Public Health Association
AUSTRALIA

Public Health Association of Australia

Submission to the Senate Standing Committees on Community Affairs on the Extent of income inequality in Australia

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Introduction

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles. The PHAA has a vision for a healthy region, a healthy nation and healthy people living in a healthy society and a sustaining environment while improving and promoting health for all.

Public Health

Public health includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and environmental determinants of health, provides particular relevance to, and expertly informs the Association's role.

The Public Health Association of Australia

PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups concerned with the promotion of health at a population level.

Key roles of the organisation include the development of policy, capacity building and advocacy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. PHAA supports a preventive approach for better population health outcomes by championing appropriate policies and providing strong support for Australian governments and bodies such as the National Health and Medical Research Council in their efforts to develop and strengthen research and actions in public health. The PHAA is an active participant in a range of population health alliances including the *Australian Health Care Reform Alliance*, the *Social Determinants of Health Alliance*, the *National Complex Needs Alliance* and the *National Alliance for Action on Alcohol*.

PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a providing a close involvement in the development of policies. In addition to these groups the PHAA's Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

Advocacy and capacity building

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of governments and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

Preamble

PHAA welcomes the opportunity to provide input to the Senate Standing Committees on Community Affairs (the Committee) for an inquiry into the extent of income inequality in Australia by the Commonwealth Government. The reduction of social and health inequities should be an overaching goal of national policy and recognised as a key measure of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on reducing health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally as well as internationally.

Health Equity

As outlined in the Public Health Association of Australia's objectives:

> *Health is a human right, a vital resource for everyday life, and a key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions of society that underpin people's health. The health status of all people is impacted by the social, political, and environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease.*

The PHAA notes that:

- health inequity differs from health inequality. A health inequality arises when two or more groups are compared on some aspect of health and found to differ. Whether this inequality (disparity) is inequitable, however, requires a judgement (based on a concept of social justice) that the inequality is unfair and/or unjust and/or avoidable. Inequity is a political concept while inequality refers to measurable differences between (or among, or within) groups. [8]
- Health inequity occurs as a result of unfair, unjust social treatment – by governments, organisations and people [9], resulting in macro politico-econonmic structures and policies that create living and working conditions that are harmful to health, distribute essential health and other public services unequally and unfairly, preventing some communities and people from participating fully in the cultural, social or community life of society.

Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries [1].

The determinants of health inequities are largely outside the health system and relate to the inequitable distribution of social, economic and cultural resources and opportunities. Health inequities are the result of the interaction of a range of factors including: macro politico-economic structures and policy; living and working conditions; cultural, social and community influences; and individual lifestyle factors [2-4,5,6,7].

Response to Committee Terms of Reference

Additional to the previous response provided to the Committee in reference to the *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"* report released in March 2013, this submission urges the Committee to implement the recommendations advised in order to progress issues relating to Social Determinants of Health and the extent of income inequality in Australia.

a) The extent of income inequality in Australia and the rate at which income inequality is increasing in our community;

b) the impact of income inequality on access to health, housing, education and work in Australia, and on the quality of the outcomes achieved;

There is evidence that health inequities may be increasing in Australia [10,11]. The absence of specific indicators and measurement of health determinants hinders the ability to measure progress towards reducing health inequities across population groups [12]. Improvement in general population health outcomes may obscure the changes within specific groups.

Richer countries, with a lower disease burden, use more health resources than poorer countries with a higher disease burden [13]. However, even within developed nations that have an established public health system, cost-effective interventions to improve life expectancy are not adopted on a scale required to close the inequities gap because adequate funding is generally not committed where there is greatest need.[14].

The cost of government inaction on distributing the social determinants of health fairly and justly within populations is substantial; gains from enabling more Australians who want paid employment to access meaningful paid work could close the gap in self-assessed health status between most and least disadvantaged Australians of working age and could generate AUD$ 6 to 7 billion per year in extra earnings [15].

c) the specific impacts of inequality on disadvantaged groups within the community, including Aboriginal and Torres Strait Islander peoples, older job seekers, people living with a disability or mental illness, refugees, single parents, those on a low income, people at risk of poverty in retirement as well as the relationship between gender and inequality;

Health inequities exist both within and between countries [16, 17-18]. Australians have high life expectancy enjoying one of the highest life expectancies in the world [19]. However, this longevity is not shared equally among Australians. Significant differences remain across a range of health outcomes for differenct groups of Australians, including rates of death and disease, life expectancy, self perceived health, health behaviours, health risk factors and health service utilisation. These "health inequities" are associated with a range of socio-economic factors including differences in

education, occupation, income, employment status, rurality, ethnicity, Aboriginality, gender, housing status and disability [7,19, 20, 21, 22].

While socioeconomic status is the most significant determinant of health inequities, population groups of particular concern include homeless people, people affected by chronic mental illness, alcohol and other drug addictions or disability (and their carers), people with insecure low-paid employment, or who are not participants in the paid workforce, people living in remote areas, and some immigrant groups.

Aboriginal peoples and Torres Strait Islanders have experienced the greatest social, economic, political and cultural deprivation of all population groups in Australia – the health consequences of which have been profound compared with the broader community. Indigenous life expectancy is approximately 10 years lower than the non-Indigenous population and Indigenous people have higher rates of death for almost all causes. Indigenous people also bear a greater burden of disability and illness in a range of areas including cardiovascular disease, accidents and injuries, respiratory diseases and diabetes [5, 20, 21].

People with mental illness experience poorer health outcomes that the mainstream population [23]. Multiple risk factors (e.g. alcohol and drugs, food insecurity) combined with a lack of protective factors (e.g. childhood experiences, income) can predispose a person to the development of mental illness [24]. People experiencing mental illness or homelessness also face significant barriers to accessing services which contribute to poor health outcomes [23,24].

Climate change and environmental degradation are closely linked with health inequity as the adverse impacts are unequally distributed and the burden is borne disproportionately by those who are already of lower socioeconomic status, poor health, advanced age, and lacking access to appropriate housing [25].

There are different dimenstions of poverty which contribute to poor health. Impoverished people experience multiple forms of deprivation including material deprivation, marginalization, exclusion, powerlessness and the denial of opportunity of choice. They are significantly less able to participate in society: economically socially, culturally and politically.

There is a socioeconomic gradient in health. Generally speaking, people in lower socioeconomic groups have shorter life spans and poorer health. They have higher rates of death and disease, are more likely to be hospitalised and are less likely to use specialist and preventative health services. It is not only people in poverty whose health is affected by inequity; the higher a person's socioeconomic status, the more likely they are to be healthy [5,20,21].

d) the likely impact of Government policies on current and future rates of inequality particularly the changes proposed in the 2014-15 Budget;

Cuts to funding and the abolition of a number of key advisory bodies already undertaken in the initial months of the new Australian Government are the PHAA has serious concerns regarding a possiblea negative impact of these cuts. We believe that any further cuts of this nature will invariably have a further negative impact on both service delivery and outcomes across portfolios.

Examples include the loss of the Alcohol and Drug Council of Australia (ADCA) and a consequential lack of access to information being available through their library service and the loss of leadership around alcohol, obesity and tobacco issues with the demise of the Australian National Preventive Health Agency. The cumulative impact of the changes proposed in the 2014-15 Budget will be on those who most need sensible policy responses to community need.

At the same time as regulations are being slashed by governments the NGOs who are in a position to present coherent arguments to governments are also coming under threat. The Alcohol and Drugs Council of Australia was defunded without notice. This is the national peak body representing the alcohol and other drugs sector, including front line service delivery agencies, researchers and policy makers. ADCA has played this role for the best part of half a century and has accumulated a considerable library and resources used by hospitals, treatment facilities, researchers and those developing policy for government.

It is a similar story with the National Aboriginal and Torres Strait Islander Legal Services (NATSILS), which is the national peak body for Aboriginal and Torres Strait Islander Legal Services (ATSILS), and the positions of all Law Reform and Policy Officers within each State and Territory which were also cut. This cut is ironic considering the personal commitment of the Prime Minister to Aboriginal and Torres Strait Islander peoples. However, there is a common thread. Continuing funding for these bodies may make the mantra of less taxes, smaller spending and less regulation more difficult to deliver.

The abolition of a number of key advisory panels further highlights this approach. Among the most notable are the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF) and the Immigration Health Advisory Group. The latter included psychiatrists, psychologists, nurses and GPs who provide independent policy advice on the health needs of asylum seekers and refugees. Similarly, the government has announced its intention to "wind down" the operations of the Prime Minister's Council on Homelessness and the Australian Charities and Not-for-profits Commission (ACNC).

Early action of the Abbott Government in defunding the Climate Commission may have resulted in its phoenix like reincarnation as the Climate Council, made possible by 'crowd-funding' activities. However, it is unlikely that many of the other bodies that exist to support improved health outcomes for the most vulnerable, by the nature of what they do, will be able to gain similar financial support.

The reports of Sir Michael Marmot and others on the 'social determinants of health' illustrate the prime fallacy in the push for more and more emphasis on personal responsibility. Prevalence of diabetes, for example, is currently better explained by where you live than behavioural risk factors such as smoking or exercise. Policies that utilise a broad understanding of all these issues have most chance of success.

Cuts to jobs, cuts to NGOs, cuts to advisory boards may not have an immediate impact. However, the cumulative effect is a matter for grave concern. Environmental impacts on health, limitations on the ability to deliver sensible policies around drugs and alcohol and understanding the detail on

issues around migrant and refugee health are just the tip of the iceberg. The real challenge is that these cuts are already likely to have the heaviest impact on the most vulnerable.

Cuts and abolitions undertaken that are of significant concern to PHAA in terms of their potential impact on public health and related outcomes include:

- Nearly $8.6 billion worth of cuts to the Health Budget over 4 years
- $5.5 billion of total funding cut from the Medicare Benefits Schedule including:
    - $266.7 million (over 4 years) from 'simplifying Medicare safety net arrangements'
    - $3.5 billion (over 4 years) from introduction of a $7 co-payment for GP, pathology and diagnostic imaging services
    - $1.7 billion (over 4 years) from pausing indexation of MBS fees, Medicare Levy Surcharge & Private Health Insurance Rebate thresholds
- Abolition of the Australian Medicare Local Alliance
- Replacement of Medicare Locals with a vastly reduced number of 'Primary Health Neworks' to be established via a tender process and start operating in July 2015
- $1.9 billion total funding cut (over 4 years)
- $1.3 billion funding cut (over 4 years) achived by increase in co-payments ($5 co-payment for PBS listed medicines) and safety net thresholds
- $115 Million and $142 Milling in funding cuts respectively (over 4 years) from 'rebuilding GP education and training to deliver more GPs' and 'Smaller Govt – More Efficient Health Workforce Development'.
- $54 million (over 2 years) in reduced funding for Partners in Recovery
- $365 million funding cut from dental services (over 4 years) including
    - $229 million (over 4 years) from cessation of the Dental Flexible Grants Program; and
    - $391 million (over 4 years) by deferral of the National Partnership Agreement for adult public dental services
- Overall funding cut of $275 million from prevention measures including
    - $9.6 million cut for the National Bowel Cancer Screening Program
    - $368 million via cessation of the National Parnership Agreenment on Preventive Health
- Health Flexible Funds – 'pausing indexation & achieving efficiencies': $197M in funding cuts (over 3 yrs from 2015-16). Note that this is where current funding for many NGOs comes from.
- Abolition of the Australian National Preventive Health Agency - $6.4M in funding cuts (over 4 yrs).
- Indigenous Affairs Programs 'rationalisation': $ 121M in funding cuts over 4 years. Implications of this measure are unclear.
- $141M in funding in 2014-15 for continuation of the Personally Controlled Electronic Health Record System.

- Defunding of the Alcohol and other Drugs Council of Australia (ADCA) – the national peak body representing the alcohol and other drugs sector, including front line service delivery agencies, researchers, policy makers etc.
- Defunding of the National Congress of Australia's First Peoples – the national voice for Aboriginal and Torres Strait Islander Peoples.
- Defunding of the National Aboriginal and Torres Strait Islander Legal Services (NATSILS) - the national peak body for Aboriginal and Torres Strait Islander Legal Services (ATSILS) - and Law Reform and Policy Officer positions within each State and Territory based ATSILS.
- The Rural Health Education Foundation (RHEF) is shutting down due to a decline in government-contracted work. RHEF provides up-to-date information to health practitioners and consumers via the Rural Health TV Channel and produces online and DVD resources to assist the continuing professional development of health workers and service managers in remote areas.
- Cuts to Family Violence Prevention Legal Services, Legal Aid and Community Legal Centres (policy and reform work), potentially impacting on the effectiveness of frontline legal assistance and the evidence-base of law reform.
- Abolition of the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF) – potentially impacting on compliance with international obligations under the International Code of Marketing Breast Milk Substitutes (WHO Code).
- Abolition of the Immigration Health Advisory Group - which included psychiatrists, psychologists, nurses and GPs - providing independent policy advice on the health needs of asylum seekers and refugees.
- Abolition of the Climate Council (now operating as the donor-funded Climate Council) and the Climate Change Authority – vital to informing Australia's response to climate change.
- Defunding of the First Peoples Education Advisory Group, comprising Indigenous academics and education experts, which provided policy advice to the Australian Government on Closing the Gap in educational outcomes.
- Abolition of the position of Coordinator General for Remote Indigenous Services, overseeing all Government activity relating to the delivery of services to the 29 Indigenous communities under the Remote Service Delivery National Partnership designed to reduce the gap between Indigenous and non-Indigenous Australians.
- Abolition of the position of Independent Inspector General of Animal Welfare and Live Animal Exports – a new statutory authority that was to provide independent oversight of the live export system.
- Abolition of the Australian Social Inclusion Board - and the related Social Inclusion Unit in the Department of Prime Minister and Cabinet - charged with advising the government on how to address education, health and social disadvantage for the most marginalised and disadvantaged Australians.
- 'Winding down' of the operations of the Prime Minister's Council on Homelessness (providing advice to government on the progress, risks and emerging issues in

homelessness) and the Australian Charities and Not-for-profits Commission (the independent national regulator of charities).

- Additional cuts to program funding impacting on NGO service delivery and projects at the local level, for example withdrawal of funding for the Newcastle Ethnic Communities Council's Multicultural Men's Shed

In addition, cuts to public service program areas and staffing – such as the Population Health Division in the Australian Government Department of Health - are of significant concern as they are highly likely to result in a diminished emphasis on key policy and program areas impacting on long term public health outcomes.

Many of the funding cuts appear to be short sighted approaches that do not recognise the health and economic costs associated with the growing burden of chronic disease.

Australia has seen massive cuts to preventive health programs and policies that assist low income earners and the vulnerable in our community since the 2014-15 Budget was released in May 2014. The proposed changes threaten to further erode the low incomes of many families.

Free market economic approaches to health care provision have been shown to widen socio-economic and health inequities. There can be, however, a place for a limited market approach, or private sector, in health care planning and delivery as long as accountability measures are established by governments to ensure that there is no increase in inequity, consumer exploitation or rising health care costs, or that such problems can be identified early and addressed [18, 26, 27].

It has long been said that prevention is better than cure – certainly prevention is cheaper than treatment – and its false economy to cut funding in these areas to achieve short term savings[15]. As it stands, only about 2% of the health budget is spent on prevention – if the Government wants to reduce pressure on the health budget over time, they should actually be looking to increase that figure. Instead, expenditure on prevention is reduced dramatically.

e) the principles that should underpin the provision of social security payments in Australia;

There are many reasons to reduce health inequities as part of broader social security policy in Australia:

- Health inequities are unjust as they are generally not biological, but are determined by factors which are largely outside the control of the individual and are potentially avoidable.
- Health inequities are avoidable and amenable to change: shifts in socioeconomic conditions can change the health of populations in the short term both positively and negatively[15].
- Because of the socioeconomic health gradient, virtually everyone's health can be improved if inequity is reduced[15].
- Health inequities arguably affect everyone's health and wellbeing. The excessive burdens of health and welfare problems such as infectious disease, alcohol and other drug misuse, mental illness, housing insecurity and violence in disadvantaged groups also have adverse health and social impacts on all sectors of society[15].

- There are major economic impacts of social and health inequities. [15] Excess morbidity and mortality directly attributable to disadvantage is a major economic burden, both in terms of increased health and social costs and reduced economic productivitiy. Programs to reduce health inequity can be cost effective and may be propoted on efficiency grounds. Addressing health inequities will also help address the currently increasing burden of chronic lifestyle diseases by assisting in the achievement of key health promotion and prevention goals.
- There is evidence that some relative health inequities may be increasing [20,21,28]. Overall improvements in population health status may obscure the relative lack of improvement or deterioration in the health of some groups, for instance Aboriginal populations.

f) the practical measures that could be implemented by Governments to address inequality, particularly appropriate and adequate income support payments.

Excess morbidity and mortality, self-reported health and risk factors for many chronic diseases are associated with socioeconomic disadvantage [29, 30, 31, 32] and with persistent, systematic social exclusion, and must be addressed outside as well as within the health system.

Providing equal opportunities to access social, economic and environmental conditions and health services that sustain and promote the highest attainable state of health is a fundamental responsibility of governments and societies [33,34].

All levels of government in Australia have a responsibility for the health of all people in Australia, which can be fulfilled only by the provision of adequate social conditions and health services. All levels of government should ensure that public health and health care systems progress towards reducing health inequities through a universal approach for all, with greater emphasis for disadvantaged and vulnerable groups[39].

Innovative public health policies that address health inequities are best framed around the social determinants of health [16, 35]. Interventions to reduce health inequities should also take a life course perspective [40].

Ensuring that people and communities are engaged in decisions affecting their lives, health and wellbeing is fundamental to good health. This is particularly the case for socially and economically excluded populations who are also most likely to have been politically excluded as well. The provision of accurate information and engagement of civil society to promote these objectives are integral to achieving this outcome.

Environmental, health and equity agendas must be addressed together through coherent policy at global, national and local levels, recognising that climate stabilisation, eradication of poverty, and health gains are inextricably linked [36].

The Health in All Policies (HiAP) approach is a key strategy for ensuring that health and well being are core considerations in policy development in all sectors [37].

Reduction in social and health inequity nationally as a result of government policy directives should be recognised as a key measure of our progress as a society. The Australian Government, in

collaboration with the states, territories and local governments, should outline a comprehensive national cross-portfolio and cross-government framework to reduce health inequities. This policy framework should include the following policy objectives:

Reduce social inequity by:

- Ensuring the equal distribution of the social determinants of health is a priority of policies in all sectors;
- Adopting a Health in All Policies (HiAP) approach [37] at all levels of government;
- Recognising that economic inequality is a major health determinant; and
- Undertaking Health Inequity Impact Assessment of significant public policies to eliminate (or reduce) any inequitable impacts and/or to increase equity of impacts and outcomes.

Ameliorate adverse effects of social disadvantage on health by:

- Investing in strategies and programs to support the perinatal period and the early years of life; and
- Working with local communities and governments in disadvantaged regions to increase environmental and social infrastructure and thereby improve health and wellbeing.

Provide public health and health care services, especially to those most in need and disadvantaged communities, by:

- Enabling the participation of disadvantage groups across the continuum of health care including prevention;
- Providing comprehensive Primary Health Care; and
- Providing a high quality, accessible, culturally competent and safe publicly funded health system that includes access to essential medicines and holistic care, particularly for vulnerable, excluded or disadvantaged population groups.

The policy framework should be linked to or incorporated into the National Health Performance Framework endorsed by the Australian Health Ministers' Conference (AHMC).

The Australian Government should work towards correcting inequities in health at the regional and global levels, through policies in all sectors (including foreign policy, development policy, official development assistance and trade policy). This requires both an adequate foreign aid budget and ongoing commitment to work towards achieving the United Nations Millennium Development Goals and the recommendations from the World Health Organization's Commission on Social Determinants of Health [38].

Recommendations

As per the previous submission from the PHAA to the Committee regarding the March 2013 Inquiry report on *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report Closing the gap within a generation*, PHAA's input is grouped into four key priority areas as follows:

Research and Data Needs

Beyond the general need for increased funding support for various forms of public health research in Australia, we suggest that particular areas of research priority include:

- Understanding social determinants of physical and mental health in Australia;
- Evaluation of public health interventions;
- Aboriginal and Torres Strait Islander health research;
- Health and social policy research, to generate evidence regarding what kinds of policy are best placed to support gains in population health and well-being, and improve health equity;
- Health services research, including in primary health care;
- Research on translation of public health evidence into effective public policy;
- Understanding, managing and preventing the adverse health effects of climate change; and
- Examining the impact of trade and macroeconomic policy on health and health inequities.

Further, it is vital that NH&MRC is directed to fund research into these areas, particularly in relation to interventions.

Whole of Government Response

It is essential that Australian governments address the social determinants of health to improve people's health and well-being. This 'Whole of Government' approach should include:

- The Senate Standing Committee on Community Affairs conducting a Senate inquiry to investigate the effectiveness of whole-government policy solutions to address the social determinants of health, and promote mental and physical health and wellbeing;
- Development of a comprehensive policy framework to address the social determinants of health and reduce health inequities;
- Federal and State Governments adopting a 'Health in all Policies' approach;
- Continued implementation of the recommendations of the 2008 WHO report, including:
    - Investment in policies and programs that improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age; and
    - Policies that reduce the inequitable distribution of resources.

Complex Needs and Social Inclusion

PHAA seeks the Australian Government's assistance to break down identified structural and systemic barriers to the development and implementation of comprehensive, multifaceted, cross-sectoral approaches to achieving better health and social outcomes for people with complex needs. We believe that consideration of these issues is vital in progressing the Australian Government's agenda

in relation to adopting a social determinants of health approach and improving awareness of the social determinants of health.

Contribution of the Natural Environment

PHAA believes the Commonwealth should be developing policy responses in relation to the impacts and contributions of the natural environment to health and other inequities. This should be under the leadership of the Department of Health to inform relevant Commonwealth programs and services, the activities of national health agencies, and Commonwealth data gathering and analysis.

Environmental determinants of health and wellbeing should be included in activity to improve awareness of social determinants of health in the community, within government programs, and amongst health and community service providers.

The PHAA further recommends immediate implementation of the five recommendations resulting from the Senate Standing Committee on Community Affairs' 20 March 2013 Inquiry report on *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report Closing the gap within a generation*:

> **Community Affairs Committee: Recommendation 1**
>
> 4.45 The committee recommends that the Government adopt the WHO Report and commit to addressing the social determinants of health relevant to the Australian Context.
>
> **Community Affairs Committee: Recommendation 2**
>
> 4.63 The committee recommends that the government adopt administrative practices that ensure consideration of the social determinants of health in all relevant policy development activities, particularly in relation to education, employment, housing, family and social security policy.
>
> **Community Affairs Committee: Recommendation 3**
>
> 4.71 The committee recommends that the government place responsibility for addressing social determinants of health within one agency, with a mandate to address issues across portfolios.
>
> **Community Affairs Committee: Recommendation 4**
>
> 5.36 The committee recommends that the NHMRC give greater emphasis in its grant allocation priorities to research on public health and social determinates research.
>
> **Community Affairs Committee: Recommendation 5**
>
> 5.38 The committee recommends that annual progress reports to parliament be a key requirement of the body tasked with responsibility for addressing the social determinants of health.

Conclusion

The PHAA appreciates the opportunity to make this submission and looks forward to the possibility of further participation in the inquiry of the parliament into "the extent of income inequality in Australia" by the Senate Standing Committee on Community Affairs.

We hope that during the deliberations that the Community Affairs Committee will be particularly cognisant of the four main areas that we have raised:

- Research and data needs
- Whole of government response
- Complex needs and social inclusion
- Contribution of the natural environment

Please do not hesitate to contact the PHAA should you require additional information or have any queries in relation to this submission.

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References

1. World Health Organization, Commission on Social Determinants of Health, (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. Geneva: World Health Organization.
2. Mackenbach, J., Bakker, M. (Eds.) (2002). *Reducing Inequalities in Health: A European Perspective*. London: Routledge
3. Acheson, D. (1998). *Independent Inquiry into Inequalities in Health Report.* London: The Stationary Office.
4. Graham, H., (Ed.) (2000). *Understanding Health Inequalities.* Buckingham: Open University Press.
5. Commission on Social Determinants of Health (2008). *Final Report – Closing the gap in a generation: Health equity through action on social determinants of health.* Geneva: World Health Organisation.
6. United Nations (2008). *The Millennium Development Goals Report 2008.* New York: United Nations.
7. Homelessness Taskforce, Department of Families, Housing Community Services and Indigenous Affairs (2008). *The Road Home: A National Approach to Reducing Homelessness.* Canberra: Commonwealth of Australia.
8. Kawachi et al. (2002) 'A glossary for health inequalities'. Journal of Epidemiology and Community Health. vol. 56, pp. 647-652.
9. Whitehead, M. (1990) The Concepts and Principles of Equity and Health. Copenhagen: WHO Regional Office for Europe.
10. Kendig, H. and C. Browning (2011). Ageing well in a healthy Australia. ASSA Dialogue, Academy of the Social Sciences in Australia, Canberra, 31(2): 22-30.
11. World Health Organization (2012) The World Health Report 2010. Geneva: World Health Organization. Accessed 28/5/2012 at http://www.who.int/whr/2010/10_summary_en.pdf
12. Reidpath DD, Allotey P. Measuring global health inequity. Int J Equity Health. 2007 Oct 30;6:16.
13. World Health Organization. (2012). World Health Statistics 2012. Geneva. Retrieved from: http://www.who.int/gho/publications/world_health_statistics/2012/en/index.html
14. Department of Health. Tackling inequalities in life expectancy in areas with the worst health and deprivation. Report by the Comptroller and Auditor General, National Audit Office. Prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons Session 2010–2011. Accessed on 07/06/2012 from http://www.nao.org.uk/idoc.ashx?docId=51afdb75-b6b9-4a21-9c6a-9e9475a66333&version=-1
15. Brown L, Thurecht L, Nepal B. The cost of inaction on the social determinants of health, Report no. 2/2012. CHA-NATSEM Second Report on Health Inequalities (June 4, 2012) accessed on 07/06/2012 from http://www.cha.org.au/images/CHA-NATSEM%20Cost%20of%20Inaction.pdf

16. CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.
17. World Health Organization (2012) The World Health Report 2010. Geneva: World Health Organization. Accessed 28/5/2012 at http://www.who.int/whr/2010/10_summary_en.pdf
18. Wilkinson, R. (2005) The Impact of Inequality: How to Make Sick Societies Healthier. New York: The New Press.
19. Australian Institute of Health and Welfare 2008. Australia‟s Health 2008. Cat. no. AUS 99. Canberra:AIHW.
20. Draper G, Turrell G and Oldenburg B 2004. Health Inequalities in Australia; Mortality. Health Inequalities Monitoring Series No. 1 AIHW Cat. No PHE 55. Canberra: Queensland university of Technology and the Australian Institute of Health and Welfare.
21. Australian Institute of Health and Welfare 2008. Australia‟s Health 2008. Cat. no. AUS 99. Canberra:AIHW.
22. Australian Government 2009. Closing the Gap on Indigenous Disadvantage: The Challenge for Australia. Canberra: Australian Government.
23. Psychiatric Disability Services of Victoria (VICSERV) (2008). *Pathways to Social Inclusion Proposition Papers.* Elstonwick, Victoria: VICSERV.
24. From Margins to Mainstream: 5th World Conference on the Promotion on Mental Health and the Prevention of Mental Health and Behavioural Disorders. (2008). The Melbourne Charter for Promoting Mental Health and Preventing Mental Health and Behavioural Disorders. Melbourne, Australia: Global Consortium for the Advancement of Promotion and Prevention in Mental Health (GCAPP).
25. The Garnaut Climate Change Review: Final Report. Cambridge University Press, Port Melbourne.
26. Morone, J. and Jacobs, J. (Eds.) (2005) Healthy, Wealthy, & Fair: Health Care and the Good Society. New York: Oxford University Press.
27. Purohit, B. C. (2001) 'Private initiatives and policy options: recent health system experience in India'. Health Policy and Planning vol. 16, no. 1, pp. 87-97.
28. Australian Institute of Health and Welfare and Australian Bureau of Statistics 2008. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008. (AIHW Cat. No. IHW 21; ABS Cat. No. 4704.0) Canberra: Commonwealth of Australia
29. Brown L, Nepal B. Health lies in wealth. Health inequalities in Australians of working age, Report no. 1/2010. CHA-NATSEM Report on Health Inequalities (September 2010) accessed on 07/06/2012 from http://www.carersnsw.asn.au/storage/pdfs/ebulletin/HealthLiesInWealthCatholicCareReport.pdf
30. Feldman, P., Warr, D., Tacticos, T. and Kelaher, M. (2009) People, places and policies – trying to account for health inequalities in impoverished neighbourhoods. ANZJPH 33(1): 17-24.

31. Backholer, K., Manna, H.R., Magliano, D.J., Walls, H.L, et al (2012) Projected socioeconomic disparities in the prevalence of obesity among Australian adults. ANZJPH DOI: 10.1111/j.1753-6405.2012.00885.x
32. Giskes, K., Turrell, G., Bentley, R., and Kavanagh, A. (2011) Individual and household-level socioeconomic position is associated with harmful alcohol consumption behaviours among adults. ANZJPH 35(3): 270-277.
33. United Nations (1966) International Covenant on Economic, Social and Cultural Rights. Accessed 30/05/2012 at: http://www2.ohchr.org/english/law/cescr.htm
34. United Nations Economic and Social Council (2000) Substantive Issues Arising in the Implementation Of The International Covenant On Economic, Social And Cultural Rights. General Comment No. 14. The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights). Accessed 30/5/2012 at: http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument
35. Commission on Social Determinants of Health (2005) Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health Draft Discussion Paper. May, Geneva: World Health Organization.
36. Friel, S. Marmot, M. McMichael, AJ. Kjellstrom, T. Vagero, D. 2008 Global health equity and climate stabilisation: a common agenda. The Lancet 372: 1677-83.
37. World Health Organization and Government of South Australia (2010) Adelaide Statement on Health in All Policies. Report from the International Meeting on Health in All Policies, Adelaide 2010.
38. Department of Health. Tackling inequalities in life expectancy in areas with the worst health and deprivation. Report by the Comptroller and Auditor General, National Audit Office. Prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons Session 2010–2011. Accessed on 07/06/2012 from http://www.nao.org.uk/idoc.ashx?docId=51afdb75-b6b9-4a21-9c6a-9e9475a66333&version=-1
39. Kickbusch, I and Buckett, K (eds) Implementing Health in All Policies: Adelaide 2010 (Department of Health, Government of South Australia) 2010. P7 (accessed on 29/08/2014 http://www.who.int/sdhconference/resources/implementinghiapadel-sahealth-100622.pdf
40. Australian Institute of Health and Welfare 2014. Australia's Health 2014 p194 (accessed 29/08/2014) http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548150