A Fair and Healthy Tasmania Strategic Review

Final Report

A Report and Call to Action from the *Fair and Healthy Tasmania Strategic Review* in 2011

About this Report

In 2010 the Hon. Michelle O'Byrne, Minister for Health initiated the *Fair and Healthy Tasmania Strategic Review* to find the best ways of improving health and reducing health inequity in Tasmania.

This report presents the major findings of that strategic review.

It is also a call to action for the many parts of society that can help build the conditions that will keep Tasmanians healthy and well.

This report should to be read together with *A Healthy Tasmania*: *Settings New Directions for Health and Wellbeing.*

A Healthy Tasmania is the Tasmanian Government's response to the recommendations of the *A Fair and Healthy Tasmania Strategic Review.*

A Healthy Tasmania is a long term approach for building good health and wellbeing in collaboration with communities.

If you would like to be a part of this work – now or in the future – you are strongly encouraged to contact the Department of Health and Human Services (DHHS).

Population Health

Department of Health and Human Services

GPO Box 125

Hobart TAS 7001

Ph: 1800 671 738
Email: preventive.health@dhhs.tas.gov.au
Web: www.dhhs.tas.gov.au

Acknowledgements:

The DHHS thanks everyone who contributed to the *Fair and Healthy Tasmania Strategic Review.* In particular, the great work of the Tasmanian Council of Social Services' *Our Island, Our* Voices campaign, leading to the Health in All Policies Collaboration, has helped start a vital conversation about building good health and wellbeing in Tasmanian communities.

Suggested Citation:

Department of Health and Human Services. *A Fair and Healthy Tasmania Strategic Review.* Hobart, Government of Tasmania: 2011.

Foreword

Tasmania offers such a beautiful quality of life that it can be easy to forget that some of us don't have the health to enjoy it.

Like other rural areas, our health and wellbeing outcomes linger behind the rest of Australia. This rings particularly true for those who lack the social and economic resources everyone needs for a healthy life. Despite the best efforts of dedicated health professionals, and whatever improvements we can make to the healthcare system, the patterns of inequity that exist in income, education and aspiration in Tasmania have a profound effect on the lives of many.

Despite historic investment into healthcare and significant population health achievements in many parts of the developed world, the gap between the health and wellbeing outcomes of the 'haves' and 'have nots' in our society is widening.[1]

We know that prevention saves lives. It reduces illness and disability. It frees resources needed elsewhere. The social and economic benefits of prevention are profound. A healthy economy, for example, requires a healthy population to sustain it. Health and wellbeing also underpins the quality of life of Tasmanian families and their ability to participate in the community around them.

Clearly, we need to reframe the way that we work in health and in Government at every level. We can no longer rely on new and additional funding to be the solution. There are, however, ways that we can target the resources that we have, and work smarter and positively to assist places and people to secure a fair and healthy future.

The Fair and Healthy Tasmania Strategic Review's main findings are that *leadership across sectors* and *place-based approaches* are the best ways of improving health and reducing health inequity in Tasmania.

At the heart of this is the notion that getting people to maintain their wellbeing is part - not all - of the solution. For lasting change, we need to create the conditions in communities that enable wellbeing.

Employment, education, transport, poverty, early childhood, housing, social inclusion – these factors all underpin health and so the health of Tasmanians is a measure of our progress on a number of fronts. While the health and social care sectors provide vital care to our communities, working across sectors can help to influence the underlying conditions that determine a person's chances of achieving good health in the first place.

Through *A Healthy Tasmania*, the Tasmanian Government's response to the findings of this Strategic Review, I hope to see this approach carried forward.

I encourage all Tasmanians to think about what they can do as people, businesses, governments and communities to contribute to securing a healthy Tasmania, for all Tasmanians.

Dr Roscoe Taylor

Director of Public Health

Director, Population Health

Table of Contents

1. Key Messages 5
2. Introduction 6
3. Everyone's Talking About Determinants 8
4. What the Strategic Review Told us 11
   4.1 Why Wellbeing Matters 11
   4.2 What Builds Well Communities 13
   4.3 Why Health isn't Equitable 16
   4.4 Counting the Cost of Inequity 22
   4.5 Recommendations 25
5. What we Think we Should do 30
   5.1 Recommended Model 30
   5.2 Activity Streams 31
   5.3 Advisory Council 33
   5.4 Community Action Zones 33
   5.5 Health Intelligence 36
6. Appendices 39
   6.1 Glossary 39
   6.2 Key Characteristics of the Tasmanian Community 42
   6.3 Draft Terms of Reference - Health and Wellbeing Advisory Council 47
7. References 51

Talking About the Social Determinants of Health

Choosing the right words can be difficult. Different people use the same words in different ways. Policy makers and academics have their own language to describe issues that affect health which can seem complicated to people outside of the health sector. Having a shared understanding of key words will help more people join the conversation.

Below is a list of terms that are used throughout this document to discuss health and wellbeing. They are not technically accurate, but they reflect the general meaning of these words in everyday language.

Chronic Condition – A chronic condition is a sickness or disability that affects a person's quality of life over a long period of time.

Community – A community is a group of people who are linked by work or social ties, share the same interests or point of view, and often live in the same location.

Health – Health doesn't just mean being free from sickness and disability. Health is a complete state of physical, mental and social wellbeing.

Health Inequity – Health inequities are differences in the health of groups of people that could have been avoided under fairer circumstances.

Health Promotion – Any activities that enable people to increase control over and improve their health.

Intersectoral Action – Brings together different parts of government and other organisations to improve health and reduce health inequity through action on the social determinants of health.

Preventive Health – Preventive health refers to any action to stop or lessen the onset, progression and return of sickness or disability and its causes.

Policy – Policy is a process of making and carrying out decisions. Policy is used to guide the actions taken by government, business and other organisations. It is often in the form of a plan, procedure, strategy or set of principles.

Sector – The word sector is used to tell apart different parts of society, such as the education, health, business, public, private and community sectors.

Social Determinants of Health – These are the conditions that a person lives in everyday that determine their chances of achieving good health. They have been described as the conditions in which people are born, grow, live, work and age.

Wellbeing – Wellbeing is a state of being happy, healthy and prosperous.

For a list of technical definitions of these and other words see the glossary at the end of this document.

1. Key messages

There is a growing awareness of the underlying causes of health and the influence of all parts of society upon it.

Many factors build the health and wellbeing of people and communities. These factors can be personal, social, economic and environmental, they are often complex and interact.

No matter how effective healthcare becomes, there will always be some differences in the health and wellbeing of people and communities because of factors outside of healthcare.

There are vulnerable population groups who are at greater risk of poor health and have fewer resources to cope when illness strikes.

Every day health and social inequity costs the Tasmanian community dearly in both human and financial terms.

The Fair and Healthy Tasmania Strategic Review found *leadership across sectors* and *place-based approaches* to be the best ways of improving health and reducing health inequity in Tasmania.

Population and social health information and research are the 'health intelligence' that will build a better understanding of health and wellbeing in Tasmania.

2. Introduction

Health means more than just treating people when they are sick and that's why it's everyone's business.

Health isn't Equitable

While the Tasmanian lifestyle is the envy of the rest of Australia – our health and wellbeing outcomes certainly are not and arguably, health inequity is one of Tasmania's biggest challenges. There are differences between the health of Tasmanians and the rest of Australia across a number of measures, including the highest burden of disease and injury outside of the Northern Territory.

There are also differences between the health outcomes of Tasmanians themselves. Many Tasmanians who are already vulnerable because of age, cultural and linguistic diversity (CALD), mental health, carer responsibilities or other factors, are at greater risk of poor health and have fewer resources to cope when they are sick. This is a particular concern for Tasmanians who have less money, less education and insecure working and living conditions.

Tasmania is not alone. Differences in health outcomes exist in and between countries all over the world for many reasons. Some differences are due to natural, unavoidable factors that are unchangeable, such as age, disability and genetics. Other differences are unnatural and avoidable, caused by factors that are unfair and unjust, such as poverty or racial status.

It is these differences that are changeable – 'health inequities' - which society can address in new ways for better outcomes for all Tasmanians.

There is a Social Gradient in Wellbeing

There is a gradient that runs across all people and communities and is a measure of their social and economic status in society. The effect of the gradient upon health means that potentially the health of everyone can be lifted - even the well off - to match the people at the very top of the social gradient. People who are worst off in life are not the only ones who could have better health.

It is well known that social and economic factors determine health and wellbeing. Factors like employment and working conditions, education and early childhood, transport, economic wellbeing, housing and neighbourhoods, social inclusion, and access to essential services all underpin the health of Tasmanians.

For example: [2]

- People who leave school early are more likely to be high-risk drinkers;
- Obesity rates of people living in public housing are three times higher than among home owners; and
- People in jobless households are more likely to have a long-term health condition.

Therefore, while it is important to establish affordable lifestyle choices, lifestyle factors account for just 35 per cent of the total disease burden; meaning that more complex factors are obviously at play.

We Need to Act Together

There is a growing awareness that the key to closing the health inequity gap is for the different parts of society that influence health and wellbeing to work together.

This is called 'intersectoral' action.

Intersectoral action acknowledges that the major causes of health and wellbeing are out of the control of hospitals and health services. Sectors outside of health like housing, education, agriculture and transport need to champion collaborative action for better health; if the major determinants of health are intersectoral, then so too must be their solutions.

By working together, there is greater capacity, knowledge and expertise to address problems more effectively, to improve cohesion and to reduce duplication of effort.

All sectors of the Tasmanian community have a potential role because social and economic factors strongly drive health and wellbeing.

As well as influencing political, economic and social factors, action to address health and social inequity at the community and neighbourhood level is important to provide people with greater opportunities in their lives, reduce some of the barriers to good health and protect people from the consequences of disease and injury.

Community driven action can help create more socially supportive environments and develop the personal skills that will improve health.

3. Everyone's Talking About Determinants

There is a growing awareness of the underlying causes of health and the influence of all parts of society upon it.

Closing the Gap in a Generation[3], the World Health Organization's (WHO) recent call to action on the social determinants of health, has sparked worldwide debate on the need for 'intersectoral action' on heath inequity. The report named the conditions in which people are born, grow, live, work and age as issues of concern for all governments, sectors, communities and civil society.

Other major publications quickly followed this land-mark report, further highlighting the health inequity gap and the need to address this through intersectoral action.

Fair Society, Healthy Lives[4] was Sir Michael Marmot's take on how the directions of the WHO report could apply to the United Kingdom. Marmot emphasised the need to address the social gradient in health through factors that included early childhood, education and skills, employment, minimum income and sustainable communities.

Similar publications have echoed these sentiments in Australia and State and Territory Governments are now moving towards intersectoral action on health inequity by 'joining up' activities across portfolios.

As these reports have so clearly articulated, health departments working in isolation, have little influence over the underlying determinants of health.[5]

There have been calls for the Tasmanian Government to take a lead in driving intersectoral action on health inequity. The *Our Island Our Voices* campaign by the Tasmanian Council of Social Services raised the issue in 2009.

Since that time, the Health in All Policies Collaboration, led by the Tasmanian Chronic Disease Prevention Alliance, has continued to advocate for intersectoral action. The Minister for Health answered the call in 2010 and initiated the *Fair and Healthy Tasmania Strategic Review* to explore the issues, and to make recommendations for action.

Intersectoral Action on Health

Intersectoral action brings all parts of society together to improve health and reduce health inequity through action on the social determinants of health.

The concept was first introduced by the WHO as a key part of the 'primary healthcare model' described by the *Alma Ata Declaration* in 1978.

A primary healthcare model of medicine calls for a healthcare system that not only provides services, but also addresses the underlying social, economic and political causes of poor health.

In 1997 the WHO formally defined the concept during its Conference on Intersectoral Action for Health and called for new governance systems for implementation:

A recognised relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve heath outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone.

A Fair and Healthy Tasmania Strategic Review

The *Fair and Healthy Tasmania Strategic Review* considered the most appropriate approaches to improve health and reduce health inequity in Tasmania.

Key tasks that were completed by the DHHS in 2010 as a part of the strategic review were:

- A review of international evidence and approaches for intersectoral action on health inequity;
- A review of contemporary approaches in other parts of Australia;
- A consideration of the relevant action already being taken within Tasmania, and opportunities for more work across sectors;
- A briefing from the Minister for Health to cross sector representatives and interest groups, followed by ongoing liaison;
- Consideration of the implications of a health services commissioning framework and links to National Partnership Agreement reporting for Prevention and Healthcare;
- An analysis of the cost burden of Tasmania's poor health outcomes and the evidence for improvements made through prevention;
- A review of concessions programs available through services provided by DHHS, including advice provided to clients and protocols for collecting co-payments where they are applicable; and
- Consideration of the relevance of the Arts for reducing avoidable health inequities and improving health literacy.

We Need to Work Together

During the course of the Strategic Review it became clear that Tasmania's social, economic, business, infrastructure, planning and industry sectors can no longer be considered separately. Education, early childhood, housing and social inclusion factors have a far greater impact on the wellbeing of Tasmanians than health and hospital services ever will.

It also became clear that the health of people and communities has a major and ongoing impact on Tasmania's employment, economic, sustainability, environmental, community and justice outcomes. So while health will always have its own role and responsibilities to optimise service performance and accountability, there is also much to be gained by working across sectors.

Principles of the Strategic Review

Actions recommended within the *Fair and Healthy Tasmania Strategic Review* are strongly focused on addressing the underlying causes of health and wellbeing in Tasmania.

The recommendations are based on best available evidence and are in line with the general principles that change can only be effected by:

- A long-term approach that lays down the foundations for a fair and healthy Tasmania that can be built on over time;
- Addressing the root causes of health inequity – the social determinants of health;
- Providing strong leadership across sectors with clearly articulated priorities for action;
- Resourcing communities to build resilience and connectedness; and to increase participation in decision making so that people have greater control over their own lives;
- Increasing investment into prevention and committing to improving the health and wellbeing of Tasmanians for the long term; and
- Building the foundations for the health intelligence, research and evaluation we need to make sustainable change.

Policy Drivers

The Tasmanian Government recognises the importance of a preventive health agenda and many of the State's key policy documents acknowledge the need to address the social determinants to improve health and wellbeing. *Tasmania's Health Plan*[6] recognised that the origins of a healthy population are in the provision of safe, quality healthcare, delivered as close as possible to where people live. The plan introduced a much stronger focus on a primary healthcare model of medicine to Tasmania and the need to address the underlying causes of chronic conditions.

The release of *Tasmania's Health Plan* paved the way for further policy advancements, including the *Connecting Care: Chronic Disease Action Framework 2009-2013* and *Working in Health Promoting Ways: a Strategic Framework for DHHS 2009-2012,* both of which place a strong emphasis on pursuing action that addresses the social determinants.

At a whole-of-government level, the *Social Inclusion Strategy for Tasmania* has raised awareness of how community connections relate to broader social and economic outcomes in Tasmania.

The *Tasmania Together* vision, goals and indicators also relate to health. The gains associated with good health will benefit all sectors associated with *Tasmania Together*. The *Tasmania Together* process also monitors the underlying conditions that determine health, like education, employment and social inclusion.

Tasmania Together continues to offer a sound mechanism for monitoring health and wellbeing in Tasmania and the conditions that determine good health. Achievement of *Tasmania Together* goals may also prove to be the incentive needed to bring together key parties for intersectoral action on health inequity.

4. What the Strategic Review Told us

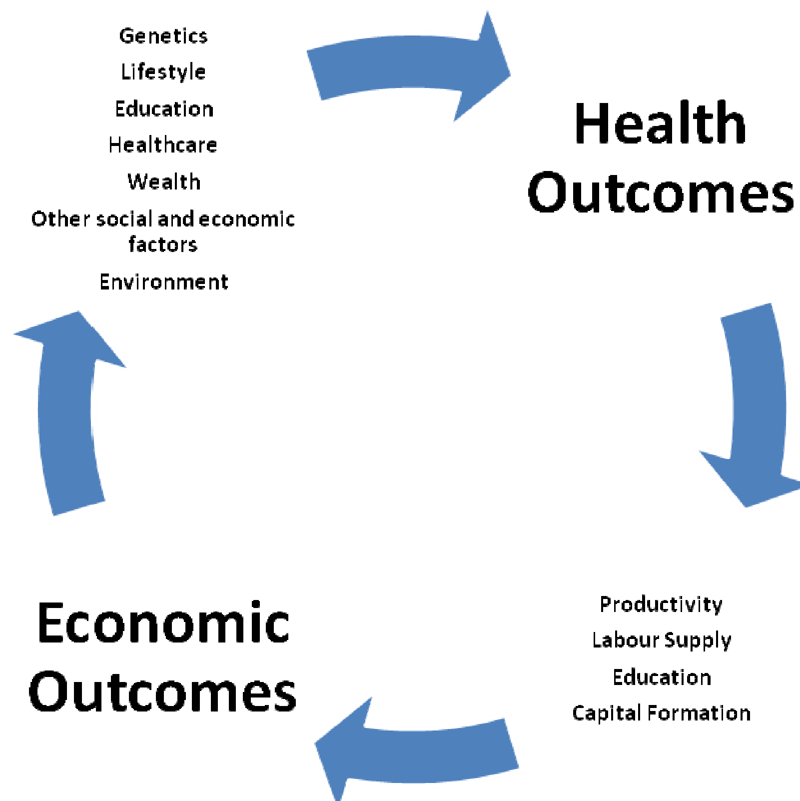
4.1 Why Wellbeing Matters

Wellbeing underpins the quality of life of Tasmania's families and communities, the strength of the economy and the amount of pressure placed on the healthcare system.

Health and wellbeing produces significant social and economic benefit. The factors that build people's health are the same as the factors that build the health, wealth, safety and vitality of families and communities.

A healthy economy, for example, relies upon healthy people to sustain it (see Figure 1). For health underpins a person's capacity to participate in education, employment, and a whole host of other social and leisure activities. Health outcomes influence workforce participation rates, reliance on government pensions and allowances, and involvement in community activities and services.

Figure 1. Relationship between Health and Economic Outcomes[7]



Likewise, access to transport, cost of living, literacy and social disadvantage influence health. Many Tasmanian families and communities lack the basic social and economic resources to choose and sustain a healthy lifestyle. For example, the cost of food, electricity, housing, transport and health as a proportion of income for low-income households is 92 per cent, leaving little disposable income after the cost of living[8]. This makes health a critical indicator of both social and economic development that can serve as the common ground for stakeholders in moving towards fairer and more equitable communities.

Economic and Social Benefit of Wellbeing

The cost of health inequities can be measured in human terms, by years of life lost and years of active life; and in economic terms, by the cost to the economy of additional illness.

This means that significant economic and social benefits are to be gained from better wellbeing and is why healthcare is increasingly focusing on the prevention of chronic conditions that cost the Australian community so much.

The rising importance of preventive health is evident in the policies and strategies of the current Australian Government, such as the *National Preventive Health Strategy* and the Australian National Preventive Health Agency, and the recently appointed Preventive Health Agency Council.

Latest Australian Institute of Health and Wellbeing figures show that the increasing focus on preventive health is decreasing premature deaths from potentially avoidable chronic conditions (down by 17 per cent in the last 10 years).

On the other hand, only some of the behavioural risk factors for chronic conditions are decreasing (eg smoking), while others are increasing (eg obesity).

Overall, in keeping with our ageing demographic and risk factor distribution, the prevalence for many chronic conditions is on the rise, showing that there is much more work to be done to realise the full social and economic benefits of better wellbeing.

(Source: Preventative Health Taskforce, *Australia: The* Australian Institute of Health and Wellbeing, *Key Indicators of Progress for Chronic Disease and Associated Determinants,* Cat No PHE 142, Canberra: AIHW)

4.2 What Builds Well Communities

Many factors build the health and wellbeing of people and communities. These factors can be personal, social, economic and environmental, they are often complex and interact.

The WHO has grouped the determinants of health into seven broad categories: [9]

1. Social and economic environment;
2. Physical environment;
3. Early childhood development
4. Personal health practices;
5. Individual capacity and coping skills;
6. Biology and genetics; and
7. Health services.

The Physical Environment and Health

The natural and built environment can have a significant influence on the way that people eat, move, play and connect with others.

The way that cities and communities are designed impacts upon the behaviour of people in many ways. People are more likely to make healthy choices when they are easily available to them and so environments that support healthy behaviours can promote good health.

Built environmental factors that can influence physical activity include: public spaces and recreation areas; foot paths and cycleways; street connectivity and design; public transport; distance between workplaces, shops and residential areas; and the layout of buildings.

Nutrition can even be influenced by the location of food stores, vending machines, advertising and the location of agricultural land.

Likewise, community connectedness can be facilitated by shared spaces, community arts and gardens and perceptions about public safety. Neighbourhoods that encourage people to get out and about and meet others build a sense of community.

The positive impacts of moving to a healthier built environment extend beyond health and into many other sectors. Active transport like walking and cycling benefit the environment by reducing greenhouse gas emissions; and businesses in pedestrian friendly neighbourhoods benefit from increased foot traffic.

A number of publications are available that aim to guide the development of physical environments that better support health and wellbeing. Examples include the Heart Foundations' *Healthy by Design: A Planner's Guide to Environments for Active Living* and NSW Health's *Healthy Urban Development Checklist.* Both encourage planners, developers and policy makers to adopt healthy built environment principles.

In Tasmania, a number of local councils are adopting this approach. For example, Hobart City Council's Intercity Cycleway receives more than 250 bicycle commuters each day and the *Greater Hobart Arterial Bicycle Network Plan* is expanding the number of bike lines around Hobart. Similar tracks and walkways are also in place in Burnie, Latrobe, Devonport and Launceston.

Early Childhood Development and Health

Poverty experienced during early childhood has been shown to strongly influence health outcomes later in later.

Children who grow up in poverty are more likely to develop and die earlier from a range of diseases than their wealthier peers.

This effect has been shown to be especially strong for cardiovascular disease and Diabetes Type 2.

It appears to result from biological factors determined in the early years, which are only modestly reversed by improved social and economic circumstances later in life.

(Source: Raphael, D. 'Poverty in Childhood and Adverse Health Outcomes in Adulthood,' in *Maturitas*, *69*, 22-29, 2011)

The social determinants of health are those conditions of daily living that determine a person's chances of achieving good health: the conditions in which people are born, grow, live, work and age.[10]

Some of the most important determinants are social.

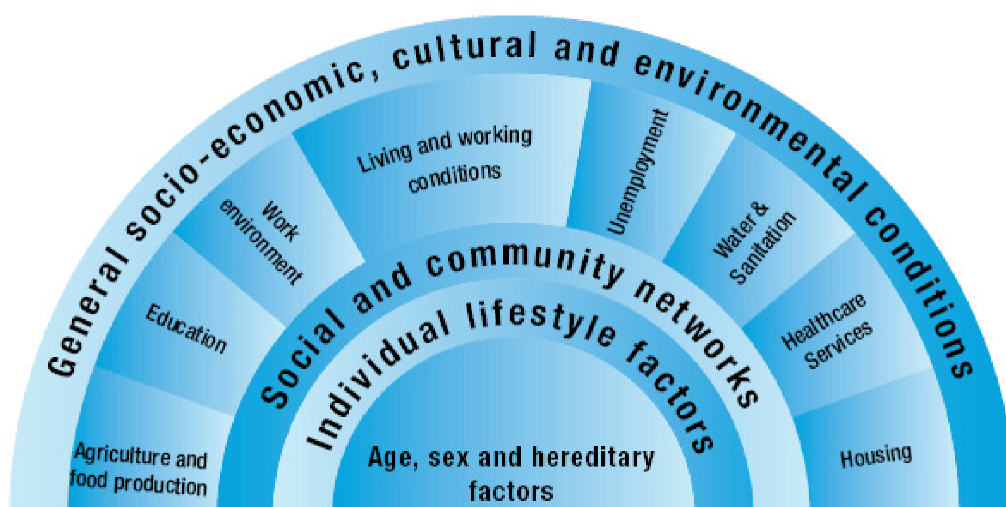
Also known as the *causes of the causes*, they include: a safe environment, adequate income, meaningful roles in society, secure housing, higher levels of education and social support within communities, all of which are associated with better health and wellbeing.[11]

The social determinants of health are vitally important because they can play a greater role in determining health than access to hospitals and other health services ever will.

For example, researchers have found that people who are more educated are more likely to have access to and eat healthy foods, which has a positive impact upon health.[12] Similarly, low-income households are more likely to report their health as poor, experience depression, have time off from work due to illness and report physical impairment.[13]

In this way, the social determinants also determine the degree of inequity between the health of individuals and groups, and those who have the least resources in life have the poorest health.

Figure 2. The Dahlgren and Whitehead Model of Health Determinants, 1991[14]



The Importance of Social Capital[15]

The notion of social capital first came to prominence in the 1990s through the work of Robert Putnam who recognised social capital as a valuable resource for local communities.

Putnam argued that social connections have value, both to the individual and society, and coined the term 'social capital' to describe the effect.

Pierre Bourdieu furthered Putnam's work. Bourdieu argues that social capital is a resource held by individuals that can facilitate access to a range of other capitals (eg economic capital, education capital). Access to capital determines an individual's position in the social gradient.

Bourdieu links power and inequity to social capital theory. He argues that differences in power can act to reinforce existing inequities - those who are more economically disadvantaged have lower levels of social capital which make it more difficult to accumulate economic capital.

In this way, people and communities need to develop the power to affect their own lives and life choices to achieve positive outcomes.

The Solid Facts

In 2003 the WHO commissioned an analysis of evidence on the social determinants of health from across Europe.

This seminal document, titled *The Solid Facts*, identified ten key social and economic factors with the greatest influence upon health:

1. The social gradient
2. Stress
3. Early life
4. Social exclusion
5. Work
6. Unemployment
7. Social support
8. Addiction
9. Food
10. Transport

There are established links between social capital and health and wellbeing. In addition to having greater social support, people with high levels of social capital have greater access to the resources that positively influence health.

Studies have shown that social capital correlates with individual health outcomes, including coronary heart disease, mortality and mental health outcomes. For example, people with less social support are two to three times more likely to die of all causes than people who are more socially connected.

Research at a community or state or country level is limited, but there is emerging evidence that places that have higher levels of social capital have better population health outcomes.

Social capital theory now influences many community-based health promotion approaches. Community action to build social capital can help create more socially supportive environments and develop a wide range of personal skills that can contribute to personal and community health.

The *Ottawa Charter for Health Promotion* by the WHO states that 'health promotion is the process of enabling people to increase control over, and to improve their health.' Community action to create places that empower people to be healthy may offer a means of achieving this.

4.3 Why Health isn't Equitable

No matter how effective healthcare becomes, there will always be some differences in the health and wellbeing of people and communities because of factors outside of healthcare.

Some degree of difference in health outcomes across populations is inevitable because of factors that are uncontrollable by the health sector alone – factors like access to transport, the cost of living, literacy and social disadvantage.

These differences exist all throughout the world.[16] They exist because of natural, unavoidable factors like biology and genetics that are unchangeable; but they also exist because of unnatural, avoidable factors that are social and economic and are changeable.

These unnatural, avoidable factors are of greatest concern. They are called 'health inequities' because they usually stem from some form of social injustice and are commonly judged as unfair.

Differences in health outcomes are described as health inequities if they result from:

- Unhealthy behaviour where the degree of choice for a healthy lifestyles is restricted;
- Exposure to unhealthy living and working conditions;
- Inadequate access to essential health and other public services; and
- Reduction in social mobility involving the tendency for sick people to move down the social scale.

Judgements as to which health differences are health inequities are often controversial, and views on what is equitable vary socially, culturally and historically. [17]

Health inequity is a particular concern for Tasmania, which falls behind the nation on many important measures of health and lifestyle, experiences greater levels of disease and disability and has a number of vulnerable population groups at increased risk of poor health outcomes (see Appendix 8.2).

Health Inequity and Biology

To date natural, biological differences in health have not been thought of as health inequities.

However, as medical science advances, researchers are finding that a person's individual characteristics vary or interact with their social and economic status.

Height, for example, has now been linked to social disadvantage in early childhood.

There is even a suggestion that environmental conditions can affect a person's genetic makeup and how it is expressed, which in turn affects their susceptibility to poor health. This phenomenon is known as 'epigenetics.'

Why Tackle Health Inequity?

There is a strong moral and ethical argument for tackling health inequity:

It's a matter of fairness:

- ✓ Improving health and wellbeing by reducing inequity is a matter of fairness and social justice.
- ✓ Tasmania is a beautiful place to live and while we enjoy an enviable quality of life, there is a concerning gap between out health and the rest of Australia.
- ✓ Tasmanian falls behind the rest of Australia on a number of health and lifestyle measures and Tasmanians experience greater levels of disease and disability.
- ✓ Tasmanians are dying prematurely and thousands experience hardship, do not reach their potential and have poor quality of life.
- ✓ The indirect cost of health inequity costs the whole community – for example lost productivity, lost wages, absenteeism, family leave, and premature death.

Those with the least face the worst:

- ✓ Disadvantaged Australians are more likely to have shorter lives (3.1 years less on average) and more likely to suffer illness and disability throughout their lives.
- ✓ People living in areas of low socioeconomic status experience a 32 per cent greater burden of disease than people living in high socioeconomic areas.[18]
- ✓ This is particularly concerning for Tasmania, where 34.1 per cent of households are dependent on government pensions and allowances – the highest rate in the country and rising.[19]
- ✓ While it may not be possible to eliminate the social gradient in health, it is possible to have a shallower gradient. This is a matter of social justice.

Health Inequity is a Triple Inequity:

- ✓ Vulnerable population groups are at greater risk of poor health because of a triple inequity:
  1. The quality of the environment in utero and in early childhood has a profound impact on a person's neurological development, immune system development and hormone levels, all of which influence the likelihood of good health throughout the lifespan;
  2. Disadvantage throughout life makes people more susceptible to the lifestyle risk factors associated with poor health (smoking, poor nutrition, physical inactivity and psycho-social distress are all linked to socioeconomic status); and
  3. Disadvantage throughout life reduces access to services and resources during times of poor health (access to transport, health literacy, level of education and type of employment are all linked to ability to access effective health and social care).
- ✓ To address the triple inequity in health, prevention initiatives need to occur at three levels: social and economic determinants, behavioural determinants and access to services.

Health and wellbeing follows the social gradient. A person's place in society strongly influences their chances of achieving good health.

There is a social gradient that reflects a person or community's position in society, including their level of:

- Access to and security of resources such as education, employment and housing; and
- Participation in society and control over life.

Health and wellbeing clearly links to this social gradient. Life expectancy is shorter and most diseases are more common further down the social ladder in every society.[20]

Not only are there dramatic differences between the 'best off' and 'worst off' in society, but the relationship between social circumstances and health is a graded one: the higher a person's social position, the better his or her health.[21] In other words, the effect of the gradient is so strong that there are potential gains to be made in all those who sit beneath the very wealthiest in society.

To illustrate the effect of the social gradient on health, researchers working on the Marmot Review in England calculated that even after excluding the poorest five per cent and the richest five per cent of society, the gap in life expectancy between low and high income earners is six years, and in disability-free life expectancy 13 years.

International research has found that people from low-income households are more likely to:

- Report their health as fair or poor;
- Have depression;
- Have days off work due to ill health;
- Report greater levels of disability;
- Have difficulty accessing and affording healthcare; and
- Be treated differently by the health system than their more wealthy counterparts.[22]

Even the behavioural factors associated with poor health are linked to social and economic conditions. Australian researchers have linked nutrition to social status, with people who are socially disadvantaged at increased risk of unhealthy eating.[23] People who are disadvantaged are more likely to buy foods that are high in fat and sugar as these are often a cheaper and more readily available source of calories; and access to healthy foods are shown to be more difficult in disadvantaged areas due to greater distance to food stores and poorer access to transport.[24]

The Social and Economic Determinants of Stroke

People living in disadvantaged areas have a 70 per cent higher chance of having a stroke than those living in more affluent areas, according to research released by the George Institute for Global Health in 2011. People living in disadvantaged areas who had strokes are more likely to be blue-collar workers, smokers, of European descent and have a history of hypertension and diabetes. On average they are also more likely to have a stroke at a younger age compared to wealthier people (68 versus 77 years).

Health Inequity in Rural Areas[25]

Living in a rural area may be a significant risk factor for health inequity in itself. There are documented differences between the social determinants of health in rural and urban areas. People living in rural areas consistently report lower incomes, lower levels of education, higher unemployment and poorer access to healthcare. Rural people also experience poorer housing, less secure and costlier fresh food and water and greater exposure to occupational hazards.

While it is not possible to say exactly to what extent the social determinants of health adversely impact health and wellbeing outcomes in rural areas, it is certain that they play a substantial role.

Australian Institute of Health and Welfare data[26] show that regional, rural and remote areas right across Australia experience higher levels of many of the common behavioural risk factors for poor health and report their own health as poorer. These areas have:

- 20 per cent higher reported rates of only fair or poor health;
- 10 per cent higher levels of mortality;
- 24 per cent higher rates of smoking;
- 32 per cent higher rates of risky alcohol consumption;
- 20 per cent higher rates of injury and disability;
- 20-40 per cent higher levels of sedentary behaviour (for males);
- 10-70 per cent higher rates of perinatal deaths; and
- 15 per cent higher rates of overweight and obesity.

Even life estimated expectancy is up to four years lower in rural, regional and remote areas than it is in Australia's major cities (equal to 4600 premature deaths per year in rural and remote Australia).[27]

Some of these risk factors may be greater in rural and remote areas because public health campaigns that work in major cities do not translate as well into rural and remote settings that experience greater levels of stress and isolation and lower levels of control over day-to-day living. For example, while smoking rates in urban areas declined by about 15 per cent between 1995 and 2005 because of anti-tobacco measures, rates have not fallen as much in rural areas.

Being a rural and regional area[1] may explain why many of Tasmania's health outcomes are lower than national averages. It may also mean that the health and wellbeing of Tasmanians is similar to that of people in other parts of Australia who are facing the same challenges, and that the State's health outcomes are not as behind the rest of the country as they appear.

It is important to note that despite the many challenges that rural areas face, there are significant advantages too.[28] Many people choose to live in rural areas because of the relaxed and enjoyable lifestyle. In comparison to urban areas, perceptions of personal safety, community connection and a general sense of wellbeing are higher in some rural areas. All of which can have a positive effect on health and wellbeing. In this way, Tasmania's rural and regional status is both an asset and a challenge.

Literacy, Health and Wellbeing

The influence that poor literacy has on a person's everyday living is bad enough; let alone the fact that it negatively affects their health and wellbeing outcomes too.

The Department of Health and Human Services has defined health literacy as, "the knowledge and skills needed to access, understand and use information related to physical, mental and social wellbeing."

For example, a person's ability to understand the instructions given to them by their Doctor about how to take a medication or modify their lifestyle is strongly influenced by their level of health literacy.

The complex, busy and sometimes intimidating nature of healthcare today means that even people with quite high literacy, can have poor health literacy.

Poor health literacy has been linked to unnecessary hospital admissions and emergency department presentations, medication and treatment errors and service access difficulties.

Research in the United States has shown that there is an overall link between literacy, health outcomes and disease status.

Health literacy is a significant concern for Tasmania, where education and literacy levels are lower on average compared to the rest of Australia, with disadvantaged groups particularly vulnerable.

According to the Australian Bureau of Statistics, more than 60 per cent of people in Tasmania do not have adequate health literacy, including 30 per cent of people educated to the level of a Bachelor Degree.

The Department of Health and Human Services is developing a Communication and Health Literacy Action Plan to improve communication between staff and clients and improve health literacy across Tasmania.

[1] Note: Under the Australian Standard Geographic Classification (ASGC) system, the Australian Bureau of Statistics (ABS) classifies Tasmania as regional and even remote and migratory in parts. (See the ABS remoteness structure at www.abs.gov.au.)

There are vulnerable population groups who are at greater risk of poor health and have fewer resources to cope when illness strikes.

Some groups of people are more susceptible to disease and disability because of disadvantage, and those who have the least resources often experience the poorest health.

Australian population groups who are vulnerable to poor health include Aboriginal people, people with disabilities, people with mental health issues, migrants and refugees, people in the criminal system, carers, young people in state care and people with unstable living conditions, including people who are homeless.[29] Health inequity is a particular concern between Aboriginal people and the Non-Aboriginal population, and the life expectancy for Aboriginal people is around 17 years shorter than the Australian average (in both urban and rural areas).[30]

There is a need for action to tackle unfair and unnecessary differences in the quality of life in Australians.[31] It is unlikely that the social gradient in health and wellbeing can be eliminated

Case Study – What are Warren's chances of achieving good health?

Warren is seven years old and has just started primary school. His mother is unemployed and living on a disability support pension. Warren hasn't seen his father since he was three years old.

Warren's mother often worries about him and how she will cope when he gets older. She has always struggled with Warren, ever since he was a baby - he was born underweight and developed bad asthma.

Doctors told Warren's Mum that her smoking was bad for his asthma. She tried quitting, but found it hard to do this alone and the clinic in Hobart is not easy for her to get to. Besides, it's hard to quit when the cigarettes are such a comfort. It's getting even harder now he's at school – last week the other kids picked on him because he didn't have any money to go on a school excursion, and then he got in trouble for fighting.

Given what is known about the social determinants of health, what are Warren's chances of achieving good health? Consider this:

- The stress and disadvantage Warren experienced in his Mother's womb and in his early years have already impacted on his neurodevelopment and his immune system, making him more susceptible to a range of health conditions in later life.
- If Warren's troubles with the education system continue he may leave school early, making it more difficult for him to find meaningful employment, further impacting upon his chances of achieving good health.
- Warren is more likely to take up smoking as he lives in a house with smokers, this would have a profound impact upon his future health and wellbeing.
- If Warren's social and economic status continues, he will be more likely to suffer illness and disability throughout life and have difficulty accessing the support services required to deal with this.
- If Warren develops illness and disability in later life, this will impact on his employment options, risk of social isolation and susceptibility to depression and mental illness, continuing the cycle of inequity.

completely, but it is possible to have a shallower gradient than is currently the case.

4.4 Counting the Cost of Inequity

Every day health and social inequity costs the Tasmanian community dearly in both human and financial terms.

While the total human and financial cost of health inequity is impossible to quantify, estimates in purely economic terms show that the impact is likely to be very costly to individuals, families, communities and society as a whole.

For example:

- Researchers have shown that if all Australians had the same health as the wealthiest 20 per cent of the population, healthcare costs would be around $3 billion dollars lower and government would save close to $1 billion dollars on the disability support pension every year;32
- In New South Wales, average hospital inpatient costs for those on the lowest incomes have been shown to be 16 per cent higher than those on the highest incomes;33
- European economists calculated that the loss of labour productivity associated with the inequitable burden of avoidable mortality decreases gross domestic product by 1.4 per cent or €141 billion Euros each year;34 and
- European economists have also estimated that the inequitable burden of avoidable mortality accounts for 15 per cent of social security system costs and 20 per cent of healthcare costs each year.35

Estimating the Global Cost of Chronic Conditions

In 2011 Professor David Bloom of the Harvard School of Public Health costed the economic impact of a key group of chronic conditions - diabetes, ischemic heart disease (including strokes, cerebral vascular disease, chronic obstructive pulmonary disease) and breast cancer.

Professor Bloom's team estimated that the lost economic output associated with these diseases alone during the 25 year period from 2005 to 2030 will amount to $35 trillion or seven times the current level of global health spending.

The global cost of treating chronic disease was estimated at more than $300 billion for newly diagnosed cancer cases and $400 billion for chronic obstructive pulmonary disease in 2010.

Nearly two-thirds of deaths in the world are caused by chronic, non-communicable diseases, a problem felt by both developed and developing nations.

Assessing the Cost-Effectiveness in Prevention

The *Assessing Cost-Effectiveness (ACE) in Prevention Report*[36] is the result of five years of research by the University of Queensland and Deakin University on the potential returns of investment in preventive health. The report is the most comprehensive of this type ever conducted and shows there is significant opportunity to cut the cost of health inequity.

The ACE Team found that with annual health and aged care expenditure projected to grow to $246 billion dollars in Australia by 2033, the need for proven, affordable illness prevention is pressing. Yet while the economic case to increase funding into initiatives targeted at preventing ill health is compelling, public health currently receives only two per cent of the Australian healthcare budget.

The report argues that Governments must place greater importance on prevention to avoid a massive rise in preventable illness in the next few decades and identifies a number of proven strategies for investment, which if fully implemented, could potentially prevent a million premature deaths among Australians now alive.

The ACE Team also modelled the likely impact of a package of national prevention initiatives identified as most cost effective and found that an investment of $4.6 billion dollars could ward off $11 billion dollars in healthcare costs and one million Disability Adjusted Life Years (DALYs) over the lifetime of the 2003 Australian population.

Why Invest in Prevention?

There is compelling and undeniable evidence for greater investment into prevention:

Prevention delivers[37]

- ✓ Prevention reduces the personal, family and community burden of disease, injury and disability.
- ✓ Prevention allows better use of health system resources.
- ✓ Prevention generates substantial economic benefits, which are tangible and significant over time.
- ✓ Prevention produces a healthier workforce, which in turn boosts performance and productivity.

Prevention saves lives

- ✓ In the 1950s three-quarters of Australian men smoked. Less than one fifth smoke now.[38] Between 1975 and 1995 an estimated 400,000 Australians were saved from dying prematurely through smoking prevention.[39]
- ✓ Deaths from cardiovascular disease have also decreased dramatically from all-time highs in the late 1960s and early 1970s to today.[40]
- ✓ Road trauma deaths on Australian roads have dropped by 80 per cent since 1970, bringing death rates back to levels not seen since the 1920s.[41]
- ✓ Deaths from Sudden Infant Death Syndrome (SIDS) have declined by almost three-quarters between 1997 and 2002 (from 195.6 deaths per 100,000 live births, to 51.7 per 100,000).[42]

Prevention saves dollars

- ✓ Prevention saves the health system and broader community money that could be spent more effectively elsewhere – it reduces waiting list numbers, reduces people living on the pension, reduces crime and reduces suicide.
- ✓ For every $1 invested into evidence-based prevention programs (eg targeting smoking, physical activity, nutrition), an estimated $5.60 in savings is delivered back into the community within five years.[43]
- ✓ Between 1975 and 1995, reduced smoking rates saved the Australian economy an estimated $8.4 billion dollars.[44]
- ✓ If all Australians had the same health status as the most affluent 20 per cent of the population, annual health care costs would be around $3 billion dollars lower, and the government could save close to $1 billion dollars on the disability support pension annually.[45]
- ✓ If Tasmania can meet the National Partnership Agreement on Preventative Health targets, it will access reward payments of up to $7.1255 million across 2013-14 and 2014-15.
- ✓ European economists conservatively calculate that the loss of labour productivity associated with the unequitable burden of avoidable mortality decreases gross domestic product by 1.4 per cent or €141 billion Euros each year.[46]

4.5 Recommendations

The *Fair and Healthy Tasmania Strategic Review* found *leadership across sectors* and *placed-based approaches* to be the best ways of improving health and reducing health inequity in Tasmania.

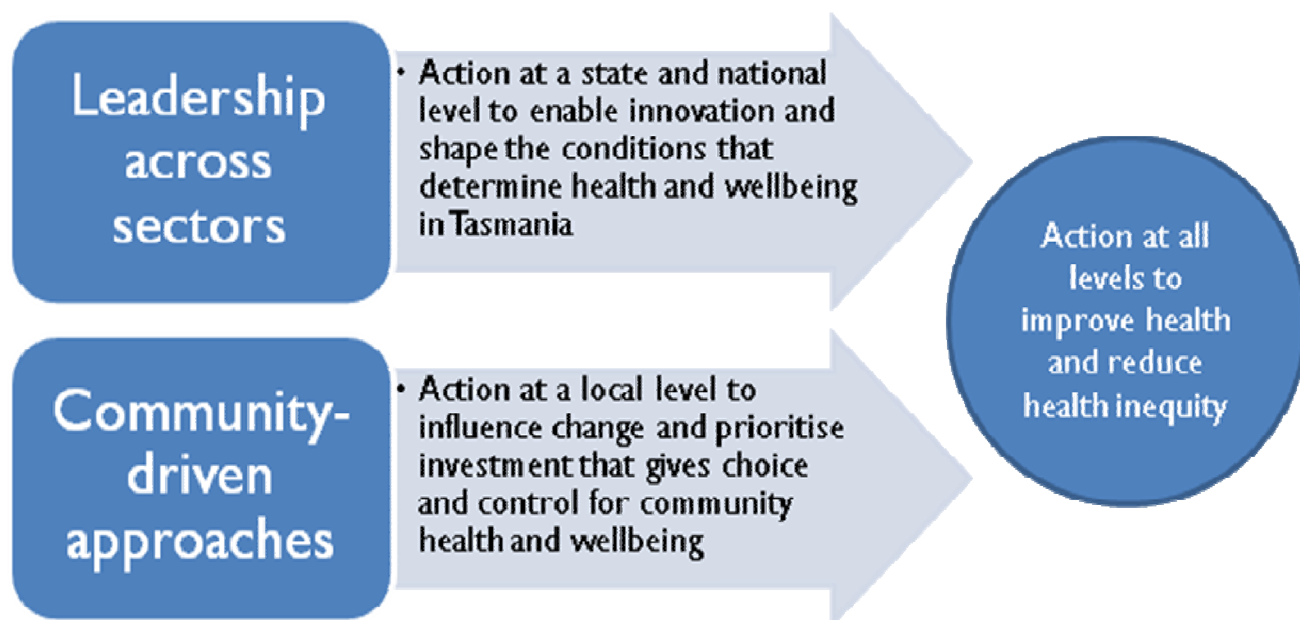
The *Fair and Healthy Tasmania Strategic Review* looked at the best evidence available from around the world for direction on how to improve the health and wellbeing of Tasmanians. It found that to improve health outcomes and reduce the gap between rich and poor, the Tasmanian community needs to get real about working together.

There are a number of possible approaches for bringing together the resources and expertise of all sectors. Bringing all parts of society together to work on the challenges shared by many will improve how Tasmania can position itself into the future as a whole-of-state.

The Strategic Review recommends whole-of-community action through collaborative partnerships with communities, government, non-government and private sectors, to improve the conditions in which Tasmanians are born, grow, live, work and age.

The review's main findings are that *leadership across sectors* and *place-based approaches* are the best ways of improving health and reducing health inequity in Tasmania (see Figure 3).

Figure 3. Recommendations of the *Fair and Healthy Tasmania Strategic Review*



The Fair and Healthy Tasmania Strategic Review recommends a long-term approach for building good health and wellbeing in collaboration with communities. It calls for action from the many parts of society that can help build the conditions that will keep Tasmanians healthy and well.

This would involve a combined approach of structural action to improve environments and conditions to support healthy lifestyles and choices; together with community action that builds capacity, reduces barriers for health, builds on strengths and assets, develops resilience and positively encourages policies that reduce avoidable inequity.

Sectors that fall within the scope of intersectoral action on health inequity in Tasmania include:

- *The broad public sector*: all government agencies, e.g. health and human services, education, economic development;

  As well as

- *The private sector*: all parts of civil society, e.g. business, professional, media and community groups.

Leadership across Sectors

A coordinated, statewide approach will bring together all the sectors that shape the conditions of daily living that determine health and wellbeing in Tasmania. Leadership will drive intersectoral action on health inequity.

The establishment of a Health and Wellbeing Advisory Council to provide high-level direction across all sectors and guide specific measures targeted at improving health and reducing health inequity is recommended.

Enhancing and coordinating existing preventive health activity and information, as well as establishing new action to tackle social and health inequity could also be a role of the Council. Specific measures recommended included: health outcomes monitoring and surveillance, community needs assessment, and legislation and regulation activities across sectors. A strong priority in the first instance will be to put a fair and healthy Tasmania at the forefront of thinking in all Gvoernment agencies, and within the broader Tasmanian community.

There are partnerships with key stakeholders to be built on. Through the *Fair and Healthy Tasmania Strategic Review* the DHHS has already forged strong relationships with the Health in All Policies Collaboration, the Tasmanian Chronic Disease Prevention Alliance, other non government and community sector organisations, Tasmanian Government agencies, the University of Tasmania, local government, general practice, and the Public Health Association (Tasmanian Branch). The Health and Wellbeing Advisory Council would be a way of continuing the collaborative approach that has already begun.

There are many successful examples of intersectoral action already underway in Tasmania. The Tasmanian Government needs to build on these approaches and learn from their many challenges and achievements. Examples include the *Tasmanian Food and Nutrition Policy* and the Food Security Council, the Interagency Working Group on Drugs, *Our Children Our Young People Our Future – Tasmania's Agenda for Children and Young People,* Children and Family Centres, and the development of a Liveability Strategy for Tasmania.

Collaboration – A Tasmanian Government Approach[47] was developed by the Department of Premier and Cabinet to provide a framework for such interagency work in Tasmania. It outlines the critical factors for successful collaboration and the potential structures that can be used to pursue them. This document will be a further useful resource for the proposed Advisory Council.

Building Capacity for Intersectoral Action

In 2008 the WHO commissioned the discussion paper, *Health Equity at the Country Level: Building Capacities and Momentum for Action*, on how countries had built up momentum for intersectoral action for health equity.

The report found that three separate but related phases of work are recommended:

1. *Increasing the visibility of social determinants of health and heath equity issues* – for example, by using data on health inequities to stir public concern and generate political will for action;
2. *Creating an institutional structure* - to take the social determinants of health agenda forward, for example, a commission or reference group; and
3. *Developing a national action plan* - this can usefully highlight specific opportunities for action in a relatively short time frame (e.g. one year), while also looking towards more ambitious horizons of structural change to reduce social inequities.

The report also suggests the key steps that health departments can take to build momentum for intersectoral action:

1. Clearly define the role the department of health will play;
2. Communicate with other departments to identify shared concerns and potential areas of action;
3. To expand intersectoral buy-in, consider incorporating the social determinants of health into a broader, more accessible vocabulary of social justice and wellbeing;
4. Use tools such as Health Impact Assessment to evaluate policies outside the health sector and show why and how health concerns should be incorporated in these areas;
5. Support innovative government management models and incentive structures that can encourage intersectoral cooperation; and
6. Line up the support of government and administrative actors with broad mandates (eg Office of the Premier).

Place-Based Approaches

The *Fair and Healthy Tasmania Strategic Review* recommends placing the empowerment of people and communities at the heart of intersectoral action to improve health and reduce health inequity.

While traditional health promotion approaches have produced many successes (eg anti-smoking and seatbelt campaigns have reduced related mortality) there is still a long way to go to reduce the health inequity gap, and policy makers continue to look for new answers to population health problems.

International experience suggests that place-based approaches could provide a part of the solution. This is because local communities with high levels of social capital have better health and wellbeing outcomes and greater resilience (see 5.2).

Place-based approaches are widely used overseas and increasingly in Australia. They focus on addressing the concerns of particular communities, in partnership with the community members themselves.

Place-based approaches commonly acknowledge the assets that already exist within communities, and work by supporting and building this capacity to empower communities to address their own issues, in their own ways.

Throughout the process of building community capacity, it is important to remember that each community is unique. This means that infrastructure and characteristics of communities shape the particular issues faced by members. It also means that the unique knowledge and resources of communities can help develop and implement solutions.

A placed-based approach can focus the collaborative efforts of state government agencies, the non-government sector, local government and local communities on issues affecting particular communities.

Building Community Capacity

Community capacity building is a process that increases the assets and attributes a community is able to draw upon to take more control of and improve the things that influence people's lives.

The process has developed in various settings and sectors as a strategy for sustaining skills, resources and commitment.

In health promotion, community capacity building refers to the process of engaging the ability of a community to address their own health issues and concerns. This process relies heavily on collaborations and partnerships.

Health related benefits that are associated with community capacity building are:

- Empowerment of people and groups within communities;
- Development of skills, knowledge and confidence;
- Increased social connections and relationships (ie social capital);
- Responsive service delivery and policy, based on community needs and solutions;
- Strong community voices;
- Community involvement;
- Responsive and accountable decision-making;
- Resources for communities in need; and
- Community support for programs they have been involved in developing.

Place-based approaches are a long-term process rather than time bound projects. They are about ongoing relationship building, engagement, collaboration and teamwork.[48]

Tasmania may be particularly suited to place-based approaches for several reasons. Many Tasmanian communities are rich in natural, built, cultural and social assets. The dispersed nature of the Tasmanian population has arguably helped to foster local communities all over the State who are high in social capital. New and existing community infrastructure, such as community houses and neighbourhood centres, community health centres and child and family centres, provide a natural focal point for many communities that may be an ideal starting point for a place-based approach.

It is perhaps for these reasons, that many parts of government are currently exploring the possibilities of place-based approaches in Tasmania, including the Tasmanian Food Security Council and Interdepartmental Committees on liveability, mental health, suicide prevention and alcohol and other drugs. The development of social capital in local communities is also a strong theme in the *Tasmanian Social Inclusion Strategy*. Given the number of stakeholders that are exploring the potential of place-based approaches, now may be an ideal time to pursue this in Tasmania.

Community Action and the Primary Healthcare Model

Place-based approaches to health promotion are consistent with the principles of a primary healthcare approach to addressing the social determinants of health and health inequity (eg community level collective activity, lay knowledge). The aim is to encourage people to take control over decisions that affect their lives by providing support to create the conditions needed for a healthy life.

5. What we Think we Should do

5.1 Recommended Model

***The Fair and Healthy Tasmania Strategic Review* recommends a model for supporting Tasmanians to be healthy, well and in control of what matters to them.**

Figure 4. A Fair and Healthy Tasmania – Recommended Model for Health and Wellbeing

5.2 Activity Streams

The recommended model identifies six streams of activity.

Combined these activities would form *A Fair and Healthy Tasmania Model of Health and Wellbeing* (see Figure 4.) Collaborative partnerships that support the development of healthier communities are at the heart of much of this work.

Build leadership by…

Working together – to drive collaboration across government and community sectors for the attainment of shared goals and responsibilities.

Taking intersectoral action for health and wellbeing – highlighting the urgent need to address how the root causes of health are influenced by all sectors.

Addressing inequity and health – so that we have increased understanding of patterns of inequity; how they affect health to create unfair, unjust and avoidable differences; and how to address this.

Support the health and wellbeing of Tasmanians who are vulnerable by…

Adopting a life-course approach – to coordinate programs across key life-transitions, from pregnancy and the early years, to young adulthood, ageing and dying well.

Targeting social determinants of health – acting across sectors to influence the underlying causes of health and health inequity.

Spread the message of a healthy Tasmania so that we…

Empower people and communities – to have more control over their lives and the conditions that affect them.

Connect to support – by linking marketing to services and programs that support people to change (eg smoking cessation services and walking groups).

Enable access – to all available services in the health and social care system by, for example, adopting 'no wrong door' and client first approaches.

Build supportive environments and policies that will…

Promote and protect – to make healthy choices easier through legislation, regulation and settings-based strategies (eg food labelling, school canteens).

Build healthy people and places – by promoting facilities and spaces that are healthy by design, providing more access to alternative transport options and more opportunities for physical activity.

Explore health equity impact assessment – that will deliver evidence of the impact of all sectors on wellbeing.

Address locational disadvantage by…

Encouraging place-based approaches – so that we can mobilise the strengths of communities to help them overcome the barriers Tasmanians face to living well.

Using people-centred planning – to develop health and wellbeing programs with consumers and communities, in accordance with their needs.

Bring together and strengthen our health intelligence by…

Fostering Social Action Research – by developing partnerships between citizens, researchers and health practitioners to find out what keeps Tasmanians healthy and well.

Establishing health and wellbeing indicators – to improve the data and analysis needed to profile the health of our communities and meet national reporting requirements.

Investigating health outcomes-oriented commissioning – with the aim of funding services more effectively to meet the health and wellbeing needs of local populations.

Progressing the Primary Healthcare Model through National Reforms

It is now over 30 years since the members of the WHO signed the Alma Ata declaration, which identified the need to move to a primary healthcare model of medicine that focuses on health promotion and illness prevention, rather than purely the treatment of illness.

Despite such high level endorsement, and many subsequent reiterations of this commitment (ie Ottawa Charter, Jakarta Declaration, Bangkok Charter), most healthcare systems have failed to substantially translate this promise into practice.

Achieving better integration of health promotion and prevention activities across the entire health system can improve treatment. Preventive healthcare has been used to drive treatment in the United Kingdom, resulting in shorter hospital stays.

A significant opportunity exists now in Australia to progress this. The establishment of a National Preventive Health Agency and Medicare Locals is driving debate about how community health promotion and population health programs including preventive health can be maximised.

Medicare Locals will have oversight of general practice and other primary healthcare organisations, providing the potential for greater innovation, reform and culture change across these services.

5.3 Advisory Council

The Health and Wellbeing Advisory Council will be a high level, strategic, leadership body that focuses the resources of all sectors towards improving the health and wellbeing of Tasmanians and closing the gap between rich and poor.

The Advisory Council will bring together the sectors that have the power to shape the social determinants of health and health inequity in Tasmania (See Appendix 8.3). The Council will champion the vision to secure a fair and healthy Tasmania, and provide innovative and strategic advice to establishing new action to reduce avoidable social and health inequities.

The Hon. Michelle O'Byrne MP, Minister for Health will appoint the members of the Advisory Council for Cabinet. Membership will be drawn from the community, business and research sectors to collaborate on issues that influence health and health inequity in Tasmania.

To be effective the Advisory Council will need an appropriate balance of members who have knowledge and expertise in equity and contemporary thinking regarding place-based approaches, and leadership capacity to drive intersectoral action for improving health determinants.

5.4 Community Action Zones

One of the priorities for consideration by the proposed Advisory Council is the development of place-based approaches to support communities to develop and implement their own initiatives to improve local health and wellbeing.

A possible way of progressing place-based approaches in Tasmania would be through the creation of Community Action Zones. Community Action Zones could bring people from a range of sectors, and with a diverse range of skills, together, with a common focus on improving health and wellbeing outcomes in their community.

Community Action Zones could empower communities to address their own local health and wellbeing issues. Communities themselves would take responsibility for decision-making and identifying needs and priorities. Community members would work directly with public services, the non-government sector and local government to develop health and wellbeing programs in accordance with their needs.

Community Action Zones could provide a 'grass roots' or 'bottom up' style of community development. As part of a Community Action Zone, members would identify concerns shared across their community, and develop and implement local solutions to those concerns. Community Action Zones could foster social capital and resilience, both of which are associated with improved health and wellbeing outcomes in local communities.

Community Action Zones could provide the opportunity for government, community, business and research sectors to work together on creating environments that promote health, wellbeing and equity in communities. Issues of shared importance might include education, employment, transport, early childhood, family support and the environment.

Community Action Zones could include clusters of service planners and providers grouped around particular locations, communities or populations. The way they would operate would be dependent on the values, interests and priorities shared by its partners. Some might take a 'life-course

approach' by focusing on health and wellbeing needs at key transitions across the life-course (eg the early years, adolescence, adulthood, old age). While others might take an issue-based approach, that targets specific health and wellbeing issues (eg employment, smoking, social support).

Key Elements of Effective Place-Based Approaches

The Australian Social Inclusion Board identifies the following as key elements of effective place-based approaches: [49]

- *Clear connection between economic and social policy and programs in the local area* - The focus should be on aligning economic and social development, so that they reinforce and strengthen each other. To this end, it is important that local employers and education providers be actively involved in the governance of placed-based approaches, from early planning stages, through to the development and implementation of initiatives.
- *A framework for providing integration of effort across government* - One of the key barriers to the success of placed-based approaches is the inability of government to coordinate effort across its different portfolios. This lack of integration and collaboration can result in duplication and inefficiencies, and can ultimately leave communities feeling frustrated and disillusioned in the face of, what they perceive, should be simple straightforward issues.
- *Sound governance arrangements with a level of devolution that allows significant and meaningful local involvement in determining the issues and solutions* - Devolution of responsibility is part of capacity building. The more heavily government is involved in directing, delivering and making decisions, the less capable community organisations will be of performing these roles themselves.
- *Clear strategic objectives in response to which local communities can develop practical, achievable and evidence based initiatives* - Hugely ambitious, aspirational targets may put undue pressure on communities; this in turn, can have a negative effect of undermining confidence.
- *Capacity development at both local and government levels without which greater community engagement and devolution of responsibility will be impossible* - Capacity building will need to be tailored, as needs will differ from place-to-place, and will depend on the skills and knowledge of the participants. An initial assessment of what capacity already exists should inform future activity.
- *Sound accountability, measurement and evaluation mechanisms* - Designed to support the long term, whole-of-government and community aims for an initiative, rather than attempting to build an initiative around unsustainable measurement and accountability.

Successful Place-Based Approaches

Variations on Community Action Zones have produced effective outcomes over time in other parts of Australia and overseas. For example:

- Head Start is one of the most successful, longest running and most replicated programs addressing poverty in the United States. By providing education, health and social services to low income children and families in school communities, Head Start has increased the high school retention and college attendance rates of participants - achievements that will have flow on effects for the rest of their lives.
- Victoria's Neighbourhood Renewal Program has brought communities together with government, business, schools, police and service providers to tackle disadvantage and to create vibrant places where people want to live.
- In the United Kingdom, the Social Action Research Project[50] in Salford involved community members in the development of policies that affect them and in designing and delivering the services they use. Doing this in ways that improved the social status of individuals and perceptions of that community by outsiders required a change of mindset from both community members and public service organisations.
- The Parks Urban Regeneration Project[51] is the largest neighbourhood regeneration project in Australia, encompassing five suburbs in South Australia. It is an example of how Government Departments can collaborate with other agencies and across sectors to tackle the social determinants of health and health inequity.

Factors that have been associated with the success of these and other programs include[52] : dedicated and enthusiastic staff, planning, consultation, community participation and involvement, management coordination and collaboration, a social capital approach, building on community strengths, flexibility, building trust and considering the long-term implications.

The Parks Urban Regeneration Project

Prior to regeneration commencing, 'The Parks' in South Australia were widely regarded as an area of concentrated social disadvantage.

Parks communities were characterised by high levels of unemployment, poverty and higher than average rates of mental and physical health issues; as well as poor educational outcomes, and problems with crime and anti-social behaviour.

Initiatives to improve the quality of housing, neighbourhood safety, schooling and social networks, along with the associated social capital resources gained through these networks, are seen as key factors that have impacted on tenant wellbeing, both in terms of resident satisfaction and improved health outcomes.

The Parks have held host to a number of community capacity building projects including The Parks Helix Project. This ArtsSA project brought arts and non-arts organisations together to address issues of social inclusion through the use of art in communities within The Parks neighbourhood.

Helix was an intersectoral partnership that involved government and non-government agencies from the local government, health (community health service and hospital outreach program), education (primary school), private development (Westwood) and University sectors.

Community arts initiatives included a range of visual arts (drawing, painting, design, mosaics and photography), drama, song writing, singing, story writing, digital film making, knitting, designing and landscaping.

The project showed that cooperation between agencies can promote the participation of marginalised residents in community activities. It also showed that the arts can be an effective way of achieving positive social change.

Many community members reported improvements in their mental and physical wellbeing in the course of their involvement.

Participants also felt the arts brought people closer together, closer to their community, increased perceptions of safety and cohesiveness of the community, and brought about a sense of pride and ownership of public spaces.

5.5 Health Intelligence

Population and social health information and research are the 'health intelligence' that will build a better understanding of health and wellbeing in Tasmania.

Population and social health information and research refers to the resources and activities that provide the health intelligence and knowledge necessary to identify health equity issues, support effective action, and monitor changes in health and social outcomes over time.

Little information is currently available about how the social determinants of health and health inequity play out at the local level or how they affect different population groups in Tasmania. This is a real barrier to needs based planning and the evaluation of health services and health promotion activities in Tasmanian communities.

Access to adequate information will allow community members working with researchers and professionals to identify strengths and resources, to monitor and understand barriers and evaluate the effects of different interventions.

The Department of Health and Human Services will work to increase its research capacity by collaborating with the University of Tasmania to develop and trial an applied social action research methodology for involving health and community service workers and their clients in the design and evaluation of health services. Learning from the trial will help pursue national research grants funding for further applied social research on improving health outcomes and reducing health inequity.

There is also a significant opportunity to improve the breadth and quality of information available about the health and social outcomes of Tasmanian communities. A number of advancements are also improving the quality of demographic information available to assist service planning and development:

- Kids Come First is a whole-of-government initiative that has established a database of key indicators of the health, wellbeing, safety, development and learning outcomes of Tasmanian children. The database measures children from birth to age 17 and allows analysis at a locality/suburb level.
- The Tasmanian Web-Epi System is a web-based epidemiological reporting system that houses the latest data about hospitalisations, cancer incidence, infectious diseases and mortality in Tasmania.
- The Data Linkage Project is a partnership between the DHHS and the Menzies Research Institute of Tasmania that is bringing together and enabling cross-referencing of a range of different health and other social data sets.
- The Departments of Education, Health and Human Services and Police are developing Data Warehouses that centralise multiple reporting sources into a single location.

An important opportunity exists to bring this and other information together to better understand the health and social outcomes for the whole of the Tasmanian population, with a particularly emphasis on regional and local community outcomes.

This could include the development of Health and Wellbeing Indicators that profile the economic, social, environmental, demographic, cultural and other trends affecting the health and wellbeing of local communities.

Why We Need Health and Wellbeing Indicators

Information, be it anecdotal reports of how the conditions of daily living affect health or formal academic research, is one of the most powerful catalysts for bringing sectors together to work on improving health and equity.

Tasmania is the only jurisdiction in Australia without access to adequate local community data about the determinants of health and wellbeing and how they affect different population groups. This is a real barrier to needs based planning and the evaluation of health services and health promotion activities in Tasmanian communities.

Health and wellbeing indicators are local community data and reporting activities used by researchers and service planners to identify and communicate the economic, social, environmental, democratic, cultural and other trends affecting the wellbeing of communities.

Health and wellbeing indicators can be used as a democratic resource to support consumer and community engagement, a policy resource to guide evidence-based policy and a reporting resource to monitor and communicate progress against agreed goals or priorities. They are expected to be useful for a wide range of people and organisations within communities, including:

- People with an interest in the wellbeing of their community;
- Local government service planners and policy makers;
- State government service planners and policy makers; and
- Non-government and private sector organisations.

Local level information has greatly increased the capacity of other states and territories to respond to local needs. For example, Community Indicators Victoria publishes health and wellbeing profiles of local government areas for the purposes of:

- Helping local governments to govern better through improved knowledge and accountability mechanisms;
- Informing local people and organisations about local issues to encourage active consumer and community engagement;
- Ensuring policy, budget and other decision making is informed by evidence;
- Illustrating how different issues affecting communities are interrelated and effect one another;
- Focusing service planners on results (output for input); and
- Encouraging stronger government reporting, accountability and transparency at the local level.

6. Appendice

6.1 Glossary

Capacity Building - Capacity building in health promotion refers to the process of enhancing the ability of an individual, organisation or a community to address their health issues and concerns. The process of capacity building relies heavily on collaborations and partnerships. Capacity building has also been defined as the actual knowledge, skill sets, participation, leadership and resources required by community groups to effectively address local issues and concerns.[53]

Community Capacity - *Community capacity* is used to define the actual knowledge, skill sets, participation, leadership and resources accessible to (or required by) community groups to effectively address local issues and concerns.[2]

Chronic Conditions and Chronic Disease - The term chronic condition encompasses disability and disease conditions that people live with over extended periods of time (ie more than six months).

Chronic disease is a subset of chronic conditions and refers to a specific medical diagnosis. It may be more likely to have a progressively deteriorating path than other chronic conditions.[54]

Community - At a minimum, community refers to a collection of people in a geographical area. The term community is also used to refer to:

- A collection of people with a particular social structure
- A sense of belonging or community spirit
- All the daily activities of a community, work, non-work, take place within the geographical area.[55]

Community Development - In health promotion, community development refers to the process of involving a community in the identification and reinforcement of those aspects of everyday life, culture and political activity which are conducive to health. This might include support for political action to modify the total environment and strengthen resources for healthy living, as well as reinforcing social networks and social support within a community.[56]

Determinants of Health - The range of personal, social, economic and environmental factors that determine the health status of individuals or populations. The determinants of health can be grouped into seven broad categories: socio-economic environment; physical environments; personal health practices; individual capacity and coping skills; biology and genetics; and health services.[57]

Disadvantaged Populations - Populations that share a characteristic associated with high risk of adverse health outcomes (eg indigenous populations, single mothers in poverty, women, homeless people, and refugees.[58]

Health - Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease of infirmity.[59] Using this definition, social and economic conditions and the broader environment are considered key determinants of health.

Health Inequalities - Are measurable differences in the health status of individuals and groups that can result from natural, unavoidable factors that cannot be changed (eg age, genetics, disability) or avoidable factors that can be changed (eg the social gradient, early life).

Health inequities – Are measurable differences in the health status that result from avoidable factors that can be changed and which are also considered to be unfair, unacceptable or unjust.

(The key difference between the health inequalities and inequities is that equality can be assessed against measurable outcomes, whereas equity is decided by value judgements.[60] Not all inequalities are inequities).

Health Impact Assessment - Health Impact Assessment is a combinations of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.[61]

Health in All Policies - Health in All Policies (HiAP) is an innovative strategy that introduces better health – improved population health outcomes – and closing the health gap as shared goals across all parts of government. By incorporating a concern with health impacts into the policy development process of all sectors and agencies, it allows government to address the determinants of health in a more systematic manner.[62]

Health Promotion - Health promotion can be defined as the process of enabling people to increase control over, and to improve, their health.[63]

The Ottawa Charter identifies three basic strategies for health promotion. These are: advocacy for health, to create essential conditions for health; enabling all people to achieve their full health potential; and mediating between the different interests in society in the pursuit of health.

These strategies are outlined by five priority areas as outlined in the Ottawa Charter for health promotion:

- Build healthy public policy
- Create supportive environments for health
- Strengthen community action for health
- Develop personal skills
- Re-orient health services.[64]

Illness Prevention - Prevention refers to action to reduce or eliminate the onset, causes, complications or recurrence of disease.[65] There are three levels of prevention:[66]

- *Primary* – preventing ill health before it occurs through reducing exposures to risk factors and risk conditions, and promoting factors that are protective of health
- *Secondary* – reducing the progression of disease though early detection, usually by screening at an asymptomatic stage, and early intervention
- *Tertiary* – effective management or rehabilitation of people with chronic problems to reduce complications and maintain an optimum level of functioning.

Intersectoral Action - Intersectoral action for health equity is an approach that acknowledges the many determinants of health that are controlled or influenced by sectors outside of healthcare – like education, environment and finance – and aims to bring these sectors together for collaborative action.

Population Health - An approach that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health (eg income, education, environment, biology).[67]

Social Determinants of Health - The social determinants of health are the conditions of daily living that determine a person's chances of achieving good health: the conditions in which people are born, grown, live, work and age.[68]

Social Exclusion - Exclusion consists of dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions - economic, political, social and cultural - and at different levels including individual, household, group, community, country and global levels. It results in a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities.[69]

Socioeconomic Status / Social Gradient - A term that describes the position of an individual group in a population or society, reflecting the overall hierarchy. The most frequently used indicators of socioeconomic status are income, education and occupational categories.[70]

The spread of distribution of socioeconomic status in a population or society is referred to as the social gradient.

Social Inclusion - Social inclusion refers to the idea that everyone should have access to the resources and relations that make life healthy, happy and productive. Central to this is the importance of strong families and communities, in all their traditional and new forms. When families and communities are working well they are places and spaces that generate healthy lifestyles, safety, creativity, innovation, trust and belonging. Families and communities that are caring, confident and resilient are the best buffer against social exclusion.[71]

Social Inequities - Social inequities in health are systematic differences in health status between different socioeconomic groups. These inequities are socially produced (and therefore modifiable) and unfair.[72]

Vulnerable Population Groups - People from vulnerable or at risk population groups have a greater risk of health inequity because of social and economic disadvantage.[73]

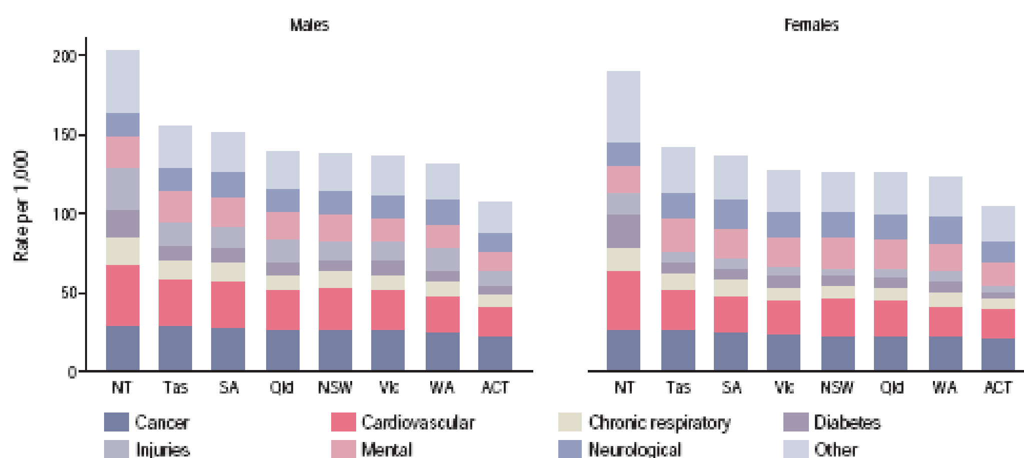
6.2 Key Characteristics of the Tasmanian Community

Health Inequity in Tasmania

While we know that Tasmanians enjoy an enviable quality of life, health inequity is a particular concern in our State. The overall health of the population falls below the national average in a number of important health and lifestyle measures. [74] Of greatest concern, is the number of disadvantaged population groups in Tasmania at increased risk of poor health outcomes, and who have fewer resources to cope when illness strikes.

At a jurisdictional level, age standardised rates show Tasmania has the highest burden of disease and injury in Australia outside of the Northern Territory (as measured by Disability Adjusted Life Years or DALYs)[75] (see Figure 5). At the same time, a far greater proportion of Tasmanians (46 per cent) report some form of physical disability, which restricts everyday activity than the national average (36 per cent).[76].

Figure 5. Age standardised DALY rates by 1,000 by state/territory, broad cause group and sex (*Source: AIHW, Burden of Disease and Injury in Australia 2003)*[77]



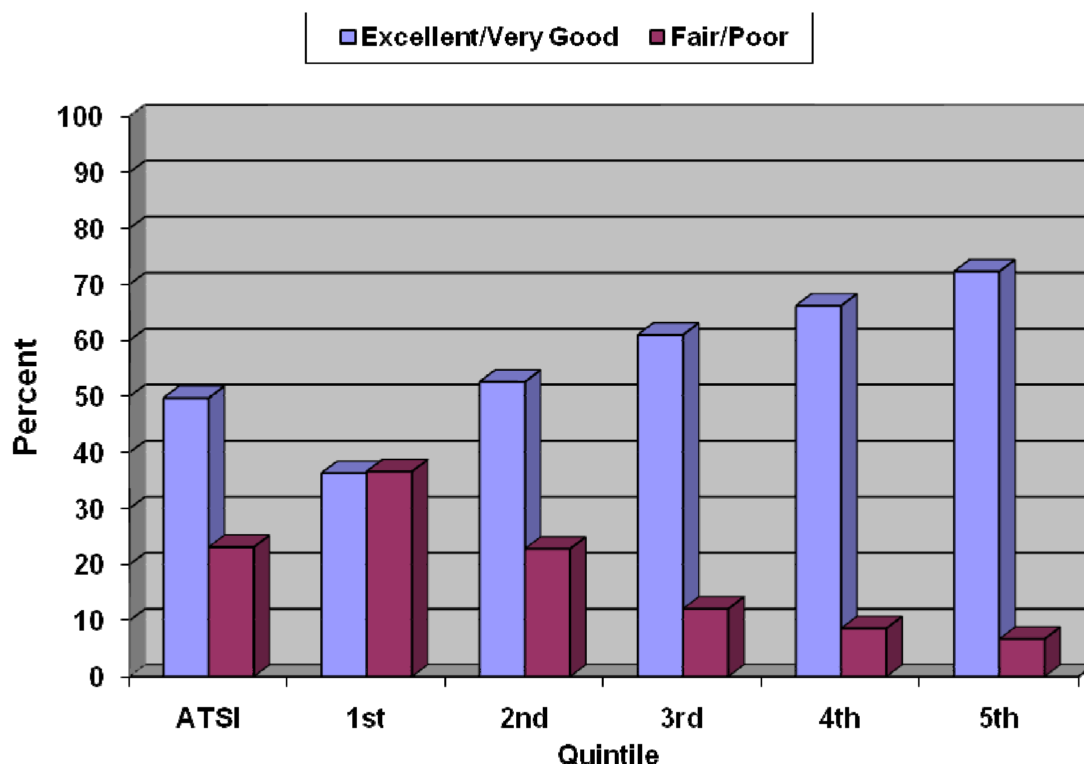
Tasmanians also display higher levels of some of the behavioural risk factors for chronic conditions[78]. For example, compared with the national average, they are more likely to be overweight or smoke. Physical inactivity, while at a similar level to the rest of Australia, is still unacceptably high. Table 1 provides a comparison of selected risk factors for chronic disease in the Tasmanian population compared to the national average.

Table 1. Selected chronic disease risk factor prevalence (% adults aged 18+) *(Source: National Health Survey Data 2007/08)*

Risk Factor	Indicator	Tasmania	National Average
Smoking	Current daily/occasional smokers	24.9	20.8
Alcohol misuse	At risk of long-term alcohol-related harm	13.6	13.4
Physical inactivity	Classified as sedentary	72.1	72.3
Overweight	Overweight/Obesity Body Mass Index	64.0	61.2

Tasmania's higher burden of disease from chronic conditions and poor risk factor profile is demonstrably linked to its higher proportion of lower socioeconomic populations[79]. Figure 6 shows the effect of the social gradient on the self-assessed health status of Tasmanians, showing that persons on lower income levels report much higher levels of poor or only fair health (36.6 per cent) compared with those in the highest household income levels (6.7 per cent).[80]

Figure 6. Self-assessed health status by household income quintiles (persons aged 15+) *(Source: National Health Survey 2004/05)*



Similarly, Table 2 shows the distribution of selected risk factors for chronic disease across Tasmania's social gradient, with those on lower incomes more likely to be physically inactive or smoke. Risky alcohol consumption levels are the exception to this pattern, remaining stable across the lower income quintiles and increasing in the highest income group.

Table 2. Selected chronic disease risk factor prevalence by household income *(Source: National Health Survey Data 2004/05)*

Risk Factor	**% within household income quintile**				
	1st (Lowest Income)	**2nd**	**3rd**	**4th**	**5th (highest income)**
Daily/occasional smoking (persons aged 18+ years)	32.1	29.4	24.9	23.9	15.6
Alcohol consumption levels at risky/high risk for long term harm	9.4	9.6	9.9	15.6	17.0
Sedentary activity levels (persons aged 12+ years)	41.9	41.9	33.8	27.4	17.8

Social and Economic Disadvantage in Tasmania

We know that there are limited but worrying data about disadvantage in Tasmania. With the release of *A Social Inclusion Strategy for Tasmania*[81] in 2009, the State's Social Inclusion Commissioner, Professor David Adams, brought to light some concerning statistics about disadvantage and social exclusion. For example:

- The proportion of Tasmanian households dependent on government pensions and allowances has risen from 31.5 per cent in 2005-06 to 34.1 per cent in 2007-08, and remains the highest proportion of all states and territories.
- Over 64,000 Tasmanians or 13 per cent of the population live on or below the poverty line.

A summary of the Social Inclusion Commissioner's analysis of the estimated number of Tasmanians with risk factors for social inclusion (eg poverty, housing, employment, access to services, vulnerable group status) is reproduced at Table 3. Given the known links between these risk factors and health, this level of disadvantage is cause for concern. The number of Tasmanians living at risk of poor health as a result of social and economic disadvantage is significant.

Research also suggests that the spread of disadvantage in Tasmanian means that certain communities are more at risk of poor health than others. For example:

- In 2006, 38,600 people or 8 per cent of the population were living in communities ranked among the most disadvantaged 5 per cent in Australia, the second highest proportion of all states and territories after the Northern Territory. [82]
- In 2007, just four of the State's 29 Local Government Areas accounted for 43.3 per cent of the State's top ranked positions of the key indicators of disadvantage. [83]

These statistics suggest that Tasmania has a particularly high level of 'locational disadvantage' compared to other states and territories.

In 2007 Catholic Social Services Australia released *Dropping off the Edge,* the most comprehensive national research to date on locational disadvantage in Australia. The report warned that despite Australia's strong economic growth, some communities (rural, remote and suburban) are caught in a cycle of low education, high unemployment, poor health, high imprisonment rates and child abuse. Just 1.7 per cent of all the post codes and communities across Australia were found to account for more than seven times their share of top ranked positions on the major factors that cause intergenerational poverty.

Little detail is known about the distribution of health outcomes and behavioural risk factors at a community level within Tasmania, or between its vulnerable population groups. The Director of Public Health has consistently called for improved public health surveillance mechanisms in Tasmania,[84] which would help to more adequately monitor these differences, as well as the effects of healthcare interventions overall, throughout the State.

Table 3. Estimated Tasmanians living with risk factors for social exclusion[85]

Risk Factor	Number (rounded)	Reference Year
Poverty and financial hardship		
People living below the poverty line	64,000	2005-06
Households dependent on government pensions llowances	69,000	2007-08
People worried about food security	18,000	2005
People accessing emergency relief services	16,000	2007-08
Exclusion from housing		
People who are homeless	2,500	2006
People waiting for public housing	3,000	2009
Exclusion from jobs and skills		
Adults with poor literacy skills (aged 15-74)	174,000	2006
Adults (aged 25-64) with no qualifications	116,000	2008
Long term unemployed (aged 15 and over)	2,200	2008-09
People employed part-time	75,000	2008-09
Children living in jobless families	21,000	2006
Locational disadvantage, service and transport exclusion		
People living in rural areas (with population <1,000 people)	130,000	2006
People living in disadvantaged areas (as identified by ABS Socio-economic Indexes for Areas (SEIFA) Index of Relative Socio-Economic Disadvantage)	39,000	2006
People who cannot easily access transport	9,400	2006
People who have difficulties in accessing services they need	81,000	2006
Households who do not have access to the internet (digital exclusion)	79,000	2006
Risk Behaviours		
People consuming alcohol at risky levels (aged 14 and over)	39,000	2007
People who use illicit drugs (aged 14 and over)	60,000	2007
Population groups at-risk		
People with disability	24,000	2006
Tasmanian Aborigines	17,000	2006
Older Tasmanians (65+) living alone	20,000	2007
Lone parent families with children aged under 15	12,000	2007

6.3 Draft Terms of Reference - Health and Wellbeing Advisory Council

Background

A Healthy Tasmania is the Tasmanian Government's approach to keeping Tasmanians healthy, well and in control of what matters to them.

The approach has developed in response to the work of the Health in All Policies Collaboration and the findings of the *Fair and Healthy Tasmania Strategic Review*.

The Strategic Review recommended *leadership across sectors* and *place-based approaches* as the most appropriate way to improve health and reduce health inequity amongst Tasmanians.

The six policy directions set out in *A Healthy Tasmania* will bring all sectors together with local communities to enhance wellbeing through action on the underlying causes of health and wellbeing.

The approach will create collaborative partnerships to support the development of healthier communities.

The Hon. Michelle O'Byrne MP, Minister for Health is establishing an Advisory Council to provide advice and work with other parts of the Tasmanian Government, other sectors and the broader community. The Council will report directly to the Minister for Health.

Priorities

The priorities that the Advisory Council will focus on initially are:

- Appropriate measures to reduce health and social inequities; and
- Advice on the best approaches to place-based health and wellbeing.

Purpose

The purpose of the Advisory Council is to:

- To inform and champion new solutions and approaches, drawing on the available resources and opportunities, to reduce avoidable health inequities and improve wellbeing for all Tasmanians.
- Increase understanding of patterns of inequity and how to address them;
- Promote collaboration across sectors, including the pooling of resources and attainment of shared responsibilities;
- Provide direction and advice on the implementation of *A Healthy Tasmania* initiatives (in relation to equity and community driven or place-based approaches);
- Support the development of new information and research on population health approaches relevant to the focus of equity and place-based approaches)

Membership

Membership of the Advisory Council will represent a wide range of fields, backgrounds, views and expertise. This may include, but is not limited to the following areas:

- Economic and social policy
- Public/population health and prevention
- Community development
- Arts
- Knowledge and sector brokers/boundary spanners
- Determinants (or 'the causes behind the causes') of health and wellbeing

Members might be health professionals, public policy professionals, service managers, consumers, advocates, community sector professionals, business leaders, academics or researchers by background and must have a strong interest in championing *A Healthy Tasmania*.

To be effective the Advisory Council will need an appropriate balance of members who have knowledge and expertise in equity and contemporary thinking regarding place-based approaches, and leadership capacity to drive intersectoral action for improving health determinants.

Roles and Responsibilities

The roles and responsibilities of individual Health and Wellbeing Advisory Council members are to:

- Be committed to the *A Healthy Tasmania* approach;
- Endorse and champion *A Healthy Tasmania*;
- Provide expert advice based on individual experience, organisational experience and/or field of interest;
- Advocate for action on the underlying causes of health and health inequity within their sector and others;
- Pursue collaborative working relationships across sectors;
- Build the community of interest in *A Healthy Tasmania*;
- Actively contribute to all Health and Wellbeing Advisory Council meetings and any out-of-session business; and
- Provide a leadership voice for a greater focus and investment into *A Healthy Tasmania*.

Meeting Protocols

Secretariat

The Population Health area of the Department of Health and Human Services will provide secretariat. This role will encompass the organisation of meetings and venues; the preparation, clearance and distribution of agendas and meeting papers; coordination of research and analysis on behalf of the group; coordination and preparation of papers and reports on behalf of the Council; day-to-day administrative support and the development and implementation of the Council's work plan and communication strategy.

Sitting Fees and Reimbursement

In general, sitting fees will not be paid in exchange for participation on the Advisory Council. However, the Department of Health and Human Services will cover all costs associated with travel and accommodation to attend meetings.

Meeting Frequency

The Council will meet four times in the first year, followed by three times in subsequent years.

Chair

The Minister for Health will appoint a Chair as part of the general membership selection process.

Venue

Wherever possible, the Department of Health and Human Services will hold meetings in its facilities. Members may attend via videoconferencing where necessary.

Guests and Ex-Officio Members

The Advisory Council may include guest speakers or ex-officio members to attend meetings from time to time, with the permission of the Chair. The Secretariat will manage invitations to attend meetings on behalf of the Chair.

Guest speakers and ex-officio members will not have decision-making rights.

Reporting Requirements

As a part of the broader *A Healthy Tasmania* reporting process, the Advisory Council will provide an annual report to Cabinet through the Minister for Health, as Cabinet Sponsor.

Reports will encompass:

- Progress towards the implementation of *A Healthy Tasmania*;
- Tasmania's status against selected health and wellbeing measures;
- Progress towards the implementation of the Group's work plan and communications strategy; and
- New and emerging strategies for place based approaches in Tasmanian communities.

Budget and Expenditure

The Advisory Council will not have responsibility for financial decision-making, but may have access to small amounts of funding through the Department of Health and Human Services for example, funds for the publication of documents.

Part of the role of the Council may include looking for opportunities to gain additional funding or to pool resources in order to increase the proportion of health and social system expenditure directed towards or consistent with *A Healthy Tasmania*.

Other Resources

Population Health and other parts of the Department of Health and Human Services will provide expertise and human resources to assist the work of the Advisory Council. This may include access to expertise in areas population and public health, public policy, budget and finance, data analysis, epidemiology. Other resources might include health and human service design and chronic conditions and access to data sets for analysis and the development of intelligence, or access to epidemiological reporting tools.

6. References

[1] Department of Health. *Tackling Health Inequalities: 10 Years On.* London, Department of Health: 2009.

[2]National University of Canberra. *Health Lies in Wealth: Health Inequalities in Australians of Working Age.* Canberra, prepared for Catholic Health Australia: 2010.

[3] World Health Organization (WHO) Commission on the Social Determinants of Health. *Closing the Gap in a Generation.* Geneva, WHO: 2008.

[4] Strategic Review of Health Inequalities in England post-2010. *Fair Society, Healthy Lives: The Marmot Review.* Edited by M. Marmot. London, Government of England: 2010.

[5] The Royal Australasian College of Physicians (RACP). *Inequity and Health: A Call to Action.* Sydney, RACP: 2005.

[6] Department of Health and Human Services. *Tasmania's Health Plan Summary 2007.* Hobart, Government of Tasmania: 2007.

[7] Adapted from: Kickbush, I. *Healthy Societies: Addressing 21st Century Health Challenges.* Adelaide, Government of South Australia: 2008.

[8] Tasmania Together Progress Board. *Tasmania Together 2020: Progress Report 2010.* Hobart, Tasmania Together Progress Board: 2010.

[9] World Health Organization (1998). Cited in Kickbush, I. *Healthy Societies: Addressing 21st Century Health Challenges.* Adelaide, Government of South Australia: 2008.

[10] World Health Organization (WHO). Commission on the Social Determinants of Health. *Closing the Gap in a Generation.* Geneva, WHO: 2008

[11] Department of Health and Human Services. *Connecting Care: Chronic Disease Action Framework for Tasmania 2009-2013.* Hobart, Government of Tasmania: 2009.

[12] Melchers, N.V., Gomez, M., & Colagiuri, R. 'Do socio-economic factors influence supermarket content and shoppers' purchases?' in *Health Promotion Journal of Australia,* 2009, 20(3), 241-246.

[13] VicHealth. *Research Summary: Burden of disease due to health inequities.* Melbourne, Government of Victoria: 2008.

[14] Margaret and Whitehead (1991). Cited in Department of Health and Children. *The National Health Promotion Strategy.* Ireland, Department of Health and Children: 2000.

[15] Pomagalska, D., Putland, C., Ziersch, A., Baum, F., Arthurson, K., Orchard, L., & House, T. *Practical Social Capital: a Guide to Creating Health and Wellbeing.* Adelaide, Flinders University: 2009.

[16] House of Commons Health Committee. *Health Inequalities: Third Report of Session 2008-09.* London, House of Commons: 2009.

[17] Williams, S.J. et al, (2004). Cited in Kickbush, I. *Healthy Societies: Addressing 21st Century Health Challenges.* Adelaide, Government of South Australia: 2008.

[18] Begg et al (2007). Cited in Australian Institute of Health and Welfare. *Australia's Health 2010.* Canberra: Australian Institute of Health and Welfare: 2010.

[19] Adams, D. *A Social Inclusion Strategy for Tasmania.* Hobart: Government of Tasmania: 2009.

[20] Ibid.

[21] Strategic Review of Health Inequalities in England post-2010. *Fair Society, Healthy Lives: The Marmot Review.* Edited by M. Marmot. London, Government of England: 2010.

[22] VicHealth. *Research Summary: Burden of disease due to health inequities.* Melbourne, Government of Victoria: 2008.

[23] Vinkeles Melchers, N., Gomez, M., & Colagiuri, R. 'Do socio-economic factors influence supermarket content and shoppers' purchases?' in *Health Promotion Journal of Australia*, 2009, 20(3), 241-246.

[24] Ibid.

[25] National Rural Health Alliance Inc. *The Determinants of Health in Rural and Remote Australia.* Canberra, National Rural Health Alliance Inc: 2011.

[26] Australian Institute of Health and Welfare data cited in: National Rural Health Alliance Inc. *Measuring the Metropolitan-Rural Inequity.* Canberra, National Rural Health Alliance Inc: 2011.

[27] National Rural Health Alliance Inc. *The Determinants of Health in Rural and Remote Australia.* Canberra, National Rural Health Alliance Inc: 2011.

[28] Australian Institute of Health and Welfare. *Australia's Health 2010.* Canberra, Australian Institute of Health and Welfare: 2010.

[29] Department of Health and Human Services. *Connecting Care: Chronic Disease Action Framework for Tasmania 2009-2013.* Hobart, Government of Tasmania: 2009.

[30] Australian Bureau of Statistics 2007a. Cited in VicHealth. *Research Summary: Burden of disease due to health inequalities.* Melbourne, Government of Victoria: 2008.

[31] Ibid.

[32] Walker (2005). Cited in VicHealth. *Research Summary: Burden of disease due to health inequalities.* Melbourne, Government of Victoria: 2008.

[33] Walker et al (2006). Cited in VicHealth. *Research Summary: Burden of disease due to health inequalities.* Melbourne, Government of Victoria: 2008.

[34] Mackenback et al (2007). Cited in VicHealth. *Research Summary: Burden of disease due to health inequalities.* Melbourne, Government of Victoria: 2008.

[35] Ibid.

[36] Vos, T., Carter, R., Barendregt, J., Mihalopoulos, C., Veerman, L., Magnus, A., Cobiac, L., Bertman, M., & Wallace, A., ACE-Prevention Team. *Assessing Cost-Effectiveness in Prevention.* Queensland, University of Brisbane and Melbourne, University of Deakin: 2010.

[37] National Preventative Health Taskforce. *Australia: The Healthiest Country by 2020.* Canberra, Commonwealth of Australia: 2009.

[38]Australian Institute of Health and Welfare. *Australia's Health 2008.* Canberra: Australian Institute of Health and Welfare: 2008.

[39] Taylor, R. and Clements, M. In *Returns on Investment in Public Health: An epidemiological and economic analysis.* Canberra, Department of Health and Ageing: 2003.

[40] Australian Institute of Health and Welfare. *Australia's Health 2008.* Canberra: Australian Institute of Health and Welfare: 2008.

[41] Ibid.

[42] D'Espaignet, T, Bulsara, M., Wolfenden, L., et al. 'Trends in sudden infant death syndrome in Australia from 2980 to 202.' *Forensic science, medicine and pathology,* 2008 (1547-1769X).

[43] Trust for America's Health. *Prevention for a Healthier America: Investments in disease prevention yield significant savings, stronger communities.* Trust for America's Health: 2008.

[44] Taylor, R. and Clements, M. In *Returns on Investment in Public Health: An epidemiological and economic analysis.* Canberra, Department of Health and Ageing: 2003.

[45] Walker (2005). Cited in VicHealth. *Research Summary: Burden of disease due to health inequalities.* Melbourne, Government of Victoria: 2008.

[46] Mackenback et al (2007). Cited in VicHealth. *Research Summary: Burden of disease due to health inequalities.* Melbourne, Government of Victoria: 2008.

[47] Department of Premier and Cabinet. *Collaboration – A Tasmanian Government Approach.* Hobart, Government of Tasmania: 2010.

[48] Australian Social Inclusion Board. *Governance Models for Location Based Initiatives*. Canberra, Australian Government: 2011.

[49] Ibid.

[50] Pickin, C. 'Tackling health inequalities,' in *Essential Public Health,* Ed. Stephen Gilliam, Jan Yates and Padmanabhan Badrinath. United Kingdom, Cambridge University Presss: 2007.

[51] Pomagalska, D., Putland, C., Ziersch, A., Baum, F., Arthurson, K., Orchard, L., & House, T. *Practical Social Capital: a Guide to Creating Health and Wellbeing.* Adelaide, Flinders University: 2009.

[52] Ibid.

[53] NSW Health (2003). Cited in Kickbush, I. *Healthy Societies: Addressing 21st Century Health Challenges.* Adelaide, Government of South Australia: 2008.

[54] Department of Health and Human Services. *Chronic Conditions Self-Management: A Strategic Framework for DHHS Discussion Paper.* Hobart, Government of Tasmania: 2010.

[55] Kickbush, I. *Healthy Societies: Addressing 21st Century Health Challenges.* Adelaide, Government of South Australia: 2008.

[56] Ibid.

[57] World Health Organization (1998). Cited in Kickbush, I. *Healthy Societies: Addressing 21st Century Health Challenges.* Adelaide, Government of South Australia: 2008.

[58] Public Health Agency of Canada. *Crossing Sectors – Experiences in intersectoral action, public policy and health.* Geneva, World Health Organization Health Systems Knowledge Network: 2007.

[59] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

[60] Williams, S.J. (2004). Cited in Kickbush, I. *Healthy Societies: Addressing 21st Century Health Challenges.* Adelaide, Government of South Australia: 2008.

[61] Developed by the European Centre for Health Policy, World Health Organization in the 1999 Gothenburg consensus paper on Health Impact Assessment.

[62] Kickbush, I., McCann, W., & Sherbon, T. 'Adelaide revisited: from healthy public policy to Health in All Policies.' *Health Promotion International,* (2008): 23 (1), 1-4.

[63] World Health Organization (WHO), *Ottawa Charter for Health Promotion*. Geneva, WHO: 1986.

[64] World Health Organization (1986). Cited in Kickbush, I. *Healthy Societies: Addressing 21st Century Health Challenges.* Adelaide, Government of South Australia: 2008.

[65] Australian Institute of Health and Welfare, *Australia's Health 2004.* Canberra, AIHW Cat. No. AUS 44, p.496: 2004.

[66] National Public Health Partnership (NPHP). *The Language of Prevention.* Melbourne, NPHP: 2006.

[67] Health Canada (2003). Cited in Kickbush, I. *Healthy Societies: Addressing 21st Century Health Challenges.* Adelaide, Government of South Australia: 2008.

[68] World Health Organization (WHO) Commission on Social Determinants of Health. *Closing the Gap in a Generation.* Geneva, WHO: 2008.

[69] Popay, J. et al. *Understanding and tackling social exclusion: Report to the WHO Commission on Social Determinants of Health.* Geneva, Social Exclusion Knowledge Network: 2008.

[70] Public Health Agency of Canada. *Crossing Sectors – Experiences in intersectoral action, public policy and health.* Geneva, World Health Organization Health Systems Knowledge Network: 2007.

[71] Adams, D. *A Social Inclusion Strategy for Tasmania.* Hobart, Department of Premier and Cabinet: 2009.

[72] Whitehead, M. & Dahlgren, G., *Concepts and principles for tackling social inequities in health: Levelling up Part 1*. Copenhagen, WHO regional Office for Europe: 2006.

[73] Marmont, M., 'Social Determinants of Health Inequalities.' *Lancet*, (2005): 1099-1104.

[74] Department of Health and Human Services. *Connecting Care: Chronic Disease Action Framework for Tasmania 2009-2013.* Hobart, Government of Tasmania: 2009.

[75] Ibid.

[76] Australian Bureau of Statistics. *Tasmanian State and Regional Indicators, 2010 1307.6.* Canberra, ABS: 2010.

[77] Begg, S., Vos, T., Barker, B., Stevenson, C., Stanley, L., & Lopez, A. *The Burden of Disease and Injury in Australia 2003.* Canberra, Australian Institute of Health and Wellbeing: 2003.

[78] Department of Health and Human Services. *Connecting Care: Chronic Disease Action Framework for Tasmania 2009-2013.* Hobart, Government of Tasmania: 2009.

[79] Ibid.

[80] Department of Health and Human Services. *State of Public Health Report 2008.* Hobart, Government of Tasmania: 2008.

[81] Adams, D. *A Social Inclusion Strategy for Tasmania*. Hobart, Government of Tasmania: 2009.

[82] Adams, D. *A Social Inclusion Strategy for Tasmania (Appendix 1).* Hobart, Government of Tasmania: 2009.

[83] Vinson, T. *Dropping off the Edge: The Distribution of Disadvantage in Australia.* Sydney, Catholic Social Services Australia: 2007.

[84] Department of Health and Human Services. *State of Public Health Report.* Hobart, Government of Tasmania: 2008.

[85] Vinson, T. *Dropping off the Edge: The Distribution of Disadvantage in Australia.* Sydney, Catholic Social Services Australia: 2007.

POPULATION HEALTH

Department of Health and Human Services

GPO Box 125, Hobart 7001

Ph: 1800 671 738

Email: preventive.health@dhhs.tas.gov.au

Visit: www.dhhs.tas.gov.au