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Are the National Preventive Health initiatives likely to reduce health inequities?

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Abstract:

This paper examines commitments to address health inequities within current (2008-2011) Australian government initiatives on health promotion and chronic disease prevention. Specifically, the paper considers: the Council of Australian Governments' *National Partnership Agreement on Preventive Health*; the National Preventative Health Taskforce report, *Australia: The healthiest country by 2020*; and the Australian Government's response to the Taskforce report, *Taking Preventative Action*. Arising out of these is also the recent establishment of the Australian National Preventive Health Agency. Together these measures represent a substantial public investment in health promotion and disease prevention. The present paper finds that these initiatives clearly acknowledge significantly worse health outcomes for those subject to social or economic disadvantage, and contain measures aimed to improve health outcomes among Indigenous people and within low socioeconomic status communities. However, we argue that as a whole these initiatives have (thus far) largely missed an opportunity to develop a whole of government approach to health promotion able to address upstream social determinants of health and health inequities in Australia. In particular, they are limited by a primary focus on individual health behaviours as risk factors for chronic disease, with too little attention on the wider socioeconomic and cultural factors which drive behaviours and so disease outcomes in populations.

Key words: social determinants of health; health equity; health promotion; health policy

Introduction

This paper examines health promotion and chronic disease prevention (hereafter 'health promotion') initiatives of the Rudd and Gillard Labor Governments, and the Council of Australian Governments (COAG), in order to assess the likelihood of them contributing to a reduction in health inequities. In so doing we draw on the understanding of social

determinants of health (SDH) and health inequity consolidated in the work of the WHO Commission on the Social Determinants of Health (CSDH) (2008). Its report defined SDH as the circumstances which shape everyday life, including macro-level social, economic and cultural structures, some of which operate globally. It particularly focused on the distribution of these circumstances within or between countries. Health inequities are defined as inequalities in health outcomes, 'judged to be avoidable by reasonable action' (2008, p. viii). The CSDH focused on the importance of the health gradient whereby health is graded according to measures such as educational level or socio-economic status. Inequities also are identified by differences in health outcomes between a socially or economically disadvantaged group and the general population (Blas and Kurup 2010). Socially structured inequalities in risk factor behaviours can also be considered as a form of health inequity (CSDH 2008, p. 3). Health promotion actions by government may or may not seek to address SDH and often focus on improving average population health status rather than on reducing the health gradient or gaps between groups. The CSDH report concludes that in order to reduce health gradients and improve the health of disadvantaged (including low SES) groups it is necessary to address the underlying social and economic determinants of health. The report also considered the evidence of what policies and strategies are most likely to reduce health inequities and concluded it was those that change the environments in which people live their lives and those that make the macro-level social and economic structures more equitable.

In this paper we consider the extent to which current Commonwealth initiatives on health promotion incorporate equity as one of their aims and then assess the likelihood of the policy directions contributing to equitable health outcomes. Although these initiatives are welcome and incorporate measures to address socioeconomic disadvantage, we draw the conclusion that they have largely missed the opportunity to advance a health promotion agenda that will tackle the persistent and underlying causes of health inequities. We consider why this may have been the case and conclude with some ideas for how Australian health policy could be more effective in reducing health inequities.

Equity intentions of current Australian Preventive Health initiatives

Current Commonwealth initiatives on health promotion are aimed at reducing the prevalence and costs of chronic disease in Australia, primarily by addressing 'health

behaviours' known to increase risk of these conditions; especially tobacco smoking, excessive alcohol consumption, and diet/exercise factors leading to overweight or obesity. In this paper we assess measures described in three main documents shaping current health promotion strategy: the Council of Australian Governments' (COAG) *National Partnership Agreement on Preventive Health* (NPAPH) (2008); the report of the National Preventative Health Taskforce (NPHT) (2009); and the Commonwealth Government's response to the Taskforce report (2010). Our comments offer a considered view of directions and measures described in these strategic-level documents in relation to health inequities, rather than a systematic policy analysis. In this section we consider the extent to which these initiatives identify the achievement of equity as an aim.

COAG's NPAPH, firstly, establishes the basic Commonwealth policy and funding framework on health promotion with the aim of reforming 'Australia's efforts in preventing the lifestyle risks that cause chronic disease' (2008, p. 1). It states that the parties are committed to addressing social inclusion and indigenous disadvantage, and indicates an intention to implement some programs in ways which address needs of particular disadvantaged groups (2008, pp. 3, 5, 6). However, this focus on the needs of the socioeconomically disadvantaged is not reflected in performance benchmarks established to monitor implementation of the agreement, all of which are concerned with gains in *average* levels of health or risk factor indicators in the population; with no attempt to measure equity outcomes (2008, p. 8). Funding terms for States and Territories specify that over $300 million of total funding available is conditional on meeting these benchmarks (Commonwealth of Australia 2010, pp. 9-12), presenting a major incentive for State efforts to focus on average gains only. The potential limitations of this in relation to health inequities will be discussed below.

The National Preventative Health Taskforce (NPHT) was established in April 2008 with terms of reference to 'provide a blueprint for tackling the burden of chronic disease currently caused by obesity, tobacco, and excessive consumption of alcohol' (NPHT 2009, p. 287). Notwithstanding these limited terms, the Taskforce's National Strategy makes considerable efforts to take account of evidence on inequities in chronic disease and associated risk factors in Australia, to use the language of health equity, and to argue for actions specifically to address 'the unequal distribution of health and risk in Australia' (2009, p. 32). Two of its seven key strategic directions are to 'reduce inequity through targeting disadvantage – especially low SES population groups' and to contribute to

'closing the gap' in health outcomes between Indigenous and non-Indigenous Australians (2009, p. 40); and these show through in specific recommendations. It also calls for on-going measurement of health outcomes and behaviours by 'Indigenous status and relative social disadvantage' (2009, p. 38). However, of the Strategy's four key targets, three specify only average gains in health behaviours. The fourth is to contribute to 'reducing the life expectancy gap between Indigenous and non-Indigenous people.' These targets are explicitly intended to align with COAG's NPAPH performance benchmarks (2009, p. 36).

In 2010 the Federal Government released *Taking Preventative Action* (TPA), their response to the Taskforce's Strategy. On January 1, 2011 it also launched the new Australian National Preventive Health Agency. TPA's response to Taskforce recommendations frequently appeals to measures already in train under the NPAPH or other policies (e.g. COAG 2007; Commonwealth of Australia 2009). This includes two of the main NPAPH programs, the 'Healthy Workers Initiative' ($289.4 m.) and the 'Healthy Children Initiative' ($325.5 m.), to promote improved health behaviours (especially diet/exercise related) in workplaces and among children. On our reading, neither of these is specifically intended to target disadvantage. However, elements of the smaller 'Healthy Communities Initiative' ($71.8 m.) are targeted (e.g. 2010, pp. 51-52). Also, a number of specific measures on tobacco, alcohol or obesity, and primary health care services are aimed to address health behaviours within Indigenous groups, low SES communities, and several groups with especially high smoking rates, such as people with mental illness (e.g. 2010, pp. 14-16, 44, 51-52, 56, 73, 77-78, 90, 97). Otherwise, there is no overt recognition of an association between the overall distribution of socioeconomic advantage/ disadvantage and chronic disease or health behaviours.

Thus, taken together the COAG agreement, the Taskforce and the Government's response display variability in the extent to which they establish health equity as a policy goal, as indicated in table 1.

Table 1: Equity goals in Preventive Health documents

✓: main commitments in this area ✓ : minor or lesser commitments in this area	**Preventive health policy/strategy document**		
Expression of equity in policy goals: health goals/targets expressed as…	**COAG NPAPH**	**NPHT Report**	**Com'wealth Response**
Gains in average health status across the population	✓	-	-
Gains in average health status + gains in specified high-disadvantage groups	✓	-	✓
Gains in average health status + gains in both lower SES populations & other disadvantaged groups	-	✓	✓
Gains in health equity between low SES groups/ other disadvantaged groups, & the wider population	-	✓	-
Gains in health equity across the whole population ('flattening' of social gradients)	-	-	-

Assessment of Preventive Health initiatives in relation to evidence on what reduces health inequities

Taking account of the CSDH report (2008) and other recent major reports consolidating evidence on social determinants of health and drawing out implications for public policy (e.g. Marmot *et al.* 2010), there are several key things which a developed country's disease prevention and health promotion strategies can reasonably be expected to do to address health inequities effectively.

Firstly, it ought to look beyond health behaviours and recognise other systemic socioeconomic factors amenable to preventive action which also influence chronic disease incidence, and contribute to health inequities. Factors to consider include low income (Turrell *et al.* 2006; Kessler *et al.* 1994), insecure or poor standard housing (Weich and Lewis 1998), unemployment (Montgomery *et al.* 1999), low social capital (Ziersch *et al.* 2009), and low-control work environments (Stansfeld *et al.* 2003). Evidence suggests that these factors contribute in their own right to the greater risk of chronic disease in Australia among lower SES groups, and for Indigenous Australians (ABS 2009; Draper *et al.* 2004; Glover *et al.* 2006; Turrell *et al.* 2006). International evidence suggests that effectively

tackling such systemic determinants of health inequities is likely to yield gains in overall population health, as well as in economic productivity and social cohesion (Navarro and Shi 2001; Wilkinson and Pickett 2009; Kawachi and Kennedy 1997). The narrow terms of reference set for the NPHT focused their work on 'lifestyle' risk factors for chronic disease and promoting individual behaviour change. Although they did call for strategies to assist high-risk sub-populations, they did not encourage attention on a range of broader socioeconomic factors shaping the distribution of chronic disease in populations. It is clear from the CSDH's work that if health inequities are to be reduced then these factors have to be tackled.

Secondly, it is essential to recognise that health behaviours reflect social contexts. Most forms of risky health behaviour in Australia, as elsewhere, are more prevalent among those of lower socioeconomic status (SES) (Turrell *et al.* 2006), and among population groups subject to particular disadvantage, such as Indigenous people (AIHW 2010). Despite this the documents considered in this paper are largely premised on tacit assumptions about health behaviours as purely reflecting *individual* 'lifestyle' choices; in a similar manner to policies in several comparable countries (Alvaro *et al.* 2010; Popay *et al.* 2010). From this position it seems like common sense to believe that disseminating information about the 'lifestyle' risks or benefits associated with different health behaviours will motivate individuals to modify their behaviour accordingly (Lefebvre and Flora 1988). This behavioural stance on health promotion has drawn on a number of influential theories from social psychology (Nutbeam and Harris 2004). It also provides the basic rationale for the 'social marketing' campaigns (Egger *et al.* 1990) which are now often a main element of governments' health promotion strategies. We do not discount the potential value or importance of informed choice. However, the weaknesses of this individualised view of health behaviour are that it views people outside of socioeconomic or cultural context, and essentially shifts the locus of the problem away from the actions of government or the private sector and onto the flawed 'lifestyle' choices of individuals (Baum 2008). The NPAPH (DoHA 2011), the TPA policy statement and the planned role of the new preventive health agency each clearly place a strong emphasis on social marketing campaigns and portrayal of health behaviours as individual 'lifestyle' issues (e.g. Commonwealth of Australia 2010, p. 26, 44; COAG 2008, p. 3).

Social marketing campaigns have a limited evidence base for their effectiveness (Syme 2004; Baum 2008, pp. 460-5; Egger *et al.*1983), and if they do work this tends to be with

higher socioeconomic groups (Slama 2010; Acheson *et al.* 1998). Thus they play some limited role in decreasing the overall prevalence of a behavior within a population, especially when used with strategies to change policies (Lefebvre and Flora 1988; Randolph and Viswanath 2004). However, evidence also suggests they tend to generate significantly less or little improvement within lower SES or other disadvantaged groups (Layte and Whelan 2009; Alvaro *et al.* 2010; U.S. Department of Health 2005, p. 8). The overall effect, therefore, may be to entrench or exacerbate *inequality* in health behaviours and so in health outcomes. The experience with many tobacco control campaigns has been that better-off sections of a population are more likely to quit smoking and less likely to take it up, so that the net effect is to increase inequity (Slama 2010; Baum 2007; Layte and Whelan 2009). This is despite the fact that tobacco control initiatives often employ both behavioural strategies and restrictive policies and regulations. None of the health promotion initiatives considered here have explicitly noted that in cases where health promotion has been successful it has often resulted in increased inequity, except in the Taskforce report's discussion of a growing gap in smoking rates between Indigenous and non-Indigenous people since the 1970s (2009, p. 62). Such information is crucial to inform policy on health inequities. Furthermore, while more intensive behavioural strategies targeted at smaller at-risk groups may have a positive effect (Gordon *et al.*2006), they are likely to only have a marginal effect on overall rates of a risk behaviour such as smoking in the whole population (Chapman 1985; Rose 1992).

Although the TPA policy statement describes a number of measures targeting disadvantaged groups, it consistently advocates the use of predominantly behaviourist (especially social marketing) strategies to address their typically higher rates of risky health behaviours. For example, in relation to smoking and other health behaviours among indigenous people, TPA adopts a mainly behaviourist approach to the problem; such as in its intentions to 'reach out to Indigenous communities… to increase awareness of the harms from smoking and facilitate smoking prevention and cessation programs' (2010, p. 74). In itself, this approach fails to take adequate account of historical and systematic factors which lead to social injustice, and underlie the behaviours. For example, Thomas et al. note that smoking is far more prevalent among Aboriginal people who were part of the stolen generation than for those who were not (Thomas *et al.* 2008). Brady (2004) has shown the clear links between the history of colonial dominance and the existence of alcohol abuse among Aboriginal people. Campbell *et al.* (2011) have shown that

Aboriginal people who participate in land management are less likely to have diabetes, renal disease or hypertension than those who don't. The latter study is significant because it also indicates the importance of approaches which seek to identify and build 'health assets' and health promoting environments in localised settings, rather than focusing more narrowly on addressing health and behavioral 'deficits'(Morgan and Ziglio 2007). The national health promotion initiatives do not adequately acknowledge these underlying causes of disease and health which is somewhat surprising given that the COAG *Closing the Gap* initiative does recognise the importance of social determinants (2007). It includes among its objectives the need for access to early childhood education, increasing literacy and numeracy achievements for Indigenous children and improved year 12 completions, and sets out to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade. Thus two of the most powerful determinants of health – education and employment – are central to the policy. This suggests somewhat of a disconnection between the Preventive Health agenda and the Closing the Gap agenda. We suggest the national Preventive Health agenda would look very different if it could take on board (and apply more widely) the social focus of the *Closing the Gap* (CTG) policy. This social focus evident in the CTG strategy is more consistent with the CSDH's report recommendations and so represents sound public health practice.

On a third point, the CSDH report highlighted a need for 'public sector leadership in effective national and international regulation of products, activities, and conditions that damage health or lead to health inequities' (2008, p. 14). The TPA policy statement is inconsistent on this front. For example, it commits to increased, direct regulation of tobacco prices, sales and marketing, coupled with social marketing and other strategies (2010, pp. 61-70). However, in relation to obesity the stance is far weaker, with emphasis on voluntary self-regulation by the food industry, and rejection of several Taskforce recommendations; including the use of taxation and pricing mechanisms to reduce consumption of 'energy-dense, nutrient-poor' foods (2010, p. 37). On alcohol issues the Commonwealth can use pricing incentives to reduce excessive consumption, as it has done effectively with 'alcopops' (Commonwealth of Australia 2010, p. 97), while regulation of issues such as opening hours and venue licensing lie with the States. It is clear that direct regulation of factors such as price and opening hours can have significant moderating effects on drinking behaviour (Tanne 2010; Wagenaar *et al.* 2010). In addition government

regulation of the content of alcohol advertisements is likely to be more effective that industry self-regulation.

Finally, since the publication of the 1986 Ottawa Charter the 'new public health' movement has recognised the importance of healthy public policy and a supportive environment to achieve population-wide changes in health behaviours (Baum 2008; Kickbusch 2009). In recent times this has evolved into calls for health impact assessments and health promotion measures to be applied to policy across all sectors of government. This approach has been taken up by a number of governments, including in South Australia's program of 'health in all policies' (HiAP) (Kickbusch and Buckett 2010). Although TPA did undertake to monitor SA's HiAP program, it did not commit to extending this approach at a Commonwealth level, despite Taskforce recommendations to that effect (Commonwealth of Australia 2010, p. 36).

The Taskforce also paid attention to the need for healthy public policy in relation to the regulation of alcohol advertising and tobacco but its hands were tied in its limited terms of reference and it did not consider the many ways in which a healthy public policy approach could have prompted action across a range of portfolios (and all levels of government) to reduce social inequalities and address environmental factors.

Speculation about why Australia's Preventive Health agenda has focused on behaviour

Our discussion above indicates that the Preventive Health agenda of the Australian Labor Governments from 2007 has been centrally focused on a behavioural approach to health promotion and chronic disease prevention, despite its limitations. Why might this be the case? We suggest a number of possible reasons, all of which may be exerting some measure of influence on the policy agenda. Firstly, at an ideological level, a stance on health promotion which puts the onus on (de-contextualised) individual choice and responsibility will clearly have sympathetic resonances with the neo-liberal worldview which has dominated Western politics in recent decades (Harvey 2005). Secondly, it is essential to consider the increasing efforts of large corporations to influence governments' and international agencies' health promotion policies. This issue has been well-aired in relation to the tobacco industry (Ullrich *et al.* 2004). However, recent years have also seen

similarly aggressive lobbying from the food industry (Egger and Swinburn 2010; Ullrich *et al.* 2004). While the private sector can play a significant and constructive role in health promotion, it is in the long-term public interest for societies to reaffirm the central role of governments 'in the regulation of goods and services with a major impact on health (such as tobacco, alcohol, and food)' (CSDH 2008, p. 15). Thirdly, in relation to practical issues of public implementation, behavioural approaches have an established history and methodology based in the emergence of the post-WWII health education movement. Furthermore, without strong political leadership, competitive or ideological differences between departments may make cross-sectoral approaches difficult (Alvaro *et al.* 2010; de Leeuw 1993).

The way forward: a whole of government approach to health promotion

A social determinants view of health promotion certainly does not discount the significance of informed choice about which behaviours to adopt. What it does, however, is to recognise that individual and population health outcomes are not only affected by biological and behavioural factors, but also by the social, cultural, economic and political settings in which people live, and by the distribution of social and economic advantage and disadvantage (Baum 2008). It sees that behavioural choices are shaped by a range of factors, including social and economic resources, living conditions, and dispositions acquired over the life course, with early life conditions likely to be particularly influential (Lantz *et al.* 2007; Lindsay 2010). It understands how history, culture and structural constraints make it hard for people to change their behaviours and how seemingly health-damaging behaviours are often a means of coping with difficult life circumstances.

Thus social marketing, health behaviour change or health literacy programs are useful tools only when part of a broader approach to promoting health which considers the socioeconomic settings in which behavioural choices – and other risk factors – occur (Kickbusch 1997).

In summary, we argue that significant gains in promoting health, preventing disease and reducing health inequities requires a whole of government commitment at Commonwealth and State level. This should include progressive policy reform across a range of portfolios

to reduce overall levels of socioeconomic inequality and free up resources for responsible social investment.

Allied to this, it would be useful for the national Preventive Health agenda to link in a systematic way to the *Closing the Gap* campaign and the Social Inclusion Board's agenda. *Closing the Gap* (as noted above) does give consideration to education and employment and so provides a good basis for extending action on social determinants. The Social Inclusion agenda also seeks to improve the lives of very marginalised people (the bottom 5%) through labour market participation and place-based initiatives. Such social investment should not be reserved for groups who suffer the worst outcomes but should form the basis of population-wide strategies to improve health status.

Cross-sectoral approaches are vital in promoting health (Kickbusch 2010; Ollila 2010) The Commonwealth should start a series of evaluated trials of a health in all policies approach led from the Prime Minister's Department; incorporating an equity perspective and what the Marmot Review called 'proportionate universalism' (Marmot *et al.* 2010) to ensure that measures both promote overall population health and do so in a manner that reduces the inequity gradient and places a special focus on the most disadvantaged. Further development of health impact assessment to assess and predict effects of policies on health and health equity will be an important tool.

Redistributive investment in social infrastructure should be sustainable and collaborative. This will mean engaging local communities and agencies in processes to identify local needs, build capacities and assets for health, and through these processes create health-promoting environments. The widely adopted 'Healthy Cities' strategy is a successful example of such an approach (WHO 1996; Kickbusch 2003; Baum *et al.* 2006). While the Commonwealth rejected NPHT recommendations for a national, integrated approach to health promoting environments, it has supported some efforts in this direction, including funding for sports and recreation infrastructure (Commonwealth of Australia 2010, p. 34-35).

A life-course perspective, and programs to support families and promote early childhood development are important preventive measures for improved health outcomes in later life (Marmot *et al.* 2010) and more investments in these areas would be a good investment for Australia. While there are limits to the actions that can be taken within the health sector to address social determinants of health, primary health care in particular can play a role and

the sector as a whole has crucial leadership and stewardship responsibilities for social determinants which one of us has elaborated on elsewhere (Baum *et al*. 2009). WHO has set out agendas to take account of social determinants of health in primary health care (WHO 2008) and public health action (Blas and Kurup 2010).

Finally, there is strong evidence to show that targeted regulatory action by Governments in areas of the economy which directly influence health behaviours could drive substantial, cost-effective gains in long-term chronic disease prevention (Vos *et al.* 2010). Thus while the focus on prevention in the government's agenda is welcome, there is significant scope for the initiatives to build on the work of the CSDH and embrace the range of measures canvassed in this article that will make social and economic environments more health promoting, particularly to improve the health of the most disadvantaged Australians (especially Aboriginal people) and work to flatten the health equity gradient.

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Conflicts of interest

The authors state that they have no conflicts of interest in relation to the content of this article.

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