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“Never mind the logic, give me the numbers”: Former Australian health ministers’ perspectives on the social determinants of health

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Abstract

The articulation of strong evidence and moral arguments about the importance of social determinants of health (SDH) and health equity has not led to commensurate action to address them. Policy windows open when, simultaneously, an issue is recognised as a problem, policy formulation and refinement happens and the political will for action is present. We report on qualitative interviews with 20 former Australian Federal, State or Territory health ministers conducted between September 2011 and January 2012 concerning their views about how and why the windows of policy opportunity on the SDH did or did not open during their tenure.

Almost all ex-health ministers were aware of the existence of health inequalities and SDH but their complexity meant that this awareness rarely crystallised into a clear problem other than as a focus on high needs groups, especially Aboriginal people. Formulation of policies about SDH was assisted by cross-portfolio structures, policy entrepreneurs, and evidence from reviews and reports. It was hindered by the complexity of SDH policy, the dominance of medical power and paradigms and the weakness of the policy community advocating for SDH. The political stream was enabling when the general ideological climate was supportive of redistributive policies, the health care sector was not perceived to be in crisis, there was support for action from the head of government and cabinet colleagues, and no opposition

from powerful lobby groups. There have been instances of Australian health policy which addressed the SDH over the past twenty five years but they are rare and the windows of opportunity that made them possible did not stay open for long.

Keywords: Australia, social determinants of health, health equity, political economy of health, health ministers, health policy

Introduction

The final report of the World Health Organization (WHO) Commission on the Social Determinants of Health (CSDH) consolidated evidence on the social determinants of health (SDH) and reiterated their importance in determining both overall population health and the distribution of health within and between countries (CSDH, 2008). Recognising that evidence by itself was unlikely to bring about policy change, the report also called on heads of national governments to provide leadership and adopt a whole-of-government approach to tackling SDH. However, the health sector was seen to have special stewardship responsibilities to take account of SDH in its own actions and advocate for other sectors to address the health impacts of their policies. Here we report on qualitative interviews with former Australian health ministers concerning their views about how and why the windows of policy opportunity on the SDH did, or did not open during their tenure.

The Australian political and social context

Australia has a liberal-democratic, federal system of government, consisting of the Commonwealth (national) Government, six State and two Territory governments (hereafter, 'States'). The Commonwealth government holds most of the revenue-raising capacity while States are responsible for delivering most public services. Over several decades, national and State governments have been controlled by either the social-democratic Australian Labor

Party (ALP) or a conservative coalition of the Liberal Party and the smaller, rural-based National Party (Woodward et al., 2010).

State governments manage public hospitals and other public health services and the Commonwealth funds general medical practice. In 1984 a federal Labor Government introduced Medicare, a universal public health insurance scheme which has remained central to the health system despite measures introduced by subsequent Coalition governments which have increased reliance on private health insurance (Duckett, 2007). The potential for differences of ideology and political interest between levels of government, along with the division of responsibilities for health, have provided fertile ground for blame-shifting and regulatory complexity (Woodward et al., 2010).

Despite State and Commonwealth interventions over several decades, and gains in land rights and political recognition, significant gaps remain between Australia's Indigenous Aboriginal and Torres Strait Islander peoples (hereafter, 'Aboriginal people') and non-Aboriginal people in life expectancy, chronic disease, education, employment, smoking and access to health services (AIHW, 2012). The relatively poor health of Aboriginal people reflects a history of colonisation, dispossession, paternalism and economic marginalisation. A national strategy to 'Close the Gap' includes health service, education and employment interventions (Baum et al., 2012).

Poverty (as measured by those living on less than half the median income) has slightly increased in Australia over the last decade and in 2012 stood at 12.3% (ACOSS, 2012) while the peripheries of Australia's major cities contain pockets of extreme disadvantage. Income inequality in Australia has increased in recent years and Australia remains one of the six most unequal countries in the OECD (OECD, 2011) despite a cultural perception of egalitarianism.

Continuing health inequities

Despite a history of evidence, enquiries and statements about SDH and health inequity (DHSS, 1980; CSDH, 2008; WHO, 2011), and while average life expectancy continues to increase, progress is uneven and inequities are increasing both within and between countries (Labonté et al., 2007; Stamatakis et al., 2010). In Australia, persistent health inequities are evident in the ten year gap in life expectancy between Aboriginal and non-Aboriginal people, and in a socio-economic health gradient (AIHW, 2012). Despite this, there have only been limited policy responses addressing health inequities and progress has been uneven across jurisdictions (Newman et al., 2006). Dahlgren and Whitehead (2006) noted that health policies often focus on increases in average health status rather than reducing inequities. Many (e.g. Baum, 2008; Blackman et al., 2010; Bryant et al., 2010; Carter et al., 2009) also argue that biomedical, individualised views of health excessively influence health policy and detract from actions to improve population health. Taken together, the long history of evidence on SDH and the failure to reduce health inequities clearly points to the need for research that asks why there have been so many political and policy failures in relation to action on SDH.

Theories of policy making and policy action

Exworthy (2008) elaborated on the complexity of taking policy action on the SDH by noting it requires a long term perspective, has trouble making attributions of change to specific policies, and involves decisions and non-decisions by multiple agencies and stakeholders with interconnected policy programs. Exworthy et al. (2003) and Collins et al. (2007) recommended a political and policy theory lens to understand why the policy processes that lead to action on the SDH have often been marginalised.

Theoretical perspectives of policy making as a rational process directly informed by evidence (Anderson, 1984) are not supported by empirical observation, and contrast with Kingdon's (2011) 'multiple streams' theory which argues that policy action on an issue is most likely when the three streams of problem definition, policy formulation and political will converge. In Kingdon's view, prospective policies are drawn from a 'primeval soup' where ideas are constantly being developed and floated. Kingdon also gave a central role to 'policy entrepreneurs' who use any available windows of opportunity to advance ideas. He saw policy development as messy and driven by the ideologies and values of key actors. Lewis (2005) showed how Australian health policy networks are imbued with a bio-medical ideology, supporting studies on the ideological underpinning of public health policy by Tesh (1988), who demonstrated that 'hidden arguments' determine the nature of policy. In particular she highlights the individualism that is implicit in much United States (US) health policy. Consequently, modern policy analysis frequently follows Bacchi's (2009) work by asking 'what's the policy problem' and deconstructing the ways in which policies are developed from unspoken values.

In researching the influence of evidence on policy in Canada, Lomas and Brown (2009) found that complex forces compete with research for the attention of civil servants and politicians and that research evidence is variably received at different stages of policy development. Other research has shown how research collaboration between academics and policymakers facilitates translation of evidence into policy (Best et al., 2009; Howlett, 2009), but it tends to underplay Kingdon's insights about political support and timeliness as a vital feature of policymaking. Knowledge translation and knowledge exchange models appear naïve unless they can recognise the role of political will. DeQuincy and Reed (2007) argued that political will has been understudied in public health policy and needs more attention. Our qualitative study presents empirical information relevant to theoretical debates about political

and other factors influencing translation of evidence into policy. It reports on the views of twenty former health ministers about policy opportunities during their tenure to address SDH and health inequities.

Methods

Health minister interviews

This study is based on qualitative interviews with 20 former Australian Federal, State or Territory health ministers, conducted between September and December 2011. There were 38 health ministers who met the study criteria: having held office for at least two years between 1985 and the time of sample (May 2011), and not currently in parliament. The research team identified initial contacts for 37 of these from their own knowledge, publicly available records via an internet search, or via the former minister's political party. One had died and one was in jail. Direct contact was made with 25, of whom 20 agreed to be interviewed, four did not respond and one declined. Eighteen were interviewed face to face and two by telephone. Thirteen of these represented the Australian Labor Party (ALP) in government, six the Liberal Party, and one was an independent (in a Liberal government). Four were national health ministers and the remaining sixteen were from State and Territory jurisdictions. The final sample contained a higher proportion of members of the ALP than the original 38 but contained sufficient diversity to adequately represent the position of health minister within Australian national and State governments over the last quarter of a century. The interviews began with questions about the health ministers' foci and achievements and their role in cabinet. Then, we asked about the respective roles of evidence about public health, SDH and health inequalities, and the role of medical professionals and interest groups in influencing their actions on policy. A draft of the schedule was sent for review to Hon.

Monique Begin, Canadian Federal Health Minister between 1977 and 1984, a Commissioner on the CSDH, and social science academic. Her review resulted in some revisions and the introduction of an additional set of questions about the media. All interviews were conducted by PL who drew on his knowledge and experience of Australian health policy. Prior to each interview he researched policy documents relevant to that minister to ensure probing questions and an informed discussion of each minister's period in office. Interviews lasted 40 to 90 minutes, with most approximately 60 minutes. We recognise the potential limitations of interviews identified by Patton (2002: 306) including possible distortion due to personal or political bias, or recall error which may also be influenced by the length of time since the events discussed occurred. However, we also note that subjects in this research are often discussing events on the public record, used to being interviewed by people who check facts, and were deliberately chosen as former politicians no longer subject to the possible constraints of an active public office. A number of subjects have also written accounts of their period in office or kept diaries, which they may have referred to in preparing for the interview. Ethics approval was granted by Flinders University Social and Behavioural Research Ethics Committee.

Analysis

Interviews were digitally recorded and transcribed verbatim then sent as text to the relevant ex-Minister to read, approve and clarify where required. We then thematically analysed the transcripts drawing on Ritchie and Spencer's (1994) stages of familiarisation with data, development of coding frameworks using targeted and emerging themes, coding, and charting and mapping. Qualitative analysis software (NVivo 9) was used to manage data and organise the coding. Each member of our research team read all transcripts. Our coding frame was developed iteratively as we read the transcripts and developed new codes. Each

transcript was then coded by two team members. After double coding, each transcript was discussed in detail by the two team members involved and agreement reached, involving the full research team if necessary. Our thematic analysis was shaped by the theoretical framework of Kingdon which enabled us to code for accounts of the problem, the policy, the political stream of influences and the role of policy entrepreneurs, networks, values and ideologies. A draft of this paper was sent to each health minister for checking and advice on whether there was potential to identify people inappropriately. Only one minister requested a change and this was to shorten a quote to make the meaning more transparent.

Results

Ministers' perceptions of social determinants and equity

All former ministers claimed explicit awareness of inequalities in health outcomes or risk factors between population groups during their tenure; especially mentioned were inequalities between Aboriginal and non-Aboriginal people, or between low SES groups (or areas) and the rest of the population. Only a small minority used the concept of a health gradient driven by SDH and, of those, two commented that this awareness had developed since their period in office. Only a very small minority of interviewees spoke in explicit terms about health being determined through combined effects of multiple social factors; or about structural, economic and social factors influencing the distribution of social advantage/disadvantage and health across populations. Again, these appeared to be perspectives acquired or more fully developed after the period as Minister:

It was a period before some of the broader social determinants of health problems began to emerge; for example, arguments about how public transport, housing,

related to public health, which has become of much more interest since that period. We were more concerned with, I suppose, a narrower view of preventive health. (Commonwealth, Labor, 1980s)

Despite the 1980s being seen in this way as a period characterised by a “narrower” view, the only example (described below) of a minister really paying serious attention to the SDH and explicitly talking extensively about a social health agenda came from that period. For the rest of the health ministers health inequity was seen in terms of the poor health of disadvantaged groups and they rarely spontaneously used the language of SDH except in response to prompts and in relation to Aboriginal health. Nearly all expressed strong appreciation that action on the SDH in relation to the health status of Aboriginal Australians was essential, as it could not be addressed through better targeted and better resourced health care services alone:

Indigenous health was clearly an area where social determinants were far more important than any service the Health Department might or might not deliver... in the absence of really substantial investment in housing and infrastructure in the remote areas in particular there wasn't going to be much improvement in the quality of peoples' lives. (Federal, ALP, 1990s)

Extent of action on the social determinants

While nearly all health ministers demonstrated some understanding of the importance of SDH, they took limited explicit actions to address them in order to promote health or improve health equity. Table 1 divides the action reported into three categories: improving access to health care; implementing public health policies informed by an understanding of the SDH; and policy initiatives aimed at addressing and modifying SDH that sit outside the health sector. Only a very small minority reported action in the latter category.

One exception was an ALP State health minister from the 1980s who had developed a Social Health Strategy and a range of inter-sectoral work. The reasons for the successes of those that managed to take action on the SDH and the barriers to others doing so are discussed below.

Table 1: Actions on health equity reflecting an understanding of SDH reported by health ministers

Jurisdiction	Improving access to health services especially for disadvantaged	Public health policies informed by understanding of SDH	Action on SDH
State & territories	Relocation of hospitals to area of high socio-economic disadvantage	Needle exchange	Adoption of Social Health Strategy
	Deinstitutionalisation of mental illness care	Support for vulnerable groups in changing lifestyles	Leadership of government social justice strategy
	Expansion of PHC services beyond medical care	Harm minimisation as basis of drug policy	Support for community health sector to take local action on SDH
	Improving rural health services	Tobacco control measures	Cross-sectoral human services committees
	Improving Aboriginal access to services	Strengthening infrastructure and capacity for health promotion	Establishment of VicHealth and its work on health equity and SDH
	Health Rights Commission	Healthy lifestyle campaigns Nurse home visiting for newborns and targeted early childhood support program	Reforms to Aboriginal housing in remote communities
Common-wealth	Introduction of Medicare providing universal access to primary medical care and public hospitals	National strategies developed in consultation with affected groups (e.g gay men and HIV/AIDs)	Better Cities Program to improve urban infrastructure to promote population health equitably
	National rural health program to increase access	Better Health Commission to translate WHO goal of health for all by year 2000 to Australia	
	National Aboriginal health policies		
	Women's Health program		
	Immunisation Program leading to increased uptake		

Enablers and barriers

Box 1 summarises the factors affecting action on the social determinants reported by the health ministers and these points are expanded on below.

Box 1: Factors affecting action on the SDH

Views on individual or structural determinants of health status

Availability of convincing evidence necessary but not enough

Political ideology

Competition between interest groups influencing health policy

The power of the medical lobby in the health portfolio

Policy entrepreneurs and policy communities for SDH are weak

The power to affect SDH often lies outside the purview of the health portfolio

Political factors need to align and create window of opportunity for action on SDH

Individual or structural responsibility for health status?

Most of the contemporary discourse on SDH locates responsibility for health primarily in the political, economic and social structures and forces that shape peoples' lives. Nearly all the ministers reflected current public health debates on the complexity of the interaction between individuals and the structures constraining their agency and argued the importance of tackling underlying causes:

The problem is that if you don't attack the root cause of why they got addicted in the first place they'll be back to it in no time at all so you need those sorts of social programs that try to attack... or indeed you need to look at the individual, why the individuals go on heroin, and it may not be anything to do with because the kids around the street did it, it maybe something to do with some problem in the family... (State/Territory, ALP, 1990s)

A minority of health ministers (all from the politically conservative Liberals) explicitly framed the problem of health inequities in terms of individual responsibility:

I sought to try and help, assist, source, both Indigenous Aboriginal organisations that were into preventative health – preventative ill health perhaps is a better way to say it – in other words, people taking responsibility for themselves with assistance
(State/Territory, Liberal, 1990s)

The ministers more inclined to action on the SDH were most likely to see peoples' health as largely shaped by factors outside individual control. These philosophical positions related to the ways in which they viewed evidence on the SDH.

The role of evidence in policy-making

Nearly all former Ministers said they were aware of evidence on health inequalities during their tenure, and many described it as motivating and supporting the kinds of policy actions outlined in Table 1. Within the cabinet, ministers described population health evidence as an important tool for making an argument for new policy, sometimes in the face of strong opposition from colleagues:

Well it [evidence] was certainly pivotal for me because I needed to have a defensible framework to work from and if it wasn't based on best evidence of the day then I was vulnerable because, you know, 'why aren't you doing this?' or 'why are you doing that when there's no evidence to support it?' (State/Territory, ALP, 2000s)

However, a majority of ministers also took a circumspect view on the role of evidence in policy decisions, such as:

Evidence is a lovely idea but it's got to actually fit with the direction or the trendy issues of the time or the direction of the government at the time. Evidence doesn't dictate health policy, never has and possibly never will. It backs up policy directions.

(State/Territory, Liberal, 1990s)

Thus, evidence was seen as helpful but certainly not sufficient for success without timely political support; a view summarised by a minister who quoted a former Senator as saying 'never mind the logic, give me the numbers'.

Ministers also explained that, for them, some of the most compelling evidence would specify solutions not just problems, and while there was good evidence for the existence of health inequities, evidence was less robust (and more contested) on what works to reduce them:

A good advocacy group is somebody who comes to you with the data, with the evidence, with the solutions... they understand the importance of being able to give government a solution that will work within their policy parameter....

(State/Territory, Liberal, 1980s)

The ministers' accounts are consistent with Kingdon's view (2011) that evidence describing a problem, unless accompanied by policy options that are seen as feasible, political opportunity and powerful supporters, is unlikely to produce policy change. These forms of political pragmatism also appeared on occasion to reduce the range of evidence-informed policy options to those compatible with the ideology of those in power at the time. For example:

The public health community has done nothing that I can see to dispel the myth that this desire, to have a Marxist command economy, and I'm being extreme. If anything it's potentially counterproductive and it comes back to, I think – you know, public health is not enormously practical and, yes, there's this great world movement on

social determinants of health but, you know, to what end? We're all going to have a Swedish social democracy? I don't think so. (Federal, Liberal, 1990s)

Thus the ministers saw public health evidence as a necessary part of policy making but, not surprisingly, these former politicians were also conscious of limitations on the role of evidence in the face of their political 'realities' and ideological values.

Political ideology

All health ministers' accounts suggested that underlying ideologies affected the extent to which they championed action addressing health equity through action on the SDH. A small number made clear statements about supporting the redistributive role of the state:

I take the view that health and education are the prime redistributive mechanisms today to look after people, not as a safety net but if you've got a brilliant public education, brilliant public health system then you're well down the path towards having a more egalitarian society. (State/Territory, ALP 2000s)

Having had a look at a lot of literature in a range of fields, those things like poorer education, unemployment or areas where people have low control over employmentthe single most important determinant is inequality and that's a set of economic policies and Australia has kidded itself for quite some time that we're an equal society. (ALP, Federal, 1990s)

Two ministers from the 1980s felt that the 1970s were characterised by a more wide-spread commitment to the idea of resource redistribution and regretted that this had changed in the ensuing decades. One noted:

I was a bit unfortunate in that I was there in the 1980s. In the 1970s there'd been a great spirit of generosity abroad but in the 1980s the bean counters were back in control, by and large... I mean people talk about progressive taxation now as though it's creeping socialism... There's no longer a commitment to redistributive income justice. (State/Territory, ALP, 1980s)

Federally, while the 1980s saw the introduction of some elements of a neo-liberal economic agenda – favouring market de-regulation, privatisation of government services, etc. – there remained a strong commitment to a socially progressive agenda by the then Federal Labor government. This was marked by the *Accord* – an industrial relations agreement between employers, trade unions and the government – and this broader policy environment provided the ideological support for the introduction of Medicare, Australia's universal health insurance scheme. Thus the Minister noted:

Medicare was central to the government's economic program. It was part of the social wage commitment to the trade unions, part of the commitment to get restraint into real wages. (Federal ALP, 1980s)

This was a clear statement of the role of the health sector in increasing access to health care within a broader program of action on social equity. These reforms rested on a broader commitment to social justice, pragmatically linked to an economic reform agenda.

Competing interest groups

Every health minister made it clear that their health policy agendas were 'crowded' (Kingdon, 2011) with many demands, and influenced by competing and conflicting interest groups. Each highlighted the dominance of the demands of the acute health care sector and described with regret how that constant pressure left them unable to take adequate action in

other areas. The State-level ministers were most pressured, being principally responsible for health service delivery in the Australian system. These comments convey the pressure experienced by nearly all these ministers:

It's acute services, always acute services, always the tragic case or accident and emergency or elective surgery waiting lists... I mean there's a million of those and they always end up right smack dab on the front page with the microphone in your face. (State/Territory Liberal, 2000s)

From what I've observed, the job of many Ministers for Health has been to keep the lid on things and put out the inevitable bushfires and even then it's just pouring money into stopping the emergency waits and reducing elective surgery lists – you know, it's all the acute sector because that's where the media and the political noise of powerful stakeholders unite to get political action. (State/Territory, ALP, 2000s)

Ministers' accounts identified many specific ways in which the constant threat of an acute care crisis had crowded other issues off the health policy agenda or effectively prevented long term planning for action on social determinants.

This meant that a policy area outside the provision of health care services was unlikely to surface from Kingdon's 'primeval soup' without strong support from a minister. Even a minister very strongly convinced of the importance of prevention recounted difficulties in bringing it to the policy agenda:

I found there was a huge emphasis - I discovered on the first day as a minister - on the tertiary hospitals and on the emergency situations and on doctors being able to push their campaigns for additional funding based on care... I found that the

emphasis on prevention in health was almost non-existent. (State/Territory, ALP, 2000s)

Another lamented that despite their aim of increasing access to health services by reorienting the system to primary health care:

... you had these huge – I think it was the federal minister who called them ‘cathedrals’ – built and expanded and expanded and expanded and it was ‘we are here, bring us the work’, not ‘take the services to the people’. I would very much indeed like to have driven the other model of ‘take the service closer to where the people are’. By all means of course keep the tertiary services in a tertiary setting but secondary particularly, and primary, should be where the people are.... I’m sad that I was never really able to do that. (State/Territory Liberals 1990s)

Each minister recounted stories of how health became a front page story when doctors’ lobby groups spoke to the media about how lives would be threatened by a change to service provision or failure to allocate more funding to acute care from an already stretched health budget. About half described how, in this environment, their efforts and successes in public health could not compete:

...it doesn’t change the fact that what will be on the front page of the paper is the fact that there was an eight hour wait in accident and emergency, not the fact that 90 something percent of kids are immunised or that our AIDS infection rates were falling or all of that sort of stuff. (State/Territory, Liberal, 1990s)

It seemed that, for these ministers, in the face of a very crowded policy agenda, the policy influence of the acute care sector and lack of comparably powerful interest groups arguing for

action on prevention and SDH meant that policy in the latter areas was nearly always pushed to the margins.

Medical power within health portfolios

This dominance of the health portfolio policy agenda by the concerns of acute care leads straight to the question of who holds power within the health portfolio. Account after account described how doctors and their professional bodies, especially the Australian Medical Association, wielded considerable power over decision making in both Labor and Liberal-led governments, and used it to ensure the health minister's focus remained on providing acute care services. There were many examples of this; shown most clearly by a Minister recounting his experience after deciding to close a trauma centre in one hospital and centralise services at another:

Well, the doctors went berserk. Particular doctors went berserk and there was a demonstration of 2500 people at [location] Entertainment Centre, which I had to go along to. They wheeled out this guy in a wheelchair onto the stage while I was sitting there and they just wheeled out patient after patient after patient to beat me up. They did me enormous political damage to make what was absolutely the right decision.
(State/Territory, Liberal, 1990s)

It is significant that the minister who established a Social Health Strategy saw this as possible only if he first ensured that health care services were in order:

One of the things I came to realise very early was that you had to have a reasonable degree of satisfaction with your hospital services before you could get too far with constructing a social health strategy that encompassed community health, public

health, let alone affordable housing and accessible education. You had to be able to demonstrate that the hospital system was functional. (State/Territory, Labor, 1980s)

This insight appeared vital in light of the very many accounts of medical power which ministers gave; described by some as further reinforced by a history of budget allocation strongly favouring acute services in hospitals. This minister spoke of how hard it was to “turn the ship around” in the relatively brief term of a health minister:

Again the inertia was the problem. I mean, I was very strongly committed to the community health, health prevention, education approach. I fully identified with the people who said ‘Why aren’t we getting more money in this area?’ but again, of course, you’ve had 50, 100 years of the hospitals getting most of the money and how do you in fact divert some of that money away from the hospital system into community care, preventative stuff and so on? Not easy unless you can identify more money, additional money, which your colleagues may or may not give you, which can then go into prevention. (State/Territory, ALP, 1990s)

A clear majority of State ministers mentioned that this problem was aggravated for State governments because health took up so much of the jurisdiction’s budget; meaning cabinet colleagues were very unlikely to welcome funding proposals for health-related policies outside the politically sensitive and expensive acute services, including on social determinants of health. As one minister succinctly put it, *‘there’s always the suspicion in Cabinet that it’s a cunning ploy to get your hands on some money’*.

Policy entrepreneurs and policy communities

Kingdon (2011: 180-181) sees policy entrepreneurs as advocates for particular policies who have a particular claim for a hearing on the issues (such as expert knowledge or an

authoritative position), political connectedness or negotiating skills, and considerable persistence. In ministers' accounts there were very few examples of SDH policy entrepreneurs with these attributes. A notable exception was the head of a social health office in the 1980s. Of her, the minister she reported to said:

The person who I would single out above all would be [names person] who came in as the women's advisor and then subsequently, of course, was the social health guru. She was a very clear thinker, very methodical, very committed... I had an extremely good working relationship with her and she was very influential in moving our thinking from looking at single issues to the generality of social health.

(State/Territory, ALP 1980s)

The minister described earlier as feeling that many public health advocates proposed impractical solutions did point to one advocate who he felt had been effective:

I think in Victoria Vic Health has been extraordinarily successful and quite practical and we're very lucky to have [names person] in this State... to me [their] success has been highly practical, very, very highly practical. (Federal, Liberals, 1990s)

Internationally, WHO was mentioned as influential for a minority of ministers and Dr. Halfdan Mahler (WHO Director General 1973-1988) was singled out by one:

I'd been enormously influenced by Mahler as the Head of the World Health Organisation, I'd met him a number of times both overseas and in Australia, and he was very much on this first wave of preventive activity. With Medicare we argued that one of the reasons for this lower status of health was the problems of access for poorer people so Medicare, one of the arguments for it, was that it would help to redress some of these problems. (Federal, ALP, 1980s)

Despite these examples, the accounts suggest that there have been very few policy entrepreneurs with a sufficiently strong power base to motivate policy making on health equity or the social determinants in Australia, especially in contrast to the effectiveness of powerful medical groups lobbying for acute services. The successful SDH policy entrepreneurs mentioned were linked to some formal structure which had as part of its remit paying attention to SDH – a social health office, a review of preventative health and a health promotion foundation, the WHO, or the CSDH.

Policy mechanisms available to health ministers

Nearly all ministers identified increasing access to good quality health services as the aspect of health equity most within their control. However, they also frequently recognised that many factors influencing health were outside the control of the health sector:

There was always this ongoing thing about occupational health and safety being a matter for the Department of Labour and Industry rather than for Health and some of my biggest struggles in Cabinet were in that area. (State/Territory, ALP, 1080s)

Thus a major limitation health ministers saw in their capacity to take action on wider social factors affecting health was that such factors largely lay outside their colleagues' and the wider community's understanding of what health ministers and health departments should do. Thus one Federal minister, when asked specifically about policy responses to SDH, responded, 'Well I'm very aware but they're not the sort of things that a health minister can immediately have an impact on'. One minister who had been strongly committed to improving Aboriginal health acknowledged this when he reflected:

The biggest issue they had, they saw, was lack of jobs. The medical service wasn't going to fix that. (State/Territory ALP, 1990s)

A sense of powerlessness arising from this realisation was evident in this and other ministers' comments, and is likely to be a common response when health ministers are lobbied about social determinants without due regard to the limits of their power to act.

Political mechanisms to keep policy windows open

Ministers accounts suggested that the political opportunities for advancing new policy were generally most favourable when the following elements combined: the health minister acted as a policy entrepreneur for the issue; both cabinet colleagues and Treasury showed at least no major opposition and preferably offered support; and there was support from their Government leader. They also suggested that this rarely happened for policy on the SDH. We can, however, learn from accounts of ministers who did strive to take some action on SDH about their commitment, careful planning and, for new governments, extensive preparation in opposition; although, once in government, support had to continue from the cabinet and head of jurisdiction. One minister described a wide-ranging health reform agenda but reported that *'I found it very difficult to garner support for significant reform in Cabinet, with certain powerful colleagues unwilling to engage in any real way...'*. Others spoke of how they had won support for their agenda. One recounted doing this with their premier:

The Premier needed to support what you were doing and any wise person would have – if there was something difficult or controversial coming up I would have gone to the Premier and said 'Look, this is a priority for these reasons. This is where it fits into the overall scheme of things' and hopefully it would enjoy support. (State/Territory, ALP, 2000s)

Nearly all the Ministers described how gaining broad political support for ideas was vital, including on SDH. Broader support depended not only on the political benefit outweighing the risk, but also on the willingness of the head of the jurisdiction and cabinet colleagues to

accept even limited political risks. Two examples illustrate this. Firstly, a minister recounted how their Premier had been especially moved by the suicide of a 15-year old Aboriginal girl which led to the immediate opening of a policy window:

He then said 'Right, well, we need a whole of government response to this and we're going to do something completely extraordinary' and he did it. He had hundreds of millions of dollars allocated in addition to the budget for remote Aboriginal communities.... [Premier] actually put all the services, child protection workers, police, improved health services, all of those sorts of things, into Indigenous communities throughout the state... I think that's had a tremendously beneficial effect.
(State/Territory, ALP, 2000s)

The second instance concerned gun control legislation supported by the government despite very vocal opposition from community groups:

Gun control was an unmitigated political disaster for the Coalition, absolutely unmitigated political disaster. Was it the right thing to do? Sure. Did we pay a price for it? You bet. (Federal, Liberal, 1990s)

This is a very clear example of a government prepared to manage political risk because they believed it was the right thing to do; a stance consistent with the Commission on Social Determinants of Health's position that action should be taken on SDH for moral reasons. Ministers seemed more willing (or able) to pay attention to social determinants and make subsequent political decisions when they either held more than one portfolio or were a minister of human services with a portfolio including health. One example was the Federal *Better Cities* program of the early 1990s. Its benefits were noted by the Federal Minister responsible for it: *'It cut across silos and it was very successful in that way'*. State ministers

also saw their States benefiting because this program improved infrastructure in particular regions and was seen to have health benefits.

The political importance of cross-sector structures was noted by a number of ministers. The minister with the explicit social health agenda chaired a human services subcommittee of cabinet considering equity issues across a range of portfolio areas. He saw this structure as enabling a more whole-of-government approach than might otherwise have been possible and noted: *'You could actually sit down with four or five of your colleagues in a less frantic sort of atmosphere... That was a much more constructive forum in many ways than the full Cabinet'*.

More generally, however, it seemed either a lack of political support inside Cabinet or an absence of well-established cross-portfolio mechanisms could and did, in effect, limit policy opportunities for action on SDH.

Discussion

Our study indicates that health ministers from both Australian political parties can point to important health sector reforms (summarised in Table 1) that were seen to contribute to health equity. However their appraisals indicate that, with one exception, they were able to make little progress in advancing comprehensive policies to address SDH. The main actions they described were increasing access to health care services, and implementing disease prevention and health promotion programs in ways that took account of social effects on behaviour. Although in the latter case, it appeared that behavioural solutions sometimes overrode good intentions concerning SDH, akin to the lifestyle drift described by Hunter et al. (2010) whereby policies start off with statements about social determinants but end up with behavioural solutions only. We found only a few instances of the health sector leading cross-sectoral action on the SDH. We are aware of more recent policy achievements in this

area (most notably the current Health in All Policies work in South Australia) but ministers responsible for these were still in parliament and not, therefore, included in our sample.

The health ministers' accounts are consistent with Exworthy's (2008) explanations that social determinants are hard to act on in conventional policy-making environments because they are complex. Complexity science is increasingly drawn upon to examine the implementation of health promotion policy (Alvaro et al., 2010; Hawe et al., 2009) in terms of it occurring in systems that are non-linear, emergent, adaptive, unpredictable, dynamic and very dependent on history. This is especially difficult because the SDH agenda competes for policy attention with problems that are more straightforward and do not carry the demand for complex, multifaceted responses implicit in the evidence on SDH (Exworthy, 2008).

This study also indicates that responses to inequities depend on whether ideologies stress personal responsibility or the impact of structural disadvantage. This is consistent with Tesh (1988), who argues that politicians with a strongly individualist political ideology tend to support a health policy agenda focused on treatment and individual behaviour. Proposed solutions to health inequities are contested because they can be divided on ideological lines, contrasting with policies about health care which do not divide as strongly on ideological grounds. Even ministers favouring more structural solutions faced significant disagreement about what these should be. Figure 1 maps the relative success of different forms of health policy in Australia over the period covered by this research, seen through this intersection between the complexity of the problem to be addressed and the extent to which policy options are contested by decision-makers. Policies most likely to be adopted are those which are not complex and about which there is broad agreement. By contrast, SDH policies, sitting in the upper right quadrant, have proved far harder to gain agreement on because of both their complexity and their contested nature.

Figure 1: Complexity and agreement shaping health policies

Low agreement	Redistribution of health services to areas of disadvantage	Social Health Unit/focus in health portfolio Intersectoral structures for health	Re-distributive policies to level up the health gradient Changing policies in non-health sectors to promote health
High agreement	Provision of PHC services Provision of acute care services	Behavioural change strategies	
	Not complex	Highly complex	

All the health ministers consistently stressed the extent to which the power of organised professions within health, especially the medical profession, drove the health policy agenda and captured their attention, confirming other research which points to ‘medical dominance’ (Smith et al., 2009; Busfield, 2010). Medical power was evident across each of Kingdon’s streams. In the problem stream, health policy is dominated by the immediacy of illnesses requiring acute care services, with public opinion and the media strongly reinforcing this position. In policy, bio-medical paradigms propose a clear solution to illness. Generally these solutions are understandable to politicians and the community, which contrasts strongly with the complexity of SDH. Based on the ministers’ accounts, medical policy entrepreneurs are powerful, experienced players and not afraid to hold politicians to ransom through the media and during elections campaigns. This ability to influence public mood and its impact on elections reinforces the point made by Kingdon (2011: 164) that the forces shaping policy are

far from equal in practice and that *'The mood-election combination has particularly powerful impacts on the agenda. It can force some subjects high on the agenda and can also make it virtually impossible for governments to pay serious attention to others'*. In the politics stream, ministers' accounts suggested that advocates for the SDH hold far less power than most other players on the health policy field and are easily crowded out by advocates for acute health care services.

Health equity concerns both gradients and disadvantaged groups. However, in Australia, potential policy solutions for gradients – generally requiring reduced levels of socioeconomic inequality 'across the board' – have been more highly contested than policies targeted toward disadvantaged groups (Baum et al., 2012). Thus we place them firmly in the right hand, upper quadrant of Figure 1. The limited record of policy action on socioeconomic and health inequalities by Australian governments – despite the long-standing evidence on the association between the two – may perhaps also reflect a degree of normalisation. As Kingdon (2011: 170) notes, *'The longer people live with a problem, the less pressing it seems. The problem may not change at all, but if people live with it, it appears less urgent. It becomes less a problem and more a condition than it seemed at the beginning'*. This description seems to fit well with Australia's policy record on the SDH. In Bacchi's terms (2009) the SDH and especially concern with a health gradient have become silent in the policy field.

Only a small minority of ministers discussed the need to flatten the health gradient, and then tended to focus on the need for redistributive policies across all portfolio areas and the political difficulties of these strategies in an age of neo-liberalism that favours market-driven policies. Ministers who held office in the 1980s noted that redistributive policies had become progressively less favoured since that time. The lack of supportive environments for a SDH

agenda in the face of neo-liberal ideologies has been noted previously in Canada (Bryant et al., 2010), the US (Navarro, 2002) and Australia (Nutbeam & Boxall, 2008).

Our study indicates that policy spaces for action on the SDH require that the rest of the health portfolio area is not perceived to be in crisis. Yet in the past decade health systems in Australia and elsewhere have been presented as such because of increasing costs of, and demand for, health care services (Australian Government, 2010; WHO, 2009). The accounts of former health ministers when faced with similar issues sheds light on the political difficulties in re-directing attention and resources to SDH, when such actions would not appease demand for resources from the acute care sector, and would present their colleagues (and the public) with long term, complex and contested policy options. We found that there have been instances of Australian health policy addressing the SDH over the past twenty five years but they are rare and the windows of opportunity that made them possible have not stayed open for long. The political stream was enabling when the general ideological climate was supportive of redistributive policies, the health care sector was not perceived to be in crisis, and there was support for action from the head of government, cabinet colleagues and no opposition from powerful lobby groups.

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