Building healthy and equitable societies: what Australia can contribute to and learn from the Commission on Social Determinants of Health

Fran Baum and Sarah Simpson

Introduction to the Commission on Social Determinants of Health

The Commission on Social Determinants of Health (the Commission) was launched by the World Health Organization (WHO) in 2005 and will complete its initial work by reporting to the World Health Assembly in May 2008. The commissioners comprise 20 leading innovators in science, public health, policy making and social change to support countries and global health partners to act on social factors leading to ill-health and health inequalities. In addition to the commissioners, there are five streams of action:

1. Organisation of knowledge to inform health policy proposals and action on the social determinants of health, through nine knowledge networks (KNs).
2. Demonstrating and highlighting the opportunities and possibilities of action, which is being formalised in country partnership agreements and action plans – the country work stream.
3. Social mobilisation and long-term political sustainability of the social determinants of health (SDH) agenda, which is being organised through an extensive civil society process.
5. Developing the plan for institutional change at WHO so that it can also provide long-term support to countries in advancing the SDH agenda after the Commission has ended.1,2

The Commission brings an impetus to national, regional and international efforts to act on the social determinants of health in order to improve health equity. Its focus is not only on knowledge about the impact of social determinants on health and what can be done to make the health impact more health promoting (KNs will develop inventories of policy and program actions), but also on taking action through the civil society and country work streams. The country work stream involves more than 10 countries and, at the time of writing, partners include Sri Lanka, Chile, Canada, England, Sweden, Kenya, Iran, Brazil, and Bolivia.

The Commission is paying attention to what it can learn from previous experience to improve health equity, particularly:

1. The enabling factors that will result in change upstream.
2. Identifying existing programs, policies and initiatives that can, have or are improving health equity.
3. How to move from theory to practice – collecting knowledge that is policy and advocacy relevant.3

Australia has significant knowledge and experience in the area of social determinants and the Commission offers an important opportunity for Australia to have an input on existing and previous programs and policies. It is important that the

Abstract

The Commission on Social Determinants of Health (the Commission) was launched by the World Health Organization in 2005. It aims to support countries and global health partners to act on social factors leading to ill-health and health inequalities. Taking action on the social determinants of health is not new for Australia. This paper provides a description of the work of the first 18 months of the Commission and relevant Australian examples. Taking action on the social determinants of health is never simple or easy even in the most supportive of policy environments. The global focus of the Commission should ensure that knowledge and examples of successful action will be collected from a diverse range of country and policy environments, particularly low to middle-income countries. Given Australia’s experience, we encourage practitioners to contribute to the deliberations of the Commission. It is also critical that Australian practitioners engage with the Commission’s different actors and stakeholders, particularly knowledge networks, to derive important policy lessons from the knowledge generated by the Commission.
opportunity is taken to contribute Australian knowledge to this
global process to ensure that the knowledge and experience
collected is contextually relevant. Without input from Australia,
the findings of the Commission will be less easily translated into
action, particularly where context is critical. Thus the focus of
this paper is on looking at the present and future implications
of the Commission’s work for Australia, especially in terms of
action to improve health equity.

Policy attention to social determinants
in recent Australian history

Attention to the social determinants of health is not new for
Australia. State and federal governments have been investing in
activities that promote health since at least the Second World
War. The conservative Menzies Government, which was in
power for 18 years, had a program of action that stacked up very
well against the areas that the Commission has defined as
important to health. These initiatives included a high top
marginal tax rate (compared with contemporary rates),
investment of state resources in crucial infrastructure including
roads, schools and public housing, and a full employment policy.

In the early 1970s, during the three-year term of the Whitlam
Government, many of the changes introduced reflected a strong,
progressive social determinants of health approach across many
sectors. Key examples were the Community Health Program, which
foreshadowed many of the messages of the WHO 1978
Alma Ata Declaration that launched Health for All by the Year
2000; making university attendance free; and an Australian
Assistance Plan that focused on social development.

At State government level, the Dunstan Government of the
1970s in South Australia brought about many changes that
improved the quality of life for poorer South Australians and for
the first time gave land rights to Indigenous Australians (a crucial
determinant of health) and used social planning to develop
communities. The Menzies, Whitlam and Dunstan governments are
each examples of periods when governments were prepared to
invest government resources in nation building with measures
that tended to have equitable outcomes. This approach to nation
building was progressively lost from the 1980s, when a small
government and economic rationalist policy direction came to
dominate thinking about public policy in Australia. Despite
this, there have been some important developments that have
attempted to keep a focus on health inequities and the crucial
role social determinants have in policies designed at reducing
them.

A few of these initiatives are described to demonstrate that as
well as its nation-building legacy in the three post-war decades,
Australia has further examples of progressive thinking about the
social determinants of health.

Equity policy in New South Wales

In 2004, New South Wales (NSW) Health released the NSW
Health and Equity Statement In All Fairness, a policy statement
that included actions that could be taken by the health sector
within NSW to improve health equity – including working with
other sectors. The statement was developed on the premise
that while knowledge of action that could be taken to improve
health equity was not perfect, the ‘glass was half full’ and so in
All Fairness provides a framework for NSW Health to build on
existing work.

A key aim of the policy is to integrate equity into the core
business of NSW Health. There are six key focus areas for action,
from which strategies have been developed:

1. Investing in the early years of life.
2. Engaging communities for better health outcomes.
3. Developing a strong primary health care system.
4. Regional planning and intersectoral action.
5. Organisational development.

While the statement has not been fully implemented, it has
provided a foundation document for practitioners to act by
consolidating what they know, as well as a mandate for some to
strengthen their efforts. It has also contributed to strengthened
or new action (particularly at the organisation or system level)
to increase the equity focus of the system. For example, the
NSW Chief Health Officer’s Report provides data on equity
and so practitioners have a mandate to act on and monitor
action to improve equity. One example of a new initiative is the
NSW Health Impact Assessment (HIA) project, a five-year
investment to build capacity in developing healthy public policy
through the use of HIA for improved policy/program development.

The Commission is well aware that action on the social
determinants is not new and is particularly interested in what
can be learnt from previous experience to improve health equity.
Therefore, a valuable contribution to the Commission would be
to reflect on what works, what doesn’t work, and what could
be strengthened in developing and implementing a state policy
to integrate equity into the health system. A more detailed
assessment of the NSW equity policy that answers these
questions would be one that the Commission’s country partners
would find particularly useful.

Family violence

Since the 1980s, federal and State governments have introduced
a series of policies and campaigns designed to reduce domestic
or intimate partner violence. These policies, especially at the
State level, have had a strong intersectoral flavour and have
provided shelters for women and children leaving violent
relationships, trained police in appropriate responses, re-
educated the judiciary with the message that violence in the
home is a crime and should be treated as such, started campaigns
to encourage people to disclose sexual abuse, and then increased
institutional determination to prosecute perpetrators. This
concerted cross-sector and jurisdiction approach has meant that
domestic violence and child sexual abuse are no longer hidden
and are widely seen as determinants of health and responded to
as such.
Community health services

The community health sector (started as a result of the Whitlam Government's Community Health Program in 1973) has left a strong legacy in Victoria and South Australia. In both these States, investment in this sector continued once Commonwealth funding was withdrawn. These centres have been innovators in terms of action on the social determinants of health. Examples of this work are described in the collection on South Australia in Baum, nationally in Legge et al., and in relation to women's health centres in Broom.

Data for social determinants

Australia has also been a trailblazer in producing information to support a focus on the social determinants of health. The first Social Health Atlas was published in 1990 and since then atlases have been published for Australia as a whole and for States and Territories. They include a broad range of data on social inequity in general and on health inequity and provide an important policy tool for governments that want to monitor their progress on reducing inequality.

Data on health inequities has also been produced by Turrell, Oldenburg et al., in association with the Health Inequalities Research Collaboration (which was funded by the Federal Government) and subsequently in association with the Australian Institute of Health and Welfare. While these documents do not address social determinants to any significant degree, they are important in documenting the extent of inequities that other evidence indicates is largely a result of the impact of social determinants. Australia, therefore, has a sound knowledge base from which to act and is ahead of many other nations that may not even have vital registration systems, let alone data on the extent of inequities.

Implications of the Commission for Australia in the future

Our considerations of the implications of the Commission for Australia are provided in terms of action in and outside of the health sector.

Outside the health sector

The Commission is well aware that action on the social determinants of health requires a whole-of-government approach and particularly the backing of the head of state in recognition that their support would be essential to any national effort on social determinants. As part of their regular meetings, the commissioners meet with the government of the country hosting the meeting including the head of state, minister for health and other ministers including ministries for planning, education and employment. By the end of 2006, the commissioners will have met in Chile, Egypt, India, Iran, Kenya and Brazil.

An equity focus in healthy public policy

For Australia, the importance of whole-of-government approaches is relevant to each jurisdiction – federal, State and local. Building healthy public policy requires cross-sectoral approaches with the involvement of communities. Increasingly, HIA is being used to strengthen the development of healthy public policy with a focus on health inequities. HIA is a structured process for improving a proposal by providing decision makers with information on potential health effects (positive and negative, intended and unintended) and recommendations for improving the proposal, thereby contributing to improved policy development. Australia has been a leader in the development of environmental health frameworks where health effects are usually considered as part of environmental impact assessment processes.

More recently, Australia has explored the use of HIAAs for policy development. This has resulted in a range of activity at both the State and national levels, including the development of a framework for the systematic consideration of equity in each step of HIA, the equity-focused health impact assessment (EFHIA) framework. The framework for EFHIA provides practitioners of HIA (within or outside of the health system) with a structured approach for identifying the potential differential effects of a proposal on the health of specific groups within a population and to assess if these differential effects are inequitable (unfair, unjust and potentially remediable). The framework was tested in six sites in the Australian context.

The work of the Commission provides an opportunity for further testing of the EFHIA framework, including by working with the Commission's country partners to undertake EFHIAs of their proposed new or revised programs to address the social determinants of health, and/or undertaking EFHIAs of programs recommended by the Commission's knowledge networks. Australian practitioners could benefit from such exercises because they can add knowledge about the relevance and applicability of such frameworks in different policy contexts.

Importance of social solidarity

Action on the social determinants of health is not a value-free enterprise. It is unlikely that a government will be committed to take action unless it has a philosophical belief that equity results from government action (rather than it reflecting individual agency) and a belief that increasing social solidarity is an important goal of government. Stretton has noted the growing individualism of Australian governments of the past two decades. He notes that investment in increasing a fairer Australia will rely on government action within the following policy areas: employment, housing, explicit policy support for child rearing (he proposes a parental wage), health, education, and income distribution. His solutions depend on increasing government intervention, financed by increased taxation for the purpose of investment in these areas. The investment would be explicitly targeted to reduce inequities and increase social solidarity. While increasing taxes may not seem a feasible policy option, there is evidence that Australians are becoming more willing to pay higher taxes if it means better investment in health and education services.

With thanks to Dr. Baum and Dr. Simpson for the opportunity to contribute to this volume of the journal.
Some State governments are clearly committed to the value of social solidarity through working to build it through government policy on social exclusion. The South Australian Government has a Social Inclusion Board supported by a unit. Key goals are to reduce homelessness, increase school retention and improve the inclusion of people with mental illness in society. The Department of Victorian Communities is developing a range of projects to increase social inclusion and strengthen local communities. The Commission’s civil society work might provide some useful insights for Australian practitioners on how to improve social solidarity, particularly knowledge from civil society organisations that operate in constrained political environments.

Need for planned, vision-driven approaches

Beyond this broad policy picture, which is crucial to shaping policy responses, action on the social determinants will depend on co-ordinated policy and practices responses. At State level, broad strategic plans that integrate social determinants into a statewide response appear a very sensible approach. The article by Newman, Baum and Harris (this issue) describes the way in which the South Australian strategic plan incorporates several equity indicators and provides a framework for action to improve the social determinants of health across all government sectors. It appears to give public servants a sense of the way their particular work contributes to making their State a better place to live. In that sense, it is akin to the Healthy Cities projects that have stressed the importance of a sense of vision to creating healthy communities.

More locally and regionally, we suggest that a series of multi-agency healthy community initiatives should be funded. These should draw on the lessons from the WHO Healthy Cities project, the Local Agenda 21 initiatives, and other projects that stress cross-sector working with meaningful community involvement. Funding would be for 10 years (given our knowledge of the limitations of short-term project funding) and granted to communities where a range of agencies and organisations express a desire, keenness and energy to work together to promote health and well-being with a focus on equity and a range of social determinants. Drawing on lessons from Healthy Cities, the establishment of a change catalyst unit that would work with local agencies and communities to facilitate and encourage local initiatives is likely to be important. The change catalyst unit would draw up a vision and action plan with a built-in monitoring and evaluation cycle including impact evaluation. It would be valuable to our own efforts to test these proposals with the Commission’s different actors, particularly the knowledge network on urban settings and other country partners.

Within the health sector

Health sectors have responsibility for protecting and promoting the health of the communities they serve. In Australia (like elsewhere), it has tended to be the health sector that advocates for action on the social determinants of health. But this advocacy generally comes from the margins of the system – public or community health workers. In the main, health systems spend the vast majority of their time planning for and managing acute hospital services. The sector is most properly described as the illness care system. A key platform of the Commission is that health systems should be taking a major role in advocating for and encouraging the action across sectors to improve social conditions that have an impact on population health status and the distribution of health. The article in this issue by Newman, Baum and Harris shows that each State and Territory is taking at least some action on these issues, but that there is significant room for more concerted action.

Health promotion as a discipline in Australia has strong roots in behavioural understandings of health. Appreciating the limitations of behaviourism is an important aspect of achieving health promotion action on the social determinants of health. This will require retraining and including much more about the social determinants of health in medical, nursing and other health discipline training courses. A very positive sign is that the Australian Health Promotion Association has taken a strong stand on the social determinants of health. For health promoters to be able to implement a health promotion approach based on social determinants, however, requires organisational change of a quite significant nature within our health service organisations. These are still largely based on medical understandings and elevate the importance of curative interventions and at best pay lip service to the importance of social factors as determinants of population health. The work of the Commission will act to strengthen the hand of the increasing number of health promoters keen to base their work on an understanding of the ways in which social and economic factors affect people in their day-to-day lives. For instance, there is a strong focus on treating and preventing chronic disease in all Australian jurisdictions. Most effort focuses downstream and the Commission’s work will point to the importance of understanding the more distal determinants of chronic diseases if the projected epidemic is to be curtailed.

Most health promoters and other health professionals who engage in health promotion, such as general practitioners, will work at a local or regional level and typically will find that the actions that they can take concerning the social determinants of health is limited. What is crucial, however, is that programs and initiatives are planned in a way that appreciates the constraints people face in changing their behaviour and that the health promoter engages in action to remove the structural constraints to healthy behaviour. Thus, in a remote Aboriginal community it is little use telling people to eat a healthy diet if their community store stocks a lot of high-sugar drinks and high-fat food and only sells very expensive fruit and vegetables. A key role for the health promoter in this case is to advocate for improved food supply. Many health promotion programs still have a strong focus on directly changing behaviour, despite the evidence that doing so meets with very limited success especially with people living in disadvantaged economic and social conditions.

Health Promotion Journal of Australia 2006 : 17 (3)
circumstances. The Commission's message that behaviours are strongly shaped by social and economic circumstances is one that health authorities across Australia need to hear and act on in the design of all health promotion initiatives.

The focus of the ninth Commission knowledge network is on priority public health conditions, including non-communicable and therefore some chronic diseases. This aims to review the equity effectiveness of public health programs (including poverty initiatives) and ultimately to improve the equity focus so that health outcomes are equitably distributed across the population. The network is just being established and Australia could easily contribute case studies (for example, taking an equity focus in the design of services for people with diabetes) and/or learn about integrating an equity and social determinants focus into primarily behavioural health promotion programs.

The special case of Indigenous health

The most burning area in which Australia needs to take urgent action to address social determinants of health is in relation to Indigenous health. There are many statistics that document the vast differences in health status between Indigenous and non-Indigenous Australians, but perhaps one of the most telling is that while 70% of Indigenous peoples die before they are 65, only 21% of non-Indigenous Australians do so. The Co-operative Research Centre in Aboriginal Health (CRAH) has adopted the social determinants of health as one of its five core program areas (the others are primary care health, chronic disease, social and emotional well-being and healthy skin). This approach clearly says action inside and outside the health sector is crucial and acknowledges that access to health services is, in itself, one of the social determinants of health. The CRAH Program Statement for the Social Determinants uses work from the Commission to justify and support its case and notes that the conditions set by employment, education, housing and other physical infrastructures are crucial to improving health status. The physical infrastructure in many remote Australian communities is appalling – the housing is often inappropriate to the harsh, remote conditions, basic infrastructure such as plumbing and drainage does not work, food choices are extremely limited and expensive, poverty levels are much higher than in the general population, there is little to engage young people, and employment opportunities are very limited.

The CRAH Program Statement also sees racism as an important and under-researched influence on health status. The history and legacy of more than 200 years of colonisation, including periods in which children were stolen from families, is a fundamental social determinant that has to be understood in order to inform action on Indigenous health. So much of this history has meant that Indigenous people have had very little control over their lives and our recent knowledge indicates that lack of control is bad for health. We hope that mutual learning can be encouraged between the Commission and researchers and practitioners in Indigenous health in Australia. To this end, it is hoped a workshop on Indigenous health will be held with the Commission in Australia in 2007.

Conclusions

In conclusion, it is clear that Australia has a strong basis from which to act – both in terms of our sound data on health inequalities and knowledge of actions on the social determinants of health that do work or show promise. Australia can make an important contribution to the work of the Commission and global knowledge on how to act, including contributing case studies to the knowledge networks and connecting with country partners and civil society organisations. Such contributions will help ensure that the Commission findings are more contextually relevant to Australia. There are lessons to be learned from practitioners who make a difference while operating in resource and policy environments that are significantly more constrained than the Australian environment.

The work of the Commission offers an important opportunity for Australian health promoters and health promotion researchers. The Commission is creating a network of activity on the social determinants of health by bringing together researchers, civil society activists, policy makers and health promotion practitioners in a way that encourages dialogue and the development of innovative ideas. This should lead to new forms of policies and action around the world. We are not saying that this is simple or easy. However, Australia's experience means it is well placed to both make a crucial contribution to these discussions and to benefit from the Commission's deliberations.

References

1. For more information about the Commission's work streams and in particular details of the scope of the INSO visit the Commission website at http://www.who.int/social_determinants/en/ (accessed 12 October 2006). (See also Contact details for knowledge networks of the WHO Commission on Social Determinants of Health, p. 173 in this issue of the Journal.)
3. Irwin A, Scall E. Action on the Social Determinants of Health: Learning from Experience. Geneva: Commission on Social Determinants of Health (CSDH); World Health Organizations; 2005
Policy

What Australia can contribute to and learn from the CSHDH


34. To make a contribution or find out more about the Commission's knowledge networks visit the Commission's website and/or contact Sarah Simpson, Coordinator Knowledge Networks, at simpson@who.int

Authors

Fran Baum, Department of Public Health, Flinders University, South Australia
Sarah Simpson, Commission on Social Determinants of Health, World Health Organization

Correspondence

Professor Fran Baum, Department of Public Health, Flinders University, GPO Box 2100, Adelaide, South Australia 5001.
Tel: (08) 8204 5983; fax: (08) 8374 0230; e-mail: fran.baum@flinders.edu.au

Health Promotion Journal of Australia 2006; 17 (3) 179