

Southgate Institute for Health Society & Equity Flinders University, Adelaide, South Australia

Submission

Senate Standing Committees on Community Affairs inquiry on:
*Australia's domestic response to the World Health Organization's (WHO)
Commission on Social Determinants of Health report
"Closing the gap within a generation"*

Summary of recommendations

CSDH & the Australian Government

1. Establish an independent national Commission to review evidence on SDH and health inequities in Australia and make recommendations for a whole-of-government response from local, state and federal governments.
2. Extend the role of ANPHA to lead and advocate for ongoing research and action on SDH and health inequities in Australia
3. Adopt a 'proportionate universalism' approach to address key social determinants of health and reduce inequality in areas such as public education and housing affordability
4. Extend programs to support parents and promote healthy child development in pregnancy and the first 5 years and use proportionate universalism to provide services to those parents and children living in the most disadvantaged circumstances.
5. Work with State and Territory governments to implement appropriate regulation of food, gambling and alcohol industries to enhance public health.
6. Develop coordinated initiatives in areas of building standards, urban planning and transport to achieve health promoting environments and improve environmental performance
7. Increase women's representation in parliaments, governments and boards of management
8. Assess broader family and work policies to ensure they encourage gender equity, and continue work to address violence against women and their children

A whole of government approach

1. Develop a comprehensive and co-ordinated suite of national policies to address SDH and reduce health inequities
2. Implement an across government *health equity in all policies* initiative led by State Premier's Departments and the Department of Prime Minister and Cabinet

3. Routinely apply HIA methodologies to assess health *and* health equity impacts of policies and policy changes across federal departments, including in relation to trade and foreign policy.

Promoting Better health

1. Progressively trial and develop an on-going national program of action to engage communities in creating health promoting, inclusive and sustainable settings and communities, based on co-operation between levels of government, and with NGOs
2. Ensure coherent policies between sectors for early childhood and through the school years
3. Implement more policies to support parents in pregnancy and during the first five years of a child's life
4. Develop environments that encourage child health such as play parks and wide spread availability of healthy food in child care and schools

Health Research

1. This submission supports the recommendations of the recent Public Health Association of Australia submission to the 2012 *Review of Health and Medical Research in Australia*, including its call for greater research funding and effort in the following areas.
 - "Understanding social determinants of physical and mental health in Australia
 - Evaluation of public health interventions
 - Indigenous health research
 - Health and social policy research, to understand what kinds of policy are best placed to support gains in population health and well-being, and improve health equity
 - Health services research, including in primary health care
 - Research on translation of public health evidence into effective public policy
 - Understanding, managing and preventing the adverse health effects of climate change" (2012, pp. 8-9)
2. We also recommend that the National Health & Medical Research Council be directed to develop a sustained and significant program of research funding on the social determinants of health.
3. Trial and evaluate sustained programs of action within localised settings (including areas of disadvantage) to: engage community action; address multiple factors impacting on health; and to build endogenous resources for positive health and social and economic participation.

1. Introduction & Background

The **Southgate Institute for Health, Society and Equity** (Southgate Institute) at **Flinders University** congratulates the Senate Standing Committees on Community Affairs for establishing this important 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"*.

Prof Fran Baum, Director of the Southgate Institute, was appointed by the Director General of WHO as a Commissioner on the **Commission on Social Determinants of Health** (CSDH). With the active support of Flinders University, she established the Institute in 2008 in order to further develop the University's record of achievement in policy and practice-relevant research on the social determinants of health (SDH) and

health equity. In 2008 she was also awarded a prestigious Australian Research Council Federation Fellowship focusing on development of effective government and community responses to social determinants of health inequity and social exclusion. She holds several other national competitive grants investigating aspects of health inequity.

Since the publication of the Commission's Final Report (2008), Prof Baum has sought to promote and foster action by governments, researchers and civil society actors in Australia to understand the domestic and international implications of the report, and take action on its key recommendations. Flinders University has a proud record of working closely and collaboratively with the South Australian Government and SA Health, including in the establishment of the ground-breaking and now internationally recognised *Health in All Policies* program – led by the Department of Premier and Cabinet – as a mechanism to advance whole-of-government action on SDH.

1.1 The Southgate Institute for Health, Society & Equity

The Southgate Institute's aims are: to contribute to a healthy and fair global community, with a particularly focus on Australia, by conducting high quality, policy-relevant research on the social and economic determinants of health, health equity and Aboriginal health; and to build capacity to conduct such research. Since its establishment in 2008, the Institute has developed a reputation as one of Australia's leading research groups on SDH, and maintains extensive national and international research linkages.

In plain terms, the Southgate Institute's research focus is on understanding and addressing the underlying factors that determine the distribution of health and well-being outcomes and influence social inclusion or exclusion. Current research includes work in: housing, stigma and discrimination, social capital, social exclusion, work and its impact on mental and physical health, primary health care, aging, Australian health policy, digital technologies, health in all policies, and gambling.

The Southgate Institute incorporates the **South Australian Community Health Research Unit (SACHRU)**, also led by Prof Baum, which seeks to contribute to the quality of primary health care, health promotion and population health initiatives through research, evaluation and building the capacity of the workforce. This Unit receives core funding from the SA Department of Health.

1.2 The Commission on the Social Determinants of Health

The **World Health Organisation's (WHO) Commission on the Social Determinants of Health (CSDH)** released its final report in 2008. The Report, titled '*Closing the Gap in a Generation*' documented the growing gap in health outcomes for people across the globe that could be clearly traced to social determinants. That is, health inequalities result from social inequalities. 'Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequalities between and within countries' (CSDH 2008, pg. 1). The CSDH defined health *inequities* as systematic health inequalities that are avoidable by reasonable means, and thus unfair. The report also contained clear recommendations for countries on how to start making the changes necessary to 'close the gap' by addressing the social determinants of health. The message was clear, '[t]he high burden of illness responsible for appalling premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age' (CSDH 2008, pg. 1). The Commission's three key recommendations called on governments to: improve people's daily living conditions, with a particular focus on early childhood and gender equality; take action to address inequities in the distribution of power

and economic resources; and ensure ongoing research to measure, monitor and better understand the key social determinants of health.

Within the CSDH process a number of '*Knowledge Networks*' brought together academics and practitioners from around the world to review and collect evidence on policies and interventions to improve health and reduce health inequities across a range of areas including: early child development, employment conditions, globalization, women and gender equity, urban settings, social exclusion, health systems, measurement, and priority public health conditions.

In 2009-10 the former Chair of the CSDH, Prof Sir Michael Marmot led an enquiry into health inequalities in England. The subsequent report, titled '*Fair Society, Health Lives*' (2010), provides an excellent example of how the CSDH's recommendations can be taken up and applied in a developed economy. Of particular interest from this report is the recommendation that social and health policies should be based on idea of proportionate universalism where by the principle of universalism is applied (and see to be good for overall action to reduce the health gradient) and within that special attention can be paid to those who are most heavily disadvantaged. Thus a home visiting scheme for newborns would be universal and reach all new babies and their parents with special consideration being given to those parents and babies who live in high risk circumstances.

1.3 Social Determinants of Health and Health Inequities in Australia

In some key respects, Australia has an enviable track record on health with average life expectancy one of the highest in the world (AIHW, 2010). However, evidence consistently shows that Australians who are socially and/or economically disadvantaged, including Indigenous Australians, face significantly greater risk of premature mortality, poor health and chronic disease than more advantaged and non-Indigenous Australians (ABS 2009; Draper et al. 2004; Glover et al. 2006; Hetzel et al. 2004; Turrell et al. 2006). This is similar in other developed countries, including Europe and the USA (Banks et al. 2006; Crombi et al. 2005; Mackenbach 2005), demonstrating that health varies predictably according to social and economic characteristics. In some developed countries, inequities in health are even widening in response to changing social and economic conditions (Graham 2007; Draper et al. 2004; Stamatakis et al. 2010).

Two recent reports conducted by the *National Centre for Social and Economic Modelling* (NATSEM) for *Catholic Health Australia* demonstrate that health inequalities exist for Australians of working age and that social gradients are common. The factors identified as most influential on health outcomes were housing security, household income, employment, level of education and social connectedness (Brown and Nepal 2010; Brown et al. 2012). The more recent report found that '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 younger men up to four to five times more likely (Brown et al. 2012, pg. 8).

Much of the current health inequality experienced by Australians is avoidable (Turrell et al. 2006). Thus there are clear grounds for action on health inequities on the grounds of fairness. However, there are many other important reasons for action to address SDH and reduce health inequities, including to reduce health care costs, improve productivity, and promote social participation (Laverty and Callaghan 2011). The recent NATSEM report on '*The Cost of Inaction*' argued that by not addressing the social determinants of health the government overlooks major social and economic benefits and savings to government expenditure and the health system (Brown et al. 2012). It suggests that if systematic action on SDH were taken in Australia, \$2.3 billion dollars in hospital costs could be saved, 500,000 Australians could avoid chronic illness, and an

extra 170,000 Australians could enter the workforce. Also, they calculate potential annual savings of \$4 billion dollars in welfare payments and \$273 million dollars on Medicare services.

Marmot (2010) argues that all sectors of government and a civil society need to be involved in action on SDH and health equity, not just those in the health sector. In addition, health inequalities will not be reduced by focusing only on those most disadvantaged in our community. The issue of the health gradient must be tackled (Baum and Fisher, 2011). The CSDH found that in with many of the more common health conditions in both developed and developing country settings, health and illness follow a social gradient. That is, increasing rates of morbidity and mortality are associated with declining socioeconomic position across the social spectrum. This indicates that the social factors influencing health are not only impacting on those who are worst off.

Crucially, as Baum (2008) argues, our actions as a society to promote better health and prevent disease needs to be less concerned with treating illness after it occurs, and with behaviour change, and more concerned with *creating the conditions in which health and well-being flourish* across the life course. With the right conditions for cognitive, emotional and behavioural development, and opportunities for meaningful social and economic participation, people are able to and generally will take responsibility for their lives and family, and contribute productively to their community.

2. CSDH & the Australian Government

- *From Terms of Reference:*
 - (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***

2.1 Positive developments in Australian health and social policy

The Australian Government's *Social Inclusion* agenda recognises the complex nature of entrenched social disadvantage, and the importance of ensuring that people have access to employment opportunity, social services, secure housing and community connections. However, the recent NATSEM report (Brown et al. 2012) has demonstrated that we have a long way to go with the most economically disadvantaged in Australia, who are much more likely to experience poor health.

The Council of Australian Governments (COAG) *National Indigenous Reform Agreement on 'Closing the Gap'* in health and other social outcomes between Indigenous and non-Indigenous Australians incorporates goals in areas of early childhood education, literacy and education improvements, employment outcomes, healthy homes and safe communities, and governance; as well as improved access to healthcare. As such it is a good example of policy recognising and taking action on SDH within a particular segment of the Australian population. The regular reporting of progress towards achieving these goals set out within the 'Closing the Gap' initiative is also welcome.

The *National Indigenous Health Equality Council* and the *National Hospitals and Health Service Reform Commission* along with the establishment of *Medicare Locals* acknowledge the need for improved primary health care that is responsive to local needs and concerns. *Medicare Locals* aim to reinvigorate a model of comprehensive primary health care including area-based public health planning, preventive health programs, and collaboration with non-health agencies such as local governments. Thus they have the potential to address some of the SDH in local settings. It is vital that the Medicare Locals adopt a comprehensive approach to their work and do not merely focus on treatment and prevention of particular diseases. They are charged with producing Healthy Communities report and as such would be able to comment on the ways in which the social determinants of health affect the health and equity of the populations in their catchment area. By working with local government, state government funded primary health care services and community groups they have the potential to spearhead reporting and action on the social determinants of health in local areas.

Reflecting on what can be done in Australia to take up the SDH perspective, Baum (2009) advocated extending Medicare to include dental services. The recently announced *Child Dental Benefits Schedule* (CDBS) provides for some dental coverage yet is targeted at a small proportion of the population. Further details about the extent to which Medicare will broaden this scheme and therefore its coverage of dental services are eagerly awaited. The CSDH emphasised the importance of universal health insurance schemes and public provision of health services.

Recent initiatives on health promotion and the establishment of the *Australian National Preventive Health Agency* (ANPHA) are aimed at reducing the prevalence and costs of chronic disease in Australia by addressing tobacco smoking, excessive alcohol consumption, and behavioural factors leading to overweight or obesity. However, while the preventive health agenda does attempt to focus on the causes of disease it is limited by the absence of a national agenda devising strategies to address social determinants of health in a systematic way. The predominant focus on individual 'lifestyle choices' and behaviour change as the target of interventions does not adequately address the social context in which behaviours occur, or give sufficient emphasis to the role of health promotion strategies focused on creating healthy settings and development of healthy communities (Baum and Fisher, 2011). Rates of smoking and obesity also follow a social gradient in Australia (AIHW, 2010), and evidence suggests that low socioeconomic status (SES) independently increases risk of cardiovascular disease, over and above the impact of 'lifestyle' factors (Marmot et al, 1978; Laverly and Callaghan, 2011). Alcohol abuse is more common among those subject to social dislocation.

The world-leading initiatives of Australian Governments to regulate the tobacco industry have contributed to reduced smoking rates, and need to be matched with appropriate regulation in areas of food, alcohol and gambling. Australia is also a leader in effective public policy measures to control the spread of HIV infection.

Gender has also been highlighted a significant SDH. Gender based violence has been found to be the leading contributor to death, disability and illness for women aged 15 to 44 in Victoria (Vic Health 2004). Approximately 350,000 women experience physical violence and 125,000 sexual violence each year in Australia. Violence against women also leads to significant economic costs, estimated at \$8.1 billion per year in 2004, and potentially rising as high as \$15.6 billion per year by 2021-22 if incidence and the impacts on women are not reduced (NCRVWC, 2009). These are in addition to the personal and social costs to the Australian community. The *National Plan to Reduce Violence against Women and their Children* (COAG 2010) is a welcome response, but much remains to be done.

Child abuse and neglect is strongly associated with increased risk of mental and physical ill-health across the life course, and prevalence is inversely associated with socioeconomic status (Hetzel et al. 2004). Segal et al. (2011) argue that social inequalities in child abuse and neglect are under-recognised as a driver of the socioeconomic gradient in health. The *Protecting Children is Everyone's Business* framework (COAG 2009) aims to develop a comprehensive public health model of strategies to improve child safety.

Initial roll-out of the *National Disability Insurance Scheme* is a positive move toward addressing the unequal burden on individuals and families dealing with disability.

In summary, there are significant developments in recent Australian Government and COAG health and social policy which go some way to addressing SDH and health inequity, particularly among those who are most disadvantaged. While this is important and welcome, it does not address SDH as they affect the broader population or the link between socioeconomic and cultural inequalities and social gradients in health across the population at large. The Marmot report in health inequalities in England recommended a policy approach of 'proportionate universalism' where 'actions [are] universal, but with a scale and intensity that is proportionate to the level of disadvantage' (2010, p. 10). Recommendations of the recent *Review of Funding for Schooling* led by David Gonski are in keeping with this principle, and if implemented would be likely to contribute over the long-term to a reduction in health inequities. Recent policy developments on urban design in Australian cities are also welcome such as the *Our Cities- the challenge of change* report (Australian Government, 2010), and present an opportunity to address structural factors affecting health and health inequities, as well as to address the health effects of climate change. Building standards and urban design measures must be coupled with genuine engagement with communities to identify and implement practical measures to improve their own places.

2.2. Data gathering and analysis

The Australian Government and health research community are well served by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW). A greater focus on data linkage between existing data sources will enhance research capacity and understanding of SDH as they affect different population segments.

2.3 Recommendations

9. Establish an independent national Commission to review evidence on SDH and health inequities in Australia and make recommendations for a whole-of-government response from local, state and federal governments.
10. Extend the role of ANPHA to lead and advocate for ongoing research and action on SDH and health inequities in Australia
11. Adopt a 'proportionate universalism' approach to address key social determinants of health and reduce inequality in areas such as public education and housing affordability
12. Extend programs to support parents and promote healthy child development in pregnancy and the first 5 years and use proportionate universalism to provide services to those parents and children living in the most disadvantaged circumstances.
13. Work with State and Territory governments to implement appropriate regulation of food, gambling and alcohol industries to enhance public health.
14. Develop coordinated initiatives in areas of building standards, urban planning and transport to achieve health promoting environments and improve environmental performance
15. Increase female representation in parliaments, governments and boards of management

16. Assess broader family and work policies to ensure they encourage gender equity, and continue work to address violence against women and their children

3. A whole of government approach

- *From Terms of Reference:*
 - (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.*

“Action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies. Policies and programmes must embrace all the key sectors of society not just the health sector. That said, the minister of health and the supporting ministry are critical to global change. They can champion social determinants of health approach at the highest level of society, they can demonstrate effectiveness through good practice, and they can support other ministries in creating policies that promote health equity.” (CSDH 2008, p. 1)

The CSDH clearly argued that effective and sustainable action to address the SDH and reduce health inequalities requires three key elements: definitive leadership and mandate from the head of government (Baum, 2008); engagement of all sectors and levels of government; and a stewardship role for the health sector to champion action on SDH; coming together in a whole-of-government approach. This key message has been central to international thinking on public health over the last several decades (WHO 1978; WHO 1986; WHO 1988), and has underpinned moves to achieve ‘joined-up’ government (Mulgan 2005), but has proved difficult to implement effectively.

Our own research on uptake of evidence on SDH within Australian health policy indicates that, while significant gains have been made in some jurisdictions, overall progress is limited and uneven (Newman et al, 2006). We hope that this inquiry will provide a stimulus for further change.

However, recent research and policy innovation in this area is now providing clear and effective mechanisms bringing together the elements identified above, to identify and address the potential impacts on population health of policies across sectors and levels of government. Two mechanisms in particular are proving demonstrably effective in Australia and similar countries: Health in All Policies, and Health Impact Assessment.

3.1. Health in All Policies

Although still relatively new, the SA government’s *Health in All Policies* Program is providing a durable and effective mechanism to drive collaboration and policy development across government sectors to address SDH (Kickbusch and Buckett 2010). It is clear that the success of the program thus far has been enabled by leadership from the Department of Premier and Cabinet, explicitly links to goals of the SA Strategic Plan, and a dedicated team within the health department. Uptake and extension of this approach at the Federal level and in other State jurisdictions, as recommended by the National Preventative Health Taskforce (2009), provides a readily implementable way to improve awareness of social determinants of health within government programs.

3.2 Health Impact Assessment

Health Impact Assessment (HIA) methodologies provide an objective mechanism to prospectively or retrospectively assess the impacts of policies in all sectors of government on population health (Harris and Spickett, 2010; Kemm, 2008). HIA methods can also be adapted to specifically assess policy impacts on health equity (Haber 2010), or impacts in a specific area of health, such as mental health (ASPP, 2011). Health assessments of various types are employed in a Health in All Policies approach to policy development. For instance the South Australian Health in All Policies approach uses a health lens assessment to provide a basis with working with non-health sectors.

3.3 International and global impacts on health outcomes in Australia

The work of the Commission's Knowledge Network on globalisation highlighted the potential impacts on population health in both developing and developed country settings arising from liberalisation in international trade relations (Labonté, et al, 2007). Trade decisions are an increasingly important social determinant of health in their own right. These issues are of relevance for Australia in current negotiations on the *Trans Pacific Partnership Agreement*, which appear to have left little space for independent assessment of the potential impacts on health within Australia and in other partner countries. It is crucial that government decision making on trade is transparent and are informed by independent research on potential health impacts.

3.4 Climate change

It is now widely recognised that climate change represents a profound challenge to human health, and is also likely to exacerbate health inequalities within and between countries. However, it is also crucial to understand that a range of actions are available to mitigate the causes of climate change while simultaneously addressing determinants of health and health inequities; both within Australia or in our region. Australian researchers are leading international research efforts in this area (e.g. Friel et al, 2008; Friel and Baker 2009; McMichael et al, 2008).

3.5 Recommendations

4. Develop a comprehensive and co-ordinated suite of national policies to address SDH and reduce health inequities
5. Implement an across government *health equity in all policies* initiative led by State Premier's Departments and the Department of Prime Minister and Cabinet
6. Routinely apply HIA methodologies to assess health *and* health equity impacts of policies and policy changes across federal departments, including in relation to trade and foreign policy.

4. Promoting better health

(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.***

As Baum and Fisher (2011) have pointed out, much of the current preventative health agenda is focused narrowly on changing individual health behaviours contributing to chronic disease, which limits opportunities to focus on and take action in relation to the social and economic structures that contribute to poor health and influence health behaviours. Social marketing and other similar strategies tend to be more effective in motivating change among those with more social and economic resources, meaning that they can in fact exacerbate inequities in health (Slama, 2010).

A shift in focus is needed from a 'fear and risk' informed approach to a 'hope and vision' one. We need to be asking 'what creates health?' The first primary recommendation of the CSDH Report was to 'improve daily living conditions'. In relation to health behaviours this means that, rather than merely exhorting individuals to change, we need to consider what kinds of environmental conditions make healthy choices the easy choices (Baum, 2009).

Current measures in health promotion are likely to produce some benefits, but are often subtly conditioned by a medical frame of reference, which tends to:

- a) Define appropriate action in terms of time-limited, targeted *interventions*
- b) Define the problem in terms of individual health or behavioural *deficits*
- c) Put excessive weight on easily quantifiable, short-term outcomes

Government funding structures and excessive 'accountability' demands for community health and other agencies can reinforce the limitations of this 'intervention' model, and prevent long-term planning and flexibility in response to local need.

There is a pressing need for a model of health promotion which works over a sustained period with communities across the SES spectrum to build and sustain endogenous resources for social, cultural and economic participation, and a sense of meaning and control over one's circumstances. Provision of resources to support such activity needs to allow for local choice and variation, and follow a principle of proportionate universalism. As noted by Brown et al (2012), lack of social connectedness is a risk factor for chronic ill-health. A recent study by Campbell et al (2011) found that Aboriginal people engaged in land management practices were significantly less likely to have diabetes, renal disease or hypertension.

Engaging with and empowering communities (schools, workplaces, etc.) to understand social factors impacting on health, and to take positive action to address those factors can be considered as a form of *social vaccine*, increasing capabilities for healthy living and providing resilience in the face of challenges (Baum et al. 2009). Australia has had great success in use of medical vaccines to prevent contagious disease. It is time we understood that 'social vaccines' can just as powerful a tool for preventing chronic disease.

4.1 Recommendations

1. Progressively trial and develop an on-going national program of action to engage communities in creating health promoting, inclusive and sustainable settings and communities, based on co-operation between levels of government, and with NGOs
2. Ensure coherent policies between sectors for early childhood and through the school years
3. Implement policies to support parents in pregnancy and during the first five years of a child's life

4. Develop environments that encourage child health such as play parks and wide spread availability of healthy food in child care and schools

5. Health research

(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.

Current funding for health research in Australia is dominated by biomedical research, and appears to be increasingly interested in underwriting commercial development of pharmaceuticals and other biomedical interventions. The National Health & Medical Research Council currently devotes very little of its total funding to public health research and even less to that for social determinants of health research. Unlike bio-medical research, public health research focuses on the health of whole population. It is concerned with documenting the incidence of disease, understanding the origins of disease, determining what factors make for healthy populations, and evaluating the impact of measures (including policies, programs and social changes) that keep populations healthy. Public health research is multi-disciplinary and focuses on how social, economic, physical and natural environments shape health and health-related behaviours. It addresses both the upstream structural drivers of health inequities (such as trade, macroeconomic policy, labour markets, environmental change etc) and conditions of daily living that affect health (health care, urban environment, working conditions and social relations). Public health research also covers evaluation of interventions, so as to determine what works in improving population health.

Thus public health research has a crucial role to play in Australia to: implement the recommendation of the CSDH; understand SDH and health inequalities; inform policy action within and outside the health sector; and to implement and evaluate programs of sustained action to address SDH within particular settings.

Recommendations

5. This submission supports the recommendations of the recent Public Health Association of Australia submission to the 2012 *Review of Health and Medical Research in Australia*, including its call for greater research funding and effort in the following areas.
 - Understanding social determinants of physical and mental health in Australia
 - Evaluation of public health interventions
 - Indigenous health research
 - Health and social policy research, to understand what kinds of policy are best placed to support gains in population health and well-being, and improve health equity
 - Health services research, including in primary health care
 - Research on translation of public health evidence into effective public policy
 - Understanding, managing and preventing the adverse health effects of climate change” (2012, pp. 8-9)
6. We also recommend that the National Health & Medical Research Council be directed to develop a sustained and significant program of research funding on the social determinants of health.

7. Trial and evaluate sustained programs of action within localised settings (including areas of disadvantage) to: engage community action; address multiple factors impacting on health; and to build endogenous resources for positive health and social and economic participation.

Finally, Professor Fran Baum would welcome the chance to meet with the Committee and discuss the ideas in this submission further.

Prepared by: Prof Fran Baum, Dr Matthew Fisher, Dr Angella Duvnjak, 3rd October, 2012

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