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# Submission to Senate Community Affairs Committee Inquiry

## Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"

7 November 2012

*This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.*

# Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"

## Introduction

The National Rural Health Alliance is comprised of 34 Member Bodies, each a national body in its own right, representing rural and remote health professionals, service providers, consumers, educators, researchers and Indigenous health (see Attachment). The vision of the National Rural Health Alliance is good health and wellbeing in rural and remote Australia, with the particular goal of equal health for all Australians by 2020.

The Alliance takes a very broad view of health and its determinants. As an organisation committed to improving health and wellbeing in rural and remote areas, it makes no sense to focus its endeavours just on the health system itself. The Alliance has therefore been pleased to have developed and published policy positions on such things as regional development, schooling in rural areas, National Competition Policy, telecommunications, drought and climate change, and Australia's taxation system.

The specific aspiration of the Alliance is equal health for people in rural and remote areas compared to their metropolitan counterparts by the year 2020. It is therefore natural for the Alliance to very strongly support a social determinants view of how health and wellbeing can be improved. In fact it is a reasonable hypothesis that rurality is not so much the driver of poorer health and wellbeing but nothing more than a marker for disadvantage on a range of social and economic indicators – compounded by poor access to health care. In aggregate, people in rural and remote Australia, compared with their peers in major cities, have lower income, a greater rate of disability, are older, have access to poorer infrastructure (roads, sanitation, recreational facilities, housing, communications technology), lower levels of completed education, higher rates of risky alcohol consumption, and higher rates of smoking and obesity.

The World Health Organisation Commission on Social Determinants of Health made three overarching recommendations in its report, “Closing the gap within a generation”. It outlined three principles for action for achieving health equity through action on the social determinants of health:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age.
2. Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

In its own work, the Alliance subscribes fully to the three principles of action in the WHO Commission’s report. We have a focus on comprehensive primary health care, as close to home as possible, for people living in rural and remote communities. The WHO definition of

comprehensive primary health care requires engagement with the broader determinants of health through intersectoral action and partnerships.[1]

The Alliance has promoted the potential benefits of a joined-up or whole-of-government approach to health by many means, including through its biennial conference, the policy work it undertakes, its media work and its delegations.

The challenge to such an approach seems to be to overcome the natural tendency to make governments practicable by dividing them up into departments and ministries. This tendency to divide also results from the distinctions between professional groups. There are of course significant differences between professional groups within the health sector, and one of the successes of the Alliance has arguably been to set these aside in favour of the things all health professionals agree on. But when it comes to differences between health professionals on the one hand and, on the other, between them and engineers, agriculturalists, mining technologists, lawyers and accountants, it becomes intuitively clear why civil society and its governance is not a single homogenous entity.

The Alliance will continue to do anything it can to encourage governments and taxpayers to see expenditure on things like education, employment, community development and community services as investments in better health and wellbeing. The point is often made that successful investments in further education for individuals, including women, will result in better health and reduced health expenditures and should therefore be seen as societal benefits rather than costs. Presumably what is needed is a strong appreciation by politicians at all levels that citizens do indeed see the world this way. Just how this is to be achieved is the key question for this inquiry and into the future.

## Response to the terms of reference

### a) Government's response to other relevant WHO reports and declarations

Australia has long been a good international citizen and is a signatory to most of the United Nations conventions relating to human rights and health, including the Declaration of Alma-Ata (1978), the Ottawa Charter (1986) and the Jakarta Declaration (1997).

Australia considered the WHO report on primary health care[2] in the development of its first National Primary Health Care Strategy, where a number of submissions proposed that it should encompass a broad definition of comprehensive primary health care including consideration of the social determinants of health.[3]

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[1] World Health Organisation: **Primary health care (PHC)** refers to the concept elaborated in the 1978 Declaration of Alma-Ata, which is based on the principles of equity, participation, intersectoral action, appropriate technology and a central role played by the health system. http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/primary-health-care/main-terms-used accessed 31 October 2012.

[2] World Health Organization, 2008. *The World Health Report 2008: Primary Health Care Now More Than Ever*, p. 43, available from: http://www.who.int/whr/2008/whr08_en.pdf

[3] Australian Government Department of Health and Ageing. Primary Health Care Reform in Australia - Report to Support Australia's First National Primary Health Care Strategy. http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc~nphc-draftreportsupp-ch3~nphc-draftreportsupp-ch3-scope#.UJHAvYbWpfx

It may be that Australia's accession to temporary membership of the Security Council of the United Nations can strengthen its hand, even a little, in encouraging an international approach to the social determinants of health.

The Alliance sees the issue of how the government approaches the social determinants of health through the lens of relatively poor health and poor access to health services in rural and remote areas. The point needs to be made that, overall, Australians have one of the highest life expectancies in the world. However it is often said that, in Australia, the gap between rich and poor is increasing: "the rich are becoming richer and the poor more numerous". This is because of the distribution of work, income and assets and services.

Australia's health system is not blameless in this. Our 'universal' medical care system does not effectively delivery universal care, especially for rural Australians, and even more so for remote Australians. There can also be a political blame game and inadequate development of primary care services on the ground, so that the overall health system helps to perpetuate other inequities.

With something as palpably beneficial to all societies and their governments as a social determinants approach to health and health equity, Australia's government, or any other government, would put itself at risk if it did not respond to the WHO Commission on Social Determinants of Health.

In a federal system such as Australia it is very unlikely that either of the two upper echelons of government – Commonwealth and State – could effectively adopt a social determinants approach to health without the collaboration of the other.

**b) extent to which the Commonwealth is adopting a social determinants of health approach through:**

**i. relevant Commonwealth programs and services**
**ii. the structures and activities of national health agencies**
**iii. appropriate Commonwealth data gathering and analysis**

Through the Council of Australian Government's National Health Care Agreement, Australia has made a commitment to social inclusion and responding to Indigenous disadvantage. One of the agreed targets is that the health system will promote social inclusion and reduces disadvantage, especially for Indigenous Australians.

It is widely recognised that this cannot be achieved without widespread and strong commitments to address the social determinants of Indigenous health – commitments that are currently lacking, not so much because of indifference to the goal but because of difficulties with a whole of government approach. In particular, the COAG work has a focus on the 'distal determinants' of health rather than the proximal social determinants associated with engagement, empowerment and mechanisms to support greater personal control over life circumstances.

On the positive side, the Alliance has welcomed the improvements to Commonwealth data gathering and analysis, particularly through the auspices of the COAG Reform Council and the recommendations, now adopted by COAG, that all performance indicators, where it is possible and appropriate to do so, are to be disaggregated by Indigenous status, disability status, remoteness area and socio-economic status to assess whether these social inclusion

groups achieve comparable health outcomes and service delivery outcomes to the broader population.

The Alliance also believes that the National Primary (Health) Care Strategic Framework, a priority reform for better health services under the National Healthcare Agreement, provides a useful precursor for Health Ministers to agree on the next steps to take in order to deliver on social inclusion, resulting (hopefully) in a true National Primary Health Care Strategic Framework by 2015.

The recent party politicisation of how to provide a greater number of graduates from Australia's medical schools with internships is a case study in the difficulty of intergovernmental collaboration across party lines. Obtaining such collaboration on something as intangible and invisible to the public as investing in the social determinants of health is likely to be even more challenging.

One ray of hope with which the Alliance has been closely involved is the current work by Ministers for health and culture, and their respective departments at both national and state and territory levels, to agree a strategic framework for arts and health. In this case people in the *arts sector* or community are the practitioners, with patients, families, clinicians and facilities in the *health sector* the beneficiaries.

In the health sector itself some comfort can no doubt be drawn from the success of multipurpose services (MPSs). These see hospital or acute care dollars from the States pooled with aged care dollars from the Commonwealth to provide flexible services which can be responsive to local needs.

Governmental responses to mental health are also a fertile area for interdepartmental and inter-professional collaboration and one in which Australia is doing some good work.

High speed broadband is essential infrastructure for households, businesses, services and health, which extends across Commonwealth departments including health, as well as across layers of government. By whatever means, people in all parts of Australia should have access to high speed broadband at the same affordable price. Important progress has been made in this direction, but people who live in rural and remote communities want to be informed about the schedule for the provision of fast broadband services, including through interim satellite service, and want to be assured about the full price they will pay. People most in need of broadband, including those who are isolated, on low incomes, or with disabilities, should have special assistance to enable their access as soon as possible.

**c) Scope for improving awareness of social determinants of health**

**i. in the community**
**ii. within government programs**
**iii. amongst health and community service providers.**

Dealing with the social determinants of health and wellbeing in rural and remote areas remains an issue of the greatest importance to the Alliance. The Alliance has adopted a three tiered approach to improving awareness and understanding of the social determinants of health. This work will underpin our ongoing advocacy for improving awareness of the social determinants of health within government programs and practical design and implementation responses.

First is this Submission to the Senate Inquiry. That will be followed by submission of an article on the matter for publication in the Australian Journal of Rural Health. Thirdly, and in the longer term, the Alliance intends to continue with the development of a broader paper looking at clarifying our definition of the social determinants theme for the Alliance's work and developing recommendations for action.

The Alliance believes that a better understanding of the social determinants, or a clearer conceptualization of what they are and how they arise, may assist it in establishing more meaningful and achievable actions to reduce their negative consequences over time. This then would add substance to the Alliance's invocations about these vital determinants of health, and reduce the collective sense of impotence in the face of highly complex challenges to the health of rural and remote Australians.

The Alliance's strategic plan already includes significant references to the importance of the social determinants of health and to the value of the Alliance working through them.

The biennial National Rural Health Conference continues to provide important avenues for improving awareness of social determinants of health in the community, within government programs and amongst health and community service providers. There is a wealth of practical experience with successful cross-sectoral programs and initiatives in rural and remote communities that address the social determinants of health from the past 11 conferences.[4] The 12th National Rural Health Conference to be held in Adelaide in April 2013 will once again have a strong focus on the social determinants of health and provide a venue, not only for raising awareness through exchange of ideas and experience from people across all these sectors, but for putting the aspirations of the WHO Commission report into practice.

The National Strategic Framework for Rural and Remote Health[5], auspiced by the Standing Council on Health, provides a strong starting point for improving awareness of the social determinants of health within government programs. The Vision of the National Strategic Framework is "People in rural and remote Australia are as healthy as other Australians". It is directed at decision and policy makers at the national, State and Territory level and is intended for use by all engaged in the planning, funding and delivering of health services in rural, regional and remote Australia – governments, communities, local health service providers, advocacy and community groups and members of the public. The Strategic Framework emphasises that health service planning and delivery in rural and remote settings must take account of the social determinants of health and recognise the role of other sectors such as housing, education, infrastructure and transport in maintaining the health of those who live in these communities. Five goals are set, with strategies identified in key outcome areas: access; service models and models of care; health workforce; collaborative partnerships and planning at the local level; and strong leadership, governance, transparency and performance.

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[4] The National Rural Health Conference website includes proceedings of all past conferences and information about the 12th National Rural Health Conference, Adelaide, 7-10 April 2013.
http://nrha.ruralhealth.org.au/conferences/?IntCatId=9

[5] Australian Health Ministers Council, Standing Council on Health. National Strategic Framework for Rural and Remote Health. November 2011.
http://www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/NSFRRH-homepage

The development of Key Performance Indicators and a national action plan to underpin the National Strategic Framework for Rural and Remote Health would contribute to government programs by providing them with a greater awareness of the social determinants of health – and would contribute also to Australia's response to the WHO Commission report.

## Conclusion

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', whole of government 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.

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 parlance: to have a fair go at leading a flourishing life. This will only be the case if the social and economic determinants of good health and wellbeing are actively addressed for people everywhere in the nation.

**Senate Standing Committees on Community Affairs**

**Inquiry into Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"**

**Terms of Reference**
Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation", including the:

a) Government's response to other relevant WHO reports and declarations;
b) impacts of the Government's response;
c) extent to which the Commonwealth is adopting a social determinants of health approach through:
    i. relevant Commonwealth programs and services;
    ii. the structures and activities of national health agencies, and
    iii. appropriate Commonwealth data gathering and analysis; and
d) scope for improving awareness of social determinants of health:
    i. in the community,
    ii. within government programs, and
    iii. amongst health and community service providers.

Please note: **This is not an inquiry into the social determinants of health themselves**. Submitters should address the terms of reference, which focus on the government's response, adoption of a social determinants of health approach, and scope for improving awareness of the social determinants of health.

Please note: The World Health Organization's report "Closing the gap in a generation" is available at: www.who.int/social_determinants/thecommission/finalreport/en/index.html

**Attachment**

## Member Bodies of the National Rural Health Alliance

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| **ACHSM** | Australasian College of Health Service Management |
| **ACRRM** | Australian College of Rural and Remote Medicine |
| **AGPN** | Australian General Practice Network |
| **AHHA** | Australian Healthcare & Hospitals Association |
| **AHPARR** | Allied Health Professions Australia Rural and Remote |
| **AIDA** | Australian Indigenous Doctors' Association |
| **ANF** | Australian Nursing Federation (rural members) |
| **APA (RMN)** | Australian Physiotherapy Association Rural Member Network |
| **APS** | Australian Paediatric Society |
| **APS (RRIG)** | Australian Psychological Society (Rural and Remote Interest Group) |
| **ARHEN** | Australian Rural Health Education Network Limited |
| **CAA (RRG)** | Council of Ambulance Authorities (Rural and Remote Group) |
| **CHA** | Catholic Health Australia (rural members) |
| **CRANAplus** | CRANAplus – the professional body for all remote health |
| **CWAA** | Country Women's Association of Australia |
| **ESSA (NRRC)** | Exercise and Sports Science Australia (National Rural and Remote Committee) |
| **FS** | Frontier Services of the Uniting Church in Australia |
| **HCRRA** | Health Consumers of Rural and Remote Australia |
| **ICPA** | Isolated Children's Parents' Association |
| **NACCHO** | National Aboriginal Community Controlled Health Organisation |
| **NRHSN** | National Rural Health Students' Network |
| **PA (RRSIG)** | Paramedics Australasia (Rural and Remote Special Interest Group |
| **PSA (RSIG)** | Rural Special Interest Group of the Pharmaceutical Society of Australia |
| **RACGP (NRF)** | National Rural Faculty of the Royal Australian College of General Practitioners |
| **RDAA** | Rural Doctors Association of Australia |
| **RDN of ADA** | Rural Dentists' Network of the Australian Dental Association |
| **RHW** | Rural Health Workforce |
| **RFDS** | Royal Flying Doctor Service |
| **RHEF** | Rural Health Education Foundation |
| **RIHG of CAA** | Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia |
| **RNMF of ~~RCNA~~CAN** | Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia |
| **ROG of OAA** | Rural Optometry Group of the Australian Optometrists Association |
| **RPA** | Rural Pharmacists Australia |
| **SARRAH** | Services for Australian Rural and Remote Allied Health |