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# Federal, State and Territory government responses to health inequities and the social determinants of health in Australia

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## Introduction

*Inequalities in health are of concern to all countries and represent one of the biggest possible challenges to the conduct of government policy.*<sup>1</sup>

An important part of the social determinants in health agenda is the quest to reduce health inequities through planned action by governments. This concern has a considerable history with strong roots in the 19th Century, evident through the work of such public health reformers as Rudolf Virchow in Upper Silesia<sup>2</sup> and the British social reformers such as Rowntree. More recently

the British Black Report published in 1982,<sup>3</sup> although soundly rejected as a basis for policy by the Conservative Thatcher Government, did provide a clear agenda for governments that wanted policies that might reduce inequities. In Australia, concern about health inequities has been shown federally through reports and initiatives in the past two decades that were concerned about the impact of social determinants in maintaining health inequities.<sup>4-8</sup> These reports have made several policy recommendations.

Through the 1990s, as evidence accumulated to indicate that

## Abstract

**Issue addressed:** Planned actions by governments can play an important part in addressing the social determinants of health and health inequities. We assess the extent to which Australian health departments are committed to health equity as a core value, and the extent to which strategic directions and policies show evidence of action and achievement in reducing health inequities and attention to the social determinants of health.

**Methods:** Key documents guiding each health department since 2000 were sought from a key informant in each jurisdiction (State/Territory/federal). An analysis was made of the content in terms of stated values, strategies, objectives, intended and current initiatives, collaborations, funding, and reporting of achievements in relation to the reduction of health inequities and the attention accorded to the social determinants of health.

**Results:** All jurisdictions are explicitly or implicitly committed to reducing health inequities and to addressing the social determinants of health to at least a limited extent. The extent of commitment varies from those who make a clear statement of the importance of achieving health equity at both whole-of-government and health department level, to others who have extremely limited commitment. There is also variation in the extent to which directions are transformed into planned initiatives to improve health outcomes or access to health services for disadvantaged groups or areas, and variations in the degree of monitoring and evaluation.

**Conclusion:** Although substantial health inequities exist in Australia there is explicit or implicit recognition of the underlying value of equity within all jurisdictions and some policies designed to increase health equity in all. However, in most jurisdictions health equity could be more explicitly incorporated into core government and health department strategies and initiatives, and there is room for the development of the capacity to monitor change over time in access to services, quality of care, and improved health outcomes.

**Key words:** Health inequities, social determinants of health, governments, Australia.

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## So what?

Reinforcement of fairness and equity as core values of Australian society is the responsibility of governments supported by civil society. The health sector should provide leadership and evidence of the impact of social determinants on health and equity. A National Health Equity Framework should be developed to encourage comprehensive and co-ordinated national action.

health inequities were increasing both within countries and between countries,<sup>9-11</sup> more and more governments have expressed concern with this issue and a determination to do something to reduce them. Much literature has described the inequities and the underlying reasons, but there has been less focus on what action should be taken. When announcing the formation of the Commission on the Social Determinants of Health at the 2004 World Health Assembly, the late director-general of the World Health Organization said: "The goal is not an academic exercise, but to marshal scientific evidence as a lever for policy change – aiming toward practical uptake among policy makers and stakeholders in countries." This clearly is the key challenge in regard to health inequities.

An important aspect of the quest for practical uptake is the assessment of existing policies. This issue of the journal shows that reducing health inequities will require concerted action across many sectors. Although the health sector is likely to make only a relatively small contribution to the reduction,<sup>12,13</sup> it nonetheless has an important role to play especially in providing leadership and evidence of the relationships between health and the social environment.

There have been no recent systematic assessments of the policies of Australian health jurisdictions relating to health inequities and this paper sets out to address this gap. The paper describes the methods used to do this and then summarises plans and action from State, Territory and Federal governments to assess the extent to which they are recognising and addressing health inequities.

## Methods

The chief health officer, chief medical officer or executive director of each Australian health department was identified as a key informant and was asked to provide the key strategic documents that they felt had been guiding their health department's strategic directions since the year 2000. This person was also asked to identify any documents or policies specifically aimed at reducing health inequities. Although initial inquiries were to this person, they or their department often nominated a delegate to provide the documents. All recommended documents were analysed.

However, in some instances additional documents were also analysed (such as a health department's annual report, State-level health indicator documents, or recent reviews of the health system). This was done in order to make a more detailed assessment of attention to health equity issues if this was not evident from the documents nominated by the department, or if these documents were mentioned within the documents provided and appeared relevant to the review questions. The main emphasis was on analysing documents that the health department staff felt were influencing their directions, and not on analysing the same types of document for each department.

A review framework was developed to analyse documents in two main ways. First, it sought to determine whether health equity was a driving value in the documents, whether documents

used language consistent with an understanding of equity and the social determinants of health, and whether there was an explicit or implicit commitment to reduce health inequities. Second, it considered whether commitment was reflected in general or specific actions or plans, whether there were initiatives and a funding allocation directed at reducing health inequities, and whether there was infrastructure to support equity action (such as staffing or tools). Initiatives targeted at the areas of early childhood or refugee health were used as indicators of the responsiveness to health equity issues because these were felt by the researchers to be issues of particular contemporary relevance.

The resulting summaries were checked with the key informant and with an 'equity-friendly policy commentator' (mostly university academics) in each jurisdiction. The review framework, full-length summaries and documentary references for each jurisdiction are available at [http://som.flinders.edu.au/FUSA/PublicHealth/AHIP/projects\\_list.htm](http://som.flinders.edu.au/FUSA/PublicHealth/AHIP/projects_list.htm). The analysis is based on documents that were publicly available up to and including August 2006; where the word 'Aboriginal' is used this does not necessarily exclude people of Torres Strait Islander background.

## Results

This section provides results in two parts. The first section discusses the extent to which jurisdictions have made progress on addressing health inequities, as judged on the basis of the documentary evidence outlined above. A continuum of progress was identified from those jurisdictions exhibiting a strong philosophical commitment to equity and health equity and demonstrating this with concrete initiatives, to those where the strength of value commitment was less clear and where funding allocation or planned actions could be made more evident. All jurisdictions acknowledged the need for collaborative work with other sectors to improve health, and to consult with 'the community'. The second section of the results provides short summaries for each jurisdiction, emphasising strengths and areas for improvement.

Those jurisdictions whose documentation suggests that they have made the most progress in concrete action to reduce health inequities are New South Wales, Victoria, South Australia and Tasmania. Their progress is evidenced in two main ways. First, there is a commitment to health equity as a value at both State Government and health department level, with documentation explicitly using language that is consistent with an understanding of the social determinants of health and health inequities. A commitment to reduce health inequities is written prominently into the values, mission, strategies and objectives in their State strategic plan and/or their health department strategic documents. In the best circumstances, the health department draws directly on the State-level plan to formulate health department priorities and targets, and then reports these back in a State progress report. Drawing on these directions to prioritise actions, there are planned and evaluated initiatives to reduce differences in health outcomes between named groups

or areas and/or to address the broader social determinants of health.

Second, these jurisdictions show a commitment to re-orient the government and the health system to address equity issues more widely, and health inequities in particular, recognising that health is both a foundation of, and an indicator of, an economically prosperous and socially harmonious society. In these ways, both commitment to health equity and the development of concrete actions are clearly evident.

These jurisdictions are also committed to developing a wider support base and structure to address health equity. They have mechanisms to collect and report on state-wide health indicators, including indicators of the distribution of health and disadvantage that can be used in health equity targets and evaluations. They also have strategies or objectives to build capacity to better understand the causes of health inequities and to identify the most effective interventions and initiatives. They are allocating significant funding specifically to reduce disadvantage, or are redistributing funding under population-based models. Those most serious about reducing health inequities are aiming for health equity to become integrated into 'core business', and for all government initiatives and policies to be reviewed using an 'equity filter'.

Those jurisdictions that have not made as much progress are the Australian Capital Territory, Western Australia, Northern Territory, Queensland, and the Federal Department of Health and Ageing. Their documents either show little or no evidence of a clear commitment to equity as a value, or to health equity in particular, either at whole-of-government or health department level, and they do not overtly use health inequities language or talk about the social determinants of health.

In some jurisdictions, their chronic disease or healthy lifestyle strategies take an equity focus that may reflect greater levels of understanding within these policy areas of the substantial burden of disease related to health inequity and the need to directly address the social determinants of health in program implementation. Furthermore, while some jurisdictions do clearly state a commitment to address health inequities, this commitment does not necessarily pervade their strategic directions or targets in such an obvious way, nor to the same extent, as the jurisdictions that have made better progress. It is also more difficult in the documents of these jurisdictions to track how ideas of equity are informing policy, initiatives, funding or measurable targets to improve health outcomes or access.

The following summaries outline specific aspects of each jurisdiction.

### New South Wales

The Office of the Chief Health Officer of New South Wales (NSW) recommended a range of documents that state "equity in health" to be "a major goal for the NSW Government" and "a core value of NSW Health". These values, and a commitment to improve health for "health-disadvantaged groups", are reflected in the *Planning for the Future*<sup>14</sup> consultation documents.

The department's new health plan for the next 20 years, which is to be developed from these, will hopefully continue to reflect a clear commitment to reducing health inequities. The values are also reflected to some extent in the state government's draft *State Plan*,<sup>15</sup> which, although it does not set improved health outcomes as a clear priority (in the same way that the Victorian and South Australian State documents do), does acknowledge the need to improve health for specified groups and for areas of "entrenched disadvantage", and aims to address some social determinants of health.

Goals in the Health Department's current *Strategic Directions*<sup>16</sup> include "fairer" access and "fair" allocation of health funding and resources across health areas. The department also states a commitment to strengthen policies and programs to address inequalities in health status and to undertake initiatives to reduce health inequities in specific communities (particularly Aboriginal communities). Some examples are the Housing for Health Program for Remote Aboriginal Communities, and funding for Community Health for Adolescents in Need, an early intervention and primary health care initiative for young homeless people. Documents identify a variety of other health-disadvantaged groups, including children and refugees.

The *Chief Health Officer's (CHO) Report* included a chapter on refugee health indicators in 2004, and the department funds the NSW Refugee Health Service and initiatives such as promotion of HIV prevention to African refugee communities. Trends in key health indicators are provided in the CHO Report and department *Annual Report*, with some disaggregated for example by area, rurality, Aboriginality, socio-economic status, and country of birth.

New South Wales has the most comprehensive range of structural supports to encourage health equity, including a health and equity statement (*In All Fairness*)<sup>17</sup> to provide direction for planning, a resource distribution and funding formula to allocate resources between the eight health areas on the basis of population numbers and degree of disadvantage, and funding for research to further the understanding of health inequalities and to strengthen links between research and policy/practice. The department also supported a NSW Health Promotion Directors' Equity Project that resulted in the *Four Steps Towards Equity* toolkit<sup>18</sup> to embed health equity into health promotion practice. It encourages local health services to develop 'health and equity profiles' in their health plans to identify where action is needed, and encourages review of existing initiatives using an 'equity filter' and review of 'best-buy' policies and practices to address health inequities. The department sees itself having an important role in advocating for a reduction in health inequities in the broader public policy arena.

While some evaluation is conducted, for example the three-year review of the NSW Aboriginal Maternal/Infant Health Strategy, which showed some increases in the proportions of Aboriginal mothers using antenatal care and reductions in Aboriginal perinatal mortality and prematurity, the health and equity statement's recommendations need to be advanced to

allow NSW to further develop its capacity to assess whether actions and investments are reducing health inequities.

## Victoria

The Victorian Department of Health's health inequalities project officer recommended a range of documents and these clearly demonstrate a strong overarching philosophical commitment by the Victorian Government to reduce disadvantage in general and health inequities in particular. This commitment is reflected in the strategic directions and key objectives of the Victorian Department of Premier and Cabinet's State Strategic Plan (*Growing Victoria Together*<sup>19</sup>), and those of the Department of Human Services (DHS) and the Department of Health (DH), which include, for example, "disadvantage in health, education and housing will be reduced".

The Victorian Government also has a specific action plan to reduce disadvantage.<sup>20</sup> Documents in general define and describe disadvantage, health inequalities and groups with greater health problems, including children and refugees. Responsibility for leading action on reducing health inequities is allocated to the DHS and VicHealth (Victorian Health Promotion Foundation) through developing programs, building capacity in health equity knowledge, and advocating for health equity in the wider arena. A significant amount of funding is clearly directed by the Department of Premier and Cabinet to reducing disadvantage and it is easy to identify a range of actions and projects under way to address the social determinants of health and health inequities. The Neighbourhood Renewal Program is one obvious major initiative in this regard.

Nevertheless, monitoring and evaluation of progress is mixed, with some measurable indicators used (e.g. increases in life expectancy), and improvements reported for some groups or areas (e.g. rural/urban), but not always for more obvious groups such as those with low income. While objectives and achievements are reported in annual progress reports, the impact of actions is often described retrospectively or measures are based on change in numbers of services/patients or numbers of projects established, rather than on change in health-related indicators. Victoria could strengthen and refine evaluation and monitoring systems that report its progress in addressing health inequities.

## South Australia

The South Australia (SA) Department of Health's executive director of Health System Improvement and Reform recommended a range of State Government and departmental documents guiding the department's directions, including *South Australia's Strategic Plan*.<sup>21</sup> Collectively, these show a clear commitment at both government and department level to improve overall standards of living to support and reflect State prosperity, as well as a specific commitment to the Government's health reform agenda and to action on issues of inclusion, equity and health inequality. This includes addressing the social determinants of health and targeting scarce resources to "the most vulnerable" to improve health and well-being and "close

the gap in outcomes". Although strategies and plans address early childhood health, refugee health is not mentioned.

What clearly stands out for South Australia is that the Health Department's priorities for action link in with the overall philosophy and specific health targets in the State strategic plan, and the department therefore has actions that direct resources to improve access and equity in health. Nevertheless, disadvantage and health inequalities are most obviously defined and described in the resource documents *Inequality in South Australia*<sup>22</sup> and the *Social Health Atlas of South Australia*,<sup>23</sup> although these inequities are not necessarily clearly addressed in the Government's (and hence department's) generally worded targets.

The State Government sees responsibility for health equity vested in both itself and the general community, and there are strategies for collaborative partnerships, cross-agency work and community participation to improve health outcomes. There is retrospective description of relevant initiatives and funding, although fewer initiatives addressing health equity and the social determinants of health are evident when compared with NSW and Victoria. The Department of Health commits to influence other government departments to have a positive impact on the social determinants of health, and to develop health strategies to address inequities in the State strategic plan's target areas for which the department has lead responsibility.

Other planned actions include developing population-based funding models and integrating health targets into the State budget process. Monitoring and evaluation of health-related targets in the department documents and South Australian strategic plan is to occur biennially based on quantitative indicators, although, as with other jurisdictions, inclusion of more specific variables to identify health improvements in particular disadvantaged groups or areas would improve transparency of progress.

## Tasmania

The Department of Health and Human Services' (DHHS) manager of the Policy Unit in Community Population and Rural Health recommended five documents, including the vision for the State – *Tasmania Together* – which was developed at the request of the Premier by an independent board through community consultation.<sup>24,25</sup> These show some attempt to align strategic directions and outcome indicators with those of other Tasmanian and national policies, but not to the same extent as in South Australia and Victoria. The documents do demonstrate a commitment by the Tasmanian Government to improve overall health and well-being, as well as improving living standards and health for the disadvantaged, but health equity is not as explicit in the values, objectives and outcome measures in DHHS or broader government documents as it is in other jurisdictions.

Furthermore, the health inequities language that is used in DHHS documents is not reflected to the same extent in whole-of-government documents. There is nevertheless still a strong emphasis on the social determinants of health and the

importance of social capital in creating a healthy, harmonious and economically prosperous state. The DHHS has responsibility to improve overall health and to reduce disparities in the impact of chronic conditions between groups. Health inequities are defined and discussed in the DHHS documents, and groups at risk of greater health problems are identified.

Events in early childhood are seen as crucial to lifelong health, and the achievement of a major reduction in the prevalence of cigarette sales to children is highlighted. Immigrant groups are also identified as at increased risk of disadvantage and poorer health. Departmental and government-level objectives aim to improve health outcomes through action on the social determinants of health and through access to health services. Some objectives are clearly linked to measurable targets and *Tasmania Together* has specific benchmarks (e.g. annual percentage reductions in proportion of population living below poverty line).

Other documents give examples of initiatives such as the Health-Promoting Schools model, or quantify increase in services, but not all clarify whether disadvantaged groups are targeted and quantitative indicators to measure improvement are not always included. Improving data collection and the monitoring and evaluation of priorities and change in health indicators is a future objective, although some documents (e.g. *Food & Nutrition Policy*<sup>26</sup>) already have an associated action and monitoring plan. Documents acknowledge the importance of working collaboratively across sectors to address complex problems, and one of the most striking aspects for Tasmania was the very broad community consultation underpinning *Tasmania Together* and its review. Discussion of funding is patchy, although the DHHS is to develop annual work plans for the Aboriginal Health Plan, which includes annual resource allocation.

### Australian Capital Territory

Three documents were provided from the Department of Health by the Office of the Chief Health Officer. They show the Australian Capital Territory (ACT) Government having achievement of health equity as a value and being committed to addressing health inequities through action on the social determinants of health. This reflects the Government's vision for health, which includes a community that is "inclusive" and "fair". The aims are to maintain good health for the whole population while working to "narrow the gap in health outcomes" experienced by disadvantaged and vulnerable groups. Some documents provide health indicators but these are not disaggregated by socio-economic status. Ensuring equitable access to appropriate health services is also intended. However, the aim to increase coverage of private health insurance may well widen the health gap in the ACT and reduce the acceptability and possible quality of public hospitals if they come to be seen as a residual service. The ACT Government states an intention to be open and accountable about resource allocation, but the need to shift the mix and allocation of resources is only mentioned in relation to the increasingly ageing

population. The ACT documents acknowledge the need for cross-sectoral approaches to address health inequities, and the Health Department is seen as having a lead role in this.

However, intentions to "narrow the health gap" are not overtly translated into plans or actions that clearly target the disadvantaged groups mentioned. Refugee health is not mentioned, although there is an intention to prevent the worsening of detainee health. The most explicit action in the ACT is in regard to Aboriginal health, where the ACT Government commits to intersectoral work. The ACT Government and Health Department's commitment to reduce health inequities could be better evidenced in concrete actions, along with more intensive reports of monitoring and evaluation of equity in health outcomes.

### Northern Territory

For the Northern Territory (NT), the senior policy officer, Health Services Policy Branch, recommended one main document guiding the Department of Health & Community Services' (DHCS) vision from 2004 to 2009 (*Building Healthier Communities*).<sup>27</sup> The department's latest annual report was also reviewed.<sup>28</sup> What is most noticeable when compared with the other jurisdictions discussed so far is that strategic directions and core priorities in the NT documents do not explicitly mention health inequalities or health inequities, or link with any higher-level philosophical commitment by the Government to equity as a value.

However, health inequities are implicitly addressed in the obvious emphasis given to improving the "unacceptable situation" in health that exists for the Aboriginal population (29% of all NT residents in 2001). The social determinants of health are also discussed implicitly when mentioning the need to provide "health hardware" and to address the many pathways to health such as through schools, jobs, housing and justice. There is, however, no clear allocation of responsibility for health equity in the NT Government or DHCS and no specific health equity documentation. The department does aim to improve overall health and services, and to improve health outcomes for those with poorer health, and there is a stated aim to not only increase social and physical access to services, but to improve technological access to health promotion and prevention information, particularly for rural and remote communities.

*Building Healthier Communities* has 10 core strategic areas targeting specific groups, particular behaviours, or particular service issues. Children's early-years health is one of the 10 key areas, but refugees are not mentioned at all (although this is not surprising considering the minimal number of refugees moving to the NT). Both within *Building Healthier Communities* and the DHCS annual report, the impact of actions is described retrospectively or measures are based on change in numbers of services or new projects, rather than measuring change in health-related targets.

Documents also do not mention specific funding mechanisms

to address inequities or provide transparency of funding allocation for each priority. Despite a focused commitment to achieve improved health outcomes for the Aboriginal population, NT documents could go further and explicitly introduce social determinants and health inequities language, identify funding allocations for specific initiatives, and have clear monitoring and evaluation processes.

### Western Australia

For Western Australia (WA), the Department of Health's senior policy officer, Population Health Policy Branch, and manager of State-Commonwealth Relations recommended 11 government documents plus the *Healthways Strategic Plan* (Health Promotion Foundation). Documents exhibit a commitment to improve health for all and to work for equitable and fair treatment and access to health services. However, while some documents talk of the need to address the social determinants of health, WA has only patchy acknowledgement of the need to address health inequities and improve equity of health outcomes. This is despite the Reid Review of the WA health system including "reduce inequities in health status" as the second point in its first of 86 recommendations.<sup>29</sup>

Health Department priorities that focus on disadvantaged settings and groups are clearly mentioned in some documents (e.g. the *Aboriginal Health Strategy* and *Eat Well Strategy*), and most clearly in the *Healthways Strategic Plan*.<sup>30-32</sup> The WA Department of Health would exhibit a clearer commitment to reducing health inequities if it were to enact the Health Review recommendation to emphasise in its vision and mission the values of "equity and justice" and an aim for health improvement for "Indigenous, rural and remote, and disadvantaged populations", and to explicitly highlight these in strategic documents and funded initiatives. Children are targeted in several strategies, and planned initiatives include assistance to newly arrived families. Support for refugees is most obvious in the *Substantive Equality Framework* (although this focuses mainly on reducing racism) and in *Languages in Health Care*, which focuses on improving access to health care.<sup>33,34</sup> Some WA initiatives directly target non-Aboriginal groups (e.g. a free tuberculosis screening program for migrants), although initiatives addressing disadvantage most obviously aim to target the Aboriginal population. Targeted initiatives, such as one which encourages breast screening for Aboriginal rural women, could be duplicated for other disadvantaged groups such as refugee women.

WA shows little evidence of plans that are resulting in concrete health improvements for disadvantaged groups, and few measurable health targets with allocated funding. The overall absence of targets may reflect the lack of data disaggregated by indicators of disadvantage, or the annual report focus on service provision rather than health outcomes. Future department plans include improved data collection and performance evaluation, and the Health Review recommended an annual epidemiological report on health in WA. These could help develop more targets that could enable performance progress

to be regularly evaluated in relation to the reduction of health inequities.

The Department of Health also states an intention to move from resource allocation based on submissions to population based resource allocation, although this is not yet developed.

### Queensland

The director of the Policy and Development Unit, Population Health Branch, recommended six documents for Queensland, but pointed out that Queensland Health is redrafting its directions following a health systems review. The Queensland Government and Health Department have documents outlining broad objectives that include "a fair, socially cohesive and culturally vibrant society", and which note the need to address social determinants of health and reduce "disparities in health" between groups. The latest *Strategic Directions 2006-2011*<sup>35</sup> does not include equity as a fundamental value but does include "equitable health outcomes" as a strategic direction, and "equity" as a key performance indicator (albeit with no details of measurement).

The Health Department ascribes itself a leadership role in supporting "wider socio-economic health improvements opportunities". While some department documents talk of health inequalities, "equity issues for people in low socio-economic circumstances" and the need for targeted programs to improve health for disadvantaged groups (particularly for the Aboriginal population and for rural and remote areas), there are no obvious benchmark targets that clearly aim to reduce health inequities in other disadvantaged groups. There is also some discrepancy between indicators reported in *The State of Health of the Queensland Population*,<sup>36</sup> which highlight certain health inequities, and policy directions that do not clearly address these. As an example, *State of Health* notes that suicide rates are higher in socio-economically disadvantaged areas and are affected by social factors such as poverty, yet Health Department strategies to prevent suicide do not target socio-economically disadvantaged groups or areas.

The *Smart State: Health 2020* document and *Chronic Disease Strategy*<sup>37,38</sup> have plans to start developing responses to equity issues, but other documents focus more on areas of illness and increasing the funding of services and numbers of staff. Examples of initiatives that do target the social determinants of health and disadvantaged groups include the Community Renewal Program and the Child Health Partnership Project with Rio Tinto, which will introduce preventive measures to reduce antenatal exposure to smoking and alcohol in Aboriginal communities. Children's health is also targeted, including in a specific *Aboriginal Children's Health Strategy*,<sup>39</sup> and refugee health in the *Multicultural Action Plan*.<sup>40</sup> The latter reports on "local activity directed at specific disadvantaged groups" and gives details of a refugee health clinic in Logan and the Nourishing New Communities project to help settlement agencies familiarise refugees with healthy eating and kitchen safety.

Queensland Health has plans to develop funding models based

on population and health data, and health targets for strategic health improvement. Monitoring and evaluation programs are just being established, and these could include clearer articulation of achievements in addressing or improving health equity for both Aboriginal and non-Aboriginal disadvantaged groups and areas.

### Federal

The senior adviser, Population Health Division, Federal Department of Health and Ageing, recommended a range of key documents, including the *Corporate Plan*, *Annual Report* and *Portfolio Budget Statement*.<sup>41-43</sup> Compared with the health inequities language and commitment that is evidenced extensively in the documents of some State-level jurisdictions, the federal documents exhibit scarce mention of health inequities and the social determinants of health. The *Portfolio Budget Statement* does make passing comment about improving health for “low income Australians” to be comparable with that of the general population, yet this is not obviously reflected in any vision or mission statements, strategic directions, initiatives, funding or outcome measures, except for Aboriginal people.

The *Corporate Plan* notes the need to improve health outcomes, health access and quality of life for the Aboriginal population, the aged, and rural communities, but does not mention socio-economically disadvantaged groups in general. Some quantitative targets are set to generally address social determinants of health (e.g. “greater than 86% of secondary schools participating in ‘MindMatters’ mental health literacy program”), but this is not linked to improvement in disadvantaged groups or areas (again, except for Aboriginal people). Indeed, most progress indications are reports on a selection of positive achievements, rather than measures against benchmarks.

As with other jurisdictions, data highlighting health inequities by socio-economic status (for the national level produced by the Australian Institute of Health and Welfare) is therefore not reflected in performance outcomes to make progress transparent. The main departmental contribution to improving outcomes and access for low-income groups is implicit in the desire to maintain accessibility to affordable health care through funding of the Medicare universal health system and the Pharmaceutical Benefits Scheme.

However, the annual report notes that the Medicare Benefits Schedule still requires more equitable distribution between localities. As with some other jurisdictions, while there is no obvious health equity documentation, the *National Chronic Disease Strategy*<sup>44</sup> does include some discussion about the social determinants of health and the importance of inclusion, strong communities and healthy environments. It also notes the disproportionate prevalence of chronic disease for certain groups, including the socio-economically disadvantaged, and has a key principle which includes “reducing health inequalities” and a key direction of “focusing on health inequalities” in prevention and intervention initiatives.

The Department of Health was a key developer of this document, to which the Australian Health Ministers’ Advisory Council (AHMAC) contributed under the aegis of the National Health Priority Action Council and the National Public Health Partnership. The document’s perspective on equity is not linked to any stated fundamental commitment to equity at the whole-of-government level. It would be encouraging to see a national health equity strategy or framework alongside the plethora of other national strategies and frameworks that are guiding health directions in Australia.

### Discussion and Conclusion

This review of health equity policies being developed and used by Australian governments suggests that all jurisdictions have an implicit or explicit recognition of the underlying value of equity and at least some policies designed to increase health equity. All jurisdictions, in at least some of their policies, pay attention to the importance of social determinants in influencing health outcomes and health access. The vital importance of improving Indigenous health status is recognised in each jurisdiction. Our study suggests that some jurisdictions (New South Wales, Victoria, South Australia and Tasmania) demonstrate a higher level of commitment to social justice principles and have more equity-friendly policies than others. The study also highlights the important role that State governments can play in advocating for a whole-of-government commitment to health equity, and the important role that the Commonwealth Government plays in ensuring continued access to health services through such universal programs as Medicare and the Pharmaceutical Benefits Scheme. As a nation we have made progress in attempting to prevent and redress health inequity, but initiatives need to be preserved and strengthened.

Our review leads to the following conclusions concerning ways in which commitments and policies to reduce inequities could be strengthened:

1. Governments have a responsibility to recognise and reinforce fairness and equity as core values of Australian society. Civil society groups (such as the Australian Health Promotion Association and the People’s Health Movement – Australia) have an important role in advocating for them to do this. Promotion of these values will encourage citizens and corporations to take action in the interests of equity. Regulations will be required in some instances. The creation of an equity climate is important to encourage health systems to be proactive within their services and programs to increase equity and also to invest in whole-of-government initiatives. Public and private debates about values are essential to creating this kind of climate. Such debate is being actively encouraged by the editors of this journal.
2. Key programs of cross-sectoral activity should be identified within each State and nationally where there is potential to make long-term investments that will result in improved equitable health and social outcomes for the community. This approach is preferred to investing in a series of short-



- term pilot projects. Potential long-term initiatives include investing in early childhood, measures to include more people in employment, and locally based and locally driven healthy community projects (see also article by Baum and Simpson in this issue). These long-term initiatives should be well monitored and evaluated, and government departments should be required to collect and report on health equity indicator data.
3. Jurisdictional networks of staff (which also include key academic groups) should be established with responsibility for equity-related programs, to pool expertise, to develop capacity across the health system and, in the longer term, to develop links with other sectors. Our documentary review indicates that the involvement of academic groups outside the bureaucracy appears to encourage the inclusion of health equity language, the commitment to social justice and detailed understanding of the social and economic determinants of health.
  4. Each jurisdiction should commit explicitly to health equity in their values, mission, goals and strategic directions, and should reflect this in well-funded, long-term programs of work to improve health and reduce health inequity.
  5. Each jurisdiction should continue to develop specific, high-profile and well-funded strategies to address health inequities between Indigenous and non-Indigenous Australians that are based on principles of solidarity and principally designed by Indigenous peoples.
  6. The implementation of health equity impact assessments should be funded and encouraged as a means of accountability and monitoring of cross-sector policies that have an impact on health and equity.

If each measure were implemented in each jurisdiction in Australia, then the outcome in 5-10 years should be measurable reductions in health inequities. The adoption of these measures would be significantly helped if the Federal Government were to develop a national health equity framework that was endorsed by AHMAC and included incentives. Funding should be provided through the agreements between the Federal and the State and Territory governments to implement the list of measures above.

After five years, a Senate Select Committee Review could report on the Federal Government's progress and similar review processes should be held in each jurisdiction. In addition, the chief medical officer in each jurisdiction should report on progress to reduce inequities in their annual report. As a final comment, the authors draw attention to the conclusion of a similar study for Europe<sup>45</sup> that, at the macro level, policy makers need to work to ensure that "strategies to tackle the macroenvironmental factors feature in policy on inequalities in health, and to ensure that health becomes a prominent issue in social justice policy". The European Community is in the process of implementing a 'Health in All Policies' statement and Australia would be well serviced by designing and enacting a similar initiative.<sup>46</sup>

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