

Raphael, D. (2008) ‘Grasping at straws: a recent history of health promotion in Canada’. *Critical Public Health*, 18: 483-495.

See, for example: Syme, S.L. (2004) ‘Social Determinants of Health: The Community as an Empowered Partner’. *Preventing Chronic Disease [serial online]* 1.

The Treasury (2010) *Australia to 2050: Future challenges.* Barton ACT: Commonwealth of Australia.

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Partnering for positive change

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St John of God Health Care and Barwon Youth

A shocking phone call at 3.30am was the beginning of Jane's journey 'down hill'. The caller told Jane that her boyfriend—a drug user and the 'love of her life'—had died. Jane's turmoil grew considerably in the coming months.

'I was no stranger to grief because in the next six months, I'd buried the five people I loved the most,' Jane said. 'Over a stream of tears and a string of funerals … I was sure I was stuck in a rut never to return. Later … I realised I was not only an alcoholic, but a drug addict as well.'

At the time Jane (whose true identity is protected) was 20 years old and homeless. She could not see a way out. The issues she was facing were considerable and complex.

Jane needed help but her problems were not unique or uncommon. In 2006, 43 per cent of Australia's homeless population were below the age of 25—that's 44 577 young people without adequate or stable long-term accommodation.[36] Young people who are homeless experience significant negative social and health consequences. Homeless young people have high levels of mental health problems, including anxiety, depression, behavioural disorders, self-harm, and

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[36] ABS. 2006.

alcohol and drug misuse.[37]

Fortunately for Jane, the Youth Engagement Program (YEP), operated in the Geelong region as a partnership between Barwon Youth and St John of God Hospital Geelong, provides a pathway to improved health and wellbeing—a brighter future.

YEP delivers interventions for young people experiencing problematic substance use, providing education and a range of treatment options. Each intervention forms part of the pathway out of drug and alcohol problems and many elements are involved.

For Jane, one key element of her recovery journey was a period of residential withdrawal and she cites this as the reason she is 'still here':

> It took me years to work up the courage to go to rehab but with the support of my AOD (alcohol and other drugs) Worker and several others, I did it.

The YEP has also guided Jane's ongoing involvement with mental health and homelessness services. This included referral and support to secure short-term accommodation (via mental health services) while assisting the process of looking for more permanent accommodation.

Another pathway Jane was guided along was the Great Ocean Walk—in a wilderness adventure known as The Outdoor Experience. Walking 22 kilometres, 500 metres with heavy packs along the coast of western Victoria is no easy feat but, with the help of Jane's AOD worker, who was there for Jane when things got tough, she made it to the end. Not all of the young people involved in the trek made it to the finish and Jane had several opportunities to quit but she completed the adventure with a sense of pride—in herself, from her family and from those supporting her through the YEP.

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[37] AIHW (2011). People turned away from government-funded specialist homelessness accommodation 2009–10.

Jane has also found a positive pathway through music, organising studio time with the help of Barwon Youth's Zones program after her talents were recognised and brought to the fore. 'Someone at Zones (an AOD Day Program offered by Barwon Youth) had suggested that music could be my ticket out of my life of destruction,' she reflects. 'I worked at it until I was good enough, since then I have been provided support to do what I do best.

'The shattered pieces of my life are coming back together piece by piece, my future is in my reach and I'm going to grab it.'

A person-centred partnership

Instilling that determination into Jane after years of doubt, uncertainty and damage are the results of a comprehensive approach to addressing the social determinants of health. The various causal factors affecting health and wellbeing can rarely be isolated and should not be treated in isolation. An holistic approach to improving health and wellbeing outcomes is essential in effective social health models and the various needs of each person have to be carefully considered to put people experiencing disadvantage on a positive pathway to a healthier future and a more fulfilling life.

The notion of treating the whole person rather than individual symptoms and conditions is important in many social health models but one key aspect that sets YEP apart is the implementation of assertive outreach—striving to engage young people who are not necessarily seeking help. Many young people using alcohol or drugs in a harmful, or potentially harmful, manner may not have identified that they have a substance use problem. These individuals will not feel the need to engage with a service early in their cycle of use and therefore are likely to miss the opportunity for early intervention. If substance use escalates it often requires a greater amount of treatment and can lead to worsening mental health issues if and when the young person does seek medical help.

Reaching out in the community

The YEP model is designed to provide young people, particularly those who are difficult to reach, with access to services within the community. It is conducted in out-of-office settings including streets, homes and parks—the engagement process is often less formalised than accessing other AOD or mental health services. The social model of health does not provide one single treatment method; rather it encompasses a number of approaches based on broad, developmentally appropriate, systemic principles such as relationship-based, holistic and client-centred methods.

The flexibility to work with the specific needs of a client is also central to this model of care with specific attention given to the client's view of issues and functionality of substance use. The therapeutic relationship that the YEP staff build with the client is as important as the interventions offered and is the vehicle in assisting clients to be an 'expert' in their own treatment. As Larner asserts, many of the outcomes for treatment are not related to the treatment provided, rather the therapeutic relationship the worker has with a young person and the client's resourcefulness and expectations and hope for change.[38]

The YEP service is mindful that substance use is often a function of the client's attempt to deal with other issues in their life—many of which are social determinants of health in their own right. Assessing the function of their substance use is essential in understanding how the young person deals with other problems. Substance use itself is rarely a singular issue and therefore dual diagnosis of co-occurring drug use and mental health is vital alongside awareness of other issues in a young person's life. Since its inception in January 2007, YEP has found that clients often use substances in a response to, or to manage, other difficulties in their lives. As well as mental health issues, other behaviours that may be diagnostically important include gender,

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[38] Larner, G. 2004.

culture, childhood experiences, social and economic circumstances and history of trauma.

For example a client with problematic substance use experiencing anxiety is unlikely to be able to fully withdraw from their drug use if that is treated in isolation. However, YEP would work with that person to help manage their anxiety because improving their mental health should enable the client to make positive traction with minimising their drug use and empower them in working towards their goals.

The person-centred approach of YEP means that AOD workers agree goals with clients of the service rather than telling them what their goals should be. A key component of the social health framework is that clients engage with the program and consider realistic targets for their own personal circumstances.

The YEP has been invaluable in Geelong and the surrounding areas, providing additional capacity in Youth AOD services that had been at or near capacity. When young people are highly motivated to change their substance use but are unable to access practical assistance the resultant sense of helplessness can exacerbate and entrench drug using behaviour. The YEP service has been able to assertively follow up those young people who have not been able to access services by providing immediate treatment and support. As highlighted by Jane's story above, the YEP model engages young people with other agencies that provide support. The program also enables assertive follow-up and engagement of young people unable to maintain relationships with other drug treatment providers.

Clients of YEP include Indigenous young people, pregnant young women, young parents and those involved in the justice system. Young people also present with a range of complex co-morbidities including mental health issues and Acquired Brain Injury (ABI). Often these young people are distrusting of services and regularly speak of stigmatisation and discriminatory experiences when interacting with health professionals. Working with such client groups requires specialist skills and a considerable time commitment to assess treatment needs and develop Individual Treatment Plans (ITPs) appropriate to cultural backgrounds.

Goals are agreed with clients through development of ITPs after a comprehensive assessment. This plan specifies the nature of contact outreach workers will have with the young person and sets out their issues and goals as well as the steps or tasks required for reaching each goal.

Outreach workers structure their contact with young people based on the ITP and the circumstances and presentation of the individual. For example, following an episode of care the outreach worker may only have contact fortnightly with some additional telephone contact if the client's needs are moderate. However, if a client is in distress, workers may have daily contact, including assertive street-based interventions. Some young people may present at the service on a daily basis to check in on their health or for a homeless young person they may be contacted via street outreach.

The nature of assertive outreach means that the total number of clients engaged with the program at any given time can vary considerably. From July 2008 to December 2009 the concurrent caseload fluctuated from 18 to 32 with the average concurrent case load of 27 substantially exceeding the anticipated caseload (20) on inception of YEP.[39]

Significant treatment goals

The outcomes of YEP are measured against defined Significant Treatment Goals (STGs), taken directly from the ITPs developed, and relate to the range of outcomes that improve the health and wellbeing of the young person.

An evaluation of the YEP conducted by Deakin University shows that between July 1, 2008 and January 1, 2010 a total of 538 STGs were

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39 McKenzie et al. 2010.

achieved by clients with only 24 referred clients failing to achieve an STG in this time. On average, each client engaged with YEP achieved 3.04 STGs in this 18-month period. Reduced substance use indicators account for almost half of all STGs recorded (45%). The other STGs achieved show further improvements against social determinants of health including improved level of connectedness (19% of the total), improved physical health indicators (15%), improved emotional and psychological wellbeing indicators (15%), and reduced crime indicators (6%).[40]

Reduction in substance use, improved physical health, and improvements to emotional and psychological wellbeing are all encouraging results but it is usually the personal stories of achievement which best illustrate the importance of addressing social determinants of health.

Rebuilding family ties

Daniel was 23 when he was referred to YEP through the Barwon Health Community Mental Health Service, where he was seeking support for depression due to a relationship breakdown. Daniel's ex-partner had moved out of the region and taken their 15-month-old son with her.

Daniel had developed a dependent use of cannabis over the previous seven years due to ongoing pain associated with injuries caused by a serious motorbike accident at the age of 16.

Daniel was assigned an AOD outreach worker through YEP, who arranged weekly appointments with him. Significant Treatment Goals were aimed at stopping cannabis smoking and undergoing a withdrawal in a residential service in order to manage his pain issues. Daniel also received support to access legal advice regarding custody and access to his son, as well as referrals to parenting programs.

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[40] McKenzie, S et al. 2010.

Having completed a residential detoxification and accessing treatment for his leg through acupuncture and massage sessions. Daniel also gained access to his son three times a fortnight.

Social outreach and advocacy services

Stories like these are common throughout the social outreach and advocacy services operated by St John of God Health Care. Many of these services are operated solely by St John of God Health Care but the organisation is acutely aware that working in partnership is an essential element of tackling the social determinants of health, as demonstrated by the success of partnering with Barwon Youth to develop the YEP.

Developing early intervention services for young people has become a key strategic focus of the social outreach and advocacy services, partly because St John of God Health Care has existing expertise in this area. Recognition of the positive impact these services can have in the long term was another factor guiding this growth strategy as well as the identification of a long standing gap in service provision. The 2007 National Survey on Mental Health found that one in four young people aged 16 to 24 had experienced a mental health issue in the preceding 12 months.[41]

Early intervention methods often result in effective management of mental health issues, giving young people a better quality of life, or at least prevent further deterioration in identified mental health issues. Preventing chronic psychological disorders from developing reduces the need to engage with mental health services over the long term whilst distress caused to the client is also decreased.

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[41] AIHW. 2011. Young Australians—their health and wellbeing 2011.

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Partnering for a positive future

Drug and alcohol, mental health and dual diagnosis services need to address a wide range of issues to be effective. Personal, cultural and financial circumstances are key factors determining health and wellbeing as are relationships, education and employment. Addressing a single issue presented by a client in isolation often misses the opportunity to treat the person in an holistic way, decreasing the scope to improve health and wellbeing over the long term.

Another example of this approach is demonstrated by Horizon House. One of the social outreach and advocacy services operated by St John of God Health Care, Horizon House provides long-term accommodation and support for young people who are at risk of homelessness. Horizon House does not only provide a place to stay but ongoing support for education, training and employment as well as regular access to counselling and mental health support. The model of care gives young people the opportunity to develop life skills while accessing the health interventions they need to get on a positive pathway to independent adult life.

There is no maximum amount of time that a young person can stay in the home-like environment of the nine Horizon Houses across Western Australia and Victoria. And ongoing evaluation of life skills shows that the longer a resident stays in the home, the greater their improvement. In 2010 those living in Horizon House for up to 18 months showed an improvement in life skills of more than 40 per cent while those who had been living in Horizon House for more than two years showed improvements well in excess of 50 per cent.

Vitally important for the success of Horizon House is a full understanding of the reasons why young people access the service and the various factors at play. This model of care has had many successes and further contact with those who have left Horizon House helps ensure that the young people don’t return to homelessness after leaving this supportive environment.

A central theme for growing social outreach and advocacy services aimed at young people is to partner with various organisations in order to deliver early intervention. Services utilising a whole-of-person approach have a much higher chance of producing positive long-term outcomes in improving health and wellbeing and that usually requires the involvement of various agencies.

This approach is not dissimilar to that of headspace and it is important to note that headspace centres are usually consortia of other agencies partnering to improve mental health and wellbeing for young people. These consortia are made up of clinical providers, education services, local government, and various not for profit organisations. The importance of this framework is that it provides a network of support to provide pathways for young people in an holistic way.

Effectively tackling the social determinants of health pertinent to young people requires effective partnerships between a variety of agencies in the medical, social health, government, not-for-profit and corporate sectors. In delivering essential improvements to the long-term health and wellbeing of our young people it is vital that we work collaboratively in effective, efficient partnerships.

References

Australian Bureau of Statistics (2006). Australian Census Analytic Program, Counting the Homeless Australia 2006.

Australian Institute of Health and Welfare (2011). People turned away from government-funded specialist homelessness accommodation 2009–10.

Australian Institute of Health and Welfare (2011). Young Australians—their health and wellbeing 2011.

Larner, G. (2004). Family therapy and the politics of evidence. *Journal of family Therapy* 17-39.

McKenzie, S; Droste, N; Miller, P (2010). Evaluation of Barwon Youth's Youth Engagement Program May 2010.

3

Health inequalities in Australians of working age

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Continuing progress in health

Australia's health today compares well from historical and global perspectives. In the past 100 years, life expectancy at birth has increased by approximately 25 years. Boys and girls born in Australia at the beginning of the 20th Century could expect to live, on average, about 55 and 59 years respectively. Boys and girls born today can expect to live 79 and 84 years respectively.[42] These are extraordinary gains in survival with progress in health occurring across the entire life cycle—infants, children and adults all have higher survival rates than in the past.

At the international level, a child born in Afghanistan has a life expectancy of only 44 years, the lowest life expectancy in the world. A dozen African countries such as Lesotho, Zimbabwe, Swaziland, and Zambia all have life expectancies of less than 50 years of age.[43] These life expectancies are worse than those in Australia 100 years ago. Today four out of 1000 babies born in Australia may die before their first birthday compared to rates as high as 134 of 1000 babies born

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[42] ABS. 2010.

[43] World Bank. 2010.

in Afghanistan.[44] A worldwide study of adult mortality estimated that in 2010 the probability of dying between the ages of 15 and 60 years was 4.4 per cent for females and 7.6 per cent for males in Australia. These rates place Australia in the top 10 countries in the world for life expectancy over the working-age for both women and men, and are 100-fold lower than the risk of mortality reported in many developing countries.[45]

The continuing progress in Australia's health is underpinned by improvements in physical living conditions such as: sanitation, water supply and housing; changed lifestyles and improved socio-economic well-being including nutrition, schooling, workforce participation, backed up by national and household economic prosperity; and better access to health care. However, despite being a world leader in health achievement, not all Australians enjoy the same level of health. Socio-economic inequalities in the health of Australians of working age are examined in the remainder of this essay.

Social determinants of health

Among those Australians who do not enjoy good health are those of low socio-economic status, and especially those Australians who are the most socially and economically disadvantaged within our society. A large gap remains between the health of Indigenous Australians and that of other Australians. The fact that Indigenous Australians survive 10 to 12 years less than non-Indigenous people[46] sums up the health condition of the Indigenous population in Australia. But the story does not end here. Even in the Australian population in general, socially disadvantaged people fair poorly. Why in an economically prosperous country, such as Australia, should one's health depend on one's wealth and social standing?

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[44] World Bank. Ibid.

[45] Rajaratnam, JK et al. 2010.

[46] ABS. 2009.

This question has been attracting attention internationally. Essentially, diseases and ill-heath are outcomes of the conditions in which people are born into and live. The World Health Organisation's Commission on Social Determinants of Health (CSDH) states:

> … inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces … Social and economic policies have a determining impact on whether a child can grow and develop to its full potential and live a flourishing life, or whether its life will be blighted.[47]

Thus, social inequalities in health arise because of the inequalities in the conditions of daily life under which we are born, develop as young children, grow into teenage years and adulthood, and live into old age. The material and social circumstances under which we live are in turn shaped by the unequal distribution of money, power and resources at both the national and local levels. We have different access to household goods and services, to health care, schools and higher education, conditions of work and leisure, housing and community resources, and different opportunities to lead flourishing and fulfilling lives.[48,49] These determinants of health can be described as a 'web of causes' or as part of broad causal 'pathways' that affect health.[50]

It should not be surprising that health inequalities persist—'persisting inequalities across key domains provide ample explanation: inequalities in early child development and education; employment and working conditions; housing and neighbourhood conditions; standards of living; and, more generally, the freedom to participate equally in the benefits of society'.[51] While this was written with respect

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[47] CSDH. 2008.

[48] Turrell, G et al. 1999.

[49] Baum, F. 2008.

[50] AIHW. 2010.

[51] Marmot, M et al. 2010, p17.

to England, this equally applies to Australia.

The social determinants of health span the life course. Education, employment and income are the most commonly used measures of socio-economic status[52], but a number of other factors have been identified as important social determinants of health. These include: early life (poor intrauterine conditions and early childhood experiences); living conditions/housing; working conditions; social exclusion and discrimination; social support/social safety net; stress and violence; and food security.[53,54,55,56,57,58] Lifestyle or behavioural risk factors such as poor diet, drug addiction, tobacco smoking, and lack of exercise or alcohol misuse are also often regarded as social determinants of health.

Health disparities in Australians of working age

Australia's working age population is diverse in its socio-economic characteristics. Data from the 2008 Household Income and Labour Dynamics in Australia (HILDA) survey[59] shows that nearly 14 per cent of persons of working age lived in Australia's poorest 20 per cent of households.[60] One of every four Australians aged between 25 and 64 years had left high school before completing year 12. One in eight individuals lived in a jobless household, ie a household where no adult was in paid employment. Over 500 000 Australians of working age lived in public rental accommodation and over 20 per cent experienced a low level of social connectedness, expressed in terms of gathering infrequently with friends or relatives, having no

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[52] AIHW. 2010.

[53] National Public Health Partnership. 2001.

[54] Marmot, M and Wilkinson, R. 2003.

[55] Raphael, D. 2004.

[56] Laverty, M. 2009.

[57] Marmot, M et al. 2010.

[58] CSDH. 2008.

[59] Watson, N. 2010.

[60] Defined by annual disposable (after-tax) household income including government transfers (government benefits) in the past financial year where income is equivalised to household size and structure, and is reported by quintile.

one or struggling to find someone to confide in at difficult times, and often feeling lonely.[61]

Health inequalities exist for Australians of working age with social gradients in health being common, ie the lower a person's social and economic position, the worse his or her health is. The health gaps between the most disadvantaged and least disadvantaged socio-economic groups are often very large. For example, one in ten 25–44 year old Australians and over one in five aged 45–64 years report they have poor health.[62] However, those who are most socio-economically disadvantaged are much more likely to report being in poor health compared with those who are least disadvantaged (Table 1).

Table 1: Per cent of persons reporting poor health, by sex, age and socio-economic disadvantage

	Men				**Women**			
	25-44 years		**45-64 years**		**25-44 years**		**45-64 years**	
	Most[a] Disadv	Least[b] Disadv	Most Disadv	Least Disadv	Most Disadv	Least Disadv	Most Disadv	Least Disadv
Income	23	7	49	13	22	8	47	14
Education	18	7	34	15	14	7	28	12
Employment	37	9	50	18	30	9	43	16
Housing	30	8	54	22	28	9	55	17
Social connectedness	18	6	29	18	19	6	35	14

a.Most disadvantaged is defined as: lowest income quintile, left school before completing year 12, living in a jobless household, living in public rental accommodation, experiencing a low level of social connectedness.

b. Least disadvantaged is defined as: highest income quintile, having a tertiary educational qualification, not living in a jobless household, home-owner, experiencing a high level of social connectedness.

Source: Brown and Nepal, 2010.

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[61] Brown, L and Nepal, B. 2010

[62] The five standard levels of self-assessed health status have been collapsed into two: 'good health' and 'poor health' where 'good health' includes excellent, very good and good health; and 'poor health' refers to fair and poor health.

Around half of men and women aged 45–64 years who are in the poorest 20 per cent of households by income, or live in households where no member is in paid work, or live in public rental accommodation report their health as being poor. These men and women are 2.5 to 3.5 times more likely to report having poor health compared with those who are least socio-economically disadvantaged. The greatest inequality for both males and females occurs between those in the bottom versus the top household income quintile. Women aged between 45 and 64 years and who live in public rental are also over three times more likely to report being in poor health compared to women living in their own home.

About one in three individuals aged 45–64 years who left secondary school before completing high school or who were least socially connected assessed their health as being poor. These individuals are 1.5 to 2.5 times more likely to report having poor health compared with those who are least socio-economically disadvantaged.

In the younger working age group, around 15 to 30 per cent of the most socio-economically disadvantaged individuals report having poor health compared with only 5 to 10 per cent of those who are least disadvantaged. This group of disadvantaged Australians are 2 to 4 times more likely to report being in poor health than those who are least socio-economically disadvantaged. The greatest inequality occurs for both males and females living in jobless households compared to those living in households where at least one member is in paid employment. This is closely followed by housing tenure inequalities with three of every ten 25–44 year olds living in public rental accommodation ranking their health as being poor, compared with only one in ten living in their own home.

Likewise, around 15 per cent of all Australians aged 25–44 years and a third of those aged 45–64 years report that they have at least one long term health condition or disability that affects their everyday activities. Those who are most socio-economically disadvantaged are twice as likely as those who are least disadvantaged to have a long term health condition, and for some disadvantaged younger males of working age (those in the bottom income quintile or living in jobless households) up to four to five times as likely.[63] Around 45 to 65 per cent of persons living in public rental accommodation have long term health problems compared to only 15 to 35 per cent of home-owners. Over 60 per cent of men in jobless households report having a long term health condition or disability, and over 40 per cent of women.

Using smoking as one example of lifestyle risk factors for health, less than 20 per cent of Australian adults of working age now smoke but rates of smoking are much higher in socio-economically disadvantaged especially those aged 25–44 years. A third to two-thirds of the most disadvantaged males and females aged 25–44 years are current smokers, depending on the socio-economic indicator studied. The most discriminating factors for smoking are level of education, followed by housing tenure for females and household income for males and females. The most disadvantaged 25–44 year olds in terms of educational qualifications, housing tenure and income are two to four times more likely to be current smokers than the most advantaged groups.

Household income, level of education, household employment, housing tenure and social connectedness all matter when it comes to health. But does where people live also matter and are those who are most socio-economically disadvantaged dying earlier than those who are better-off? Work by the Victorian Department of

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[63] Brown, L and Nepal, B. 2010.

Health[64] indicates that Australians born and living in socially more disadvantaged communities have shorter lifespans than those born and raised in the least disadvantaged areas. Across local government areas of Victoria, the life expectancy of males born and raised in the most disadvantaged areas was nearly 3.5 years less than those born and living in the least disadvantaged areas and for females there was a gap of two years in life expectancy.

When death rates for the period 2005–07 for the statistical local area (SLA) populations across Australia also are compared by the ABS Index of Relative Socio-economic Disadvantage[65] then the median SLA death rate for Australians aged 25–45 years living in the most disadvantaged one-fifth of areas is 2.7 times higher than that for 25–44 year olds living in the most advantaged 20 per cent of areas. While death rates rise for those aged 45–64 years, the median SLA death rate for individuals in this older age group living in the most disadvantaged quintile of areas is still double that for those living in areas in the top quintile. If the populations of the most disadvantaged areas had the same death rate as those living in the most socio-economically advantaged areas then around a half to two-thirds of current deaths of Australians of working age living in disadvantaged communities would not occur.[66]

While mortality rates in the working age population have fallen substantially over time there remain major socio-economic inequalities in the risk of dying. An estimate by the Australian Institute of Health and Welfare showed that between the period 1966 and 2001, mortality rates for males aged 20–59 years decreased steadily but death rates remained consistently higher for men engaged in manual jobs than those in non-manual work.

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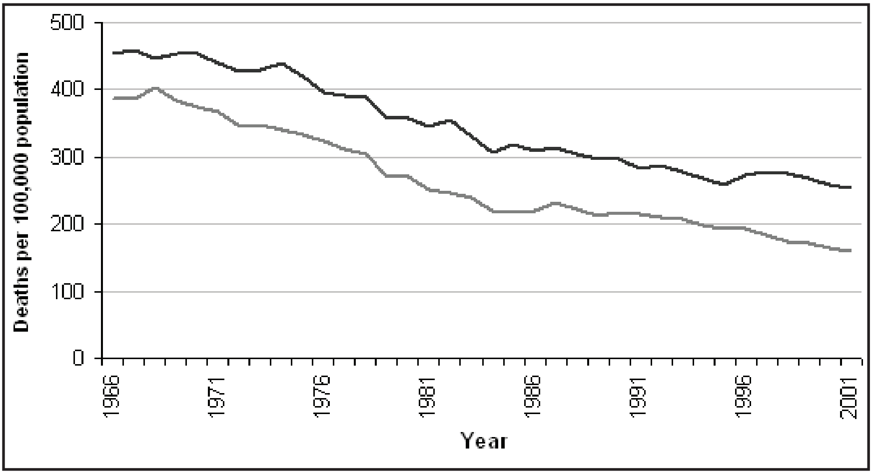
[64] Victorian Department of Health. 2010.

[65] ABS. 2008.

[66] Brown, L and Nepal, B. 2010.

Figure 1: Age-standardised mortality rates among males aged 20-59, 1966–2001.



Source: de Looper and Magnus, 2005.

Conclusions

Australia has made impressive progress in its state of health over time and compares very well among the nations of the world. Despite its overall level of health being very sound, there are substantial health disparities between socio-economically disadvantaged and advantaged Australians of working age. These inequalities need to be understood within the context of a range of factors that interact in complex ways—does a person have enough money to live healthily, to live in decent housing, with a good level of knowledge and understanding, support from family and friends, and to eat and drink healthily and take sufficient exercise and not smoke?

The health inequalities reported in this essay have not arisen by chance and cannot simply be attributed to genetic makeup or difficulties in accessing health care. The Commission on Social Determinants of Health argues that the:

> Unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.[67]

Professor Michael Marmot and colleagues on the English Strategic Review of Health Inequalities in England post-2010 stated that:

> The fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair. Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health.[68]

This is no less true for Australia. Taking action to reduce inequalities in health does not require a separate health agenda but action across the whole of society.[69]

Australia's Social Inclusion Agenda provides an opportunity to address social determinants of health and the health inequalities that persist within the population. The Australian Government's vision of a socially inclusive society is one in which all Australians feel valued and have the opportunity to participate fully in the life of our society. The magnitude of health inequalities is a good marker of progress towards creating a more just and socially inclusive Australia.

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67 CSDH. 2008, p.1.
68 Marmot, M et al. 2010, p37.
69 Marmot, M et al. 2010.

References

Australian Bureau of Statistics (2010) *Deaths, Australia, 2009*, cat no. 3302.0, ABS, Canberra.

Australian Bureau of Statistics (2009) *Experimental life tables for Aboriginal and Torres Strait Islander Australians, 2005-2007,* cat. no. 3302.0.55.003, ABS, Canberra.

Australian Bureau of Statistics (2008) *An Introduction to Socio-Economic Indexes for Areas* (SEIFA) 2006. Information Paper, cat. no. 2039.0, ABS, Canberra.

Australian Institute of Health and Welfare (2010) *Australia's health 2010,* Australia's health series no. 12, cat. no. AUS 122, AIHW, Canberra.

Baum, F. (2008) *The New Public Health*, Oxford University Press, 3rd edition, Melbourne.

Brown, L. and Nepal, B. (2010) Health lies in wealth: Health inequalities in Australians of working age. Available at www.cha.org.au/site.php?id=15.

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

de Looper, M and Magnus, P. (2005) Australian health inequalities 2: trends in male mortality by broad occupational group. Bulletin no. 25. AIHW cat. no. AUS 58, AIHW, Canberra.

Laverty, M. (2009) *The central place of Health in Australia's Social Inclusion Agenda: Addressing the social determinants of health to achieve social inclusion*, Policy Paper, Catholic Health, Canberra.

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M. and Geddes. I. (2010) *Fair Society, Healthy Lives—the Marmot Review*, Strategic Review of Health Inequalities in England post-2010, London.

Marmot, M. and Wilkinson, R. (eds) (2003) Social Determinants of Health: The Solid Facts, World Health Organisation, Geneva.

National Public Health Partnership (2001) *Preventing Chronic Disease: A Strategic Framework*, Melbourne.

Rajaratnam, J.K., Marcus, J.R., Levin-Rector, A., Chalupka, A.N., Wang, H., Dwyer, L., Costa, M., Lopez, A.D. and Murray, C.J.L. (2010), Worldwide mortality in men and women aged 15-59 years from 1970 to 2010: a systematic analysis, *Lancet*, vol. 375, no. 9727, pp. 1704-1720.

Raphael, D. (2004). *Social Determinants of Health: Canadian Perspectives*, Canadian Scholar's Press, Toronto, Canada.

Turrell G., Oldenburg B., McGuffog I. and Dent R. (1999) *Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda*. Queensland University of Technology, School of Public Health, Ausinfo, Canberra.

Victoria Department of Health (2010) Life expectancy at birth: Victoria 2003 - 2007, available at www.health.vic.gov.au/healthstatus/le-03-07.htm, Accessed 1 July 2010.

Watson, N. (ed) (2010) *HILDA User Manual—Release 8*, Melbourne Institute of Applied Economic and Social Research, University of Melbourne.

World Bank (2011) World Development Indicators, available at data.worldbank.org/indicator.

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The social and cultural determinants of Aboriginal and Torres Strait Islander health and the human rights-based approach of the Close the Gap Campaign for Indigenous health equality

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Close the Gap Campaign for Indigenous Health Equality

Building on the efforts of Aboriginal and Torres Strait Islander health activists working since the late 1960s, the Close the Gap Campaign for Indigenous Health Equality (CTG) has mobilised behind a right to health based approach to achieving Aboriginal and Torres Strait Islander health equality.

The CTG goal is to close the health and life expectancy gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians within a generation. It aims to do this through the adoption by Australian governments of a comprehensive national plan of action that is properly resourced and that has the goal of achieving health equality by 2030.

This would be developed and implemented in partnership with Aboriginal and Torres Strait Islander peoples and their representatives. It would contain targets focusing on a wide range of health conditions, health services and the social and cultural determinants of health, where possible and practical.

The CTG approach is based on the human rights framework around health. As such it draws on the legal obligations Australia has adopted by virtue of being a state-party to international human rights instruments. These are discussed in the text box at the end of this article.

A major focus of the CTG approach is on the specific right to health-subject matters: (a) health services (hospitals, primary health care, and health education, promotion and preventative health services); and (b) goods that support good health (adequate food, potable water supplies, sanitary living conditions and so on). It also includes an address to the social and cultural determinants of Indigenous health inequality.

A brief history of the Close the Gap Campaign

The CTG human rights based approach was first set out in the Aboriginal and Torres Strait Islander Commissioner's *Social Justice Report 2005*.[70] In March 2006, the Commissioner convened the first meeting of the Campaign Steering Committee, with membership based on support for this approach. It is not an exaggeration to say the campaign is actively supported by almost every national-level

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[70] The relevant chapter has been re-issued as: Aboriginal and Torres Strait Islander Social Justice Commissioner, *Achieving Aboriginal and Torres Strait Islander Health Equality within a generation,* Human Rights and Equal Opportunity Commission, Sydney, 2006, for a full explanation of the human rights basis for the Close the Gap Campaign. See: www.humanrights.gov.au/social_justice/health/health_summary.html.

Indigenous and mainstream health peak body.[71]

Following the election of the Rudd Government in 2007, elements of the CTG campaign became government policy (following their adoption in the Labor Party's election platform).[72] In December 2007, the Council of Australian Governments adopted a target to achieve Aboriginal and Torres Strait Islander life expectancy equality with a generation. This was supported by a target to halve the mortality rate of under-five year old Aboriginal and Torres Strait Islander children within ten years. By mid-2009, a total of six COAG 'closing the gap' targets had been announced.

The CTG *National Indigenous Health Equality Summit* was held in March 2008. It culminated in the Prime Minister, the Minister for Health and Ageing, the Minister for Families, Housing, Community

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[71] Members of the Campaign Steering Committee are: Australian Indigenous Doctors' Association; Australian Indigenous Psychologists' Association; Congress of Aboriginal and Torres Strait Islander Nurses; Indigenous Allied Health Australia Inc; Indigenous Dentists' Association of Australia; National Aboriginal Community Controlled Health Organisation; National Aboriginal and Torres Strait Islander Drug Alcohol Committee, National Association of Aboriginal and Torres Strait Islander Physiotherapists; National Aboriginal and Torres Strait Islander Health Workers' Association; Australian General Practice Network; Aboriginal Health and Medical Research Council; Australian Human Rights Commission (Secretariat); Australian Medical Association; Australians for Native Title and Reconciliation; Australian Peak Nursing and Midwifery Forum; Bullana–the Poche Centre for Indigenous Health; The Fred Hollows Foundation; Heart Foundation Australia; Menzies School of Health Research; Oxfam Australia; Palliative Care Australia; Royal Australasian College of Physicians; and the Royal Australian College of General Practitioners.

[72] Clarification on the use of the terms 'Close the Gap' and 'Closing the Gap' in the Indigenous affairs space: 'Close the Gap' was adopted as the name of the Campaign for Indigenous Health Equality in 2006. In August 2007, 'closing the gap' entered the policy lexicon and has since been used to tag many different Indigenous policy initiatives from the *National Partnership Agreement to Closing the Gap on Indigenous Health Outcomes* to the renaming of aspects of the Northern Territory Emergency Response (the intervention) as *Closing the Gap in the Northern Territory.* As a general rule, any initiative with 'Closing the Gap' in the title is an Australian Government initiative. It is important to note that it does not necessarily reflect the human rights based approach of the Close the Gap Campaign as set out in these papers, nor does the use of the term 'closing the gap' in relation to these initiatives necessarily reflect an endorsement of them by the Close the Gap Campaign Steering Committee.

Services and Indigenous Affairs, and the federal opposition leader signing the *Close the Gap Statement of Intent* with Indigenous health leaders. The Statement of Intent has since been signed by almost all the governments and oppositions at the state and territory level. It contains the following commitments:

- To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non- Indigenous Australians by 2030.
- To ensuring primary health care services and health infrastructure for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gap in health standards by 2018.
- To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.

In the three years since the CTG Summit great change has taken place within the Aboriginal and Torres Strait Islander health, mainstream health and Indigenous affairs space. The Australian Government has acknowledged that the CTG has provided a significant impetus for the seven ‘closing the gap’ National Partnership Agreements (NPA) associated with the National Indigenous Reform Agreement. These have brought with them over five billion dollars in additional resources, not the least being the $1.6bn *NPA on Closing the Gap in Indigenous Health Outcomes*.

While progress has been slow, movement towards the development of a plan for Indigenous health equality and a partnership approach is now occurring within the Australian Government.

Social and cultural determinants

The total body of human rights are understood as inter-related and indivisible: one right cannot be denied without impacting on other rights. In the context of health, this holistic approach is supported by social determinants literature: the associations between education level, employment (income) and better or worse health are well documented and uncontroversial to Australian governments. For example, the *Close the Gap Statement of Intent* contains a commitment to:

> Working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples.

The poverty of many Indigenous Australians and their communities must be addressed if health equality is to be achieved. For decades now, research has clearly demonstrated associations between an individual's social and economic status and their health.[73] As such, CTG advocate for improvements to Indigenous education and employment outcomes as part of an overall address to health inequality.

Because the social determinants of Indigenous health have been widely discussed in other fora, we have chosen to focus here on the cultural determinants of Indigenous health. This does not indicate, however, a lack of value being placed on social determinants' subject matters, nor on health services and the goods that support good health by CTG. An overall address to all these factors is required if Indigenous health equality is to be achieved within a generation.

Cultural determinants can be understood as the social determinants of health that are unique to Aboriginal and Torres Strait Islander peoples/indigenous peoples in both positive terms (ie the positive

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[73] See generally - Editors, Marmot, M. and Wilkinson, R., *Social Determinants of Health*, Oxford University Press, New York, 1999.

health impacts and resilience associated with membership of strong cultures); and negative terms (for example, as resulting from racism). Cultural determinants must be acknowledged and addressed as a part of any national effort to achieve Indigenous health equality and should be—where possible—included in the scope of a plan for health equality.

In relation to Aboriginal and Torres Strait Islander peoples, it may be that the lack of *collective control* acts as a determinant of poorer health. Population groups that have less financial and other forms of control over their lives are associated with high levels of unhealthy physical and mental stress.[74] This occurs where 'prolonged exposure to psychological demands where possibilities to control the situation are perceived to be limited and the chances of reward are small'.[75] Chronic stress has physical and mental health impacts. Physically it can impact on the body's immune system, circulatory system, and metabolic functions through a variety of hormonal pathways and is associated with a range of health problems from diseases of the circulatory system (notably heart disease).[76] Mentally, it is associated with mental health problems[77] through to related problems such as men's violence against women and other forms of community dysfunction.[78] Regrettably, these symptoms have been noted too often in many Indigenous communities, both in Australia and internationally.

The control factor supports the CTG's call for a partnership approach to underpin the development and implementation of a plan

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[74] Shaw, M, Dorling, D. and Davey-Smith, G., 'Poverty, social exclusion, and minorities', in Editors, Marmot, M. and Wilkinson, R., *Social Determinants of Health, op cit.*, pp32-37.

[75] Brunner, E, Marmot, M, 'Social Organization, stress and health', in Editors, Marmot, M. and Wilkinson, R., *Social Determinants of Health op.cit*, p17.

[76] Ibid, pp32-37.

[77] Marmot, M., 'Health and the psychosocial environment at work', in Editors, Marmot, M. and Wilkinson, R., *Social Determinants of Health*, *op.cit.*, p124.

[78] Wilkinson, R., 'Prosperity, redistribution, health and welfare', in Editors, Marmot, M. and Wilkinson, R., *Social Determinants of Health*, *op.cit.*, pp260-265.

for Aboriginal and Torres Strait Islander peoples' health equality, and for Indigenous communities' control of their health services (see text box below).

Aboriginal and Torres Strait Islander peoples have long asserted that their health is linked to their collective ability to control their lives and cultures and the recognition of their rights as have Indigenous peoples around the world. In the *National Aboriginal Health Strategy*, Aboriginal and Torres Strait Islander peoples linked their health to 'control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.[79]

The CTG supports the empowerment of Aboriginal and Torres Strait Islander peoples in all contexts as having potentially beneficial health impacts, be this through the protection of identity, languages and culture, the recognition of Indigenous rights, or constitutional change that protects Indigenous rights.

Recent studies have also found associations between access to traditional lands, the practice of culture and improved health status in Indigenous peoples, particularly where that land is both culturally significant and provides sources of food and potable water.

A significant proportion of Aboriginal people—around 25 per cent—still live in remote and very remote areas—on homelands. But homelands play a significant cultural role even for those who do not live on them. In addition to the 25 per cent living on homelands, 46 per cent of Aboriginal Australians recognised homelands but did not live on them according to a 2008 social survey carried out by the Australian Bureau of Statistics among almost 10 000

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[79] National Aboriginal Health Strategy Working Group, *National Aboriginal Health Strategy,* AGPS, Canberra, 1989, ppix and xiii.

Indigenous Australians.[80]

Torres Strait Islander people were less likely to live on homelands (17%) but more likely overall to live on or recognise homelands than Aboriginal people (76% compared with 72%).[81]

Two important studies have compared the health of the residents of the remote Utopia communities and urban based Indigenous people in the Northern Territory. The first found health benefits associated with the more active outstation lifestyle, its higher reliance on bush foods, and relative isolation from readily available alcohol.

A follow up study confirmed these results, but also looked at the social determinants of health to see if they might explain the difference. However, on all the usual measures—unemployment, low income, overcrowding, lack of education—Utopia fared somewhat worse than the Northern Territory Indigenous average; obviously if their health was better than average it was not due to the usual social determinants of health.

Instead, the researchers concluded that outstation living with a better diet and greater physical activity, plus living more harmoniously with culture, family and land contributed to better health.[82]

Strong culture has been associated with better health in other studies. The 2005 Telethon Institute's *Western Aboriginal Child Health Survey* of approximately 5000 Indigenous children, for example, found that those growing up in remote communities

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80 Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander peoples - an overview 2011*, Cat. no. IHW 42. Canberra: AIHW, p44.

81 As above.

82 They also importantly identified the existence of the community-controlled Aboriginal Medical Service, and its provision of outreach (rather than just centre-based) care and chronic disease management and prevention programs such as well-person's health checks as an important contributor to better health. McDermott, R., K. O'Dea, et al. (1998). '*Beneficial impact of the Homelands Movement on health outcomes in central Australian Aborigines*'. ANZJPH 22: 543-658.

had significantly better social and emotional well-being than those growing up in non-remote settings. The health of their cultures, protected as they were by remoteness, was identified as an ameliorating factor against stressors that otherwise impacted negatively on the health well-being of Aboriginal children.[83]

In March 2011 a study published by the Centre for Remote Health reported not only that diabetes, renal diseases and hypertension were significantly improved by involving traditional owners in caring for country, but also that these activities could be expected save millions of health-dollars in these communities over time.[84] These are savings that could be used to support access to primary health care or locally driven anti-smoking initiatives in these communities, to provide but two alternatives. They have the potential to drive a virtuous health and health-spending cycle in other words.

The Close the Gap Campaign believes that the recognition and protection of the identity, rights, cultural heritage and traditional lands of Aboriginal and Torres Strait Islander people can play a significant role in the achievement of Indigenous health equality.

While not ignoring the vital importance of practical measures—medical services, housing, healthy food supplies and so on—it believes that a holistic and empowering approach that reduces the impact of negative cultural determinants (such a racism) and strengthens the support provided by culture, language and land is vital in any overall national effort to achieve health equality. That is the strength of the human rights based approach the Close the Gap Campaign advocates for.

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[83] Telethon Institute for Child Health Research, *The Social and Emotional Wellbeing of Aboriginal Children and Young People,* Perth , Summary, 2005, p.8.

[84] Campbell D, Burgess CP, Garnett ST, Wakerman J, *Potential primary health care savings for chronic disease care associated with Australian Aboriginal involvement in land management*, Health Policy. 2011 Jan;99(1):83-9. Epub 2010 Aug 13.

How the right to health operates in Australia in relation to Aboriginal and Torres Strait Islander peoples' health inequality

Australia is a signatory to the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) (1966). Article 12 is the primary expression of the right to health in human rights law. It states that everyone has the right to 'enjoy the highest standard of physical and mental health'.[85]

This obligation is met by ensuring or providing *opportunities to be healthy*. These opportunities are generally understood as being delivered by (a) health services (hospitals, primary health care, and health education, promotion and preventative health services) and (b) goods that support good health (adequate food, potable water supplies, sanitary living conditions and so on).[86]

Non-discrimination is a fundamental element of human rights law. In relation to the right to health, the non-discrimination principle obliges a state to ensure or provide *equal opportunities* to be healthy regardless of race, sex, etc. In practice this means that all citizens should have equal access to health services, and enjoy equal access to an equal standard (in terms of their capacity to facilitate healthy living) of food supplies, housing and so on. A state that does not provide equal opportunities to be healthy among its citizens is legally required by the ICESCR to institute a response referred to as 'progressive realisation'.[87] In a nutshell, this means it must ensure any disadvantaged group is given the

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[85] For a detailed examination of the obligations attaching to the right to health see: United Nations Committee on Economic, Social and Cultural Rights, General comment 14 (2000): The right to the highest attainable standard of health (article 12 of the *International Covenant on Economic, Social and Cultural Rights*), UN Doc E/C.12/2000/4, 11 August 2000.

[86] Note that many of these are the subject matters of human rights apart from the right to health. For example: the right to food, clothing and housing is found in Article 11 of the ICESCR.

[87] Article 2(1) *International Covenant on Economic, Social and Cultural Rights*.

chance to 'catch up'[88] to the rest of the citizenry in terms of the opportunities to be healthy available to them.

For a state's response to qualify as 'progressive realisation' it must satisfy certain technical requirements:

- The foundation of the response must be an ambitious but realistic plan to achieve equality of opportunity for the disadvantaged group.
- That the plan is properly resourced.
- Equality of opportunity targets and benchmarks must be a part of the plan in order to enable the monitoring of progress and provide for accountability for the achievement of the plan (and by this, equality of opportunity).
- That progress towards equality of opportunities actually occurs (as measured against baselines).

Aboriginal and Torres Strait Islander peoples' right to self-determination must be factored into any articulation of their rights in policy, including their right to health. Self-determination has many dimensions[89] but in the context of health planning it requires that Aboriginal and Torres Strait Islander peoples and their representatives have the opportunity to be fully involved in (a) planning for health equality and (b) implementing that plan. CTG understand self-determination in this context in terms of a partnership between Aboriginal and Torres Strait Islander peoples, their representatives

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[88] Australia is also signatory to the *International Convention on the Elimination of All Forms of Racial Discrimination* (ICERD) (1965). In cases of gross inequality along racial lines in relation to social and economic rights' subject matters (for example: health, housing, education), the ICERD obliges states to enact *special measures*: forms of differential treatment (a 'catch up') aimed at achieving substantive equality or equality 'in fact' or outcome for the disadvantaged race. This 'catch up' also goes beyond, ensuring equality of opportunity in relation to the enjoyment of human rights into the future. It also aims to address past injustice. For example: the higher rates of chronic disease among Aboriginal and Torres Strait Islander peoples are significantly the result of historical neglect and racial discrimination. Using our example, specific chronic disease measures would therefore be appropriate in order that the rates of chronic disease between the Aboriginal and Torres Strait Islander population and the non-Indigenous population level out.

[89] The right of self-determination is Article 1 of the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (ICESCR). For a discussion of self-determination, see Aboriginal and Torres Strait Islander Commissioner, Social Justice Report 2002 (Chapter 2), Human Rights and Equal Opportunity Commission, Sydney, 2002. Available online at: humanrights.gov.au/social_justice/sj_report/sjreport02/chapter2.html.

and Australian governments.

Self-determination also requires that, wherever possible, Aboriginal and Torres Strait islander peoples control the services that deliver health programs and so on to them. Aboriginal Community Controlled Health Services (ACCHS) have existed for over 40 years in Australia. Controlled by the communities they serve, ACCHS are an expression of self-determination. They are best placed to ensure culturally appropriate health services and to continue traditional healing practices, when appropriate, alongside the delivery of contemporary 'western' medical services. Aboriginal and Torres Strait Islander people must also have the same opportunity to access 'mainstream' health services where they exist as other Australians.

The Declaration on the Rights of Indigenous Peoples was adopted by the United Nations General Assembly on 13 September 2007, with the Australian Government formally endorsing it in April 2009. The Declaration has 46 substantive articles. It does not create any new legal standards under international law. Instead, it articulates the particular entitlement of Indigenous peoples to existing universal human rights standards under instruments such as the ICESCR. Articles of particular relevance to planning for health equality include:

- *Article 24(2)* – 'Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.'
- *Article 18* – 'Indigenous peoples have the right to participate in decision-making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions.'
- *Article 19* – 'States shall consult and cooperate in good faith with the Indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.'
- *Article 24 (1)* 'Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.'

5

Closing the gap and the Indigenous determinants of health in Australia[90]

David Cooper,
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Closing the Gap[91] on Indigenous health inequality and disadvantage has become overarching Indigenous policy. Developed under the Council of Australian Governments (COAG) framework, it has six specific time-bound targets focusing on: child mortality; literacy and numeracy; early childhood education; Year 12 attainment; employment; and closing the life-expectancy gap between Aboriginal and Torres Strait Islander people and other Australians within a generation.[92]

These are worthy targets that no one would disparage. Yet the Closing the Gap program is fundamentally flawed. Its effectiveness is hamstrung—perhaps fatally—through failure to acknowledge and accommodate important social determinants of health such as control over life circumstances, social exclusion and factors associated with

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[90] This paper is based on a longer monograph by the author: Cooper, D, 2011, *Closing the gap in cultural understanding: social determinants of health in Indigenous policy in Australia.* Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), Darwin.

[91] In this paper I use Closing the Gap to refer to related policies of Australian governments and the Council of Australian Governments (COAG) specifically addressing Indigenous health inequality and disadvantage. It should be distinguished from the *Close the Gap campaign*, which is a non-government campaign urging action on Indigenous health inequality.

[92] www.fahcsia.gov.au/sa/indigenous/progserv/ctg/Pages/targets.aspx (accessed 23 September 2010)

cultural difference. Socio-economic and cultural determinants outside direct health service provision significantly impact on the health and wellbeing of individuals and communities, as evidence shows.[93]

Social determinants of health with particular relevance to Aboriginal communities[94] are:

- Control and empowerment, including their negative expression as social exclusion, racism and discrimination.
- Culture, including language and occupation and customary use of traditional lands.

These key determinants sit on one side of a deep, longstanding divide in Indigenous policy debate in Australia. On one side of this divide is the belief that the state should accommodate cultural difference and the right of Indigenous peoples to determine and control their life circumstances. On the other side is the notion that the state should adopt an individualised, formal equality approach based on fostering Indigenous assimilation into mainstream values and the free market.

The Australian Government and Opposition favour the latter position with increasing substitution of Indigenous-controlled and Indigenous-specific programs with mainstream service delivery and increased direct government control over Aboriginal communities and individuals' lives. Closing the Gap has become a primary policy vehicle for implementing this policy agenda, and COAG the primary policy mechanism.

Closing the Gap is a complex set of National Partnership Agreements between the Australian Government and state and territory governments under the National Indigenous Reform Agreement (Closing the Gap) (NIRA).[95] It was drawn up behind closed doors

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[93] Marmot, M and Wilkinson, R. 2003.

[94] An emerging area of research is the social determinants of Indigenous health (see Carson et al. 2007, and www.crcah.org.au/research/socialdeterminants.html (accessed 23 September 2010).

[95] www.federalfinancialrelations.gov.au/content/national_agreements.aspx

without Indigenous input or consent. Both the policy process (top-down) and policy content (mainstream-focused) negatively impact on control and empowerment and on culture. I observe these through the lens of remote communities in the Northern Territory (NT).

Determinants of health and wellbeing

It is difficult to overstate the importance of control and empowerment as a determinant of health and wellbeing, particularly for marginalised and disadvantaged Aboriginal communities. The degree of control individuals have over their life circumstances determines their capacity to deal with day-to-day challenges and stresses.[96] Lack of control causes stress and anxiety and is a strong predictor of morbidity and mortality.[97] Empowerment strategies are effective in improving health and reducing health disparities, with outcomes at psychological, organisational, community and population levels, and in relation to socially excluded populations.[98]

Control is also important at community level, shown by the success of the Aboriginal community-controlled health sector in the NT in driving improved service delivery and health and wellbeing outcomes for Aboriginal communities.[99] There is also strong evidence that community control produces positive socio-economic outcomes.[100]

Professor Stephen Cornell outlines three positive outcomes of Indigenous control:[101]

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[96] Tsey, K. 2008.

[97] Daniel, M et al. 2006.

[98] Wallerstein, N. 2006.

[99] Rowley, K et al. 2008. The success of Aboriginal community-controlled health in the NT has resulted in the Australian and NT governments adopting it as the preferred model for Aboriginal primary health care service delivery in the NT (see *Pathways to Community Control*, available at www.amsant.org.au).

[100] Harvard Project on American Indian Development. www.hks.harvard.edu/hpaied/

[101] Cornell, S. 2004. Cornell is a co-director of the Harvard Project (see at n11).

- bureaucratic priorities are replaced by Indigenous priorities, thereby gaining Indigenous support for initiatives and programs
- decisions begin to reflect local knowledge and concerns
- Indigenous control creates a context for Indigenous accountability.

Culture, including language, and occupation and customary use of traditional lands (and the individual and community manifestation as cultural identity), provide powerful moderating effects on the impacts of racism and discrimination, and a foundation for stronger communities and healthier lives. Culture ameliorates existential anxiety by its capacity to give meaning and value to individual existence.[102] Widespread and persistent suppression of cultural practices severely disrupts a culture, making it susceptible to trauma, collective helplessness and endemic maladaptive coping practices that can become intergenerational.[103]

Closing the Gap and Indigenous determinants

There are numerous ways in which Closing the Gap policies negatively impact on these Indigenous social determinants. The NIRA and National Partnership Agreements contain prescriptions affecting control and culture: limitations on new housing and service delivery for smaller remote communities; relocation of individuals and families from homelands and smaller communities to larger centres; mandating a 'secure land tenure' policy that involves removing decision-making powers of traditional landowners and residents.[104]

The agreements seek behavioural change that is mainstream-focused – through the promotion of 'economic and social participation' and 'personal responsibility, engagement and behaviours

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[102] Halloran, M. 2004.

[103] Ibid.

[104] Cooper, D 2011.

consistent with positive social norms'—in response to problems affecting communities. Related policies include transferring people from Community Development Employment Program (CDEP) subsidised jobs to welfare payments, ostensibly to encourage the take-up of jobs outside CDEP; transferring Aboriginal housing to the state housing authority in order to introduce standard housing tenancy agreements and external housing management oversight; and the external management of welfare recipients' income by Centrelink bureaucrats.

Perverse impacts of these policies include undermining Aboriginal community organisations and enterprises, transferring thousands from jobs to welfare, significant loss of income to individuals and remote communities, and dismantling the Indigenous community housing sector. The underlying impact is loss of control in various significant ways by Aboriginal communities, organisations and individuals.

The pattern that has emerged in Closing the Gap policies is one of asserted Aboriginal failure or deficit being used to justify transferring Aboriginal control to government. This rests partly on the contested but increasingly influential view that traditional culture and, in particular, 'maladapted' customary behaviours, are an inappropriate basis for modern life and therefore a cause of and contributor to Indigenous disadvantage, or at least a barrier to overcoming it.[105] Maladapted behaviours are said to include communal aspects of Aboriginal cultures (including restricted common property ownership of land and associated lack of private home ownership), forms of law and punishment and kinship systems.

This pathologising of traditional culture has a history as old as colonisation. It has justified successive forms of 'native administration', and more recently has informed neo-liberal opposition to land rights

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105 Eg. Sutton, P 2009, Hughes, H. 2007.

and self-determination.[106]

The pathologising of culture downplays the dynamism of Aboriginal (and all) cultures in continually changing and adapting through innovation, intercultural exchange and, increasingly, interaction with market economies. It is not a legitimate role of the state to coercively intervene to suppress or erase 'offending' cultural characteristics. Previous failed attempts, such as the policies of assimilation, show how damaging and counter-productive the unintended consequences can be. The evidence around culture as a social determinant strongly reinforces such a conclusion. Moreover, for every instance of 'maladapted' cultural behaviours and dysfunction identified and targeted by government, there are examples of successful Aboriginal-initiated, culturally-based adaptations and solutions.

Culture is a powerful tool in tackling the intergenerational trauma that remains an underlying cause of so many problems confronting Indigenous individuals, families and communities,[107] and a protective factor in the care and protection of children.[108]

Culturally-based approaches successfully underpin programs including: traditional healing; petrol sniffing and other substance abuse treatment and diversion programs; community safety and community policing; juvenile justice and 'at risk' youth programs; offender programs and circle sentencing; social and emotional wellbeing programs; schools and education; mediation; art and other culturally-based enterprises; and cultural and natural resource

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[106] See, for example, the work of the Centre for Independent Studies and the Bennelong Society.

[107] A major source of such trauma is that of family separation and intergenerational trauma due to government policies and practices and their unresolved effects on individuals and families. Successful approaches to addressing these impacts have involved facilitating reconnection with families and culture. Current initiatives are summarised in the Stolen Generations Working Partnership at www.fahcsia.gov.au/sa/indigenous/pubs/stolengenerations/Pages/StolenGenerationsWorkingPartnership.aspx (accessed 23 September 2010).

[108] NT Government. 2010.

management activities, including 'caring for country' and Indigenous ranger programs.

Many successful examples are developed or led by Aboriginal community-controlled organisations, including reform of Aboriginal primary health care delivery, particularly in the NT. Yet, the contributions of such organisations (with the exception of the Aboriginal community-controlled health sector in the NT) remain under-recognised by government[109] and subject to questioning as to 'whether Indigenous people are culturally capable of "good" governance in western terms'.[110] On the contrary, research shows that culture can constitute an important component of governance legitimacy and effectiveness essential to improving Indigenous wellbeing and socio-economic status.[111]

Indeed, it must be acknowledged that governments *are* funding such programs, albeit on a limited and selective basis while simultaneously crafting more broad-ranging policies that have the effect of undermining culture. An example is support for land-based cultural activity through the Caring for Our Country, Indigenous Protected Areas (IPAs) and Working on Country[112] initiatives. These target the significant areas of Aboriginal-owned land, particularly in the NT, and include support for Indigenous ranger programs and natural and cultural resource management objectives that incorporate and value traditional cultural and ecological knowledge. Around 500 Indigenous people work in Indigenous land and sea management groups in the NT, with significant potential for sustainable expansion in remote areas, offering 'a low cost solution to "Closing the Gap" in a variety of sectors including health, education and employment'.[113] Other benefits accrue across the Indigenous social determinants of

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[109] Sullivan, P 2010a, 2010b, ANTaR 2010.

[110] Hunt, J et al. 2010.

[111] Ibid.

[112] www.environment.gov.au/indigenous/index.html (accessed 20 February 2011).

[113] May, K. 2010.

increased control and empowerment, recognition of culture and traditional knowledge, and increased access and use of traditional lands.

However, such outcomes are threatened by Closing the Gap policies such as the CDEP 'reforms' that detrimentally impact on many land and sea management groups,[114] and objectives to force migration away from the homelands and smaller communities that provide a network of settlement nodes and locally-knowledgeable employment pools in remote areas.

What this demonstrates is conflicted government policy development from multiple ministerial portfolios and departments—the so-called 'silos'—that continues to generate contradictory and poorly coordinated policy objectives and outcomes.

Value of culture-based policy

A grounded cultural identity provides considerable benefits in knowledge, respect and self-esteem, and it follows that opportunities for young people to learn about their cultures should be actively encouraged and facilitated. An important benefit of a strong Aboriginal identity is the encouragement and support it provides Aboriginal children to pursue educational achievement.[115] Australian research demonstrates that recognition, acknowledgement and support of culture is an important factor in improving learning outcomes for Indigenous students, yet Australia's education system in the main does not reflect or support Indigenous culture.[116]

There is a strong conjunction between the Indigenous health crisis and the challenges communities face over the maintenance and continuity of cultural knowledge and practice. The current cultural challenges are historically derived. Initially this involved the combined

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[114] Ibid.

[115] Sarra, C. 2007.

[116] ATSISJC 2009:121.

impacts of introduced disease, frontier violence and dispossession of land, causing population loss and dislocation from traditional lands. Following these calamities were the misguided, racist government policies of assimilation and child removal that further robbed Aboriginal people of their land, language, culture and families.

Equally significant has been the slow burn of unrelenting, alarmingly-high morbidity and mortality rates and the effects of entrenched disadvantage, unaddressed trauma and increasing dysfunction afflicting Aboriginal communities under variously neglectful and coercive but always changing government policies.

This is a significant cause of the current aberration in the demographic profiles of Aboriginal communities, that have disproportionately high numbers of young people and a corresponding lack of older people aged 35 years and over compared with non-Indigenous communities.[117] This severely depletes the social capital of communities and compromises the 'effective functioning of internal systems of social control and of familial support networks'.[118] A 2002 ABS survey revealed[119] that almost half the Aboriginal and Torres Strait Islander respondents reported that the death of a family member or close friend had been their greatest stressor over the previous year.[120] The impact of this corrosive attrition on cultural continuity is heightened, particularly in central and northern Australia, by the dwindling ranks of older generations with extensive direct knowledge of country and cultural traditions gained through living and working on country.

It is particularly important to acknowledge the conjunction of cultural loss with the health crisis and its impacts on the social control, leadership, authority and familial support networks of communities.

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[117] Taylor, J. 2006.

[118] Edmunds, M. 2010.

[119] ABS. 2002.

[120] ABC *The Drum Unleashed*, 10 March 2011, at www.abc.net.au/unleashed/44946.html (accessed 11 March 2011).

This is a point long recognised by Aboriginal organisations through the culturally-based programs mentioned above. But not apparently by government in devising Closing the Gap. By dismissing culture and traditional authority structures as positive factors in Closing the Gap policies, the Australian Government undermines what should be important elements in supporting and re-building social control and authority in communities.

Failures of Closing the Gap

Closing the Gap is the most expensive, extensive and far-reaching policy intervention in Indigenous affairs of recent times. But it comes at the cost of Aboriginal community control being weakened or dismantled to facilitate government control.

Even in terms of the 'normalisation' goals of Closing the Gap (notwithstanding that these were decided without the participation or consent of affected communities), little regard is given to the transitional needs of individuals and communities from their current circumstances of multiple disadvantage to their 'normalised' future. This is particularly apparent in wildly unrealistic expectations that abolishing CDEP jobs will hasten the development of market-based employment opportunities in Aboriginal communities, and the consequent disregard of the impacts of turning thousands from jobs to welfare, including impacts on income, self-esteem and community cohesion.

Closing the Gap and its related policies represent massive, rapid and uncoordinated change being imposed on Aboriginal communities without a proper evidence base or assessment of likely impacts, including unintended consequences. Change fatigue and disempowerment and its effects of increased frustration, confusion and disengagement evident in Aboriginal communities is apparent to many working at the coalface but receives scant acknowledgement by government.

The Australian Government's appeal to failure as justification for its interventionist policies borders on the disingenuous. The current circumstances of poverty and dysfunction affecting remote Aboriginal communities derive from over a century of gross government neglect, discriminatory policies and lack of basic services and infrastructure. Closing the Gap policies contribute to further cultural loss, alienation and disengagement that are themselves critical impediments to achieving Closing the Gap goals, and government appears blind to the connections between loss of control and culture and poor outcomes. Indigenous social determinants—such as control, empowerment and culture—must be acknowledged if Closing the Gap targets are to be achieved. This requires governments and bureaucrats to understand that closing the gap in health and disadvantage depends on first closing their own gap in cultural understanding.

A comprehensive, evidence-based, long-term plan is needed, addressing both direct health needs and the equally significant social determinants; and to ensure that this can be achieved, a true partnership with Indigenous communities and their representative organisations.

The current Closing the Gap policies and processes are not aligned to such outcomes. Instead, the policies are proving deeply destructive of the cultural fabric of Aboriginal communities, particularly in remote areas.

Finally, the Closing the Gap agenda proceeds against the backdrop of the Australian Government's statement of support for the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)[121] and its commitment to reset its relationship with Indigenous Australians, whose aspirations as first peoples are broadly codified in UNDRIP. Indeed, the government lists endorsement of UNDRIP

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[121] United Nations Declaration on the Rights of Indigenous Peoples, GA Res 61/295, UN GAOR, 61st session, 107th plenary meeting, UN Doc A/RES/61/295 (13 September 2007). Retrieved from www.un.org/esa/socdev/unpfii/en/declaration.html.

on its Closing the Gap website as one of its initiatives for 'restoring and strengthening relations with Indigenous people'.[122] Aligning its policy interventions with its commitments under UNDRIP remains a yawning gap as large as the health and disadvantage gap it seeks to close.

References

ANTaR (Australians for Native Title and Reconciliation) (2010), *A Better Way: Success Stories in Aboriginal community control in the Northern Territory*. ANTaR, Sydney. www.antar.org.au/abetterway (accessed 7 March 2011).

ATSISJC (Aboriginal and Torres Strait Islander Social Justice Commissioner) (2009), *Social Justice Report 2008*, Human Rights and Equal Opportunity Commission, Sydney, 2009.

Australian Bureau of Statistics (ABS) 2002, Aboriginal and Torres Strait Islander Social Survey 2002. www.abs.gov.au (accessed 10 March 2011).

Carson, Bronwyn, Terry Dunbar, Richard D Chenhall and Ross Bailie (eds) (2007), *Social Determinants of Indigenous Health*. Allen and Unwin.

Cooper, D, (2011), *Closing the gap in cultural understanding: social determinants of health in Indigenous policy in Australia*. Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), Darwin.

Cornell, Stephen (2004). 'Indigenous jurisdiction and daily life: evidence from North America', Remarks presented at the National Forum on 'Indigenous Health and the Treaty Debate: Rights, Governance and Responsibility', University of NSW, Sydney.

Daniel, Mark, Alex Brown, J Garnggulkpuy Dhurrkay, Margaret D Cargo and Kerin O'Dea (2006), 'Mastery, perceived stress and health-related behaviour in northeast Arnhem Land: a cross-sectional study'. *International Journal for Equity in Health* 2006, 5:10.

Edmunds, M (2010), The Northern Territory Intervention and Human Rights: An Anthropological Perspective. *Perspectives*, November 2010, The Whitlam Institute, University of Western Sydney.

Halloran, Dr Michael J., (2004), 'Cultural maintenance and trauma in Indigenous Australia', Paper presented at the 23rd Annual Australia and New Zealand Law and History Society Conference, Perth, Western Australia (2-4th July, 2004).

Hughes, Helen (2007). *Lands of Shame: Aboriginal and Torres Strait Islander 'Homelands' in*

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[122] Webpage: 'Closing the Gap: Engagement and partnership with Indigenous people', at www.fahcsia.gov.au/sa/indigenous/progserv/ctg/Pages/engagement_partnership.aspx (accessed 23 September 2010).

Transition. The Centre for Independent Studies Limited, St.Leonards.

Hunt, J (2008), 'Between a rock and a hard place: Self-determination, mainstreaming and community governance', in Hunt, J. Garling, S and Sanders, W (eds) 2008. *Contested Governance: Culture, Power and Institutions in Indigenous Australia*, CAEPR Research Monograph No. 29, ANU E Press, Canberra.

May, K (2010), 'Indigenous cultural and natural resource management and the emerging role of the Working on Country program', CAEPR Working Paper No. 65. Centre for Aboriginal Economic Policy Research, Canberra.

Marmot, M. and Wilkinson, R. (eds) (2003) *Social Determinants of Health: The Solid Facts*, World Health Organisation, Geneva.

Northern Territory Government (2010), *Growing them Strong, Together: Promoting the safety and wellbeing of the Northern Territory's children*, Report of the Board of Inquiry into the Child Protection System in the Northern Territory 2010, M Bamblett, H Bath and R Roseby, Northern Territory Government, Darwin.

Rowley, Kevin G, Kerin O'Dea, Ian Anderson, Robyn McDermott, Karmananda Saraswati, Ricky Tilmouth, Iris Roberts, Joseph Fitz, Zaimin Wang, Alicia Jenkins, James D Best, Zhiqiang Wang and Alex Brown (2008), 'Lower than expected morbidity and mortality for an Australian Aboriginal population: 10-year follow-up in a decentralised community', *MJA* 2008; 188 (5): 283-287.

Sarra, Dr Chris (2007), 'The Role of Schools in Shaping Behaviour', Cape York Leadership Institute Address, 26 June 2007.

Sullivan, P. (2010a), *The Aboriginal community sector and the effective delivery of services: Acknowledging the role of Indigenous sector organisations*. DKCRC Working paper 73, Desert Knowledge CRC, Alice Springs.

Sullivan, P (2010b), *The policy goal of normalisation, the National Indigenous Reform Agreement and Indigenous National Partnership Agreements*, Desert Knowledge Cooperative Research Centre Working Paper No. 76, Alice Springs.

Sutton, P (2009), *The Politics of Suffering: Indigenous Australia and the end of the liberal consensus*, Melbourne University Press, Melbourne.

Taylor, J (2006), *Population and diversity: Policy implications of emerging Indigenous demographic trends*. Canberra; Centre for Aboriginal Economic Policy Research, Discussion Paper 283/2006, Australian National University.

Tsey, Komla (2008). 'The control factor: a neglected social determinant of health', www.thelancet.com Vol 372 November 8, 2008.

Wallerstein N (2006). *What is the evidence on effectiveness of empowerment to improve health?* Copenhagen, WHO Regional Office for Europe, Health Evidence Network report. www.euro.who.int/Document/E88086.pdf (accessed 1 February 2011).

6

Promoting disadvantage —obstacles to action

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The landmark report of the WHO Commission on the Social Determinants of Health[123] placed action on the social determinants of health squarely on the agendas of governments as well as others in the community. The commission's recommendations, if implemented will do much to address health inequity both in Australia and globally.

The WHO report rightly draws our attention to the breadth of action required and the range of players that can impact on this global and local health priority.

The focus of health professionals is generally and understandably on the role and activities of governments, health agencies, health professionals and others working directly in this area.

In considering how action can be taken on the social determinants, we should also consider the role and activities of some groups that have no apparent interest in improving the human condition, let alone addressing social determinants, but that impact significantly on health and disadvantage.

Tobacco remains Australia's largest preventable cause of death and disease. Since the dangers of smoking were clearly identified in

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[123] CSDH. 2008.

1950[124], 1 million Australians have died because they smoked. Each year 15 000 still die from a galaxy of diseases caused by smoking.[125]

Globally, WHO estimates that over 5 million deaths are caused by smoking[126], with the increase of smoking in developing countries predicted to increase the tobacco death toll dramatically in coming decades. Smoking caused 100 million deaths in the last century. It will cause 1 billion deaths in this century.

The pattern of smoking uptake in developed countries is being mirrored in lower income countries. Smoking starts in higher-income groups, then spreads in the community. Higher income groups are also the first to give up smoking—but reducing smoking more broadly is an immensely challenging task. While smoking is now declining in Australia, even here we have more than 2 million smokers. In most other countries, smoking is still increasing. Those who smoke in Australia are now generally those of lower educational attainment and from disadvantaged groups and communities. While approximately 16 per cent of the adult population are regular smokers, this rises to 40–50 per cent in Aboriginal communities—and is much higher in some.

Around the world, the single group responsible for not only manufacturing and selling tobacco, but also promoting cigarette consumption is the global tobacco industry—*Big Tobacco*. Led by massive and powerful companies, this industry does everything possible to promote sales of its lethal products, including heavy promotion in developing countries. They know that cigarettes are the only product available that kills one in two of its regular users when consumed precisely as intended. We have also known for more than thirty years that passive smoking is a major cause of death and disease.

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[124] Doll, R and Hill, A. 1950.

[125] Begg, S,et al. 2007.

[126] WHO. 2009.

After decades of denial and lies about the dangers of smoking, tobacco companies have now grudgingly accepted that smoking may be harmful. Some tobacco company websites make carefully worded concessions such as, 'it is reasonable to conclude that smoking is an important cause of lung cancer'.[127] A Philip Morris spokesperson, Anne Edwards, even said recently, in response to questions from Neil Mitchell on 3AW, 'There is no doubt that tobacco is a very harmful product that is addictive and kills people', adding, with words that surely bring bathos to a new low, 'and of course it's very sad that people do get sick from smoking'.[128]

Tobacco companies are ferocious in opposing any action that might impinge on their activities. Thus, the tobacco industry has opposed action in areas such as price, advertising controls, strong public education, effective health warnings, plain packaging and a host of other health initiatives.

The position of tobacco companies was well encapsulated in a 1986 speech to an internal conference by Hamish Maxwell, the Chairman and Chief Executive of Philip Morris—then also a major alcohol (Miller Brewing) and food (Kraft) company.[129] He said, 'Many of the threats to us (Philip Morris) arise from concerns which have lost touch with common sense and reality. People (and politicians) do need causes, and in a world which is generally more peaceful and affluent than ever before, there's a shortage of big causes. That's why we hear so much about really rather little causes: smoking, drinking, dietary hazards ...'

Any doubts as to the ruthlessness of this industry have been exposed through millions of internal tobacco industry documents now available publicly following litigation in the US. It has targeted not only smokers, but children and young people, disadvantaged groups,

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[127] BAT. 2011.
[128] 3AW. 2011.
[129] Bond, L et al. 2010.

developing countries, and some of the most vulnerable people in our society.

When a tobacco company executive was asked why he didn't smoke, he reportedly responded, 'We don't smoke that s***. We just sell it. We just reserve the right to smoke for the young, the poor, the black and the he stupid'.[130]

Tobacco advertising has of course for decades been directed to all sectors of the community, but particularly to those most vulnerable to positive messages about smoking and least likely to understand the true dangers of smoking. Tobacco company activity that opposes effective action discriminates most clearly against the disadvantaged, as they are those most likely to benefit from such action.

Recent developments in Australia, following the government's decision to implement plain packaging of tobacco products, have shown the tobacco industry yet again to be targeting disadvantaged groups through the possible impact of their lobbying. Working through front organisations and indirect promotions, tobacco companies have sought to present a message that measures such as plain packaging will harm low-paid groups—rather than benefiting their health.

Even recognising the differences between alcohol and tobacco, the activities of companies in the drinks industry similarly affect disadvantaged groups disproportionately.

Alcohol advertising and promotion are rampant in Australia, as in virtually all other countries. Alcohol is promoted through formal and informal media, through conventional advertising, sports sponsorship, in-store promotions and less formal means, such as social media. The drinks industry opposes any action that will reduce its promotional activities. It also resists other measures recommended by health authorities. A current case in point is the fierce resistance by the cask wine industry to changes in the Australian alcohol tax system that would preclude sales of wine at less than $2 a litre—an invitation

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[130] WHO. 2011.

to children, young people, and people with alcohol problems to get drunk. Pressure from Aboriginal and health organisations in the Northern Territory and elsewhere to rationalise the tax system and introduce a floor price for alcohol has been strongly resisted by sectors of the industry.

The global obesity epidemic—again reflected in Australia with two thirds of the adult population and 25 per cent of children overweight and obese—is not limited to disadvantaged groups.[131] But the massive promotional budgets of junk food companies again disproportionately affect those of lower socio-economic status; and—as with alcohol—sales outlets for junk food are more evident in areas of social disadvantage.

The health and social consequences of tobacco, alcohol and obesity attract some health and medical attention and some media coverage—but rarely proportionate to the magnitude of the problems or their amenability to intervention. As the report of the National Preventative Health Taskforce[132] and other major reports from national and international health bodies have shown, while there are no magic bullets, we know the components of the comprehensive approach needed to reduce smoking and alcohol problems and at least halt the rise in obesity. We also know that any effective action in these areas is opposed by the relevant industries.

What conclusions can we draw from this?

Addressing the social determinants of health will require a specific focus on the wide range of diseases causes by tobacco, alcohol and obesity. Major global companies in these areas are significant obstacles to address in health inequities. Their advertising and promotional activities are cause for especial concern.

As other chapters in this book will show, action to address the social determinants of health must be global and wide-ranging. Action

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[131] National Preventative Health Taskforce. 2009.

[132] Ibid.

on tobacco, alcohol and obesity are far from being the sole answers to inequity; and action to constrain the activities of tobacco, alcohol and junk food companies are only part of the comprehensive approach we need.

The rise and rise of problems caused by tobacco, alcohol and obesity will, however, continue as long as major global companies are permitted to develop and promote their products in developing countries. Action taken in Australia to limit their harmful activities can help to address the social determinants of health here and to act as a beacon for those elsewhere.

References

3AW (2011). [Radio Broadcast] *Phillip Morris won't butt out*. www.3aw.com.au/blogs/3aw-news-blog/phillip-morris-wont-butt-out/20110627-1gmd1.html.

BAT (2011). [Web page] www.bat.com/group/sites/uk__3mnfen.nsf/vwPagesWebLive/DO52ANBX?opendocument&SKN=1.

Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD (2007). *The burden of disease and injury in Australia 2003*. PHE 82. Canberra: AIHW.

Bond L, Daube M & Chikritzhs T (2010). Selling addictions: Similarities in approaches between Big Tobacco and Big Booze. AMJ; 3 (6): 325-332.

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

Doll R & Hill A (1950). *Smoking and Carcinoma of the Lung*. British Medical Journal; 2 (4682): 739-748.

www.bat.com/group/sites/uk__3mnfen.nsf/vwPagesWebLive/DO52ANBX?opendocument&SKN=1.

National Preventative Health Taskforce (2009). *Australia: the healthiest country by 2020*. Canberra; Commonwealth of Australia.

WHO (2009). WHO Report on the Global Tobacco Epidemic, 2009 Implementing smoke-free environments.

WHO (2011). [Web page] Tobacco Explained: The Truth about the tobacco Industry… in its own. words. www.who.int/tobacco/media/en/TobaccoExplained.pdf.

7

The personal is political

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'There are people so wretched,' wrote Peruvian poet, Cesar Vallejo, 'they don't even have a body.' They are the ones in our midst who have had the guts kicked out of them and who are then left to bleed. They are well known to many of us.

For me, the way I looked at the world changed forever when I first read Frantz Fanon, the psychiatrist and great theorist of the confluence between the colonisation of land and the crushing of the spirit.

As a psychiatrist working in the context of a colonial war he noted and analysed the relations between the conditions of life, the causes of ill health and the social relations of health care. He spoke eloquently of the 'systematic negation of the other person and the furious determination to deny the other person all attributes of humanity'.[133]

He consciously opted in to the struggle for social justice. He did not hide behind his science. Rather, in fidelity to the pursuit of objective reality, he took sides with the people he understood to be crushed and silenced.

As someone who stood in solidarity with people who hoped for and worked for a more just and compassionate society he identified

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[133] Fanon. F. 1967:200.

both the enormity of the problem and the specificity of the solution. 'What counts today,' he wrote, 'the question which is looming on the horizon, is the need for a redistribution of wealth. Humanity must reply to this question, or be shaken to pieces by it.'[134]

Colonial Algeria, a site of incredible violence, seems like a world away from industrialized Australia at the dawn of the 21st century. It may seem to be a world away, but it is not.

It is not a world away when we are living with laws that have been forced upon sections of our population on the basis of race and 'for their own good'. It is not a world away when the First Peoples of Australia continue to live with the toxic fruits of historical colonisation and the perpetuation of the structures of internal colonisation. It is not a world away when, in the language of the beatitudes which, as Oscar Romero pointed out before his own violent death, have turned everything upside down, the people who hunger and thirst for justice here and now are really joined at the hip with those who hungered and thirsted for justice there and then. When here and now we can make our own that poignant prayer on Fanon's lips:

> 'Oh my body, make of me a human who always questions!'

This is the first point I wish to make about good health policy, and indeed all social policy, for as we shall see, you cannot separate good health from housing, social security, education, employment, transport, childcare and all the other elements of our social infrastructure.

Good health policy is a product of this questioning. It is formulated from below, not from above. It is not inherently disempowering. It is not made for a people 'for their own good'. You are well aware of the fact that one of the strongest determinants of health is the degree of empowerment.

Going back to Fanon's prayer, good policy needs not only to arise from critical questions; it should itself provide a relentless critique of existing reality.

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[134] Fanon. F. 1967:78.

When, for example, we embarked in Australia on a road of universal free health care we were collectively posing a question to the existing reality. The policy itself cried out: ‘Who has been missing out? Why is healthcare not best left to the mechanisms of the marketplace? Why were people going to prison for failure to pay their medical debts?’

The second point I would suggest regarding how to get policy right is that the solution to a problem must follow from the very conditions of the problem.

Policy is usually presented as a *fait accompli* cooked up in the rarefied atmosphere inhabited by those whose lives and learnings are alien and alienating to the people whose lives will be affected.

There is often an incredible presumption that people are incapable of analysing their own situation. This presumption carries with it a handy rejection of the notion of actually providing resources to people to allow them to articulate their analyses and proposed solutions. And yet under the guiding stars of struggle and hope the greatest social reforms have been wrought by grass-roots movements, even in Australia.

As the German poet, Bertolt Brecht, put it so well:

> ‘The compassion of the oppressed for the
> oppressed is indispensable. It is the world’s one hope.’

Without the organised analysis and agitation of the people we would never have seen gains in the fields of industrial rights, women’s rights, the establishment and public funding of refuges for women and young people, tenants’ rights, environmental justice, workers compensation, citizenship rights for Aboriginal people and so on.

In the years of the Great Depression when the families of the unemployed were being thrown out of their homes by the landlords a movement of resistance sprang up against these evictions. People gathered around the home of the soon-to-be evicted family and fought back against the police force sent to carry out the law. Given the well established nexus between homelessness and poor health, how can we not recognise this activism as *healthcare from below?*

From home after home the families were evicted by the law and the women and men and the children and their goods were forced to make the street their home while their supporters had the intellectual honesty to never stop being shocked by this brutality.

People were radicalized by reality, by their concrete analysis of the concrete conditions. Good policy was born from such struggles. As the great poet Pablo Neruda put it:

'The word was born
In the blood …'

The third point is that good health policy sees a diversity of issues as being whole cloth, of being interconnected.

With the exception of a couple of fanatical poverty-deniers who are taken seriously by nobody there is a broad consensus in Australian social science that we do have a serious problem with poverty and disadvantage, that this problem affects the lives of at least 11 per cent of the population, that the causes of poverty are primarily structural rather than behavioural, and that we can, as a society, address these causes.

According to the findings of the World Health Organization's Commission on the Social Determinants of Health in its report entitled, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,* 'Social injustice is killing people on a grand scale'.

Sir Michael Marmot, Commission Chair, said, 'Central to the Commission's recommendations is creating the conditions for people to be empowered, to have freedom to lead flourishing lives. Nowhere is lack of empowerment more obvious than in the plight of women in many parts of the world. Health suffers as a result.'

Included in the report is the fact that in the United States 886 202 deaths would have been averted between 1991 and 2000 if mortality rates between white and African Americans were equalized.

Interestingly the report also found the following:

> The members of the St Vincent de Paul Society ('Vinnies'), the organisation for whom I work, are daily witnesses to the experiences of people who are crushed and colonised by the undiluted messages that they are to blame for having been left out or pushed out of the prosperity afforded by a strong economy and the freedoms afforded by a strong democracy.
>
> 'Vinnies' has long spoken of the responsibility of governments at all levels to not abandon the dispossessed to the whims of the market. We have long maintained that the market is not designed to fairly distribute resources. Among other essentials such as housing, education, transport, childcare and access to real jobs, we have called for a strong, universal, bulk-billing Medicare system that provides health care as a public good and not as a commodity.
>
> We have also warned against following the trend of the US health system, the most expensive in the developed world and the most unequal.
>
> It will not come as a surprise that more and more people are seeking assistance from 'Vinnies' for medical expenses.
>
> We do what we can to plug the gaping holes left by a society that is organised around profits rather than people. Medicine, however, should never become a charitable work in such a highly developed nation. It should be socially organised so as to respect the human dignity of all, especially those who are consigned by our system to the peripheries; the people who are, in the global scheme of things, increasingly akin to the members of the majority world, a more accurate term for what has usually been termed the third world, a world that is, in the words of singer/songwriter, Billy Bragg, 'just around the corner'.

Listen to the stories of the people who are best qualified to tell us.

People like the Coxes, who appeared before the Senate Inquiry into Poverty in 2003. They courageously bore witness to the truth of their concrete conditions. Here are some excerpts from the Hansard[135]:

> CHAIR—*Are you happy to speak in public?*
>
> Mrs Cox—*Yes.*
>
> Mr Cox—*But nervous. I am married, I have three kids. I hurt myself at work two years ago. I have a spinal injury which is going to result eventually in the loss of my left arm. I currently receive around $280 a week; out of that I pay tax. I went from a $45 000 a year job down to $16 000 a year because the state government is using a wrong award rate. I worked in a rice mill. They class me as a checkout chick because I worked with grocery items, so now it has gone down to $16 000, that is on the statutory rate. I get no concessions, I get no health care cards. My workers compensation is not indexed to the CPI; over the last two years the basic wage has gone up $35; I have seen no increase at all ... The insurance company that looks after me—I don't know if I can say their name but I will, NRMA—are always late with my payments ... Sometimes it can be anything up to four weeks or five weeks late. They blame it on the post ... I asked them for stuff to get me through, like a mattress. I sleep on the floor at the moment. I have a bad neck, a spinal condition; I have to have a good mattress. The only thing we could get was a single mattress so I do not sleep with my wife any more. She sleeps in a separate room and I have to sleep on the floor on this mattress. I asked them for a mattress: they say no. It is hard.*
>
> Mrs Cox— … *I do have a job, but I earn the minimum wage. I earn $25 000 a year. Tax comes out of that. I am putting my three kids through school. Rent is $160 a week. At the end of last year I was forced to go into debt for a car. We could not afford to fix the one we had. Before Chris was injured he used to do all of that for us. I had to get a loan for a $13 000 car, which we knew we really could not afford but, in order to get him around in his condition, we need a decent car. It has got good seats and stuff like that, specifically for his condition.*
>
> *We get no help. I have got no health care for my children. I dread every sniffle and cough because I cannot afford to go to the doctor and, if I do go to*

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[135] Community Affairs References Committee (2003) *Senate Inquiry into poverty and financial hardship, Hansard for Newcastle Hearing*, 29 May 2003 www.aph.gov.au/hansard/senate/commttee/S6517.pdf .

> *the doctor, I cannot afford to pay for the prescriptions that they are going to need when I am finished. We may be at the top end of the poverty scale but we are on a downward slide and, if something is not fixed, then that is where we will end up.*
>
> Mr Cox—*I have no way possible that I can see of returning to the work force, so my wife has taken over that role. It is pretty disheartening; I see psychiatrists and things like that for depression—and I have to pay for that. It is an ongoing cycle. The way that WorkCover, the state and federal governments set this up is that they consider that the injury that I sustained, although I will never work again, is only worth $26 000 and that is it.*
>
> Mrs Cox—*For the rest of his life.*
>
> Mr Cox— … *How do I tell my little kids that they cannot have a birthday party? How do I tell them I cannot even afford a birthday cake?*
>
> Mrs Cox—*Or that the tooth fairy only comes on payday ...*
>
> Mr Cox— ... *I have had notices for eviction for not paying rent. I cannot count how many times I have had to go down there and sweet talk them ...*
>
> *I am a skilled worker. I worked mainly in the heavy labour sector of the steel industry and stuff like that. I have taken time out and I had a lot of tools and a lot of things like that that I pushed towards my wife and said, 'Look, you are going to have to do it now, love. Go, because I can't.'*
>
> Mrs Cox—*If I had not secured that employment, we would definitely be living in a caravan park by now. It is as simple as that.*
>
> Senator MOORE—*If you could find one.*
>
> Mrs Cox—*If we could find one.*

John Osborne, Vinnies member from Raymond Terrace, painted the following picture:

> Our conference of the St Vincent de Paul Society is one of the busiest in the Newcastle and Hunter Valley, conducting an average of 83 interviews per week. People interviewed are often families, sole parents with children, and singles. Many have addictive problems. Those with addiction problems—many of whom are on methadone and cannot obtain treatment in Raymond Terrace—must travel daily to Newcastle. This creates further difficulties as the bus fare is $5.50 each way plus there is the cost of the methadone. We are being increasingly requested to provide bus

> fares and food for these people. Further difficulties arise regarding medical services as most doctors' books are closed in our area and they do not bulk-bill, causing people to travel to other areas for medical services. This creates further travelling expenses as the nearest public hospitals are at Maitland and Newcastle, and no public transport is available from Raymond Terrace, only private transport. Few of the many people interviewed are employed; most are on welfare support or pensions. Many are breached by Centrelink and have no income at all, and others are unable to obtain any welfare assistance. Many return regularly for assistance to enable them to purchase food, as their debts of overdue rent, phone and electricity have depleted their assistance payments. We are providing $7000 worth of Bi-Lo food vouchers per month. Their debt situation often will be impossible to remove in the foreseeable future. We find in an increasing number of cases we are simply helping them to avoid starvation.'

Newcastle Vinnies member, Neil McGoldrick noted:

> 'We … see, with the decline of medical bulk-billing, older people in particular put off visits to the doctor or buying medicine, and their problems become very serious until medical treatment is necessary. Families who earn over $30 000 per year are charged more for medical care than those who earn less, so in a large family only the very sick members can be attended by a doctor. In my report here, there would be 16 families we know of just in our region who are battling on that wage of $30 000. Then when we get down to the people who are on Centrelink help, just like me, and on disability support, we find another big problem is in dental care. It is causing a great burden on many families; it is just out of reach for families to have this help available. We have assisted families recently, just two children, up to the amount of $2000 to help them to have their dental care. I was talking to a man this

> morning who is in the police force—he is employed—and he told me one of his boys has a front tooth problem, which he lost, and he has to find $2500 for this problem. He has five children, and he said that for dental care in particular it is a very awkward position of trying to choose which child should have assistance because of the financial needs.
>
> '… Regarding our public school system, we are finding that in our region we are paying the Red Cross to feed children who come to school hungry and, in the last nine months, we have paid them $1243 to assist children in a breakfast club …. The unemployed, single parents, the aged and the sick cannot survive without help and the charities themselves are critically undermined and overworked because of this situation, and many people have burn-outs. They are all volunteers and we find it very difficult to handle a lot of this, and our own age and everything like that. It is a serious problem we face of trying to help everybody. We take a lot of criticism from people we just cannot get to. They do not understand our volunteer situation—and it is a volunteer situation. So we are doing our best in that sense but the poverty gap is a problem we face.'

East Maitland Vinnies member Pamela French told the Inquiry:

> 'We have one client who has suffered brain damage, which seems to have occurred during a surgical procedure, but as far as I know he does not seem to have had any compensation for that. He has also very bad arthritis in his hands. He lives alone. He is not an old man, probably middle aged you would call him. He can walk a few steps but relies mostly for his transport on a motorised chair which he drives around quite well, but the batteries for this are very expensive.
>
> 'When they run down and he has bought his batteries, he has to come to us because he cannot get food and so forth, so we have

> to help him with that. Then we have one lady who has two children who suffer from a very rare skin type allergy disease, which I think is going to prove fatal in the finish. She has to buy special foods for these children because they are allergic to so many things. She may be able to use the foods that we supply, but the children mostly cannot eat them, so she has to have special help with vouchers and so on.
>
> 'Another one has three children and one of them requires medication which is not on pharmaceutical benefits and costs about $40 every time she has to buy it, so quite often that is all she asks for. She does her very best to try to keep the children clothed and fed, but when it comes to these extra expenses, this medication that is not on pharmaceutical benefits, she has to come to us ...
>
> 'We find that mental health things quite often are not adequate for the people. We have one client who seldom needs anything—he just wants to talk. He finds that there are always people in his house. Whenever he goes out, he thinks there has been somebody in his house and he tries to tell you what has been done to the house, and there is nothing really, it is perfectly all right. But he really needs some kind of help; he needs someone to make sure he takes his medication because he lives on his own.'

As you hear these stories you can see the sense in which *the personal is political.* These words went from being the title of feminist writer Carol Hanisch's 1969 essay[136] to being one of the most important insights not only for the Women's Liberation Movement but for all who are committed to progressive social justice and social change. Changing the world is as deeply personal as it is broadly collective. I have had the joy of knowing many, many women and men who engage in the daily practice of learning the 'art of gentle revolution' to use Leunig's beautiful coinage. I love listening to their stories and

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[136] Hanisch, C. 1969. www.carolhanisch.org/CHwritings/PersonalisPol.pdf .

watching them at work on their oft-disparaged project of building a new society. What is it that distinguishes these people from those who seek to impose solutions to social problems from above? It is that they see themselves as perpetual students. Many, but not all, of them read voraciously. All of them make it their habit to listen to, and learn from, the people in our midst who are crushed by the weight of structures of inequality. They listen to their stories and then they reflect together on how the political emerges in the heart of the personal. It is a two-way movement, though. The political is at the base of the concrete conditions in which a person lives. Their lives are bound by economic, social and legislative structures. But then the analysis of these conditions gives rise to a personal commitment to change them. This sounds all very simple. It is! It is actually simpler to tackle the social problems rather than trying to manage them in a futile attempt to salvage a crumbling status quo.

Let me be blunt. This is a radical agenda. It must go to the roots of our problems. But to do this we must first acknowledge the problems as our problems and not someone else's.

Health is not a commodity to be bought and sold. It is a complex of social relations. Like all social relations it is in a state of permanent flux. Everything is related to everything else and everything is constantly changing. Good health is a social good. It is the example par excellence of how the personal is political. Good health is hard to achieve in a context of disempowerment and a lack of self-determination.

When someone seeks assistance from the St Vincent de Paul Society our members usually visit them in their homes (if they have a home!). We see the conditions in which they are forced to live: often in inadequate, insecure and inappropriate housing. We see the goods and services that might be missing from their lives due to a lack of affordability. Some are quite tangible like bedding, heating, nutritious food and warm clothes. Some are less tangible but no less obvious, like dental care, primary health care, education and training, access to sporting and cultural activities, childcare and a sense of self-determination.

Earlier this year, the Prime Minister gave a speech on 'closing the gap' on Aboriginal disadvantage. After tabling a report on government outputs rather than outcomes she went on to intone the tired mantra that the real effort needs to be made by individuals. She didn't acknowledge that they have been pushed out. Rather, they are painted as being dysfunctional, bringing on their own 'misfortune'.

It is instructive to look at how social expenditure rates in the context of overall spending. While this is not the only measure of social awareness and connectedness, it is a very concrete manifestation of our values. We put our money where our priorities are. As the Compendium of Social Inclusion Indicators, a publication of the Australian Social Inclusion Board, tells us, Australia stands near the bottom of the list of relative social expenditures in comparison with countries in the European Union. In eight instances individual countries had a rate of expenditure that was over 30 per cent of GDP, around one and half times that of Australia.

It's not just about how much is spent though. It is about where and how it is spent. It is about making sure that the spending responds to the stories instead of the spending requiring its own carefully crafted story.

A 'Vinnies' member in the Northern Territory (NT) said to me recently that the NT Intervention will go down in history as being as shameful for the Australian Government as the Stolen Generations. No one was consulted, she said. No one was listened to.

But the women and men who are not listened to still have their stories, still carry the knowledge of what has happened, what is happening, and what needs to happen.

Another kind of world is possible because of the truth that is told by those who live on the margins. And if we look a little bit closer, we will see that the 'margins' are actually at the heart of our society. It all depends on where you stand.

As for the deaths and ruined lives caused by inequality, it is only appropriate that we honour those lives in our struggle for a society where health and wholeness is transformed into a social good, accessible to all.

The late Bobbi Sykes (1988:28), in her powerful poem, 'Final Count', issues a prophetic call to reconceptualise the terrible waste of life in terms that challenge us to build a different kind of society. I would like to end with her words:

The children are dying /
In terrible numbers of
Malnutrition and
Related diseases and /
We do not count their numbers
Amongst the brave dead of
Our revolution /
Yet their blood is surely spilled
As though shot upon the street /
Had they lived
Long enough to die.
We must count them /
We must count them /
For if we do not
They will have died in vain.

References

Community Affairs References Committee (2003) *Senate Inquiry into poverty and financial hardship, Hansard for Newcastle Hearing*, 29 May 2003 www.aph.gov.au/hansard/senate/commttee/S6517.pdf .

Community Affairs References Committee (2004) *A hand up not a hand out: Renewing the fight against poverty - Report on poverty and financial hardship*, www.aph.gov.au/Senate/committee/clac_ctte/poverty/report/index.htm.

Fanon, F. (1967) *The Wretched of the Earth* [1961] trans. C. Farrington, Harmondsworth: Penguin.

Hanisch, Carol (1969) 'The Personal is Political', www.carolhanisch.org/CHwritings/PersonalisPol.pdf .

McPhillips, K. (1995) 'Dehumanising Discourses: Cultural Colonisation and Lead contamination in Boolaroo' *Australian Journal of Social Issues* 30:1 Feb. pp.41-55.

Sykes, Bobbi (1988) *Love Poems and other revolutionary actions*, St Lucia: UQP.

Wilkinson, Richard and Kate Pickett (2010) *The Spirit Level: Why Equality is better for everyone,* London: Penguin.

WHO (2008) *Closing the gap in a generation: Health equity through action on the social determinants of health,* www.who.int/social_determinants/thecommission/finalreport/en/index.html

8

Delivering a healthier future—what a commitment to improving health status has to do with a national disability insurance scheme

Rhonda Galbally,
National Preventive Health Agency

The establishment of the Australian National Preventive Health Agency creates for the first time in Australia a body with 'the capacity to lead, facilitate, coordinate and be a catalyst for the "ramping up" of prevention and health promotion efforts'. The agency has been given the job by the government of tackling the burden of chronic disease and risk, thereby preventing premature deaths, reducing the load of health and hospital systems, increasing the productivity of the workforce, and improving the health status of the most disadvantaged.

The task ahead is huge. Even though Australia enjoys one of the highest life expectancies in the world, the impact of chronic diseases places a large strain on the health and hospital systems and the strength of the economy. It has been agreed that the initial efforts of the agency will focus on the risks and burden of disease associated with obesity, tobacco use and harmful alcohol consumption.

This initial focus is based on the need to reduce the social and economic burdens associated with common chronic diseases such as heart disease, asthma, stroke, type 2 diabetes, kidney disease, arthritis and lung and other cancers. In delivering this agenda, the agency will draw on the growing evidence on health promotion that point to 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.

But is it enough? Will targeting the identified risk factors deliver the required gains for all? Given the knowledge that good and bad health is unevenly distributed and those with less money, less education, and insecure working conditions are more likely to experience illness and to die earlier than others the need for a more comprehensive approach is suggested.

For example an examination of the health outcomes for people with disability as well as for people who already have a chronic illness confirms the suspicion that for some groups much more is required. The government is already strongly committed to closing the 17 year gap in life expectancy for Indigenous Australians and many in this group have a chronic illness and disability.

But for the general population of people with disability, it is as though once people have a disability or chronic illness, the system (and both the individual with a disability and their families) are deemed to have failed. So one could be forgiven for thinking that prevention is mainly for those who are already in pristine health and that illness and disability means that prevention hasn't really worked.

Of course if the assumption that informs policy is that individuals are responsible for their own behaviour and hence are responsible for their own good or bad health, then people with disabilities will be seen as manifest of a prevention failure, as well as a failure of the health system in general.

People with disability have poorer health

There is compelling evidence that people with disability are more likely to have poorer health than the general population—on a range of indicators. The recent report by AIHW, *Australia's health 2010*, states:

> The data show that, overall, people with disability are more likely than others to have poor physical and mental health and higher rates of health risk factors, such as smoking and overweight. Among other things, the data help to confirm that the more severe a person's disability … the poorer their health.[137]

The report noted that the rate of disease and comorbidity increased with the severity of the disability and that people with a disability were four times as likely as others to report severe or very severe levels of pain, the rates increasing with the severity of the disability. 'Nearly 40 per cent of people aged 15–64 years with a severe or profound core activity limitation had such pain compared with just 4 per cent of other Australians.'[138]

A recent report by the ABS adds to this disturbing picture.[139] Almost 69 per cent of people with profound or severe disability report having four or more long-term health conditions, six times the rate reported by people without disability. This same group tends to have higher rates of most conditions, across most age categories:

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[137] Australian Institute of Health and Welfare 2010, *Australia's health 2010*, AIHW, Canberra, p. 257.

[138] Ibid. pp. 258-9.

[139] ABS 2010, *Health and disability: Aspects of the Australian Experience*, cat.4367.0, ABS, Canberra.

arthritis; ischaemic heart disease; hypertensive disease; cardiovascular disease; type 2 diabetes; asthma; and be taking medication for a mental health condition. Of people aged 18 years and over with profound or severe disability, only 17.4 per cent considered their overall health to be very good or excellent, compared with almost 69 per cent of people without disability.

The health status of the more than 300 000 people with intellectual disability who face 'stark health and access inequities'[140] is particularly concerning. This population group has lower life expectancy and higher morbidity rates than the general population and experience a much higher incidence of mental health conditions.

In fact, there exists a history of poor response from the health sector overall—from prevention to treatment—people with disabilities have lower levels of risk identification and treatment of their needs.[141]

A practical approach to social determinants

One of the problems with many of the current approaches to applying the knowledge about the impact of social determinants on health status is that they are directed to issues that are owned by others. For example while it has been well known for decades that education, jobs and income are primary contributors to health status—there are numerous campaigns and long term systemic actions, all outside health promotion , that have been underway for eons -. Because others are working in these spaces, health's added voice can be useful but might also be hard to justify and survive with government funds.

If health promoters for example decide to put significant amounts of their efforts into ensuring that disadvantaged people acquire a top education—this can be justified because we know from the evidence that this would add significantly more to health status than

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[140] National Health and Hospital Reform Commission 2009, *A Healthier Future For All Australians: Final Report*, Australian Government, Canberra, p. 82.

[141] www.ncid.org.au/submissions/submissions/1011/NCID%20Health.pdf.

focusing on a social marketing or local health promotion campaigns to promote healthy eating. But justifying prevention efforts focusing on improving education rather than more usual health promotion interventions is hard to achieve even with the conceptualization of 'Health in All Policies'.

Yet we know beyond doubt that health status and wellbeing impact broadly on a person's life. We know that good health outcomes are positively correlated with social inclusion and connectedness, employment and workforce participation and higher incomes.[142] And the population group that is highly interactive with the health sector is people with disability and chronic illness—a group that is also disadvantaged on all social determinant measures. Research by the Social Policy and Research Centre found that people with disability were particularly likely to experience social exclusion:

> People with a disability also face severe problems of exclusion is [sic] several areas, including no child care and jobless households. People with a disability are also more likely than any other group not to participate in community activities and this, combined with the large proportion who [are] not having regular contact with other people are evocative illustrations of the association between disability and social isolation.[143]

A recent report, *Shut out: The experience of people with disabilities and their families in Australia*, describes the social, cultural and political isolation experienced by many people with disability. It noted:

> A lack of social inclusion and the multiple barriers to meaningful participation in the community faced by people with disabilities were the most frequently raised issues … People with disabilities and their families, friends and carers reported daily instances of

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[142] VicHealth 2005, *Background paper to VicHealth position paper on health inequalities*, VicHealth, Melbourne.

[143] Saunders, P et al 2007, *Towards new indicators of disadvantage: Deprivation and social exclusion in Australia*, Social Policy Research Centre, Sydney (find page).

> being segregated, excluded, marginalised and ignored. At best they reported being treated as different. At worst they reported experiencing exclusion and abuse, and being the subject of fear, ignorance and prejudice.'[144]

We know that economic participation is central to social inclusion, but many people with disability are being denied the benefits derived from employment: income; satisfaction; achievement; contribution. In 2003, the workforce participation rates of people with disability sat well below those of people without disability (about 30 percentage points lower for males and 22–25 percentage points lower for females). Participation rates for people with severe or profound disability were even lower and, of particular concern, declined between 1998 and 2003. For women with severe or profound disability, this decline occurred during a period of significant increase in the general female workforce participation rate.[145]

Action is urgently needed

This brief snapshot of the health status of Australians with disability is concerning, but when coupled with knowledge of the impact that unnecessary poor health and inadequate access and support have on individuals' lives, it is clear that the situation borders on scandalous and that urgent action is required.

Given the high proportion of people with disability who engage in risk behaviours, ensuring prevention activities specifically include them is an obvious place to start:

> Based on the 2007–08 NHS [National Health Survey], people with disability are also more likely than other Australians to have behavioural risk factors such as smoking and experiencing stressful

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[144] National People with Disabilities and Carer Council 2009, *Shut Out: The experience of people with disabilities and their families in Australia*, FaHCSIA, Canberra, p. 3.

[145] AIHW, Disability in Australia: trends in prevalence, education, employment and community living, Bulletin 61, 2008, p. 22.

> life events. In particular, 15–64 year olds with disability were more likely to be overweight or obese (48% compared with 39%) and to smoke daily. They were also more likely to have experienced a stressful event in the 12 months before the interview (60% compared with 45%). In contrast, 15–64 year olds with disability were only slightly more likely than other to drink alcohol at risky or high-risk levels, and the rates were the same among people aged 65 years and over.[146]

Risk behaviour in this population group in particular is related to co-morbidities associated with low self esteem, depression, poverty, physical, social and economic exclusion and lack of hope. To date, most large-scale prevention activities are not based in the well-established evidence of co-morbidities; so it is not surprising that when they do mention people with disabilities that Indigenous Australians often seem to be included as an add-on. This means that the evidence-based community development methods about what works in Indigenous communities are, surprisingly, rarely generalised to all communities.

Similarly, health promotion strategies are not developed that specifically include people with disability and those who already have a chronic illness. And that also means that methods that ‘work with’ rather than ‘targeting’ are not developed even though ‘working with’ is a very different concept from ‘targeting’. There is strong evidence, now used to develop interventions with Aboriginal and Torres Strait Islander populations, that prevention is far more likely to work when programs are designed and delivered by disadvantaged groups themselves rather than imposed on them, as is implied in the term targeting. This is also the case for people with disability.

The Australian National Preventive Health Agency has the opportunity to ensure that all of its initiatives include consideration of people with disability from whatever cause including chronic

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146 Australian Institute of Health and Welfare. 2010, op. cit. p. 260.

illness—and that they are included rather than targeted—from planning through to implementation. As it will work closely with primary health care organisations such as Medicare Locals, the agency can help invigorate preventive health efforts at the local level and ensure that they also include people with disability.

But this will not be enough. Informed by the social determinants discourse, preventive health initiatives need to be part of a broader agenda.

The solution must be based on major reform

In February 2011, Australian governments endorsed the National Disability Strategy, an ambitious, whole-of-government, 10-year plan, which will help give practical effect to the United Nations Convention on the Rights of Persons with Disability (to which Australia is a signatory). As expected, the strategy covers health and well-being:

> Australia's mainstream health services are not always well informed or well equipped to respond to the needs of people with disability. Research indicates that despite increased longevity, the mortality and morbidity rates for adults with disability/impaired decision-making capacity are still significantly higher than for the general population.[147]

It also defines the desired policy outcome: 'All health providers (including hospitals, general practices, specialist services, allied health, dental health, mental health, population health programs and ambulance services) have the capabilities to meet the needs of people with disability.'[148]

Other domains addressed are: economic security; learning and skills development; rights and justice; accessible communities; and personal support— all of these relate to health status.

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[147] Commonwealth of Australia 2011, *2010–2020 National Disability Strategy*, Attorney General's Department, Canberra, p. 60.

[148] Ibid. p.60.

The links between the social determinants of health and this broad National Disability Strategy are clear. Improving the capacity of many people with disability to exercise their rights to be treated as equal citizens will improve their health.

But there is one critical step to achieving this. What is needed is major reform so that people with disability have sufficient levels of high-quality support to actively engage in their communities—whether in early intervention and rehabilitation, at work, in quality education and training, or participating in community and civic life.

The solution lies in implementing the Productivity Commission's recommendation for the creation of a National Disability Insurance Scheme. Such a scheme is the best buy for prevention because it would enable people with disability from whatever cause — including those with a chronic illness—to participate in their communities, exercise their rights, undertake education and training, and find employment. It would change their lives.

Reducing inequalities in the health of people with disability does not require a separate health prevention agenda. While greater effort must be put into ensuring that prevention initiatives actually include people with disability, as with social determinants generally, the real gains are to be found elsewhere. Action across the whole of society, to ensure universal design so that physical, economic and social infrastructure is accessible and underpinned by adequate levels of disability support, will reduce the inequalities experienced by people with disability. A reduction in the differential between the health outcomes for people with disability and the general community will follow. This is why we need a government commitment to introducing the National Disability Insurance Scheme in response to the strong recommendations by the Productivity Commission.

Gaining a National Disability insurance Scheme will go a long way to ensuring that the social determinants of health for people with disabilities and chronic illness will be realistically addressed—and it is then that health status will be able to improve. If social determinants mean anything practical to health promotion, it is vital for the public health and health promotion communities to join the campaign for a National Disability Insurance Scheme.

9

Health—covering all the bases

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The Australian Medical Association (AMA) has for many years encouraged governments to consider all the social determinants of health when developing health policy. This is particularly important when considering policies for Indigenous peoples and other disadvantaged groups.

Social determinants are the social and environmental conditions in which people live and work.

People's social and economic circumstances are intertwined with their perception of and ability to attain an acceptable health status throughout their life.

Disadvantage has many forms and can be absolute (for example, not having access to quality education or housing) or relative (for example, poorer education, and insecure employment).

Each of life's many transitions—such as leaving school or getting a first job—can affect health by moving people onto a more advantaged or less advantaged path. People who have been disadvantaged in the past are at greater risk in every subsequent transition.

Disadvantages tend to congregate among the same people, and their effects tend to accumulate through life and be passed on from generation to generation.

Social and psychological circumstances can cause long-term stress and be damaging to health, and may lead to premature death. Continuing anxiety, insecurity, social isolation, and lack of control over work and home life are examples of such stressors.

As well as contributing to poor mental health, the inappropriate and regular activation of the body's stress response negatively affects the cardiovascular and immune systems. While of some concern in the short term, in the long term these feelings of stress make people more vulnerable to conditions such as infections, obesity, diabetes, hypertension, stroke and depression.

In industrialised countries, these conditions are more common in people who live in the lower levels of the social hierarchy.

It is now well understood that the foundations of adult health are laid before birth and in early childhood.

Slow growth and poor early experience increase the lifetime risk of poor emotional health and reduce physical, cognitive and emotional functioning into adulthood.

Poor experiences during pregnancy such as nutritional deficiencies, maternal smoking, alcohol and drug use, and inadequate prenatal care can lead to poor foetal development and consequent low birth weight babies, which are risk factors for poor health later in life.

Poverty—absolute and relative—has a major impact on health and premature death. Poverty denies people access to full participation in the life of the community. In the international context, those who are homeless have the highest rates of premature death.

Social exclusion also results from racism, discrimination, stigmatisation and unemployment. The greater the length of time that people live in disadvantaged circumstances the greater the risk for ill-health, particularly cardiovascular disease.

Generally, those with the lowest health status also have low educational and literacy levels. Poor education means a person is less likely to attain secure and well paid employment and this can lead to poverty and other predictors of ill health.

As a general rule, having a job is better for health than being unemployed. However, stress at work also increases the risk of disease. Jobs that are demanding and where employees have little control or decision making in their employment are the most detrimental to health.

Improved work conditions will lead to a healthier workforce that will, in turn, improve productivity and decrease absenteeism. Occupation is often used as a measure of socio-economic status. Those in 'blue collar' occupations have poorer health status across almost all indicators compared with those in professional/managerial occupations.

People who are unemployed, and the families of those who are unemployed, experience a much greater risk of premature death. These risks are higher in regions where there is widespread unemployment and when the risks relate to the psychological and financial (particularly debt) effects.

The health effects begin when people first feel their jobs are under threat, prior to becoming unemployed. Job insecurity or very unsatisfactory employment is harmful, with increasing effects on mental health, heart disease, and the risk factors for heart disease.

Adequate income affects the ability to have safe housing (including appropriate plumbing and infrastructure, to avoid overcrowding, and to avoid unsafe locations away from violence) and to afford sufficient and quality food and health care. As income continues to rise above a threshold level there is no longer a correlation between increased income and increased health. The health benefits of increased socio-economic status become smaller as socio-economic status increases.

In the past 20 years, income inequality has been increasing in Australia. As an example, between 1994-95 and 1998-99, there was a 20 per cent increase in the taxable income of Australians.

However, the poorest postcodes achieved an increase of only 16 per cent, whereas the wealthiest postcodes achieved an average increase of 25 per cent. This trend also exists internationally with income inequality increasing in nearly all countries since the 1980s. Income inequality is higher in the United States of America than in Nordic countries such as Sweden.

Social support and social relations give people emotional and practical resources as well as a sense of mutual respect where people feel loved and valued. All these aspects have a protective effect on health and provide a buffer against health problems. Without them, people are likely to experience less wellbeing, more depression, and higher levels of disability from chronic diseases.

At the societal level, social cohesion (the quality of social relationships and the existence of trust, mutual obligations and respect in communities) helps to protect people and their health. Societies that have high levels of income inequality tend to have less social cohesion and more violent crime.

Alcohol dependence and illicit drug use are sometimes symptoms of social breakdown and can sometimes also contribute to further escalation of health inequities.

People can turn to alcohol and other drugs as a way of avoiding their harsh social and economic realities. Unfortunately, apart from a temporary release, these substances only intensify the factors that lead to the use in the first place. These substances are a large drain on people's incomes, reduce participation in society, and are a large cause of ill-health and premature death.

Food quality is an important issue in parts of Australia and internationally. Quality food poverty can exist side by side with food plenty. Ready access to good quality food makes a greater difference to what people eat than nutritional education.

Generally, people on low incomes—including young families, elderly people and those who are unemployed—are often most at risk from poor nutritional choices.

In Australia, there is a particular issue with food quality for isolated Aboriginal and Torres Strait Islander communities. Fresh fruit and vegetables often must be carried many hundreds of kilometres, often in un-refrigerated trucks, and much of the nutrient value of the food can perish on the journey. Once it arrives at the local store, it may or may not be able to be stored in conditions to maintain the nutrient value, and it is much higher in cost than what would be paid in urban areas.

There may not be the appropriate kitchen and cooking facilities to be able to store and then prepare nutritious well-balanced meals.

Under-nutrition can lead to susceptibility to disease in addition to specific disorders. Equally, the overconsumption of energy-dense and nutrient-poor food products and beverages is a major contributor to the epidemic levels of obesity in Australia today.

Cycling, walking, and use of public transport promote health through exercise, reducing accidents and air pollution, and increasing social contact. People without private transport and people in places with poor or no public transport are less able to participate fully in the life of the community and experience its health benefits.

Other significant factors that affect equity in health outcomes are racism and other biases, whether at an individual level or institutionalised.

In *A Public Health Perspective on Cannabis and Other Illegal Drugs*, the Canadian Medical Association highlights the profound impact a criminal record has on heath status.

A criminal record can severely limit employment prospects, leading to poor health. Prisoners also require equity in access to health services given their burden of disease. People with a criminal record are less likely to be employed, or more likely to be employed in lower skilled or temporary work.

Institutional racism and other biases against minority groups refer to the ways in which beliefs or values have been built into the operations of social institutions in such a way as to discriminate against, control and oppress those groups.

It has been argued that these biases are embedded in some Australian institutions and are often unrecognised by the agents involved in it.

These biases can occur are at many levels:

- access to primary care medical practitioners—fewer doctors in lower socio-economic areas
- attitudinal barriers—'they don't help themselves'
- medical system being 'less foreign' or intimidating for those from higher socio-economic groups
- less optimal form of treatment
- more likely to get medical as opposed to surgical intervention for a problem such as coronary artery disease, and
- less likely to be referred to rehabilitation services.

Often inequities are made invisible under the guise of treatment decisions—for example, the risk of poor outcomes due to multiple other health problems: complicated lives; lack of transport or other means to keep appointments; challenging treatments such as transplant; and lack of carer support to make choices.

People from higher socio-economic groups are often more comfortable standing up for their rights, and often more able to educate themselves on their condition and challenge or ask doctors for specific treatments (all assist in being able to work in partnership with their doctor).

AMA position on social determinants and prevention of health inequities

The AMA has developed a Position Statement on the Social Determinants and Prevention of Health Inequities. Based on that Position Statement the AMA has made the following recommendations:

- *Governments must make the first priority in addressing health inequities in Australia the improvement of Aboriginal and Torres Strait Islander peoples' health until their health outcomes and life expectancy equal that of other non-Indigenous Australians. This is a human rights issue and Australia's greatest shame.*
- *Governments must improve the quantity and quality of services to those in the poorest and most disadvantaged communities and make such services accessible to the resident populations. The AMA calls on the Federal Government to do this as a human rights issue.*
- *Governments must recognise that while addressing health inequities is a human rights issue, doing so is also cost effective in the long term.*
- *Governments and politicians of all parties must speak openly about the importance of social determinants of health and the health inequities that exist in Australia, and put them higher on the government agenda. It is time for a public debate on health inequities and immediate interventions to reduce them.*
- *Governments must make health outcome equity the explicit goal of all public policy—health education, employment, housing, economic. The AMA calls on governments to develop initiatives with the explicit intent of reducing health inequities. All current and future policies must be assessed according to their impact on health and equity. Governments must stop policies and funding decisions that exacerbate inequities. Systems must be established to monitor for unintended consequences of policies that may increase inequality.*
- *The Federal Government must make research into effective*

interventions to reduce inequities a priority area for the National Health and Medical Research Council and Australian Research Council research. While monitoring changes in levels of inequality is important and necessary, priority must be given to research that identifies and evaluates interventions to reduce inequities.

- *The AMA calls for a whole-of-government response to health inequities to be the responsibility of the Council of Australian Governments (COAG). Targets in reducing inequality would be set and regularly reported against at COAG meetings. Prime Minister and Cabinet and the Premiers' departments at state level should have carriage of, and be responsible for, initiatives to address inequities in the social determinants.*
- *Governments must develop a universal approach to evidence based early childhood promotion and prevention and early intervention programs to ensure every child has the best start in life, as is their human right, and to provide funding to match.*
- *Governments and bureaucracies must recognise and eliminate institutional racism. This is imperative in order to reduce inequalities based on race.*
- *All state and local health authorities must have explicit indicators of inequities in their population and commit to reducing them. These should be publicly available and reported against annually.*
- *Policies addressing education, employment, poverty, housing, taxation and social security must be assessed for their impact on health.*
- *Governments must adopt targets to close the gap in educational opportunities and outcomes between different social groups. Heads of education should be responsible for adopting and meeting the targets.*
- *The AMA believes that as the nature of work changes and evolves, governments should ensure access to retraining and reemployment schemes. Employment contracts should provide security of employment*

and 'quality living' conditions.

- *The AMA calls for approaches to the food system to ensure affordable and nutritious food for everyone, particularly the most vulnerable.*
- *The AMA believes that there are adverse health impacts associated with criminal records and prison sentences and that these health impacts should be taken into account in the development and review of public policy and legislation.*
- *Government responses to licit and illicit drug misuse must include policies and interventions that address the underlying social conditions and experiences that give rise to drug use.*
- *Doctors should regularly reassess their own practices to ensure that their treatment decisions contribute to improving health equity for both individuals and communities.*
- *Doctors should be passionate and informed advocates for equity and be mindful of the social determinants that are in play in a patient's life during consultations.*
- *Medical colleges and professional societies should increase their members' awareness of health inequities in general, and potential bias in medical treatment decisions. This can be done by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curricula, in medical journals, at professional conferences, and as part of professional peer review activities.*
- *The AMA encourages those involved in medical education to develop and implement policies that support the entry and completion of medical studies by students from disadvantaged groups.*
- *The AMA encourages those involved in developing practice and clinical guidelines that reduce health inequities to recognise and support the needs of disadvantaged groups.*

Sources:

AMA Position Statement on the Social Determinants of Health

AMA Indigenous Health Report Card series

10

From description to action—using health impact assessment to address the social determinants of health

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Introduction

The potential for policies, programs and projects to impact on population health has been understood for many decades. Health impact assessments (HIAs) have emerged as a preventive response to these concerns, by attempting to address potential population health issues before they arise. HIAs have been increasingly recognised internationally as a mechanism to ensure that the potential health benefits of policies, programs and projects are maximised, that the potential negative health consequences and health risks are minimised and that potential health inequities are addressed.[149,150,151,152]

The development of HIAs has been linked to the increased recognition of the importance of the social determinants of health and

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[149] WHO. Closing the Gap in a Generation. 2008.

[150] WHO. World Health Report. 2008.

[151] IFC. Introduction to Health Impact Assessment. 2009.

[152] IFC. Performance Standards on Social & Environmental Sustainability. 2006.

health equity.[153,154,155,156,157] HIAs have been on the public health agenda in Australia and New Zealand for more than 15 years,[158,159] and there has been some activity in every Australian state over the past decade to develop HIAs.[160,161,162] Internationally HIAs are now required by agencies as diverse as the International Finance Corporation[163,164], the lending agencies who are signatories to the Equator Principles[165], the UK Department of Health[166] and the European Commission.[167,168,169]

Importantly HIAs provide a process for considering the impacts of decisions on the social determinants of health and health equity before they're made. They follow a series of steps[170,171,172] that provide a framework to identify potential impacts of proposed policies, programs or projects on determinants of health and then to recommend changes. This framework has been found to be useful when working intersectorally[173], as it provides clarity about the process and purpose of the HIA, as well as assisting in collaborative learning about the social determinants of health but also about the details and

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[153] Harris-Roxas, B and Harris, E. Differing Forms, Differing Purposes. 2011.
[154] Harris, E and Harris-Roxas, B. Health in All Policies. 2010.
[155] Corburn, J and Bhatia, R. 2007.
[156] PHAC. 2007.
[157] WHO. Report on a Conference on Intersectoral Action for Health. 1997.
[158] NHMRC, 1994.
[159] enHealth. 2001.
[160] Simpson, S et al. 2004.
[161] CHETRE. 2009.
[162] Harris, P et al. 2011.
[163] IFC. 2009.
[164] IFC. 2006.
[165] Equator Principles. 2006.
[166] UK Department of Health, 2010.
[167] Salay, M and Lincoln, P. Health impact assessments in the European Union. 2008.
[168] Salay, R and Lincoln, P. The European Union and Health Impact Assessments. 2008.
[169] Stahl TP. 2010.
[170] enHealth. 2001.
[171] Harris, P et al. 2007.
[172] Simpson, S et al. 2005.
[173] Wismar, M et al. 2007.

nuances of the proposal being assessed.[174,175]

This essay presents examples of several HIAs that have been conducted in the south west of Sydney.[176,177] They illustrate the flexibility and applicability of HIAs across a number of decision-making contexts. They highlight the role that HIAs can play in moving from describing the importance of the social determinants of health to acting on them. They also illustrate the important role that health services can play in catalysing activity to address the social determinants of health.

Health impact assessment of health service planning: SSWAHS overweight and obesity plan HIA

The former Sydney South West Area Health Service (SSWAHS) Overweight and Obesity Prevention and Management Plan 2008–12[178] was developed in response to the increasing prevalence of overweight and obesity. It was the first such plan for the area health service and provided a framework on which to build further strategies to address overweight and obesity issues. The plan was developed in consultation with clinicians, staff, external agencies and services, and community members and was intended to be a flexible and responsive document so that any new policies and directions could be incorporated.

Senior staff from Population Health, Planning and Performance requested that an Equity-focused Health Impact Assessment (EFHIA)[179,180,181] be conducted to inform the implementation of the plan. The purpose of the EFHIA was to focus on strategies that

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[174] Harris-Roxas, B et al. A Rapid Equity Focused Health Impact Assessment of a Policy Implementation Plan. 2011.

[175] Glasbergen P. 1999.

[176] Maxwell, M. 2007.

[177] Maxwell, M et al. 2008.

[178] SSWAHS. 2008.

[179] Harris-Roxas, B et al. A Rapid Equity Focused health Impact Assessment of a Policy Implementation Plan. 2011.

[180] Harris-Roxas, B et al. 2004.

[181] Mahoney, M et al. 2004

were identified as having potential to create or increase inequities, to develop recommendations for the implementation planning group to ensure that the plan is implemented equitably, and to identify and determine the possible impacts of the plan on different population groups.

A reference group was also established to provide input into the EFHIA, including representatives from Population Health, Health Service Planning, and the UNSW Centre for Primary Health Care and Equity. The screening process for the EFHIA (the first step of an HIA) determined that there was agreement to proceed to add value to the original planning process. A scoping meeting (the second step) determined that the EFHIA would utilise a rapid equity focused HIA framework with a stakeholder workshop and a review of current evidence and SSWAHS data. Eight treatment and management strategies were selected for assessment and these were then grouped into four key issues of: surgery; clinics and outreach services; pre-school children; and staff training.

A half-day workshop was held to assess the eight strategies against key equity questions. Stakeholders who had been involved in the development and implementation of the plan, as well as representatives of key population groups and services, were invited to participate in the workshop. The recommendations from the workshop were then discussed with and endorsed by the Implementation Plan Committee, with agreement to include them in the existing action plan. The relevant working groups also agreed to the responsibility for implementing and reporting on the recommendations. Recommendations included: monitoring and reviewing access to clinical services by disadvantaged groups; identifying opportunities to re-orient and link services; replicating specialist services in different geographic locations; investigating effective models of outreach service delivery for disadvantaged groups; and developing skills of staff working in specific population groups.

Health impact assessment of land use planning: the Oran Park and Turner Road HIA

Oran Park and Turner Road were the first precincts to be developed in the South West Growth Centre which was detailed in the Sydney Metropolitan Strategy, *City of Cities—A Plan for Sydney's Future*.[182] These precincts were planned to provide 12 000 new homes in Sydney's south west. The former SSWAHS had previously participated with the Western Sydney Regional Organisation of Councils (WSROC) and the former Sydney West Area Health Service (SWAHS) in conducting an HIA on the Sydney Metropolitan Strategy. SSWAHS was keen to apply the broad recommendations of this HIA, and develop more location-focused recommendations through undertaking a HIA on this first precinct development.

A steering committee was established which was comprised of representatives of SSWAHS (Population Health, Health Services Planning and the Centre for Research, Evidence Management and Surveillance), the Centre for Health Equity Training, Research and Evaluation (CHETRE), and Camden Council. The steering committee initially applied an impact assessment screening tool to assess if a HIA would add value to the planning process. A rapid prospective HIA was undertaken which focused on the issues of public transport, active transport, social connectivity, physical activity, injury and food access.

While the HIA showed that the development had generally adopted best practice for urban design in many areas, a total of 24 recommendations were developed. The findings were presented to the developers who committed to facilitate the recommendations, many of which have been incorporated into a strategic social plan that was established by the developers. A strategic social plan implementation group was formed and the HIA recommendations have been a regular item on the agenda of these meetings.

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[182] DIPNR. 2005.

A monitoring and evaluation plan was developed, with progress being formally reviewed by Population Health and Camden Council at 15 months and 3 years after the completion of the HIA. Population Health will remain engaged with council and the developers to continue monitoring and assisting to facilitate actions that arose from the HIA.

Key issues that have ensured positive outcomes of this HIA have been early engagement with the key players in the planning and development process, and the establishment of processes and mechanisms to ensure sustained engagement beyond the completion of the HIA to facilitate monitoring and evaluation and other activity on land use planning.

Health impact assessment of local services: Chesalon Living, Oran Park HIA

The former SSWAHS has had a long-standing and active community representatives' network, whose members participate in health service activities and committees at strategic levels. Increasingly the community representatives have been asked to comment on and be involved in the planning and monitoring of complex health service activities. They identified the need for a mechanism by which they could determine how these plans and activities would impact on the rest of community.

The community representatives determined that a HIA could provide them with a framework and process to contribute to the decision-making processes by providing comments on proposals that were both evidence-based and consultative. They also identified the capacity for them to initiate HIAs independent of the health service as being important.

A HIA training program specifically tailored for the community representatives was developed by the UNSW Centre for Primary Health Care and Equity. The training adopted the 'learning by doing' approach[183] to look at the Chesalon Living, Oran Park proposal. This is an aged living community being developed by Anglicare in the south west of Sydney. It was identified as an appropriate proposal to assess because:

- The former SSWAHS had already conducted a HIA on the Oran Park, Turner Road development, which is the area Chesalon Living is to be situated in.
- The community representatives had knowledge of the needs of the over 55 age group.
- The HIA had the support of Anglicare to proceed.
- There was sufficient evidence and literature available on the subject of seniors living to enable the community representatives to conduct a HIA and develop useful recommendations that could be implemented by Anglicare.

The community representatives formed the steering committee and conducted the HIA following the steps outlined in the *Health Impact Assessment: A Practical Guide.*[184] A recommendation report containing 22 recommendations was developed for consideration by Anglicare.

As a result of the training and a subsequent HIA the community representatives have:

- gained insight into the range of possible applications of HIAs
- gained the skills and knowledge to participate in future HIAs
- established a direct relationship with Anglicare, who have indicated a desire for them to have input into plans for future seniors living precincts

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[183] Harris-Roxas, B and Harris, P. 2007.

[184] Harris, P et al. 2007.

- developed an understanding of the relationships between the determinants of health and the possible impacts, positive and negative, of plans, policies and projects.

Discussion

A HIA may have greatest usefulness when it is used selectively and strategically. As these cases show, HIAs can be used on different types of proposals and in different ways, for example the community representatives conducting the Chesalon Living Oran Park HIA. In South West Sydney this selective use has led to a number of related activities, for example work with Housing NSW on HIAs has led to a partnership between the former SSWAHS Housing NSW and the UNSW Centre for Primary Health Care and Equity regarding ongoing work.

To date most HIAs in Australia have been done voluntarily by government agencies with the goal of improving decision-making and implementation,[185] and these cases reflect that. It is tempting to imagine that if a HIA was required on all policy and project development it would result in the consideration of the social determinants of health in most decision-making. We need to learn from experiences elsewhere that have shown this sort of requirement for HIAs may either place a significant burden on the health sector, when it may not be sufficiently oriented to working intersectorally, or become tokenistic.[186,187,188] Either way, this may lead to weariness with the topic of health and the social determinants of health that could be counter-productive in the medium and long-term. As the SSWAHS Overweight and Obesity Plan HIA shows there can also be significant benefits from the health sector considering the impact of

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[185] Harris-Roxas, B and Harris, E. Differing Forms, Differing Purposes. 2011.

[186] den Broeder, L et al. 2003.

[187] Banken, R. Health impact assessment. 2003.

[188] Banken, R. Strategies for instutionalising HIA. 2001.

its own decision-making on health and health inequities.

Across the HIAs we have discussed, the health issues and determinants encountered are often similar, even though the scale of the proposals differs, for example the Oran Park and Turner Road and Chesalon Living HIAs identified a number of similar potential health impacts even though the proposals detailed change at different scales, from regional to quite local. This shows that HIAs can be relevant to decision-making at different scales. Increasingly HIAs are also being used by communities and NGOs for advocacy. This presents an opportunity for other groups to provide evidence-informed input into decision-making.

Conclusion

The appeal of HIAs lies in their practical nature. HIAs provide a useful way to move beyond discussing the social determinants of health to acting on them, as the examples in this essay have shown. These cases illustrate the importance of an organisational commitment to HIA's use through building capacity to undertake HIAs, doing them, acting on and monitoring the implementation of their recommendations. They also illustrate HIA's relevance in a number of different contexts.

HIAs are not a panacea. They seek to act on complex health causal pathways by intervening at the decision-making level. As such their impact is not always readily apparent. Often the benefits of HIAs lie in their direct and indirect impacts on decisions, implementation, ways of working and understanding.[189,190]

HIAs can provide a useful way forward to act on the social determinants of health. They provide health sector agencies, both government and non-government organisations and communities

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[189] Wismar, M et al. 2007.

[190] Harris-Roxas, B et al. A Rapid Equity Focused health Impact Assessment of a Policy Implementation Plan. 2011.

with a framework to engage with decisions constructively. They provide the opportunity to influence decision-makers early in the planning process with a focus on those population groups likely to be affected.

Whilst we need to be realistic about what HIAs can achieve, they clearly provide a practical mechanism to move beyond understanding the importance of the social determinants of health to acting on them.

References

Banken R. Health impact assessment—How to start the process and make it last. *Bulletin of the World Health Organization* 2003;81(6):389.

Banken R. Strategies for Institutionalising HIA. *ECHP Health Impact Assessment Discussion Papers Number 1*. Brussels: European Centre for Health Policy, WHO Europe, 2001.

CHETRE. Health Impact Assessment in Australia and New Zealand: Centre for Health Equity Training, Research and Evaluation (CHETRE), University of New South Wales, 2009.

Corburn J, Bhatia R. Health impact assessment in San Francisco: Incorporating the social determinants of health into environmental planning. *Journal of Environmental Planning and Management* 2007;50(3):323-41.

den Broeder L, Penris M, Put GV. Soft data, hard effects. Strategies for effective policy on health impact assessment--an example from the Netherlands. *Bulletin of the World Health Organization* 2003;81(6):404-7.

DIPNR. City of Cities: A Plan for Sydney's Future. Sydney: NSW Department of Infrastructure, Planning and Natural Resources, 2005.

enHealth. Health Impact Assessment Guidelines. Canberra: National Public Health Partnership, Commonwealth Department of Health and Aged Care, 2001.

Equator Principles. The Equator Principles: A financial industry benchmark for determining, assessing and managing social & environmental risk in project financing. Washington D.C.: Equator Principles Financial Institutions, 2006.

Glasbergen P. Learning to Manage the Environment. In: Lafferty W, Meadowcroft J, editors. *Democracy and the Environment: Problems and Prospects*. Cheltenham: Edward Elgar, 1999:175-93.

Harris E, Harris-Roxas B. Health in All Policies: A pathway for thinking about our broader societal goals. *Public Health Bulletin South Australia*, 2010:43-46.

Harris P, Harris-Roxas B, Harris E, Kemp L. Health Impact Assessment: A practical guide. Sydney: UNSW Research Centre for Primary Health Care and Equity and NSW Health, 2007.

Harris P, Spickett J. Health impact assessment in Australia: A review and directions for progress. *Environmental Impact Assessment Review* 2011;31(4):425-32.

Harris-Roxas B, Harris E. Differing Forms, Differing Purposes: A Typology of Health Impact Assessment. *Environmental Impact Assessment Review* 2011;31(4):396-403.

Harris-Roxas B, Harris P, Harris E, Kemp L. A Rapid Equity Focused Health Impact Assessment of a Policy Implementation Plan: An Australian case study and impact evaluation. *International Journal for Equity in Health*, 2011.

Harris-Roxas B, Harris P. Learning by Doing: The value of case studies of health impact assessment. *NSW Pub Health Bull* 2007;18(9-10):161-63.

Harris-Roxas B, Simpson S, Harris E. Equity Focused Health Impact Assessment: A literature review. Sydney: CHETRE on behalf of the Australasian Collaboration for Health Equity Impact Assessment, 2004.

IFC. Introduction to Health Impact Assessment. Washington DC: International Finance Corporation, 2009.

IFC. Performance Standards on Social & Environmental Sustainability. Washington DC: International Finance Corporation, World Bank Group, 2006.

Mahoney M, Simpson S, Harris E, Aldrich R, Stewart Williams J. Equity Focused Health Impact Assessment Framework. Newcastle: Australasian Collaboration for Health Equity Impact Assessment, 2004.

Maxwell M, Harris P, Peters S, Thornell M, D'Souza L. A health impact assessment on the construction phase of a major hospital redevelopment. *Australian Health Review* 2008;32(3):509-19.

Maxwell ML. A health impact assessment of the Liverpool Hospital redevelopment. *New South Wales Public Health Bulletin* 2007;18(9-10):172-73.

NHMRC. National Framework for Environmental and Health Impact Assessment. Canberra: National Health and Medical Research Council, 1994.

PHAC. Crossing Sectors: Experiences in intersectoral action, public policy and health. Ottawa: Public Health Agency of Canada, 2007.

Salay M, Lincoln P. Health impact assessments in the European Union. *The Lancet* 2008;372(9641):860-61.

Salay R, Lincoln P. The European Union and Health Impact Assessments:Are they an unrecognised statutory obligation? . London: National Heart Forum, 2008.

Simpson S, Mahoney M, Dixon L, Kelly M, Lynch V, Katscherian D, et al. Health Impact Assessment in Australia: Context and diversity. In: Unit HIAR, editor. *6th United Kingdom and Ireland Health Impact Assessment Conference*. Birmingham, 2004.

Simpson S, Mahoney M, Harris E, Aldrich R, Stewart-Williams J. Equity-Focused Health Impact Assessment: A tool to assist policy makers in addressing health inequalities. *Environmental Impact Assessment Review*, 2005:772-82.

SSWAHS. Overweight and Obesity Prevention and Management Plan 2008-2012 Sydney: Sydney South West Area Health Service, 2008.

Ståhl TP. Is Health Recognized in the EU's Policy Process? An analysis of the European Commission's impact assessments. *European Journal of Public Health* 2010;20(2):176-81.

UK Department of Health. Putting Health in the Policy Picture: Review of how health impact assessment is carried out by Government departments. London: UK Department of Health, 2010.

WHO. Closing the Gap in a Generation: Health equity through action on the social determinants of health. Geneva: Commission on the Social Determinants of Health, World Health Organization, 2008.

WHO. Report on a Conference on Intersectoral Action for Health: A Cornerstone for Health-for-All in the 21st century, 20-23 April 1997, Halifax, Nova Scotia, Canada: World Health Organization and the Canadian Public Health Association, 1997.

WHO. World Health Report 2008: Primary health care - Now more than ever. Geneva: World Health Organization, 2008.

Wismar M, Blau J, Ernst K, Figueras J, editors. *The Effectiveness of Health Impact Assessment: Scope and limitations of supporting decision-making in Europe*. Copenhagen: European Observatory on Health Systems and Policies, World Health Organization, 2007.

11

Towards a 21st century system of mental health care—an Australian approach[191]

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Our most precious natural resource, as individuals and as a nation, is our health. Sadly, in both developed and developing countries a major part of our health is sorely neglected—our mental health. Good mental health allows us to live longer, achieve more, have a better family life, more friends, and contribute to a safer and more productive society. Put simply, mental health means national wealth.[192]

We are increasingly coming to understand that mental ill-health lies behind a young woman's concerns about her body image, behind bullying and youth violence, and behind binge drinking and drug abuse. Mental ill-health weakens workplaces, burdens working families and drives the senseless loss of life from suicide. Our growing awareness of the widespread impact of mental ill-health on our lives has created overwhelming support for national action to break the silence around these issues, to end the neglect, and build a 21st century model of mental health care.

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[191] This article is adapted from an earlier article entitled '21st Century mental health care: what it looks like and how to achieve it' published in the *Australian and New Zealand Journal of Psychiatry*, volume 19, pages 5-11, 2011.

[192] Beddington J et al. 2008.

A 21st century approach to mental health is about solving the problems of needless disability and loss of life. Our current mental health care system, and its supports and services, are woefully inadequate. We need a new approach *today*, because *every* day here in Australia:

- Over 300 Australians with mental health issues will present in distress to emergency departments and be turned away without being referred to an appropriate service. Our current system has collapsed under the strain and keeps all but the most desperate at bay.
- Six Australians will die by suicide. Many more will attempt suicide or self-harm.
- Over 1000 years of healthy life will be lost to mental ill-health. This costs us up to $30 billion every year—three times the mineral resources rent tax.
- Australians are up to three times less likely to receive quality care for mental ill-health than for physical ill-health. This is healthcare apartheid.
- Thousands of Australians with severe mental illness are in our jails because there are no other options and they have not received the mental health care they needed, when they needed it.
- Thousands of Australians, mostly young people with mental illnesses, will sleep outside tonight because we don't have adequate accommodation services to give them shelter.

These are not just numbers—they represent the pain and anguish of real people and real families. A 21st century approach to mental health must fix these problems and can provide real benefits to everyone.

What a 21st century approach to mental health will do

At the community level, a 21st century approach to mental health means that people understand what it means to be mentally healthy and are able to recognise, as they do with physical illnesses like heart disease and cancer, the earliest signs of mental ill-health. People need to feel comfortable about sharing their experience of mental ill-health with those close to them, and to ask for help if they need it. Currently, many people do not recognise when their mental health is failing and do not seek help. With the right information, everyone can be equipped with the knowledge and skills to respond to mental health issues in a helpful way, just as we do now when someone sprains their ankle, has an asthma attack, faints or develops chest pain. A better understanding of mental health issues means that words like ‘nutter’, ‘schizo’ and ‘psycho’ will become as unacceptable as racist and sexist language is now. This is the antidote to the poison of stigma.

At the health care system level, a 21st century approach to mental health provides stigma-free comprehensive community-based mental health care closely linked to the primary care system. This includes assertive mobile teams available 24 hours a day, just like all our other emergency services. This will stem the flow of people with mental health issues into our emergency departments and our hospitals. Currently, Australians with serious mental illnesses have poorer access to quality physical health care and on average die 20 years earlier than expected, typically from suicide, cardiovascular disease, or cancer. A 21st century health care system needs to deliver equity in access to mental and physical health care; these people need high quality physical health care so that their life expectancy comes to equal to that of the rest of the population. Furthermore, this approach ensures that all people with persistent serious mental illness are able to live in a safe and secure environment, namely their own home. Stable housing is a basic human right; let’s finally correct this great failure of deinstitutionalisation.

A 21st century approach to mental health takes an active stance on preventive opportunities and tackles the key drivers of mental ill-health in childhood and youth, such as social disadvantage, child abuse, bullying, and poorly treated mental illness and addiction in the parents. Because the peak period for the onset of mental health difficulties that may well persist into adult life as serious mental illness is between 12 – 25 years[193,194], a 21st century approach to mental health provides a stigma-free stream of care to young Australians that offers integrated, multidisciplinary expertise in a youth-friendly environment that creatively uses new technologies.

A 21st century approach to mental health sets targets for reducing the suicide toll and delivers a national suicide prevention strategy on the same scale as the campaign to reduce the road toll. Currently, suicide is the biggest killer of adults up to the age of 40. This is a public health scandal 40 per cent greater in magnitude than the road toll, and is hidden from public view by fear and shame. Let's bring it out in the open.

Finally, a 21st century approach to mental health features strong investment in research, especially research into novel treatments. Only 3.5 per cent of today's national health research budget goes to mental health research. This is another serious side effect of stigma and prejudice. Although we do have effective treatments, just like in heart disease, cancer and diabetes we always need to strive for safer and even more effective treatments, not only drug therapies, but novel psychological interventions and social care.

The 21st century approach in practice

Because I am most familiar with it personally, as one example of a 21st century approach that is already available to some people, I am going to present the youth mental health model that is slowly emerging around

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[193] Kessler RC et al. 2005.

[194] Australian Institute of Health and Welfare. 2007.

Australia. This model is built around two closely linked components: *headspace*[195], for young people with mild-to-moderate mental health issues; and EPPIC[196]], for young people with emerging serious or complex mental illnesses.

The best way to grasp the 21st century nature of the approach represented by *headspace* and EPPIC is to think of that other 21st century advance—the iPhone. The breakthrough behind this modern icon is that it simply brings together in a single platform so many of the key tools or 'applications' we need to function in the modern world. It is engaging, efficient and hence popular; everyone wants one. *headspace* and EPPIC are based on the same simple idea—the one stop shop, where the main applications that young people need to protect or recover their mental health can be found.[197] There's a range of applications available: youth-friendly doctors; allied health professionals; drug and alcohol clinicians; educational/vocational expertise; and other back-up programs such as community awareness and outreach. *headspace* is an enhanced form of primary care based in the heart of the community, providing real expertise without stigma or strings attached.

Young people with more complex or severe forms of mental ill-health need access to additional applications such as hospital or residential care, 24-hour home-based interventions, access to specialist psychiatrists or specialised clinics—hence the need for an integrated back-up system for *headspace*. This back-up is EPPIC[198], which provides more specialised care aimed at maximising recovery from serious mental illnesses, especially the psychotic disorders, during the challenging early years of illness when great therapeutic tenacity and sophisticated scaffolding is essential. EPPIC has been so successful in promoting early detection and access, and reducing the

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[195] McGorry PD et al. 2007.

[196] McGorry PD et al. 1996.

[197] Purcell R et al. 2011.

[198] McGorry PD et al. 1996.

disability, mortality and costs of potentially serious mental illnesses like schizophrenia, that it has been implemented in hundreds of locations across the developed world.[199] Of course there are other potentially serious disorders such as severe mood disorders, personality disorders, eating disorders and substance use disorders which need to be covered by a back-up system like this in support of *headspace* and other primary care settings.

Just as the iPhone was made possible by innovative engineering, so too the 21st century model of youth mental health represented by *headspace* and EPPIC is based on the latest in smart design and consumer-driven understanding of young people and their mental health. So what are these distinctive innovations? Let's start with the youth focus. Traditionally mental health services have been divided between services for under 18s and over 18s. This makes no sense—we know that the emerging adult phase of 12–25 years is distinct from early childhood or older adulthood. *headspace* and EPPIC focus on this age range, with a youth-friendly culture that can engage young people, and offer flexible and agile responses. Early intervention is a key principle, which means as soon as problems emerge they are recognised and responded to. This does *not* mean early use of medications or an excessively narrow clinical approach, but rather a stepwise pathway of care. Early intervention is an established principle in general medicine, but in mental health it has only recently broken into the mainstream.[200] New technologies, especially internet-based information and therapies are a feature, and *headspace* and EPPIC seek to work in collaborative and complementary partnership with other innovative youth mental health services like ReachOut! and young beyondblue. Families are welcomed and supported as a key resource in a young person's recovery. Youth participation is a hallmark—*headspace* and EPPIC are services that innovate new ways of being

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[199] Edwards J and McGorry P. 2002.

[200] Insel TR. 2007.

accountable to young clients and incorporating their ideas in further service improvements. Finally, *headspace* and EPPIC are optimistic, with a recovery focus. There is real faith in the resilience of young people while ensuring they still receive the most expert help. The aim is to provide some of the extra scaffolding and specific interventions that so many young people need to lead healthy and fulfilled lives.

First steps towards creating this 21st century approach

All of us—governments, mental health workers and the wider community—have a common interest and important roles to play in creating a 21^{st} century approach to mental health care here in Australia. The federal government's recent allocation of 1.5 billion of much needed new investment in mental health is an important initial step towards transformational reform. Although the scale of this initial reform investment does not yet fully reflect the level of unmet need, the government's package is nonetheless well balanced, smartly targeted and lays the groundwork for future reforms. The package contains measures to reduce the burden of mental illness on children and young Australians through prevention and early intervention and to improve the social inclusion and economic participation in the middle and later years of people with severe and enduring mental illness.

Some of these measures, such as the scaling up of *headspace* from the current 30 centres nationally to a total of 90 centres, and the first stage of a national rollout of the EPPIC model of care, are groundbreaking and will deliver better health, social and economic outcomes as well as radically changing the culture and design of Australia's mental health system. Hard research evidence shows these programs will greatly reduce the numbers of young people ending up on disability support.[201,202,203,204,205] However, care needs to be taken to ensure that this new funding is focused where it has optimal prospects for improving lives and achieving significant changes in culture and practice. Much is riding on the successful rollout of the EPPIC model, so it is imperative that these new services have full fidelity to the EPPIC model, and that they are led by enthusiastic, capable change agents and are given mandates appropriate to the level of funding they are allocated. This will require specific governance, as was achieved with the national rollout of *headspace*. The result there has been rapid scaling up of a model with benefit to tens of thousands of Australians, and this long-overdue creation of a nation-wide stream of mental health care specifically designed for young people will benefit many thousands more.

More broadly, to close the huge gap in access and quality compared with physical health care, the government's investment package must be the first instalment of a 10-year program of scaling up of capacity in Australia's system of mental health care. The ball is now in the court of the state and territory governments. The federal government's package is targeted at strengthening primary and community-based care—action from the premiers is still required if acute and hospital-based care are also to get the urgent attention they need. A credible national reform and investment plan that adds state and territory investment to the federal mental health package is now crucial to successful reform.

Australia's mental health professionals should embrace the opportunity to become change agents by engaging positively and creatively with these new measures. We should be ready to partner with government and the community in sharing the responsibility and

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[201] Bertelsen M et al. 2008.

[202] Gafoor R et al. 2010.

[203] McCrone P et al. 2010.

[204] McGorry P et al. 2010.

[205] Mihalopoulos C et al. 2009.

accountability for achieving real outcomes. Success for this round of funding will help secure future investment, and as the fiscal climate improves, to comprehensively fix Australia's mental health system. As a sector, we need to unite and work cohesively to achieve the changes our chosen field so desperately needs.

At the community level, we can all challenge and defeat stigma whenever we encounter it. It's vital that every person who has been touched by mental ill-health share these experiences in an open and unashamed way—that's the first step. We can all talk openly about both mental health and mental ill-health with family members, friends and colleagues. Consider doing a mental health first aid course to increase your skills and confidence about responding to the mental health needs of the people around you. We can also donate: philanthropists large and small can support mental health research, innovation and advocacy. And all of us who have been let down by our current system can let people know why they insist on a 21st century approach to mental health for all age groups by writing to the newspapers, ringing talkback radio, arranging to meet their local MP, or forming a local action group. We need to make our message heard—Australians deserve a better deal, and the community has a critical role to play in continuing to express strong support for mental health reform as one of our most pressing national priorities.

Finally, it is heartening to see how our community's concerns and our increasing expectation that we should have access to the same quality of care for our minds as we do for our bodies has now been reflected by government action. Mental health reform now has champions across the Australian parliament, with politicians of all parties and, notably, all the leaders and the key independents committed to tackling this long neglected but vitally important challenge. Australians applaud this tri-partisan political leadership, which puts mental health above politics. I sense we have passed the tipping point; our calls for action have been heard, and our need for a new approach to mental health is now matched by our determination and the first steps towards a new capacity to deliver it. If all of us play our parts in this reform agenda, together we have every chance of creating the 21st century system of care that we so desperately need.

References

Australian Institute of Health and Welfare. Young Australians: their health and well-being 2007. Canberra: Australian Institute of Health and Welfare; 2007.

Beddington J, Cooper CL, Field J, Goswami U, Huppert FA, Jenkins R, et al. The mental wealth of nations. Nature 2008;455(7216):1057-1060.

Bertelsen M, Jeppesen P, Petersen L, Thorup A, Ohlenschlaeger J, le Quach P, et al. Five-year follow-up of a randomized multicenter trial of intensive early intervention vs standard treatment for patients with a first episode of psychotic illness: the OPUS trial. Archives of General Psychiatry 2008;65(7):762-771.

Edwards J, McGorry P. Implementing early intervention in psychosis: a guide to establishing early psychosis services. London: Martin Dunitz 2002.

Gafoor R, Nitsch D, McCrone P, Craig TK, Garety PA, Power P, et al. Effect of early intervention on 5-year outcome in non-affective psychosis. British Journal of Psychiatry 2010;196(5):372-376.

Insel TR. The arrival of pre-emptive psychiatry. Early Intervention in Psychiatry 2007;1(1):5-6.

Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry 2005;62(6):593-602.

McCrone P, Craig TK, Power P, Garety PA. Cost-effectiveness of an early intervention service for people with psychosis. British Journal of Psychiatry 2010;196(5):377-382.

McGorry P, Johanessen JO, Lewis S, Birchwood M, Malla A, Nordentoft M, et al. Early intervention in psychosis: keeping faith with evidence-based health care. Psychological Medicine 2010;40(3):399-404.

McGorry PD, Edwards J, Mihalopoulos C, Harrigan SM, Jackson HJ. EPPIC: an evolving system of early detection and optimal management. Schizophrenia Bulletin 1996;22(2):305-326.

McGorry PD, Tanti C, Stokes R, Hickie IB, Carnell K, Littlefield LK, et al. headspace: Australia's National Youth Mental Health Foundation—where young minds come first. The Medical Journal of Australia 2007;187(7 Suppl):S68-70.

Mihalopoulos C, Harris M, Henry L, Harrigan S, McGorry P. Is early intervention in psychosis cost-effective over the long term? Schizophrenia Bulletin 2009;35(5):909-18.

Purcell R, Goldstone S, Moran J, Albiston D, Edwards J, Pennell K, et al. Towards a 21st century approach to youth mental health care: some Australian initiatives. International Journal of Mental Health 2011; in press.

12

The challenge of health inequalities in rural and remote Australia

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Introduction

In general, Australians enjoy good health status, with a life expectancy that is among the highest in the world.[206] However, substantial health inequalities and inequities exist between certain population subgroups in Australia and, in aggregate, those living in rural and remote Australia are relatively disadvantaged. Health outcomes of Australians deteriorate with increasing remoteness.[207] Life expectancy was on average 1-2 years lower in regional areas and seven years lower in remote areas than in major cities. These differentials are not totally accounted for by the much poorer health status of the larger proportion of Indigenous people living in rural and remote areas, meaning that residence in sparser and more remote areas is itself a health risk factor.[208]

Rural Australians

About 34 per cent of the Australian population (or 7.5 million people) live in rural and remote areas as classified by the Australian

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[206] UNDP. 2010.
[207] AIHW. 2008.
[208] AIHW. 2008; Humphreys 1999.

Standard Geographic Classification (ASGC) system based on physical remoteness from goods and services.[209] Table 1 below summarises some key characteristics of people living in rural and remote areas as compared to those living in major cities.

It is important to bear in mind that rural communities are highly diverse: 'While the defining characteristic of rural health remains its geography (and related issues of access to healthcare services), rural and remote Australia is also sociologically, culturally, economically and spiritually different from metropolitan areas, as well as internally diverse. It is these characteristics that define the health behaviour of its residents, determine their health status and influence the way health and medical care is provided'.[210]

For example, regional centres of 1000 to 100 000 tend to have a younger age profile and employment is concentrated in the retail, health and manufacturing industries, whereas in small towns of 200 to 1000, people tend to be older and there is a higher proportion of low-income households. In places of less than 200, people tend to rely more on agriculture for employment and many of these places are losing population.[211]

There is also great diversity due to the existence of the two-speed (or 'patchwork') economy. Many mining towns and nearby rural service centres are experiencing strong economic and population growth, while towns and regions dependent on agriculture or tourism are not.[212]

The nature and extent of health inequalities in rural Australia

There is strong evidence that those living in rural and remote areas have poorer health outcomes than their city counterparts. They face

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[209] AIHW. 2008.

[210] Wakerman, J and Humphreys, J. 2002.

[211] Bureau of Rural Sciences. 2008.

[212] ABS. 2008.

higher levels of risk behaviours, morbidity and mortality—with the result that they have lower life expectancy. The National Health Survey 2007–08 shows that rural residents live with higher levels of lifestyle-related risk. They are more likely to smoke, to drink alcohol excessively (for males), to have had a substance use disorder, be physically inactive, eat insufficient fruits and be overweight or obese.

Table 1: Key characteristics of people living in rural and remote Australia

Per cent of:	**Major Cities**	**Inner Regional**	**Outer Regional**	**Remote**	**Very Remote**
national population living in each area	66	21	10	2	1
Indigenous population living in each area	30	20	23	9	18
population in each area who are Indigenous	1	2	5	12	45
people living in areas classified in the most disadvantaged SEIFA quartile (1996)	20	28	33	26	53
non-Indigenous youth starting tertiary study	39	27	24	13	21
adults employed in primary production and mining	<1	4	11	20	16
households with internet connection	66	58	55	53	42

Source: ABS 2006 and AIHW 2008 (as cited in Phillips 2009)

Consequently, rural residents have significantly higher levels of morbidity and mortality. Compared with their city counterparts, those living in rural and remote areas had a 26.5 per cent greater burden of disease, with the excess burden contributed largely by injuries (29.1 per cent for intentional and unintentional injury combined), followed by diabetes (19.5 per cent) and cardiovascular disease (9.1 per cent).

Rural residents were also more likely to be affected by some form of disability, mental illness or behavioural problems. Quality of life is also lower, with rural residents being more likely to assess their health as fair or poor, as well as being more likely to experience asthma and back pain.

Mortality rates increase with increasing remoteness. For those living in inner regional, outer regional, remote and very remote areas respectively, mortality rates were 1.07, 1.12, 1.18 and 1.69 times higher than for metropolitan residents. Survival rates for cancer also fall with increasing remoteness.[213] Furthermore, despite a general fall in mortality rates in Australia between 1992 and 2003, mortality due to some causes has remained unchanged in rural areas, including that due to chronic obstructive pulmonary disease among rural women, and that due to suicide for both men and women in rural areas.[214]

Because of the great diversity among rural and remote places, it has been suggested that differences in health status *within* those places may be as pronounced as those between rural and urban areas.[215] For example, people living in inland inner regional areas had 1.1 times higher mortality rates than metropolitan residents, whereas the mortality rate for those living in coastal inner regional areas was similar to that for metropolitan residents.[216,217]

Why do rural Australians experience health inequalities?

The health inequalities experienced by rural Australians can be partly attributed to the 'social determinants of health'—the social and

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[213] AIHW. 2008.

[214] AIHW. 2006; AIHW National Mortality Database 2002–04; Begg et al 2007; NHS 2004–05; NHS 2007–08.

[215] Wilkinson, D et al 2000.

[216] AIHW. 2007.

[217] It may be that the coast is a mitigating factor for the influence of remoteness on health status; if this is the case, and as someone has recently tweeted, government could fix such problems by providing all inland areas with a stretch of coastline.

environmental conditions in which people live, work and play.[218] The final report of the Commission on Social Determinants of Health by the World Health Organisation published in 2008 describes social determinants of health as:

> ...the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives—their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities—and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.

Rural location itself contributes to the health inequalities experienced by rural people. In a review by Smith et al[219], the authors conclude that 'rurality *per se* does not necessarily lead to rural-urban disparities, but may exacerbate the effects of socio-economic disadvantage, ethnicity, poorer service availability, higher levels of personal risk and more hazardous environmental, occupational and transportation conditions'.

In the following paragraphs, we elaborate on the individual social determinants of health specific to rural communities and how they influence knowledge, attitudes and behaviours related to health.

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[218] Marmot, M. 1999.

[219] Smith, K et al 2008.

Socioeconomic factors

People living in rural and remote areas have lower socioeconomic status than those in the major cities, and that single variable has been strongly associated with greater health risk factors and poorer health outcomes.[220] Residents of rural areas in Australia tend to experience higher levels of poverty[221], with exceptions being those living in coastal regions and areas close to popular amenity areas.[222] They are also more likely to have lower levels of education, which can translate into lower health literacy and fewer employment options and opportunities. Rural residents are also more likely to work in primary production (including agriculture, forestry, fishing) and mining industries which tend to have greater occupational hazards and risk of injuries.[223]

Those working in farming experience the economic and social consequences of climatic variability, while primary industries (including fishing) are likely to be significantly impacted by climate change.[224] Furthermore, rural residents are more affected by disability, which is also strongly associated with poverty.[225]

Sociocultural factors

Rural residents tend to possess stoic attitudes and a more functional view of health and may delay seeking treatment until they are unable to perform their usual tasks[226] noted ‘Rather than concerns over pain or cosmetic attractiveness, maintaining performance or productivity, despite adversity, is an important concept for well-being amongst rural dwellers’. In addition, a delay in seeking care can result from a perceived lack of privacy and confidentiality in rural communities as

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[220] Beard, J et al 2009; Turrell et. al. 2006.

[221] Tanton, R et al 2009.

[222] Bureau of Rural Sciences. 2008.

[223] Driscoll, T and Mitchell, R. 2002.

[224] Bi, P and Parton, K. 2008.

[225] Community Affairs References Committee 2004.

[226] Judd, F et al 2006, Veitch, C. 2009, Elliot-Schmidt, R and Strong, J. 1997.

healthcare professionals are more likely to be personally known to the patient.[227]

On the positive side of the ledger, rural communities tend to experience higher levels of social support and a 'sense of belonging'.[228] For example, volunteering rates in rural communities are considerably higher than the national average.[229] However, out-migration of young people and families with children can reduce the number of social networks and thus the level of social support.

Environmental factors

In rural and remote areas, road quality tends to be poorer and distances greater, which increases the risk of motor vehicle accidents and related injuries and deaths.[230] In more remote areas, there are additional environmental factors that adversely affect people's health, such as limited access to fresh fruit and vegetables, lack of fluoridated water, limited access to sports and recreational facilities as well as poor infrastructure for housing and sewage disposal. On the other hand, there are potential health benefits to living in a rural environment, with those commonly cited including being closer to nature and having more open spaces, less traffic and congestion and a slower pace of life.

Barriers to access and utilisation of health services

Rural residents— who are already disadvantaged socioeconomically— face the additional burden of poorer access to preventive and acute health services. While state jurisdictions do provide some primary care services, the lack of Medicare funded services often means that hospital treatment remains the default option. Additionally, analysis

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[227] Brown, W et al. 1999.

[228] Wolstenholme, R. 1995.

[229] Bureau of Rural Sciences. 2008.

[230] Veitch, C. 2009.

undertaken by the National Rural Health Alliance (2011) shows that there are major deficits in the government's recurrent expenditure on health services in rural areas. The estimated total deficit is $2.46 billion, comprising a Medicare deficit of $811 million, a pharmacy deficit of $850 million and 'other primary care' deficit of at least $800 million. This poorer access to health services contributes to the lower utilisation of health services by rural residents. Table 2 shows that utilisation of Medicare-funded services decreases with increasing remoteness.

Table 2: Utilisation of Medicare-funded services by remoteness

Services received as a proportion of services received in Major Cities	**Inner Regional**	**Outer Regional**	**Remote**	**Very Remote**
MBS GP services	84%	79%	71%	54%
MBS specialist services	74%	59%	38%	30%
MBS allied health services	75%	45%	24%	9%

Source: NRHA 2010 and AIHW health expenditure database 2006-07

Lower levels of utilisation of health services are due to various factors, including shortages of healthcare professionals across-the-board[231], ageing infrastructure and the budgetary underspend described above.

Rural residents also face higher costs in accessing health services. A report by the National Institute of Industry and Economic Research (2009) showed that rural residents face higher costs than urban residents in accessing essential services including doctors, hospitals, schools, TAFE colleges and universities. Increased costs also result

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[231] ABS. 2006.

from higher travel and accommodation costs when seeking health services away from home. Greater travel distance required to access health services and the lack of public transport in rural areas present further barriers to access and utilisation.

Reducing health inequalities and inequities

It is essential that there be strong government leadership and commitment to address health inequalities in rural and remote Australia. A good example is the current COAG National Healthcare Agreement with its stated objectives to address health inequalities of population subgroups, including rural Australians. The strategies proposed include improving rural Australians' access to health services through better travel and accommodation, telehealth and workforce initiatives as well as through 'linking health interventions into broader activities designed to redress disadvantage'.

A review undertaken by Newman et al (2006) found that there is explicit or implicit commitment from all state and territory governments to reducing health inequities and to addressing the social determinants of health—at least to a limited extent. However, there are also policies that further disadvantage the poor, such as 'user pays' schemes for basic infrastructure (roads and telecommunications). The lack of government initiatives to provide public transport in rural areas further disadvantages rural residents. The entrenched nature of vested interests remains a barrier to achieving the sort of legislative change that is required to overcome these difficulties.

Correcting the situation needs a strong societal commitment to address health inequalities and to build a fairer society. Rural Australians should be valued for the major contribution they make to the economy and community.

Even projects with great capacity to improve social equity, such as a universal wholesale price for high-speed broadband, have met stiff opposition as the existence of a cross-subsidy comes into focus. The

National Broadband Network is a good example of the need to depart from a user pays principle to a needs based approach to funding. The services of the National Broadband Network, if provided at an affordable and uniform retail price, have huge potential health and social benefits for those living in rural and remote areas, including through the wider availability of e-health technologies.[232]

Despite the increased government focus and funding for rural health in recent years, the inequalities faced by rural residents persist. Federal and state governments will need to develop a comprehensive policy and action plan that focuses on reducing health inequalities and improving social determinants of health in rural communities.[233] Multiple strategies will be required, including those focusing on poverty reduction, early child development, education and lifelong learning, employment opportunities and work conditions, healthy environments (such as public transport and affordable housing) and the prevention of ill health.[234]

The strategies will need to include both upstream and downstream measures. An example of an upstream measure would be policy addressing the supply and ease of access to alcohol. A 'whole-of-society' approach is required, involving non-health sectors such as education, employment, transport, housing, welfare and taxation as well as the private and community entities.[235] Strong coordination across different government agencies is also required.

The development of the strategy will require strong community consultation so as to engage and empower rural communities. Given that rural communities have unique and diverse characteristics as described previously, solutions will need to be localised rather than follow a one-size-fits-all approach. Local governments play a key role too, in the creation of healthy environments through their provision

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[232] NRHA. 2011.

[233] Friel, S. 2009, Smith, K et al. 2008, Turrell, G et al. 2006.

[234] Australian Council of Social Service. 2003, Marmot, M. 2010.

[235] Turrell, G. 2006.

and management of facilities and services that are supportive of healthy lifestyles. As local coordinating agencies, the proposed Medicare Locals should be required to improve delivery of integrated health services as well as health promotion programs in rural and remote areas. Medicare Locals should also provide opportunities to develop service models that reduce health inequalities in rural and remote areas through stronger collaboration with the rural health research community.[236]

Conclusions

The significantly poorer health experienced by people in rural and remote Australia is caused in large part by a number of interrelated socio-economic and socio-cultural characteristics and by the rural environment. Their health inequalities are further exacerbated by barriers to access and utilisation of health services in the locations in which they live and work.

Health care reform should be focused on, and judged by, its effect on those with the greatest current needs, including those in rural, regional and remote Australia. Strong government leadership, commitment and action is required to address health inequality through multiple strategies and a 'whole-of-society' approach. Because rural and remote communities are highly diverse, interventions to reduce the health inequalities they experience must be made 'fit for purpose' through localisation and community consultation.

With the Australian economy experiencing a sustained and strong period of growth, now is a good time to take action on the social determinants of health. Everyone will gain, but especially those who are currently bearing the brunt of the inequity. Even governments will benefit in the medium term, through improvements in the population's health and reductions in early and substantial acute interventions that are preventable.

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[236] Perkins, D. 2011.

In the UK context the Marmot Review concluded:

> It is inaction that cannot be afforded, for the human and economic costs are too high. The health and well-being of today's children depend on us having the courage and imagination to rise to the challenge of doing things differently, to put sustainability and well-being before economic growth and bring about a more equal and fair society.

Here in Australia, the vision of *Healthy Horizons Outlook 2003–07* remains to be achieved: 'People in rural, regional and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities.'

All of us, regardless of our place of residence, should have equal opportunity to develop our potential or, in Australian slang: have a fair go at leading a flourishing life.

References

Australian Bureau of Statistics (2011). Australian Social Trends. Health outside major cities.

Australian Bureau of Statistics (2008). Australian Social Trends. Towns of the mineral Boom. Available at www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Chapter3102008.

Australian Bureau of Statistics (2010). Australian Standard Geographical Classification.

Australian Bureau of Statistics (2009). National Health Survey: Summary of Results, 2007–2008. Available at abs.gov.au/AUSSTATS/abs@.nsf/mf/4364.0/.

Australian Bureau of Statistics (2006). 2006 Census of Population and Housing.

Australian Bureau of Statistics (2003). Survey of Disability, Ageing and Carers (SDAC): Summary of Findings, 2003. Available at www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0.

Australian Council of Social Service (2003). Paper 127. The Bare Necessities: Poverty and Deprivation in Australia Today. Submission to the Senate Inquiry into Poverty and Financial Hardship.

Australian Government. Department of the Prime Minister and Cabinet. Social Inclusion Unit (2010). A Stronger, Fairer Australia – a new social inclusion strategy.

Australian Institute of Health and Welfare (2010). Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure. Health and welfare expenditure series no. 50. Cat. no. HWE 50. Canberra: AIHW.

Australian Institute of Health and Welfare (2008). Rural, regional and remote health: indicators of health status and determinants of health. Rural Health Series no. 9. Cat. no. PHE 97. Canberra: AIHW. Available at www.aihw.gov.au/publications/index.cfm/title/10519.

Australian Institute of Health and Welfare, Cancer Australia & Australasian Association of Cancer Registries, 2008. Cancer survival and prevalence in Australia: cancers diagnosed from 1982 to 2004. Cancer Series no. 42. Cat. no. CAN 38. AIHW: Canberra. Available at www.aihw.gov.au/publications/index.cfm/title/10484.

Australian Institute of Health and Welfare (2007). Rural, regional and remote health: a study on mortality (2nd edition). Rural health series no. 8. Cat. no. PHE 95. Canberra: AIHW.

Australian Institute of Health and Welfare (2006). Rural, Regional and Remote Health – Mortality Trends 1992–2003. AIHW Cat. No. PHE 71. Rural Health Series no. 7. Canberra: AIHW, 2006.

Beard, J. R., Tomaska, N., Earnest, A., Summerhayes, R. and Morgan, G. (2009). Influence of socioeconomic and cultural factors on rural health. Australian Journal of Rural Health, 17: 10–15.

Begg S,Vos T, Barker B, Stevenson C, Stanley L, Lopez AD. (2007). The Burden of Disease and Injury in Australia 2003. AIHW cat. no. PHE 82. Brisbane: School of Population Health (University of Queensland) &AIHW, 2007. Available from www.aihw.gov.au/publications/hwe/bodaiia03/bodaiia03-c00.pdf.

Bi, P. and Parton, K. A. (2008). Effect of climate change on Australian rural and remote regions: What do we know and what do we need to know?. Australian Journal of Rural Health, 16: 2–4.

Brown WJ, Young AF, Byles JE. (1999). Tyranny of distance? The health of mid-age women living in five geographical areas of Australia. Australian Journal of Rural Health 1999; **7**: 148–154.

Bureau of Rural Sciences (2008). Country Matters: 2008 Social Atlas of Australia.

Community Affairs References Committee (2004), A Hand Up Not a Hand Out: Renewing the Fight against Poverty. Report on Poverty and Financial Hardship, The Senate, Parliament House, Canberra.

Dixon, J. and Welch, N. (2000). Researching the Rural–Metropolitan Health Differential Using the 'Social Determinants of Health'. Australian Journal of Rural Health, 8: 254–260.

Driscoll T, Mitchell R. (2002). Fatal work injuries in New South Wales. New South Wales Public Health Bulletin 2002; 13: 95–99.

Elliot-Schmidt R, Strong J. (1997). The concept of well-being in a rural setting: Understanding health and illness. Australian Journal of Rural Health 1997; 5: 59–63.

Friel S. (2009). Health equity in Australia: A policy framework based on action on the social determinants of obesity, alcohol and tobacco.

Humphreys, 1999: Rural health status: what do statistics show that we don't already know?, Australian Journal of Rural Health, 7: 60-63.

United Nations Development Programme (2010). Human Development Report 2010. 20th Anniversary Edition. The Real Wealth of Nations: Pathways to Human Development.

Judd F, Jackson H, Komiti A. (2006). Help-seeking by rural residents for mental health problems: the importance of agrarian values. The Australian and New Zealand Journal of Psychiatry 2006; 40: 769–776.

Marmot, M. (2010). Fair society, healthy lives. In The Marmot review: Strategic review of health inequalities in England post-2010. London: The Marmot Review. www.marmotreview.org/.

Marmot M, Wilkinson R (eds) (1999). Social Determinants of Health. Oxford: Oxford University Press, 1999.

National Institute of Industry and Economic Research (2009). Essential Services in Urban and Regional Australia – a Quantitative Comparison.

National Rural Health Alliance (2011). Australia's health system needs re-balancing: a report on the shortage of primary care services in rural and remote areas.

National Rural Health Alliance (2011). Universal broadband offers better health for the bush. Media Release, 4 March 2011.

National Rural Health Alliance (2010). Measuring the metropolitan-rural inequity.

National Rural Health Alliance (2003). Healthy Horizons - Outlook 2003-2007: A Framework for Improving the Health of Rural, Regional, and Remote Australians. A Joint Development of the Australian Health Ministries' Advisory Council's National Rural Health Policy Sub-committee and the National Rural Health Alliance for the Australian Health Minister's Conference.

Newman L, F Baum, E Harris (2006). 'Federal, State and Territory government responses to health inequities and the social determinants of health in Australia', Health Promotion Journal of Australia, 17(3):217-225.

Oldenburg B, McGuffog ID & Turrell G 2000. Socioeconomic determinants of health in Australia: policy responses and intervention options. Medical Journal of Australia 172:489–92.

Paradies, Y., Harris, R, Anderson I. (2008). The Impact of Racism on Indigenous Health in Australia and Aotearoa: Towards a Research Agenda, Discussion Paper No. 4, Cooperative Research Centre for Aboriginal Health, Darwin.

Perkins, D. (2011), The Australian health care reforms: Better services for rural residents?. Australian Journal of Rural Health, 19: 57–58.

Phillips, A. (2009), Health status differentials across rural and remote Australia. Australian Journal of Rural Health, 17: 2–9.

Rolley, F. (2000). 'Establishing research priorities for healthy rural communities'. Discussion paper, Health Inequalities Research Collaboration (HIRC) Workshop, 12 July 2000, Canberra.

Royal Australasian College of Physicians (2005). Inequity and health: a call to action: addressing health and socioeconomic inequality in Australia, policy statement.

Smith, K. B., J. S. Humphreys, M. G. A. Wilson (2008). 'Addressing the health disadvantage of rural populations: How does epidemiological evidence inform rural health policies and research?' Australian Journal of Rural Health 16(2): 56-66.

Tanton, R., McNamara, J., Harding, A. and Morrison, T. (2009) Rich suburbs, Poor suburbs? Small area poverty estimates for Australia's Eastern Seaboard in 2006, in A. Zaidi, A. Harding, & P. Williamson (eds), New Frontiers in Microsimulation Modelling, Ashgate, London.

The Royal Australasian College of Physicians (2005). Inequity and Health: A call to action. Addressing Health and Socioeconomic Inequality in Australia Policy Statement 2005.

Turrell G, Stanley L, de Looper M, Oldenburg B (2006). Health Inequalities in Australia: Morbidity, health behaviours, risk factors and health service use. Health Inequalities Monitoring Series No. 2. AIHW Cat. No. PHE 72. Canberra: Queensland University of Technology.

Turrell G, Oldenburg B, McGuffog K and Dent R. (1999). Socioeconomic determinants of health: Towards a national research program and a policy and intervention agenda, Queensland University of Technology School of Public Health, Ausinfo, Canberra.

Veitch, C. (2009), Impact of rurality on environmental determinants and hazards. Australian Journal of Rural Health, 17: 16–20.

Wakerman J, Humphreys JS. (2002). Rural health: why it matters. Medical Journal of Australia, 176: 457-458.

Wilkinson D, Hiller J, Moss J, Ryan P, Worsley T. (2000). Mortality variation across Australia. Descriptive data for states and territories, and statistical divisions. Australian and New Zealand Journal of Public Health 2000; 24: 226–233.

Wolstenholme R. (1995). Understanding small rural communities, The Rural Development Centre, University of New England, Armidale.

World Health Organisation (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.

13

Determining the determinants—is child abuse and neglect the underlying cause of the socio-economic gradient in health?

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The socio-economic gradient in health is well documented in a large body of published research. It applies across countries and over time. People of higher socio-economic status (SES) are observed, on average, to have better health than those of lower SES. This relationship is seen in age and sex standardised mortality ratios[237], incidence and prevalence of mental and physical health conditions[238] and total disability adjusted life years (DALYs).[239] Differences can be considerable, for instance mortality rates were 2.7 times higher in the lowest quintile of relative SES disadvantage compared with the highest quintile for Australians aged 25–44 in 2005–2007.[240] Differentials also tend to increase or decrease monotonically, across the entire

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[237] Thomas, B et al. 2010.

[238] Brown, L and Nepal, B 2010.

[239] Begg, S et al. 2007.

[240] Brown, L and Nepal, B 2010.

SES range (although not at the same rate of change). Differentials in health can be considerably greater for pockets of severe deprivation. For example, the median survival for indigenous Australian males was 52.5 years in 2009, 25.5 years lower than for non-indigenous males[241], while across local areas of Glasgow, life expectancy is estimated to vary between 54 and 83 years.[242]

Relationships are documented between health and composite variables of SES as well as individual components; such as income, employment status, education, housing tenure and crowding, and related social variables such as crime, experience of racism, etc. The observed correlation between SES and health has seen wide acceptance of the importance of the 'social and economic determinants of health'.

Cause of the SES gradient in health

While, the existence of an SES gradient in health is not contested, the underlying causal mechanisms are not yet fully understood. The very language, 'social determinants' presumes that all factors so designated have a causative relationship with health, but of course correlation does not imply causation.

Given a policy aim of reducing health inequalities, then identifying those causative factors that are modifiable and quantitatively important in their influence on health is critical. Attributes that have a statistically significant relationship with health, but are of small influence or unresponsive to practice or policy manipulation are not good candidates for intervention. If effective solutions are to be found, it is critical to understand the causal mechanisms that can be interrupted.

Various theories and mechanisms have been proposed to explain the relationship between SES and health. We have grouped

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[241] ABS. 2011.

[242] Hanlon, P et al. 2006.

commonly espoused explanations for the SES gradient in health into five interrelated categories: (i) the direct effects of perceived or actual disempowerment (including racist attitudes, hierarchical structures etc.) as an environmental stressor, with associated physiological sequelae (especially proposed by the Marmot Review, 2010), (ii) direct effects of economic factors (especially low income), limiting access to health care and undermining basic living conditions (housing, nutrition, etc.), (iii) lack of education and low health literacy, which have a range of impacts reducing capacity for effective self care, (iv) adoption of harmful lifestyle behaviours such as smoking, excessive drinking, unsafe sex, often related back to issues of low educational attainment and disempowerment, and (v) social isolation/lack of social connectedness arising from loss of community, with both direct and indirect effects on health and wellbeing.

An underlying theme is the imbalance in social and economic power, with the suggested solution of redirecting power and resources from the wealthy and the powerful to the poor and the marginalised.[243] For example the WHO Commission recommended action to (i) 'improve daily living conditions—the circumstance in which people are born, grow, live work and age', (ii) 'tackle the inequitable distribution of power, money and resources—the structural drivers of those conditions of daily life', and (iii) 'measure and understand the problem and assess the impact of action'.

Reducing the inequality in social and economic power is certainly a worthwhile goal and one to be pursued, quite apart from the relationship with health. But this may not be the most effective way to improve health. Very little of the variation in health is explained by income inequality (as is clear from the data collated by Wilkinson and Pickett 2009), and it may be a goal over which citizens, policy makers and bureaucrats have little influence.

The challenge is to find options for change that are amenable

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[243] CSDH 2008, Wilkinson, R and Pickett, K 2009.

to policy and practice drivers, have a substantial effect on health differentials and represent an efficient way of tackling health inequalities. A sound understanding of the underlying theory and mechanisms is crucial to establishing the best way to intervene. The causal mechanisms and pathways need to explain both the diversity at each SES level as well as the differences across SES levels. Not all people in lower SES categories have poor heath and not all persons in higher SES categories attain good health.

The argument of this paper is that the focus on societal level factors underplays a powerful explanatory factor that sits at the family level, albeit influenced by broader societal factors; that of early childhood experience (from pre-birth). The provision of a safe and nurturing family environment that meets the physical and emotional needs of the developing child is increasingly recognised as core to healthy physical and mental development. However, its central role in the SES gradient in health and in the observed differentials at each SES level has neither been fully integrated into the social determinants discourse, nor into the development of policy options.

The argument developed here presumes the setting of a welfare state, like Australia, which has a social security system that provides a safety net of income support, free/low cost access to health care, education and other core services, the rule of law, policies of non-discrimination, laws against exploitation etc. In such countries where the necessities for daily living are, at some basic level, catered for by society the absence of a safe and nurturing early childhood environment is more likely to indicate child neglect and/or physical, sexual or emotional abuse. This is not to say that broader social factors are not important—they are; but what is happening within families is also important. The argument presented here is consistent with the report of the WHO Commission on Social Determinants of Health, which identifies the early childhood environment as one strategy for improving ‘the conditions of daily life’, but with a difference in emphasis, partly because of the assumed setting of the welfare state.

The period from conception to early childhood (defined by WHO to 8 years old) offers a powerful way of understanding the universally observed SES gradient in health and also the marked differences in health at each SES level.

Child abuse and neglect as the primary causal determinant of the socio-economic gradient in health

There is a growing evidence base that the absence of a safe and nurturing environment for the young child, commencing pre-birth, has large and wide-ranging impacts on health and wellbeing for the child, and into adulthood, including premature death.[244] A childhood characterised by neglect, physical, sexual and/or emotional abuse has a strong causal link with poor mental and physical health, low education outcomes, high levels of welfare dependency, low income, poor social relationships, drug and alcohol dependence, housing instability, involvement in crime (as perpetrator and victim) and teenage parenthood.[245]

The central role of child abuse and neglect in explaining health differentials rests on a five stage argument: (i) the widely documented relationship between child abuse and neglect and mental and physical health, (ii) the observed exponential relationship between measures of child abuse and neglect and socioeconomic status, (iii) a strong theoretical basis and clear mechanisms that explain these associations in a way that establishes causality, (iv) a model that places child abuse and neglect at the centre of a vicious cycle of poor mental and physical health, low educational attainment, poor employment outcomes, poverty, crime, drug and alcohol abuse and teenage pregnancy in a potentially never ending cycle of intergenerational abuse, and finally

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[244] Brown, D et al. 2009, Clark, D et al. 2010, Currie, J and Spatz Widom, C 2010, Irish, L et al. 2010.

[245] Gilbert, R et al. 2009, Lalor, K and McElvaney, R. 2010, Pinheiro, P. 2006, Dube, S et al. 2003.

(v) the success of interventions to address child abuse and neglect, that *do* improve health via pathways consistent with the postulated mechanisms of action. These are briefly expanded on below:

i) The relationship between child abuse and neglect and mental and physical health:

The quality of the childhood environment, from conception has a direct and contemporaneous effect on physical development, illness, mortality and quality of life, as well as on-going health consequences. Child development is compromised by poor physical nourishment—starting with inadequate nutrition, excess alcohol consumption, smoking (tobacco and cannabis) and/or illicit drug use of pregnant/breast feeding mothers. This has immediate and potentially severe consequences for health (at the extreme foetal alcohol syndrome or death), but also longer term impacts for risk of chronic disease and more rapid rate of disease progressions.[246]'The biological effects of an adverse childhood environment are wide-ranging and include effects on neurodevelopment and affecting brain function and structure.[247]

Abuse and neglect are the dominant causes of excess hospital admissions and emergency department presentations in the early years of life for injury and are directly implicated in failure to thrive and poor neonatal outcomes.[248] The presence of child abuse or neglect is the major risk for childhood behavioural problems and compromised mental and physical development, and is a risk for on-going poor mental and physical health.[249]

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[246] Dube, S et al. 2003.

[247] Chugani, H et al. 2001, Cohen, R et al. 2006.

[248] Cohen, J et al. 2006, O'Donnell, M et al. 2009.

[249] Dube,S et al. 2003, Hussey, J et al. 2006, Walker, E et al. 1999.

Impacts on health are indirect as well as direct mediated through the socioeconomic pathways. The social and economic consequences of child maltreatment are well documented and wide ranging and include increased rates of drug and alcohol abuse, involvement in crime and violence (as victim and perpetrator), low educational attainment, poor employment outcomes, higher rates of welfare dependency, and unstable housing.[250]

ii) The relationship between child abuse and neglect and socioeconomic status:

Children in lower SES areas are considerably more likely to experience abuse or neglect than children living in higher SES neighbourhoods. This relationship is both very large in terms of level of excess risk in low SES areas and very tight, in terms of extent of variance explained. In Western Australia for example, it was found that children from the most disadvantaged 10 per cent of statistical local areas (SLAs—defined by the ABS SEIFA index of socioeconomic disadvantage for areas) had substantiation rates 19.7 times that of children living in the least disadvantaged SLAs (ie ~2000% greater).[251] These rates increased across the entire SES range. A large gradient is also reported in South Australia , where children in the 10 per cent most disadvantaged SLAs had more than 10 times the rate of child abuse or neglect substantiations than children in the top 10 per cent of SLAs.[252] The gradient is observed across the entire SES range and all abuse and neglect categories and is steeper in the lowest

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[250] Currie, J and Spatz Widom, C. 2010, Gilbert, P et al. 2009, Vinnerljung, B and Sallnäs, M 2008.

[251] O'Donnell, M et al. 2009.

[252] Hirte, C et al. 2010.

SES segment. The finding is unlikely to be an artefact of greater surveillance in low SES neighbourhoods (the ratio of substantiations to notifications is higher in low SES areas). The gradient is considerably steeper than for other commonly identified social determinants of health (such as education or income) and could plausibly underlie the observed SES gradient in health.

iii) Well defined causal mechanisms:

There is a growing literature across the areas of neurobiology, developmental psychopathology, evolutionary psychology, psychiatry and trauma describing the mechanisms by which child abuse and neglect pose ongoing threats to physical, mental and social health. Early relational disturbances in the mother/child relationship and the attendant child abuse and neglect are serious forms of trauma.[253] That this occurs during a period of rapid brain development in the infant/toddler, in a context where intimate, family relationships are the source of trauma, undermines the developing child's trust in and ongoing capacity to form co-operative relationships. This is increasingly being explained in terms of effects on neurobiological maturation. Alterations have been documented in systems, fundamental to adult personality and functioning, such as the stress response system.[254] and how this influences brain-body relationships and emotional response[255], systems of memory[256], systems of defence and safety

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[253] Schuder, M & Lyons-Ruth, K. 2004, van der Hart, O et al. 2006, van der Kolk, B. 2005.

[254] Schore, A. 2003.

[255] Panksepp, J. 2009, Porges, S. 2009, Schore, A. 2003.

[256] van der Hart, O et al. 2006, van der Kolk, B. 2005.

seeking.[257] Theoretically based, longitudinal studies of development from infancy to adulthood have investigated how the combined effects of insecure early attachment relationships, disturbed family functioning and adversity affect outcomes in adulthood. An example from this study is how the quality of the primary attachment/care-giving relationship, in combination with the ongoing relational environment, explains the observed associations between severe persistent conduct problems evident at age 3 years, and learning difficulties at 7 years and helps differentiate 'life course persistent' from 'adolescent only' offending behaviour.[258] These neurological and evolutionary based explanations, predict the range of observed social and economic impacts including poor physical and mental health.[259]

*S*uch explanations place education (and income etc) along the causal pathway as consequence of abuse and neglect; although not excluding the possibility of an independent causal role.

iv) A pattern of intergenerational abuse:

The theoretical and empirical literature suggests a powerful combination of direct and indirect effects of child abuse and neglect on health, which is compounded via several reinforcing pathways, as illustrated in Figure 1, 'The Choices Cycle'. The conceptual model draws on an understanding of mechanisms whereby the quality of the early childhood environment affects every aspect of human development and behaviour. The lower circle

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[257] Amos, J et al. , Belsky, J et al. 1991, Cantor, C. 2009, Cortina, M and Liotti, G. 2005, Gilbert, P. 2001, Liotti, G. 2004, Schore, A. 2003.

[258] Sroufe, A. et al. 2005.

[259] Schore, A. 2003, Sroufe, A et al. 2005, van der Hart, O et al. 2006.

describes the set of inter-related factors that generate a vicious cycle, reinforcing disadvantage and poor health for the individual and setting up an on-going and potentially escalating pattern of inter-generational neglect and abuse.[260]

The model can explain the observed relationship between child abuse and neglect and health, the extraordinary strength of the relationship between child maltreatment and SES and also the relationship between SES and health and the indirect consequences of child abuse and neglect (see Figure 1). This 'virtuous/vicious feedback model' is consistent with the mechanisms described above and is reflective of the theory and observational data.

We propose that the early childhood environment represents a pivotal factor in the model; and thus the prevention of child abuse and neglect and the creation of a nurturing family environment can turn a destructive (vicious) cycle into a virtuous cycle. In terms of Figure 1, if a set of policies can be put in place to move the child (and family) from the bottom to the top circle, a set of positive reinforcing consequences are set in train that will improve health and a wide range social circumstances and economic outcomes. Other social, economic or health policies are still able to influence a shift from one cycle to the other, but in a more indirect and possibly peripheral manner. The model also highlights the potential power of adopting an inter-related set of policies.

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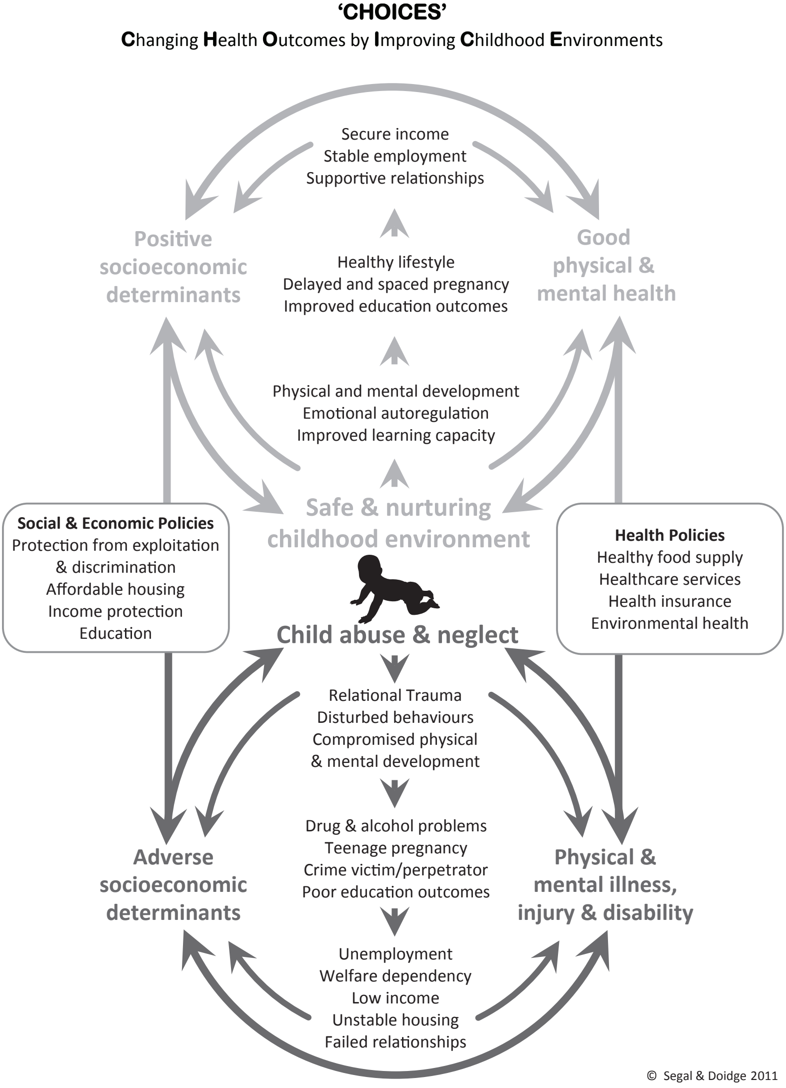
260 Amos, J et al. [in press], Sroufe, A et al. 2005.

Figure 1: Direct and indirect mechanisms through which the childhood environment drives health & wellbeing



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v) Interventions:

There is a growing literature reporting on the development and evaluation of programs to improve the childhood environment and reduce rates of child abuse and neglect. Programs are typically evaluated with respect to their immediate goals, but there is also a small but important literature reporting on the long-term effects upon health and socioeconomic outcomes. This literature confirms the considerable benefits of effective policies that address child abuse and neglect to enhance the quality of the early childhood environment. Benefits are documented in relation to current and future physical and mental health, educational and labour market performance, involvement in crime and other markers of socioeconomic status. Effective interventions cover several portfolios and include nurse visiting for infants.[261] intensive early childhood education[262], parenting programs for families at risk[263] and mental health interventions.[264] The latter address the quality of the emotional relationship between mother and infant/child and the consequences of early childhood trauma in children and adults and can be a powerful vehicle for switching out of the destructive cycle.

Policy implications

The correct conceptualisation of the observed SES gradient in health and of the causal mechanisms is required in order to develop a suite of policies to address health inequalities that is effective and efficient.

The ideas presented here have profound policy implications. Health in the most vulnerable and highest risk groups can be enhanced

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[261] Olds, D et al. 1997, Quinlivan, J et al. 2003.

[262] Reynolds, A et al. 2007.

[263] Chaffin, M et al. 2004, Dawe, S and Harnett, P. 2007.

[264] Cohen, J et al. 2006, Skowron, E and Reinemann, D. 2005, Tarabulsy, G et al. 2008.

and health differentials reduced by addressing root causes of social inequality. The environment in which children grow and develop is not merely prominent but primary amongst such causes and represents a key point at which the vicious cycle of abuse and neglect, poor health and compromised socioeconomic outcomes can be broken.

While adverse childhood environments represent a complex and challenging set of problems, there are well established effective strategies that can be employed to improve the daily living conditions for children, prevent child abuse and neglect and improve outcomes, for health but also across social and economic domains. The ultimate benefits for the individual and for society from an effective investment strategy modelled around these goals are extensive. Furthermore benefits accrue not just for a current generation at risk and those with a history of abuse, but also for all future generations, in the switch from a vicious cycle to a virtuous cycle that contains positively reinforcing elements.

Whilst societal level factors are important, either compounding harms or providing an opportunity for effecting change, ignoring what happens within families and especially the role of childhood trauma will not lead us to the best solutions. Childhood trauma affects not just children but parents and other adults who carry the damage of a history of child base and neglect.

The logical policy response is a well-resourced strategy to address child abuse and neglect, designed to take children and families out of a destructive cycle into a virtuous cycle. Whilst the centre of the model is the family environment in which children are nurtured, this is not to limit policy interventions to the family or to individual level. Rather, a cross-portfolio ecological approach that draws on the evidence base of effective and cost effective strategies across program and department boundaries will be the most efficient way to proceed (see for example work of the Washington State Institute for Public

Policy[265], although narrower in scope than we would recommend). The efficient mix of strategies will depend on the broad political, economic and social context and the extent to which income transfers and the provision of public goods and services ensures access to the basic necessities of life.

Conclusion

This is an optimistic story, holding out the real prospect for interrupting the damaging inter-generational cycle of abuse and neglect. There are successful and cost-effective ways of enhancing the quality of the family environment to increase the chances of children obtaining the nurturing they need. Arguing that families matter is not to apportion blame; there are many reasons why families fail to provide a nurturing environment. Societal factors are important, as are the early childhood experience of parents. If parents are not nourished as children, their capacity to parent well is affected directly as well as indirectly, through the wide-ranging and damaging consequences of child abuse and neglect on mental and physical health and social and economic outcomes. If we don't intervene, succeeding generations will continue to perpetuate this cycle. On the other hand we have the possibility of improving the health and wellbeing of the most vulnerable members of our society, to lead happier more productive lives.

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[265] Lee, S et al. 2008.

References

ABS (2011) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, Oct 2010*, catalogue no. 4704.0, Canberra: Australian Bureau of Statistics.

Amos, J., Furber, G. and Segal, L. ([in press]) 'Understanding Maltreating Mothers: A Synthesis of Relational Trauma, Attachment Disorganization, Personality Fragmentation and Experiential Avoidance', *J of Trauma and Dissociation,* Accepted October 2010.

Begg, S., Voss, T., Barker, B., Stevenson, C., Stanley, L. and Lopez, A. (2007) *The burden of disease and injury in Australia, 2003*, PHE 82, Canberra: AIHW.

Belsky, J., Steinberg, L. and Draper, P. (1991) 'Childhood Experience, Interpersonal Development, and Reproductive Strategy: An Evolutionary Theory of Socialization', *Child Development,* 62(4), 647-670.

Brown, D., Anda, R., Tiemeier, H., Felliti, V., Edwards, V., Croft, J. and Giles, W. (2009) 'Adverse Childhood experiences and the risk of premature mortality', *American Journal of Preventive Medicine,* 37(5), 389-96.

Brown, L. and Nepal, B. (2010) *Health lies in wealth: health inequalities in Australians of working age*, Report No. 1/2010, Canberra: University of Canberra National Centre for Social and Economic Modelling.

Cantor, C. (2009) 'Post-traumatic stress disorder: evolutionary perspectives', *Aust N Z J Psychiatry.,* 43(11), 1038-48.

Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J. and Bonner, B. L. (2004) 'Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports', *J Consult Clin Psychol.,* 72(3), 500-10.

Chugani, H. T., Behen, M. E., Muzik, O., Juhász, C., Nagy, F. and Chugani, D. C. (2001) 'Local Brain Functional Activity Following Early Deprivation: A Study of Postinstitutionalized Romanian Orphans', *NeuroImage,* 14(6), 1290-1301.

Clark, D. B., Thatcher, D. L. and Martin, C. S. (2010) 'Child Abuse and Other Traumatic Experiences, Alcohol Use Disorders, and Health Problems in Adolescence and Young Adulthood', *Journal of Pediatric Psychology,* 35(5), 499-510.

Cohen, J. A., Mannarino, A. P., Murray, L. K. and Igelman, R. (2006) 'Psychosocial interventions for maltreated and violence-exposed children', *Journal of Social Issues,* 62(4), 737-766.

Cohen, R. A., Grieve, S., Hoth, K. F., Paul, R. H., Sweet, L., Tate, D., Gunstad, J., Stroud, L., McCaffery, J., Hitsman, B., Niaura, R., Clark, C. R., MacFarlane, A., Bryant, R., Gordon, E. and Williams, L. M. (2006) 'Early Life Stress and Morphometry of the Adult Anterior Cingulate Cortex and Caudate Nuclei', *Biological Psychiatry,* 59(10), 975-982.

Cortina, M. and Liotti, G. (2005) 'Building on attachment theory: Toward a multimotivational and intersubjective model of human nature', in *Annual Meeting of* *the Rapaport-Klein Study Group*, Stockbridge, Psychomedia.

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

Currie, J. and Spatz Widom, C. (2010) 'Long-Term Consequences of Child Abuse and Neglect on Adult Economic Well-Being', *Child Maltreatment,* 15(2), 111-120.

Dawe, S. and Harnett, P. (2007) 'Reducing potential for child abuse among methadone-maintained parents: Results from a randomized controlled trial', *Journal of Substance Abuse Treatment,* 32(4), 381-390.

Dube, S. R., Felitti, V. J., Dong, M., Giles, W. H. and Anda, R. F. (2003) 'The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900', *Preventive Medicine,* 37(3), 268-277.

Gilbert, P. (2001) 'Evolutionary approaches to psychopathology: the role of natural defences', *Aust N Z J Psychiatry.,* 35(1), 17-27.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E. and Janson, S. (2009) 'Burden and consequences of child maltreatment in high-income countries', *The Lancet,* 373(9657), 68-81.

Hanlon, P., Walsh, D. and Whyte, B. (2006) *Let Glasgow Flourish: A comprehensive report on health and its determinants in Glasgow and West Central Scotland*, Glasgow: Glasgow Centre for Population Health.

Hirte, C., Rogers, N., Wilson, R., Gao, F. and Segal, L. (2010) 'Relationship between socio-economic status and child abuse and neglect in South Australia', in *11th Australian Institute of Family Studies Conference: Sustaining families in challenging times*, Melbourne, AIFS.

Hussey, J. M., Chang, J. J. and Kotch, J. B. (2006) 'Child Maltreatment in the United States: Prevalence, Risk Factors, and Adolescent Health Consequences', *Pediatrics,* 118(3), 933-942.

Irish, L., Kobayashi, I. and Delahanty, D. L. (2010) 'Long-term Physical Health Consequences of Childhood Sexual Abuse: A Meta-Analytic Review', *Journal of Pediatric Psychology,* 35(5), 450-461.

Lalor, K. and McElvaney, R. (2010) 'Child Sexual Abuse, Links to Later Sexual Exploitation/High-Risk Sexual Behavior, and Prevention/Treatment Programs', *Trauma, Violence, & Abuse.*

Lee, S., Aos, S. and Miller, M. (2008) *Evidence-based programs to prevent children entering and remaining in the child welfare system: benefits and costs for Washington*, Doc. No. 08-07-3901, Olympia: Washington State Institute for Public Policy.

Liotti, G. (2004) 'Trauma, Dissociation, and Disorganized Attachment: Three Strands of a Single Braid', *Psychotherapy: Theory/Research/Practice/Training,* 41(4), 472-486.

Marmot Review (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010*, Strategic Review of Health Inequalitites in England post-2010, London: Marmot Review.

O'Donnell, M., Nassar, N., Leonard, H., Jacoby, P., Matthews, R., Patterson, Y. and Stanley, F. (2009) 'Rates and types of hospitalisations for children who have subsequent contact with the child protection system: a population based case-control study', *Journal of Epidemiology and Community Health,* 64(9), 784-788.

Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L. M. and Luckey, D. (1997) 'Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect', *JAMA: The Journal of the American Medical Association,* 278(8), 637-643.

Panksepp, J. (2009) 'Brain emotional systems and qualities of mental life: rom animal models of affect to implications for psychotherapeutics' in Fosha, D., Siegal, D. and Solomon, M., eds., *The healing power of emotion: Affective neuroscience, development and clinical practice*, New York: W.W. Norton & Co.

Pinheiro, P. S., ed. (2006) *World Report on Violence against children,* Geneva: United Nations Secretary-General's Study on Violence against Children.

Porges, S. (2009) 'Reciprocal influences between body and brain in the perception and expression of affect: A polyvagal perspective' in Fosha, D., Siegal, D. and Solomon, M., eds., *The healing power of emotion: Affective neuroscience, development and clinical practice*, New York: W.W. Norton & Co.

Quinlivan, J. A., Box, H. and Evans, S. F. (2003) 'Postnatal home visits in teenage mothers: a randomised controlled trial', *The Lancet,* 361(9361), 893-900.

Reynolds, A. J., Temple, J. A., Ou, S.-R., Robertson, D. L., Mersky, J. P., Topitzes, J. W. and Niles, M. D. (2007) 'Effects of a School-Based, Early Childhood Intervention on Adult Health and Well-being: A 19-Year Follow-up of Low-Income Families', *Arch Pediatr Adolesc Med,* 161(8), 730-739.

Schore, A. N. (2003) *Affect dysregulation & disorders of the self,* New York: W.W. Norton & Co.

Schuder, M. and Lyons-Ruth, K. (2004) 'Hidden trauma in infancy. attachment, fearful arousal, and early dysfunction of the stress response system' in Osofsky, J., ed. *Young children and trauma. intervention and treatment*, New York: The Guildford Press, 69-104.

Skowron, E. and Reinemann, D. H. S. (2005) 'Effectiveness of Psychological Interventions for Child Maltreatment: A Meta-Analysis', *Psychotherapy: Theory/Research/Practice/Training,* 42(1), 52-71.

Sroufe, A., Egeland, B., Carlson, E. and Collins, W. (2005) *The development of the person: the Minnesota study of risk and adaptation from birth to adulthood,* New York: The Guildford Press.

Tarabulsy, G. M., Pascuzzo, K., Moss, E., St-Laurent, D., Bernier, A., Cyr, C. and Dubois-Comtois, K. (2008) 'Attachment-based intervention for maltreating families', *Am J Orthopsychiatry.,* 78(3), 322-32.

Thomas, B., Dorling, D. and Smith, G. D. (2010) 'Inequalities in premature mortality in

Britain: observational study from 1921 to 2007', *British Medical Journal,* 341.

van der Hart, O., Nijenhuis, E. and Steele, K. (2006) *The haunted self: Structural dissociation and the treatment of chronic traumatization,* New York: W.W. Norton & Co.

van der Kolk, B. (2005) 'Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories', *Psychiatric Annals,* 35(5), 401-408.

Vinnerljung, B. and Sallnäs, M. (2008) 'Into adulthood: a follow-up study of 718 young people who were placed in out-of-home care during their teens', *Child & Family Social Work,* 13(2), 144-155.

Walker, E. A., Gelfand, A., Katon, W. J., Koss, M. P., Von Korff, M., Bernstein, D. and Russo, J. (1999) 'Adult health status of women with histories of childhood abuse and neglect', *The American Journal of Medicine,* 107(4), 332-339.

Wilkinson, R. and Pickett, K. (2009) *The Spirit Level: Why more equal societies almost always do better,* London: Allen Lane.

14

The built environment as a social determinant of health

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Most discussions about the social determinants of health focus on issues such as income, wealth, social class (a British favourite), socioeconomic position, education, culture, gender, age and race (a favourite in the USA). These issues are referred to as *social* determinants of health because the ways in which they are produced by and distributed across society are determined by decisions made collectively by people—that is, they are the outcomes of social rather than natural biological or environmental processes. In the cases of gender, age and race, social decisions do not, of course, determine these actual attributes but other people make decisions that discriminate positively or negatively on the basis of these attributes, thereby shaping or determining the access that individuals and groups of specific gender, age or race have to socially determined resources and rewards.

In this chapter we focus attention on a determinant of health that arises entirely from collective decision-making that is frequently forgotten in discussions about the social determinants of health—the built environment. We suspect that it is frequently forgotten because the word social has other connotations: of something that is interpersonal (as in socialising and social capital); of something that is quite personal, private and difficult to talk about (for instance personal income level); and for both of these meanings, of something that is a bit hard to pin down and measure in a scientific sense. These are not the qualities that spring to mind when we think about bricks and mortar, roads and railways, parks and squares, farms and factories—the features of the built environment. All the features of the built environment are, however, the outcome of decisions made by people, and in the context of 20th and 21st century urban planning laws and regulations, almost all of those decisions are made socially not individually.

But the built environment is not simply another social determinant of health. Because of the resources required to develop (and demolish) the built environment and the ways in which decisions are made about the form of the built environment in different places, the built environment is a strong influence on other determinants of health (for instance housing conditions and access to work and educational opportunities), reflects existing social inequalities and hierarchies, and potentially entrenches these inequalities and hierarchies for years to come. On the other hand, it can sometimes be easier and quicker to change this social determinant to be a better influence on health than it can be to change, for instance, levels of wealth, cultural practices or discrimination based on gender, age or race.

In the remainder of this chapter we provide some brief examples of the ways in which the built environment can influence health and conclude with some suggestions for how individual citizens and the community can become more involved in decision making to make the built environment healthier.

Planning the city

Built environments do not occur only in cities of course—they are created in towns and rural areas, along coastal zones and highways. But globally, and in Australia especially, most of the population lives in cities and this trend is increasing. It is crucial, therefore, that we build cities that promote healthy behaviours and minimise threats to health.

Although there were many positive outcomes associated with better housing and improved neighbourhood amenities in the 20th century, the styles of urban development that appeared in the second half of the century in high income countries often had unintended harmful consequences for community health. The urban sprawl and separation of residential areas from employment zones and shopping and service areas that were features of many cities has been harmful for health in many ways. The development of far flung residential suburbs, almost always without adequate public transport services, would have been impossible without the increase in car ownership but the people who live in them are totally dependent on their cars—for getting to school, work, shops, recreational facilities and public transport hubs. This had led to decreased physical activity as a normal part of day to day life and contributed to the increasing prevalence of chronic diseases such as obesity, diabetes and heart disease.

It has also reduced the opportunities available for social interaction (an important influence on physical and mental health) within households and with neighbours, relatives and friends through, for instance, increasing commute times to and from work and school, isolating anyone left at home during the day without a car, and separating families from relatives and friends in distant suburbs. The increased dependency on private cars has also increased air pollution and greenhouse gasses, not to mention created the unproductive and unhealthy road congestion experienced in most large cities.

Rapidly developing countries like China have the opportunity as they create many entirely new cities to avoid the mistakes made in developed counties over the last century. Australia, however, will have to remodel the cities we already have. Stopping further urban sprawl, and the accompanying loss of productive agricultural land close to the city, and creating low-rise, medium density residential areas along major transport corridors, served by first-class public transport services, is a crucial element. While many residents of attractive long-established neighbourhoods currently oppose such policies, fearing the loss of a treasured environment, such developments can increase amenity and contribute to better health in many ways: easy walking and cycling access to schools, shops, services, work, public transport and recreational opportunities; greater demographic and cultural diversity; and more affordable, more diverse housing, with increased opportunities for people with disabilities and ageing-in-place.

Building healthy, safe, liveable neighbourhoods

What creates a neighbourhood that is nice to live in, that people want to live in, that helps people to be healthy? The people themselves are important of course, but having nice, well-meaning individuals is not enough. The local built environment also influences whether people are able to live physically, psychologically and socially healthy lives. To give just a few examples:

- There was a vogue in the 1960s and 1970s to abandon grid patterns for streets and build suburbs with sinuous crescents and many cul-de-sacs. The idea was to create quiet, private streets that had no dangerous through-traffic and where children could play safely. Unfortunately, the outcomes often were physically and socially disconnected streets, little shared sense of community and long indirect routes from home to nearby (as the crow flies) common destinations such as shops, schools and bus routes. As a consequence, residents used cars for relatively short journeys and the resulting absence of people and interest on the streets further discouraged incidental walking and socialising. An absence of 'eyes on the street' also creates opportunities for mischief and crime, and for residents this rapidly translates into a real or (just as limiting) perceived lack of safety. Greater attention is now being paid in urban design to good street connectivity and attractive, safe, interesting, welcoming streetscapes.

- During the 20th century cars, both moving and parked, progressively displaced people on foot and bicycle from the streets, a domain where before 1900 pedestrians (and animals) had been supreme. The situation became so ridiculous in the later decades of the 20th century that some new suburbs had streets without any pavements, or at best on one side of the street only. For the fit and healthy, walking and cycling became difficult; for people with disabilities and people pushing prams the situation was nigh impossible. In recent years we have seen the development of networks of walking and cycling tracks in cities and towns, not principally for 'exercise' but rather as legitimate modes of transport between daily destinations. To maximise their use, progressive municipal authorities and employers also provide end of trip facilities such as secure bicycle storage areas and shower rooms.
- Urban public open space comes in many guises (for instance playing fields, parks, squares, beaches, town centres, nature trails) and has many uses (for instance playing, celebrating, educating, people watching, artistic and cultural expression). The opportunities for physical activity, relaxation, social interaction, creating a sense of community and a sense of historic, geographic and cultural place, and the opportunities for personal and political expression can all contribute to better health—provided that the space is well planned and well maintained. Experience has demonstrated that it is not enough simply to provide an open space and let people use it as they wish.

> To be successful and used, open space must have defined purposes and rules, defined (though open and inviting) boundaries, interesting features and events, appropriate formal and casual surveillance. If the space is large, it also needs to be sub-divided into smaller areas that people can engage with more easily.

Creating healthy built environments

We know that not all built environments produce good health—in fact we can map those parts of the built environment where people have poorer health and poorer opportunities for health (for instance access to good jobs, transport and housing). We also know that the same built form can have very different impacts in different places, for example the Radburn Design found to be so dysfunctional in public housing estates in outer Sydney because of its focus on cul-de-sacs and houses facing away from the street has created healthy environments in other parts of Australia. Similarly the public housing high-rise estates in inner Sydney and many parts of Europe and the USA often created ghettos of disadvantage, while high rise buildings on the foreshores of Sydney and adjacent to Central Park, New York, are highly desirable and people living there have some of the best health outcomes. This emphasises the complex inter-relationship between the built environment, the people who live there, the relationships that develop within the community and the extent to which government, the private sector and civil society invest in the 'soft infrastructure' that makes communities work (such as access to community centres and services, sites and opportunities for interaction between groups, policing and crisis services).

The good news about the built environment as a social determinant of health is that it is possible for concerned citizens to have an influence on the planning and design of their own neighbourhood, town and city. In small but potentially important ways, individuals can also influence their own and other people's health through the design and appearance of their own homes. And the health and education sectors can play a significant direct role by ensuring that their own hospitals, health centres and schools make healthy, sustainable contributions to the built environment.

There is now a large body of evidence that indicates that various elements of the built environment influence people's health and it is incumbent on everyone who wants to help create healthier built environments to ensure that this is brought to the attention of developers, architects, urban planners, engineers and decision makers, many of whom, it should be said, are already knowledgeable and sympathetic. We may not have all the answers but ignorance of the influence of the built environment on health is no longer an excuse for fundamentally poor urban design.

For those who are new to this arena there are tools and information available to help. For instance:

- Health Impact Assessment (HIA) is a structured method for examining policies and plans to identify the health promoting and health damaging aspects so that the former can be supported and the latter reduced and/or mitigated. Considerable emphasis is placed on the involvement of all stakeholders and on identifying the groups most likely to benefit and those most likely to suffer in an attempt to make the outcomes as equitable as possible. HIA can be used on town or city wide strategic plans or plans for individual developments. Overviews of HIA are provided by two reports: Health Impact Assessment: a practical guide[266] and Good Practice Guidance on Health Impact Assessment[267] (see also Essay 10, Harris-Roxas et al).

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[266] Accessed at: www.hiaconnect.edu.au/hia_a_practical_guide.htm

[267] Accessed at: www.icmm.com/document/792

- The NSW Healthy Urban Development Checklist[268] (assists health professionals to review urban development policies and plans and provide comprehensive and consistent advice to planners about their likely health effects. The core of the checklist is ten ‘chapters’, each focusing on a feature of the built environment that is important for health (for instance housing, transport, physical activity, safety and social connectedness) and each containing health-related questions about specific elements of that feature. The checklist also provides many useful references and websites.
- Many organisations provide useful guides, tools, references and case studies on the web. For instance:
    - The Planning Institute of Australia’s Healthy Spaces and Places website (www.healthyplaces.org.au/site/)
    - The NSW Healthy Built Environments Program (www.fbe.unsw.edu.au/cf/HBEP/)
    - The NSW Premier’s Council for Active Living (www.pcal.nsw.gov.au/)
    - The Heart Foundation’s Healthy by Design guidelines (www.heartfoundation.org.au/SiteCollectionDocuments/Tasmania-healthy-by-design.pdf)
    - The International Academy for Design and Health (www.designandhealth.com/)

Knowing the evidence and having checklists is not sufficient, however. To have an influence on the built environment, whether in a new-build greenfield site or the redevelopment of an existing suburb, it is essential that would-be participants understand the local planning processes, understand and engage with the local communities, form partnerships with other concerned individuals, groups and agencies, and establish long-term relationships with planners (especially in local government) and developers. The built environment is not

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[268] Accessed at: www.health.nsw.gov.au/pubs/2010/hud_checklist.html

transformed overnight but it is progressively changed everywhere by the decisions society makes. The challenge is to ensure that each change creates a healthier place for people to live.

15
Turning the social determinants of health into a story that people care about

Melissa Sweet,
health journalist and author

Although I have been making my living from writing for more than 25 years, writing rarely comes easily for me. But some stories are more difficult than others to tell.

One that recently had me struggling was an attempt to tell the history of a community-building initiative in south-western Sydney, the Community 2168 project. Every time I drove back to the suburb of Miller, where the project is based in the heart of an area of ageing public housing and social disadvantage, I kept asking myself, what is this story really about?

At one level, the answer was straight forward enough—the project began in 1999 as a 'major community renewal and capacity building partnership'. Amongst other things, it has set up forums for residents and local service providers, including NGOs, police, the council, and housing, health and community services, to come together to identify problems and devise ways of dealing with them. But at another level, it was much more difficult to answer the question.

The best I could come up with, after repeated visits to the area, was that it was a story about complexity, and how a multitude of factors contribute to disadvantage and health inequities. Part of the reason for my struggle was the difficulty of creating a narrative that would engage general readers in a story about the people and the issues of the 2168 postcode, and to do this in a way that wouldn't just add to the stigma and discrimination that already weigh heavily upon local residents.

As someone who specialises in health reporting, I have sat in on many medical procedures and surgical operations over the years. These stories almost write themselves, thanks to the human interest provided by the patient and family, the whizz bang provided by the technology, and the heroic action generally provided by the health professionals involved. Of course, the reality of these stories is often much more complex than how they're portrayed—often the technology and the procedure are not quite so wondrous, and often the story we're being sold by the media and its sources has a happier ending than generally occurs in the real world.

Gary Schwitzer, an experienced health journalist in the US who publishes the watchdog HealthNewsReview.org, says his analyses show that too much media coverage of health care amounts to a form of 'cheerleading'. He says, 'Most stories are giving a kid-in-a-candy store view of health care, where you're making everything look terrific, risk-free and without a price tag, and nothing could be further from the truth.'

Stories about promising medical interventions tend to dominate media coverage of health, reinforcing popular perceptions that the major determinant of a population's health is access to secondary and tertiary health services (primary health care generally receives relatively little coverage).

While the public (including politicians and policymakers) often receive an often over-inflated view of the impact of high-tech health care, the social, economic and cultural factors that influence health rarely receive such sustained media attention, at least not within a health framework.

In the end, I wrote in the 'Understanding Miller' article for the online publication, *Inside Story*:

> The 2168 project also stands out as a rare effort to tackle the social and economic factors that shape the health of individuals and communities. The 'social determinants of health' receive plenty of rhetorical attention, but there is far less investment in action to tackle them. We prefer to spend billions on acute healthcare services, which are often ill equipped to pick up the pieces of social disadvantage, when intervening in the root causes of so much poor health is clearly a more effective approach. Perhaps one of the reasons that funding priorities are so often askew is the difficulty of telling the stories of places like Miller. These are often complex, lack simple take-home messages, and are ill-suited to the short attention spans of political debate and much of the mainstream media.

The wider context for the story was a sense of frustration that the previous several years of public debate about health reform in Australia had, in many senses, been an opportunity lost.

The national health reform process has been a major investment of political capital and public money, as well as absorbing significant resources from many non government organisations. It could and should have been seized as an opportunity to advance public dialogue and understanding around health—to move us from our fixation on hospitals and medical services to a broader understanding of the dynamics influencing a population's health.

The National Health and Hospitals Reform Commission nominated 'major access and equity issues' as one of the three goals of health reform in its final report, *A Healthier Future for All Australians*. However, its focus on improving equity was very much around the role of health services.

The report made some mentions of the need to 'address the social determinants of health' but didn't offer a clear roadmap of how to achieve this. There was no discussion, for example, of the potential for tools such as health impact assessments to introduce a health focus into wider policy considerations.

The social determinants of health were also noticeably absent from the terms of reference to the National Preventative Health Taskforce, which were narrowly focused on 'the burden of chronic disease currently caused by obesity, tobacco and excessive consumption of alcohol'.

Nor did our political, professional or bureaucratic leaders pick up the ball. For a country that has traditionally prized itself as the 'land of the fair go' it was remarkable, especially given the colours of the federal government driving the reform process, that concerns about equity were not given centre stage in the reform process that followed the NHHRC report.

Given the role that primary health care is held to play in addressing health inequities, it was noteworthy, for example, that the Department of Health and Ageing guideline documents for Medicare Local applicants did not even mention the social determinants of health and paid only a cursory reference to equity issues. (By contrast, the Closing the Gap strategy has taken a broader approach to improving one population's health).

More broadly, there has been no concerted national acknowledgement of or response to the calls to action that have come in recent years from the WHO's Commission on the Social Determinants of Health and the Marmot Review in the UK.

Who or what should we blame for this?

The media, with our fixation on medical breakthroughs and hyper-responsiveness to professional lobbies such as the AMA?

Or politicians and their perennial quest for the quick grab and simple, easy-to-sell solutions?

Or professional leaders and the health sector more broadly for failing to look beyond narrow sectional interests?

Or has there been a failure of advocacy on the part of those who argue for a fairer distribution of health?

Professor Fran Baum, who was a member of the WHO's Commission on the Social Determinants of Health, believes one reason that successive Australians governments have paid so little attention to health inequities is that Australians remain wedded to the notion that we are a classless society or at least one where class counts less than in Europe. As Professor Baum points out, acknowledging health inequities requires acknowledging class and entrenched privilege.

Several years ago, the Robert Wood Johnson Foundation (RWJF) in the US began searching for better ways of discussing the social determinants of health. One of the driving concerns was a wish to present the topic in a way that didn't align it 'with any existing political perspective or agenda'.

The RWJF worked with communication experts, conducted research involving more than 3000 Americans, and in 2010 published a report, *A new way to talk about the social determinants of health.*

It developed a message that was revised, tested and revised again based on what the research showed, and was consistently the most persuasive message among all groups, regardless of their political perspective. The message states:

> America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on earth. Yet on some of the most important indicators, like how long we live, we're not even in the top 25, behind countries like Bosnia and Jordan. It's time for America to lead again on health, and that means taking three steps. The first is to ensure that everyone can afford to see a doctor when they're sick. The second is to build preventive care like screening for cancer and heart disease into every health care plan and make it available to

> people who otherwise won't or can't go in for it, in malls and other public places, where it's easy to stop for a test. The third is to stop thinking of health as something we get at the doctor's office but instead as something that starts in our families, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and the water we drink. The more you see the problem of health this way, the more opportunities you have to improve it. Scientists have found that the conditions in which we live and work have an enormous impact on our health, long before we ever see a doctor. It's time we expand the way we think about health to include how to keep it, not just how to get it back.'

Clearly, Australia is not America and some fine-tuning would be needed to make that statement relevant and engaging for a local audience. But the broader point raised by the RWJF deserves consideration by those wishing to put the social determinants of health onto the political, policy and public agenda.

This is that a concerted effort is required, involving collaboration beyond the usual suspects. Experts in social media and Gov2.0, for example, may have much to offer, and collaboration with sectors beyond health is clearly critical. Experience from other areas where advocacy has been successful, such as tobacco control, also reinforces the importance of developing advocacy on the back of research to guide communication messages and strategies.

Above all there is a need for clarity about the objectives of advocacy. Wishy-washy calls for 'action on the social determinants of health' are unlikely to produce anything other than wishy-washy responses.

The experience of the tobacco control field also teaches the need to nurture advocates, to recognise the substantial investment of time and effort that is involved, and to support those engaged in advocacy, which often requires significant courage. Challenging the status quo means challenging some powerful vested interests, including within the health sector.

There is also much to be learnt from other initiatives attempting to influence media and public discourse around health, such as Gary Schwitzer's HealthNewsReview.org, which was modelled on a local project, Media Doctor Australia. Perhaps there could be a similar watchdog site—to look at the health and equity impacts of wider policy decisions, or to highlight when media stories have neglected mention of the social determinants of health.

But above all, advocates need to work out how to turn the social determinants of health into stories that will resonate in a meaningful way across a range of audiences. It is these stories that may help galvanise public, and thus political, support for action.

Researchers from Cornell University, in an article published in *Milbank Quarterly* in 2008, titled *Message Design Strategies to Raise Public Awareness of Social Determinants of Health and Population Health Disparities*, described the importance of narrative for effective communication.

> 'From Aesop's Fables to Super Bowl commercials, human beings have used stories to interact and exchange information, pass on knowledge, convey ideas, and influence behaviors for thousands of years,' they wrote.
>
> 'Researchers studying the impact of narratives generally agree that stories enhance readers' message recall and comprehension and facilitate attitude and behavior changes in the real world by transporting readers into the narrative. Narratives also provide opportunities for individual readers to connect with broader social groups and populations represented by story characters.'

The good news is that the digital revolution is opening up a whole new world of opportunity for telling the difficult and complex stories that have traditionally been neglected by the commercial media.

16
The hidden victims of crime

Helen Wiseman, Gloria Larman,
SHINE for Kids

> *My partner was the breadwinner. When he went inside we couldn't keep up the rest so we lost the house. My kids lost their dad and their home*[269]

When a child's mother or father becomes involved in the criminal justice system their entire life is destabilised. We know it increases their risk of facing poverty, dropping out of school, and of one day becoming a prisoner themselves. Yet why is it that when we discuss victims of crime we rarely mention these innocent bystanders?

Early life experiences are one of the key social determinants of future health, yet in Australia there is marked absence of policy, and appropriate funding, to specifically support these vulnerable children. After 30 years experience working with these children and their families, SHINE for Kids believes that with the right interventions we—the society at large—*can* help redirect the trajectory of a child's life away from intergenerational cycles of crime and social exclusion. To give more children the opportunity of a successful and healthy adulthood, broad-ranging, evidence-based policy urgently needs to be developed that targets the needs

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269 Comments from a participant in the *Families of Prisoners Value Creation Workshop* 2005, run by Centrelink and Shine for Kids, Parramatta, NSW.

of this group of children.

The number of children being affected by parental involvement in the criminal justice system has increased dramatically in recent decades, in line with unprecedented growth in the prison population. Between 1992 and 2008 the number of prisoners in Australia rose by 31 per cent, 5 per cent more than the average increase in all other OECD countries.[270] Indigenous people are being imprisoned at a rate 14 times higher than non-Indigenous people, and the number of incarcerated women has increased by 60 per cent over the last decade.[271] This means more children are being impacted by their parent's incarceration, with Indigenous kids disproportionately affected. And high rates of recidivism mean some children are experiencing this trauma over and over again.

Across Australia there is no routine collection of data to identify how many children are impacted by parental incarceration—this is indicative of the policy shortfalls in this area. 2001 research into the NSW prison population found that 69 per cent of all female prisoners reported being a providing parent, as did around 61 per cent of men.[272] Extrapolating on these figures Quilty asserted that nationally 38 000 children in Australia lose a parent to prison every year, and 145 000 experience it over the course of their childhoods. This accounts for an astonishing close to 5 per cent of all children, and 20 per cent of all Indigenous kids.[273] With the rapid expansion of the prison population in the decade since this research was done, the true numbers of children currently being impacted are likely to be much higher.

As SHINE for Kids has repeatedly seen, having a parent involved in the criminal justice system can set off a chain of adversity for a child. They may witness the arrest (possibly violent

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270 ABS. 2009.

271 ABS. 2010.

272 Quilty, S. 2005, p.256.

273 Ibid

and unexpected), be suddenly thrown into poverty, have to change houses and primary carers, have their education disrupted, and face extreme stigma. In many cases the entire family structure dissolves. The children we work with frequently struggle with strong feelings of sadness, shame, separation anxiety, and anger.

The following comment is testimony from a former female prisoner to a NSW parliamentary committee, describing what happened to her son when she went to prison:

> My son changed from a 12 year old little boy who loved fishing, surfing and watching movies on a Friday night to a complete street boy who managed to look after himself on the streets. His personality has completely changed. He may be 14 now but he has changed from an innocent little boy to a 20 year old minded criminal.[274]

Australian and international research strongly supports our view that these children form a significantly 'at risk' cohort. Phillips and Gleeson[275] found that even when compared with other children who had been in contact with the child welfare system, children with parents in the criminal justice system are more likely to be exposed to a greater number of risk factors, including parental substance abuse, domestic violence, mental illness, and extreme poverty. Quilty[276] found that children of prisoners are at a high risk of negative health outcomes. Research also suggests a child's educational performance deteriorates when their mother or father is sent to prison.[277] Research into SHINE clients found the school-drop out rate of children of prisoners was 34 per cent, compared to 10 per cent in same-gender best-friend peers.[278] Parental

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[274] Standing Committee on Social Issues. 1997, p.13.

[275] Phillips, S and Gleeson, J. 2007.

[276] Quilty, S. 2004.

[277] Department of Families, Community Services. 2003.

[278] Research done into Shine for Kids children's files.

imprisonment is also a strong predictor of several antisocial-delinquent outcomes, including truancy and running away.[279] Most alarmingly, there is an increased risk of these children offending later in life.[280]

Intergenerational involvement with the criminal justice system is an especially acute issue for Indigenous Australians—it is not unusual for generations of the same Aboriginal family to have all experienced incarceration.[281]. A recent survey of the NSW prison population found that around one in three Aboriginal prisoners reported having had a parent in prison.[282] The Commission for Children and Young People and the Aboriginal and Torres Strait Islander Advisory Board has suggested some young men want to emulate their imprisoned father, seeing him as a role model in the absence of other male role models in the community.[283]. SHINE for Kids believes that Indigenous children of prisoners are some of the most vulnerable in our community, with huge and currently unmet needs.

Despite extensive research that shows children with parents in the criminal justice system face a series of social determinants that increase their risk of an unsuccessful transition to adulthood, they remain a largely hidden group. A report from the Federal Department of Families and Community Services[284] (2003) found that 'the legal, prison, welfare and education systems usually overlook the special needs of prisoners children … the families of prisoners do not appear to be the core business of any government department and are often overlooked in developing

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[279] Murray, J and Farrington, D. 2005.

[280] Murray, J and Farrington, D. 2005, Wildeman. C.

[281] Standing Committee on Social Affairs. 1997, p.4.

[282] Justice Health. 2009.

[283] The Commission for Children and Young People and the Aboriginal and Torres Strait Islander Advisory Board . 2001, p.4,15.

[284] Families and Community Services. 2003.

and implementing new social policy or in changes to existing social policy and programs'.

Corrective Services NSW is a notable exception. Through the development of a Child Protection Unit they have taken active steps towards recognising that prisoners are often connected to children, and that the best interests of these children need to be considered. Aside from this example, there exists few integrated policies and procedures around the country that help inform the actions of police, prisons, government departments and agencies and schools when dealing with these children.

According to the child of a prisoner:

> I was an A student, then my grades ran down and I stopped going to school. Not one teacher asked me why or sought to take an interest in me.[285]

This lack of visibility exposes these children to the risk of systemic neglect. According to the Victorian Association for the Care and Resettlement of Offenders (VACRO)[286]: 'This policy vacuum has a profound and negative effect on the thousands of children, primary carers and interim carers caught up in the criminal legal system. And these negative consequences—social, psychological and financial—can extend for long after the prison sentence has been served'.

Negative outcomes however are not inevitable, as Laverty[287] pointed out: 'most social determinants of health can be modified to improve personal and population health outcomes'. Recent research by the Australian Institute of Criminology has highlighted the need for intervention programs to target the children of prisoners.[288]

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285 Standing Committee on Social Issues. 1997, p.10.

286 VACRO. 2006, p.108-109.

287 Laverty, M. 2009.

288 Australian Institute of Criminology. 2011.

SHINE for Kids is an example of an organsation working closely with this group of children to mitigate the adverse impacts of parental incarceration to their long-term health and wellbeing. SHINE for Kids strongly advocates for the value of early-intervention in the lives of these children. We take a child-centric approach, emphasising holistic and integrated solutions. SHINE stands for Support, Hope, Inspire, Nurture and Empower. By providing these things we work towards building resilient children, who are less likely to become the next generation of offenders.

A large focus of SHINE for Kids work is our Child and Family Centres. These are operations located on the non-secure grounds of (or adjacent to) correctional centres. In NSW we have them at Silverwater, Parklea, Windsor, Bathurst, Cessnock, Junee, Wellington and Kempsey. Two new Child and Family Centres will be opened at Goulburn and Nowra Correctional Centres by the end of 2011. Visiting a parent in prison can be a confusing and frightening experience for a child. Our centres provide respite, and fun activities for kids during these visits. It gives them an opportunity to meet peers in the same situation, and to interact with child-care professionals and trained volunteers. It enables us to connect these children and their families with our services, including counselling and support, mentoring, and financial assistance for educational and social needs. A high proportion of the children we service are Indigenous, including 42 per cent of all attendees to our Bathurst Centre in 2010.[289]

SHINE for Kids also works to facilitate contact between children and their imprisoned parent. We assist with transport to prison, phone calls, and video conferencing for families in remote areas. While for some children the incarceration of a parent may provide a welcome relief from abuse or violence, for the majority it is a great source of grief. Yet visiting prison can be too expensive,

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[289] Internal analysis of SHINE for Kids clients.

difficult, or stressful for the carer left on the outside to achieve, and many children have little contact with their incarcerated parent. Like all our work, our approach of supporting ongoing contact is evidence based. Hairston has compiled extensive research that shows maintaining family ties between incarcerated parents and their children can help prevent intergenerational crime, assist in developing more positive parenting relationships, and assist the family structure post-release. It also suggests that male prisoners with strong family ties are more likely to succeed post-release.[290]

One of SHINE's flagship programs is 'Breaking the Cycle', a highly successful project that's been running in Bathurst, NSW, since 2005. Based on its success, we hope to expand the project to other regional centres. The project works with the non-incarcerated parent or carer and their dependent children, and provides four key programs: mentoring; education (we work within the local primary schools); casework and counseling; and carers group programs. In 2010, 43 per cent of all enrolees in the mentoring program were Indigenous, as were 60 per cent of kids in the education program. Local school principals reported that children involved in the program demonstrated improved confidence and willingness to be engaged in the curriculum.[291] External evaluation said the program made a 'significant positive impact on the families of inmates at a critical time when strategic support has the potential to shift the trajectory of their lives for the better'.[292]

A mother whose child was mentored by SHINE reported:

> Looking back, I feel my child would not have been able to cope with her dad's incarceration without the quality time her mentor spent with her and the support that was offered when I was not able to give my child what she needed … having my child in the

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[290] Hairston, C. 2001.

[291] Feedback given to SHINE for Kids from local primary schools.

[292] MATRIX on Board. 2008.

> mentoring program has helped me become a better mum. I felt lifted when I was down.

And this, from a child mentored by SHINE:

> At school we have news every week where we have to stand up in front of the class and talk about what we did on the weekend. This was hard for me because I visited dad in gaol on Saturdays and Sundays and I couldn't tell this for news. Now I have my mentor, the other kids think it's cool and I can talk about different places.

The external evaluation by MATRIX[293] found that 'no other comparable services (were) offered anywhere in the region', and that many parents and carers felt that SHINE for Kids was 'all that they had'. While general services to address disadvantage do exist in the area, it is SHINE's experience that families of prisoners are generally reluctant to access mainstream services, fearing the stigma surrounding having a family member in prison. SHINE for Kids offers understanding of the criminal justice system, and an opportunity for children to feel safe and not judged.

At SHINE for Kids we see daily the positive impact of our work on the children, but we are also painfully aware that we are only just scratching the surface in terms of meeting the existing need. Our current services are primarily targeted at those children who visit a correctional centre and use our Child and Family Centres. Many children never get to visit an incarcerated parent at all. Funding constraints mean our Supported Transport Service is only offered in Sydney and Bathurst. This means that particularly in regional and rural areas, many children are experiencing the trauma of having a parent caught up in the criminal justice system without any additional support. Unless we can find a way to start supporting these children, we risk creating a new generation of offenders and the socially excluded.

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[293] MATRIX. 2008.

SHINE for Kids sees an urgent need for the development of an evidence-based policy approach that informs every aspect of government and non-government agency service delivery to children impacted by parental involvement in the criminal justice system. To this end, we strongly support projects like that currently underway at the Criminal Justice Research Consortium at Monash University, which is undertaking extensive research into the care needs of these children. We would also like to see improved funding for organisations like SHINE for Kids, which are well placed to meet the specific needs of these children.

Parental incarceration is a strong determinant of poor outcomes in adulthood, but with the right interventions we have the opportunity to create a better pathway for these children. When kids follow their parents into intergenerational cycles of offending it extracts an economic and social price on society at large—it is in everyone's interests we support these vulnerable children.

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References

Australian Bureau of Statistics (ABS) 2009, 4102.0 *Australian Social Trends,* viewed 22 June 2011, www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features60Dec+2009.

Australian Bureau of Statistics (ABS) 2010, 4517.0 *Prisoners in Australia,* viewed 22 June 2011,

www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4517.0Media%20Release12010?opendocument&tabname=Summary&prodno=4517.0&issue=2010&num=&view.

Australian Institute of Criminology 2011, *Trends and issues in crime and criminal justice*, no. 414, AIC, Canberra.

Commission for Children and Young People and the Aboriginal and Torres Strait Islander Advisory Board 2001, *Discussion paper on the impact on Aboriginal & Torres Strait Islander children when their fathers are incarcerated*, Australia.

Department of Families, Community Services (FACS) 2003, Occasional Paper No.10, viewed 22 June 2011, www.fahcsia.gov.au/about/publicationsarticles/research/occasional/Documents/op10/pmt.htm.

Hairston, Creasie Finney 2001. *Prisoners and Families: Parenting Issues During Incarceration*, National Policy Conference, From Prison to Home:The Effect of Incarceration and Reentry on Children, Families and Communities. U.S. Department of Health and Human Services. The Urban Institute.

Justice Health, 2009, *NSW Inmate Health Survey: Aboriginal Health Report.* NSW Health.

Laverty, M. (2009) *The central place of Health in Australia's Social Inclusion Agenda: Addressing the Social Determinants of Health to achieve social inclusion,* Catholic Health Australia.

MATRIX on Board (2008). *Final stage of a three year (2006-2008) external evaluation of the Central West Breaking the Cycle Program.*

Murray J, Farrington DP (2005), *Parental imprisonment: effects on boys' antisocial behaviour and delinquency through the life-course.* Journal of Child Psychology and Psychiatry, Dec;46(12):1269-78.

Phillips, Susan D. PhD, Gleeson , James P. PhD (2007). *What we Know Now that we Didn't Know Then about the Criminal Justice System's Involvement in Families with whom Child Welfare Agencies have Contact. Findings from a Landmark National Study.* Center for Social Policy and Research, Jane Addams College of Social Work, University of Illinois, Chicago.

Quilty, S. (2005). *The magnitude of experience of parental incarceration in Australia.* Letter to the editor. Psychiatry, Psychology and Law. 12 (1): 256-257.

Quilty, S. Levy, M. Howard, K. Barratt, A. Butler, T. (2004) *Children of prisoners: a growing public health problem*, People on the Margin, Australian and New Zealand Journal of Public Health, 2004 Vol 28 No.4.

Standing Committee on Social Issues 1997, *A Report into Children of Imprisoned Parents*, NSW Legislative Council, Macquarie Street, Sydney.

Victorian Association for the Care and Resettlement of Offenders (VACRO) 2006, *Children: Unintended victims of legal process – A review of policies and legislation affecting children with incarcerated parents.*

Wildeman, Christopher. *Paternal Incarceration and Children's Aggressive Behaviours: Evidence from the Fragile Families and Child Wellbeing Study.* Princeton University.

17

Addressing social determinants of health—structural change or targeted charity

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In their final report in 2008, the Commission on Social Determinants of Health (CSDH) called 'on the World Health Organisation and all governments to lead global action on the social determinants of health with the aim of achieving health equity'.[294]

The report of the Commission had three main recommendations:

1. improve daily living conditions
2. tackle the inequitable distribution of power, money, and resources
3. measure and understand the problem and assess impact of action.

It also emphasised that health and illness follow a social gradient and that it is not just about addressing the most disadvantaged.

This essay discusses the situation in Australia in relation to the first two recommendations. It assumes a knowledge of the well documented inequities in health outcome and status in this country

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[294] CSDH. 2008

Improving the daily living conditions

Improving the daily living conditions involves an emphasis on early childhood development, fair employment and decent work, having a universal social welfare system, and universal health care. In Australia a comprehensive framework for early childhood education and care is being implemented. Recent policies are intended to improve employment, especially amongst the disadvantaged. Our social welfare system is well targeted but there is evidence it is far from generous compared to other rich countries, despite the fact that child poverty levels in Australia are higher than the mean for 20 rich countries.[295]

The CSDH regards the provision of universal health care as an essential part of improving daily living conditions and health care as 'a common good rather than a market commodity'. We have a universal health system which guarantees entitlement but not access. There are significant financial, geographical, physical, and cultural barriers to access across Australia. A survey of 7000 Australians by the Australian Bureau of Statistics (ABS) found that 6.4 per cent delayed or did not see a general practitioner (GP) in a year because of cost, 10 per cent delayed or did not see a specialist because of cost, and 9 per cent delayed or did not obtain a prescribed drug because of cost.[296]

Rather than looking at the general population, the Commonwealth Fund survey from 2005 was performed on sick Australians, those who had recently been hospitalized, had surgery, or reported health problems. In this group who are the very ones whose access should be facilitated by a health system, 34 per cent described access problems due to cost. Thus, 22 per cent didn't fill a prescription, 18 per cent did not see the doctor when sick, and 22 per cent did not get recommended test or follow-up.[297]

Geographical barriers to access continue despite many targeted

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[295] UNICEF. 2010.

[296] ABS. 2009.

[297] Schoen, C. 2005.

programs to improve distribution of the workforce. Using the Australian Standard Geographical Classification (ASGC), the Productivity Commission found that population to practitioner ratios in very remote areas for GPs, dentists, and physiotherapists are about 20 per cent that found in major cities but importantly there is a steady gradient of decreasing availability as one moves from major cities, through inner regional, outer regional to remote and very remote.[298]

Whilst there are many factors contributing to the unequal distribution of the medical workforce, most of these factors are largely or completely out of control of government. The method of funding however is determined by government. It has chosen to persist with fee for service plus copayment as its main funding mechanism. This inevitably contributes to the medical workforce distributing itself in areas where copayments can be afforded, and where lifestyle choices of the workforce are optimised. Although many programs have been devised to counteract this poor distribution of workforce, the success of such programs will always be limited as they are working in direct conflict with the major funding structure.

The main funding of health care outside public hospitals in Australia is through fee for service plus copayment. This applies to most GP services and specialist services, private hospital services, and increasingly now to psychologists, nurse practitioners, physiotherapists and other allied health professionals. Thus health professionals paid in this way are free to provide publicly subsidised services wherever the market will support them and at whatever level of copayment the market will support. Financial and geographical barriers to access are inevitable. This structure reflects a view of health care as a market commodity rather than a common good. Rather than addressing this structure, the government is expanding it to more groups and entrenching inequity. This basic funding structure is ripe for change.

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298 Productivity Commission. 2005.

Tackle the inequitable distribution of power, money, and resources

The distribution of power, money, and resources is seen by the CSDH as a key structural driver of conditions of daily life.

We know from Wilkinson that income inequality correlates with health and well being status.[299] We also know that on most comparative measures of disposable income over the period 1994 to 2008, there has been increasing inequity in Australia.[300] But the approach of the government to the inequitable distribution of power, money and resources is limited although well directed in parts. Thus, improving employment, long term plans for improved housing affordability and availability, etc will all help to address these inequity issues.

Changes resulting from the recent budget are very directly aimed at redistributing income but are minor and will directly affect only a small number of people. Income inequality will only be marginally affected and then mainly for those who can be employed. The Commission states that to tackle this issue requires 'a strong public sector that is committed, capable, and adequately financed'.[301]

Such a requirement is not evident in our health system. The Minister for Health noted recently that there was a nine year high in uptake of private health insurance and welcomed the continued growth (Roxon 2011). This growth occurs because of the perception by the public that the public system, particularly the hospital system is increasingly inadequate. What about a strong public sector for primary health care?

Primary health care is largely publicly funded but predominantly runs on a small private business model. Between 2003–04 and 2007–08 there was an over 20 per cent increase in emergency department presentations, with no change in the make-up of the triage categories.

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[299] Wilkinson, R and Pickett, K. 2010.

[300] ABS. 2008.

[301] CSDH. 2008.

Thirteen per cent were non urgent and 46 per cent semi-urgent.[302] The increase in emergency department presentations for problems which could be addressed in general practice would suggest that our publicly subsidised private primary health care system is failing as patients default to the emergency departments.

The way general practice is both structured and functions is changing. There has been a 51 per cent decrease in home visits from 1997 to 2007[303], and a 37 per cent decline in the proportion of GPs working in practices that provide their own after-hours services[304], contributing to the use of emergency departments. In addition, there is an increasing need for a more robust business model as the number of solo practices decrease and the number of large practices of more than ten GPs increases.[305]

More broadly there exist inequalities in access to education, housing, and employment opportunities.[306] Education funding structures are controlled largely by government. Despite some moves to address the complicated causes of inequitable access to educational resources, the basic funding structure in primary and secondary education continues to support inequitable access. Thus, the federal government continues to fund the richest schools in the nation with money which could be being spent on the most disadvantaged schools. These and other factors contribute to inequities in health outcomes.

Approaches to inequities

There are a variety of ways in which these different inequities are addressed in Australia. Charitable organisations frequently help the most disadvantaged, for housing, employment, education or access to health care. Another form of charity is exemplified by the doctor

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[302] Australian Institute of Health and Welfare. 2010.

[303] Joyce, C et al. 2008.

[304] Britt, H et al. 2010.

[305] Ibid.

[306] Argy, F. 2006.

or other health professional who chooses not to charge a copayment (bulk bill) or another type of professional who goes way beyond the expectations of their position to help the disadvantaged.

The third form of charity comes from government. It is the system of safety nets introduced to address the gross inequities in access to health, quality education, housing, food security, and all of the other social determinants. Such safety nets are required because the societal structures result in inequities. Many of these structures are largely or entirely due to government policy eg, a copayment is required for pharmaceutical but 22 per cent sick Australians don't fill a prescription because of cost (that's even with a safety net).

Governments frequently correctly identify disadvantaged groups and introduce programs or projects specifically targeted to such groups. Such an approach is entirely appropriate when combined with addressing the structural drivers of such inequity. This approach aims for equity. When targeted programs are not combined with addressing the structural problems however, the approach is aiming only to reduce gross inequity. In such situations, one could consider programs as yet another form of charity, picking up the pieces resulting from structures of the government's own making.

The approach to the vexed question of the health of indigenous Australians has demonstrated an understanding of the broad range of factors contributing to health inequity. Recent funding for mental health with targeted funding initiatives across different areas including housing, education, and employment, is a recognition of the range of social determinants, and the mechanism of funding does begin to address the structural problems of funding through fee for service.[307]

The inclusion in the functions for Medicare Locals of a population health approach is also encouraging[308], but to date there is no evidence

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[307] National Mental Health Reform. 2011.

[308] Department of Health and Ageing. 2010.

of the recognition of the structural barriers to equitable funding and access with which Medicare Locals will have to contend to fulfil its multiple functions. Whilst these initiatives are encouraging the general approach to health care and health reform has been to ignore the structural drivers of inequity whilst addressing some areas of gross inequity.

The federal government has appointed the Australian Social Inclusion Board (ASIB) which states its task as … 'the main advisory body to the government on ways to achieve better outcomes for the most disadvantaged in our community and to improve the social inclusion in society as a whole'.[309]

It is puzzling that the task of the Board does not seek to achieve better outcomes (health or other) for all, given the very clear gradient of health outcomes documented previously. This gradient means that for example those in the 2nd highest quintile for health outcomes are still disadvantaged compared to those in the highest quintile.

Barriers to addressing social determinants

There does not seem to be sufficient recognition that there are fundamental structural barriers to equity in our society, particularly in the health and education systems and in income distribution. There also appears to be a lack of recognition of the social gradient, which therefore supports the concept of targeting the most disadvantaged and ignoring those structural barriers.

Instead, the approach to health inequities appears to be largely focused on targeted programs, safety nets, and other forms of charity. The other concern about a reliance on charity is that it deflects those interested in equity from pursuing that idea through the much harder to achieve structural reform. Those who spend all their time in charity work including well targeted programs, feel they are doing the right thing. They are. But whilst they may believe strongly in equity, they

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[309] ASIB. 2008.

have no time left for the pursuit of the big changes required.

Politicians who start off with ideals of equity must turn into practical people, doing what is possible. Thus, even the well intentioned target gross inequity and feel they are doing well, and then they ignore or have no time and energy to address the structures which are amenable to change. The changes required to tackle the root causes of the inequity are major, but what is being done is minor if not minimal. For other politicians, targeting gross inequity is perfect as they don't actually believe in equity, and much prefer the idea of charity, which fits well with their belief in a class based tiered society.

Conclusion

There is recognition amongst our politicians that to achieve health equity one needs to address both the health system and many factors outside the health system. There is a failure of recognition however that heath inequity follows a social gradient, and structural change is required to address this issue. A targeted approach to the most affected groups ignores this gradient and ignores the structural causes of the inequities. Indeed, one could view the approach of relying just on targeting as another form of charity, striving to reduce gross inequity but ignoring the goal of equity.

References

Argy F (2006). Equality of Opportunity in Australia: Myth and Reality. The Australia Institute: Discussion Paper Number 8 April 2006 ISSN 1322-5421.

ABS (2008). Household income and income distribution 2007-8 6523.0.

ABS (2009). Health Services: Patient Experiences in Australia, 2009 4839.0.55.001.

AIHW (2010) Health services series Number 34. Australian Institute of Health and Welfare Canberra Cat. no. HSE 84 Australian hospital statistics 2008–09.

Australian Social Inclusion Board (2008), www.socialinclusion.gov.au/Partnerships/Board/Pages/default.aspx.

Britt H et al (2010). General practice activity in Australia 2000-01 to 2009-10: 10 year data tables. General practice series no. 28. Cat. no. GEP 28. Canberra: AIHW. Viewed 26 March 2011 <http://www.aihw.gov.au/publication-detail/?id=6442472440>.

Commission on Social Determinants of Health (2008). Closing the gap in a Generation. World Health Organisation. Commission on Social Determinants of Health Final Report.

DOHA (2010b), Medicare Locals – Discussion Paper on Governance and Functions. accessed 27/01/2011 at www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/MedicareLocalsDiscussionPaper.

Friedman M. *The New York Times Magazine*, September 13, 1970.

Invest Smart (2011). accessed on 29/3/2011 at http://www.investsmart.com.au/shares/asx/Primary-Health-Care-PRY.asp.

Joyce C et al (2008). Trends in GP home visits. Australian Family Physician Vol. 37, No. 1, pg 1040.

Medicare Australia (2010). Accessed 29/3/2011 at .www.health.gov.au/internet/main/publishing.nsf/Content/Medicare+Statistics-1.

National Mental Health Reform - Ministerial Statement. ISBN 978-1-74241-449-2

Publications Number D0364.

Productivity Commission (2005), Australia's Health Workforce, Research Report, Canberra.

Roxon (2011). DOHA accessed on 29/3/2011 at www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-nr-nr027.htm?OpenDocument&yr=2011&mth=02.

Schoen C, Osborn et al (2005). Taking the pulse of health care systems: experiences of patients with health problems in six countries. Health Aff (Millwood). Jul-Dec; Suppl Web Exclusives:W5-509-25.

UNICEF (2010), 'The Children Left Behind: A league table of inequality in child well-being in the world's rich countries', *Innocenti Report Card 9*, UNICEF Innocenti Research Centre, Florence.

Wilkinson R and Pickett K, 2010, The Spirit Level, Penguin Books, p 21-2.

18

The role of organised primary health care in addressing the social determinants of health

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A number of recent, high-profile reviews have recognised that Australia's health system needs to be reoriented: it must be much less geared towards acute care and much more towards prevention and primary health.[310,311,312] The Australian Government has responded with a number of commendable policy platforms including the National Primary Health Care Strategy and the National Preventative Health Strategy. At the highest level, the Council of Australian Governments (COAG) has endorsed a reform agenda designed to strengthen primary health care.[313] Against this backdrop, Australia is in the midst of forming primary health care organisations (PHCOs)—known as Medicare Locals—to improve coordination and integration of primary health care in local communities, address service gaps and make the health system easier for patients to navigate.

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[310] A Healthier Future for All Australians. Final Report of the National Health and Hospitals Reform Commission, June, 2009.

[311] Australian Preventative Health Taskforce. Australia: the Healthiest Country by 2020: Discussion Paper. 2008.

[312] National Primary Health Care Strategy External Reference Group 2009.

[313] Council of Australian Governments, National Health Reform: Heads of Agreement, April 2010.

Medicare Locals will be a form of organised primary health care similar to Primary Care Trusts in the UK and Primary Health Organisations in New Zealand. This essay discusses the relationship between the social determinants of health and contemporary Australian health care policy and addresses the question, 'what is the role of organised primary health care and the primary health care setting in addressing the social determinants of health?'.

Introduction: what is health?

Medical science has made some commendable advances in treating disease over the last century—advances that can help with the diagnosis, prognosis and prolonged survival from serious disease. Yet even in wealthy countries that can afford to provide these medical treatments on a universal scale, a social gradient in health still operates whereby people who are less well-off have greater levels of morbidity and markedly shorter life expectancies than richer people. Scientific study shows that health status is extremely sensitive to the social and economic environment and is significantly affected by these so-called 'social determinants' of health such as poverty, early childhood experience, education and health literacy, working conditions, unemployment, social support, illegal drug use, good food, transport, as well as access to health care.

The underlying message is that health is more than simply the absence of disease or infirmity. Attaining good health requires more than treating illness. More important for the health of the population as a whole is the need to address the social and economic conditions that make people ill and in need of medical care in the first place. This concept has been encapsulated by the World Health Care Organisation (WHO) as comprehensive primary health care[314] and has led to a broader definition of health as 'a state of complete physical, mental

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[314] WHO. 1946. Constitution of the World Health Organization.

and social well-being'.

Reiterated through the Alma-Ata Declaration (1978) the connection between health and its social determinants has led WHO to mandate that all its member nations address the social roots of health problems through health, social and economic action and to also call on all national and international stakeholders to develop and implement comprehensive primary health care throughout the world in order to achieve 'Health for All'. The declaration specifies that, in addition to the health sector, comprehensive primary health care 'involves, all related sectors and aspects of national and community development ... [including] food, industry, education, housing, public works, communication, and other sectors; and demands the coordinated efforts of all these sectors'.[315]

A 'wicked' problem: why we need a new paradigm of health

This broader definition of health and the goal of comprehensive primary health care means that health policy must encompass much more than the provision, financing and regulation of medical care, because achieving wellbeing is a function of more than just the health sector. Moreover, the existence of the universal social gradient and the strong evidence between health and social factors means we are all affected to some extent—it is just a matter of degree. As a result, taking a comprehensive approach to health policy and practice that recognises and addresses the social determinants of health is essential to achieve overall population health improvement.

Australia has been slow to take this comprehensive view of health and the social and environmental factors that influence it, focusing instead on a more medical model of health. This is evident in the proportion of health spending devoted to prevention—in 2007–08, just over 2 per cent of total health expenditure was for preventive

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[315] Declaration of Alma-Ata. 1978.

services or health promotion.[316] It has concentrated its efforts and certainly its health expenditure either on the acute/hospital sector, or on cost-effective, short term, curative focused interventions (selective primary health care). This has, in effect, diluted the social and political dimensions of the original WHO primary health care vision.

The adverse implications of this ‘bias’ in our health system have started to surface. The focus on acute, technologically driven, reactive care has exacerbated health inequities, creating what public health experts term ‘islands of excellence in a sea of mediocrity’, as well as contributing to rising health costs. Yet evidence shows that more comprehensive primary health care oriented systems produce better outcomes and greater equity at lower costs and with higher user satisfaction.[317]

Unless Australia quickly acts to implement a comprehensive primary health care agenda that incorporates policy objectives designed to improve health by addressing some of the determinants of poor health outcome, there will be far reaching social and economic implications. Socially, in Australia and around the globe, people are increasingly holding governments to account on issues of fairness and social justice. Economically, poor health and well-being accounts for substantial productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs. Moreover, in all OECD countries, total spending on healthcare is rising faster than economic growth.[318]

If we are serious about striving for WHO’s vision of health for all in Australia, we need to make a concerted effort to balance and coordinate ’traditional’ health policy, set and implemented by health

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[316] Australia’s Health 2010 Report (AIHW).www.aihw.gov.au/publication-detail/?id=6442468376.

[317] Keynote address of Dr. Margaret Chan at the International Seminar on Primary Health Care in Rural China in November 2007.

[318] OECD. 2010. www.oecd.org/document/11/0,3746,en_21571361_44315115_45549771_1_1_1_1,00.html.

departments, with policy and action to address social determinants by non-health government agencies and sectors. Achieving this cross-sectoral collaboration in Australia presents us with a 'wicked' problem. A 'wicked' problem is broadly considered as one highly resistant to resolution, and having a number of characteristics requiring multiple and unique remedies.[319] Health in a number of its facets can be described as a 'wicked' problem, but the social determinants of health are especially so as they encompass the complex and wide ranging dynamics of the social and environmental realms.

Australia's current opportunity

The notion of comprehensive primary health care (CPHC) in Australia is gaining renewed momentum as a means of achieving more equitable and affordable population health. Recognising the gains made in countries such as New Zealand and the UK through implementation of policy that takes into account the social and environmental factors influencing health, the time is ripe for Australia to set and drive a CPHC agenda. Limitations of a narrow medical model of health, an increasingly robust evidence base for the social determinants of health and the Federal Government's commitment to reform are all converging to create a policy window that has the potential to change the way we conceive health in this country and how we deliver health solutions.

Experts and key health stakeholders have recommended the need for organised primary health care at the regional level to deliver on this comprehensive model—this has included AGPN's Primary Health Care Position Statement and blueprint for Australian PHCOs. The Australian Government has responded by designing Medicare Locals. Medicare Locals will be 'meso' level PHCO structures that will sit between governments and communities. The primary focus

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[319] Australian Public Service Commission. (2007). Tackling Wicked Problems: A Public Policy Perspective. www.apsc.gov.au/publications07/wickedproblems.htm.

of these new organisations will be on population health planning with a view to addressing priority areas of need and service gaps within their regions. There will be a strong emphasis on partnership and collaboration. Mandates of Medicare Locals also require greater community engagement and input into primary health care service development and delivery.

Most significantly, the performance of Medicare Locals will be required to be transparent. Healthy Community Reports published by the proposed National Health Performance Authority will indicate the impact of Medicare Locals on key factors such as access to services, quality of services, patient outcomes and patient experience.[320] It can be fully expected that in order to achieve their obligations and demonstrate health improvement in their communities, Medicare Locals will need to build links with other agencies beyond the traditional health sector—for example in education, housing, welfare and the like—to become a means through which health and social factors can be simultaneously addressed.

A comprehensive primary health care vision: the role of Medicare Locals

To do this, Medicare Locals must expand their scope of vision, action and responsibility to look beyond the boundaries that have, traditionally, neglected to view social, economic and environmental factors as core health business. This will especially require Medicare Locals to work collaboratively and synergistically across sectors and organisations—a way of working that demands innovative leaders and thinkers, flexibility and vision, daring and excellence. Health and social care leaders must 'think outside the square' to achieve this vision.

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[320] Medicare Locals: Guidelines for establishment and initial operations. www.health.gov.au/internet/main/publishing.nsf/Content/grantITA2491011/$FILE/Medicare%20Locals%20Guidelines%20and%20Information%20for%20applicants.pdf.

The Australian Public Service (APS) Commission has acknowledged the significant and far reaching problems that the APS has with tackling 'wicked' problems requiring highly complex solutions that are reliant on inter-sectoral team work and multi-faceted approaches.[321] Yet fundamentally, both at government and departmental levels, the APS is not structured to work in a manner that can necessarily and easily solve complex problems: our federal system creates divides between national and state governments; our democratic political system facilitates and promotes differences of view, and often fierce competition between those views; and the public finance system, perhaps as a result of this, is delivered in silos; all of which serve as barriers to innovative cross-sectoral collaboration and synergism.

To begin solving some of these 'wicked' health problems, we must therefore look beyond the hierarchical apex of bureaucracy to the grass roots actors, who do not—or at least not to the same extent—operate in such a constrained environment. It is at this level that Medicare Locals can influence, innovate, shape and drive the way health is viewed and the way its services and interventions are thus delivered. These primary health care organisations will have ample opportunity, over time, to work synergistically with broad and varying sectors and stakeholders, in what will become joint efforts to address health problems at their 'socially determined' roots.

Advantages of building on the Divisions network

As long as they have sufficient administrative and financial flexibility, a real advantage of Medicare Locals is that they are well placed to link the relevant agencies, sectors and levels of government together and bind them to a common agenda—the health needs of their particular community of interest. Moreover, by 'pooling' funding and actively coordinating effort at a regional level they could quickly become the

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[321] Australian Public Service Commission. (2007). Tackling Wicked Problems: A Public Policy Perspective. www.apsc.gov.au/publications07/wickedproblems.htm.

main vehicles for driving the social determinants of the health agenda in ways that are relevant to the particular characteristics of Australia's diverse population and geography and in ways that government agencies have never been able to do.

Medicare Locals have already been given the best start in their CPHC endeavours by being built on the existing Divisions of General Practice Network. Over the last 17 years, Divisions across Australia have increasingly implemented inter-sectoral approaches which reach beyond the traditional 'health' sector to address the social factors in health. While such approaches will need to be expanded more universally across a Network of Medicare Locals, the foundations for this approach are undoubtedly already there within the Divisions Network. Such capacity has been long recognised. The Phillips Review of the Divisions of General Practice Program noted the logic of the network evolving to operate under a comprehensive primary health care framework, building on and retaining its general practice roots.[322]

Many divisions have already identified the need for a more comprehensive, whole-of-community approach by working across settings and partnering with social care stakeholders to deliver new models of care and community projects aimed at building social capital, and strengthening inter-sectoral linkages to improve peoples' living conditions—to impact on health through starting to address these fundamental social factors. Initiatives have included the development of market gardens in remote communities where access to good quality fresh food is limited and the instigation of community support workers in drought affected rural communities to build community capacity and resilience and link people with other non-traditional health sectors, such as financial counsellors to again address the underlying issues that impact on health. Further

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[322] Phillips, R. 2003. Review of the Divisions of General Practice Program.

initiatives include new models of care such as *headspace* designed to provide 'wrap around' care and support for young people from a coordinated team of health, social services and vocational advisers and a new workforce in the form of care coordinators and outreach workers under the Closing the Gap initiative to assist Aboriginal and Torres Strait Islander peoples access care and overcome some of the structural barriers to access such as a lack of transport.

Conclusion

We must reconceptualise the way we think about health in Australia if we are to achieve the WHO's vision of 'Health For All'. This means looking beyond the traditional boundaries and models of care to the social and environmental factors that determine our health, rather than waiting for disease and infirmity to set in before treating it. To do this we need a strong, regionally responsive and locally governed primary health care sector to drive a comprehensive approach to improving health.

The policy landscape is looking promising: a number of reviews and expert opinion has converged on the need to reorient our system to one that is prevention and primary health care centric, a principle now embraced by all governments. As they are designed and mandated to do so, Medicare Locals will have an unprecedented opportunity to create innovative ways of working collaboratively and synergistically across sectors and organisational boundaries. This is what will be required to effectively address what are 'wicked' health problems, by targeting their causes at their roots. We are only in the early stages of what is going to be a long and challenging road ahead for equitable, efficient and effective health care—and the associated health outcomes that comes with it—but with a strong foundation on which to build, and the right creative and innovative clinical and local leaders steering it, the future of health care in Australia looks promising.

Conclusion
A call to action

Liz Callaghan,
Catholic Health Australia

Contributions to this book have demonstrated that aspects of peoples' living and working circumstances and their lifestyles are having an impact on their lives and a detrimental effect on their health and culture. On the surface Australia seems like a pretty fair country. It is a widely held belief that we have no class system, and that ours is a society with ready access to jobs, health services, education and housing—but just don't ask Indigenous Australians if it is fair. Or people living in rural areas. Or people with a disability or mental illness. Or the unemployed. Or those living in a low socio-economic areas.

I could go on, but I won't—it can make people feel uncomfortable, and that's fair enough. We all like to think we're not like other countries, but we are. We do have one of the most progressive welfare transfer systems in the world, our tax system is also progressive. Yet we have large gaps. Why do we have almost 60 per cent of Tasmanians over the age of 65 years living in Socio-Economic Index (SEIFA) quintile 1[323] when across the straight and up into the Australian Capital Territory—where most of our health, education, welfare policies originate—66

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[323] Socio-Economic Indexes for Areas (SEIFA) quintiles are based on the ABS Index of Relative Socio-Economic Disadvantage (IRSD), with quintile 1 being the most disadvantaged and quintile 5 being the least disadvantaged.

per cent of people aged over 65 live in the 5th quintile.[324] How will their respective experiences of ageing differ?

In pulling together the essays in this book it is hoped that a level of awareness can be raised and an informed debate commenced. This country is well behind the UK and Europe in terms of implementing health policy processes that address the social determinants of health—but we are certainly not behind in thinking and debating these issues. It is time that governments in Australia caught up.

This book has pointed to the interconnections that can be made in all areas of social life. It has pointed out that socioeconomic circumstances or living environments can hold back some Australians from making healthy life choices, and indeed that there is a social gradient in play for both 'risk' factors and 'protective' factors in terms of illness prevention.[325] This book is a call to action for governments, to obtain clear scientific evidence of the causal nature of the social determinants of health. The best way is to start with a Senate inquiry into the social determinants of health.

The 'Norway experience' will tell us why this can work, and an exploration of the 'Health in all Policies' program in place in South Australia will highlight how policy in action can lead to making a difference. The message to fellow policy wonks is clear—we need to change what we're doing—our old ways are not having the impact we desire and we urgently need to develop policies and programs that explicitly address the sensitivity of health to the social environment.

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[324] National Healthcare Agreement: Performance report for 2009-10 VOLUME 2 Performance data Report to the Council of Australian Governments 29 April 2011 Additional.6 Population 65 years and over by socioeconomic status, by State and Territory, June 2009, per cent.

[325] National Healthcare Agreement: Performance report for 2009-10 VOLUME 2 Performance data Report to the Council of Australian Governments 29 April 2011 p.21.

A lesson from Norway

The lesson from Norway is instructive. The World Health Organisation (WHO) European Office for Investment for Health and Development has organised national policy learning case studies on tackling the social determinants of health and health inequity in the WHO European Region. Norway is the first of three case studies to be carried out. There are two other case studies in development, one on Slovenia and one on Scotland.

The case study, *Setting the political agenda to tackle health inequity in Norway—Studies on social and economic determinations of population health, No.4,* tells us that the Minister for Health and Care Services in Norway supported the idea that Norway ought to preserve the good health of those who already enjoy it, while also raising the level of health of the rest of the population in line with those already in good health. That is, level the health gradient. The Norway Government believes inequality in health is socially determined, unfair and modifiable, and that it is a whole of government challenge.

In 2007 Norway developed a White Paper that was aimed at reducing social inequity in health. It contained a combination of intersectoral efforts and short and long term goals relating to health determinants and was designed to keep the issue on the agenda until 2017. As a result public health targets were transformed after only a few years.

The process was assisted by having in place specific research on the prevalence and causes of health inequity and related policy intervention, a forum for experts or communities of specialists and practitioners who could interact and generate common ground, and capacity and receptivity for tackling complex issues. There was also consistency in framing the policy challenge (an intervention map was used, see Figure 1) and a network of policy entrepreneurs to communicate the problem and assist in defining the equity goals of health and other sectors.

The need to align policy objectives with other parts of the government systems, such as budget and regulation frameworks was also important, thereby developing the national strategy based on, as far as possible, existing structures. Inter-ministerial collaboration helped to mainstream health equity policies relating to the social determinants of health, as did the continuous obligation to keeping the issue of social inequity in health on the political agenda—monitoring inequalities in health determinants, rather than inequalities in health outcomes, also helped.[326]

Figure 1 Intervention map for comprehensive policies on reducing social inequity in health

Measures	**Social reform upstream**	**Risk reduction midstream**	**Effect reduction downstream**
Universal	Public system of education, taxes, labour market policies, etc	Working and living environment, broad lifestyle measures, etc	Health systems
Selective	Means-tested social benefits, etc	Targeted lifestyle measures, etc	Targeted health services

Source: *Setting the political agenda to tackle health inequity in Norway*, p.32

Norway's *White Paper No.20 (2006-2007): National Strategy to Reduce Social Inequalities in Health* was developed in consultation with the ministries of Finance, Local Government, Regional Development, Labour and Social Inclusion, Children and Equity, Justice and Police, Culture and Church Affairs and Education and Research. The overall strategy has four priority areas with defined objectives and measurable targets:

1. *Reduction of social inequity that contributes to health differences*— and is mainly concerned with income redistribution,

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[326] Strand, M et al. 2009.

childhood development and the working environment.

2. *Reduction of social inequity in health behaviour and improvement in access to health services*—and is mainly concerned with promoting healthier choices, policy instruments to influence price in food and improving knowledge about social inequity.
3. *Targeting efforts for social inclusion*—aiming to improve conditions of life of the most disadvantaged.
4. *Increasing knowledge and developing tools for intersectoral collaboration and planning.*

Has all this made a difference to people living in Norway? The reporting system in place has been established in close collaboration with the relevant directorates/ministries and professional environments in the various sectors involved. The yearly report aims to monitor trends using a set of indicators in the areas of income, childhood conditions/education, work and working environment, health behaviour, health services and social inclusion. The 2009 report, released last year, is but the first step in the process. Work on the reporting system will be ongoing for many years, so it is really too early to tell if interventions in place have made tangible differences. There are promising signs, and the full report makes for interesting reading.[327]

Measuring and naming what is being done to counter the social determinants of health sounds like a good start.

Implementing 'Health in All Policies' in South Australia

There are pockets of innovation in this country and none more interesting than in South Australia.

In 2007 South Australia adopted a 'Health in All Policies' (HiAP) approach, placing it strategically as a central process of government

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[327] Full report can be found here www.helsedirektoratet.no/vp/multimedia/archive/00298/Norwegian_public_he_298769a.pdf.

to improve health and reduce inequities, rather than an approach run by, and for, the health sector and imposed on other sectors.[328] This approach has been framed as essential to achieve not only health priorities, but also a range of goals in the state's main planning document, South Australia's Strategic Plan.

HiAP is an approach originally conceived of and developed in Europe, most particularly in Finland.[329] The motivation to adapt it to Australian conditions arose out of recommendations by Professor Ilona Kickbusch who was appointed as an Adelaide Thinker in Residence in 2007.[330] For South Australia, HiAP starts from the recognition that the determinants of health lie largely in the policy domains of other sectors of government. It is therefore crucial for the health sector to positively engage with these other sectors to ensure sustained action on the social determinants of health.

The HiAP program in South Australia provides a mechanism for agencies to jointly reflect on a particular policy issue, and work in a collaborative and deliberative way to determine issues and take timely policy decisions. The HiAP process builds on traditional health impact assessment methodology by incorporating a suite of additional methods[331] (eg economic modelling) to allow the process to deliver rigour and flexibility. It seeks to facilitate joint exploration of policy problems and issues. As a consequence, the specific methodology employed is modified for each project. Evaluation is also built into each individual project.

A range of projects involving different sectors have been undertaken. These include water security, migrant settlement and access to digital technology. The foundations for the success of the HiAP approach in South Australia have been identified as:

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[328] Kickbusch, I and Buckett, K. 2010.

[329] Stahl, T et al. 2006.

[330] Kickbusch, I. 2008.

[331] Williams, C et al. 2010.

- a strong cross-government focus
- central government mandate and coordination
- flexible and adaptable methods of enquiry, using health lens analysis
- mutual gain and collaboration
- dedicated health resources for the process
- joint decision-making and joint accountability, and
- recognition that health is a resource which can contribute to the achievement of other sectors' goals and priorities—improved health can lead to improved overall development.[332]

In 2011 the South Australian Government moved to strengthen the mandate and sustainability of Health in All Policies approaches through specific provisions in new public health legislation (see www.sahealth.sa.gov.au/publichealthact[333]).

It is clear from this examination of HiAP that South Australia has already moved toward the systematic development of new strategies and programs and the formation of new alliances outside of health. Various sectors within other states have also taken up this challenge (as highlighted within this publication)—but there has not been a willingness demonstrated nationally to systematically address the personal, social and economic aspects of health.

If health policy fails to address these facts, it not only ignores the evidence, as outlined here in this publication, but it ignores one of the most important social justice issues facing this nation.[334]

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332 Williams, C et al. 2010.

333 More information on the South Australian experience can be found at www.sahealth.sa.gov.au/healthinallpolicies or by consulting the following publication: Kickbusch I, Buckett K, eds. Implementing Health in All Policies, at the above web site.

334 Wilkinson, R, and Marmot, M.: 2003.

Where to from here?

It is clear and undisputed—social and economic circumstances affect health throughout life. What can governments do? What should governments do? They could begin by considering the following:

1. Establish a Senate Inquiry into the social determinants of health. Terms of reference for such an inquiry may include identifying:
    - the level of Commonwealth and other funding for research addressing social determinants of health
    - the extent, adequacy and funding for programs, services, that address the social determinants of health
    - the capability of existing health and community services to meet the needs of populations who are adversely affected by the social determinants of health
    - the extent to which health and community services need to be educated about the social determinants of health
    - the extent to which the broader community requires education about the social determinants of health, and
    - the extent to which experience and expertise in the social determinants of health is appropriately represented on national health agencies, especially the National Preventative Health Agency.
2. Have the Social Inclusion Board move to develop a Cabinet process that can examine the impact of social determinants on health within all policies and cabinet proposals.
3. Like Norway, annually monitor trends using a set of indicators in the areas of income, childhood conditions/education, work and working environment, health behaviour, health services and social inclusion.
4. Ensure that Local Hospital Networks and Medicare Locales consider the existing social determinants of health within their own catchment areas and respond to these issues through service

planning and community development activities.

5. Ensure the National Health Preventative Agency and the Social Inclusion Board develop a specific interface in order to work together.

Governments, at all levels, could also seriously consider funding and supporting that old fashioned thing called 'community development'. This approach to implementation of policies and programs can help with sustainability, keep people safe, improve health outcomes, ensure services meet local needs, reduce waste and reduce duplication.

The development of critical consciousness, through community engagement, within marginalised communities could diminish the perception of inequality within that community,[335] and of course the most important component of this personal empowerment would be social action.[336]

Social disadvantage is a reality faced by many within our communities. It creates, as we have seen, many negative consequences, and the consequences lead to the creation of barriers to the advancement of marginalised people. Governments should play a pivotal role in facilitating the empowerment of such groups.

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[335] Hanna, F et al. 2000.

[336] Carr, E. 2003.

References

Carr, E S. (2003). Rethinking empowerment theory using a feminist lens: The importance of process. Affilia, 18, 8-20.

Hanna, F J, Talley, W B, & Guindon, M H. (2000). The power of perception: Toward a model of cultural oppression and liberation. Journal of Counseling and Development, 78.

Kickbusch, I and Buckett, K. (eds) 2010, Implementing Health in All Policies – Adelaide 2010, Department of Health, Government of South Australia, Australia.

Kickbusch, I, 2008, Healthy Societies: addressing 21dt Century Health Challenges, Final Report of Adelaide's 13th Thinker in Residence, Department of the Premier and Cabinet, South Australia.

National Healthcare Agreement: Performance report for 2009-10 VOLUME 2 Performance data Report to the Council of Australian Governments 29 April 2011.

Stahl, T, Wismar, M, Ollila, E, Lahtinen, E, and Leppo, K. (eds) 2006, Health in All Policies—Prospects and Potentials, Ministry of Social Affairs and Health, Health Department, Finland.

Strand M, Brand C, Torgersen T, Gaiver O, (2009), Setting the political agenda to tackle health inequity in Norway www.euro.who.int/en/where-we-work/member-states/norway/publications2/setting-the-political-agenda-to-tackle-health-inequity-in-norway, accessed 1 June, 2011.

The Norwegian Directorate of Health's annual report on measures to reduce social inequalities in health, Norwegian Public Health Policy Report 2009, accessed 1 June 2011, www.helsedirektoratet.no/vp/multimedia/archive/00298/Norwegian_public_he_298769a.pdf.

Wilkinson R, Marmot M. 2003. Social Determinants of Health: the Solid Facts, 2nd Edition.

Williams, C and Broderick, D in Kickbusch, I and Buckett, K (eds) 2010, Implementing Health in All Policies—Adelaide 2010, Department of Health, Government of South Australia, Australia.

Williams, C, Wildgoose D, Sawford, A and Williams, L in Kickbusch, I and Buckett, K (eds) 2010, Implementing Health in All Policies—Adelaide 2010, Department of Health, Government of South Australia, Australia.

Authors' biographies

Foreword

Professor Frank Brennan SJ AO is a Jesuit priest, professor of law at the Australian Catholic University and Adjunct Professor at the Australian National University College of Law and National Centre for Indigenous Studies. He was the founding director of Uniya, the Australian Jesuit Social Justice Centre. He is a board member of St Vincents Health Australia and Jesuit Social Services and is presently Advocate in Residence for Catholic Health Australia, Catholic Social Services Australia and the Society of St Vincent de Paul.

Frank Brennan is also an Officer of the Order of Australia (AO) for services to Aboriginal Australians, particularly as an advocate in the areas of law, social justice and reconciliation. In 2009, he chaired the Australian National Human Rights Consultation Committee.

Introduction

Social building blocks of good health—opportunity for action

Martin Laverty is the Chief Executive Officer of Catholic Health Australia. Trained as a lawyer with a Masters in Comparative Constitutional Laws, Martin commenced his career as a parliamentary adviser in the NSW Parliament. He has worked as the CEO of the NSW Muscular Dystrophy Association, the Head of Government at The Smith Family, the Director of Government Relations at the international consultancy Burson-Marsteller, and as the State Director of the NSW Liberal Party. He has also operated his own government policy consultancy advising clients in Australia, New Zealand, Indonesia, and the United Arab Emirates on social policy change.

In a voluntary capacity, Martin Laverty is the Chairman of the National Heart Foundation (NSW) and a member of its National Board. He is also the Chairman of Sunshine, a NSW not-for-profit organisation which provides accommodation, care, and employment to people with disabilities. He has also been Chairman of Challenge Southern Highlands, a charity providing supported employment for adults with intellectual disabilities, and has been an adviser to the Australian Red Cross Blood Service and the young person's cancer organisation Canteen.

1

Action on the social determinants of health—what does Australia need to do?

Fran Baum is Professor of Public Health and an Australia Research Council Federation Fellow at Flinders University, Adelaide. She is also Foundation Director of the Southgate Institute for Health, Society and Equity & the South Australian Community Health Research Unit. She is Co-Chair of the Global Steering Council of the People's Health Movement—a global network of health activist (www. phmovement.org). She also served as a Commissioner on the World Health Organisation's Commission on the Social Determinants of Health from 2005–08. She is a Fellow of the Australian Academy of Social Science and of the Australian Health Promotion Association. She is a past National President and Life Member of the Public Health Association of Australia.

Fran Baum is one of Australia's leading researchers on the social and economic determinants of health. She holds grants from the NH&MRC and the ARC which are considering aspects of health inequities and social capital, neighbourhoods and work. She has been involved in the Australian and International Healthy Cities Movement and from 2005–09 was a program leader with the Co-operative Research Centre in Aboriginal Health. Her book, *The New Public Health* (3rd edition 2008 Oxford University Press), is widely used as a public health text.

Dr Matt Fisher works as a Research Officer at the Southgate Institute for Health, Society and Equity, within the School of Medicine at Flinders University. He completed a PhD in philosophy on these themes at Adelaide University in 2010. His main research interests are focused on social determinants of chronic stress and mental illness, and their implications for social policy and political ethics. He is currently researching ways in which national mental health policy does or does not take account of evidence on social determinants of mental health.

Previously, Matt Fisher has worked as a policy and research officer in the non-government community housing sector. He has a long-standing commitment to values of social and environmental sustainability, and research interests in the design of urban environments to be both health promoting and environmentally sustainable. He was closely involved in the initial development of 'Christie Walk', a model ecological housing development in Adelaide's CBD.

2

Partnering for positive change

Hon Michael Board JP is St John of God Health Care's Group Manager for Youth, leading strategy for Social Outreach and Advocacy services aimed at young people aged 12 to 25. Having managed youth accommodation and support service Horizon House since its inception in 2004, he also has responsibility for mental health and dual diagnosis functions of St John of God's community-based services for young people. A former WA State Minister for Youth, Michael Board held various other portfolios in the Western Australian cabinet from 1996 to 2000, serving as a Member of Parliament from 1993 to 2004.

Salli Hickford has more than 14 years professional experience in the community and health sectors and is currently employed in the Strategy and Development function of Barwon Youth. Having completed a Diploma in Alcohol and Other Drugs she is now working towards a Masters in Social Sciences, previously studying Behavioral Sciences at La Trobe University. She spent 10 years at YSAS (Youth Support and Advocacy Service), starting at its inception, and working in both the residential and outreach services. Until recently, Salli Hickford was employed as the Manager, Alcohol and Other Drugs at Barwon Youth.

Colin Wood is the Public Relations Manager for Social Outreach and Advocacy at St John of God Health Care, overseeing communications strategy for services including Horizon House, Raphael Centres, international health programs and alcohol and other drug services. Having originally trained and worked as a newspaper journalist, he now has 10 years experience in driving PR and communications strategy for high profile community-based organisations with responsibility for copywriting and copy editing, publications, online engagement and media relations.

Taanya Widdicombe is Director of Hospital and Community Development at St John of God Hospital Geelong, holding responsibility for Social Outreach and Advocacy services in the greater Geelong region. A committee member for both of the two Horizon Houses in Geelong, Taanya Widdicombe has a long-standing involvement with the Geelong community, also managing the association with Barwon Youth since its inception. Taanya has maintained and developed partnership between St John of God Hospital Geelong and Barwon Youth over more than seven years.

3

Health inequalities in Australians of working age

Professor Laurie Brown is the Research Director of Health at The National Centre for Social and Economic Modelling (NATSEM) at the University of Canberra. She leads NATSEM's health modelling and related projects. She is a health geographer with over 25 years of experience in public policy research, particularly in relation to health and ageing, and the impacts of social change and economic restructuring.

Dr Binod Nepal is an Acting Senior Research Fellow at The National Centre for Social and Economic Modelling at the University of Canberra. He has interests in health demography, social inequality, population ageing and housing research. Binod Nepal is involved in the development and application of policy models that assess impacts of social and economic changes in health and aged care in Australia.

4

The social and cultural determinants of Aboriginal and Torres Strait Islander health and the human rights-based approach of the Close the Gap Campaign for Indigenous health equality

Dr Tom Calma is an Aboriginal elder from the Kungarakan tribal group and a member of the Iwaidja tribal group in the Northern Territory. Tom Calma was appointed as National Coordinator for Tackling Indigenous Smoking to lead the fight against tobacco use in Aboriginal and Torres Strait Islander communities in March 2010. His most recent previous position was that of Aboriginal and Torres Strait Islander Social Justice Commissioner at the Australian Human Rights Commission from 2004 to 2010. While at the Commission he was also the Race Discrimination Commissioner from 2004 to 2009. In his 2005 Social Justice Report he called for the life expectancy gap between Indigenous and non-Indigenous people to be closed within a generation and in 2006 established the Close the Gap campaign.

Tom Calma has worked in the public sector for over 38 years in roles including bureaucrat, senior academic, senior diplomat (India and Vietnam) and senior advisor to a minister. His achievements are many but most notably in recent years they include responding to the Prime Minister's Apology on behalf of Indigenous peoples and Chairing the Steering Committee to establish the National Congress of Australia's First Peoples.

In 2010, he was awarded an honorary doctorate from Charles Darwin

University in recognition of decades of public service, particularly in relation to his work in education, training and employment in Indigenous communities and in 2011 an Honorary Doctorate from Curtin University in recognition of his work in higher education both in Australia and internationally and in Indigenous health. In a special July 2010 edition by the Australian Doctor magazine Tom Calma was named one of the 50 most influential people in Australian medicine. He is patron and board member of a number of national organizations.

Mick Gooda is a descendent of the Gangulu people of central Queensland. He is a senior executive with 25 years experience and a record of attaining high-level goals and leading multi-million dollar service programs and organisational reform. Immediately prior to taking up the position of Aboriginal and Torres Strait Islander Social Justice Commissioner, he was the Chief Executive Officer of the Cooperative Research Centre for Aboriginal Health (CRCAH) for close to five and a half years. Here, he drove a research agenda which placed Aboriginal and Torres Strait Islander people 'front and centre' in the research agenda, working alongside world leading researchers. His work at the CRCAH empowered Aboriginal and Torres Strait Islander people to lead the research agenda in areas including: chronic disease management; skin infections; and promoting cultural change in hospitals to make them more appropriate to the needs of Aboriginal and Torres Strait Islander people.

Mick Gooda has extensive knowledge of the diversity of circumstance and cultural nuances of Aboriginal and Torres Strait Islander peoples throughout Australia. He has been actively involved in advocacy in Indigenous affairs throughout Australia and has delivered strategic and sustainable results in remote, rural and urban environments. He has played a leadership role in a range of areas including: Acting Chief Executive Officer of the Aboriginal and Torres Strait Islander Commission and Senior Consultant to the Aboriginal Legal Service (WA).

He is highly experienced in policy and program development in the public and community sectors. He is also currently a Board Member of the Centre for Rural and Remote Mental Health Queensland, and is the Australian representative on the International Indigenous Council which focuses on healing and addictions. He also has an interest in the Lateral Violence Program in Canada and has been working closely with the First Nation people of Canada on the relevance of this program to Australia.

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Closing the gap and the Indigenous determinants of health in Australia

Dr David Cooper is currently the Senior Policy Officer for the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), the peak body for Aboriginal community controlled health services in the Northern Territory. David Cooper has extensive research-based experience working in Aboriginal affairs over the last 25 years, mainly in the Northern Territory. From 1984 to 1995 he worked as a Field Officer/Anthropologist for the Northern Territory (NT) Aboriginal Areas Protection Authority—the statutory body responsible for Indigenous heritage protection in the NT. From 2007 to 2010 he worked as a consultant for the Northern Land Council researching native title rights and consulting with traditional owners regarding national park joint management issues in Gregory National Park and Kakadu National Park. During this period he was also employed as a Research Scientist for the CSIRO researching Indigenous water rights.

Other positions have included Senior Coordinator, Research and Policy of the Fred Hollows Foundation's Indigenous Australia Program, and National Director of Australians for Native Title and Reconciliation (ANTaR) from 2000–06. In 2004 he led the development of ANTaR's Healing Hands Indigenous Health Rights Campaign. David Cooper has a Bachelor of Science (Ecology) from the University of Queensland and a PhD from the Australian National University. His doctoral thesis examined the continuity of Aboriginal land-based cultural traditions in the context of cross-cultural relations in the remote Victoria River region of the Northern Territory.

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Promoting disadvantage—obstacles to action

Mike Daube is Professor of Health Policy at Curtin University of Technology and Director of the Public Health Advocacy Institute of Western Australia (WA). He was WA's Director General of Health from 2001–05 and Chair of the National Public Health Partnership. He is currently President of the Public Health Association of Australia, the Australian Council on Smoking and Health and the WA Heart Foundation, and Chair of the WA Alcohol and Drug Authority. He has played a leading role in tobacco control, alcohol and other public health issues nationally and internationally for many years, and has advised governments and NGOs in some thirty countries. He has received awards for his work from organisations including the World Health Organization, the Public Health Association, the Australian Medical Association, Healthway, the Heart Foundation, Curtin University, ACOSH and the Australian Red Cross

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The personal is political

Dr John Falzon is Chief Executive Officer of the St Vincent de Paul Society National Council of Australia. He has written and spoken widely on the structural causes of marginalisation and inequality in Australia and has long been an advocate for a fairer and more equitable society. He has worked in academia, in research and advocacy with NGOs, and in community development in large public housing estates.

John Falzon has studied poetics, theology, philosophy, politics and social analysis. He is also a published poet. He was a participant in the 2020 Summit, has served as a member of the ACOSS Board and has also served on government advisory committees such as the Community Response Task Force and the Energy White Paper High Level Consultative Committee. He is a member of the Australian Social Inclusion Board. Some of his recent articles and speeches can be found at http://www.vinnies.org.au/articles-reports-and-speeches-national?link=252 . See also: http://twitter.com/#!/JohnFalzon

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What a commitment to improving health status has to do with a national disability insurance scheme

Dr Rhonda Galbally AO works in international health development and social and health policy in Australia. After secondary and tertiary teaching in the late 70s she was senior policy analyst for the Victorian Council of Social Services. In the early 80s she was CEO of the Sidney Myer Fund and the Myer Foundation. Since the mid 80s, Rhonda Galbally has been the founding CEO of five new Australian organisations: the Australian Commission for the Future (mid 80s); the Victorian Health Promotion Foundation (late 80s), . the Australian International Health Institute—now the Nossal Institute for Global Health—at the University of Melbourne (late 90s); Our Community (2000–10); and most recently she set up the Australian Preventive Health Agency and developed the first five year strategic directions and operational plans

Rhonda Galbally is currently the Chair of the International Evaluation Committee for the Thai Health Promotion Foundation, the Chair of the National People with Disabilities and Carer Council, and Chair of the Royal Women's Hospital in Melbourne. She is a member of the Independent Advisory Panel for the Productivity Commission Inquiry into a lifetime care and support scheme for people with a disability and chronic illness. She is patron of the National Disability and Carer Alliance and the Compassionate Friends Victoria.

Rhonda Galbally was made an Officer of the Order of Australia in 1991, holds honorary doctorates in health and social science from RMIT and La Trobe universities, and was awarded the Centenary Medal in 2001 in recognition of her service to the community.

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Health—covering all the bases

Dr Steve Hambleton MBBS FAMA was elected Federal President of the Australian Medical Association (AMA) in May 2011, after serving a two-year term as Federal Vice President. Previous roles with the AMA include President of AMA Queensland, AMA Federal Councillor and Acting CEO of AMA Queensland, October–December 2007. He was the AMA representative on the National Immunisation Committee from 2006–10, and was a member of the Pharmaceutical Benefits Advisory Committee for two years until 2009. He has been a member of the AMA Taskforce on Indigenous Health since 2006 and is currently the Chair of the Taskforce. Steve Hambleton is a former member of the government Red Tape Taskforce and the Practice Incentive Program and Enhanced Primary Care Review Advisory Group. He currently serves on the Practice Incentive Program Advisory Group.

Steve Hambleton graduated from the University of Queensland in 1984 and commenced full-time general practice in Queensland in 1987. He has been working at the same general practice at Kedron in Brisbane since 1988. In 1989, he became one of the principals of Continuous Care Medical Centres, where he developed a strong interest in practice development and teaching medical students and GP registrars. In 2000, he was appointed Medical Director of Foundation HealthCare—the forerunner to one of Australia's largest GP corporate groups, Independent Practitioner Network. Steve Hambleton became State Director of Foundation HealthCare in 2001. He is married with four children.

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From description to action—using health impact assessment to address the social determinants of health

Ben Harris-Roxas has worked on health impact assessment (HIA) since 2003 as a research fellow at the University of New South Wales (UNSW) Centre for Primary Health Care and Equity. He has been involved in more than 25 HIAs and has trained more than 400 people. He is Co-Chair of the Health Section of the International Association for Impact Assessment and facilitates the Asia Pacific HIA Practitioner Network. He organised the first Asia Pacific HIA Conference in Sydney in 2007 with colleagues from UNSW. The second conference was held in Thailand in 2009 and the third was in New Zealand in 2010. He also created the HIA Connect website (www.hiaconnect.edu.au) and the HIA Blog (healthimpactassessment.blogspot.com).

Ben Harris-Roxas is an author of 17 articles related to HIA and is an Associate Editor for BMC Public Health and Environmental Impact Assessment Review. Ben is a member of the WHO Western Pacific Thematic Working Group on HIA and of the Steering Committee for the Society of Practitioners of HIA. He's part of a team from seven universities that has received Australian Research Council funding to evaluate the impact and effectiveness of HIAs conducted in Australia and New Zealand over the past five years. Apart from HIA, he is interested in the use of social media in population health. He co-convenes the Healthcare and Social Media Australia and New Zealand online discussion group. You can find him at @hiablog on Twitter.

Michelle Maxwell is a Service Development Officer for Population Health in the Clinical Support Division (Western) within NSW Health. She has previously worked as a health promotion officer in areas such as injury prevention, child health, physical activity, workforce development and health promoting schools. In her current role, she has been involved in several health impact assessments on: hospital redevelopment; regional plans; precinct plans for a Greenfield site; urban renewal; and health service plans. She has also recently worked on the review of the NSW Health Equity Statement, together with colleagues from the Centre for Health Equity Training, Research and Evaluation.

A large focus of her recent work has been on developing and maintaining a partnership between Health and Housing NSW to facilitate a shared vision of working together to improve the health and wellbeing of social housing communities of South West Sydney. Her role includes developing capacity within and outside of health to influence healthy urban design and working with planning agencies to develop healthy urban environments, with a focus on equity issues for disadvantaged communities.

Mark Thornell is the Assistant Director of Population Health with the Clinical Support Division, Western, NSW Health (formally Sydney South West Area Health Service). He has worked in the NSW Health system for the past 30 years, initially as a social worker in hospitals and then in Community Health Services. He held the position of Director of Community Health for Campbelltown, NSW prior to moving to his current role in Population Health. He has a long held interest in the connections between individuals' health and wellbeing, and the communities and environments they are a part of.

In recent years he has been a member of a team with a strong focus on working inter-sectorally to utilise and develop tools and approaches to promote the development of healthy urban environments. This has included undertaking health impact assessments, participating in joint urban planning and development processes, and the development of the Healthy Urban Development Checklist.

Sharon Peters has worked in health in South West Sydney since 1989 in various roles including administrative and management. She currently holds the position of Service Development Officer with Population Health, Clinical Support Division (Western), formerly known as Sydney South West Area Health Service. Much of her work focuses on healthy urban development and Health Impact Assessments. She works extensively with Housing NSW Greater Western Sydney Division conducting health impacts of urban renewal and regeneration projects. She also represents Health on several regeneration projects across the Campbelltown local government area.

Patrick Harris has been at the forefront of the development of Health Impact Assessment (HIA) practice, education and research internationally as the coordinator/research fellow on the award winning healthy public policy programme at the Centre for Health Equity Training, Research and Evaluation, University of New South Wales (UNSW). In this role, he has undertaken or been involved in 27 health impact assessments, ranging from assessing strategic plans to local community driven issues, and has trained over 400 people in HIA across Australia and internationally. Based on this work, he developed and wrote 'Health Impact Assessment: A Practical Guide' which is also internationally recognised. Patrick Harris delivers UNSW's Masters of Public Health elective on health impact assessment, one of the only international Masters level courses on HIA. His main research interests are the incorporation of health and health equity into policy, planning and assessment processes, including environmental assessment.

He has published widely on his research both in the peer reviewed and broader literature and has been involved in over $1.5 million in research and capacity building grants related to HIA and public policy. He is also currently undertaking a PhD investigating the relationship between health impact assessment and healthy public policy, funded by the Australian National Health and Medical Research Council. Patrick Harris has been a consultant for the WHO Commission on the Social Determinants of Health. He regularly presents and delivers workshops locally, nationally and internationally on HIA, equity, and healthy public policy.

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Towards a 21st century system of mental health care—an Australian approach

Patrick McGorry MBBS MD PhD FRCP FRANZCP is Professor of Youth Mental Health at the Centre for Youth Mental Health at the University of Melbourne, and Executive Director of Orygen Youth Health in Victoria, Australia. He is a world-leading researcher in the area of early psychosis and youth mental health and his innovative research has played an integral role in the development of safe, effective treatments for young people with emerging mental disorders, notably the psychotic and severe mood disorders. Orygen Youth Health's early psychosis service, known as EPPIC, was founded by Patrick McGorry in 1992, and has been hugely influential internationally. Its evidence-based model has been exported to many countries, and early intervention in psychosis has become one of the major growth points in international mental health reform.

Patrick McGorry has published over 300 papers and book chapters and has edited five books. He is a Fellow of the Academy of the Social Sciences in Australia and has been the recipient of numerous awards, including the Australian of the Year in 2010, Victorian Australian of the Year in 2009, and the Castilla Del Pino Award in recognition of his significant contribution to the field of psychiatry in Spanish-speaking countries in 2009, the Australian Government Centenary Medal in 2003 and the Founders' Medal of the Australian Society for Psychiatric Research in 2001. He serves as Editor-in-Chief of *Early Intervention in Psychiatry* and is Director on the Board for the National Youth Mental Health Foundation: headspace and Treasurer of the International Early Psychosis Association.

He has also played a major role in mental health reform in Australia as a main adviser to the *Because mental health matters: Victorian Mental Health Reform Strategy 2009-19*, and as a leader of the current lobby group that has successfully obtained a major injection of funds to the Australian mental health system over the next five years (2011–16). He has been invited to attend the US/Canada

Policy think tank on youth mental health, and is currently acting as a consultant for the establishment of Headstrong, the Irish national youth mental health initiative. As well as his contributions to the field of early psychosis, He has interests in the homeless, refugees and torture survivors, youth suicide, youth substance use and the treatment of emerging personality disorder.

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The challenge of health inequalities in rural and remote Australia

Dr Jenny May is the current Chair of the National Rural Health Alliance. She sits on Council of the Alliance as the representative of the Rural Doctors Association of Australia (RDAA). She is also Chair of the female doctors group for RDAA, and a representative on the National Breast and Ovarian Cancer Centre Implementation Committee and the Commonwealth Telehealth Advisory Committee. She has demonstrated a passion for primary health care both as a rural general practitioner and as a researcher. Her interests revolve around the interface between rural health policy and their impacts on primary care practice. Her primary research interest is in general practice workforce and this is the subject of her present doctoral studies.

A recent major clinical focus for Jenny May has been the development of a new GP practice in Tamworth with a strong emphasis on team-based care and allied health involvement. She is employed as a rural GP Academic by the University of Newcastle in the Tamworth University Department of Rural Health and Rural Clinical School. In her university role she provides teaching and research supports for GPs, GP registrars and undergraduate medical and allied health students. She is also a mentor in the PHCRED program supporting novice health researchers and developing a rural research practice network.

Colleen Koh is an assistant policy advisor with the National Rural Health Alliance. She works remotely from her residence in rural NSW. She has a Masters in Public Health (Hons) from the University of Sydney and has previously worked in health promotion research and evaluation, focusing on physical activity and workplace health promotion. The National Rural Health Alliance is Australia's peak non government organisation for rural and remote health. It brings together disparate voices from around Australia for the common purpose of improving the health of people who live and work in country areas.

The Alliance's vision is good health and wellbeing in rural and remote Australia, with a particular goal of equal health by 2020. Its broad representative base places it in a unique position to collect and disseminate information, determine key issues that affect health and wellbeing in rural and remote areas, and provide a breadth of vision on rural health matters to governments, educational and research institutions, and other professional bodies.

13

Determining the determinants—is child abuse and neglect the underlying cause of the socio-economic gradient in health?

Professor Leonie Segal is the Foundation Chair in Health Economics & Social Policy at the University of South Australia. Leonie Segal's research program is at the evidence policy interface, working in partnership with government and community agencies. She is leading a research program that incorporates two inter-relayed themes: investigation of primary care reform options in the context of a bio-psychosocial model of health; and developing, with government, an efficient investment strategy to reduce child abuse and neglect and associated harms. She is (has been) on several government policy committees, including the Minister for Health's Preventative Health Taskforce and the NH&MC Health Care Committee.

James Doidge is an early career health economist who is working with Leonie Segal and others at the University of South Australia Health Economics & Social Policy group to develop an investment strategy that effectively targets the prevention of child abuse and neglect and ameliorates the consequences for victims and for the community.

Dr Jackie Amos is a Senior Child and Adolescent Psychiatrist with Southern Child & Adolescent Mental Health Services. She is the primary developer of an intensive psychotherapy for mothers and their children aged 3–12 caught in intergenerational cycles of traumatic relationships. She has a particular interest in describing and using theoretically driven models of causation to support the development of effective mental health treatments for vulnerable families.

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The built environment as a social determinant of health

Peter Sainsbury is Associate Director of Population Health in Clinical Support Cluster Western, NSW Health, and an Associate Professor in the School of Public Health at Sydney University. He is currently a member of the Australian Health Ethics Committee and is a past member of the NH&MRC and president of the Public Health Association of Australia. His qualifications and experience cover medicine, health planning, sociology, health services management and public health. His professional interests include inequalities in health, healthy urban development, social relationships and health, the experience of illness, health needs assessment, the history of public health, mental health promotion and social policy. Other interests include figurative war memorials, cooking and eating, the arts, cricket and Florence Nightingale.

Dr Elizabeth Harris was the foundation Director of the Centre for Health Equity Training, Research and Evaluation (CHETRE), part of the Centre for Primary Health Care and Equity at the University of New South Wales, for 15 years. She has recently stood down from this role and works part-time at the Centre. She is committed to researching interventions to reduce health inequity including early childhood development, the health impacts of unemployment, working in disadvantaged communities and equity-related policy development and assessment, including Health Impact Assessment. She is on the Board of the International Society for Equity and Health. She was part of the team that developed the NSW Health and Equity Statement, *In All Fairness*, in 2004 which was recently reviewed by CHETRE with view to informing the next iteration of the policy.

Marilyn Wise is Associate Professor of Healthy Public Policy in the CHETRE. Previously she was the Executive Director of the Australian Centre for Health Promotion and a Senior Lecturer in the School of Public Health at the University of Sydney. She has more than 25 years' experience in health promotion practice, research, teaching, and policy development and analysis. Her current areas of work focus on: health equity; the role of health impact assessment in influencing public policy for health and equity; and the role of the health sector in contributing to health equity. Her PhD is exploring approaches to increasing the power of minority populations to engage in setting and implementing public policy in Australia.

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Turning the social determinants of health into a story that people care about

Melissa Sweet is an independent health journalist who writes for a variety of publications, including Crikey, the BMJ, Inside Story, and Australian Rural Doctor magazine. She founded and moderates Crikey's health blog Croakey, which promotes debate about public health and health policy issues, and encourages a focus on equity and under-served issues and groups. She is secretary of the Public Interest Journalism Foundation, which aims to promote and enable innovation in public interest journalism, and holds an honorary appointment as senior lecturer in the Sydney School of Public Health at the University of Sydney.

Together with Ray Moynihan, Melissa Sweet is the author of *Ten Questions You Must Ask Your Doctor* (Allen & Unwin, 2008), which encourages people to be more questioning about health care and health advice. She also published a non-fiction book, *The Big Fat Conspiracy: How to Protect Your Family's Health* (ABC Books, 2007), which gives families and communities some strategies for healthy living and preventing weight gain. Her book, *Inside Madness* (Pan Macmillan, 2006), examined the history of mental health care in Australia, and the work and life of murdered psychiatrist Dr Margaret Tobin. In recognition of her work on this book, Melissa Sweet was awarded a Dart Centre Ochberg Fellowship. She is also co-author, with Professor Les Irwig, Judy Irwig, and Dr Lyndal Trevena, of a book which aims to give readers some tools for critically assessing health information. *Smart Health Choices: Making Sense of Health Advice* (Hammersmith Press, 2008). For the latest news in public health, health policy, health equity, and the social determinants of health, follow her on Twitter: @croakeyblog

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The hidden victims of crime Helen Wiseman

Helen Wiseman, Chair of SHINE for Kids Co-operative Ltd since 2004, has been a strong advocate for the organisation and for the children we serve across many stakeholders including state and federal government, philanthropic foundations and donors, business, at criminal justice forums, and at a personal level. She brings to the Board of SHINE for Kids her 25 years experience as a chartered accountant and former partner at KPMG as well as many years experience of serving on other charity Boards. Helen Wiseman was recently featured in the inaugural 2010 American Express Enriched List, which highlights people who are 'using their skills, talents and dreams to give more out, get more back and realise their potential'.

Gloria Larman, CEO, SHINE for Kids Co-operative Ltd, has over three decades of experience working in community organisations in the areas of justice and disability, with a particular emphasis on the issues faced by children of prisoners. She advocates that these children are innocent and do not deserve to be punished for their parents' crimes. SHINE for Kids has grown from strength to strength as Gloria Larman has built up strong strategic partnerships and developed innovative research and programs, positioning SHINE for Kids as a respected service provider to children. She has authored papers detailing the issues faced by children whose parents are sentenced to prison and has made recommendations to government and government agencies regarding solutions to the complex issues involved. She has also presented at conferences and seminars as well as conducting radio and television interviews. She holds a diploma in welfare, degree in community management and adult education and has been employed by SHINE for Kids since 1988.

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Addressing social determinants of health—structural change or targeted charity

Dr Tim Woodruff is Vice President of the Doctors Reform Society. The society is an organisation of doctors and medical students whose aim is to support health care reforms which 'ensure justice, equity and quality care for all regardless of social or economic status'. It formed in 1974 to support the introduction of the original universal health scheme (Medibank) and has continued to advocate for improvements in the health system, particularly in relation to equity issues. Tim Woodruff is a Tasmanian born and bred specialist physician working in private rheumatology practice in Melbourne. He joined the Doctors Reform Society in 1997 and served as President from 2001 to 2010. He has been a strong advocate for addressing the inequities in the health system particularly at a structural and system level.

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The role of organised primary health care in addressing the social determinants of health

Rachel Yates is currently Director, Policy at the Australian General Practice Network (AGPN) and works across numerous primary health care policy portfolios. Prior to joining AGPN, she worked as a research manager in an academic general practice research unit where she managed a number of health research projects. Rachel Yates has broad ranging experience in health care across the UK and Australia. Her qualifications include a BTec in medical laboratory science (UK) a first class Honours degree in Psychology and an Advanced Diploma in Business Management.

Leanne Wells is currently Executive Director of Policy and Business Development at AGPN where she is responsible for AGPN's policy development, reform agenda and business development functions. Prior to joining AGPN, initially as Principal Adviser, Mental Health, she held executive positions in the Australian Government Departments of Health and Ageing and Family and Community Services. She holds tertiary qualifications in communications and business.

Scott Brown is Senior Policy Adviser at AGPN, working across a number of primary health care portfolio areas. Prior to beginning work with AGPN, he held a policy research role in the academic sector. Scott Brown holds a Diploma of Business, Bachelor of Biomedical Science and Master of Governance & Public Health Policy. He specialised in his post-graduate studies, including his Master's dissertation, in the areas of global health governance and development aid coordination. His areas of interest lie specifically around global health governance, leadership development, social determinants of health and public health more broadly.

David Butt served as Chief Executive Officer of the AGPN from 2008 to 2011, leaving recently to take up a position with the Commonwealth Department of Health and Ageing. Prior to this, he spent eight years as National Chief Executive Officer of Little Company of Mary Health Care, the national organisation which operates the Calvary public and private hospitals, aged, community and home care services in six states and territories. From 1996 to 2000, David Butt was Chief Executive of the ACT Department of Health and Community Care, and Chaired the Australian Health Ministers' Advisory Council (AHMAC) from 1998 to 2000. He has held various other executive positions in the Australian health system, including senior roles in Queensland Health, as well as positions with the Federal Government.

Conclusion
A call to action

Liz Callaghan is Director Strategic Policy for Catholic Health Australia. Prior to this role she was principal consultant for medical workforce issues in the South Australian Department of Health, where she was also involved in a state-wide review of health services (the Generational Health Review). She has extensive experience in health workforce, acute services and capital planning, as well as rural health policy, safety and quality and community care. She has qualifications in Nursing, holds a Bachelor of Social Work, a Graduate Diploma in Human Services Research, Monitoring and Evaluation, a Masters in Public Policy and Management and is currently undertaking a Masters in Theology.