

**Health equity in Australia:  
A policy framework based on action on the social  
determinants of obesity, alcohol and tobacco**

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## Executive Summary

Choosing to eat healthy food, being physically active, limiting alcohol consumption and not smoking requires people to be empowered to make these choices. It means that the healthy choice must be physically, financially and socially the easier and more desirable choice relative to the less healthy option. This is not always the case, particularly with decreasing social position.

What, and how much, people eat, drink and smoke and how they expend energy are responses to their socio-political, socio-economic, socio-environmental and socio-cultural environments. That a significant proportion of the global population now eats large volumes of energy-dense nutrient-poor foods, does not expend enough energy, smokes and consumes harmful quantities of alcohol is a sign of success – commercial success. The harmful health consequences of these behaviours, and the inequity in their social distribution, are, however, indicative of both market failure (since the outcome is not good for both parties - the seller and buyer) and failure by government to protect the health of all its citizens. Greater corporate accountability is needed. Reinstatement of a strong public sector that is the provider of public goods including health is needed and requires policies, legislation and regulations that tackle the underlying social causes of unhealthy behaviours.

Obesity, harmful alcohol consumption and tobacco use are risk factors for most of Australia's health burden, and the health-care system is straining. People with less money, less education, insecure working conditions, poor living conditions and often excluded from mainstream society, are much more likely to die early and have higher levels of behaviour related health conditions: the social system is failing.

Many of the underlying social determinants of obesity, tobacco and harmful alcohol use, including urban design, car reliance and agricultural practices, are also significant contributors (as resource-consuming, industrially-polluting and GHG-emitting processes) to environmental degradation, including climate change: our natural-care system is being eroded.

Obesity, harmful alcohol consumption, tobacco use, and their underlying causes, are each, and must be, a primary concern for the whole of government. Policies and regulations in non-health sectors are needed in order to address the underlying social causes of unhealthy behaviours. The health sector is both a determinant of health and health inequities and a steward of policy coherence and intersectoral collaboration for health.

Politically, now seems like a favourable moment to instigate action on the social determinants of healthy behaviour, population health and health equity in Australia. Much of what is outlined in this paper helps the National Preventative Health Taskforce to support the Federal government move forward on its agenda to protect and promote the well-being of all Australians, and calls for it to make the argument that the prevention of obesity, harmful alcohol consumption and tobacco use can only be achieved through action that tackles the underlying social drivers of these behaviours – the social determinants.

The paper also calls on the Taskforce to position health equity as a central overarching goal of government and the National Preventative Health Strategy, not just one of a list of issues, which can be ticked off by targeting poor and marginalised groups. A range of needed actions is described in areas of education, employment, urban development, trade, economic policy, social inclusion, each of which, if pursued, will contribute significantly to preventing obesity, alcohol and tobacco related ill-health. The Taskforce must recommend action in these areas and work with the health sector, particularly DoHA, to develop its stewardship role in brokering policy coherence and intersectoral collaboration for health. The health sector itself must get its own house in order, and the paper outlines how expansion of Medicare and a reorientation towards disease prevention and primary health care is vital. A key element of the basis for action on the social determinants of obesity, alcohol and tobacco is data and knowledge.

The Preventative Health Taskforce must outline a multilevel surveillance system that monitors the social determinants of health and stratifies behaviour and health outcomes across a range of social status indicators. Training and skills development in the social determinants of health, within health and non-health sectors, will empower

the Australian workforce with the theoretical, analytical and policy understanding that is needed for an Australian approach to health equity through the social determinants of health.

A policy framework based on a social determinants approach to health and health equity through the prevention of obesity, alcohol and tobacco related harm requires three key elements:

- i) *revise the policy framework to make it less individualistic and to better accommodate the value of collective and community through a stewardship model of government,*
- ii) *rebalance the current policy focus on targeted marginalised groups towards a focus on systems and processes and the degree to which they are socially inclusive, and*
- iii) *systematic consideration of the health effects (especially in relation to obesity, harmful alcohol consumption and tobacco use) of all government policy, systems and processes on all population groups.*

Delivery of these recommendations by the Taskforce to the Minister for Health will provide a durable, equitable and more environmentally sustainable framework and action plan for the forthcoming Preventative Health Agency – a body, which from its remit, must be evidence informed, multi-sectoral, and report to the highest level of government.

Section 1 of the main paper contextualises the focus of the paper within the global health arena, which recently repositioned action on the social determinants of health and primary health care as central agenda items. The section also provides an overview of health inequities within Australia with a particular focus on inequities in obesity, alcohol consumption and tobacco use.

Section 2 of the paper argues that a focus on individual behaviour will not address the escalating rates of obesity nor prevent large numbers in the population from participating in risky alcohol behaviour and smoking tobacco. It provides the argument and evidence for how to improve health equity through a social determinants approach to the prevention of obesity, harmful alcohol consumption and

tobacco use. Section 2 draws on the global evidence base and recommendations of the WHO Commission on Social Determinants of Health and describes action that can be taken to improve the daily living conditions and structural drivers that shape populations' practices and behaviour.

Section 3, Part 1 describes the current political landscape and highlights some of the key Federal level actions that, while not framed under the heading of social determinants, do in fact acknowledge many of the necessary issues including social equity, voice and participation, fair financing, social protection, employment and working conditions, and healthy start to life. Acknowledgement by government of the various social issues affecting Australians' way of life is one thing. Sustained commitment and action, and action that is beneficial for health and health equity, requires the introduction of some underpinning structures and approaches 'the backbone of action for health'. Part 2 of Section 3 lays out key components of this backbone. It highlights attention to the gradient and not the gap; universal and targeted not just a targeted policy approach; policy coherence and intersectoral working; strong leadership and stewardship from the health sector; and the importance of data, monitoring and evaluation, and capacity development in the social determinants approach to health equity through obesity, alcohol and tobacco.

## Section 1:

### The context for action on the social determinants of health equity

#### Part 1: The Current Global Health Agenda

Two recent global health initiatives stressed the importance of social conditions on population health and health equity. The Commission on Social Determinants of Health (CSDH) was set up in 2005 by the World Health Organisation (WHO) as a major global effort to address health inequities between and within countries through action on the social determinants of health. The CSDH took the view that where inequalities in health are avoidable, yet are not avoided, they are inequitable, and argued that for reasons of social justice, action to achieve health equity is imperative. When launching the CSDH Final Report<sup>1</sup> in August 2008, Dr Margaret Chan, Director General of WHO said

*‘This ends the debate decisively. Health care is an important determinant of health. Life styles are important determinants of health. But it’s factors in the social environment that determine access to health services and influence lifestyle choices in the first place.’*

Following the launch of the CSDH report, the British Prime Minister, Gordon Brown, hosted an international conference in London in November 2008 ‘*Closing the gap in a generation: health equity through action on the social determinants of health*’.

Attending the conference were politicians, senior public servants, leaders of international organisations, civil society activists, and academics, from all regions of the world, who discussed the issues, conclusions and recommendations made by the CSDH, and took up the call to action to develop and implement public policies, private sector responsibility and social action that put health equity as a central societal goal.

A second major global health report that emphasizes the need for a health promotion, disease prevention approach to health and health equity, and which is particularly relevant to the health care sector, is the 2008 World Health Report ‘Primary Health Care: Now More than Ever’.<sup>2</sup> This report revisits Alma Ata’s 1978 ambitious vision of primary health care as a set of values and principles for guiding the development of

health systems. The global revitalization of primary health care complements the CSDH attention to the social determinants of health, through reorientation of health systems towards health equity primarily through universal access and social health protection.

**Part 2: Why be concerned: the state of health inequity in Australia**

**The health gap**

In some countries around the world there are differences in life expectancy among population groups of nearly thirty years. Australia, one of the wealthier countries in the OECD<sup>3</sup> has an incredible gap of 18 years life expectancy between one of the most disadvantaged population groups, Indigenous males, compared to the average Australian male (Table 1). While there have been some improvements in Indigenous death rates, in particular a narrowing of the gap between Indigenous infants and other Australian infants, the overall gap between Indigenous and non-Indigenous death rates is widening.<sup>4</sup>

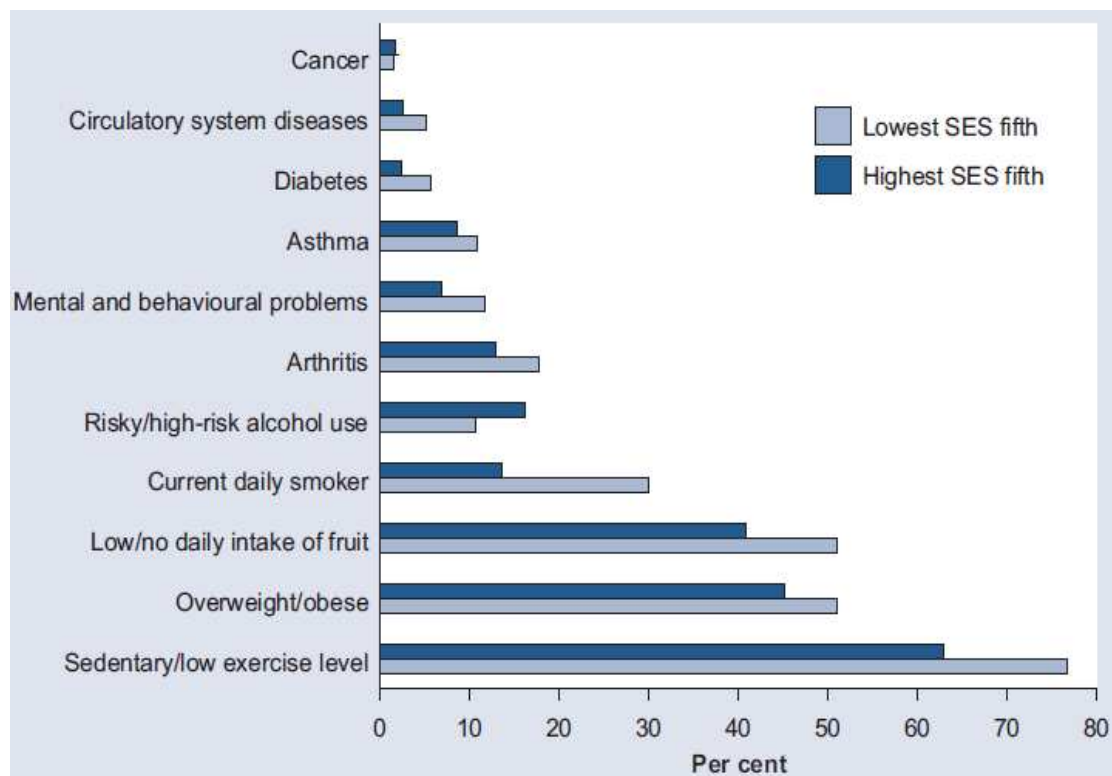
*Table 1: Life expectancy at birth, years (men), selected countries (taken from<sup>1</sup>)*

Glasgow, Scotland (disadvantaged neighbourhood)	54
Australian Indigenous	59
India	61
Lithuania	66
Mexico	72
US	75
UK	76
Australian average	77
Glasgow, Scotland (affluent neighbourhood)	82

Tobacco use, alcohol consumption, poor nutrition and inadequate physical activity are associated with a plethora of non-communicable diseases including cardiovascular diseases, obesity, diabetes, cancers and acute respiratory conditions. Health inequities exist between the top and bottom socio-economic status quintile of the Australian adult population for a number of these and their associated behavioural risk factors

(Figure 1). Overweight and obesity and regular tobacco use is significantly greater among the lowest socio-economic quintile compared to adults in the highest quintile. Interestingly, the inequity relating to risky alcohol use is in the opposite direction.

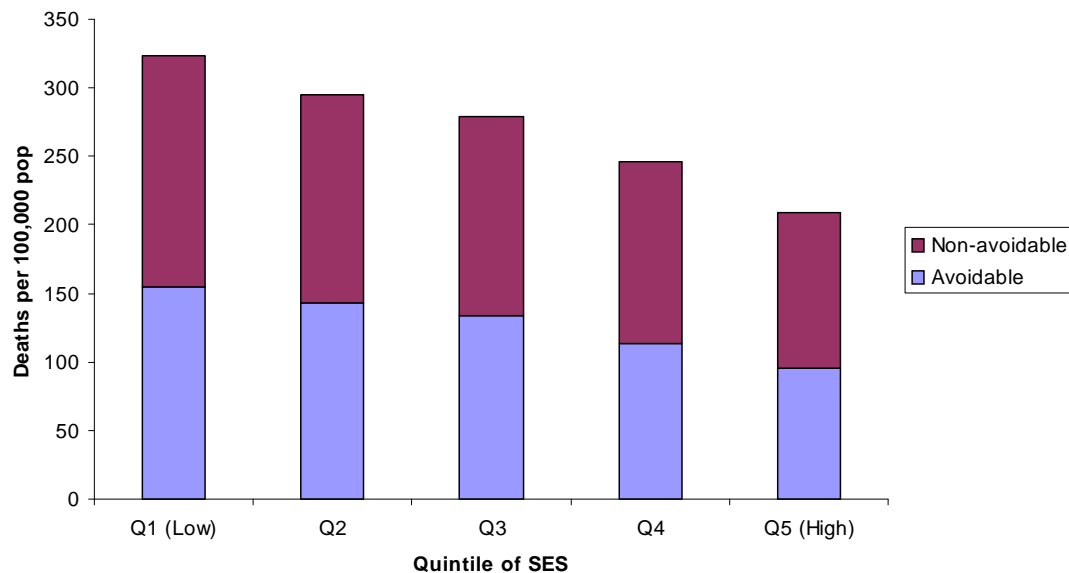
*Figure 1: Proportion of people aged 18 years and over reporting selected health risk factors and long-term conditions, by socioeconomic status, 2004–05<sup>4</sup>*



### **The social gradient**

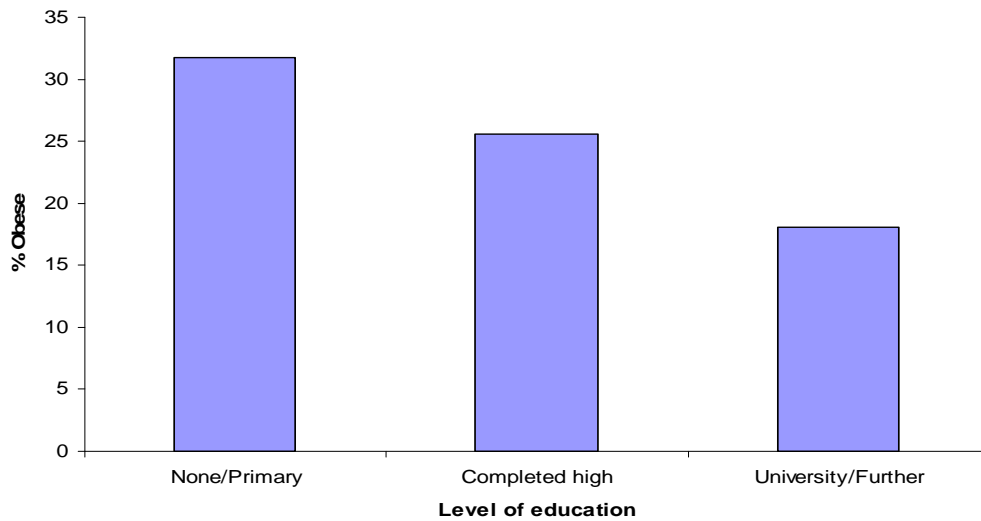
Focusing on the difference in health experience only at opposite ends of the social spectrum masks the graded relationship between social position and health. In Australia, as in most other countries, as one moves down the socio-economic ladder the risk of shorter lives and higher levels of disease risk factors increases.<sup>4,5</sup> A recent analysis of mortality rates, and notably avoidable mortality rates, illustrates how death rates decrease progressively with increasing socio-economic status (Figure 2).

Figure 2: Age and sex-adjusted mortality rates, Australia, aged less than 75 years, 2002<sup>6</sup>



Overweight and obesity have become increasingly more prevalent among socially disadvantaged groups, particularly in urban areas, with the exception of very poor countries.<sup>7</sup> In Australia, like most other risk factors for ill-health, excess body weight tends to be more prevalent among people further down the social and economic scale.<sup>8</sup> Analysis of the AusDiab 1999-2000 data shows a clear social gradient in the prevalence of obesity among adult women (Figure 3). A policy and programmatic focus only on the most disadvantaged, in this instance women with none or primary level education would miss the equally significant health burden from obesity among women along the remainder of the education spectrum.

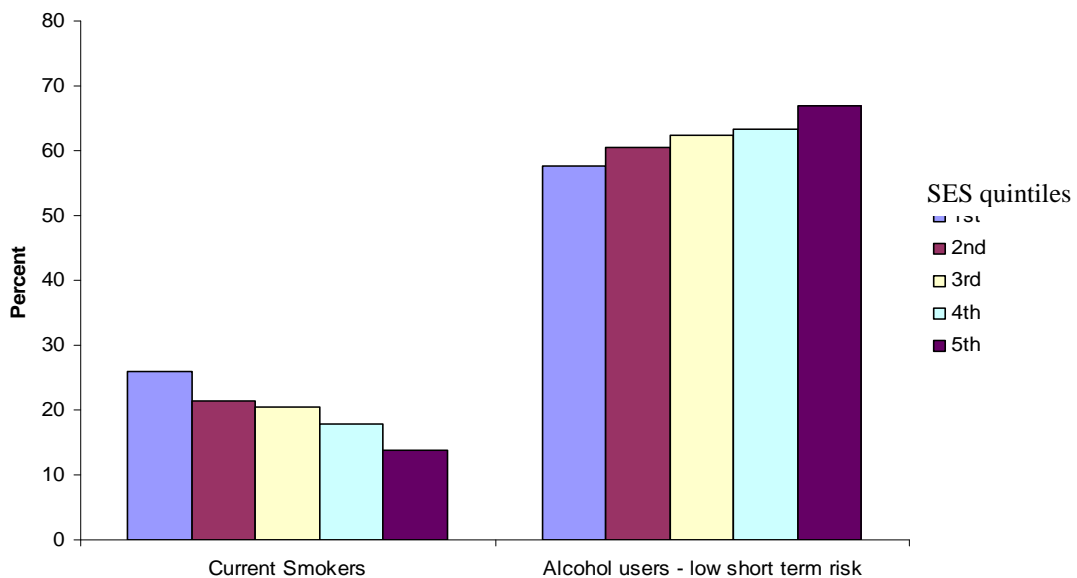
Figure 3: Prevalence of obesity among women, by level of education



Data source: AusDiab 1999-2000

Similarly, a social gradient is observed in tobacco use, with the prevalence decreasing with increasing socio-economic status. A social gradient exists in risk from alcohol use (the data shown here relate to the percentage of alcohol users that have a low health risk in the short term) but it runs in the opposite direction to both tobacco use and obesity (Figure 4).

Figure 4: Tobacco use and health risk from alcohol, people aged 14 years and above by socioeconomic status quintiles, Australia 2007<sup>9</sup>



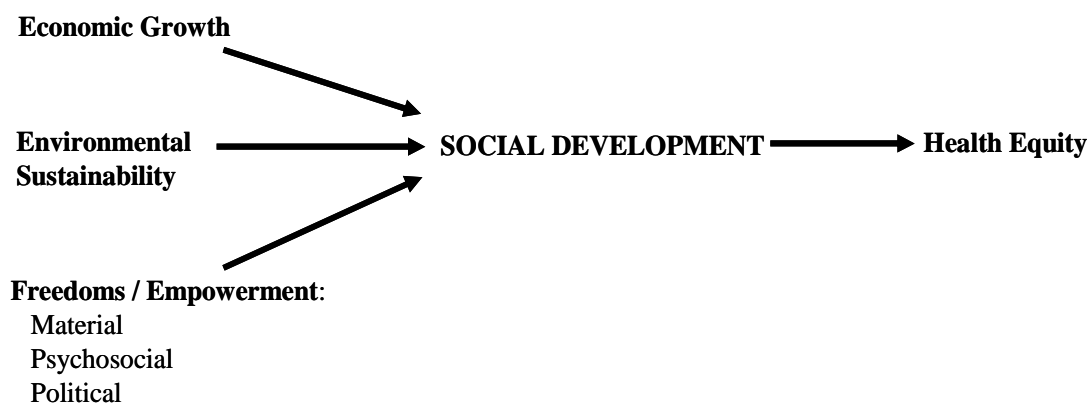
Internationally, action to reduce health inequities has tended to focus on vulnerable and marginalised groups – in Australia, Indigenous populations have often been the ‘target’ population of policies and programs aimed at improving health equity. Indigenous populations indeed have some of the worst health experiences in Australia and the many issues specific to these populations are being explored by the Preventative Health Taskforce in a separate paper [ref]. But the data provoke the question not only why the poorest of the poor and the most vulnerable and marginalised groups have bad health but why is there a socially graded relation between social position and health, in rich and poor countries alike. Understanding health inequity in terms of the social gradient in health allows us to embrace not only conditions of absolute poverty and exclusion but social conditions that affect everyone. In doing so, policies and programs will have greater potential reach to a wider population, thereby improving the health of more people.

### **Part 3: Widening the policy framework: a social determinants approach to health equity**

#### **Health equity as a societal goal**

The combined impact of gross inequities in health, economic instability, and environmental degradation is challenging people, nations and global institutions in a way never experienced before. Each of these problems has social origins and, generally, impact more on those lower down the social hierarchy. The current financial crisis and ensuing global re-construction provides an opportunity to rethink what we mean by development and societal success. Similarly, the precarious environmental situation, with humanity living beyond the Earth’s natural carrying capacity, begs a new global operating system. And, as articulated by the CSDH, the poor quality of many nations’ health and the marked inequities in health between and within countries are indicators of societal, market and development failure.

Figure 5: Re-framing global and national development



There is growing desire internationally to redefine notions of national progress, success and what we value as a society.<sup>10,11</sup> As illustrated in Figure 5, positioning health equity as a marker of successful development - a central policy goal - means reframing development to be inclusive of economic growth in a sustainable manner. It also means a society where all people to have the freedom to lead healthy and flourishing lives.<sup>12</sup> However, not everyone has the same degree of freedom to do this and this unequal distribution of freedoms, arguably, manifests as the poor health of the poor, the social gradient in health within countries, and the health inequities between countries.

### **Empowerment and the social determinants**

Having the freedom to live healthy and flourishing lives is synonymous with empowerment –material, psychosocial and political empowerment of individuals, communities and nations. The three dimensions of empowerment - *material*, *psychosocial*, and *political* - are interconnected. People need the basic material requisites for a decent life, they also need to have control over their lives (psychosocial), and they need voice, engagement and participation in decision-making processes (political).

And what lies behind empowerment and its social distribution are the social determinants - the fundamental socio-political, socio-economic, socio-environmental and socio-cultural characteristics of contemporary human societies, and their interactions with one another, shape the way in which people live, work, play and age, with consequences for health related behaviours. That is, the economic and social

policies that generate and distribute political power, income, goods and services, at global, national and local levels, also determine the conditions of daily living and the practices that different social groups follow. Depending on the nature of these daily living conditions and practices, people are exposed differentially to health damaging or promoting risk factors. Action on the social determinants can improve people's material conditions, psychosocial resources, and behavioural opportunities.

The combination of structural factors and daily living conditions – **the social determinants** - are the determinants of empowerment, freedom and ultimately health and health equity. Technical and medical solutions such as disease control and medical care are, without doubt, necessary for health but they are insufficient - medical and healthcare solutions do not exist for many of the problems that need to be addressed.<sup>13</sup> Any serious effort to promote well-being, prevent ill-health and reduce health inequities must address the social determinants that shape the way people grow, live, work and age, which ultimately affect their health.

And many of the social determinants of these non-communicable disease-related behaviours overlap substantially with the drivers of environmental sustainability and in particular climate change. Addressing the social determinants of health can lead towards greater equity in population health and have co-benefits for planetary health.

The CSDH made recommendation for action in three broad areas, the combination of which is intended to empower individuals, population sub-groups and nations through improvements in material conditions, psychosocial resource and political voice, thereby improving health equity between and within countries (Box 1).

Operationalising these recommendations requires a combination of coherent policy, multi-sectoral solutions with strong leadership by the health sector and community-level action. The framing of these overarching recommendations in relation to obesity, alcohol and tobacco use is outlined in Section 2.

*Box 1: CSDH Overarching Recommendations*

**1. Improve Daily Living Conditions**

Improve the well-being of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all, and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments, and global institutions.

**2. Tackle the Inequitable Distribution of Power, Money, and Resources**

In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities – such as those between men and women – in the way society is organized. This requires a strong public sector that is committed, capable, and adequately financed. To achieve that requires more than strengthened government – it requires strengthened governance: legitimacy, space, and support for civil society, for an accountable private sector, and for people across society to agree public interests and reinvest in the value of collective action. In a globalized world, the need for governance dedicated to equity applies equally from the community level to global institutions.

**3. Measure and Understand the Problem and Assess the Impact of Action**

Acknowledging that there is a problem, and ensuring that health inequity is measured – within countries and globally – is a vital platform for action. National governments and international organizations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health, and should evaluate the health equity impact of policy and action. Creating the organizational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health. It also requires a stronger focus on social determinants in public health research.

## **Section 2:**

### **Promoting health equity through action on the social determinants of obesity, alcohol, tobacco**

Part 1 of Section 2 layouts, briefly, the underlying social determinants of obesity, harmful alcohol consumption and tobacco use. Part 2 draws on the evidence and recommendations of the Commission on Social Determinants of Health and describes the key areas for action in the social determinants of dietary intake, physical activity, alcohol and tobacco use, and makes recommendations for possible policy options to improve health and health equity through these behavioural risk factors. How these recommendations could play out in the Australian context is described in Section 3.

#### **Part 1: Reframing action on obesity, alcohol and tobacco: addressing the underlying causes**

##### **An equity lens on obesity, alcohol and tobacco**

Public health approaches to modern day health challenges have given primary emphasis to the role of individuals, their behaviours and health services. Individual factors such as functional differences, personal skills and socio-cultural beliefs can indeed facilitate (or constrain) behaviour change.<sup>14</sup> However, the systematic evolution, continuation and, occasionally, improvement in the social distribution of obesity, tobacco and alcohol use and their related health outcomes illustrates the influence of broader societal issues and living conditions on daily practices such that people's ability to pursue healthy behaviour is compromised, increasingly so with decreasing social status. What, and how much, people eat, drink, smoke and how they expend energy are responses to their socio-political, socio-economic, socio-environmental and socio-cultural environments.

Choosing to eat healthy food, being physically active, limiting alcohol consumption and not smoking – among all social groups - requires that people are empowered to make these choices. It means that the healthy choice must be physically, financially and socially the easiest and most desirable choice to make, among all social groups.

### **The social determinants of obesity, alcohol consumption and tobacco use: Daily living conditions**

The empowerment of all social groups to live healthy lives and pursue healthy behaviours is influenced by conditions of every day life – those daily social experiences; physical environments; financial resources, and material living conditions - which together shape how people live their lives throughout the lifecourse. There are social inequities in daily living conditions, which lead to inequities in health outcomes. Of particular relevance to obesity, alcohol consumption and tobacco use is the nature of, and inequity in, the physical and social experiences in early life; access to and quality of education, particularly that of females; the nature of urbanisation - how cities are planned and designed plus the livability of rural locations; transport options; distribution mechanisms and consumer price of food, alcohol and tobacco; exposure to marketing of energy-dense nutrient-poor foods, alcohol and tobacco; the financial, psychosocial and physical conditions of working life, and the degree of social protection provided.

### **Structural determinants: power, money and resources**

Promoting health equity through healthy weight, limited alcohol and tobacco use also means tackling some of the fundamental political, economic and cultural issues (hereafter called the structural determinants) that affect people's living conditions, their daily practices and behaviour-related risks. That means dealing with matters of governance; national economic priorities; trade arrangements; market deregulation and foreign direct investment; fiscal policy, and the degree to which policies, systems and processes are inclusionary - each issue very much related to the CSDH recommendation of tackling the unequal distribution of power, money and resources. Addressing these structural determinants of health inequity not only helps empower individuals and communities but also empowers national government and other key public sector institutions. For example, good global governance and regulatory frameworks create national policy space thereby enabling government to introduce policies that tackle corporate pressures such as irresponsible marketing.<sup>15</sup>

## **Part 2: Key areas for action in the social determinants of obesity, alcohol and tobacco**

### **Across the lifecourse – conditions of daily living**

#### Early life

A large part of the global non-communicable disease epidemic - risks of obesity, malnutrition, mental-health problems, and heart disease - has been associated with disadvantage in pregnancy and in utero effects, low birth weight and improper infant feeding, and deprivation in early childhood. Child survival, rightly, has been a focus of worldwide interest. The CSDH, with others, emphasized the importance of early child development (ECD), including not only physical and cognitive development but also social and emotional development.<sup>16</sup> What children experience during the early years sets a critical foundation for their entire lifecourse - influencing basic learning, school success, economic participation, and social citizenry. Each of these provides skills and resources that influence behaviour. Interventions that integrate the different dimensions of child development are particularly successful, resulting in sustained improvements in physical, social, emotional, and cognitive development, while simultaneously reducing the immediate and future burden of disease, especially for those who are most vulnerable and disadvantaged.<sup>17</sup>

Access to quality education and health literacy are strongly associated with healthy behaviours and risk avoidance - equipping individuals with the resources needed throughout the lifecourse to achieve a secure income, provide for family, and cope with health outcomes in later life. Maternal education in particular has been shown not only to improve children's nutritional status but it also improves school attendance.<sup>18</sup> Children from disadvantaged backgrounds are more likely to do poorly in school and drop out early - and subsequently as adults are more likely to have lower incomes, higher fertility, and less empowered to provide good health care, nutrition, and stimulation to their own children, thus contributing to the intergenerational transmission of disadvantage.<sup>19</sup> Barriers to education include issues of access, quality and cultural appropriateness of education. Integrating social and emotional learning in curricula in primary and secondary schools as well as attention to the children's physical and cognitive development improves school attendance and educational attainment. Poverty relief and income generating activities together with

measures to attract quality teachers, provision of more accessible schools and classrooms, culturally relevant materials, and reduced family out of pocket expenditure on school materials are critical elements of a comprehensive strategy to make education a reality for all children.<sup>20</sup>

Early child development and quality education help equip people with material security, resilience, and personal control, each an important determinant of healthy behavioural choices.

*What could be done:*

1. Joined up working between DoHA and DEEWR: A healthy start to life is best served by a comprehensive approach to early child development, encompassing not just physical but also social, emotional and cognitive development. This requires an integrated policy framework for ECD, designed to reach all children as early as possible.
2. ECD interventions tend to show the largest effect among disadvantaged groups - special attention therefore to socially disadvantaged households will help considerably to reduce health and social inequities.
3. ECD programs and services should include, but not be limited to, breastfeeding and nutrition support, comprehensive support to mothers before, during, and after pregnancy.
4. Health-proof social protection policies: Empowering caregivers to choose healthy foods and energy intensive active travel means ensuring enough money and time to do so. This requires “family-friendly” social protection policies that guarantee adequate income, maternity benefits, and allow parents to balance their time spent at home and work.
5. Adopt a lifeskills approach to education and provide quality education that pays attention to physical, social, emotional, and cognitive development, starting in pre-primary school. Schools liaison officers, shared between DoHA and DEEWR, could lead this.
6. Education is a fundamental resource for health. Addressing the barriers to getting children, especially girls, into quality schooling and keeping them there through until secondary education requires joined up working between DoHA, DEEWR and other key sectors.

### Urbanisation

Since 2007, cities are the main mode of living globally and this growth in cities is related to the expansion of areas that have concentrated disadvantage. The urban environment influences every aspect of health: what people eat, the air they breathe and the water they drink, where (or if) they work, the housing that shelters them,

where they go for healthcare, the danger they encounter on the street, and who is available for emotional and financial support.<sup>21</sup> The foreseeable trend is for rising inequities across this wide range of social and health dimensions.<sup>22</sup> While urban living can provide many benefits,<sup>23</sup> it has been accompanied by increased prevalence of diabetes, heart disease, obesity, mental health problems, alcohol and drug abuse and violence, often more prevalent with decreasing social status. The prevailing form of urbanisation also has great environmental impact. Urban landscapes that predispose to car use perpetuate air pollution and greenhouse gas emissions. Transport and buildings contribute an estimated 21% of global CO<sub>2</sub> emissions.<sup>24</sup>

Taking a social determinants approach to improve urban health and urban health behaviours means improving housing, transport, employment, education, quality of built environment, social support, and health services. While this is not uniquely urban, the policy and practice approach is transformed when the characteristics of cities such as size, density and diversity are taken into consideration.<sup>22</sup> Local and national governments play a central role in the health of urban populations by providing municipal services, regulating activities that affect health, and setting the parameters for urban development. **A lack of consideration to health equity in urban planning results in environments that impact more adversely on low income groups who live in poorer conditions, are more constrained by lack of affordable transportation and lack of healthful purchasing choices in lower-income neighbourhoods.**

The urban environment influences behaviours in a number of ways. Poorly planned urban road networks, multi-modal patterns of traffic flow, overcrowding, poor or absent enforcement of building standards and building on unsafe lands all reduce opportunities for physical activity and increase the risk for injury and violence. Residential density and land-use mix combined with street connectivity and walkability provides opportunities for physical activity.<sup>25,26</sup> Provision of and access to local public facilities and spaces for recreation and play are directly correlated with individual level physical activity.<sup>27</sup> These, plus the increasing reliance on cars are key drivers of the societal shifts towards physical inactivity in high- and middle-income countries.<sup>7,28</sup> The nutrition transition towards highly refined foods and meat and dairy products containing high levels of saturated fats tends to begin in cities due to a variety of factors including exposure to new trends through the mass media; a food supply that is higher in fat content, sugar and salt with higher volumes

of meat, dairy and alcohol, and increasingly corporate food distribution systems that encourage bulk purchases, convenience foods, and ‘supersized’ portions; and compared to rural areas lower prices of processed foods relative to staple foods.<sup>29</sup> The socio-economic and socio-environmental changes that are taking place in urban Australia are also accompanied by socio-cultural transitions that encourage changes to ways of thinking about and practising daily living including physical activity and diets. There is a convergence of four factors: time pressure; the valuing of convenient solutions to eating; the valuing of convenient solutions to being mobile; and for parents, pressure to practice child-centred rearing. Household valuing of convenient solutions – particularly car reliance and eating foods prepared outside the home – escalated from the early 1980s and coincided with policies to deregulate the economy. They are viewed as ‘solutions’ because they facilitate flexible working lives by allowing more flexible routines.<sup>30</sup> To be effective and equitable, policy and programs aiming to address overweight and obesity must be mindful of these changing cultural practices.

Various urban lifestyles spread first from city to suburb and then to the country as a whole.<sup>31</sup> Cities, particularly in the developing world with their millions of women and young people are now the focus of the tobacco and alcohol industries. Abundant availability, relatively low price and aggressive marketing by the industries have been the driving forces behind the global alcohol and tobacco-related epidemics.<sup>32</sup> National and local level regulation of production, distribution and marketing of alcohol beverages and tobacco is shown to be an effective strategy to reduce harmful use of alcohol and tobacco, particularly to protect young people and other vulnerable groups. Lax restrictions on the sale and serving of alcohol – covering the age of consumers, the type of retail establishments that can sell alcohol beverages, and licensing, unlimited hours and days of sale and poorly enforcement regulations on vendors and the density of outlets had fuelled alcohol-related harm.<sup>33</sup> The physical and social context in which people smoke and drink also plays an important role in shaping behaviour - smoke free environments, particularly workplaces, bars and restaurants are becoming increasingly common in high and middle income countries, with increased effectiveness when adequately enforcement.

While urban living is now the dominant form globally, the balance of rural and urban dwelling varies enormously across countries – from less than 10% urban in Uganda to 100% or close to it in Singapore (Australia is 90% urban). Policies and investment

patterns reflecting the urban-led growth paradigm have seen rural communities worldwide, including Indigenous Peoples,<sup>34</sup> suffer from progressive underinvestment in infrastructure and amenities, with disproportionate levels of poverty and poor living conditions and behaviours.<sup>35</sup> These major inequities, to the disadvantage of rural conditions, contribute to the stark health inequities between urban and rural dwellers. In Australia deaths from coronary heart disease and diabetes are higher in rural and remote areas. Prostate cancer mortality in regional and rural areas is 21 per cent higher than in capital cities.<sup>5,36</sup>

Urbanisation that is good for the health of all people and supports healthy behaviour requires a sustainable development strategy that commits to investment in balanced rural-urban growth, that empowers local government with regulatory and financial control, and ensures cities are planned in such a way that prevents and ameliorates the new urban health risks and environmental degradation. Increased rural investment in education, housing and infrastructure, strengthened local regulatory control, improved urban design, decreased reliance on the petrol-based car through access to better and affordable public transport, and food systems that ensure safe nutritious food for all would help reduce obesity, undernutrition, poor mental health, heat stress and respiratory illness and, at the same time, be protective of the environment.

*What could be done:*

1. Urban public health planners make health and health equity an explicit policy goal. This should be developed and implemented through local participatory governance mechanisms that enable communities and local government to partner in building healthier cities.
2. Adapt the Healthy Cities model to be one of 'sustainable and equitable healthy cities', and expand the health in all policies approach to 'health in all local policies'. Included in this should be consideration of the impact on obesity, alcohol and tobacco use.
3. Urban design: local health departments work with urban planners to design urban areas that promote physical activity through the provision of affordable and convenient public transport and prioritise urban design for walking, cycling and playing.
4. Transport planning: an integrated approach to transport emissions reduction, primarily via improved mass transport systems, technological advances, and charges on private transport use, would bring many health co-benefits. Integrate drinking-driving policies with transport planning.
5. Local planning regulation:

- Reduce access to energy dense, nutrient poor foods through planning regulations to manage the proliferation of fast food outlets in particular areas, e.g. near schools and in socially disadvantaged neighbourhoods.
  - Control the number of alcohol outlets and their opening hours.
6. Explore a diversity of urban food supply systems: developing a diverse urban food supply systems can create greater availability of nutritious food. Sustainable land use policies, secure land tenure and supportive infrastructure including tax incentives to attract local food businesses to low income areas are needed. This requires collaboration between health, food and agriculture policymakers, urban planning bodies and environmental health agencies.
  7. Adopt, implement and enforce the WHO **mpower** recommendations at city and metropolitan levels and expand Victoria's alcohol control policy nationwide
  8. Sustainable rural development: Investment in rural development will not only help reduce poverty and improve rural health, it will also better enable rural communities to adapt to climate change. Focus on issues of rural land tenure and rights, and rural infrastructure including health, education, roads, and services; and diversification and increase in rural employment opportunities.

### Employment and Working conditions

Employment arrangements and working conditions have powerful effects on health and health equity. When these are good they can provide financial security, social status, personal development, social relations, and protection from physical and psychosocial hazards and harmful behaviours.<sup>37</sup>

The nature of employment has changed. In high-income countries including Australia, there has been growth in job insecurities and precarious employment arrangements (such as temporary work, part-time work, informal work, and piece work), job losses, and a weakening of regulatory protection of working conditions. Between the early 1990s and 2007, world employment grew by around 30%. However, there was considerable variation between and within countries - nearly 80% of women are unemployed in the Middle East, North Africa, Asia and the Pacific.<sup>38</sup>

Among those in work, the changes in the labour market have seriously affected working conditions, with increasingly less job control, financial and other types of security, work hour flexibility, and access to paid family leave.<sup>39</sup> In most households,

work is the vehicle through which to provide the financial capability to purchase a healthy standard of living and underpins compliance with national health guidelines.<sup>40</sup> For those with dependent children, minimum wages in Australia are only marginally higher, after tax, than the social welfare benefits paid to unemployed or workers with a disability. Poor quality jobs which combine material, psychosocial, and arguably behavioural stressors could be as bad for health as being unemployed.<sup>41</sup> Time and strain pressures associated with the current precarious employment conditions correlate with sedentary work, disinclination to use active transport, ready access to energy dense foods and regular tobacco use.<sup>42,43</sup> The changes in employment and working conditions reduces peoples' material and psychosocial resource, thereby disempowering them from making healthy living choices. And it is generally the case that smoking, excess alcohol consumption and less healthy dietary behaviours is each more common among those lower down the occupational hierarchy (blue collar workers), in precarious employment and unemployed people.

Employment and working conditions play a significant role in contributing to unhealthy behaviours and health inequity. Ensuring economic and social policy provides both sufficient income in order to comply with behaviour-related health guidelines and job security such that workers have a greater sense of control over their lives are fundamental requirements to support people make healthy behaviour choices.

*What could be done:*

1. Led by the health sector, health impact assessment (with a focus on health-related behaviour) of the Australian Fair Work Bill 2008 and associated policy will help ensure positive effects on health, behaviour and health equity.
2. Develop and implement economic and social policies that provide secure and decent work for all and a living wage that takes into account the real and current cost of living for health - including adequate nutritious food, shelter, water and sanitation, and social participation.
3. Reduce insecurity among people in precarious work arrangements through policy and legislation to ensure the provision of social security benefits and parental benefits
4. Through the Australian Safety and Compensation Council and State workplace health promotion programs, ensure occupational health and safety legislation and programs includes work-related stressors and behaviours as well as exposure to material hazards.

### Social protection policy

Sufficient ongoing financial and social resources are fundamental requirements to empower people make healthy behaviour choices - household income is one of the key determinants of dietary choice among low income groups.<sup>44</sup> This of course relates very closely to employment policy and working conditions. But social protection can cover a broad range of services and benefits including basic income security, particularly among those who are unemployed and the aged, and entitlements to non-income transfers such as health care and education. Many high-income countries provide for societies, to a greater or lesser extent, for vulnerable periods and for protection from specific factors such as illness, disability, and loss of work. Stimulus packages are helpful responses in times of crisis but are not a sustainable policy instrument that ensures long term health and well-being. Countries with generous social protection systems tend to have better population health outcomes.<sup>45</sup>

Just as poor employment and working conditions can disempower people from making healthy behaviour choices so too can inadequate social protection. Without material resources, having healthy behaviour options readily available and physically accessible means little. An equity oriented response to healthy behaviour seeks to address the underlying social inequities through prudent social policy initiatives such as social protection schemes and national wage agreements that provide material security based on the real cost of a healthy standard of living.<sup>40,46,47</sup>

#### *What could be done:*

1. Build universal social protection systems and increase their generosity towards a level that is sufficient for healthy living at all stages across the lifecycle
2. Focus on managing the tax-welfare system to achieve a more equitable distribution of income while generating incentives to work.

### **Power, Money and Resources**

Behaviours, community practices and conditions of daily living are shaped by deeper social structures and processes; the inequity is systematic, produced by policies and actions that tolerate or actually enforce unfair distribution of power, wealth, public goods and other necessary social resources. Addressing these issues is political.

In the context of obesity, alcohol and tobacco, a fully encompassing social determinants approach to disease prevention would address conditions of trade, market de-regulation and industrial marketing; of fiscal and social policy, and aim to counter exclusionary systems and processes, each of which affect behaviour-related inequities. It is possible to intervene in the structural determinants of healthy behaviour. For example Norway previously reversed the population shift towards high fat, energy dense diets using a combination of food subsidies, price manipulation, statutory retail regulations, clear nutrition labelling combined with individual-focused public education.<sup>48</sup> Experience across Nordic countries, generally, suggests that a policy of regulating alcohol production and trade can make a huge difference to behaviour and health.<sup>33</sup>

#### Market integration, trade liberalisation and foreign investment

Since the 1980s, key features of globalization have been the integration of most of the world's countries into the global marketplace and the spread of market relations into social life within those countries. This process has been facilitated by such measures as liberalization of trade regimes and deregulation in domestic markets.

Consequences, in countries rich and poor alike, have included the emergence of global labour markets, extensive privatization, and a scaling back of the state. Among other things, market integration, trade liberalisation, the growing influence of foreign direct investment, and the continuation of non-health focussed food subsidies has increased the availability, affordability, and desirability of less healthful foodstuffs.<sup>49</sup> Increased global market integration and trade liberalisation has also seen expanding production and consumption of health-damaging commodities such as tobacco and alcohol.<sup>50</sup> In Russia, for example, liberalisation of the economy in 1992 included a total deregulation of trade in alcohol beverages. The subsequent mortality rise in Russia has been linked to a rise in binge drinking of alcohol.<sup>51</sup>

#### *Trade liberalisation*

While trade has the potential to improve global and national health, structural inequities in the global institutional architecture maintain unfairness in trade-related processes and outcomes.<sup>52</sup> Trade and investment agreements have often been characterized by asymmetrical participation among signatory countries, and by inequalities in bargaining power that arise from differences in population size,

national wealth and capacity. Global institutions such as the Codex Alimentarius Commission show how health and health equity perspectives have been underrepresented in critical areas of international economic negotiations, through a limited interpretation of public health nutrition as one of food safety and very little effective public health nutrition representation in the negotiations.<sup>53</sup>

### *Foreign investment*

Trade liberalisation can affect availability and affordability of certain commodities through removal of barriers to foreign investment in, for example, food manufacturing and distribution.<sup>54</sup> Certainly, the market power of transnational food and beverage corporations (TNCs) throughout the supply chain has grown considerably with trade liberalisation. The world's food and beverage industries, including those in Australia, are dominated by multinational manufacturers and retail chains. Multinational corporations make up 23 of the top 50 food and beverage manufacturers operating in Australia, and produce approximately one-third of Australia's processed food and beverages.<sup>55</sup> Companies are growing in size and reach through mergers, acquisitions, vertical integration and aggressive growth strategies and restructuring to achieve greater economies of scale. The nature of the food supply has also been changed by TFCs, with increased availability of cheap to produce processed and fast foods through the growth in food processing companies and large transnational supermarkets and fast food outlets.<sup>49</sup> The Australian domestic market has reached maturity, and according to the Agriculture and Food Sector Stocktake future expansion will mean successful marketing by the processed food and beverage industry of more innovative and higher value products.<sup>55</sup>

### *Global Advertising*

Advertising and promotion has been a fundamental process of globalization. From the 1980s onwards, advertising agencies transnationalized through foreign investment, mergers and acquisitions and grew into huge, vertically integrated global corporations.<sup>56</sup> The growth of transnational advertising and communications companies has deepened the influence of food, alcohol and tobacco advertising and promotion on behaviours by speeding the flow, acceptance and desirability of these products in the global marketplace.

### *Global and National Governance*

Putting health in international trade arrangements and domestic economic policy is critical. This means good global and national level governance - tackling the balance of geo-political and economic power in agenda-setting and decision-making in relation to (food, alcohol, tobacco) trade agreements. It is accepted almost unanimously by those in the health field that trade negotiations and disputes must be made more transparent, have increased civil society involvement and need greater involvement of health interests such as the WHO and Ministries of Health. The development of the WHO's Framework Convention on Tobacco Control is an excellent example of coherent global action to restrain market availability of a harmful commodity, providing national government the policy space within which to act. Addressing the harms of alcohol as part of a global-health agenda is gathering momentum. WHO is in the midst of developing a strategy to reduce harmful use of alcohol in consultation and collaboration with member states, and a Framework Convention on Alcohol Control (a legally binding international treaty) is under discussion.<sup>57,58</sup> WHO is working with WTO, the World Bank, World Intellectual Property Organization, UNCTAD, international experts, and trade and health policy-makers from 10 countries to develop a diagnostic tool to examine five components of the trade-health relationship: 1) macroeconomics, trade, and health; 2) trade in health-related products, including medicines and intellectual property-related issues; 3) trade in products hazardous to health, such as tobacco products; 4) trade in health services – e-commerce, health tourism, foreign direct investment in health, cross-border movement of health professionals; and 5) trade in foodstuffs. Implementation of the diagnostic tool will enable policy-makers to develop national policies and strategies related to trade and health and to identify their capacity-building needs in this area.<sup>59</sup>

That a significant proportion of the global population eats large volumes of energy-dense nutrient-poor foods, does not expend enough energy, smokes and consumes harmful quantities of alcohol is a sign of success – commercial success. The harmful health consequences of these behaviours, and their social gradient, however, are indicative of both market failure (since the outcome is not good for both the seller and buyer) and failure by government to protect the health of all its citizens.<sup>60</sup> Corporate social responsibility (CSR) has been promoted as a vehicle for improving the health and social impacts of private sector actors. To date CSR is often little more than

cosmetic due to its voluntary status and no enforcement. Greater corporate accountability is needed. Reinstatement of a strong public sector, that is the provider of public goods including health, is needed and requires policies, legislation and regulations that tackle the underlying social causes of unhealthy behaviours.

*What could be done:*

1. Strengthen the public health capacity and representation in key areas of national economic policy making and international economic policy and trade negotiations with the WTO and processes including the Codex Alimentarius Commission.
2. Integrate health impact assessment into all multi-lateral and bi-lateral trade agreements, and associated policies on subsidies and tariffs, to ensure they systematically favour the production and distribution of healthy foods and control that of energy-dense nutrient-poor foods, alcohol and tobacco.
3. Reinforce the primary role of government in the regulation of the provisioning, distribution and marketing of tobacco, alcohol, and food.
  - o Use the forthcoming WHO collaboration diagnostic tool on trade and health as an aid to government in developing national economic policy and trade agreements that ensure availability and affordability of healthy commodities.
4. Establish binding international codes of practice related to advertising of alcohol, energy dense nutrient poor foods, supported at the national level by policy, enforcement and independent monitoring and evaluation.

### Economic policy

Money matters. For countries, rich and poor, increasing or re-allocating public finance to fund action across the social determinants of health and health-related behaviours is fundamental to improved health and health equity.

Within countries, adequate financial resources, progressively obtained, proportionately invested across the social determinants of health, and allocated equitably across population groups and regions, are fundamental. Health equity, and equity in health-related behaviours relies on an adequate supply of and access to material resources, health-promoting goods and daily living conditions. Supply of and access to these, in turn, requires public investment and adequate levels of public financing. The current financial crisis provides an opportunity to re-consider how national wealth is generated and allocated. Governments' recently provided a multi-billion dollar bailout of the world

financial system. It is a reasonable question to ask why investments in daily living conditions, health promotion, and disease prevention have so far been inadequate, globally and within rich and poor countries alike. If it is thought important enough, the money can be found.<sup>61</sup>

Strengthening domestic revenues for equitable public finance requires progressive taxation. Evidence suggests that taxation should focus on direct – such as income or property taxes – over indirect forms – such as trade or sales taxes.<sup>1</sup> However, it has been well established that, on average, pricing of food, alcohol, tobacco is a key determinant of access and consumption. Alcohol taxation – in the form of special excise duties, value added taxes, and sales taxes – has proven an effective societal-level intervention to reduce the overall volume of drinking and, in turn, reduce alcohol-attributable chronic health problems. Increases in alcohol retail prices reduces consumption and the level of alcohol-related problems. In most countries tax-induced price increases on alcoholic beverages has led to increases in state tax revenues and decreases in state expenses related to alcohol-related harms.<sup>33,62</sup> Taxation policies are most effective when there is strong government control of the market around alcohol production, imports and sales. This approach has been prevalent in North America and parts of South America, Eastern Europe, and the Nordic countries.<sup>63</sup> Similarly with tobacco.<sup>32</sup> And as illustrated in the Australian state of Victoria, hypothecated taxation from tobacco sales was a key mechanism for creating a long-term source of money for health promotion policy and programs.<sup>64</sup>

While effective in shifting average consumption, one of the difficulties with in-direct revenue generation through taxation, in the context of behaviour, is that it is a blunt instrument and potentially regressive. Because poorer people spend a greater proportion of their income on food than rich people they are likely to be more sensitive to price changes and in some instances a cause of emergencies for given social groups.<sup>65</sup> As is happening worldwide, as the cost of the basket of household goods starts to increase more rapidly relative to income, all but the very rich will feel the effects. Some will be able to purchase a healthy diet; some will only be able to purchase the cheapest sources of calories – energy-dense highly processed products that increase the risk of obesity and diabetes, and many millions will be unable to afford even that.<sup>66</sup>

There is relatively little information, globally, on the effect of food taxes on dietary-behaviour and health. Some preliminary work in the UK suggests that fat taxes may produce modest changes in diet but that more research is needed to better understand the potential effects, particularly on the poor. The authors point out that taxing foodstuffs can have unpredictable health effects if cross-elasticities<sup>1</sup> of demand are ignored – for example, reducing saturated fat consumption tended to increase salt consumption and that fruit consumption tended to fall as a result of taxation on milk and cream.<sup>67</sup> More boldly, Denmark’s Academy of Technical Science recommends that in order to change food behaviour using economic policy, healthy foods should be subsidized by 20% and unhealthy foods taxed by 30% percent.<sup>68</sup>

Being empowered to increase or allocate finance to address the determinants of health and health equity requires government to have strong public sector finance systems that are based on sustainable and equitable mechanisms for resource generation and allocation. While taxed based systems are the preferred pro-equity option, sales taxes can influence, effectively, tobacco, alcohol and food purchasing habits due to their impact on retail price. Price is a key driver of health-related behaviour but can be regressive.

*What could be done:*

1. Strengthen Federal and State capacity for progressive taxation
2. Assess the contribution of hypothecated taxes to national and State public finances and their allocation to action on the social determinants of health
3. Establish a cross-government mechanism to allocate budget to action on social determinants of health, and monitor allocation and outcomes between regions and social groups
4. Make “healthy” food products more financially accessible using incentives such as subsidies and “unhealthy” ones less accessible through the use of taxes
  - Before implementing economic tools, exact calculations of the scale and area of the tax changes should be carried out to establish that the tax changes will have the desired effects.

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<sup>1</sup> high price elasticity of demand means a small proportionate increase in price leads to a large proportionate change in demand. Cross-elasticities refers to small changes in the relative prices of near substitutes can lead to large changes in consumption patterns.

### Power, Voice, Social Inclusion, Participation

Creating the socio-environmental and socio-economic conditions that enable all social groups make healthy behavioural choices depends vitally on the empowerment of individuals and groups to represent effectively their needs and interests, and in so doing, to challenge and change the distribution of those conditions that affect health. This relates to matters of power and the systems and processes within society that systematically create inequity in its distribution.

Inequity in power interacts across four main dimensions – political, economic, social and cultural – together constituting a continuum along which groups are, to varying degrees, excluded, or included. The *political dimension* comprises both formal rights embedded in legislation, constitutions, policies, and practices and the conditions in which rights are exercised including access to safe water, sanitation, shelter, transport, energy, and services such as health care, education, and social protection. The *economic dimension* is constituted by access to and distribution of social resources necessary to sustain life and good health (e.g. income, education, employment, housing, land, goods and services). The *social dimension* is constituted by proximal relationships of support and solidarity (e.g. friendship, kinship, family, clan, neighbourhood, community, social movements) and the *cultural dimension* relates to the extent to which a diversity of values, norms, and ways of living contribute to the health of all and are accepted and respected.<sup>69</sup>

At the heart of the persistent inequity in the life expectancy and health conditions of Indigenous Australians is the relationship between power, participation and health.<sup>34</sup> Colonization imposed social, political and economic structures upon Indigenous Peoples without their consultation, consent or choice. This has happened to no other group in society. As such, Indigenous Peoples have distinct status and specific needs relative to others. Regaining personal and cultural continuity has major implications for the health and well-being of these communities.<sup>70</sup>

Issues of power imbalance relate not only to individuals and communities. The political, financial, and trade decisions of a handful of governments, institutions and corporations are having a profound effect on the conditions of daily living,<sup>71</sup> and consequently the daily practices and behavioural choices of millions of people.

Improving population health and health equity means that all peoples must have a voice i.e. they have the right to participate, the capacity to do so, and are represented in decision-making about how society operates, particularly in relation to its effect on health, including health-related behaviours.

Such fairness in voice, inclusion and participation requires changes in how top-down policy-making is made and it also requires bottom-up community led action. It is through the democratic processes of civil society participation and public policy-making, and with accountable and responsible private actors, that real action for health and health equity is possible. This will require social structures, supported by the government, that mandate and ensure the rights of groups to be heard and to represent themselves – such as legislation and institutional capacity; and it depends on specific programs supported by those structures, through which active participation can be realised. Beyond these, as community members, grassroots advocates, service and programme providers, and performance monitors, civil society actors constitute a vital bridge between policies and plans and the reality of change.

*What could be done:*

1. Strengthen the political and legal systems to ensure they promote the equal inclusion of all.
2. Governments acknowledge, legitimise and support Indigenous Groups, in policy, legislation and programs that support autonomy and self-determination.
3. Civil society participation in policy, planning, service delivery, and evaluation
4. Independent monitoring by civil society of government and corporate sector performance in relation to health and specifically health-related behaviour outcomes
5. Strengthen the public health representation in key areas of national economic policy making and international economic policy and trade negotiations

### Section 3:

#### **What does a social determinants approach to health equity through obesity, alcohol and tobacco mean in the Australian context?**

While the global evidence base clearly points towards the social determinants as root causes of disease that need to be addressed to achieve real progress, in practice more individual-level changes have been the political preference. While behaviour-change approaches are a necessary part of the solution, in and of themselves they are insufficient. It is vital that policy and practice responses to obesity, alcohol and tobacco address their wider social determinants, particularly if concerned with health equity, health promotion and disease prevention.

Part 1 of Section 3 describes the current political landscape and highlights some of the key Federal level actions that, while not framed under the heading of social determinants, do in fact acknowledge many of the necessary issues including social equity, voice and participation, fair financing, social protection, employment and working conditions, and healthy start to life.

Acknowledgement by government of the various social issues affecting Australians' way of life is one thing. Sustained commitment and action, and action that is beneficial for health and health equity, requires the introduction of some underpinning structures and approaches 'the backbone of action for health'. Part 2 of Section 3 lays out key components of this backbone for consideration.

#### **Part 1: Politically viable and practically pertinent?**

Obesity, harmful alcohol consumption and tobacco use are risk factors for most of Australia's health burden, and the health-care system is straining. People with less money, less education, insecure working conditions, poor living conditions and often excluded from mainstream society, are much more likely to die early and have higher levels of behaviour related health conditions: the social system is failing. Many of the underlying social determinants of obesity, tobacco and harmful alcohol use are also significant contributors to climate change: our natural-care system is being eroded.

Obesity, tobacco and harmful alcohol use and their underlying causes are each, and must be, a primary concern for the whole of government.

Much of what is written in this paper is not new for many Australian public health researchers, civil society and advocates.<sup>5,72-75</sup> Indeed, historically public policy in Australia did much to address the social determinants of health, and today in some States and Territories there are some progressive actions.<sup>76</sup> Generally however, the issues raised in this paper imply a paradigm shift in the Federal political arena and among policy makers. There are signs that this is starting to happen:

### **The apology**

The first act of the new labour government was an apology to the stolen generations of Australia's Indigenous Peoples on February 2008.<sup>77</sup> By making this apology the government indicated, among other things, its intention of respect for all people and participatory governance.

### **Australia 2020 summit: A national cry for a progressive, empowered society based on principles of equity, sustainability and health for all**

Not long after the apology, in April 2008, the Federal government invited more than 1000 people from diverse backgrounds including politicians, community leaders, artists, and scientists to a national Summit with the purpose of discussing the long-term development agenda for the nation. Here was a chance to participate in reshaping what Australia stood for and to influence the major policy challenges facing the country. After two days of deliberations a cross-section of Australia called for action that would help the nation reach the following aspirations - aspirations that embrace health promotion, disease prevention, social justice, sustainability and equity.<sup>78</sup>

- By 2020 Australia is known throughout the world for its diverse, compassionate, fair and respectful society.
- By 2020 every Australian is valued by and participating in society; has meaningful access to education, health, housing, work, justice, care and life opportunities; has a safe, healthy and supported childhood that allows them to fulfil their potential; feels a sense of belonging.
- By 2020 Australian society embraces and celebrates Indigenous people; focuses on long-term prevention and is experiencing the benefits of a return on social

investment; regards social inclusion as equal and integral to a buoyant economy and a healthy environment.

- By 2020 Australian society is a leading green and sustainable economy; maximises wealth, excellence and equity by driving up productivity to the leading edge of developed countries, focusing on human capital through early childhood development, world-class education, skills formation and innovation; encourages all Australians to realise their potential.
- By 2020 we will have achieved a healthier lifestyle, through universal access to a clever wellness-focused evidence-based system with due regard to the environment in which we live; fair distribution of health and equivalent health outcomes for all Australians, with a particular focus on closing the gap in life expectancy between Aboriginal and Torres Strait Islander people and the wider Australian population.
- By 2020, we will have a person- and family-centred health system, collaborating across disciplines; a system focused on prevention; a system that prioritises health and wellbeing in the early years (from conception to adolescence).

*(Australia 2020 Summit Final Report, Department of Prime Minister and Cabinet, 2008 - summarised by S Friel)*

### **Light on the Hill: History Repeating**

In delivering the annual Light on the Hill speech in September 2008, the current labour Minister for Health, Nicola Roxon, in honouring Australia's former Prime Minister Ben Chifely, spoke about revitalising some of the principles that Chifely governed with. She highlighted a new direction for the current government and in particular the Ministry of Health, with a refocus towards matters of prevention, of health system reform and of social equity.

“We now stand at a crossroads. Both the PBS and Medicare are being challenged by demographic and economic trends...Without change, Australian Government spending on health is projected to almost double as a proportion of GDP over the next forty years, with spending on medicines projected to grow the fastest of all health factors. At the same time, the invasion of our lives by chronic diseases like diabetes and heart disease – and the early death that they bring – threatens the sustainability of Medicare, and poses new challenges for the way we think about delivering health care. We know that health is a major indicator of inequity. If you want to judge how affluent a suburb is, you could check its tax returns – or you could look at its medical

records. Rates of diabetes, of heart disease, early deaths, infant mortality, how many teeth a person has left – all are clear markers of socio-economic status. ...In three areas – prevention, workforce, and the provision of health services by both public and private providers – a confused combination of government regulation and badly designed markets can hamper our ability to deliver the health care that people deserve. Which means health inequalities are becoming entrenched in our community. ....What these few examples show is that both the market and the government have key roles in health – but we must be prepared to ask if we have the mix of intervention, regulation, financial support and incentives right. And especially to be prepared to keep asking what mix will enable us to provide quality care across the community and close significant health gaps in the process...”

### **The Australian government’s reaction to the Global Financial Crisis**

#### Prime Ministers Rudd’s Essay

While not throwing out the idea of free-market liberal economics, in his essay Prime Minister Rudd asserts, strongly, the role of government in protecting society and being the provider of public goods, including health. He seeks a path forward that builds a fairer and more resilient order. By seeking to provide public goods and strong resilient systems and societies, the Prime Minister suggests a government which, if it delivers as he outlines, will be able to measure its success by improvements in the social distribution of health in Australia.

“The intellectual challenge for social democrats is not just to repudiate the neo-liberal extremism that has landed us in this mess, but to advance the case that the social-democratic state offers the best guarantee of preserving the productive capacity of properly regulated competitive markets, while ensuring that *government* is the regulator, that *government* is the funder or provider of public goods and that *government* offsets the inevitable inequalities of the market with a commitment to fairness for all. Social democracy's continuing philosophical claim to political legitimacy is its capacity to balance the private and the public, profit and wages, the market and the state. That philosophy once again speaks with clarity and cogency to the challenges of our time”.<sup>79</sup>

### Australian Stimulus Package

While details can be debated, as a rapid response to an acute situation i.e. the current global financial crisis, the recent Australian stimulus package is to be commended. The government pledged the equivalent of 1% of gross domestic product, providing 4.8 billion dollars for long-term pension reforms, 3.9 billion dollars for support payments for low and middle-income families, 1.5 billion dollars towards helping first-time buyers purchase a new home, and 187 million dollars to create 56,000 new training places, and speed up major infrastructure projects. Such public sector spending is based on principles of social justice and social protection, and will help improve, in the short term, daily living conditions for many of Australia's socially disadvantaged households, thereby helping to empower people and communities to live healthy and flourishing lives.

### **Council of Australian Government Commitments**

Complementing the short-term response of the stimulus package, at the 24<sup>th</sup> meeting of the Council of Australian Governments in November 2008, significant amounts of money were allocated to infrastructure necessary to sustain social development.<sup>80</sup> Five new national specific purpose payments (SPP) were created with funding of \$60.5 billion in a National Healthcare SPP; \$18 billion in a National Schools SPP; \$6.7 billion in a National Skills and Workforce Development SPP; \$5.3 billion in a National Disability Services SPP and \$6.2 billion in a National Affordable Housing SPP. Specific projects are being established (National Partnerships) and are due to begin in 2009. Many of the NPs relate to the social determinants of health (although not explicitly referred to as this), focusing on issues of social inclusion, education improvement and poverty alleviation. An explicit COAG commitment to Indigenous reform and "closing the gap" was made with \$4.6 billion to be allocated across early childhood development, health, housing, economic participation and remote service delivery and the establishment of the National Indigenous Health Equality Council. Of particular significance to the social determinants of obesity, alcohol and tobacco is the Preventative Health NP, with dedicated preventative health research funding and commitment to establishing a National Preventative Health Agency and related surveillance program.

## **A Healthier Future for All Australians. Interim Report of the National Health and Hospital Reforms Commission**

The recently published interim report from the National Health and Hospitals Reform Commission acknowledges that building healthier communities is the right thing to do: it is important in its own right and critical for economic development and poverty reduction.<sup>81</sup> The NHHRC clearly articulates two important ways to build healthier communities – by tackling health inequities, including access to health care, and through health promotion and disease prevention. Indeed one of its four overarching strategic reform themes is that of recognising and tackling the cause and impact of health inequities.

### **Social Inclusion**

A number of the Australian government's proposed initiatives around social inclusion continue to target particular groups in society. However, the general principles relate to opportunity for secure work, access to services, social connection, personal capacity and engagement and participation in policy and governance. The government has established high-level architecture to progress this agenda – the Social Inclusion Committee of Cabinet, a Social Inclusion Unit in the Department of the Prime Minister and Cabinet and in May 2008 set up an advisory group – the Australian Social Inclusion Board. Aiming to enable active engagement and participation between government and civil society, government is exploring formal mechanisms through a National Compact between government and the not-for-profit sector in Australia (<http://www.socialinclusion.gov.au>).

### **Fair Work Bill 2008**

Encouragingly, Australia is on the process of introducing a new workplace relations system, through the introduction of Australian Fair Work Bill 2008.<sup>82</sup> The new system aspires to ensure a fair and comprehensive safety net of minimum employment conditions; a system that has at its heart bargaining at the collective/enterprise level; protections from unfair dismissal for all employees; protection for the low-paid; a balance between work and family life; the right to be represented in the workplace.

## **Part 2: The backbone of a social determinants approach to the prevention of obesity, harmful tobacco consumption and tobacco use in Australia**

Politically, now seems like a favourable moment to instigate action on the social determinants of healthy behaviour, population health and health equity in Australia. In order to capitalise on this political environment, a few key factors are required to build a strong backbone with which to sustain action. These are outlined below.

### **Broaden the understanding of health equity**

To date, addressing health equity in Australia has focused on the need for a level playing field in access to health care and in behavioural outcomes rather than on changes in the circumstances of people's everyday lives. *Refocus*. This paper emphasises that inequities in health are not confined to the poorest or most marginalised but that health follows a *social gradient*. Much of the current policy and action in Australia focuses on the difference between social extremes. This has led to an emphasis on targeted interventions. A social gradient approach will mean re-formulating policy and action to improve the health of all but have proportionately more impact further down the social hierarchy.

### **Commitment at the highest level**

Underpinning action on the social determinants of obesity, alcohol and tobacco use requires political will at the highest level, supported by an empowered public sector based on principles of justice, participation, and intersectoral collaboration. This means strong core functions of government and public institutions in relation to policy coherence, participatory governance, planning, regulation development and enforcement, and standard setting. It depends on strong leadership and stewardship from the Ministry of Health. The example from the UK (Box 2) illustrates some of the key attributes of government that helped make health inequalities a central policy goal within the Prime Ministers office.

*Box 2: Example from the UK: Cross government action on health inequalities*  
In 2002, as part of the formal government-wide spending negotiations, the Department of Health and Treasury led discussions between 18 departments to inform a delivery plan for the health inequalities targets and identify the contribution required from each part of government. The Treasury's financial and political authority was instrumental and brought departments to the table, to engage them in a crosscutting

goal. It facilitated agreement between departments to combine expertise and resources behind government priorities.

The 2003 *Programme for Action* identified 82 funded commitments, owned by 12 government departments, which in the following three years would lay a foundation for achieving the 2010 health targets and provide a sustainable impact on the wider determinants of health. The *Programme for Action* provided a strategic framework to direct all actions towards a single goal. This prescribed co-ordination at both national and local levels of government, and strong performance management systems to drive delivery. An open process of regular audit, reporting and review provides understanding of the target trajectory and the ability to refine the approach. Status reports were published in 2005 and 2008.

The health inequalities target has put pressure on the government to co-ordinate activities. This has required good communication between departments and Treasury leadership. National frameworks now mandate health inequalities as a top priority for health planners and local government, while central guidance and support has targeted under-performing areas and promoted best practice. The current Secretary of State for Health, and the Prime Minister, has made health inequalities a government priority (Hayward, 2007).

### **Intersectoral collaboration and policy coherence**

The intersectoral nature of the social determinants of food, tobacco and alcohol-related problems demands an intersectoral response - reaching far beyond the realm of health and involve such sectors as development, transport, social policy, fiscal policy, trade, agriculture, industry, consumer policy, education and employment.

Healthy public policy, or Health in All Policies as it is now called, simply means that policies and actions, across key government departments are consciously developed in such a way that they do no harm to health or, preferably, improve health and health equity. This requires cross-ministerial and cross-departmental interaction and mechanisms to support it – but many government system barriers exist to intersectoral working and policy coherence. The layers of Federal and State government, and local administrations are themselves a challenging construction. Within each they are often organised into vertical silos within each layer, severely compromising the effective integration of cross cutting policy and programs. The Health in All Policies (HiAP) Initiative in South Australia (Box 3) provides an example of work undertaken recently to develop the skills and mechanisms for a whole-of-government approach to population health and health equity.

*Box 3: Health in All policies (HiAP)*

The HiAP approach in South Australia took place in the context of a commitment by government to whole-of-state strategic goals as set out in South Australia's Strategic Plan (SASP). The SASP was important, providing the legitimising framework for a HiAP approach. In 2007, through the Adelaide Thinkers in Residence programme, Illona Kickbusch developed a proposal for integrated policies and strategies around the broad theme of 'Healthy Societies'. The residency acted as a catalyst for the SA government's engagement in a HiAP approach. Actioning the proposal and recommendations made by the Thinker needed high-level commitment from both the central government agency - the Department of Premier and Cabinet - and the Health Department, which there was.<sup>13</sup> Success in whole-of-government approaches requires this political commitment combined with clear objectives, viable shared structures and a culture of collaboration.<sup>83</sup> Obesity was one of the areas included in the SA HiAP plan, building on the existing partnership working between the department of Health with PIRSA to encourage fruit and vegetable consumption; DTEI to support active transport; DECS on the Right Bite school canteen program; DEH on the Healthy Parks Healthy People program; and Recreation and Sport on 'be active' workplaces.<sup>84</sup>

Health Impact Assessment is a tool for building policy coherence. It is used to assess the potential health consequences of policy, which it feeds back into the decision-making process, thereby also helping to build the dialogue and collaboration with the relevant ministries and stakeholders. Not all States and Territories have a legislative mandate for health impact assessments but some do – this legislation should be rolled out nationally. In the absence of legislative provisions, the health sector can play an important role in encouraging and supporting other portfolios to undertake the process.

*Action*

- Examine the transferability of the Health in All policies model in South Australia to other States and Territories and Federal level.
- Led by the health sector but in collaboration with non-health departments – identify policies and programs across key government portfolios that relate to the social determinants of obesity, alcohol and tobacco and undertake a health impact assessment

**A powerful and progressive health sector**

The health sector is both a determinant of health and health inequities and a facilitator of policy coherence and intersectoral collaboration. Done well, together these aspects of the sector can effect significant improvements in population health and health

equity. Done badly, the health sector will never reach its vision of better health and active ageing for all Australians – it fails society.

#### A prevention focus

Australia, arguably, has one of the best health systems in the world but it continues to contribute to health inequities. Of concern is its ability to prevent and treat chronic non-communicable diseases – the main health burden in Australia today. But Australian health ministers and the health-care system have been principally concerned with delivery of clinical care and focussed on quick wins on medical targets (e.g. waiting times). By focusing on determinants, more emphasis is placed on the longer term through health promotion, disease prevention and primary health care, each with potentially more sustainable improvements in health. Such a focus is the only way that the current and future health burden in Australia will be alleviated.

The CSDH recommended that a health-care system should be based on the principle of equity, to be achieved through universal coverage of quality services, focusing on primary health care, disease prevention, and health promotion. The prestigious Health and Hospital Reform Commission reinforces this recommendation through its call to build healthier communities by tackling the causes of health inequities, including access to health care, and through health promotion and disease prevention gives legitimacy to this approach. The preventative health focus in the newly established National Partnerships is very encouraging although the associated budget line is almost a quarter that of the hospitals and health workforce reform.<sup>80</sup> There have been many advocates within the Australian health sector for a determinants approach but they have tended to be at the fringes, in health promotion and community development.<sup>76</sup>

Two actions seem both critical and feasible:

- Ensure universal coverage of health care regardless of ability to pay, and minimize out-of-pocket health spending through the maintenance and extension of Medicare
- Health promotion and public health professionals must rebalance the focus of their attention - and be supported to do so - towards strategies, intersectoral collaboration and programs aimed at the removal of the structural constraints to healthy behaviours, within the context of changing cultural environments, rather than on behaviour-change and social marketing.

### Stewardship for health and health equity

Ministers of Health, supported by the executive branch of government, must provide strong stewardship for intersectoral action for health and health equity, committing time and financial resources to the development of relevant skills and capacity among the health workforce and providing reward structures for intersectoral working. The Department of Health and Ageing must support the Minister and strengthen its stewardship role and brokering ability with other government departments by:

1. Making the argument for such an approach using regularly updated evidence and increasing the visibility of social determinants of health issues
2. Sensitising non-health departments to the relationship between what they do and health effects, through, for example, knowledge sharing, seminars, one to one briefings.
3. Mapping all government internal and external committees that have relevance for health and health equity, thereby identifying points of overlap and potential collaboration
4. Developing a national social determinants of health action plan
5. Creating national and local institutional structures to take forward the social determinants of health agenda;
6. Developing the appropriate workforce competencies

While Federal and State government oversight is needed to push and coordinate intersectoral action and to ensure sustainability, local-level government and community ownership is a prerequisite to sustained results. The idea of a **National Compact between government and the not-for-profit sector**, as being developed for social inclusion, could be explored for the social determinants of health more broadly.

### **The power of data and knowledge**

Evidence informed policy-making is vital if the health risks from obesity, tobacco and alcohol use are to be addressed. This requires good data on the extent of the health problem, up-to-date evidence on the determinants and on what works to reduce the problems, and an evaluation and monitoring system with which to assess progress. Applying a social determinants approach to policy and practice also requires an

understanding of the data and evidence, among current and future policy-makers and practitioners.

Technical and human capacity is essential. There is a considerable amount of data available in Australia although a paucity of dietary intake and physical activity measures at the national level. The requirement is for more relevant information and measurement tools. Critical elements of a functioning knowledge system are as follows:

- Enhance the capacity for monitoring the social determinants of health, and inequities in behavioural risk and health outcomes:
  - Modify the current national standards for the monitoring of non-communicable diseases and risk factors to effectively describe and analyse health inequities more fully, including the social gradient in health and health related behaviours
  - Establish a national health equity surveillance system, with routine collection and analysis of inequities in health outcomes, behavioural risk factors and their social determinants
- Invest into research on the social determinants of health, including obesity, alcohol and tobacco, equivalent to that invested in clinical research. The preventative health research money identified in the National Partnerships must focus on these issues and be allocated in a strategic and comprehensive manner.
- Provide training to practitioners and policy-makers, expanding progressively from the health sector out to other key sectors such as urban planning, education, on what are the social determinants of health and determinants of obesity, alcohol and tobacco, and what approaches are effective in shifting population risk as opposed to individual risk.
- Teaching institutions should institutionalise social determinants training into all medical and other health curricula, and relevant non-health programs.

In summary: applying a social determinants approach to health and health equity has profound implications for policy making in Australia, requiring three key changes:

- i) revise the liberal policy framework to make it less individualistic and better accommodate the value of collective and community through a stewardship model of government
- ii) rebalance the current policy focus on static social groups towards a focus on systems and processes and the degree to which they are socially inclusive
- iii) systematic consideration of the health effects of all government policy, systems and processes on all population groups

The action areas and recommendations outlined in this paper provides a policy framework and action plan for the National Preventative Health Taskforce, the Minister for Health and the forthcoming Preventative Health Agency – a body, which from its remit, must be evidence informed, multi-sectoral, and report to the highest level of government.

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